The Australian Peacekeeper & Peacemaker Veterans' Association,
National Executive,
(Incorporated in Victoria),

Submission to:

The Review of Military Compensation Arrangements

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Sunday, 26 July 2009

The Review of Military Compensation Review,
Department of Veterans' Affairs,
P.O. Box 895,
WODEN, ACT, 2606

Subject: Executive Summary.

The Australian Peacekeeper & Peacemaker Veterans' Association (APPVA) would like to firstly thank the Secretariat in giving an extension to submit this Document to the 31st July 2009. This has given the APPVA the opportunity to consult widely with other ESO, APPVA Practitioners, and Agencies and to further conduct Workshops in order to ensure that we have covered as much detail as possible.

We also thank the Government for initiating this Review, of which we are looking forward to a simplified, streamlined, dynamic and modern military compensation system.

This has been the most significant and complex Review that the APPVA has ever undertaken in terms of research, referencing and authoring. This is reflective of the complexities and comprehension of Multiple Eligibility under the Veterans' Entitlement Act 1986 (VEA); Safety, Rehabilitation & Compensation Act 1988 (SRCA); Defence Determination 200/1; Military Compensation Service (MCS); The Consequential and Transitional Provisions Act 2004 (CTPA); and the Military Rehabilitation Compensation Act 2004 (MRCA). In addition has been the inclusion of the effects of Economic Loss (EL), or Incapacity Payments (IP), made toward those eligible members who are invalided or retired from the ADF within the parameters of COMSUPER.

This Review, in our belief is far overdue and the promised Operational Working Party toward MRCA was to occur in July 2005. This has been not conducted and after five years of operation, finally, an opportunity has existed to place the matters of concern toward a Review Committee.

This Submission is by no way exhaustive, nor restrictive in its application. There are many areas of multi-eligibility that are still being grasped by Delegates within DVA, along with Practitioners within ESO.

Testing within the Federal and High Courts of MRCA have yet to be lodged as far as we are currently aware, however we highlight in this paper the Wright Decision, which is causing deep concern in the veteran community, particularly toward those claiming Above General Rate (AGR).

However, the APPVA has intended to make the best possible presentation of anomalies and areas of confliction that affect those who currently serve in the ADF, AFP IDG and Veterans.

There are Key Messages listed within the Document, of which this submission has been divided into Six Parts for the ease of interpretation, along with some tables that place contentions within the MRCA and CTPA. Key Messages are also highlighted in grey, in order to provide the reader with highlighted areas of concern that we believe require investigation, review and hopefully positive outcomes toward our contentions made.

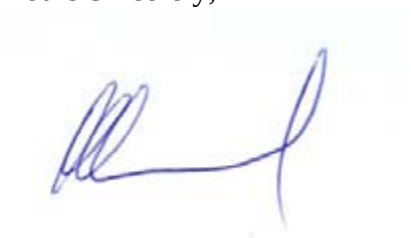
I must also acknowledge the following people for their consultation and work toward the production of this paper. They are:

WO1 Michael Quinn – APPVA Senior Advocate;
CAPT Wayne McInnes (Ret'd) – APPVA Case Officer;
Mr Michael Finnerty – Level 4 Tribunal Advocate for the Wright Decision paper;
Mr Ray Brown – National President, Injured Service Person's Association (ISPA);
COL David Jamison, AM, (Retd), National President Defence Force Welfare Association (DFWA) for his support and feedback; and
Mr Ron Coxon, OAM, National President of the Viet Nam Veterans' Association of Australia (VVAA) for his support;
Mrs Michelle Ives;
Mr Michael Ives; and
Mr Adam Charlton.

The APPVA looks forward to further consultation toward this Review. Attached is the completed Permission Form for this submission.

Please do not hesitate in contacting me, should you wish to discuss any matters in relation to our Review submission.

Yours Sincerely,



Paul Copeland, OAM, JP,
National President.

Attachment: Permission Form.

PERMISSION FORM

I, Paul Arthur Copeland of P.O. Box 552, TORQUAY, VIC, 3228, hereby grant my permission to the Department of Veterans' Affairs and the Minister of Veterans' Affairs to publish the Australian Peacekeeper & Peacemaker Veterans' Association submission to the Review of Military Compensation Arrangements in the following way:

1. Place the APPVA Submission on the DVA Website (www.dva.gov.au/pensions/milcompreview/) in it's entirety.

Signed: _____

Full Name: Paul Arthur Copeland, OAM, JP.

Date: Sunday, 26th July 2009.

Review of Military Compensation Arrangements

PART A.
Military Rehabilitation & Compensation Act 2004 (MRCA).

1. Introduction.

1.1 In 2003, the ESO Working Group (ESO WG) for the Military Rehabilitation Compensation Bill 2003 (MRCB 2003) was convened at regular periods to provide consultation with the Department of Veterans' Affairs (DVA). The MRCB 2003 was to see a newly streamlined Compensation Act that would be commensurate with the hazards and dangers of Modern ADF service. The Australian Peacekeeper & Peacemaker Veterans' Association (APPVA) was a member of this working group.

1.2 One of the most disappointing outcomes from this ESO WG was that a number of ESO placed Warlike Service (WS) in a higher regard than other service and further discriminated against those who have served on Non-warlike Service (NWLS) and/or Peacetime Service (PTS). One of the reasons cited by some ESOs was that the higher rate of compensation would encourage ADF members to go to war. Other ESOs placed WS on a higher level of service and stated that it deserved to be a higher level of compensation. This philosophy is not agreed by the APPVA.

1.3 This is believed to be a view that is not consistent with the ADF modus operandi, of which members are posted on warlike service as directed, rather than volunteer, as a part of complying with their service obligation. Warlike service for ADF personnel also attracts generous Conditions of Service, tax-free pay and Deployment Allowances.

1.4 It is an outdated view, of which it may have been pertinent for a National Serviceman during the Viet Nam War; however the dynamics of Modern Military Operations dictate a totally different environment for professional ADF service personnel. To date, there have been no known cases of ADF members refusing to deploy on warlike operations due to compensation entitlements, since the implementation of the MRCA.

1.5 The situation presented by the ESOs, in relation to encouragement of ADF members to serve on warlike operations, further complicated the MRCB 2003 and when the Military Rehabilitation Compensation Act 2004 (MRCA) was moved through Parliament after a Senate Estimates Hearing, there was no other way to have the Legislative anomalies, that were previously highlighted prior to Legislation to be rectified.

1.6 Indeed, it was promised by the Government and DVA that the ESO Working Group would be reconvened in 12 months after the implementation of the MRCA (1 July 2004), which would have been in July 2005. For over five years, since the implementation of MRCA, there has been no Operational Working Party (OWP) or

further consultation with ESOs in relation to the anomalies or operational aspects of the MRCA.

1.7 The APPVA has continually attempted to lobby Government since early 2004, to **abolish and revoke** the service, gender and age bias that is notably a feature of the MRCA, to make it one aggregate and fair payment and/or pension. This current system is consistent within Superannuation structures, not Compensation philosophy in terms of Non-Economic Loss (NEL), for effects to daily living, quality of life and workability. Unfortunately, these calls have not been answered nor addressed by successive Governments and Veterans' Affairs Ministers.

1.8 In addition to the above has been the ongoing disappointment that the previous Government ignored calls for the unfair treatment of those veterans who may elect to be eligible for the Special Rate Disability Pension (SRDP),[1] of which the value from 100% of the General Rate under the Veteran Entitlement Act 1986 (VEA), to the level of the Special Rate (SR), which is also known as the Totally & Permanently Incapacitated (TPI) Rate, will be reduced 60 cents in every COMSUPER dollar. This is a significant loss of benefit and entitlement, than previously accepted by COMSUPER superannuants who are TPI prior to 1 July 2004, under the VEA.

1.9 Offers of SRDP which have been made to veterans who have received Lump Sum PI, who are in receipt of Class A COMSUPER, have been offered zero dollars, in order for them to have TPI stamped on their Card, under the MRCA, in order to gain the concessions available to TPI Card holders.

1.10 The reason for the comments aforementioned is that the ESO WG made it quite clear to the Secretary of the Department (Dr Neil Johnston), of which it was agreed, that no veteran who is entitled under the MRCA will **not be disadvantaged** in anyway in comparison to what was available previously. This included either single or dual multi-eligibility of the VEA and the Safety, Rehabilitation and Compensation Act 1988 (SRCA).[2]

1.11 Further discussions of these anomalies are presented within this paper. However, due to complexities and size of the differences identified within the MRCA Legislation, these are represented in tabulated form, with the MRCA reference, Item, Contention and Comment (Recommendation) attached at Annex A.

1.12 The APPVA thanks the Government for the opportunity to present these long standing Legislative issues, particularly toward MRCA and Military Compensation. We look forward to positive resolution to the matters raised.

[1] S204 MRCA
[2] Inclusive of the provisions of the Defence Determination 2000/1

2. Key Messages for MRCA.

2.1 Remove the Tiered Service discrimination of compensation amounts against Peacetime Service and have a single aggregated Impairment Point system within Guide to the Assessment of Rate of Pensions (GARP M - MRCA), without reduction in compensation to any form of service. Therefore, the result will be to revoke the GARP M and utilise the current GARP V of the VEA.

2.2 Remove the Age discrimination of compensation amounts on the sliding scale, which is not consistent to Non-Economic Loss (NEL) compensation Permanent Impairment (PI) payment philosophy. The Age Discrimination is a Superannuation structure – not a compensation structure for calculation of Impairment Points.

2.3 Remove the Gender discrimination of compensation amounts on the sliding scale, which is not consistent to NEL compensation of PI compensation philosophy. The Gender discrimination is Superannuation structure – not a compensation structure for the calculation of Impairment Points.

2.4 Remove the Special Rate of Disability Pension (SRDP) under s204 MRCA, as it is not consistent with the beneficial approach as previously accessible to those on Special Rate under the VEA, who have COMSUPER (Defence Force Retirement & Death Benefits Scheme (DFRDB); and Military Superannuation Benefits Scheme (MSBS)).

2.5 Exclusions relating to serious defaults or wilful acts; Reasonable Counselling; Travelling during Peacetime Service and Tobacco Products – within Chap 2, Part 4, s32 (in it's entirety) is revoked. Rationale as discussed in this paper and within the MRCA Table.

2.6 The Department to pay travel up-front for those veterans who require travel to and from Rehabilitation and/or Treatment (s43, s47, s48, and s49). The system of Booked Car with Driver (BCWD) to continue with MRCA, in order to not place the veteran with high up-front costs, which take some months for the Department to reimburse the veteran.

2.7 That the 80 Impairment Point threshold within s80 of MRCA be reduced to 70 Impairment Points, as the 80 Impairment Points is excessively high for those who are unable to work due to their service caused serious incapacity. That those veterans unable to work 10 hours or more per week, with 60 Impairment Points to be treated in similar context to Special Rate under the VEA, if the veteran is unable to work 10 hours or more per week. Therefore, obtaining a Gold Card stamped "TPI".

2.8 That the MRCA system incorporates a card system that is recognised by State and Local Governments in terms of Concessions (Example the White Card for Specified Treatment Entitlement Card (STEC), or the Gold Card (Treatment for all Conditions). This includes access to the Pensioner Concession Card (PCC), in order to provide Concessions for the veteran and his/her family as a result of being in receipt of Incapacity

Payments (IP), as IP usually negates the access for those veterans with Qualifying Service (QS) to War Service Pension (WSP), which is provided under the VEA.

2.9 The Department investigates the use of technology to improve billing arrangements under MRCA That billing for non-Repatriation Pharmaceutical Benefit Scheme (RPBS) or standard VEA treatment entitlement or pharmaceuticals are paid with an electronic billing system which provides real-time payment. The current system is cumbersome and takes months to have the Department to pay the bills for such treatment, rehabilitation and/or pharmaceuticals. In the Information Age, of which we are a part thereof, there must be smarter technological solutions available to rectify these problems.

2.10 That the Transition Management is comprehensively over-hauled with ESO consultation. This is consistent with the Dunt Report into Suicide in the Ex-service Community; and the Independent Study of Prof Dunt into the Review of Mental Health cover in the ADF and Transition through Discharge. This is suggested to be contextualised within a multi-eligibility and multiple deployment simulation to ensure a consistent and highly professional level of service to exiting members of the ADF.

2.11 Significant Streamlining of the MRCA to make the Act a simpler system to work. This includes processing of claims ranging from Commonwealth Liability; Permanent Impairment or Increase applications; Incapacity Payments; notation of the Defence Allowance (s183) in correspondence to claimants; Needs Assessments; Rehabilitation Programs and general administration of the system. Simply, the Time Taken To Process (TTTP) of MRCA requires significant overhaul and improvement.

2.11.1 It is strongly recommended that the Government increase the Average Staffing Levels (ASL) for DVA and also train Staff to be multiple eligibility capable, rather than singular eligibility capable, in terms of handling complex cases.

2.12 That Service Chiefs in their capacity as MRCC ensure that all possible efforts have been made to rehabilitate an ADF member, retain, retrain and provide the opportunity for decisions to be made on MRCA claims for Permanent Impairment prior to Medical Discharge, along with potential retention in the Reserve and Return to Work strategies whilst on convalescence Leave. This is consistent with the ADF Rehabilitation Plan and DI-G (PERS) 16-15, Australian Defence Force Medical Employment Classification System – Deferment of Medical Termination Action paras 48-50.

2.13 That the recommendations made within the MRCA Table at Annex A, are taken into consideration for improvement and Legislative changes.

2.14 That the ADF refrains from cuts in costs to medical treatment to serving members, regardless of the type of service the member has rendered. The best possible Rehabilitation and Treatment must be made available to a serving member, regardless of which Compensation Act they are under. This is a Duty of Care by the ADF to ensure that a fit and healthy workforce is maintained.

2.15 That regardless of service type, whether current or ex-serving, a veteran or service member be entitled to the previous entitlement under the VEA of the Temporary Incapacity Allowance (TIA), for admission into a hospital and paid after 28 days after treatment for rest and recuperation of such treatment. TIA is noted not to be included in the MRCA. The intent of TIA is to provide for NEL payments for pain and suffering of a veteran undergoing such treatment and recuperation.

2.16 That a veteran under the MRCA who is over age 65, is not disadvantaged in terms of seeking NEL compensation by being able to claim conditions as a result of their service, either clinically onset, aggravated or sequelae. This is consistent with the approach made in the VEA, of which veterans are able to continue claiming conditions until their death. Consideration must be placed toward Extreme Disablement Adjustment (EDA), in terms of Lifestyle Rating of 6 and 70 Impairment Points, within the MRCA.

2.17 Incapacity Payments to be paid to the veteran at 100% up to the time of 45 weeks and beyond, if the condition is not stabilised and a Permanent Impairment Payment not paid.

2.18 DFISA **must** be removed from the responsibility from Centrelink and the processing of the DFISA applications be made directly to the Department (DVA).

2.19 If a veteran dies, regardless of living and financial arrangements, the partner and/or dependents should be entitled to compensation. However, if a veteran or ADF member dies, it is considered that compensation be only payable to those who are financially reliant on the deceased. This is consistent with Compensation structures outside of the Veteran Entitlement law. Only in special cases, should there be consideration toward such compensation if the Commission is convinced, to be payable to a person. For example if an ADF member was posted on compassionate grounds to care for a family member with a debilitating illness or disease, and dies as a result of his/her service, then compensation would be thought to be payable to the family member.

2.20 The Appeal Process is streamlined into one system that was previously available to a veteran under VEA. Specifically: s31 Review/Appeal; Veteran Review Board (VRB); Administrative Appeals Tribunal (AAT); and further appeal at Federal Court levels.

2.21 That the Police Peacekeeping veterans are provided eligibility under the MRCA.

3. General – Operational Performance of MRCA.

3.1 We view the MRCA, as a hybrid of both the VEA and the SRCA, with extant entitlements from the Defence Act 1903 (Defence Determination 2000/1).

3.2 There are several matters that are deemed to be of a substantial issue that are described within this paper. It is envisaged that the Military Compensation Arrangements Review Committee will consider all of these matters and provide consideration and positive resolution toward the issues of contention and provide for Legislative changes where required.

3.3 The situation above understandably causes frustration, anger and confusion for the veteran. Practitioners are also experiencing such difficulties. Annex B, presents some case studies. These cases have been discussed by Practitioners within the APPVA, and it has been agreed that these are common and regular problems within the operations of MRCA. It is slow, cumbersome, and bureaucratic and requires a significant overhaul to enhance service delivery of multiple-eligibility and MRCA claims.

3.4 It is apparent that the Average Staffing Levels (ASL) within the Department (DVA) is simply inadequate in terms of handling the case load and complexity of working with three separate Acts. It is known that in the Victorian State Office (VSO), that three Assessment teams and a Military Compensation team have been reduced to one team, dealing with complex and multiple Acts. The VSO is also handling the cases for Tasmania.

3.5 It is viewed that the DVA staff cut-backs have been premature in terms of the expectation of a reduced WWII and War Widow clientele over the next 5 years. The resultant outcome of the apparent lack of Staff and expertise in the field of multiple-eligibility is causing grave concerns for not only practitioners, veterans and their families; but also the Staff that are employed within DVA.

3.6 We are aware that a number of Staff members have taken stress leave, as a result of the pressure to clear backlogs and to provide timely processing, in particular toward MRCA and multiple eligibility cases.

3.7 It is therefore strongly recommended that the Government increase the ASL for DVA and also train Staff to be multiple eligibility capable, rather than singularly capable; in terms of handling complex cases, in particular MRCA.

4. Coordination of Case Management.

4.1 Working with the MRCA has generally been difficult, with a number of areas that require improvement.

4.2 Many veterans have complained about lengthy delays in obtaining any response to queries; complex understanding of the MRCA (in terms of Service, Gender and Age bias); no central point of case management; calling different Customer Support Officers in Perth, to be referred to Delegates within the Department (DVA), who are unable to provide answers to various questions; and calling from one end of the country to the other, depending on whether or not the veteran is seeking Permanent Impairment (PI), which is in Brisbane; Incapacity Payments (IP) which is delegated to someone in Sydney; and Rehabilitation Assessment within the State of origin. This includes Household Services under the SRCA and MRCA.

4.3 The case file and management of an individual claimant is not handled on a holistic approach by the one case manager and the file is moved around the country, causing inordinate delays to the process of PI; IP; Needs Assessments; Rehabilitation; and Household Services. Therefore the process approaches within the Department are not streamlined and disjointed.

5. Authorised Representation.

5.1 Experiences from our Practitioners have indicated that there appears to be, at times, no adherence toward notifying and contacting the Authorised Representative of the Claimant under VEA; SRCA; and MRCA. This has caused undue confusion with the claimant and time taken by the Authorised Representative to explain the rationale behind some of the calls being made to the claimant by Delegates of the Department. Of particular note, is the failure of the Department to advise Practitioners of decisions regarding PI.

5.2 In addition, evidence from a claimant or his/her partner, is sometimes quoted within the member's file, when there are mis-understandings as to the questioning or the intention of the questioning by a DVA Delegate. This in turn has been used against the claimant in some decision making processes.

5.3 An example of the above is where a claimant completes and submits claimant reports, without realising the implications of the information provided, particularly the complexity of the job, along with the tasks undertaken. This is pertinent particularly toward Weight Lifting Questionnaires for degenerative muscular-skeletal conditions.

5.4 Other problematic areas have been inquiries by the Authorised Representative to a DVA Claims officer for either compensation or Income Support matters; when clearly the application forms have been completed within the Authorised Representative's area and endorsed by the Claimant.

5.5 There have been a number of cases that have caused inordinate delays in Time Taken To Process (TTTP), particularly when a veteran is claiming PI, IP, and Rehabilitation, where various functions of the decision process for rejection or approval by delegates is a complicated system, of which the claimant does not understand, of which Authorised Representative assistance is imperative.

5.6 For example a veteran will apply for PI, IP Rehabilitation, and Treatment (for a range of areas within Rehabilitation and Treatment) of which each compensation area is sent to different delegates for investigation, decision and approvals for payment. The process is long and lacks central case management and coordination. This has in turn caused a number of problems to a veteran.

5.7 An example of this is that a veteran who is under Rehabilitation Program, who is not eligible for PI due to non-stabilisation of their condition, have had their IP removed by the delegate dealing with Income Support, based on the recommendations of an Occupational Physician. Therefore, applying unnecessary stress to the veteran and his/her family and the holistic approach toward case management has not been affected in a fair manner.

5.8 Difficulties in communications between various Delegates, who are geographically dispersed also provides a great deal of frustration in terms of seeking follow-up action to a number of queries.

5.9 Raising of new PI Claims, whilst previously raised PI claims that are under investigation are then further complicated by the file been sent to various Delegates and Case Officers, which causes lengthy delays.

5.10 Within s117, s118 & s128 of the MRCA, IP is payable at 100% of the former ADF member's salary on discharge from the ADF for the first 45 weeks. In addition within s183, is the amount for Defence Allowance of $100.00 per week,[3] DVA staff call this "*Remuneration Allowance*", for the loss of previous conditions of service entitlements, which range from various allowances and Married Quarter (MQ) and/or subsidised accommodation.

5.11 The IP and Defence Allowance have not been actually shown on a member's Decision document, which is confusing a number of veterans as to whether or not they are receiving the Defence Allowance. Many Young Veterans are oblivious to this allowance, of which it must be disclosed to the veteran within the IP Decision document.

5.12 The recommendation here is to provide the full disclosure of the amounts held, including comparative analysis for the ADF salary at the time of the rank and Pay Group (GORPS)[4], and Defence Allowance (s183), of which the incapacitated member is entitled.

[3] Within s404 MRCA s183 now has the value of $138.88 per week and there was an ADF pay rise of which both are in arrears from the Department (DVA) as of 17 July 2009.
[4] GORPS – ADF Graded Other Rank Pay Structure.

5.13 It has been noted that whilst PI under s79(2) MRCA, is liable for interest past 30 days of processing the claim, within IP, GORPS increases, and Defence (Remuneration) Allowance, the Economic Loss (EL) components to compensation are not subject to s79(2). We find this inconsistent and strongly suggest that EL is also included in the same context as s79(2).

6. Service Bias.

6.1 Revocation of the Service Tiered compensation system for WS, NWLS and PTS is required to place all veterans on equilibrium in terms of impairment. An example of this is if a veteran suffers a fractured pelvis on service within Australia, there is no difference of a veteran suffering the same medical condition on WS or NWLS. There is no difference to the impairment of the individual, regardless of where they serve. The impairment and/or incapacity are the same.

6.2 Therefore, considering the Impairment and/or Incapacity of a veteran, no matter where he or she serves, there is no difference in terms of physiological or psychological damage. The Tiered Service bias within the GARP M is therefore discriminative toward those who serve on PTS. This service discrimination has never been used previously to veterans eligible under the VEA or the SRCA, toward NEL payments/pensions.

6.3 Within s67(1)(e), (Guide to Determining impairment and compensation), methods by which the impairment points of a person, and the effect on a person's lifestyle, from a service injury or disease can be used to determine the compensation payable to the person under this Part (Part 2 – Permanent Impairment);

Comment: This is viewed as a fair statement within the determination of impairment and compensation for Permanent Impairment, however, s67 goes on to discriminate this statement within s67(2):

"The Guide must:
(a) specify different methods under s67(1)(e) for:
- *(i) service injuries or diseases that relate to warlike service or non-warlike service; and*
- *(ii) other service injuries or diseases; and*

(b) specify a method for determining the compensation payable to a person who has both:
- *(i) a service injury or disease that relates to warlike service or non-warlike service; and*
- *(ii) another service injury or disease."*

Explanation: Therefore, the MRCA is service biased within the GARP (M)[5] with

[5] Military Rehabilitation Compensation Commission (MRCC), Instrument No M9 of 2005, Guide to Determining Impairment and Compensation (GARP (M)).

a 2-tiered service approach. Utilising the two tables within Chapter 23, Table 23.1 Compensation Factors for Calculating Permanent Impairment Compensation – Warlike and Non-warlike Service; and Table 23.2 Compensation Factors for Calculating Permanent Impairment Compensation – Peacetime Service.

This means the highest amount of PI is paid to members who have been injured/ill/wounded accepted on warlike service and on non-warlike service; and lastly, the lowest end of the scale for those who are ill/injured or wounded accepted under Peacetime service.

Comment: This approach toward service type is recommended to be abolished or revoked and the same constant amount retained, particularly for Peacetime Service, at the highest level (warlike service & non-warlike service tier) for all three service types.

7. Age and Gender Biased.

7.1 A sliding scale of Lump Sum (Permanent Impairment (PI) or Non-Economic Loss (NEL)) Payments in terms of loss of value (s78(5)), weekly amount converted to a lump sum means the percentage of weekly amount payable to the person, as at the date of the notice given to the person under s76, converted to a lump sum in accordance with advice from the Australian Government Actuary by reference to the person's age;

Within s78(6), a lump sum that can be payable to a person must not exceed that worked out by reference to the conversion to a lump sum of a periodic payment payable to a **male aged 30 (female aged 35)**;

By definition, in terms of the Government approach within GARP (M), under *"Elements of Whole Person Impairment and Compensation"* Chapters 1 to 16 of this Guide contain two principal types of tables. Physical loss is to be rated against criteria in "Other Impairment" tables. Functional loss is to be rated against criteria in "Functional Loss" tables.

Greater emphasis has been given throughout this Guide to functional loss as a basis for assessment. It is measured by reference to an individual's performance efficiency compared with an average, healthy person of the same age and sex, in a set of defined vital functions. This is a means of compensating for the loss of ability to perform everyday functions.

Whilst Age Adjustment has been used within the GARP V (VEA) for adjustment of impairment points in line with the degeneration caused by age or different gender. However GARP (M) has provided a distinct disadvantage by then applying an age and gender bias adjustment which is made towards compensation, when impairment points have already been removed in the assessment through age and gender tables. The

compensation amounts should directly relate to the percentage rate of disability, whether paid by pension or lump sum (PI), without bias.

Comment: It is strongly put to the Government that the age and gender bias is removed in terms of Government Actuary referencing, as this is a Military Compensation Act, not Superannuation. This is the only known Compensation system to be bias toward service type, age and gender in the world. This is distinctly disadvantageous to those who have served or serve in the ADF.

8. Higher Payment for Incapacitated former ADF members.

8.1 Former Permanent ADF members who have held employment within a much higher pay in comparison to their service pay and allowances will be disadvantaged. The Reservists are able to claim higher wages without limitation – the same should be provided for a former Permanent ADF member, whose income exceeds that of their previous ADF salary and allowances.

9. Severe Incapacity.

9.1 Within s80 (MRCA), the extremely high Impairment Rating of GARP (M) of 80 impairment points allows the payment of $60,000[6] toward each dependant of the veteran. It is also felt that an additional Severely Incapacitated Adjustment (SIA) is made in the form of a lump sum of the severely impaired veteran due to the effects of a compensable injury, disease or illness, an additional amount of up to $64,284.90[7] should be payable to the veteran, as in similar circumstances under the *Defence Act 1903 (Defence Determination 2000/1)*. The *Defence Act 1903* also provides for payment of additional lump sum compensation of $67,769.94 for the benefit of each dependant child the veteran may have (indexed as per s404).

9.2 It is also noted that the 80 Impairment Points is past the point of extremely incapacitated. For example the Extreme Disablement Adjustment (EDA), with the VEA is a Lifestyle Rating of 6 with 70 Impairment Points. Under the VEA; EDA is paid to someone who is extremely incapacitated. It is therefore suggested that s80 of the MRCA is reduced to **70 Impairment Points**. This reduction in Impairment Points is believed to be a fair and reasonable degree of severe incapacity in order to allow for the Additional amounts payable if maximum compensation paid (s80 MRCA).

9.3 Under the VEA GARP V, a veteran is able to be determined as Totally & Permanently Incapacitated (TPI) at 70% of the General Rate (GR) of pension and is unable to work 8 hours or more per week and it is those conditions alone that prevent the veteran from seeking remunerated work. Normally 70% of the GR starts at 40 Impairment Points with a Lifestyle Rating of 3 points. This is placed within the

[6] The amount of $60,000 was determined in 2004 and has since been indexed under the provisions of s404 MRCA.
[7] The amount of $64,284.90 is the amount set on 15 December 2008 and indexed under s404 (MRCA).

Conversion to Degree of Incapacity on GARP V. The higher is noted to be Impairment Points of 60 to Lifestyle 4, which will equal 100% GR.

9.4 Within MRCA, 60 Impairment Points of a veteran who is unable to work 10 hours remunerative employment per week, is consistent with the VEA Gold Card level, with the stamp of "TPI" in order to provide concessions and treatment for all conditions. This is currently the practice by agreement of the Minister but needs to be included in the legislation for MRCA.

10. Special Rate Disability Pension (MRCA s204).

10.1 A paper of the Special Rate Disability Pension Offsetting (SRDP), against COMSUPER Pensions is at Annex C. The General outcomes from this discussion are the disadvantageous approach by the MRCA toward those veterans who choose SRDP, and who are in receipt of COMSUPER, superannuation, under s204(5) & (6).

10.2 If the Government is not willing to change the SRDP in order to allow the full value of income of COMSUPER, along with WSP (Means & Assets tested), then consideration must be given toward revoking **SRDP in it's entirety**.

11. Alternative Concept to Special Rate (TPI) under MRCA.

11.1 An alternative concept toward the Special Rate (TPI) Safety Net within MRCA, is to remove in total Chapter 4, Part 6 – Choice to receive a Special Rate Disability Pension (SRDP).

11.2 It is known that the SRDP or the Special Rate safety net was placed into the MRCA as an alternative mechanism toward a higher end of Incapacity, that being of 60 Impairment Points within GARP (M). Another area of benefit to SRDP or TPI, is the well known Benefits and Concessions that have been granted to veterans in their respective State of residence. The benefits of the TPI Gold Card are significant to a veteran and have been generously provided by States as recognition of the severity of the TPI veterans' medical conditions as a result of serving his/her country.

11.3 However, an alternative concept is to have the option provided within the NEL component of Compensation within Chapter 4 – Compensation for members and former members, Part 2 – Permanent Impairment. That within Part 2 (Permanent Impairment), if a former member has a rating of 60 Impairment Points (MRCA), that member is eligible, if they cannot work, to a Gold Card with the embossing of TPI.

11.4 The rationale behind this concept is that there are significant benefits available to veterans who are TPI within the VEA. Within SRCA (Severely Incapacitated Adjustment (SIA)) and MRCA SIA being at 80 Impairment Points, there is no provision for the Gold Card available with TPI embossed on the card, which as previously mentioned should be included in a change to MRCA Legislation.

11.5 Whilst there is a choice to receive Permanent Impairment within Part 2 and Part 6 (Choice to receive SRDP), it is believed that the SRDP will not be advantageous to a veteran, as much as Part 2 PI, along with IP, COMSUPER and WSP for QS. This package, along with the opportunity to be eligible for State Concessions for the possession of a Gold Card embossed TPI, will be the advantageous approach.

11.6 It is felt a Section dedicated to this Concept be raised within Part 2 (PI), with the similar approach toward the SRDP, that being not able to work more than 10 hours per week, be at the incapacitated level of 60 Impairment Points and above, to be issued a Gold Card embossed "TPI", in order to have access to the benefits and concessions available to current TPI veterans under the VEA.

12. Rehabilitation.

12.1 Rehabilitation could be excessively assessed and examined under the MRCA, placing unnecessary stress of the member concerned. In this context, if the member has any illness or injury accepted under the MRCA that requires ongoing treatment, that treatment is considered to be an ongoing legacy of preventative measures in terms of worsening of the condition, along with maintaining a degree of physical fitness for the member. This pro-active approach toward the well-being and health of the member has potential to save the Department money in terms of worsening of a given condition, or sequelae conditions.

12.2 Retention during Rehabilitation in the ADF is an important step to the serviceperson, particularly if they have a mental illness. There have been times where an ADF Member is given months to stay at home, where we feel that they should be given the opportunity to be placed on a gradual return to work program, whilst currently serving and continue to feel worthwhile to the ADF. This promotes self-esteem and self-pride. Another point is that if members are medically discharged from the ADF, and they are unable to work a full working week, then consideration be given for them to transfer to the Reserve Force in order to retain their skills, corporate knowledge and be an asset to the ADF.

12.3 One of the key philosophy's of Rehabilitation is also to provide for the well-being of the veteran and his/her family. This must be taken into consideration during the Rehabilitation phase. Within the ADF, serving members must be given every opportunity under the *Defence Instructions General - (Personnel) 16-22 ADF Rehabilitation Program (ADFRP)* to be retained or retrained within the ADF. Additionally, it should be noted by Case Managers that there are provisions within the *Defence Instructions General – (Personnel) 16-15 (DI-G (PERS) 16-15)) Australian Defence Force Medical Employment Classification System* – Deferment of Medical Termination Action paras 52-54. The text of this ADF policy is attached at Annex D.

12.4 Other observations made during and after the Rehabilitation process, particularly within the ADF, Full Time service members who have been issued a Notice of Termination (Medical Discharge), are placed into holding units. Members are not given

the opportunity to attempt to undergo a Return to Work (RTW) program. The member's unit appears to shun them and make the member someone else's problem. This does not promote self-esteem and the well-being of the veteran and may cause a negative effect in terms of rehabilitation.

12.5 Outside of the ADF of course provides a separate dynamic, where if the veteran works, it is difficult to obtain the time off from work to undergo a full rehabilitation program, particularly if there are chronic illnesses, diseases or injuries. The veteran is forced to leave work and be supported by the Incapacity Payments under MRCA. A similar situation presents itself with SRCA.

12.6 Other difficulties that have been identified is that when a member undergoes an RTW program, the employer may not necessarily hire them on a permanent basis, due to limitations of the individual's incapacity. It is well known, that despite the *Disability Discrimination Act*[8] in terms of employment, employers actively seek fit, healthy and mentally well people. This should be considered within the background of decision, if the ADF was able to retain an individual within the Reserve Force in a given specialist role.

12.7 Encouragement of the use of the ADF Career Transition Assistance Scheme (CTAS), prior to Discharge, should be made a critical priority. This would also include those who were attending University courses and other vocational courses, the opportunity to complete those courses during and post service. These members would [9]ideally have had prior approval before Medical Employment Classification Review Board (MECRB) down grading, under the Services Vocational Educational and Training Scheme (SVETS), or Defence Force Assistance in Higher Education Scheme (formerly known as DFASS).

12.7 It is strongly recommended that the ADF members who were participating in these courses that were previously approved prior to service related illness or disease, are given their full potential and opportunity to complete such studies, for preparation for return into the workforce.

12.8 Even outside of the ADF, the above would also be pertinent to those undergoing rehabilitation in order to complete their vocational goals, particularly if they were on the ADF education assistance schemes. The use of the Veteran Vocational Rehabilitation Scheme (VVRS), which is a VEA entitlement, must also consider these options for those who are determined to complete their previous studies, once stabilised then Medically Discharged.

12.9 The cost of the studies should also be met by MRCA in similar fashion to the VVRS and in particular focus on Vocation after rehabilitation, rather than Job Placement as the priority.

[8] Disability Discrimination Act 1992 of 1 July 2009, Act No. 70 of 2009.
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12.10 An example of the use of the VVRS, would be in terms of skills and experiences to be used as Recognised Current Competencies (RCC), Recognised Prior Learning (RPL) and/or life and job skills combined with educational qualifications that such an individual would be placed into a suitable vocation or degree/Masters level course.

12.11 It is important that a member's quality of life is also placed as an emphasis, in order to function and integrate appropriately within the member's family and social groups. This may not mean that the veteran will be able to work, however the focus also needs to be placed on the well-being of the member in terms of maintenance.

12.12 The Legislation appears to be given allowances for parliamentary scrutiny and may be budget reactive. The MRCA should be Legislation and remain unaffected by various policies (inalienable from Government fiscal policy) as the VEA itself has with-stood time and government policies. However, this should not prevent repeals of the Act in line with future development of the Act, particularly toward adjustment from Reviews such as this and by High Court decisions.

12.13 Cumulative addition of PI and IP payments being counted as financial income for assets for income support payments under the VEA and Social Security Act 1991 (SSA), with income to be deemed to be earned from them. Current PI payments for VEA and SRCA are not counted as income under the VEA, however the SSA includes that income – therefore the PI component should be income exempt for SSA (for example Income Taxation Benefit A and/or B) and Child Support Agency (CSA) purposes, as it is compensation for that particular person's pain, suffering and reduction to a previously enjoyed quality of life and should therefore be inalienable from such access by CSA.

12.14 Provision for PI (NEL) to be paid on or after the age of 65 years of age will no longer be available to those with service-related conditions that worsen. Currently the Extreme Disabled Adjustment (EDA) is accessed through the VEA. Additionally, veterans above the age of 65 are able to claim Disability Pension (DP) for any condition.

12.15 Although it is understood that the War Service Pension (WSP), will be available for those with Qualifying Service (QS), which is an Economic Loss (EL), or equivalent to the Aged Pension, there must be further allowances for those who are affected by their service related conditions during the life of the veteran and therefore, not restricted to age.

12.16 Former Permanent ADF members who have held employment within a much higher pay in comparison to their service pay and allowances will be disadvantaged. The Reservists are able to claim higher wages without limitation – the same should be provided for a former Permanent ADF member, whose income exceeds that of their previous ADF salary and allowances. Placing Former Permanent ADF and Reservists on equilibrium. A stop gap is whichever is the greater in terms of compensation value to the veteran.

12.17 During applications for Permanent Impairment (PI), there are different interpretations as to what a Delegate or the Commission terms as "Stabilisation". This has caused the non-payment of PI or Interim Payment, rather than the full amount of PI, which is at a disadvantage to the veteran. We view that within MRCA s5, Definitions, that the Stabilisation of a condition is based on the *Stedman's Medical Dictionary* of stabilisation.

12.18 MRCA requires a complete Legislative review. There are a number of anomalies that are viewed in terms of requiring change and to allow previously beneficial eligibility toward the VEA, and the SRCA. These points are further discussed within this paper and include Multiple Eligibility of all Acts.

PART B
Transition Management.

13. Transition Management Service - MRCA.

13.1 MRCA, Part 5 – Transition Management (Chapter 3 Rehabilitation) s63-64, is not detailed and requires a full Chapter or further explanation of Transition Management. Great difficulties have been experienced by ex-serving members who have gone through the Transition Management Process, of which there are degrees and incidences of unclear guidelines.

13.2 Within MRCA s64(2), of which the service chief must appoint a case manager for the person, it is preferred that this case manager is aware of the implications and technical matters of MRCA. Past experiences have seen that there are case managers who have received no training and are not conversant with MRCA, let alone multiple-eligibility.

13.3 It is important that the case managers are trained and aware of the entitlements under COMSUPER; VEA; SRCA & MRCA, in order to provide the member with a degree of assistance and/or referral during transition.

13.4 A moot point with case managers, is that this term is often confused with the referred external provider, that being an Occupational Therapist (OT). It has been noted that these OT's fail to provide a comprehensive Assessment of the individual, including an interactive rehabilitation plan. Most times these are drafted agreements, of which the member rarely has contact with the OT thereafter.

13.5 It must be imperative that the OT is providing the degree of care, motivation and encouragement toward Rehabilitation. Goals and milestones need to be placed and agreed by the member in an attempt to have the person at their best possible physical and mental fitness prior to discharge.

13.6 It has also been observed that OT's have been completing Compensation claim forms on behalf of the member. This practice must cease, as the OT does not have the appropriate training or expertise in the completion of claimant forms, particularly if the claimant has a range of complex matters and multiple eligibility.

13.7 A visit to Townsville during the period 10-15 November 2008, revealed some matters in relation to Transitions during Discharge. These are the following points of interest:

13.7.1 The services that are provided within this Centre are a marked improvement of interoperability between Defence and Veterans' Affairs in terms of managing Medical Discharges from the ADF in North QLD.

13.7.2 The system appears to have a seamless approach. The staff was very courteous and enthusiastic of what they have achieved.

13.7.3 One point that was noted was the question of having a uniformed Qualified Military Compensation Practitioner to be operating within the Transition Cell. The question was answered in terms that it was not within the Defence Transition Separation Service (DTSS) Strategy and Policy. We were advised that the DTSS, under decision by Defence that no ESO will have access onto the base (or any bases), to perform Advocacy services on behalf of the service member.

13.7.3.1 We have since been advised that the Army is now initiating a Regional Casualty Assistance Support Officer (RCASO); and of course the RAAF with their Military Compensation Liaison Officers (MCLO), which has been in existence for some years.

13.7.3.2 This is highly supported by the APPVA as a method of early rehabilitation and acceptance of liability whilst still serving. It is understood that the RCASO will be within the Army Chain of Command, that being the Director of Army Health Services.

13.7.4 It has been disclosed that some of the DVA staff assist with completion of the Application for Claim Forms, along with referral to ESOs outside of the Base. It was also disclosed that it was made apparent that the Clerks of the units, within the Chain of Command were assisting soldiers with the completion of Application Forms.

13.7.5 The concerns were made that these people who are assisting these soldiers with their claim forms, whilst it is appreciated that there is a requirement within the Chain of Command to have visibility over the soldier's progress with Compensation Entitlements, is that they are not qualified or have not attended Training Information Program (TIP) courses. In any case, there would be the potential risk to Defence or even the individuals assisting with the completion of these forms of not correctly providing contentions and diagnosis. This may seriously compromise the claims.

13.7.6 A clear example of this is a case by the APPVA Advocate in Melbourne, where a DVA Staff member with all good intentions filled out the veterans' claim form and lodged it to the Delegate, caused a 2-year battle with correcting the contention information within the primary claim level. Whilst it is understood that the individual who completed the form on behalf of the veteran had the veterans' best interests in mind, this has had a catastrophic affect, simply because the person was not trained or accredited to a level to ensure that all evidence, contention information and diagnosis was complete.

13.7.7 The Veteran in this case was incorrectly advised to claim acceptance of liability under the Military Rehabilitation and Compensation Act 2004 (MRCA), when he was in fact his incapacity occurred under the Veteran Entitlement Act 1986 (VEA) and SRCA.[10]

13.7.8 The effect on this veteran and his family was significant, and the 2-year period caused a great deal of stress and difficulty. This also aggravates a given psychiatric condition or could even have the potential to have a clinical onset of a psychiatric condition, which may have liability issues by suing the individual, or organisation that assisted in this case. This is a situation that we believe that Defence and Veterans' Affairs can ill-afford.

13.7.9 The method of claim completion on Lavarack Barracks, is of a concern to us, particularly toward the accreditation of anyone assisting the soldier, with further aggravation of conditions during and post-discharge. The case above was clearly an example that should be kept in context to ensure that Primary Claims are completed by competent practitioners.

13.7.10 It is strongly believed that the concept of trained and accredited uniformed Reserve members, specialising in multi-eligibility, along with the effects of COMSUPER is considered relevant and deserves positive consideration and decision by Defence.

Comment: This visit and report was made at the request by the then Minister for Defence, Science and Personnel, The Hon Warren Snowdon, MP.[11]

14. Transition Management Service for VEA & SRCA.

14.1 Whilst the Transition Management Service (TMS) has been of assistance to those transitioning from the ADF to "Civvie Street" (life outside of the ADF), the concept has merit, however there are some areas that is felt that requires further development.

14.2 For some years, the TMS appears to be a "tick and flick" approach, utilising a list of actions required for processing discharges. It would appear that whilst there are some areas easily covered and actioned by Defence Discharge Cell personnel, the knowledge of VEA, SRCA and MRCA appears to be unable to be fully explained to an ADF member.

14.3 Cases have seen TMS Staff visiting medicated psychiatric patients for signatures and briefings within the Psychiatric Ward of a given Hospital. It must be emphasised that TMS Staff must be made aware that these mentally-ill ADF members are unable to fully comprehend such complicated procedures and are not fit to sign acknowledgement forms until they have stabilised.

[10] Fitton Case.
[11] APPVA Post Visit Report Townsville (10-15 Nov 2008), dated 17 Nov 2008

14.4 It is strongly recommended that the above practice ceases, with TMS Staff specifically briefed and policy made to ensure such circumstances does not re-occur. It is important that the veteran, along with his/her partner are able comprehend the transition process and procedures when the ill veteran is at a stage of a degree of stabilisation on the recommendation of the consulting specialist.

14.5 The use of the consulting specialist, including utilising the philosophy of "fit for discharge", should be used when administering discharges. There should not be a rush to Medically Discharge members from the ADF. The member must be given every opportunity to rehabilitate, be retained or retrained; or provided the best opportunity and support for preparation into civilian life.

14.6 An observation in a number of cases for the processing of Medical Discharged members, or even those who are receiving rehabilitation and treatment is that the Department of Defence wants these people off their books and establishment as fast as possible. This is poor Human Resource practices and in numerous cases has worsened the conditions as the financial hardships follow from not being stabilised prior to discharge and that they are discharged prior to a determination of given claims.

14.7 A paper on Defence Transition is attached as Annex E to this Submission. It is put to the MRCA Review Committee that the recommendations and outcome points are considered within the Review.

15. DUNT IRT Transitions.

15.1 The APPVA has read with interest the Dunt Report on the *"Independent Study into Suicide in the Ex-service Community"* indicated that a great deal of suicides or the implication of suicidal idealisation may be as a result of how the ex-service person has been supported during service, transition and entry into civilian life.

15.2 Whilst it is acknowledged that the Government Accepted all Recommendations, with the exception of Recommendation 8.1; which was accepted in principle, however further discussion with ESOs has been indicated to provide a balanced view on this proposed system.

15.3 The unfortunate failure of claims has been the root problem is attributable to in-competent compensation practitioners. Recommendation 8.1 is the suggested two-tiered model of accreditation with educational or qualifications standards to a minimum level for volunteers (Tier 1), up to a Diploma Level qualification for full-time practitioners (Tier 2). This is highly supported by the APPVA, of which a discussion paper on the subject is due to be forthcoming from the association.

15.4 It is important that practitioners are competent, particularly in today's dynamics of multi-eligibility and multiple deployments for ADF members, particularly for those who have served post 1975.

15.5 The second report by Dunt on the "*ADF Mental Health Through Transition*", whilst the Government supported most of the recommendations, there is much work to be done in this area. The APPVA looks forward to being involved in the consultation of the improvement of the Transition system.

PART C
Multiple Eligibility of VEA, SRCA & MRCA.

16. Triple Eligibility Case Scenario.

16.1 Applying the moving over of claims under VEA and SRCA, if serving in the ADF on or after 1 July 2004, for assessment under the MRCA. The intention is not to penalise the veteran if they are placed within the MRCA.

16.2 For example if a veteran has a psychiatric condition under the VEA, of which the veteran joined the ADF in 1985, as a result of service in East Timor. In addition, the veteran has liability accepted for SRCA compensation for a Back Condition. The veteran, is retained within the ADF and is again deployed to Afghanistan in 2007. The veteran is wounded by a Gun shot to the ankle. Therefore, the veteran has eligibility for MRCA as a result of the Gun Shot Wound (GSW).

16.3 The veteran now has triple eligibility with VEA, SRCA and MRCA. In order to make the matter simple it would be logical to have the VEA & SRCA disabilities accepted by MRCA, along with MRCA GSW for re-assessment. It is stipulated that the VEA & SRCA accepted conditions should not be to the detriment of loss of financial payment to the veteran because he/she has disabilities under the MRCA.

16.4 The veteran above is medically discharged due to being medically unfit. He is not entitled to Above General Rate (AGR) under the VEA, due to the stand-alone clause in s23 or s24. He is not entitled to IP under the SRCA, as his psychiatric condition is the reason for being unable to work and not inclusive SRCA accepted back condition. The MRCA will not pay IP, because his ankle is not the reason that he cannot work.

16.5 Due to this conundrum it is recommended that all NEL payments received under any of the Acts are not offset against each other. It is also recommended that all service caused conditions be given entitlement to receive IP under the MRCA, regardless of which Act that the veteran holds liability or eligibility.

16.6 Regardless of which Act that the veteran holds eligibility, if there is any doubt as to which Act provides EL (IP or ISS, WSP, or DFISA) it is to be paid by IP Payments under MRCA, as the retention of the beneficial approach.

16.7 Within s70A of the VEA, an injury or disease or death occurs after the MRCA commencement date cannot be covered by the VEA. This should not apply to conditions that have been service caused during the VEA eligibility or are sequelae to a VEA accepted condition. The logic behind this statement is to prevent issues arising which impact on the Veterans' Entitlements, for example the AGR Intermediate Rate (IR) (s23 VEA); Special Rate (SR) Stand-Alone Clause (s24 VEA); or eligibility for 100% of the GR VEA.

17. Moving over VEA & SRCA Impairment Points to MRCA.

17.1 The provisions within the MRCA Consequential and Transitional Provisions Act 2004 (CTPA)[12] s13, MRCA s67, and GARP (M), Chapter 27, allows for the transferral of VEA Impairment Points. This facilitates for an aggravation or sign or symptom of an "old injury or disease" that has previously been accepted under VEA and/or SRCA, for the veteran to have access to MRCA under these conditions.

18. Incapacity Payments.

18.1 In context to the above arrangement is the previously mentioned case of the veteran who has separate NEL for non-MRCA conditions, along with a separate condition under the MRCA. It is emphasised that whilst it is acknowledged that the moving over of VEA & SRCA Impairment Points to MRCA will not be possible, the beneficial approach is to have the veteran have EL carried over to MRCA, therefore eligibility for MRCA IP if the veteran cannot work, is in transition for the 45 weeks post discharge, or provided IP as a "top-up" for EL due to lower earning capacity.

18.2 Previous experience with a C4 quadric-pelagic veteran who had eligibility under the MRCA, who exceeded his 45 weeks of Incapacity Payment, was reduced to 75% of his IP. This was decided without the veteran having PI or even an Interim payment of PI, within s75 (Interim Compensation).

18.3 The situation of the C4 quadric-pelagic veteran is unacceptable as he is left on 75% of a Private's salary, without compensation being paid in the form of PI. It is obvious that he would need income to sustain a standard of living, placing the veteran into financial hardship, until stabilisation.

18.4 Therefore, it is strongly recommended that the Act (MRCA) is amended to have such cases to have the extension of the 100% of salary under IP past the 45 weeks, until payment of PI, in order to provide a suitable standard of living that the veteran has been previously provided.

19. Incapacity Payments for age 67.

19.1 Incapacity Payments (IP), both under SRCA and MRCA, should also include the recently announced retirement date by the Government in the 2009 Budget as being aged 67 on 2017. This consideration must be legislated prior to implementation of the Government's plan of the extended retirement age for recipients of IP.

[12] MRCA CTPA No. 52, 2004.

20. Other Allowances.

20.1 Within the 2009 Budget, the Rudd Government rolled into ISS (WSP for those veterans with QS), allowances such as Pharmaceutical Allowance and Telephone Allowance. Within s300 (Pharmaceutical Allowance); s221 & 245 (Telephone Allowance) of the MRCA, this is a separate entitlement, of which it is felt this remains the status quo.

20.2 It is noted that the 09/10 Budget provided a boost to veterans, pensioners and war widows in receipt of ISS, WSP, of up to $32.49 a week. Couples on these pensions will receive up to an extra $10.14 combined per week. The conditions are to be additional to the normal indexation and will be in effect 20 September 2009.

20.3 However, further Legislative review on the subject appears to be needed in order to not provide confusion over the Budget change within the Allowances provided under MRCA. This is also applicable to veterans under DFISA (VEA Part VIIAB).

21. Treatment.

21.1 It is contended that treatment is made available to veterans of any service classification for any psychiatric treatment, particularly with Schizophrenia, Bi Polar disorder, and Obsessive Compulsive Disorder (OCD). This provides a wide ranging treatment for ADF veterans, and not exclusive in comparison to the current Treatment within s88A VEA and made available to a member or veteran, regardless of service type.

21.2 It is also contended that Treatment for Cancer is placed into the MRCA, as for VEA s88A and made available to a member or veteran, regardless of service type.

22. The Reconsideration and Review Processes.

22.1 The system needs to be streamlined into one process, by abolishing the status quo of the choice of two separate appeal systems within the MRCA, by a single simple system of Reconsideration (By the MRCC); Veteran Review Board (VRB); Administrative Appeal Tribunal (AAT); then to the Federal and High Court).

22.2 Include the VRB in the MRCA in the Review Process under VEA.[13] This includes time frames for s137 (VEA) documents; Procedures are simplified and not complicated; and an increased standard of documentation provided to Advocates.

22.3 The reason for the singular system is that the Reconsideration Process, similarly used as for SRCA, which uses the Reconsideration then the AAT (Post AAT is to the High and Federal Courts), does not provide in our opinion as a fair system of appeal.

[13] MRCA, Part 4, s352

22.4 Within the VEA approach or the approach within MRCA is to choose to utilise the Veteran Review Board (VRB) (s136 VEA). There may also be the opportunity for a Delegate of the MRCC to vary a given decision. In addition under s347 MRCA the MRCC may on its own initiative reconsider a decision of the Commission.

22.5 This is the preferred approach, in which the benefit to the veteran is the potential for resolution of the case, or utilise the VRB path (Review). This also provides ESOs involvement by providing the services of a competent MRCA Advocate.

22.6 The Reconsideration path also allows provision for s349 MRCA, however it is taken to a Reconsideration. Whilst it may be possible that some specific ESOs providing a competent MRCA Advocate would be capable of assisting a veteran through this reconsideration pathway.

22.7 But, there are ESOs that will influence an individual to utilise the services of a Solicitor. The Solicitor will charge at a rate that will cost the individual money, whereas specific capable and competent ESOs will provide the service free of cost. We therefore view the Reconsideration path as non-beneficial to a veteran or member as it may be cost intensive for an individual to use the services of a Solicitor. Of course there is the notation of "no win no fee", however early withdrawal will incur administration costs to the individual if they decide not to proceed or lose.

22.8 Failing the Reconsideration, the next step is the AAT (known in MRCA as the Tribunal (Chap 8, Part 5)). Again, ESOs have referred these cases onto Solicitors, which also at times requires the use of a Barrister. The cost therefore rises to the individual and if they are successful, the costs may be awarded to the plaintiff. If not successful, the claimant has to pay the Legal costs incurred and may be ordered to pay Departmental legal costs. This is a substantial amount of money to the individual.

22.9 The utilisation of the Reconsideration path poses an added complication toward the MRCA system, where we believe that the MRCA system and Legislation should be streamlined and easy to use for both the claimant and the Department (DVA or Defence in terms of MRCC Service Chiefs).

22.10 The recommended Appeal Pathway is therefore the VRB, Review method, as placed in Chapter 8, Part 4 of the MRCA, in order to provide the beneficial approach toward the veteran and/or member.

23. Recommendations of possible Legislative and Policy changes relating to MRCA.

23.1 Whilst most of the recommendations for Legislative changes are tabulated in the attached Annex A to this paper, other Legislative Changes are listed and recommended as outstanding matters within this Part.

23.2 Transitional Legislation needs to be reviewed as a result of some contentious issues that we have raised in the attached table of the Consequential Transition Provisions Act 2004 (CTPA), which is at Annex F to this paper. This is consistent with the approach of streamlining the multi-eligibility into the one Act.

23.3 Time lines legislated – Determinations under the Reasonable Hypothesis 3 months; Balance of Probability 6 months. PI within 45 weeks or continuation of 100% of the IP until Determination is made on the PI.

PART D.
The Veteran Entitlement Act 1986 (VEA).

24. VEA Intermediate Rate.

24.1 Within the VEA under s23 – Loss of Employment for Intermediate Rate, if a person undertakes or is capable of undertaking work for 50 per centum or more of the time (excluding overtime) ordinarily worked by persons engaged in that kind on a full time basis; or in a case if this is not applicable to the work the veteran is undertaking, or capable of undertaking – if the veteran is undertaking or is capable of undertaking that work for 20 or more hours per week, meeting the criteria within s23 may be eligible for the Intermediate Rate of Pension (IR).

24.2 The interpretation is therefore that a person must reduce their hours due to their incapacity to less than that of a standard working week, which according to normal workplace practice and also noted within the MRCA is 37 ½ hours per week. If using the 50 per centum within the IR criteria, then the working week would be reduced in this case to 18 ¾ hours per week. This is below the 20 hours as within VEA s23(2)(b).

24.3 The solution that is available to this problem would be that the 50 per centum criteria applied to the normal workplace be removed and solely relied on s23(2)(b) which has the veteran working 20 hours or less per week.

24.4 The second solution could be that s23(2)(a) be upheld and that Income Support (IS) be provided to assist in maintaining the veterans' income and standard of living. This is inclusive of those with QS and non-QS veterans.

24.5 We contend that the solution is to stipulate that the veteran is able to receive IR, with the potential to work up to 20 hours per week. In addition, we believe that the inclusion of Income Support is required, in order to maintain the veterans' income and standard of living, without detriment.

24.6 Hours for work per week for Intermediate Rate are no longer half, or 20 hours per week. This has caused a great deal of concern over this matter, particularly toward Intermediate Rate of Pension for those Young Veterans who want to remain in the work force.

24.7 This forces the individual to seek the beneficial approach, of which no choice is left, but to apply for increase to the Special Rate of pension.

24.8 Further consideration is also made toward a veteran who is employed 20 or less hours per week, may not necessarily meet the previously enjoyed standard of living. The part-time salary may not necessarily place the veteran into the desired financial standard. Therefore, it has been noted that the young veteran requires Income Support Supplement (ISS) to assist in making ends meet. This is crucial, particularly if the veteran is raising a family.

24.9 There is a necessity for ISS as employment income may not be adequate in terms of supporting a veteran. It is understood that DVA had previously provided WSP to Intermediate Rate veterans in the last decade. It is understood that this was removed.

24.10 The consequences of not providing a top-up of income to Intermediate pensioners places a large amount of stress in terms of younger veteran issues, particularly when the veteran has a family. In turn, this places a disadvantage toward the Intermediate Rate veteran, particularly in terms of supporting their family.

24.11 It is strongly recommended that the MRCA Review Committee review this situation, in order to allow the ongoing benefits of the Intermediate Rate vis-a-vis Special Rate.

25. VEA Special Rate.

25.1 Within the VEA s24 – Loss of Employment for Special Rate – Change 8 hours per week to 10 hours per week, consistent with MRCA and SRDP (s204), although SRDP in this paper has been recommended to be revoked as an ineffective modern compensation package. The increase of 8 hours to 10 hours per week, allows a degree of diversity for the veteran in terms of flexible part time employment.

26. The Wright Case during proceedings in the Federal Court.

26.1 The Wright Case is of a grave concern to this Association in terms of cessation of work for access to the Intermediate Rate under VEA s23 and access to the Special Rate under s24.

26.2 Simply put, the use of the Wright decision by Delegates is having an effect on young veterans in terms of seeking the Intermediate Rate, with the potential to work up to 20 hours per week. We have specific permission from Mr Michael Finnerty to use his paper that was sent to the Prime Minister's Advisory Council (PMAC), and we wish to acknowledge his authorship and our support is also extended in the strongest possible terms toward the Wright Case. The Wright Case Paper is attached at Annex G. It is put to the MRCA Review Committee that this Annex is given consideration as to the impact that the current situation of the Wright case has on other veterans.

27. VEA Home Services.

27.1 The VEA is a veteran beneficial Act, however the Home Services and Gardening Services (and/or assistance) is not inline with the generous services provided within SRCA & MRCA. Therefore, it is contended that VEA Home Services is made equivalent in value to SRCA & MRCA.

28. The Application of the Reasonable Hypothesis.

28.1 Wider understanding of PKO, Modern Military Operations, Historical data, which sometimes places a non-perspective to Delegates of the hardships encountered. It appears that Historians do in fact get the information incorrect and this therefore places a degree of prejudice toward the credibility of the claimant. (Dunt).

28.2 The Application of the Reasonable Hypothesis does not appear to be used toward warlike service and non-warlike service, in terms of determinations made by delegates. This matter is also inclusive of MRCA eligibility of warlike and non-warlike service.

28.3 We therefore contend that the Department needs to provide a greater understanding and application of the Reasonable Hypothesis when investigating claims.

29. Criminal Offences.

29.1 VEA s9(3) a & b. Criminal Offence – removed for those who have committed offences within the ADF who have used masking agents (alcohol and drug abuse) with self-management of Psychosis or have injured themselves as a result of their psychosis and/or operational stress.

29.2 We contend that the services of the Veteran and Veterans' Families Counselling Service (VVCS) allows access for Peacetime ex-serving members.

29.3 The Rationale to this contention is that there have been a reasonable number of ex-ADF members, who do not hold warlike or non-warlike service. Examples of this is classified peacetime service operations, which has included the Indian Ocean Tsunami disaster was classified only as normal peacetime service. A number of former ADF members who have since left the ADF, have developed mental illness as a result of what they witnessed and were therefore horrified.

29.4 Other areas of peacetime service should also allow for those who have been depressed as a result of being medically discharged (losing their primary career), bullying, or have witnessed range accidents with weapons and armoured vehicles etc.

30. The Veteran Supplement.

30.1 As a result of the 2009 Budget, the Veteran Supplement provides for Telephone Allowance, Utilities Allowance and Pharmaceutical Allowance to be rolled into a given Veteran Supplement. This provides for increased effect toward the WSP for those veterans with QS.

30.2 It has also been noted that this provides as a supplement of its own for those veterans who do not have QS, as a result of being TPI under the age of 60; unable to work more than 8 hours per week and/or are granted Special Rate of pension.

30.3 Normally within non-QS TPI veterans, the Telephone Allowance, Utilities Allowance and Pharmaceutical Allowance are available as separately paid periodical allowances according to the previous VEA Legislation.

30.4 Taking into consideration the difficulties of veterans going to Centrelink for DSP, which in turn may provide DFISA, it is strongly suggested that the Veteran Supplement is used in the case of non-QS TPI veterans to have DFISA, Telephone Allowance, Utilities Allowance and Pharmaceutical Allowances rolled into the one Veteran Supplement.

30.5 This is thought to provide a streamlined and simple system for non-QS veterans on TPI, or those who are unable to work 8 hours per week. DFISA **must** be removed from Centrelink and the processing of the DFISA applications be made directly to the Department (DVA).

31. TTI Veteran Income Support.

31.1 That Temporary Totally Incapacitated (TTI) veterans have access to War Service Pension (WSP), who has Qualifying Service (QS), as an Income Support Supplement (ISS), due to the financial hardships faced by Younger Veterans, particularly when the veteran is the primary income winner and the partner is the primary Carer.

31.2 Currently, a veteran who is in receipt of the Intermediate and TTI rates of pensions do not have access to Income Support from the Department of Veterans' Affairs. This is particularly critical if the veteran is not in receipt of COMSUPER or any supporting income.

31.3 Although TTI is at the Special Rate of pension, this amount on its own is not enough to support a Young Veteran, his/her family and the cost of living. Therefore Income Support is needed to help meet the costs of living.

31.4 Intermediate Rate pensioners were once able to obtain service Pension/Income Support from the Department, however this was reduced from 20hrs per week to 8 hrs per week some years ago. Intermediate Rate pensioners need this Income Support to supplement their remunerative work income of 20 hrs work per week. It is also a good incentive to provide a Young Veteran for not opting for TPI, due to financial pressures.

PART E
Safety, Rehabilitation & Compensation Act 1988 (SRCA) Matters.

32. Free Treatment.

32.1 Access to VVCS and provision of free treatment for Psychiatric and Anxiety and Depression is treated under *s88(a)(1), Determination 2000/1, dated 1 July 2000.* We contend that as an early intervention strategy to prevent the worsening of the condition, particularly if not chronic, that permanent impairment may be avoided by early treatment.

32.2 Treatment for Cancer under the SRCA. From between 6 April 1994 to 30 June 2004, if not covered under the VEA or MRCA, a former member of the ADF who served during this period does not have the provisions to this treatment as per their fellow service persons.

32.3 We submit that a commonality must be introduced toward such treatment for those who have served this country in what is viewed by the Australian Public as an honourable role. The sacrifices made in peacetime service are at times just as much as those who are deployed overseas. Therefore equality in treatment for cancers, access to VVCS and psychiatric conditions for SRCA eligible members should be provided.

33. Wilful Actions.

33.1 The removal of *s14 (Compensation for Injuries), (2) Compensation is not payable in respect of an injury that is intentionally self-inflicted. (3) Compensation is not payable in respect of an injury that is caused by the serious and wilful misconduct of the employee but is not intentionally self-inflicted, unless the injury results in death, or serious and permanent impairment.*

33.2 The reason for the above removal contention is that veterans who are suffering from service caused Mental Illness may in fact conduct self-harm. Within the sphere of Mental Illness, it is viewed as a reasonable expectation that some psychiatric patients may revert toward self-harm. If this is the case, then it must be reviewed as a Sequela medical condition for such self-harm inflicted medical conditions.

34. Removal of Whole Person Impairment (WPI) Threshold.

34. Removal of thresholds WPI for Hearing (5%) and 10%, in order to allow for access to full compensation entitlement for WPI. Further clarification of this matter is attached at Annex H. It is put to the MRCA Review Committee consider the recommendations within this Annex.

35. Stabilisation of a Claim for PI.

35.1 ADF member medically discharged due to service related or caused illness or injuries, to be deemed as stabilised, due to the amount of Rehabilitation that is undertaken

within the ADF Rehabilitation Program (ADFRP). Therefore the condition, along with the specialist's comments should be sufficient enough to warrant stabilisation of the illness or injury. That the medical reports from the Member's Medical File are taken into consideration and are used by Medico-Legal Assessors.

35.2 Stabilisation definition as per Stedman's: ***The accomplishment of a stable state***.[14] There appears to be conflicting definitions within Delegates by the interpretation of the Act (SRCA) of the stabilisation of a given condition, prior to assessment for Permanent Impairment (PI).

35.3 If a condition is considered permanent, then the former member is not forced into providing a Medical Certificate in order to receive IP. This is also contended to be the same if the member is in receipt of Class A Invalidity Pension from DFRDB and/or MSBS.

36. Non-Economic Loss Forms.

36.1 NEL Forms are at times not completed by the veteran but by a Medico-Legal Assessor, without the member's consent and/or agreement. It should be clearly emphasised that the Veteran must have interactive input into this assessment. Cases have been discovered where the NEL form was not sent to the member and subsequently non-awareness of the NEL Form of that member, which was discretely completed by the SRCA Medico-Legal officer.

36.2 The NEL Form process must allow the veteran to view the form, complete the form as to they see fit, with guidance from an ESO accredited practitioner. DVA or SRCA Delegates need to be made aware of this matter and inclusive involvement of the member and his/her appointed representative should be a part of the process.

37. Incapacity Payments (IP)

37.1 The provision of 45 Weeks for Full (100% of Salary of the ADF member at the time of Medical Discharge), should be consistent with the MRCA Legislation, of which regardless of the amount of Sick Leave or Convalescence Leave taken whilst in service, particularly for treatment and rehabilitation, there is no detriment to the member post medical discharge.

37.2 For example if a former ADF member has had 20 weeks Sick Leave prior to Discharge, this is not used to penalise the former member with only providing 25 weeks of full IP. This is a serious disadvantage to the service person.

[14] http://www.stedmans.com/section.cfm/45 Website for Stedman's On-line Dictionary.

38. Remove the 5% Superannuation Penalty for Incapacity Payments (IP):

Definition:

superannuation amount, in relation to a pension received by an employee in respect of a week, or a lump sum benefit received by an employee, being a pension or benefit under a superannuation scheme, means an amount equal to:

(a) if the scheme identifies a part of the pension or lump sum as attributable to the contributions made under the scheme by the Commonwealth, Commonwealth authority or licensed corporation—the amount of that part; or

(b) in any other case—the amount assessed by the relevant authority to be the part of the pension or lump sum that is so attributable or, if such an assessment cannot be made, the amount of the pension received by the employee in respect of that week or the amount of the lump sum, as the case requires.[15]

Division 3—Injuries resulting in incapacity for work

SRCA s20 Compensation for injuries resulting in incapacity where employee is in receipt of a superannuation pension

(1) Compensation payable to an employee who is incapacitated for work as a result of an injury is determined in accordance with this section if:

(a) the employee is retired from his or her employment (whether the employee retired voluntarily or was compulsorily retired); and

(b) the employee receives a pension under a superannuation scheme as a result of the employee's retirement.

(2) Comcare is liable to pay compensation to the employee, in respect of the injury, in accordance with this section for each week after the date of the retirement during which the employee is incapacitated.

(3) The amount of compensation is the amount worked out using this formula:

$$\text{Amount of compensation} - \left(\text{Superannuation amount} + \text{5\% of the employee's normal weekly earnings} \right)$$

where:

amount of compensation means the amount of compensation that would have been payable to the employee for a week if:

(a) section 19, other than subsection 19(6), had applied to the employee; and

(b) in the case of an employee who was not a member of the Defence Force immediately before retirement—the week were a week referred to in subsection 19(3).

(4) In using the formula in subsection (3) to calculate an amount of compensation for an employee who retired before the day on which item 22 of Schedule 1 to the *Safety, Rehabilitation and Compensation and Other Legislation Amendment Act 2007*

[15] SRCA s4(1).

commenced, use "SC" instead of "5% of the employee's normal weekly earnings". For this purpose:

SC means the amount of superannuation contributions that the employee would have been required to pay in that week if he or she were still contributing to the superannuation scheme.

SRCA s21 Compensation for injuries resulting in incapacity where employee is in receipt of a lump sum benefit

(1) Compensation payable to an employee who is incapacitated for work as a result of an injury is determined in accordance with this section if:

(a) the employee is retired from his or her employment (whether the employee retired voluntarily or was compulsorily retired); and

(b) the employee receives a lump sum benefit under a superannuation scheme as a result of the employee's retirement.

(2) Comcare is liable to pay compensation to the employee, in respect of the injury, in accordance with this section for each week after the date of the retirement during which the employee is incapacitated.

(3) The amount of compensation is the amount worked out using this formula:

$$\text{Amount of compensation} - \left(\text{Weekly interest on the lump sum} + \text{5\% of the employee's normal weekly earnings} \right)$$

where:

amount of compensation means the amount of compensation that would have been payable to the employee for a week if:

(a) section 19, other than subsection 19(6), had applied to the employee; and

(b) in the case of an employee who was not a member of the Defence Force immediately before retirement—the week were a week referred to in subsection 19(3).

weekly interest on the lump sum means the amount worked out by:

(a) multiplying the superannuation amount in relation to the lump sum benefit received by the employee by the rate specified in an instrument made under subsection (5); and

(b) dividing the result of paragraph (a) by 52.

(4) In using the formula in subsection (3) to calculate an amount of compensation for an employee who retired before the day on which item 22 of Schedule 1 to the *Safety, Rehabilitation and Compensation and Other Legislation Amendment Act 2007* commenced, use "SC" instead of "5% of the employee's normal weekly earnings". For this purpose:

SC means the amount of superannuation contributions that the employee would have been required to pay in that week if he or she were still contributing to the superannuation scheme.

(5) For the purposes of the definition of ***weekly interest on the lump sum*** in subsection (3) of this section and subsection 21A(3), the Minister may, by legislative instrument, specify a rate that applies for the period of 12 months commencing on 1 July in any year.

SRCA s21A Compensation for injuries resulting in incapacity if employee is in receipt of a superannuation pension and a lump sum benefit

(1) Compensation payable to an employee who is incapacitated for work as a result of an injury is determined in accordance with this section if:

(a) the employee is retired from his or her employment (whether the employee retired voluntarily or was compulsorily retired); and

(b) the employee receives:

(i) a pension; and

(ii) a lump sum benefit;

under a superannuation scheme as a result of the employee's retirement.

(2) Comcare is liable to pay compensation to the employee, in respect of the injury, in accordance with this section for each week after the date of the retirement during which the employee is incapacitated.

(3) The amount of compensation is the amount worked out using this formula:

$$\text{Amount of compensation} - \left(\begin{array}{c} \text{Superannuation amount in relation to the pension} \\ + \\ \text{Weekly interest on the lump sum} \\ + \\ \text{5\% of the employee's normal weekly earnings} \end{array} \right)$$

where:

amount of compensation means the amount of compensation that would have been payable to the employee for the relevant week if:

(a) section 19, other than subsection 19(6), had applied to the employee; and

(b) in the case of an employee who was not a member of the Defence Force immediately before retirement—the relevant week were a week referred to in subsection 19(3).

superannuation amount in relation to the pension means the superannuation amount in relation to the pension received by the employee in respect of the relevant week.

weekly interest on the lump sum means the amount worked out by:

(a) multiplying the superannuation amount in relation to the lump sum benefit received by the employee by the rate specified in an instrument made under subsection 21(5); and

(b) dividing the result of paragraph (a) by 52.

(4) In using the formula in subsection (3) to calculate an amount of compensation for an employee who retired before the day on which item 22 of Schedule 1 to the *Safety, Rehabilitation and Compensation and Other Legislation Amendment Act 2007* commenced, use "SC" instead of "5% of the employee's normal weekly earnings". For this purpose:

SC means the amount of superannuation contributions that the employee would have been required to pay in that week if he or she were still contributing to the superannuation scheme.

39. Superannuation Contention.

39.1 During service, the member is forced to be a contributor to COMSUPER, either the Defence Force Retirement and Death Benefit Fund (DFRDB) and/or the Military Superannuation Benefits Scheme (MSBS). Each is a Legislated Act and is not compensation. See Annex C to this submission for further information.

39.2 Defence members contribute various percentages of their salaries toward their superannuation, along with the inclusion from the Department of Defence of Employer contributions and Productivity Benefits. Normally, superannuation is not available to a person until they reach the Notional Retirement Age or National Retirement Age statuaries.

39.3 If the member is in receipt of Invalidity pension from COMSUPER, regardless of classification (Class A, B or C), this money is the member's superannuation and should therefore be inalienable toward any inclusion into SRCA. SC within the meaning of SRCA, is therefore a matter of mystery as to why it is included into a compensation Act.

39.4 The view of the APPVA is that the member is a superannuation fund contributor and after retirement is the beneficiary of such superannuation. We therefore contend that the Superannuation Contributions, which reduces the IP by 5% is not consistent with modern compensation philosophy. Therefore the removal of s20, s21, and s21A is an imperative matter.

39.5 Additionally, within the Transitional Provisions (CTPA) and SRCA, s20, s21 and s21A all penalise a retired or invalided member who holds SRCA eligibility toward compensation. The amount of IP is reduced, which is of detriment to the veteran. See Annex F, serials 009 through to 011.

40. Treatment Cards and Concessions.

40.1 The APPVA contends that Specified Treatment Entitlement Card (STEC) aka The "White Card" or "Gold Card" for all conditions is issued to the member under SRCA. If the member has satisfied the Seriously Incapacitated Adjustment (SIA), then the Gold Card is embossed with TPI. This provides for the member to have access to Concessions, consistent for those TPI veterans under the VEA.

40.2 Situations have developed, where the former member has arranged a bill paying method, which is billed directly to DVA under SRCA and the supplier/provider has refused to continue with this arrangement. The reason for this is the inordinate delay by the Department of Veterans' Affairs to pay the bill in a timely manner.

40.3 By utilising these cards, payment of Pharmaceuticals is used in place of the member paying upfront for medications. As stated in the MRCA Part, a Smart Card would alleviate such problematic areas.

40.4 As for Pharmaceutical matters mentioned above, the same approach be used for treatment, as the former member normally does not have the funds available to pay for treatment. This is consistent with the approaches within the VEA and MRCA.

40.5 Prior to the Election in November 2007, the "Smart Card" was proposed to rectify some of these anomalies and provide a simpler, smarter and streamlined system in order to provide billing and patient history. Apparently, this was rejected, as a result of Privacy Considerations. Whilst these concerns toward Privacy and Confidentiality are unknown, it is thought that cutting edge technology would be serving a complicated system of Specified Treatments, Pharmaceuticals, Allied Health Services and Specialist Health Services to a veteran.

40.6 It is noted that under the SRCA or elected MRCA by not having STEC or Gold Cards that the Australian Medical Association (AMA) practitioners would be more open toward surgery than if under VEA scheduling and costs (payments) for such treatment. In this case, it would appear that there are distinct benefits toward eligibility under the SRCA, however the problem remains with the billing and the expectation of the veteran to pay up-front costs, as most providers are reluctant to provide billing arrangements with the Department.

41. Booked Car With Driver (BCWD).

41.1 That SRCA pay Travel Allowance to those incapacitated members for treatment upfront. A case was brought to the APPVA's attention, where a former servicewoman was forced to obtain treatment for a psychiatric illness, or she would lose her IP entitlement. She was not capable of driving and was not within the 50km provision for reimbursement of costs.

41.2 She was forced to pay out of her own funds for a taxi to and from treatment as an Out-Patient at the Veteran Psychiatric Unit (VPU) at Repatriation General Hospital in Heidelberg, Victoria. The cost was considerable and the former servicewoman was very distressed over the matter, which did not help her psychiatric treatment.

41.3 However, the member concerned was eventually reimbursed her costs. The point to highlight is that the member normally does not have the money upfront to pay for taxi-cabs to take them to treatment which may be a reasonable distance. The VEA utilises the BCWD system, and it should therefore be consistent that BCWD be provided to eligible SRCA clients.

PART F.
VEA & SRCA

42. VEA & SRCA Offsetting:

42.1 Within VEA s25A, offsetting certain SRCA payments states that the section applies to s23, s24, and 25 VEA. This means that if a veteran has separated conditions under the VEA, differing those conditions to that under the SRCA, there will be offsetting provisions. This is believed to have been implemented after the introduction of MRCA on or after 1 July 2004.

42.2 Within s15 of MRCA CTPA, there is no dual entitlement for similar entitlements. Therefore, separate conditions under the two Acts (VEA and SRCA), as previously the case prior to the implementation of MRCA and CTPA. As noted, the principle behind compensation offsetting is that a person should not be compensated twice for the same incapacity.

42.3 The offsetting regardless of acceptance under the VEA/SRCA, which a claim may be accepted under SRCA and a claim for a differing condition under VEA, should remain inalienable and not offset against each other. This is also the case for what we believe to be under MRCA.

42.4 We contend that different conditions accepted under like or different Acts, should have no offsetting provisions applied.

43. Offsetting of VEA Pensions and SRCA Lump Sums for same conditions.

43.1 That the VEA & SRCA Offsetting is not used in the sense of outliving the actuarial life expectancy at the time. Therefore, if the veteran has a reduced VEA pension as a result of a Permanent Impairment (PI) Lump Sum payment under the SRCA (The same condition claimed under both Acts), and outlives his or her expected life age expectancy, then the reduction to the VEA Pension should therefore cease, as it is considered that the offsetting component has been completed.

43.2 Further contention toward this matter, please refer to CTPA anomalies, Annex F, Serial 008. It is requested that the MRCA Review Committee consider the content and Recommendations made within this Table.

44. Offsetting provisions of the Military Rehabilitation & Compensation Service (MCRS)

44.1 The APPVA submitted a paper to the Foreign Affairs, Defence and Trade Senate Inquiry into aspects of the Veterans' Entitlement Act 1986 and the Military Compensation Service (MCS), in June 2003. This Inquiry was to investigate and make recommendations to the Government as to any problematic areas in relation to the offsetting arrangements between SRCA and the VEA, inclusive of the MCRS and

Defence Determination 2000/1.[16]

44.2 Whilst the document is over six years old, the principles of the contentions toward the Offsetting Provisions within the MCRS are extent. The amounts given in this paper are based on those that were available in June 2003. This also does not include taxation changes, which may affect the accuracy of the paper.

44.3 A paper on this matter is attached at Annex I. It is suggested that the content and recommendations made within this paper are taken into consideration by the MRCA Review Committee.

44.4 The Senate Inquiry looked into the various matters toward the Offsetting of VEA & Military Compensation Service (MCS), and was registered within the Senate papers as 1997 dated 18 September 2003. A Government Response was provided on 10 March 2005 under PP No: 200/03.

44.5 Whilst the Government deliberated on the findings of the Senate Inquiry for 18 months, the Response and any recommendations appears not to be located within Parl Info Library via the APH website. It would be advantageous to have the Report and the Government Response provided to ESO and the Committee, in order to investigate the recommendations of the Senate FADT Committee and the Government Response and contextualise the Report Recommendations and Response in terms of the operations of Offsetting VEA and MCS in its current operations.

[16] We have reviewed the Defence Determination 2000/1, and found no apparent anomalies.

PART G
Australian Federal Police Compensation.

TOR: Consider the suitability of access to military compensation schemes for members of the Australian Federal Police who have been deployed overseas.

45. General.

45.1 It is the view of the APPVA, that the Australian Federal Police (AFP), particularly those who have served with the International Deployment Group (IDG), has a special place within Veterans' Entitlements and Compensation. The definition for a member of the AFP/IDG also includes State and Territory Police Officers seconded to the AFP as "special members" of the AFP.

45.1.1 The inclusion of AFP into Police overseas operations,[17] particularly with UN Peacekeeping Operations (PKO), is unique, in that a development of International Relations, Humanitarian Development and Nation Building is now inclusive of not only the ADF, Aus Aid (or other Australian Government Aid agencies), but also Non-Government Organisations (NGO).[18]

45.1.2 Such dynamic development since 1964 has seen a large number of Police deployed on PKO and being posted on overseas service. This places AFP IDG into a unique position, not previously experienced by any Conflict or war. They serve in many instances side-by-side with the Military components of UN PKO and other operations, for example the operation in Timor Leste from May 2006 to the present.

46. Police eligibility for COMCARE (SRCA).

46.1 Consideration toward the development of an 'enhanced' scheme under the COMCARE (SRCA), is believed that it will further complicate an already complex Compensation system within the Department (DVA) and a more simpler, robust and streamlined approach is needed in order to reduce staff times taken to process, along with what is believed to be an unnecessary implementation of yet another Act or amendment thereof, that the Department is burdened.[19]

46.2 The SRCA places the Burden of Proof back onto the claimant, within the Balance of Probabilities. Therefore the Burden of Proof is more difficult to prove when Police

[17] It is estimated that over 4,000 Police have deployed on PKO, with AFP IDG maintaining 375 personnel at any given time on operations overseas (APPVA PKO Table Dec 2008).
[18] It is acknowledged that the International Red Cross (IRC) was actively involved in assisting refugees and servicemen of war in WWI, WWII and other projects during the South Viet Nam War.
[19] Please note the comments on Average Staffing Levels (ASL) within DVA and the TTTP for MRCA Claims, s2.11 to this submission.

veterans are deployed. This is most notable when documentation and medical treatment is conducted by other countries within a multinational force or United Nations Operation, where it has been experienced that little or no medical evidence exists. Therefore the Beneficial Approach toward the Reasonable Hypothesis should remain extant and available to AFP IDG members.

46.3 Therefore, this paper does not support an 'enhanced' version of the SRCA, as it is viewed as non-beneficial toward the APF or Police Peacekeepers, as was previously entitled within the VEA and further complicates matters in terms of veteran entitlement law.

47. Police entitlement to the VEA.

47.1 Prior to the introduction of the MRCA on and before 30 June 2004, either ADF and AFP members, or veterans were entitled under the VEA. This is consistent with the recognition of the hazards that Police Peacekeeping Operations present during deployment and the provision of the "Beneficial Approach" toward these veterans.

47.2 Of note was the death of IDG (Australian Protective Services (APS)) seconded member, Officer Adam Dunning on the 22nd December 2004, whilst serving with the Regional Assistance Mission to the Solomon Islands (RAMSI). After investigation into veteran entitlements, it was found that even post 1 July 2004, the member, who was within the classification of "Peacekeeping Service", was under Schedule 3 of the VEA. As a result of no dependants, the veteran's family were only provided with a plaque from the Office of Australian War Graves (OAWG), for his funeral. The father did not want any ex-gratia payment from the Commonwealth.

48. Development of Police Overseas Compensation Provisions.

48.1 There appears to be a great deal of confusion as to where the status quo is of veteran entitlements for IDG members post 1 July 2004. It was suggested by the previous Department Secretary, Mark Sullivan[20] that an Instrument had been passed for access by AFP IDG members to the MRCA. Further investigation and the request for referencing found that this has not been the case.

48.2 A great deal of confusion has therefore arisen as a result of the above, with representations by the APPVA, Australian Police Federation (AFP) by Mark Burgess and the Australian Federal Police Association (AFPA), to the previous and current Ministers for Veterans' Affairs. It appears that the AFP IDG is currently on the lesser or non-beneficial veteran entitlement or compensation, which is COMCARE (SRCA). This is simply inappropriate, for the dangers that Sworn Police Officers face daily in the field on a given Operation or, in some circumstances postings overseas.

48.2.1 The APPVA has had discussions with the PFA and AFPA and understand

[20] Stated by Mark Sullivan at the Repatriation Medical Authority ESO/DVA Forum in Canberra March 2008.

their desire to have an enhanced or dedicated Compensation system for AFP IDG who serve on Operations overseas, along with AFP Officers or seconded Police Officers, who are posted to a range of Agencies overseas in order to provide generous and beneficial compensation for those who may become injured, wounded, ill or killed during these duties.

48.2.2 The APPVA understands that this is a first option for the PFA and AFPA, with the second option being eligibility under MRCA. APPVA respects this approach, however we are focussed on the Military Compensation inclusion of AFP IDG and AFP members serving on operations and posting overseas.

48.2.3 A matter that has been noted through some discussions with the PFA and the Minister (Veterans' Affairs), is an indication that Senior Defence Officers will not welcome such inclusion into the MRCA. This appears to be at odds with the Administering body, which is DVA, who has administered and provided eligibility of the VEA for AFP IDG members since the Australian Police Contingent in 1964 to Cyprus (UNFICYP).[21]

49. Under-Classification of Police on PKO.

49.1 Of significance is that the AFP IDG has on a number of occasions, been under-classified in terms of equal classification with their ADF counterparts serving on operations within the same Area of Operations (AO), or Theatre of conflict. For example, Police Contingent officers serving in Cambodia during 1992-1993, of which their service was classified as "Peacekeeping Service" within Schedule 3 of the VEA; whereas the ADF in Cambodia were classified as Allotted to Duty for Operational Service (Warlike Service), within Schedule 2 of the VEA. The same situation exists today with AFP IDG members posted to Afghanistan.

49.2 The above presents a distinct disadvantage toward AFP IDG members who have been serving on various operations in comparison toward ADF members with conflicting or differing classifications of service.

50. Police eligibility toward MRCA.

50.1 It is presented to the Review Committee that the most appropriate approach toward compensation for ADF IDG members is to have access to the MRCA, of which it is strongly suggested that the Military Rehabilitation Compensation Commissioner (MRCC), in terms of Rehabilitation and classification of service for various IDG operations is the responsibility of the AFP Commissioner, or the Minister responsible for the AFP.

[21] UNFICYP = The United Nations Force in Cyprus, which was raised in 1964. This is thought to be the world's first inclusion of Police Officers to be deployed to such a Peacekeeping Operation. UN Police are known as UN Civilian Police or UNCIVPOL on UN PKO.

50.2 The Commissioner, Australian Federal Police, (MRCC), may have the responsibility for recommending to the Minister responsible for the AFP, in consultation with the Minister for Veterans' Affairs being the Minister responsible for the MRCA, any overseas deployment that meets the definition of *'extraordinary overseas policing'* (viewed as MRCA definition as warlike service) or *'overseas policing'* deployment (viewed as MRCA definition as non-warlike service); and overseas postings, attachments or other service that is not within the auspices of warlike or non-warlike service (viewed as MRCA definition as Peacetime Service).[22]

50.3 The classifications of operations are recommended to be commensurate to those ADF members who are classified for "Warlike Service" is the same for IDG "high-risk" (extraordinary service) overseas operations which are interpreted as "Warlike Service" for the purposes of veteran entitlements within the MRCA for AFP IDG Members.

50.4 A similar approach toward AFP IDG Peacekeeping service or Overseas operations that are deemed as "overseas policing", be commensurate to that of the ADF for the purposes of the MRCA to be classified as "Non-warlike Service."

50.5 In terms of Peacetime service, which is available to ADF members who serve within Australia; or who are posted overseas to various exchange programs; Defence Cooperation Program (DCP) and Defence Attaché postings: are also made available toward AFP serving on overseas postings or operations that may not necessarily meet the requirement for warlike or non-warlike service.

50.6 Hence, in terms of Peacetime service a generous and beneficial compensation system is made available for AFP and/or IDG personnel posted overseas on various activities, such as advisors in policing in various countries, or even whilst on duty overseas for any purpose aside from warlike and/or non-warlike service.

51. Conclusion to Police Eligibility.

51.1 In conclusion, it is strongly recommended that a simple instrument or amendment is made to the MRCA within the Interpretations (s4) that allows for AFP and/or IDG members access to a beneficial veteran entitlement Act. This simplifies and streamlines the outstanding requirements that have been previously highlighted by the APPVA, PFA and AFPA.

[22] Revised eextract from the PFA Proposed Policy to the Minister of Veterans' Affairs, UN Police Association of Australia "True Blue" p.16, Autumn edition.

Annexes:

A. The Australian Peacekeeper & Peacemaker Veterans' Association, Response to the Military Rehabilitation and Compensation Act 2004 and Military Compensation Review June 2009.

B. Case Studies of MRCA Operations.

C. Special Rate Disability Pension Offsetting against COMSUPER Pensions.

D. Defence Instructions General (Personnel) 16-15, Military Employment Categorisation; Deferment of Medical Termination Action, paragraphs 52-54.

E. Problems Within the Army when Injured Soldiers Discharge or are Medically Discharged by Warrant Officer Class One Michael Quinn.

F. Table of the Consequential Transitions and Provisions Act 2004.

G. The Wright Decision Paper by Mr Michael Finnerty.

H. COMCARE Submission by Paul Copeland.

I. Offsetting aspects of the *Veterans' Entitlement Act 1986* and the *Military Compensation & Rehabilitation Scheme (MCRS).*

The Australian Peacekeeper & Peacemaker Veterans' Association.
Response to the Military Rehabilitation and Compensation Act 2004
and Military Compensation Review.
June 2009.

Serial	Reference	Item Description	Matter of Contention.	Remarks & Recommendations.
001	Chap 1 – Introduction, Section 5, Definitions p.7.	s5 (Definitions) ***disease***. Namely within disease sub-para (c), "but does not include:" (c) the aggravation of such an ailment, disorder, defect or morbid condition; or (d) a temporary departure from: (i) the normal physiological state; or (ii) the accepted ranges of physiological or biochemical measures; that results from normal physiological stress (for example, the effect of exercise on blood pressure) or the temporary effect of extraneous agents (for example, the effect of alcohol on blood cholesterol levels).	This definition suggests that compensation for a disease will not include aggravation of ailments, disorder, defence or morbid condition; or temporary departure from the normal physiological state etc (s5 ***disease,*** *(c) & (d) inclusive).* At this point within the definition, it is interpreted that the Act (MRCA) will not provide for treatment, rehabilitation, compensation or death to an ADF member who suffers from various physiological conditions that may be service related and additionally, be aggravated or intensified as a result of service.	An example of this is if an ADF member has a high cholesterol reading and is advised to diet and exercise, by the ADF doctor. This ADF member complies with this plan however suffers a massive heart attack whilst exercising, in order to not only retain the Service fitness Standard, but to also improve his/her physiological condition. Alcohol is also a masking agent for stress and psychiatric illness. The interpretation from this definition within s5 appears to implicate that such a situation would not be covered under the Act (MRCA). This requires removal and revocation.

002	Chap 1, Section 5, Definitions, p. 13.	Definition inclusion.	**Insert** "***Veteran*"** and describe as either a member or former member of the ADF.	Consistent with the Veterans' Entitlement Act 1986 (VEA), s5c (1).
003	Chap 1, s 14, p. 18 *(s204(5)&(6))*	Definition of Commonwealth Superannuation scheme for a person who has chosen a Special Rate Disability Pension (SRDP).	Requires removal, toward SRDP.	Revoke this section.
004	Chap 2 – Accepting liability for service injuries, diseases and deaths; Part 2 – When the Commission must accept liability for service injuries, diseases and deaths, s25	Limited effect of acceptance of liability. The Commission's acceptance of liability for an injury, disease or death only has effect for the purposes of this Act.	The note states: "This means that a person cannot rely on the Commission's acceptance of liability for an injury, disease or death in a common law action against the Commonwealth.	Note – Question of Law?
005	Chap 2, Part 4, s 31 p.34	Simplified outline of this Part – (a) Serious Defaults. (b) Reasonable Counselling (d) Travel during Peacetime Service. (e) Tobacco Products.	Previously not a restriction within the VEA, with the exception of Tobacco products (explained later). Sub-sections (a), (b) and (e) are previously allowed within the Statement of Principles of the RMA.	No-smoking allowed within the SRCA, however the SRCA is considered not to be the beneficial approach in a number of contexts. Revoke this section.

006	Chap 2 Part 4, s32 (entirety)	Exclusions relating to serious defaults or wilful acts etc.	Serious breaches of discipline, injury was self-inflicted and injury or disease may be attributed toward outbursts of anger, violence, drug or alcohol abuse, cause disruption in the workplace and potential self-harm and damage to property. These may incur charges as serious defaults or wilful acts within the Defence Force Disciplinary Act 1982 (DFDA). This is considered to be out of context in terms of service caused or service related conditions, of which the ADF has strict discipline code of which there is no room for members with psychiatric illnesses or symptoms.	Refer to the DSM IV for psychiatric diagnostic protocols; GARP M (GARP V under VEA); Clinician Administered PTSD Scale (CAPS) Assessment, or Davidson's Interview for PTSD. It is believed that breaches of discipline may cause injury to the veteran if ordered to participate in physical punishment. Self-inflicted injury or disease as a result of drugs or alcohol should be considered as a problem masking a psychological condition of the veteran. In particular should the veteran decide to attempt or has committed suicide due to psychosis. Therefore in these circumstances the veteran could well have contracted an injury or disease as a result of his/her service. Revoke this section.

007	Chap 2 Part 4, s33,	Exclusions relating to reasonable counselling about performance	Depressive Disorder SOP within a Category 2 Stressor (28 of 2008) is referred over to the next column. This description of sound scientific-medical evidence in itself presents that s33 is wrong in law and context. In a range of psychiatric SOP, the member may become isolated, fatigued and have effects of occupation. Therefore, exclusions relating to reasonable counselling about performance may in fact aggregate a condition due to excessive worry and pressure within the workplace. In addition, it is been known that counselling in relation to workplace performance normally happens twice per year, within the ADF and if there is a personality clash between the counsellor (superior officer) and the member (in the subordinate), this has had cause to affect the latter into an aggravated state if suffering a given psychosis.	(c) having concerns in the work or school environment including: on-going disharmony with fellow work or school colleagues, perceived lack of social support within the work or school environment, perceived lack of control over tasks performed and stressful work loads, or experiencing bullying in the workplace or school environment; (d) experiencing serious legal issues including: being detained or held in custody, on-going involvement with the police concerning violations of the law, or court appearances associated with personal legal problems; and (e) having severe financial hardship including: loss of employment, long periods of unemployment, foreclosure on a property, or bankruptcy. Under SRCA, a Specialist may deem the member to have had a significant reaction toward reasonable counselling, particularly if the person is suffering psychosis, the superior officer is sceptical of the illness and that the poor work performance is due to psychosis for any mental illness. Revoke this section. Therefore, this exclusion is deemed to be

				abolished as it does not match precedents in previous Acts (VEA & SRCA). It is restrictive and is actually discriminative action toward securing acceptance of Commonwealth Liability under the Australian Federal *Disability Discrimination Act 1992.*
008	Chap 2, Part 4, s35	Exclusions relating to Travel.	Discussion within s35 in relation to Substantial delay commencing a journey, substantial interruptions to journey etc, may be from a number of reasons that are not the intention of deceiving, or intending to fraud. The reasons for these cases are varied and must be taken into consideration, without an automated indication of fraud or deception. This section requires further explanatory inclusion into the Act.	There have been service members who have had long-haul flights (Overseas) to and from posting, who have suffered Deep Vain Thrombosis (DVT); Pulmonary Embolus; back problems and inhaled diseases such as the common flu. In today's climate of Terrorism around the world, flights may also be delayed due to such threats. Other areas are car troubles when travelling to and from duty. These scenarios need to be placed into a fair and reasonable system of natural justice and procedural fairness. Understandably, there have been cases in the past where a person may have consumed alcohol on base prior to departing on leave to a nominated location. This contention does not support the latter, however a commonsense approach must be used when relating to Exclusions relating to travel.

009	Chap 2, Part 4, s36 pp 40-41.	Exclusion relating to use of tobacco products.	The exclusion does not appear to account for battle or operational stress suffered by a veteran, whilst on Warlike Service or Non-Warlike Service. DVA SOP accepted as Sound Scientific-Medical Evidence suggests that a range of conditions within the SOP system are proven to be service related, regardless of the time frame, in terms of changes to societal approaches toward tobacco products. Therefore, the RMA SOP provides evidence that illness or disease relating to tobacco products may be related to service caused links.	Previously accepted by VEA until 1 Jan 1998. It is believed that the VEA was changed due to the Warning notices on cigarette packets; therefore the decision to smoke is up to the veteran. This is rejected, as the veteran may have been placed into a situation of undue stress and may commence the habit of smoking as a result of that operational stress. The veterans of WWII, Korea & South Vietnam have had this accepted in the past – we are asking for consistency. Tobacco products are used as a vice on operations since 1998, due to the ADF enforcing "dry" deployments. Meaning that alcohol use is not available for the term of the deployment. Many ADF members have reported turning to smoking as an addiction during an 8 month deployment due to the amount of operational stress and combat stress. In addition, are smokeless tobacco products, where, ADF members serve alongside US Forces, who often use chewing tobacco as a form of a vice from the stresses of operational tempo. This is no different in context to those who served on service previously, nor should it be a restriction or exclusion

				today. Whilst the SRCA does not accept conditions as a result of smoking outright, the beneficial approach of the VEA SOP provide for such coverage. The end state of this is to remove the caveat of exclusion toward tobacco products, particularly under the VEA 1 Jan 1998, and continue the sound scientific-medical evidence that has been provided under the RMA SOP. Revoke this section.
010	Chap 3, Part 1, Division 1, s37	Rehabilitation Part 1 – General Provisions. Division 1 – Simplified outline of this Chapter.	It is recommended that the Service Chief who is a Military Rehabilitation Compensation Commissioner (MRCC), ensures that the ADF Rehabilitation Plan (ADFRP) is utilised to the maximum benefit of the member suffering illness or disease. This is strongly recommended to be completed prior to any decision for medical discharge (if necessary).	The 3 Goals of the ADFRP is to: 1. Rehabilitate – Retain; 2. Retrain to another trade or specialist role; and/or 3. Failing the above, Medical Discharge. Dunt highlighted the strong requirement within the ADF and DVA to produce a seamless transition from serving member to civilian. There is a lot of work and policy is required to ensure that this seamless transition is functional, which includes decisions made on claimants well before discharge from the ADF.

011	Chap 3, Part 1, Division 2, s38	Aim of Rehabilitation.	*"The aim of rehabilitation is to maximise the potential to restore a person who has an impairment, or an incapacity for service or work, as a result of a service injury or disease to at least the same physical and psychological state, and at least the same social, vocational and educational status, as he or she had before the injury or disease"*	This aim to include or specifically note the use of the ADF Career Transition Assistance Scheme (CTAS), prior to Discharge. This would also include those who were attending University courses and other vocational courses, the opportunity to complete those courses during and post service. These members would have had prior approval under the Services Vocational Educational and Training Scheme (SVETS), or Defence Force Assistance in Higher Education. It is strongly recommended that the ADF members who were participating in these courses that were previously approved prior to service related illness or disease, are given their full potential and opportunity to complete such studies, for preparation into the workforce.
012	Chap 3, Part 1, Division 3, s39(3)(a)(ii)	Definition of rehabilitation authority. The person: *"has not been identified by or on behalf of the person's service chief as being likely to be discharged from the Defence Force for medical reasons."*	The contention toward this is that it should not matter if the person has or has not been identified for Medical Discharge from the ADF. The Rehabilitation process must be affected whilst the members is serving and remains consistent with Defence Policy under the ADFRP.	The Rehabilitation process must commence immediately within the reporting of the injury or illness within the ADF. Liability for the illness or injury should be claimed in the first instance with rehabilitation. The member is not identified for discharge until adequate and appropriate rehabilitation methods have been exhausted.

013	Chap 3, Part 2, Division 1, s43(2)	Persons to whom this Part Applies - (Rehabilitation Programs, Application of Part 2). Member to pay up-front for travel.	The MRCC to pay upfront the cost of travel for a member who needs to travel to rehabilitation or specialist or medical treatment. This includes the VEA Booked Car With Driver (BCWD) provisions.	Experience has seen former members unable to drive a motor vehicle or use public transport, having to pay out of their limited financial resources, to travel by cab to rehabilitation. There is one specific case of a female member who had to travel to the Veteran Psychiatry Unit (VPU) in Heidelberg, Victoria as an out-patient to Ward 18, twice per day for a number of months. The Department promised to repay the amount, however this did not occur for some time. Assistance was rendered by Welfare assistance from the APPVA.
014	Chap 3, Part 2, Division 2, s46.	Requirements for examinations.	Should include the appointment of the veterans' treating or Consulting specialist to conduct the examination.	It is deemed that the veterans' treating and consultative specialist is the best person to comment on the veterans' capacity for rehabilitation and work capacity potential. This specialist should be inclusive of the assessment or examination process.
015	Chap 3, Part 2, Division 2, s47, s48, s49	Amount of compensation for journey and accommodation costs.	Consistent with the VEA that the Incapacitated member is provided with a BCWD.	Retention of the beneficial approach from the VEA to the MRCA in terms of not expecting the veteran to pay up-front for travel costs by cab.

016	Chap 3, Part 2, Division 3, s51.	Provision of rehabilitation programs.	Whilst the emphasis is focussed on getting incapacitated members to work under the MRCA, there must be an emphasis to improve the member's Quality of Life.	It is important that a member's quality of life is also placed as an emphasis, in order to function and integrate appropriately within the member's family and social groups. This may not mean that the veteran will be able to work, however the focus also needs to be placed on the well-being of the member in terms of maintenance.
017	Chap 3, Part 3, Division 2, s59(2)	Whom compensation for alterations etc, is payable to.	Alterations, appliances relating to rehabilitation to also include a physical fitness program and maintenance of such a program in order to prevent relapse, further deterioration and prevention of sequelae conditions.	In this context, if the member has any illness or injury accepted under the MRCA that requires ongoing treatment, that treatment is considered to be an ongoing legacy of preventative measures in terms of worsening of the condition, along with maintaining a degree of physical fitness for the member. This pro-active approach toward the well-being and health of the member has potential to save the Department money in terms of worsening of a given condition, or sequelae conditions.

018	Chap 3, Part 4, s61(3)	Assistance in finding suitable work for full-time members	For MRCC (Service Chiefs), it should be noted that the ADFRP, should be reviewed at 12 months, with the opportunity of up to 2 years of rehabilitation in order to retain the member.	Retention during Rehabilitation in the ADF is an important step to the serviceperson, particularly if they have a mental illness. There have been times where an ADF Member is given months to stay at home, where we feel that they should be given the opportunity to be placed on a gradual return to work program, whilst currently serving. This promotes self-esteem and self-pride. Another point is that if members are medically discharged from the Army, and they are unable to work a full working week, then consideration be given for them to transfer to the Reserve Force in order to retain their skills, corporate knowledge and be an asset to the ADF.
019	Chap 3, Part 5, s64	Transition Management.	It has been noted that Transition Staff, who assist within the ADF need to be knowledgeable of all 3 Acts (VEA, SRCA & MRCA), inclusive of COMSUPER. In addition, Case Managers (Occupational Therapists) and unit Clerks are completing the claimant forms for members, of which they are not trained, nor hold Indemnity insurance.	The risk to non-TIP qualified people assisting discharging members with claims can be highly critical. If these claims are submitted, without intimate knowledge of eligibility, SOP and service links, the claim has the potential to fail. The member may take out legal action against the individual if they have been given poor advice or a failed case. It is suggested that this practice cease and Defence Transition Cells are provided with a list of competent and qualified

				practitioners who are qualified for the particular Act (VEA, SRCA & MRCA), inclusive of COMSUPER knowledge and the effects that COMSUPER will have on Compensation.
020	Chap 4 Compensation for members and former members, Part 2 – Permanent Impairment, s67(2)	The guide must: (a) specify different methods under para (1)(e) *(Methods of impairment points)* for: (i) service injuries or diseases that relate to warlike service or non-warlike service; and (ii) other service injuries or diseases; and (b) specify a method for determining the compensation payable to a person who has both: (i) a service injury or disease that relates to warlike service or non-warlike service; and (ii) another service injury or disease.	As mentioned within the main Submission document, the Key Message is to make the MRCA a more streamlined and user-friendly compensation Act. It is the view of the APPVA that there is no difference toward the degree of impairment toward any ADF member, whether the injury or illness was contracted on peacetime service or warlike or non-warlike service. Therefore, an unfair and unprecedented system of service bias exists within the MRCA due to type of service.	It is strongly recommended that the provisions within GARP M and Part 2 – Permanent Impairment relate to the Incapacity of the member **only**, not where the incapacity was contracted. The incapacity of a member on separate service as noted in the Act, is inconsequential, in terms of effects to daily living, incapacity and Impairment Points. ADF Members of today are professionals and expect whether their incapacity was attained either within Australia or service overseas, they are given equal status. This is the only compensation system known to this organisation for service bias and it is not beneficial to peacetime serving members. In addition it is not beneficial in terms of compensation value to a peacetime service member. The MRCA and GARP M are strongly recommended to abolish the service bias and utilise the one Guide with equal Impairment Points no matter where the incapacity was contracted on service.

				The MRCA and GARP M are also inconsistent with the Permanent Impairment for SRCA, and Impairment Points under the VEA.
021	Chap 4, Compensation for members and former members, Part 2 – Permanent Impairment, s78(5) & (6)	Weekly amount converted to a lump sum means the appropriate percentage of the weekly amount payable to the person, as at the date of the notice given to the person under s76, converted to a lump sum in accordance with advice from the Australian Government Actuary by reference to the person's age at that date.	One of the Key Messages to this submission is to abolish bias of compensation Permanent Impairment by age. It is felt that this is not consistent with the previous beneficial approach and the increase by the Government in the Lump Sum is because the SRCA Permanent Impairment (Lump Sum) had not been CPI indexed from 1988 to 2004. A significant loss of compensation value under SRCA.	It is strongly recommended that the Lump Sum (Permanent Impairment) remains at the same level, regardless of age, sex or service. The MRCA approaches toward the bias of age, sex and service is unprecedented and is against the philosophy of the beneficial approach, along with the promise by the Government that this Act (MRCA) will not be of any detriment to the then current arrangements under VEA & MRCA. Therefore, the Lump Sum (Permanent Impairment), must remain in aggregate as a single value, not biased by age, sex or service.
022	Chap 4, Compensation for members and former members, Part 2 – Permanent Impairment, s79(2)	When Lump sum is payable. The Commonwealth is liable to pay interest to the person on the amount of lump sum if the lump sum is not paid to the person before the end of that period. The interest is payable in respect of the	To date, this interest from the Commonwealth has not been noted as received to claimants by our practitioners.	A system within the determination forms, or offer, needs to include this notice. Many claimants or practitioners are not aware of this section and it should be a constant reminder. There have been significant delays in the payment if PI to claimants in the past.

		period starting at the end of that period of 30 days and ending on the day on which the lump sum is paid.		
023	Chap 3, Part 2, s80 (1)	Additional amounts payable if maximum compensation paid.	Constitution of 80 impairment points. The contention is that a severely injured person, depending upon limitations to the veterans' Lifestyle can also be severely injured or ill with 70 impairment points.	Under the VEA GARP V, a veteran is able to be determined as Totally & Permanently Impaired (TPI) as 70% of the General Rate (GR) and is unable to work 8 hours or more per week and it is those conditions alone that prevent the veteran from seeking remunerated work. Normally 70% of the GR starts 40 Impairment Points with Lifestyle 3. This is placed within the Conversion to Degree of Incapacity on GARP V. The higher is noted to be Impairment Points of 60 to Lifestyle 4, which will equal 100% GR. It is therefore contended that the 80 Impairment Point threshold within s80 of MRCA be reduced to 70 Impairment Points, as the 80 Impairment Points is excessively high for those who are unable to work due to their service caused incapacity.

024	Chap 4, Compensation for members and former members, Part 3, Compensation for incapacity for service or work for members, Division 4 – Working out normal and actual earnings for part-time Reservists who were previously Permanent Forces Members (Entirety)	Compensation for incapacity for service or work for members.	Reservists have the opportunity to be paid their NWE as an example a Professional on around $100,000 p.a. There is also available a Safety Net for those reservists who earned below the standard wage benchmark. Ex-Regular or Permanent members do not have the opportunity to be provided NEL for income that was higher than that when in service.	This leads to a disparagement in entitlement for former Permanent ADF members, in that the NEL component of compensation is only paid to what they were receiving in the ADF (After various calculations within Chap 4, Part 3), however if they were to earn a larger wage post-discharge and have been rendered incapable of further work or reduced hours of work, the NEL is not consistent with that of their Reservist counterpart.
025	Chap 4, Part 4 Compensation for incapacity for work for former members, s120	Compensation for those over 65. Other than as provided in section 121, the Commonwealth is not liable to pay compensation to a person to whom s118 applies if the person is 65 or older.	As per May 2009 Budget announcement – the Retirement Age for work will be increased to age 67 in 2017.	This should remain as a flagged area for action for 2017, in order to amend the Act accordingly.
026	Chap 4, Part 4, Div 1, s121	Compensation for those over 63.	As per May 2009 Budget announcement – the Retirement Age for work will be increased to age 67 in 2017.	This should remain as a flagged area for action for 2017, in order to amend the Act accordingly.

027	Chap 4, Part 5, Div 2, s183	Indexation of $100 in ADF Pay.	The Defence Allowance, or Indexation of $100 under s183, needs to be included in the Incapacity Payment calculations. To date, it has taken over 18 months with one query to ascertain whether or not s183 has been included into the allowances for a non-working veteran under MRCA.	There has yet to be an answer on this request and it is strongly recommended that the calculated amount under s183 are included (with indexation (s404)), with each Incapacity Payment statement. This has caused a great deal of confusion and members or former members want to know if they are in receipt of this entitlement.
028	Chap 4, Part 6, s197	Choice to receive a Special Rate of Disability Pension. (SRDP).	Remove references to the Offsetting of COMSUPER for Permanent Impairment (PI) or Non-Economic Loss payments.	It is strongly recommended that the SRDP is removed from the MRCA, in order to make the MRCA simplified. The use of a simplified aggregated system, without age, gender and service bias, should not be reduced with age and therefore remain as a substantial Permanent Impairment to a member or former member. SRDP is simply not the choice of claimants.
029	Chap 4, Part 6, s204	Offsets para (5) and para (6).	Delete mention of reduction for veteran in receipt of COMSUPER.	As for previous. Mentioned further in depth within the Submission paper. However if SRDP is removed, this section will no longer be relevant, which is our strong recommendation.

030	Chap 4, Part 7 – Other types of compensation for members and former members, Division 4 – Telephone allowance for members and former members, s221	Eligibility for telephone allowance.	With the recommendation that claimants who have **60** Impairment Points and above (s181(1)), it is deemed that the Telephone allowance should be made available to these incapacitated veterans if they are unable to work due to their accepted incapacity.	Whilst the May Budget for 2009-2010, has recently been released, how does the budget affect telephone allowance, Pharmaceutical Allowance and the WSP under the MRCA for post 65 y.o. (67 in 2017)? Further explanation is available within the Main Submission to this Table.
031	Chap 5, Part 2, Division 2, s234	Amount of compensation for wholly dependent partners. (Entire section). Emphasis on Partner's age-based number. Subsection (7) defines partner's age-based number.	Should be the same amount of compensation, no matter what the age of the partner's age-based number relates to the calculation for compensation for wholly dependent partners. The use of Australian Actuary figures is not in the true context of compensation but in terms of Superannuation. This is a precedent previously not espoused onto widows(ers) or in this case partners and goes against the "no detriment" statement used during the ESO Working Group to the MRCB in 2003.	A Key Message in this submission is that the use of age, gender and service bias be removed in total. This is inclusive of partners who have lost their loved one as a result of their service related or caused death. The payment should be the same and consistent as to what has been philosophically used within the VEA and SRCA – **REGARDLESS OF AGE.** It is therefore strongly recommended that the calculations for Partner's age-based number are irrelevant and a single aggregated amount is paid for compensation.

032	Chap 6 Part 3, Division 1, s281	Treatment for persons (veterans) with 60 impairment points.	Veterans with 60 or more impairment points are considered to have a high rate of disability and therefore should be entitled to the **Gold Card** – Treatment for All Conditions.	60 or more impairment points, dependant upon Lifestyle rating (LS 4 and above), usually provided the veteran with 100% General Rate of Pension under the VEA, Guide to the Assessment of Rates of Veterans' Pensions Fifth Edition (GARP V). Therefore the veteran was entitled to the Gold Card. The MRCA takes this opportunity away from veterans. It is therefore strongly recommended that the GOLD CARD is made available to members with 60 or more Impairment Points under MRCA.
033	Chap 6, Part 4, Division 3, s297	Compensation for other person's transportation costs.	It is interpreted within this section that the transport costs are to be incurred by the person to a range of variables, including treatment, that the Commonwealth is liable for these costs. The problem that has been noted is that members are unable to front up with continual costs of travel for treatment.	As for s43, the Booked Car with Driver (BCWD) should be the preferred method of up-front payment by the Commonwealth or issue of Travel Warrants. It is not appropriate to expect incapacitated veterans to pay up-front for their travel costs, particularly when seeking on-going treatment.
034	Chap 6, Part 4, Division Pharmaceutical allowance for members, former members and	Eligibility for Pharmaceutical allowance. A person is eligible for pharmaceutical allowance if the person is entitled to treatment under Part 3 of	Results of the Budget 2009-2010, holds a degree of uncertainty toward this section within the MRCA. Will this be a rolled allowance into a Service pension? What if the person is not eligible	Whilst it is understood that 2 methods exist for pharmaceutical payments, with the Repatriation Pharmaceutical Benefit Scheme (RPBS), and full payment within the MRCA, the matter of the pharmaceutical allowance as a result of

	dependents, s300	Chapter 6.	for Service Pension?	the 2009-2010 budget remains uncertain. In addition, members under both MRCA and SRCA who have had arranged billing processes with the provider to the Department (DVA), have had their access to pharmaceuticals cease as a result of the lengthy period of time that DVA takes to process and pay the supplier. This holds grave concerns for the veteran and it is obvious that there needs to be a simplified streamlined process, potentially with automatic payment by an electronic card, similar to Hi-CAPS, available to non-veterans.
035	Chap 7 – Claims, Part 1, Making a Claim, Division 2 – Making a claim, s321.	Survival of claims and of right to claim. Claim before death. Note 1: The legal personal representative cannot convert compensation for permanent impairment to a lump sum (s78) Note 2: The legal personal representative of a deceased dependant cannot choose to receive a lump sum for a deceased partner (s236).	S78(7) of the Act states that the legal representative of a deceased person is not entitled to choose to convert any percentage of a weekly amount that was payable to the deceased person to a lump sum. Within s236(5), the Act states that the legal personal representative of a deceased partner is not entitled to choose to be paid the lump sum..	This interpretation within s321 and 236(5), is confusing, as it would be expected that if a eligible person was liable for compensation by the Commonwealth, how is the Permanent Impairment paid? By weekly payment? It would be assumed that if a eligible member is in a severe state of health that he or she is unable to work, therefore access to Incapacity Payments and if the claim is successful, the full benefit of the Lump Sum for the Permanent Impairment should therefore be made

036	Chapter 7, Part 1 – Making a claim, Division 3, What happens after a claim is made, s328(2)	Subdivision C – Medical Examinations. Power to require medical examination. The Commission may, at any time after the claim is made, require the person to undergo an examination by one medical practitioner nominated by the Commission.	The Medical Practitioner nominated is strongly recommended to be the consulting specialist to the member or former member. This is pertinent toward the sensitivities of the person, particularly if the person is highly agitated or has his or her psychosis, preventing to provide a full disclosure of the condition at hand. This is also applicable to other consulting specialists of any kind, who have a better diagnosis and potential prognosis for the veteran.	On a number of occasions, it has been brought to our attention of people being forced to see non-consulting medical specialists. This is very relevant toward SRCA, where Government contracted businesses with Occupational Physicians assess or examine a member or former member for periods of less than one hour. Of particular interest is that whilst it is understood that medico-legal requirements insist on this approach, the consulting specialist must be approached to provide a full examination and assessment to the Commission.
037	Chapter 7, Claims, Part 2 – Determination of Claims, s332.	Simplified outline of this Part.	This Part introduces the standards of proof, the more beneficial standard of proof and other standard of proof. This Part also introduces the Statements of Principles regimen under s338 and 339. This means that for claims to be accepted for liability, an injury, disease or the cause of death is covered by a Statement of Principles (SOP) that is found in Part XIA of the VEA. The Repatriation Medical Authority (RMA) is the responsible body to investigate particular injury, disease or death or review one of its previous decisions about SOP.	Under Part XIB of the VEA, THE Specialist Medical Review Council (SMRC) can review decisions of the RMA about SOP. The Commission can also override an RMA decision about a SOP under s340 of this Act. To date, this approach has yet to be tested, however there have been cases where un-diagnosable conditions have not been accepted and the expense of lawyers have been used, where guidance was required from the Commission. It is a preferred option to seek such decision reviews under the SMRC and MRCC more often for cases that particularly relate to non-SOP conditions that are clearly as a result of the person's service.

038	Chap 7, Part 2, s334.	Commission not bound by technicalities.	It is interesting to note in this section that under s334(1)(b), the MRCC must act according to substantial justice and the substantial merits of the case, without regard to legal form and technicalities.	Attention is drawn to the Dunt Review, where it was mentioned that the VRB should have a psychological specialist on the board in order to provide further technical information to the VRB. To date and on too many occasions, particularly under the VEA, technicalities by legal terms and interpretation have had a negative effect toward a claim of a veteran. It is strongly recommended that this section is highlighted to VRB members when handling MRCA cases.
039	Chap 7, Part 2, s335	Standard of proof for Commission and service chiefs. S335(1), in particular toward standards of proof for claims relating to warlike or non-warlike state that the service disease, injury or death unless it is satisfied, beyond reasonable doubt, that there is no sufficient grounds for making that determination.	To apply the Reasonable Doubt to the Reasonable Hypothesis appears to provide a legal decision by a given delegate, without potential of a panel of legal specialists. The power to use the term "Beyond Reasonable Doubt" by a Delegate does not provide equity toward case law for Reasonable Hypothesis. The power to use the term "Beyond Reasonable Doubt" is a term that should be used by the VRB by a panel of judges, within the AAT or the Federal Court – not within the initial decision making of a claim.	Reasonable Hypothesis must be afforded its true definition and that all evidence provided, is consistent with what would be a reasonable expectation to occur during a particular eligible service during warlike or non-warlike service. The Reasonable Hypothesis is the beneficial approach within the terms of the VEA, however, over a period of time, the Standard of Proof for the Reasonable Hypothesis has turned into the Balance of Probabilities, as though on Peacetime service, with the evidence required within that Burden of Proof onto the claimant. The satisfaction of the standard of proof is suggested to be that of the satisfaction of a Delegate or the MRCC as being reasonably expected to occur to the member under the Reasonable Hypothesis and maintain the Beneficial Approach.

040	Chap 8, Part 1, s344.	Simplified outline of this Chapter (Reconsideration and review of determinations).	Remove the 2 possible paths in the reconsideration and review process One path is applicable to WLS & NWS, however Peacetime service is provided with a different review process. In order to provide equity for service, as is within our Key Message, those on Peacetime Service should not be placed into a discriminatory manner toward Reconsiderations or appeals.	It would save administration problems and avoid confusion by placing the Peacetime Service in the same review path as WLS & NWS. Therefore remove the review path for Peacetime service and place into a uniform review path with all service. Therefore the recommended review or reconsideration path is via s31 (VEA), VRB, AAT, Federal and High Courts. Elimination of s349 & s350 to remove the Reconsideration is required to make the pathway a single, simplified and streamlined approach.
041	Chap 8 Reconsideration and review of determinations, Part 3 – Reconsideration of Determinations.	S347 Commission or service chief initiating reconsideration of original determinations.	Within s347(4), it is noted that the Commission or a service chief (MRCC), must ensure that, if the original determination was made by a delegate and reconsideration of the determination is also to be made by a delegate, the reconsideration is done by a delegate who was not involved in making the original determination.	This section appears fair and consistent toward the rule of bias, however in a number of cases, both SRCA and MRCA, it has been observed that during the Reconsideration stage, that there is a high rate of claims being upheld. That is, until they are taken to the AAT. Within the Reconsiderations, many of them have been signed by the Director of Reconsiderations (Mr Paul Ontong). The interesting point of the Director of Reconsiderations is, that he is consistently at the AAT against a claimant and advising the Australian Government Solicitor (AGS) and has been intimately involved with such advice and mediation or settlement. This appears inconsistent with the rule of Bias, which must be reinforced. Therefore, a person from the Reconsiderations Branch, advising the AGS, must be someone other than Mr Ontong or involved Delegates of the MRCA or SRCA, to ensure non-bias.

042	Chap 8, Part 4, s352.	Review by the Board of warlike service, non-warlike service and peacetime service determinations.	Include Peacetime service under this Review path. Retain the appeal pathway for those under the VEA, to be implemented within the MRCA in the same fashion.	This means, that s349 & s350 be removed as a pathway and the extant pathway described within s352 be a component of the pathway of appeal. Therefore, s31 (Review under VEA); VRB; AAT (s354 MRCA); Federal and High Courts – are strongly recommended to be the pathway and framework for reviews and appeals within the MRCA, maintaining a beneficial approach.
043	Chap 8, Part 5 – Review by the Tribunal.	S357 – Costs of proceedings before the Tribunal (AAT s354 MRCA)	Legal Aid to be provided to those who have warlike and non-warlike service at the AAT and higher courts. VRB representation by an accredited Level 3 MRCA Advocate.	It should be beneficial to those who served on warlike or non-warlike service in today's modern military operations and the demands placed onto non-warlike service, particularly Peacekeeping Operations (PKO). These demands should be reflective of the same approach used for those under the VEA for warlike service, however the added feature of providing those who have served on PKO under Non-warlike Service must be also recognised as demanding, difficult and dangerous service. The provision of Legal Aid to veterans of PKO, would recognise the dangers of such service on an equilibrium to that of warlike service. It is also important that training is further developed and accreditation made toward Level 3 and Level 4 Advocates for MRCA, not just VEA Advocates to appropriately represent the claimant of any service at the VRB and AAT, within the realms of the MRCA.

044	Chap 9, Part 5, s364.	Membership of the Commission. Para (1)(b)(iii) a person who is nominated by the Defence Minister and is either a Permanent Forces member or engaged under the *Public Service Act 1999* and performing duties in the Defence Department.	The person nominated by the Defence Minister is to be a Permanent Forces member. Not a Public Servant within the Defence Organisation.	Allows consistency of a Defence Uniformed service person presence within the MRCC. The uniformed member of the ADF is considered to be the subject matter expert in ADF medical, administrative and service life. Therefore an advantage is presented for the veteran who is required to be reviewed by the MRCC.
045	Chap 9, Part 5, s367, para (2)(b).	Acting appointment for the member described in subparagraph 364(1)(b)(ii) or (iii)	The nominated person of the Defence Minister is to remain a uniformed person, **not** a Public Servant.	As for above.
046	Chap 10, Part 2, s389 (5).	Choice to institute action for damages against the Commonwealth etc. for Non-Economic Loss (NEL).	The amount of $110,000 for NEL suffered by the person is consistent with the SRCA 1988. It is believed that the amount should be a higher amount.	The amount of $110,000 was an amount decided and not indexed since 1988. Clearly, this is an inadequate amount in today's dollar terms. We suggest that the amount is up to the highest amount of Permanent Impairment of $330,000 (as at 1 Jul 04 and indexed under s404), consistent with NEL paid by State Governments.[1]
047	Chap 11, Part 1, s404 p 322.	Indexation of amounts.	Omission of Lump Sum NEL for Commonwealth damages as in s389.	As described above.

[1] Comparison of Worker's Compensation Arrangements in Australian Jurisdictions as at 1 July 2002.

Surf Coast Regional Veterans' Centre

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Friday, 10th July 2009

Mr Mike O'Meara,
The Deputy Commissioner,
The Department of Veterans' Affairs,
GPO Box 87A,
MELBOURNE, VIC, 3000

Subject: VSM16461 – Michael James IVES.

Dear Mike,

I am writing to you in relation to a number of concerns of the delay in the processing of a number of claims for VSM16461, Michael James IVES.

Mr Ives was Medically Discharged from the Army on 26 January 2007. Mr Ives is married with three children and lives in a house, which is mortgaged, in Colac, Victoria. He has lived in this location since January 2007. Since January 2007, until September 2008 (18 months), Mr Ives has had no contact with the Department, nor was he or his wife aware of his potential veteran entitlements.

On 3 September 2008, a letter was written to the Delegate MRCG Melbourne to seek Rehabilitation for Mr Ives. I am advised today that an OT was sent, with recommendations recently received after a visit in May 2009. I am awaiting a copy of the recommendations from the OT, as this has taken over 2 months to get this far.

This is a period of 8 months to await a requested Needs Assessment for a veteran who has been discharged from the ADF since 26 January 2007. This veteran appears to have slipped through the cracks in relation to the Transition Management System (TMS) and seeking a rehabilitative program and needs assessment for his claims, of which he successfully claimed and received Commonwealth Liability for the following conditions:

1. PTSD;
2. Ruptured ACL of Left Knee;
3. Medial Meniscus tear of the Left Knee; and
4. CMP Left Knee.

The above conditions were accepted by the Brisbane Office of the MRCG on 20 March 2007. Within this decision document, was that action under s325 for a "Needs Assessment" was to be undertaken to provide for rehabilitation and Permanent Impairment of the accepted conditions. This was not conducted until it was brought to the attention of the MRCG Melbourne on 3 Sep 2008.

In addition to the accepted conditions, the matter of outstanding claims for Liability remains for three conditions that have been claimed. These are the following:

1. Skin Condition;
2. Tinnitus; and
3. Bilateral Hearing Loss.

Claims for Liability and Reassessment of Compensation were made and sent in October 2008 to the MRCG Melbourne, including the previously Accepted Disabilities, with no recording of this claim at the MRCA PI section at the MRCG in Brisbane. This has raised concerns that the file has been lost within the DVA system.

The Claims for Liability of the three claims mentioned above are also not recorded on the veterans' case file within the MRCG.

A request was made to MRCG Melbourne on 3 September 2008, seeking clarification if the veteran was receiving the $100 Defence Allowance under s183, which is indexed under s404 of the MRCA. This request has yet to be answered and it is strongly recommended that this be given an immediate answer, along with a break-down of Incapacity Payments, with the addition of the weekly payment of Defence Allowance under s183.

On 3 October 2008, a Request for Invalidity Service Pension for Mrs Ives, the veterans' wife, in order to secure a Pensioner Concession Card (PCC), with the hope of a small pension, with concessions, was submitted (under the auspices of the VEA, to which MRCA Veterans with QS are therefore entitled).

I was advised today that this has been finalised, yet I could not be told as to what extent and whether or not a letter of decision had been sent to the applicant, despite the fact that I am noted on the application as the authorised representative.

I have since learned, through a very frustrated Mrs Ives, that it has been rejected for the reason that Mr Ives' PI case has not been received and that the MRCG views that he currently holds no incapacity for the inability to work 8 hrs or more per week.

This is a confusing situation as documentation has been provided to the Department stating by his psychiatrist that he is unable to work 8 hrs or more per week. However it appears that this documentation has been misplaced.

In order to expedite the PI for Mr Ives' PTSD Claim, a Specialist report was conducted by Dr Van Ammers on 15 October 2008 and sent to the MRCG on 5 December 2008. To date, this specialist report, along with the PI Application mentioned that was sent in October have not been answered nor recorded as received.

As a result of this Specialist Report, the Veteran required RSL support to pay for the Assessment of $500 plus GST. Thankfully, the RSL Victoria Branch came to the veterans' aid in this case, although it would appear to have been a fruitless exercise, particularly when this report is not recorded within MRCG Brisbane.

Of another note is that the MRCG Brisbane does not have the recorded Needs Assessment under s38 MRCA for the veterans' file in that location, whilst it is recorded in the MRCG Melbourne office.

I am sure that you will agree with me, that this case now requires urgent attention and appropriate processing commensurate with the time delay as demonstrated in this letter. As a result of the sequence of events, I have had to re-lodge the claim on behalf of Mr Ives to the MRCG to have these matters investigated. This is after a period of 9 months of searching his claim to see if it has been received by the Department and indeed actioned.

Please also find attached a copy of the VPAD Claimant Details Report IRT Mr Ives' case, of which all calls etc have been kept by diary and the effort taken to get this veteran his rightful entitlements.

I look forward to hearing from you in relation to the rapid resolution toward this case.

Yours Sincerely,

(Signed)

P.A. Copeland, OAM, JP.
Level 3 Advocate.

Attachments:

1. VPAD Claimant Details Report. *(Annex B to this submission)*

2. Letter – PTSD and Skin Condition report from Dr Van Ammers 5 Dec 08. *(Not Provided for MRCA Submission)*

3. Claims for Liability and/or Reassessment of Compensation. *(Not Provided for MRCA submission)*

4. Letter – Rehabilitation of M. Ives dated 3 September 2008. *(Not Provided for MRCA Submission)*

5. Letter – MRCG, query IRT Defence Allowance (weekly) under s183. *(Not Provided for MRCA submission).*

***NB:** The dossier of documents was sent to the Department on 10 July 2009 and has yet to be receipted.*

VPAD

Veteran Practitioner Activity Database

Claimant Details Report

As at Wednesday 15 July 2009 10:39 am

File

File Number:	VSM16461
Practitioner:	PAUL COPELAND
Created on:	01 Aug 2008
Created by:	PAUL COPELAND
File Location:	Paul
Archived:	

Main Details

Name:	Mr Michael IVES
Initials:	M.J.
Gender:	Male
Date of Birth:	03 Apr 1974
Date of Death:	
Marital Status:	Married
Preferred Name:	Mick

Address

Type	Address	Suburb	State	Postcode
Home				
Email				

Phone

Type	Number
Home	
Mobile	

Contacts

Name	Relationship	Address	Phone	Email	Next of Kin
Michelle Ives	Wife				Yes

Service Details

Service No.	Act	Conflict	Force	Type	Start	End
8299759	Safety, Rehabilitation and Compensation Act 1988	SM	Australian Army	Eligible	08 Oct 2002	30 Jun 2004
8299759	Veterans Entitlements Act 1986	ET	Australian Army	Non-Warlike	07 Apr 2004	03 Jun 2004
8299759	Safety,	ET	Australian	Non-Warlike	07 Apr 2004	03 Jun 2004

	Rehabilitation and Compensation Act 1988		Army			
8299759	Military Rehabilitation & Compensation Act	AI	Australian Army	Warlike	29 Dec 2004	20 May 2005
8299759	Military Rehabilitation & Compensation Act	AA	Australian Army	Eligible	01 Jul 2004	28 Dec 2004
8299759	Military Rehabilitation & Compensation Act	AA	Australian Army	Eligible	06 May 2005	26 Jan 2007

Conditions

Status	Name	Effective Date	Decision Date	Act	Notes
Accepted	PTSD	20 Sep 2006	20 Mar 2007	Military Rehabilitation & Compensation Act	As a result of War Service in Iraq.
Accepted	ACL MMT of Left Knee	20 May 2007	20 Mar 2007	Military Rehabilitation & Compensation Act	Authorised Army Sport.
Accepted	CMP Left Knee	20 Sep 2006	20 Mar 2007	Military Rehabilitation & Compensation Act	Result of injuring during Aussie rules game of organised sport.
Pending	Bilateral Sensorineural Hearing Loss (Both Ears)	20 Sep 2006	20 Mar 2007	Military Rehabilitation & Compensation Act	As a result of ELSER AND OPSER
Pending	Tinnitus	20 Sep 2006	20 Mar 2007	Military Rehabilitation & Compensation Act	Result of firing crew-served and small arms weapons in the capacity of an infantryman during ELSER and OPSER
Pending	PTSD	20 Sep 2006	20 Mar 2007	Military Rehabilitation & Compensation Act	Applying for PI under MRCA
Pending	ACL & MMT of Left Knee	20 Sep 2006	20 Mar 2007	Military Rehabilitation & Compensation Act	As a result of Aussie Rules match.
Pending	Condramalacial Patella Left Knee			Military Rehabilitation & Compensation Act	PI Application
Pending	Skin Condition			Military Rehabilitation & Compensation Act	PI Application

Cases

Type	Submitted Date	Decision Date	Notes	Withdrawn

MRCA	20 Sep 2006	20 Mar 2007	Application for PI
MRCA	20 Sep 2006	20 Mar 2007	Application for PI
MRCA	20 Sep 2006	20 Mar 2007	Application for Acceptance and PI.
MRCA	03 Oct 2008		Application for Acceptance and PI.
MRCA	03 Oct 2008		Application for acceptance and PI.
MRCA	03 Oct 2008		App for PI
MRCA	03 Oct 2008		App for PI
Welfare	29 Aug 2008	11 Sep 2008	Requested funding of $500 incl GST for specialist report to support Veterans' claim for PI under MRCA to Dr van Ammers of the Geelong Clinic. This was through the RSL.
Allowances	03 Sep 2008		Request for s183 ($100 allowance) to MRCC.
Allowances	03 Sep 2008		Request for Gym Allowance for Rehabilitation.
MRCA	03 Oct 2008		APP for Acceptance and PI
MRCA	03 Oct 2008		App for Acceptance and PI.
IS	03 Oct 2008		WSP Application on Invalidity (Partnered).

Entitlement - VEA Compensation

LSR	Impairment	Rate	Effective Date	Decision Date
None recorded.				

Entitlement - VEA Income Support

Type	Effective Date	Decision Date
None recorded.		

Entitlement - SRCA Payment

Type	Amount	Payment Date
None recorded.		

Entitlement - MRCA Payment

Type	Amount	Payment Date
None recorded.		

Entitlement - Card

Card:

Entitlement - Other

Welfare	Yes/No	Welfare	Yes/No	Welfare	Yes/No
None recorded.					

Diary

Time	Item
Friday 10 July 2009 12:17 pm	Contacted DVA svc office located Perth. Tfr Melb. Liability does not have applications rx. Tfr Bris PI. Steve Dare (lunch) - req info on Ives PI. Not on system for PI. Needs Assessment not recorded 2009. Ack WSP finalised. Unk if letter sent IRT Invalidity WSP for Michelle. Sent back to MLB for IP MRCA. Got put onto MRCA Rehab - Req OT Needs Assessment info. NA - received, to send copy to me. IP - Sharyn Galvin MLB. Unk on s183 Defence Allowance.
Friday 10 July 2009 12:57 pm	It would appear that Mick"s file for PI and Liability are missing, along with the request for further information on the s183 Defence

	Allowance. Re-copied claim forms and resent to DVA. Veteran notified.
Wednesday 15 July 2009 10:17 am	Contacted Sue looked at file Friday IP continuing. Person managing not in office at the moment. Owed the last Military Pay Rise, Defence Allowance (Remuneration) is included $130.88 p.w. as at 1 July 09. Not updated as yet. PI not on system (4 AD), with 3 Pending. Not on file - latest is application for PI, which was declined August 2007. I stated that there was a claim for PI for 7 Conditions in October 2008 and another one sent last week. Claims not on file. IP out of date and needs to be addressed. Sue requested for the PI Claims to be re-submitted. Lost. Advised that I sent the PI Claims last Friday.
Wednesday 15 July 2009 10:32 am	Advised veteran via phone of discussion with Sue in Melbourne Office, along with update of situation. Suggested that wife Michelle contact Sue in Melbourne Ext 6432 and ask to be put into contact with Brisbane Office for the situation with the Invalidity WSP, as they would not provide me with the outcome, despite being the authorised representative on the original WSP claim form. Advised that the claims have been re-submitted, as it appears that they have been lost in the system.
Friday 1 August 2008 01:35 pm	Raised claim for BSHL, as a result of exposure to crew served weapons and small arms during service, as a result of inadequate hearing protection.
Friday 1 August 2008 01:38 pm	Raised claim for Tinnitus
Friday 1 August 2008 01:39 pm	Claim for PTSD raised for purposes of PI.
Friday 1 August 2008 01:57 pm	Application for PI of Left Knee
Friday 3 October 2008 12:13 pm	Contacted MRCG IRT payment of Gym Fees; and Defence Allowance ($100 +). Sarah Roberts 9284 6441 (Rehab).
Friday 3 October 2008 12:25 pm	Cheque sent to Dr Van Ammers from RSL (Jeff Jackson). Cheque sent 11 September 08. Sent to Mandy Szokolik.
Friday 5 December 2008 09:38 am	Contacted Sarah Roberts of Rehab IRT Rehab for Mick. Needs Assesssment? Letter to Dr Jones, able to consider Rehab, gym, swim program completed. Refer Mick to Physio for assessment. Physio to complete enclosed form and Medical Certificate to be provided.
Friday 5 December 2008 09:46 am	IP and s183 (ADF Allowance) requested to be sent to us in a break down. Delegate stated that she would send a letter of this request to Mick Ives.
Friday 5 December 2008 09:54 am	WSP - Check. Sent to QLD Office. Cathy Brauer. To call back.
Friday 5 December 2008 10:08 am	Letter received QLD Office IRT WSP J. Stevenson 31 Oct 08. Nil SVC Pension due to MRCA Compensation. Mrs Ives may be eligibile for payment depening on total income. POI needs to be completed, along with 3 pay slips, COMSUPER payments may affect the WSP and Telephone allowance with internet Connection allowance.
Friday 5 December 2008 10:13 am	Sent Dr Van Ammers report to Delegate for PI of PTSD.
Monday 23 February 2009 12:12 pm	Contacted DVA for update on Veterans" Claim.

To-Do items

Raised Date	Target Date	Completed Date	Item
	None recorded.		

General Comments

Comments: Have conducted numerous calls to Delegates and veteran at home base. Communications via

Email and phone to the veteran and his wife. This has occurred during the period Aug 08 through to the current (15 Jul 09).

Related Text

Text:

Related Files

Files

P:\Pensions Work\Pensions Work 2008\Mick Ives\Let - Van Ammers 1 Aug 08.doc
P:\Pensions Work\Pensions Work 2008\Mick Ives\Let - Gym Rehab Allowance MRCA Ives.doc
P:\Pensions Work\Pensions Work 2008\Mick Ives\Let - Defence Allowance MRCA Ives.doc
P:\Pensions Work\Pensions Work 2008\Mick Ives\Let - PI PTSD Report Ives.doc

End of Report

Impact Statement of the Processing of Claims
For former Private Michael IVES,
By Mrs Michelle IVES, 21 July 2009.

Words cannot truly express how dealing with Veteran Affairs impacts your life, but I shall attempt to convey what we have had to go through over the last three years.

One of the main things we found right away is that you are treated like a number; that is if you could treat a number with a complete lack of respect. Every time our file has been lost it shows that not only does VA not appreciate what we have gone through and are going through, but treat it with utter contempt. Our private medical documents, financial details and private information has been lost on quite a few occasions by different departments within VA and no apology is ever made.

Considering that the legislation is so antiquated you have to submit everything as a certified document, repeatedly, and for the last few years, it amazes me that it can be treated in such a manner. It makes us feel like what my husband Michael went through in Iraq and what he has experienced does not matter. What we have gone through as a family with PTSD (as one person does not just suffer from it, everyone does) does not matter. Surviving a marriage does not matter nor does our two young children.

When we finally found Paul Copeland and the APPVA, it was such a relief as we could not continue to deal with VA ourselves any longer. It is completely soul destroying to have VA say in so many words, 'yes we accept liability for all claims submitted but we will not compensate you for it.' The main excuse given so far is "the legislation". On numerous occasions we have been told this only to be able to prove it wrong. It is the VA department member default setting if they don't know the answer to anything or do not wish to follow up with any request.

One sticking point is VA does not want to compensate fully as they are not sure if the condition is permanent. So in the meantime you are meant to flounder along and try to raise two small children and have a mortgage and a husband with PTSD on a very small pension. Also Mick has to prove his continuing mental condition with a certificate of capacity every three months which is very debilitating. We feel like we cannot move forward with our life as we are waiting for compensation. Veteran affairs make everything so hard in the hope you will a: just go away, b: die.

I had to start working again 6 weeks after having our second son Adam (via caesarean) because we could not afford for me to stay at home and Mick was, and is, in no condition to work. Despite the length of time he has been discharged we still have not received compensation. His condition is such that there is good times and bad. Such as me coming home on my lunchbreak to make sure he was still alive after a really bad night of PTSD symptoms. Having VA deny claims, lose files and take so long directly affects Mick's mental health. He feels that there is no recognition or respect for his work with the army.

VA make you feel like you are trying to scam someone out of a dollar or that you are lying to make money. The people who work there constantly require validation of every condition and completely impeach your integrity. To have your honour so besmirched goes against everything the government is supposed to stand for. It is very hard for us to ask for help, especially when you are

made to feel like you have done something wrong. As Mick's brother David said "I just got $900 from the government in the stimulus payment. I did not work for it. I work at my job and pay my taxes and the government hands me free money, where Mick went to Iraq, served his country, got injured at home endures a crippling mental condition which prevents him from working and he gets nothing". We truly believe Veteran Affairs only respect you after you die, and before that they could not care less. It is designed for WW2 veterans and not recent diggers.

I wish I could remember every occasion VA has been inadequate or how it affects our day to day life, but honestly after 3 years we have to try to focus on trying to move forward without any support from the government as they really do not care at all, because if they did things would be different.

Yours sincerely

Michelle Ives

Contact Details removed for Privacy reasons.

Case Story – Adam Charlton

Further to our phone conversation this morning, I'll briefly expand upon the main issues I'm currently having with MCRS (DVA) that are impacting on my current employment as well as home life:

- Frequently unable to receive timely and continued programmes of treatment and rehabilitation even though the required paperwork has been submitted and approved. This has seen, at times, disjointed and untimely treatment of my medical condition - resulting in further time off work and unnecessary regression of my medical condition.

- Frequently unable to receive clear advice and guidance on policy related matters pertaining to current entitlements and MCRS processes. I sight the recent examples of :
  a. the cancellation of an MRI examination I had booked two weeks in advance because MCRS did not provide approval in the required timeframe, then later to be informed by MCRS I did not need approval;
  b. cont. swimming pool membership and access required for core stability strengthening which lapsed in early February 2009 - still waiting for new membership to be granted even though it was approved six weeks ago; and
  c. inability to receive clear guidance on how to submit Comcare certificates for time already taken off work (I currently have another 5 days that need to be put through).

- cannot be guaranteed that MCRS will action something, even when they have been provided with all required information and paperwork and I have spoken to them directly- this often results in several follow up phone calls, repeat submission of the same paperwork - all during business hours - to ensure that an agreed/ approved action has been followed through - an example has been approval and payment of customised orthotics (a process which took seven months from start to finish).

- Constantly changing POC and case managers (currently onto my fourth case manager since MCRS centralised to Melbourne) who have ranged from having no knowledge of MCRS policy and procedures to a satisfactory level.

- Phone messages which go unanswered for up to 72 hours and in some instances receive no response.

- Messages left with staff who I have spoken to directly that are not passed on to my case manager and other relevant parties when a response is required

- A recently emerging trend of passing blame onto service providers and in instances calling them lairs *(sic)*, recent examples are approvals that were never received by my podiatrist, approval of membership at the Canberra International Sports & Aquatic Centre never received by the membership manager, approval for an MRI by the Canberra Imagery Group never received. In all off these instances, MCRS claimed that the approvals had been provided; who am to believe? It doesn't matter because it still me who is affected!

The time I am taking in dealing with MCRS from my desk is affecting my work, not just from the impact it has on my time but also the frustration and angst caused in trying to get things actioned, progressed and approved - which can only be discussed during working hours. This is not helped by the fact that my case manager is part-time and that I am also often away from work when I am not well.

I am a very patient person and completely understand the heavy case loads that MCRS case managers are currently carrying. I also understand that because I am currently employed that I am not a high priority for MCRS; however, I don't believe that what I am currently experiencing as a client of DVA and have been experiencing for a considerable amount of time has always been acceptable. I am now at a stage where my Director has questioned what is going on with the amount of time I am taking off in relation to my medical condition and whether I should be at work or doing rehab? While I am concerned with the impact it is starting to have on my job as well as my future ability and willingness - after four years - to deal with MCRS in a professional manner.

The CPAC Manager I spoke to was Virginia Billington. She was very helpful and contacted my Director, Cathy Tiller to discuss the current situation and the possibility of a case manager to deal with future Comcare certificates.

I hope this hasn't overwhelmed you, and I completely understand that at the end of the day I might not be entitled to a civilian case manager. Thank you for your time.

Please note, it won't be until tomorrow that I'll send an email to CMCM for an INA.
Kind Regards,
Adam Charlton

Case of Three Former Soldiers

Feedback on MRCA cases by Mr Wayne McInnes Level 2 Practitioner, Goulburn Valley Veteran Centre, Shepparton, Victoria.

Case One, Cpl X medically discharged in 07 with a Major Depressive Disorder, limited course of rehabilitation, through the VVCS, had to purchase his own medication then claim reimbursement although liability had already accepted, had to wait six months for specific treatment card, Defence failed to hold the member in abeyance until MSBS Class of Pension determined, Cpl X received a phone call from MSBS 7 pm the evening of his discharge, the case was progressed over another two years to have Special rate approved.

Case One:

Case Two, Trooper Y discharged at own request, although his wife knew he had problems, in fact he was suffering from Major Depressive Disorder attributed to the death of a digger on a promotion course in NT several years ago. Trooper Y tried to get help was referred to the VVCS, I raised a MRCA claim, Liability was accepted, Major Depressive Disorder, a Needs Assessment was done via teleconference, which turned into a very hostile situation as the case officer spoke poor English, the wife of the young digger broke down in tears.

I had to cut the conversation short, and had to take the necessary steps to calm the situation. The needs assessment produced very little. Trooper Y was told because you discharged at own request and continued working you are not entitled to incapacity allowance, Trooper Y had been purchasing his medication, and I got reimbursement for him and a White card.

We asked for partial incapacity allowance equal to up to the difference of Trooper Level pay, and basic labour pay, still on going three years later, asked to be re-skilled to level equal to Army prior to discharge, still ongoing as well. Requested MSBS to grant an A or B class of pension still on going, all on going issues now in the hands of an Advocate to progress the case, case been going for three years.

Case Three, Pte 6RAR, War service in Iraq) Medically discharged December 2006, Major Depressive Disorder, Anxiety, Agoraphobia and PTSD. Discharged on a host of strong medications, a year after being discharged, Pte Z contacted me to inform me that he is having all manner of problems that he is frightened to leave the house that he has not had any rehabilitation therapy that he has no idea what has happened to his MRCA claim of a year ago.

I managed to get Pte Z to come into the office and started to back track his claim. I contacted MRCA who informed me that because Pte Z failed to answer to

correspondence sent out they did not go ahead with the claim. Pte Z informed me that his wife as you would expect is quite particular of such matters, he was not aware of any correspondence being delivered.

I mentioned to MRCA, didn't they take a look at the claim to see the seriousness of the claimed conditions, which should have set the alarm bells ringing, to contact the GV Veterans Centre to follow up, no answer to that. So I had to start a new claim.

Now another eighteen months on Pte Z is receiving incapacity allowance, he now has a white card, still waiting on his permanent impairment claim to come back. Significantly Pte Z is now receiving regular therapy and his medications have been changed. MRCA state that they may have to send Pte Z to a specialist in Melbourne to be assessed for the permanent impairment. I have strongly apposed this because of the severity of Pte Z's agoraphobia, Pte Z's specialist Psychiatrist agrees. This case is still on going Pte Z was medically discharged December 06 it is now Apr 09.

Additional Information Provided 22nd April 2009:

Wednesday the 28th Jan 09 called Sue Denton MRCG, asked whether Pte X file had been forwarded to PI in Brisbane, Sue informed me that it was still in the office, she apologised stating that the MRCG had been dealing with a large backlog of pay increases, furthermore that the file would be sent to PI Brisbane the following week.

Wednesday the 22nd Apr 09 I again called to speak with Sue Denton, the call was taken by another staff member who handed the phone call on to the team leader Ian. I informed Ian that I had spoken to Sue on the 28th Jan 09 including the detail of our conversation which I had written down on the Younger Veterans file. I informed Ian that I wish to know whether PI Brisbane had been in contact as both the Younger Veteran and I have not had any correspondence to date. Ian asked me to hold while he checked with Sue Denton.

Sue took the call stating that the file was still in the office, she could not recall the conversation and that she could not see any notes to that effect. I informed Sue that I had made a record of our conversation of the 28th Jan 09 and read to her the notes that I had taken. Sue was most apologetic. I stated that I was very annoyed, also that the Younger Veteran with four significant psychological disabilities needs to be contacted by letter of apology explaining the unacceptable situation.

Although Sue Denton is at fault, blame can also be apportioned to those charged with the responsibility to ensure cases are progressed in a timely manner.

Additional Information provided 10 July 2009:

Pte 6RAR, War service in Iraq) is having with regards to his MRCA claim. To say that this younger Veteran is being treated poorly by DVA/MILCOMP would be an

understatement indeed. Without going into a long story, I have condensed the time line of events to dot point:

1. The younger Veteran was medically discharged from 6RAR Dec 06, with four significant psychiatric illnesses; PTSD, Anxiety, Major Depressive disorder and Agoraphobia.

2. The Veteran received a B Class MSBS medical discharge pension, no ongoing prescriptions for medication, no referral for specialist treatment.

3. The Veteran recalls being given a MRCA claim form by a person at the Discharge unit in Brisbane two days prior to discharge, he was not given any assistance in completing the form. The Veteran was so bombed out of his head on 200mg of Zoloft and whatever of Valium, very confused as to what to do with the claim form, he stuffed it in his bag and sent it to DVA on return to his home in Shepparton Victoria.

4. Around about July or August 07 the Veteran recalls (can't be exactly sure) that he phoned DVA regards the progress of his claim, he was informed because he did not respond to their correspondence sent to him, that they have not made progress with his case. The Veteran was completely gutted at this news, very angry and confused as to what to do, understandably.

5 Several months later the Veteran out of sheer desperation called into the Shepparton RSL for assistance, they sent the Veteran to our Goulburn Valley Veterans Service office at the rear of the RSL.

6 As you can imagine the Veteran was in a very angry and distressed state of mind. I made enquires with DVA regarding the Veterans MRCA case. I was informed because the Veteran failed to respond to their correspondence earlier in the year, his case has not progressed. I requested to know what address the correspondence was sent to. MILCPOMP were unable to locate the file. My response to that news was, didn't anyone at MILCOMP realise the extent of the Veterans Psychiatric illnesses. I was informed, sorry the Veteran will have to send in a new MRCA claim form. On hearing that news the Veteran went ballistic.

7 A new MRCA claim was sent on the 21st Dec 07. After speaking with the Veteran I found out that he was living on his B class MSBS medical discharge pension. The veteran is married his wife works full time. I organised the Veteran to obtain on going medical certificates from his GP in order to get incapacity payments. Also organised the Veteran to commence counselling with VVCS and to regularly attend treatment with our local Psychiatrist Dr Percival. Up to this point in time the Veteran was taking a host of medication, which he was paying for, he had not received any professional treatment other than talking to his GP who was making out the prescriptions for his medication. I called DVA and managed to negotiate to get a White Card for the veteran.

8 Letter from MILCOMP 11th Apr 08, need POI documentation – they had lost it again, sent a second time. Same again in July for a third time.

9 At long last MRCA decision accepts all four conditions, 12th Aug 08.

10 Needs Assessment 10th Sep 08. Dr Percival to do medical assessment. File to be sent to PI office Brisbane.

11 28t h Jan 09 called Sue Denton, MILCOMP, reference Veterans file going to PI, haven't received any correspondence to date, what is going on. Sue is Sorry file still on her desk, will send to Brisbane by end of the week.

12 22nd Apr 09 again called Sue Denton, still no correspondence from PI Brisbane, where is the file. Sue Denton is very sorry, has been going flat out with extra work, and forgot to forward the file to PI Brisbane. Not happy with her reply, ask to speak with her team leader (Ian). Team leader now aware of the situation, I requested the file to be sent to PI Brisbane as a matter of urgency. Also requested that someone send a letter of apology to the Veteran regarding their disgraceful lack of management of his case, please explain the situation.

13 30th Apr 09, called the veteran, no letter of apology, called MILCOMP, Sue on leave, Sue sent a letter of apology last week - please check which address, letter sent to Veterans old address, he informed DVA of change of address months ago and has a copy of the letter sent to DVA. Spoke to Team Leader, Ian, will fax a letter of apology ASAP, letter received and given to the Veteran.

14 17 Jun 09 called PI Brisbane, have file, was sent 22nd Apr 09, received 4th May 09, spoke to a Daryl (Maclaryn I think). I explained that the Veterans Psychiatrist Dr Percival has requested that he is to do the Veterans PI assessment. Dr Percival is most concerned regarding the severity of the Veterans four psychiatric conditions, he is serious that the Veteran stays close to the support that he has in Shepparton. In other words the Veteran is not capable of travelling to Melbourne, due to his anxiety, panic attacks and agoraphobia. Daryl is to write to Dr Percival, Daryl can be contacted on 0732238588.

15 1st Jul 09, called Daryl, PI Brisbane, sorry Daryl is on leave so has left the matter for Arthur to do, who was on leave but now back at work, asked to speak to Arthur. Asked Arthur what is going on, I was expecting a letter from PI a couple of weeks ago. Arthur explains that he is just back from leave, he will have to arrange a specialist appointment for the Veteran in Melbourne. I explained no that is not the case, as stated to Daryl the Veterans Psychiatrist will be doing the PI assessment. Arthur states that he can't see any notes to that effect on the Veterans file. I said well Arthur I can because I am reading from my record of conversation that I had with Daryl over two weeks ago. Arthur stated that he would speak to Dr Percival. Several minutes later Arthur called me back to say, yes, Dr Percival will be doing the PI assessment on the 14th Jul 09.

16 8th Jul 09 letter received from PI Brisbane for PI assessment appointment, with Dr Percival. Also received and sent lifestyle questionnaire. Also the veteran is now separated from his wife.

As of 12 July 2009, the veteran has undergone a PI Needs Assessment. Later discussion of the practitioner with the veteran has indicated that he was seriously contemplating suicide and he is now estranged from his wife as a result of this case and handling thereof.

Synopsis:

It is apparent that the Average Staffing Levels (ASL) within the Department (DVA) is simply inadequate in terms of handling the case load and complexity of working with three separate Acts. It is known that in the Victorian State Office (VSO), that three Assessment teams and a Military Compensation team have been reduced to one team, dealing with complex and multiple Acts. The VSO is also handling the cases for Tasmania.

It is viewed that the DVA staff cut-backs have been premature in terms of the expectation of a reduced WWII and War Widow clientele over the next 5 years. The resultant outcome of the apparently lack of Staff and expertise in the field of multiple eligibility is causing grave concerns for not only veterans and their families, but also the Staff that are employed within DVA.

We are aware that a number of Staff members have taken stress leave, as a result of the pressure to clear backlogs and to provide timely processing, in particular toward MRCA cases.

It is therefore recommended that the Government increase the ASL for DVA and also train Staff to be multiple eligibility capable for handling complex cases.

Wayne McInnes.

AUSTRALIAN PEACEKEEPER & PEACEMAKER VETERANS' ASSOCIATION
NATIONAL EXECUTIVE
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Listed Ex-Service Organisation with the Department of Veterans' Affairs ESO Directory

Saturday, 17th March 2007

Annex C: Special Rate Disability Pension Offsetting against COMSUPER Pensions.

The Special Rate Disability Pension (SRDP) will be offset 60 cents to each dollar of received COMSUPER Pension (either Invalidity or Retirement), under the Military Rehabilitation & Compensation Act 2004 (*MRCA), s204(5) &(6).*

Having studied the COMSUPER Home pages (www.comsuper.gov.au) and gleaning information in support of the Australian Peacekeeper & Peacemaker Veterans' Association (APPVA) contention, that the SRDP, or "Safety Net", under the MRCA is unfair and reduces the prospective veterans' income for life.

To support the above comment, I offer you the following for rationale:

1. **DFRDB.** The scheme ceased to new ADF members in 1991. The provisions of the Scheme are complex, however some principle provisions are:

   a. Contributions by members are at 5.5% of salary.

   b. Invalidity benefits.

   c. Redundancy or Retrenchment benefits.

   d. Death Benefits.

   e. Commutation of Lump Sum.

   f. Pensions paid for life.

2. **MSBS.** The MSBS scheme is compulsory for all members of the ADF since 1991. A copy of the MSBS Investment Performance is attached to this paper.

a. Member Contributions are at 5%, with increase available as an option to members at 1% increments, to a maximum of 10% of salary. The Member Component of the MSBS Structure is Member Contributions plus accumulated earnings on the contributions.

b. Employer Contributions consists of a defined benefit equal to Total Accrued Multiple X Final Average Salary over a period of three (3) years (FAS 3).

c. 3% Benefit is Employer contribution of 3% of salary less 15% employer contribution tax together with accumulated earnings. The 3% forms part of the employer component.

The member contributions from DFRDB are deposited into the Commonwealth Consolidated Revenue Fund (CRF), and is paid after the member retires after 20 years service (15 years if enlisted at 40 years of age), upon invalidity or to the family of the member on death. The CRF is not a wealth created or invested fund and it is used by the Commonwealth as necessary by the Department of Finance. The DFRDB is more or less a deal that was made with the ADF that service and contributions and retirement will provide generous benefits to those members of the DFRDB, who would be enticed to stay in the ADF for 20 years. One would say an excellent personnel retainer, given today's competitive job market and falling ADF member retention.

The member contributions of MSBS however, are placed into a very different situation that those in DFRDB. The MSBS member contributions are governed by a Trust Deed and rules set out the full membership, contributions and benefits of the *MSBS Act 1991*. Therefore, in contrast to DFRDB, which is Legislation, the MSBS Trust is able to change Rules and conditions, as has been witnessed in the past. The Member Contributions of MSBS are invested by the Trust into Global Share markets and other investment strategies, similar to investment strategies for other Superannuation and Investment entities in Australia.

If a loss is recorded for MSBS, then the Member's fund will suffer that loss. For example from FY 01/02, the MSBS Fund earned -8.7%, in FY 02/03, the MSBS Fund earned -2.0%, as a result of market pressures. In contrast to DFRDB, the Fund did not lose its base, as it is CPI indexed, whereas the MSBS fund is not CPI. Another consideration to note is that the Public Sector Superannuation Scheme (PSS) is legislated to not provide losses for its contributing members in accordance in with the legislation. So, when MSBS members lost -8.7% in FY 01/02, PSS remained on 0% earnings, as the loss below 0% is legislated to be provided by the Government. Hence, the Government does not provide this safety measure to the MSBS Fund, which any loss is borne by the Contributing members and the superannuants of the Scheme.

The relevance of the above comparisons of schemes is deemed necessary to understand how the member's contributions are not counted by the Government in the case of Offsetting IAW *s204 (5) & (6) of the MRCA 2004*. The Government has stated in its reasons behind this Offsetting Provision, is that the COMSUPER Pensions are solely provided by the Government, and therefore constitutes "***Double Dipping"*** of entitlements to entitled members. This is because the Government provides a Non-Economic Loss payment/pension of the SRDP, and believes the veteran in receipt of COMSUPER is taking double payment.

MSBS members who elect to take the Safety Net of the *MRCA, Chapter 4 Part 6,* will be fundamentally disadvantaged, as the Government has stated that they also fund the Superannuation. This is not exactly correct, as the Member Contributions are invested by the MSBS Board, is market reactive and market dependant. The Government Contributions

(Employer Contributions) are as a result of Superannuation Guarantee Legislation, in which they are obliged to contribute to its employee's superannuation, as much as the employee him/herself.

The SRDP is to be calculated using the current Totally & Permanently Incapacitated (TPI) Special Rate (SR) of pension under the *Veterans' Entitlement Act 1986 (VEA)*. Within the *VEA*, it does not appear to breakdown SR from 100% of General Rate up to the Special Rate as an earnings loss. In Clarke, SR was described as Non-Economic Loss (NEL) for loss of function, Lifestyle effects, pain and suffering.

Economic Loss (EL) is deemed to be income lost, due to the inability to work – therefore veterans with Qualifying Service (QS) are entitled to War Service Pension (WSP), which is Income Support Supplement (ISS) to assist veterans to achieve a quality of life. Those veterans without QS do not have ISS; however the Government has initiated the Defence Force Income Support Allowance (DFISA), in order to provide a form of ISS to veterans under Schedule 3 (Non-warlike or Peacetime service) of the VEA. DFISA is provided after application by the veteran to Centrelink for the Disability Support Pension (DSP), which reimburses the amount of SRDP loss when the DSP is means and assets tested.

Regardless, the EL or Superannuation is Income and Assets tested, in which the ISS is reduced according to Assets and Income that the veteran holds.

Therefore, the veteran will be hit twice with offsetting in the form of *s204 (6) (Offsets)*, which will be the reduction of the SR value by 60 cents in the dollar **and** having their COMSUPER reduced in the means and assets testing of WSP, or Disability Support Pension (DSP)/.DFISA.

SR under the VEA is not reduced because of income received from COMSUPER.

Therefore, in consideration of the above, a veteran who is Severely Incapacitated as a result of their service on or after 1 July 2004, who elect the Safety Net Provisions under the *MRCA Chapter 4 Part 6*, will be significantly disadvantaged, in comparison to a TPI veteran under the VEA.

The offsetting provisions of MRCA under the election to choose the option of the SRDP *(Chapter 4 Part 6*), with severe penalty for receiving either or both a pension or lump sum under a Commonwealth Superannuation (COMSUPER) scheme as a result of the retirement under *s204 (Offsets) (5) & (6)* is considered unfair and harsh. It is also noted that further reduction may be inflicted if the person has retired voluntarily, or has been compulsorily retired, from his or her work, under *s204 (5) (a)* of the MRCA. This is seen as a brutal reduction to a given veteran under the MRCA. Under the VEA and/or SRCA (if the member has dual eligibility or not), the Special Rate of pension and/or Lump sum Permanent Impairment (PI) is **not offset** as for *s204 of MRCA*.

This is an anomaly that requires rectification to make the SRDP a viable option for those who are in receipt of COMSUPER pensions or lump sums and wish to make the election toward an attractive option within the MRCA, and provide a reasonable quality of life for a veteran.

(Signed)

P.A. Copeland,
CBUS (USQ), Adv Dip Comms Mgt, Dip Proj Mgt (UNE), Dip WAT (RMIT), Dip FM (I), Cert Radio Freq Mgt,
National President

Investment Market Update - May 2009

By any measure 2007–08 was a difficult year for financial markets and investors, given the extreme volatility experienced in global markets as a result of what is now widely labelled the 'Global Financial Crisis' (GFC).

However, the second half of 2008, and the first quarter of 2009, has only seen this situation deteriorate further as the GFC's grip extended beyond world financial markets to negatively affect wider world economic growth, employment markets and ultimately consumer confidence generally.

The past nine months has as well seen a number of major economies fall into recession, including the USA, UK, Japan and most major EU countries. While the March quarter data is expected to confirm that Australia is now in a technical recession, as determined by two consecutive quarters of negative GDP growth, as many commentators have argued, it doesn't really matter—it feels like a recession in any event.

Many commentators attribute the collapse of Lehman Brothers investment bank as the catalyst that pushed the World's investment markets over the edge, sparking a rout on world stock exchanges and other listed markets as investors sought to de-risk and de-leverage themselves and make for the relatively safer havens of cash and sovereign bonds (fixed interest). At the same time, banks the world over were limiting access to credit in the last quarter of 2008 and into 2009.

While Australia's economy arguably fared better during this period, it was far from immune from these tumultuous events. Indeed, our share market, as measured by the ASX200 Index, finished 2008 some 30% lower than its July 2008 level. During this period, Australia's commodity prices suffered as well, which affected its export earnings, and the Australian Dollar retreated from being near-parity with the US Dollar at the start of 2008 to around $0.68c.

During the first quarter of 2009 the governments of a number of major world economies, such as the US, Japan and Europe, rolled-out a range of stimulus packages and measures designed to stem the economic carnage and to, in the words of the US President, "stabilise the patient".

At the time of producing this report it appears that these actions may be having the desired effect. The Australian and other World share markets clawed back some of the losses experienced over the past 12 months and performed positively in March, daily volatility in these markets has moderated, banks have resumed lending (albeit cautiously) and the price falls experienced in the commodity markets have stabilised.

So, against this background, how has Military Super fared?

Military Super's Investment Performance

Military Super, like all superannuation funds, maintains a diverse spread of investments across both listed and unlisted investments and markets. Just as Australian households and businesses have seen their balance sheets affected by falling asset prices, so too has Military Super and all other superannuation funds.

Listed share markets have fallen some 50% over the past year, directly impacting on Military Super's investment returns, as reflected in the reduction in the value of our daily unit prices. However, we have been somewhat cushioned from the full brunt of negative returns as a result of our strategic investment policy and asset allocation model which provides that Military Super maintains a sizeable exposure to unlisted assets, such as infrastructure, property and private equity, which to a degree do not move in parallel with the movements in listed markets.

This investment strategy, coupled with a decision by the Board in late 2007 to invest net new funds in cash rather than equity and growth-orientated asset classes, has held us in good stead, as evidenced by the table below which illustrates the relative performance of Military Super's default (Growth) option, which most Members are invested, as against it peer universe.

The relative performance of Military Super's default (Growth) option

	1 Month Return	3 Month Return	FYTD Return	1 Year Return	3 Year Return	5 Year Return
Military Super's Net Return	-3.78%	-5.91%	-5.01%	-4.48%	3.17%	7.75%
SuperRatings's Median Fund return	-4.73%	-7.43%	-22.85%	-26.03%	-6.60%	2.43%
Military Super's Out performance	**0.95%**	**1.52%**	**17.84%**	**21.55%**	**9.77%**	**5.32%**
Military Super's Rank	22nd of 78	20th of 78	1st of 77	1st of 79	1st of 73	1st of 62
Quartile	2nd	1st	1st	1st	1st	1st

As at end February 2009. Source: SuperRatings

This has been a strong and durable performance for our Fund, especially during the past 12 months, but more importantly over the longer term. Unlisted assets are formally valued less frequently (usually monthly or quarterly) than listed assets (daily by stock markets and other indices). Therefore, where these assets have experienced a similar, or more moderate fall in value during the last quarter of 2008 and early 2009, these lower values have and are being factored into unit pricing as these are received.

Despite the difficult investment environment we are currently experiencing, for the financial year to March 2009, Military Super continues to achieve competitive investment returns net of taxes, fees and charges as follows:

Investment Options Performance (at 5 April 2009)

Strategy	Percentage change since 1 July*
Cash	+3.9662%
Conservative	-3.0995%
Balanced	-7.2259%
Growth (default)	-7.7834%
High Growth	-15.0280%
SuperRatings Median Growth Fund (to March 2009)#	-22.47%

Source: SuperRatings Survey
* Financial year to date rates of return are from 1 July 2008 to 5 April 2009 and are net of taxes and fees.

We understand that for some it is difficult to maintain a long-term perspective during 'bear' markets such as the one we are all presently experiencing. But it must be remembered that superannuation is a tax-effective savings vehicle for retirement and as such is best formulated on the basis of long-term, risk-adjusted, investment strategies and plans that transcend short-term 'boom' and 'bust' investment cycles.

For example, in the period from 2002 to late 2007, Australian super fund investors witnessed very strong growth in investment returns, largely as a result of sustained "bull" runs in both domestic and international equities. During this period members of most super funds, including Military Super, enjoyed returns in the mid to high teens fuelled predominantly by Australia's domestic equity market.

However, investment markets tend to run in cycles and as referred to above, since the beginning of 2008 we have witnessed extreme volatility in markets around the world. Indeed from the high in November 2007 to the current lows in the Australian share market in February 2009, the market has experienced its worst performance in some 26 years.

In this environment most superannuation funds, but particularly those with larger exposures to listed equities, have declared significant negative returns for the first time in many years. For many new superannuation investors this is also the first time that they have experienced negative returns on their retirement savings.

It is important to remember that for most Members superannuation is a long term investment and a super fund's investment performance will change from year to year. Over the long term your retirement savings will grow, but there will be years, or even periods of several years, such as now, where there will be multiple quarters of negative returns.

As unnerving as these periods are, this is a natural feature of investment markets and cycles—even ‘super’ cycles such as the one we are presently in.

Looking Ahead

Military Super will continue to identify and put into effect strategies and plans that seek to preserve Member’s capital and grow their retirement savings as we have done for many thousands of serving and retired military personnel and their families for many years.

In particular, we will continue to critically examine and fine-tune our successful investment strategy which has to date acted to soften the impact of the current market down-turn on the Fund’s investment performance.

Additionally, we see the current investment landscape as soon offering once in a generation opportunities to identify and invest in good quality companies and business enterprises—be they in listed or private markets, at prices that represent good value and that afford Military Super, as a long-term investor, great opportunities to invest and grow the Fund.

We look forward to reporting to you further as to our progress and experiences in these connections in both your 2008–09 Annual Report later this year and in the meantime via Latest News.

Paul Watson
Chief Executive

(2) **MEC 402.** If a member has been deemed medically unfit for deployment in their current occupation, they may be suitable for a deployable profile in an alternative occupation. Any transfer to an other occupation is to be offered after MECRB consideration. The member's change in MEC as a result of occupation transfer can only be approved by the appropriate career management agency. Any member who does not accept the offer of occupation transfer is to be medically terminated and their MEC status confirmed as MEC 402.

(3) **MEC 403.** MEC 403 indicates that the member must be terminated as medically unfit for further service, in accordance with Defence Personnel Regulations (2002).

DEFERMENT OF MEDICAL TERMINATION ACTION

52. In order that a member may be considered for a deferment of medical termination date their case must be considered by a MECRB. No agency outside the MECRB has the authority to defer administrative action or amend a member's MEC in order to prolong a medical termination date. It would be expected that all supporting organisations would continue administrative action to ensure establishing a medical termination date is identified in a timely fashion.

53. When a member has been recommended for medical termination the authorised delegate may consider deferment of termination for a period of up to six months. The authorised delegate may seek further advice from JHSA. Such a deferment should be made where:

a. a claim has been made but not determined under the applicable military compensation legislation, that is, the *Safety, Rehabilitation and Compensation Act 1988*, the *Veterans' Entitlements Act 1986*, the *Military Rehabilitation and Compensation Act 2004*, and preceding compensation/repatriation legislation; and the claim directly relates to the medical condition which resulted in the determination by a MECRB that the member is medically unfit for all further service. However, where liability is subsequently not admitted, any extension approval which has been granted will lapse on the date of determination of the claim; or

b. the injury or illness is attributable to service, ie, where the claim for compensation has been accepted, or is likely to be accepted, under the applicable military compensation legislation; where the authorised delegate, on advice from JHSA, considers that a particular member's recovery, or rehabilitation into civilian life, may be furthered bysuch a decision; or

c. the member is suffering from an incurable disease and the expectation of life is a matter of months.

54. In cases of severe illness or injury attributable to service (as described in paragraph 53.b.) in which the treatment is necessarily prolonged, the authorised delegate may seek further advice from JHSA and a further period of up to six months additional to that specified in paragraph 53., making a total maximum period of 18 months' absence whilst receiving active medical treatment before termination. Any consideration under these circumstances would be deemed exceptional.

Problems within the Army when

Injured Soldiers Discharge or are

Medically Discharged

By

Warrant Officer Class One Michael Quinn

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Executive Summary

Army has a growing problem of the mismanagement of injured soldiers separating from the army without acceptance of liability for service caused injuries. To add to this problem the transition of army personnel who are injured to the point of a medical discharge are not being handed over to the Department of Veterans Affairs for ongoing management with acceptance of liability.

The current system for handling an injured soldier on transfer to the Inactive Army Reserve or medical discharge is very complex and is failing in the majority of cases. Soldiers are missing out on entitlements and acceptance of liability for service caused injuries. This is because the legislation has become so complex that it has become difficult to gain professional case management over the multitude of acts.

Current serving soldiers in the majority of cases are covered by 3 different legislations for compensation and rehabilitation and 2 differing superannuation schemes. Families are being put under financial hardship as the confusion of all entitlements is not being finalized until long after discharge. Those soldiers being discharged with psychological conditions are having their conditions worsened due to discharge with no acceptance of liability, medical treatment or income.

Consideration has to be given by Army to set up an advocacy cell to ensure the correct entitlements are obtained by the relevant compensation and rehabilitation scheme. Transition management of injured soldiers over to the Department of Veterans Affairs needs to be seamless to provide the appropriate level of medical care and compensation.

Failure to implement a system that looks after an injured soldier on discharge will have a significant effect on the family and friends of that soldier. The number of soldiers affected by the current system who have deployed on current operations in Timor, Solomon Islands, Iraq and Afghanistan continue to grow. Multiple deployments are becoming more common than periods of peacetime operations; the army needs to provide for the needs of the men and women who are injured.

It is proposed that an advocacy cell be set up within army to ensure that the army looks after their injured personnel and ensure a people first approach that will enhance capability and public perception. The men and women that have served Australia deserve this level of care. The Army needs to be seen doing the right thing by injured personnel.

PROBLEMS THAT EXIST WITH INJURED DEFENCE PERSONAL LEAVING SERVICE

Aim

1. To provide a briefing on the short falls that exist within army for injured soldiers and those who are being medically discharged. This brief does not target any programmes or departments but is more aimed at the gaps that exist in the current way injured soldiers and medically discharged army personnel transit from the military over to the care of the Department of Veterans' Affairs. Each of the following issues will be addressed:

    a. Transition Management System (TMS);

    b. Australian Defence Force Rehabilitation Plan (ADFRP);

    c. Integrated People Support Strategy (IPSS);

    d. The problems that current serving soldiers face with multi eligibility of rehabilitation and compensations acts being the (Veterans Entitlement Act 1986 (VEA1986), Safety Compensation and Rehabilitation Act 1988 (SCRA) and the Military Rehabilitation and Compensation Act 2004 (MRCA 2004);

    e. COMSUPER for both DFRDB and MSBS and the medical classification at discharge and the offsetting complications and decisions that soldiers under medical discharge are faced with when this is combined with Compensation and Rehabilitation elections;

    f. The handover of injured solders to the Department of Veterans' Affairs (DVA) after discharge;

    g. Shortage of suitably qualified practitioners to assist current serving members in the complex arena of multi eligibility; and

    h. Soldiers falling victim to high priced law firms.

Background and knowledge base of the writer

2. I served in the Army for 21 years as a communicator and transferred over to the Inactive Reserve (IAR) in 2002 at the rank of WO1. During my period of service and the nature of my work in the Royal Australian Corps of Signals (RASigs), I have been employed in; tri service environments, within most Corps in the army and nearly every environment that the army employs soldiers. I have also served on operational warlike service. I served for 2 years as a Career Manager when the army was going through the process of discharging soldiers that were not

deployable and the introduction of AIRN. On completion of my time as a Career Manager in RASigs, I worked as the Trade supervisor of ECN 266 at the Defence Force School of Signals and after giving notice of transfer to the IAR, I spent 12 months in 138 Sig Sqn which at that time had 60% of it's soldiers under medical discharge action and medical waivers; my primary role in this unit was as resettlement officer which was secondary to the role of Communications Manager.

3. I assisted my wife through a medical discharge after 17 years of service and after finding little or no expertise in the area of multi eligibility in the Ex Service Organisations, I became self taught on the 2 relevant compensation acts at the time (SRCA 1988) and (VEA 1986) along with COMSUPER invalidity assessments under DFRDB and MSBS. I later gained the non accredited qualifications through the Training Information Program (TIP), which is a program funded by The Department of Veterans' Affairs, aimed at training selected practitioners in the field of veteran support in rehabilitation, compensation and welfare.

4. For the past 2 years I have been employed by the Australian Peacekeeper & Peacemaker Veterans' Association (APPVA) as a Pension Officer and Advocate. I am qualified under the TIP programme under the SRCA, VEA1986 and MRCA2004 and been deemed competent to Advocate level 3. During this employment period I have only dealt with cases involving post 1975 veterans, current serving and ex-serving ADF members. I have handled approximately 700 claims over this period and have assisted many soldiers through the complex process of; being medically discharged, acceptance of liability, permanent impairment, medical services, rehabilitation and repatriation. I assisted the Victorian TIP training group in the development of the MRCA 2004 advanced course (Level 2) through consultation which is now being delivered as current training.

5. As part of my work for the APPVA I represent on a number of forums concerning younger veterans' entitlement issues and have provided presentations to promotion courses, unit induction training and resettlement seminars.

6. My office is located at the Heidelberg Repatriation Hospital, Melbourne, and a large percentage of my cases have involved current and ex-serving ADF psychiatric patients. I have kept abreast of the development of Transition and other changes within the ADF and have first hand experience in handling soldiers, sailors and airmen/airwomen with broken bodies and minds both in and post service.

Transition Management System (TMS)

7. This system was introduced into Military Discharge Procedures around 2000 in order to assist those members who were being medically discharged. This means that a soldier who is carrying a number of service related conditions does not get picked up by the system unless they are medically discharged; those who are being medically discharged are explained the process and given the paper work to access superannuation and apply for acceptance of liability for service related injuries or disease. These soldiers are also provided a brief on how the DVA entitlement system works and potential compensation entitlements.

8. Unfortunately, it has been observed that the TMS Case Officers are mainly conversant with entitlements under the Military Compensation and Rehabilitation Service (MCRS). Therefore, the soldier does not comprehensively receive information on the VEA 1986 and MRCA 2004. If they have multi-eligibility under the 3 Legislative Acts there is limited knowledge available within TMS. There is also limited knowledge being provided on invalidity retirement under MSBS and DFRDB.

9. All the clients that I assist after their TMS interview are extremely confused about multi eligibility and invalidity COMSUPER assessments. I step them through the process step by step until all the bases are covered and they are ready for discharge. Acceptance of liability for service caused conditions often occurs during the medical discharge process and this is often too late, and results in soldiers not being able to access medical treatment or compensation until long after the discharge process has taken place; leaving them with no compensation for long periods. TMS has become a service that hands out application forms and limited advice. There is little or no case management to transitioning soldiers over to the care of the DVA. The soldiers who suffer the most at the hands of TMS are those with psychiatric conditions who require absolute case management and follow up.

10. An observational problem that exists with the TMS is that it is part of the DVA, which from a soldier's perspective makes them part of the insurance company that handles injured soldiers and therefore; does not provide confidence to the soldiers in the management of the entitlements. TMS does not provide advocacy on behalf of soldiers and this is often to the soldiers' detriment. Many of the cases which I have provided assistance with post army, have been to fix up the guidance given by TMS in relationship to acceptance of liability and incorrect assessments of permanent impairment by DVA contracted practitioners. The soldiers lacked adequate representation at the primary level of the claim.

11. A previous practitioner of the APPVA and current National President (Paul Copeland), whilst operating out of the Heidelberg Repatriation Hospital (HRH), was aware of 2 cases where the TMS Case Officer of soldiers receiving treatment within Ward 17 (Veteran Psychiatric Unit (VPU), were told to sign their pre-

discharge checklist. In addition they were apparently provided with briefings of their entitlements. These soldiers were heavily sedated and could not comprehend what they had signed or assimilate the TMS briefing. On further investigation, it was found that the TMS Case Officers were acting on a deadline to enact the fastest Discharge of the member.

12. The cases above highlight that there appears to be a lack of empathy toward soldiers who are very ill, are on debilitating medication and are not responsive toward their awareness in comparison with a person who is mentally alert. The emphasis of these cases is to provide feedback that TMS Case Officers **must** process these ill soldiers after they are discharged from hospital, with the approval of their consulting psychiatrist and the soldier has stabilised to a degree where they are able to comprehend the information and sign the forms in a sound mind.

Australian Defence Force Rehabilitation Programme (ADFRP)

13. The introduction of this rehabilitation plan was a good initiative which requires much more development; the rehabilitation management of soldiers will become better over time but a number of issues need to be addressed, these are;

    a. There is reluctance by the medical practitioner to hand personnel over to case managers.

    b. The case managers are civilian contractors who have little or no understanding of army. Soldiers need to give a civilian contractor authorisation to access their medical files and they then deal with civilian rehabilitation managers who have little knowledge of the ADF requirements.

    c. Soldiers who are under case management are confused by the myriad of personnel who are looking after them and do not fully understand who does what. They have a rehabilitation manager, a rehabilitation coordinator, a TMS manager, a resettlement officer, a doctor and in most cases an advocate/pension officer from one of the Ex Service Organisations (ESO) explaining it all to them. On top of this they need to have an understanding of a myriad of acronyms of which many financial decisions need to be made.

    d. The ADFRP has only concentrated on the rehabilitation side of the MRCA 2004 and has made no provision to address the problems of acceptance of liability. The latter is understandable as the Service Chief is designated a Military Rehabilitation and Compensation Commissioner (MRCC), only at the Rehabilitation phase of the soldier. The ADFRP is inclusive of all soldiers, regardless of Legislative eligibility.

e. Soldiers have been historically given 3 months and at times less that 3 weeks notice for Intent to Discharge (Termination Notice). This situation is simply inadequate for the soldier to rehabilitate, stabilise, and be fit for Discharge.

f. Opportunities for soldiers are not actively managed by Career Managers and the MECRB, in that rehabilitation, vocational training, re-training, and resettlement appear to be not of a priority. It should be emphasised that soldiers require at least 12 months from date of Termination Notice to be adequately prepared for Discharge. This is most pertinent to those with families.

g. Once downgraded to MEC3R or MEC4, Unit Commanders appear to want to get rid of the soldier, in order to maintain an Operational Level of Capability in manning.

h. The ADFRP needs to be cognisant that these soldiers are experiencing a difficult period of their lives and in many cases it has been observed that the soldier develops Anxiety Disorders and/or Depression during the Transitional Period.

i. Members need to have their compensation entitlements finalised prior to discharge. This alleviates the stress on the soldier post-discharge in obtaining adequate income and receipt of their veteran entitlements.

j. Anecdotal evidence suggests that a full Rehabilitation Plan, with aims, goals to be achieved and time to heal do not appear to be provided to the soldier. Simplistically, under MRCA, Division 3 – Provision of Rehabilitation Programs, section 51 (Rehabilitation authority may determine that a person is to undertake a rehabilitation program), we have yet to see a comprehensive Rehabilitation Program, Plan and incentive for soldiers who have been injured/wounded or ill. Closer consultation is required to fully develop the protocols of these Rehabilitation Plans.

k. As a result of confusion and frustration at the system, soldiers are resorting to the assistance of lawyers, which is costing them time and money, whereas ESO, who specialise in this complex environment, such as the APPVA, provide this service for **free.**

Integrated People Support Strategy (IPSS)

14. The briefings I have been involved with to date and the information I have been able to gain from this programme have been very positive. The concept of management of ADFRP to encompass medical rehabilitation to tie in with Medical review boards, Medical classification, Medical discharge and acceptance of liability for soldiers and where necessary the handing over of cases to the DVA for ongoing management is to be applauded.

15. When a medical discharge takes place or a soldier who discharges at own request with service injuries that have liability accepted; it will show that the army is a people first organisation. The perception of people first organisation will hopefully help retention and recruiting. The Public image of the Army will also be potentially improved.

16. In addition to the above, IPSS policy has yet to be developed nor released. It would be prudent for the Army if skilled practitioners, who have the skills and qualifications of multi-eligibility, experience in the Legislations, COMSUPER and knowledge of the transition process, would be able to consult with the IPSS policy and development team.

Multi-eligibility

17. Current serving soldiers in the majority of circumstances are now covered by 3 differing Legislative Compensation acts, including the Defence Act 1903 for Seriously Ill or death. Some have dual eligibility under the VEA1986 and SCRA with post Jul 2004 service being under the MRCA 2004. Some defence members have long periods of time under the VEA1986 due to when they enlisted. Some are covered by VEA and SCRA when they were operationally deployed prior to 1 Jul 2004 and some are not. Army reservist also have the same complications of multi eligibility with some also having coverage under all 3 acts.

18. Soldiers also have elections they may need to make which have serious financial implications that can not be reverted once the decision is made. The ESO community are making good efforts to provide a quality service however the problem remains that unless the advice and assistance is of the highest quality the soldier may end up making ill informed decisions or in some cases not even get the rehabilitation and compensation they are entitled to.

19. Suffice to say, that the complexity of multi-eligibility requires a specialist approach in order to manage and advise current serving and exiting members of Defence.

DFRDB/MSBS invalidity discharge

20. When a soldier is under the medical discharge process they need firm advice as to how they will be assessed for COMSUPER purposes and what entitlements comes from an A, B or C invalidity determination. The solders not only need assistance understanding the remunerative effects of an invalidity assessment but also what happens with off-setting provision within compensation and rehabilitation Legislation from DVA.

Examples of the failing of the current system

21. These are three actual cases that I have handled and the members concerned have given me permission to use their information but wish to have their names excluded from this document. The names can be provided separately "Medical-in-Confidence" for validity if required. These particular cases are ones that have stood out within the past 12 months however is only a sample of the cases being handled by my office.

Case one

a. I was approached by an RMO to speak to a soldier who was going to be medically discharged. The soldier had been diagnosed with a number of psychiatric conditions (4 in total and all had been determined as not related to service after he was advised by DVA to lodge a claim under the MRCA 2004 for acceptance of liability). After interviewing the soldier I found that he had been passed between 5 psychiatrists since his psychological problems had started. He had also been posted from Brisbane to Darwin and then to Melbourne during this period and had operational deployments to both Solomon Islands and Kuwait.

b. After some quite extensive interviewing and investigation the soldier revealed that he had a number of fairly significant stressors during his deployments and that the psychiatric symptoms he was suffering came under his VEA and SRCA eligible service. The soldier was medically discharged prior to his claims being processed and he was assessed as a Class A for COMSUPER purposes. Three months after his discharge another advocate I work with and myself were able to consolidate the psychiatric reports and provide evidence to have the condition of schizophrenia accepted as being aggravated as the result of a severe stressor he was exposed to in the Solomon Islands.

c. His case is also being processed under the VEA and his full entitlement will be determined within the next few months. This soldier, under the current handling procedures of TMS, ADFRP and the MEC Review Board (MECRB) was discharged with a service aggravated condition with no medical assistance available from DVA and the financial hardship of having no compensation. This soldier is now receiving the entitlements he should however the current system let him and his family down severely during the current medical discharge system.

Case two

a. A soldier who was on posting from Victoria to Sydney was diagnosed with a severe anxiety disorder and was put on sick leave over the Christmas period 2006. He wasn't handed over to a rehabilitation manager and his psychiatric treatment started at the Heidelberg Repatriation Hospital and he was managed by the local RMO at Watsonia. He approached a local RSL near where he lived and a claim was lodged under the VEA for his service caused anxiety for a condition that developed in Iraq in 2006. As the claim progressed the

pension officer assisting him became confused when his claim was moved from the VEA 1986 to MRCA 2004 and he also realised he had dual eligibility under the VEA 1986 and SCRA 1988 for other peacetime injuries. The soldier concerned was also under DFRDB and needed information as to what were the implications of a med discharge after 24 years in army.

b. The soldier was referred to me to gain assistance and the long process of identifying his entitlements and making claims began. Whilst this was happening the soldier was unable to understand the complex legislation he was making application under. His claims were finalised under the MRCA 2004 for his severe anxiety disorder/PTSD and loss of earnings were applied for and are in the process of being recovered. Prior to his deployment to Iraq he had also been in Timor and had 24 years of service in infantry where he had suffered from a number of injuries based on wear and tear, parachuting incidents and a significant barotrauma. Acceptance of liability for his psychiatric condition has been accepted under the MRCA 2004 and his physical disabilities have been accepted under the VEA1986. He has made a reasonable recovery and is nearly ready to step from the army to a civilian career. Liability still needs to be accepted under the SRCA due to dual eligibility for peacetime injuries.

c. The MECRB has advised that once he is stabilised he will be discharged. He gained no assistance from his rehabilitation manager and as yet has not been contacted by TMS. TMS will be involved once a letter of termination is issued. He will be discharged as a Class C (requested) or Class A under DFRDB, 80% disability pension under the VEA 1986 for his physical injuries and is awaiting MRCA 2004 to make a determination on Permanent Impairment for which his condition needs to be considered stable prior to assessment. His claims under the SCRA 1988 will be submitted once MRCA 2004 has made determinations on a few outstanding issues. He will be in receipt of Incapacity payments until employable from the MRCA 2004 once discharged. In this particular case the soldier was extremely lucky to get assistance at this early stage and will allow for an easy handover to DVA for ongoing management with all claims being processed. Assistance for this kind of complex claim is not available from the majority of ESO, TMS or Defence. The soldier is still currently serving, Med 3 and is to be presented to the MECRB. From a case management point of view as his advocate he is ready for discharge but his case is not finished. The soldier once discharged will need the assistance of ESOs for ongoing management.

Case three

a. A current serving soldier receiving treatment for PTSD, Anxiety and Depression at ward 17 in the Heidelberg Repat Hospital approached me for assistance with making claim for acceptance of liability. He had advised me that he was to be discharged within 3 weeks and that TMS had given him

forms but he had not been able to cope with addressing the problem of dealing with DVA; TMS failed to do any follow up on the soldier who was suffering severe psychiatric symptoms at the time. I contacted SCMA to have his discharge date changed to allow time to process his claims; after some reluctance the SCMA SO3 Separations agreed that there was a duty of care for the army however; I had to meet their deadlines for lodgement of the claims or his discharge would take effect. The claim was lodged and SCMA advised me verbally that the discharge date would be changed to allow for acceptance of liability and handover to DVA for ongoing treatment and the financial fall back of economic loss. After this agreement was reached with the SO3 Separations the soldier was discharged prior to acceptance of liability and had a gap period of approx 1.5 months before liability was accepted for all conditions applied for at the primary level under the MRCA. The SO3 Separations at the time I was dealing with was Capt Waters; I advised of the situation by formal correspondence and received a verbal reply by telephone. The soldier is very disappointed with army and accepted this early discharge without notifying me of his circumstances. He is currently under going treatment as an inpatient at ward 17 and could have easily been another suicide statistic awaiting investigation. This failing on army to assist this soldier considerably contributed to this soldier's current mental state. I would believe that this particular case would prevent any family or associates of this veteran considering a career with army. Therefore may affect future potential enlistments.

Current Problems highlighted by these example cases

22. All the above three cases failed in the same simple areas, these being:

    a. No firm linkage between Medical, Rehabilitation Manager, Rehabilitation co-ordinator, SCMA, TMS and DVA.

    b. TMS failed to provide advocacy to manage the soldiers to the point of acceptance of liability for handover to DVA.

    c. The soldiers had to rely on the Australian Peacekeeper & Peacemaker Veterans' Association, to provide advocacy and briefs of entitlements and organise the linkage from the Department of Defence to the Department of Veteran's Affairs.

Shortage of qualified practitioners

23. Traditionally advocacy for compensation has come from volunteers within the ex-service community. There have been some paid advocates provided by the ex-service organisations that have represented the soldier at the Veteran's Review Board under the VEA 1986. The speciality of these organisations has primarily

been focused on the VEA1986 and there is a small amount of assistance available under the SCRA.

24. To date there are very few practitioners who are qualified and practiced under the MRCA 2004. A combination in knowledge of all 3 acts is required for current serving members along with a full understanding of COMSUPER medical discharge assessments and entitlements. The end result is that a large number of ex-defence personnel with defence caused injuries and disabilities do not get the rehabilitation and compensation they are entitled to.

Soldiers Falling Victim to high priced law firms

25. A number of the cases I handle have already had representation from law firms. I have had a number of clients who have had their disabilities that pay lump sums processed by law firms like Slater and Gordon and Darcy's (these 2 firms have recently amalgamated). The soldiers' sailors and airmen/airwomen have paid up to $14,000 in fees to receive $27,000 in compensation. Therefore the service person is disadvantaged and only receives $13,000 from the potential $27,000. I have had a number of clients with minor disabilities that I have processed for the member after the law firm had finished their claim; this is because the law firm would not make any money on these claims. Another problem these legal firms have caused a number of ex defence members is making claims under the act that pays the largest lump sum to ensure payment rather than the act that is more beneficial to member (i.e.: VEA 1986 or MRCA 2004).

To fix the problem

26. Potentially, the Integrated People Support Program **"may"** address the majority of the issues I have raised in this paper. The problem that is not being addressed is; assistance of current serving members to gain acceptance of liability while they are still serving and before they are advised they will be medically discharged. Also current serving members who discharge at own request that don't have their service caused disabilities accepted for liability and treated by the DVA.

27. Once a Soldier has been identified as requiring the services of a rehabilitation officer there should be a direct linkage to professional assistance to gain acceptance of liability from the Department of Veterans Affairs. The soldier would be rehabilitated and hopefully returned to work in Army. If the injury deteriorates and causes a medical discharge there would be the ability for a smooth handover to the Department of Veteran's Affairs and linkage to an Ex-Service Organisation for ongoing management post service.

28. I firmly believe that this advocacy should be provided within the army chain of command by qualified and experienced practitioners. In an ideal environment these advocacy services are suggested to be provided by reservists in uniform, who would have the interests of the injured soldiers, reservists or cadets as there

primary task; not an extra regimental appointment. There are a number of suitably qualified practitioners who could be in uniform providing this service now. However to grow an adequate amount to service the whole of Defence would take considerable planning and the implantation of an appropriate training programme.

29. I am very keen as an inactive reservist to work on a project with aim of providing these services across army and or defence. As a practicing advocate for post 1975 veterans' and defence personnel I feel that I can offer the professional assistance to help plan for these services being available to all soldiers in the future by creating an advocacy cell and a network of army reservist that could service the whole of army. The network is available amongst some inactive reservist now however medical waivers for ARES or ARA, or the appointment of Specialist Service Officers would need to be recommended in order to obtain the specialist skills required to form a fully trained and working advocacy cell. I am personally prepared to take on this project under DA50 contract, full time under CFTS, or transfer from IAR to ARA and relocate to Canberra.

WO1 Michael Quinn
Advocate APPVA

The Australian Peacekeeper & Peacemaker Veterans' Association.
Response to the Consequential and Transitional Provisions Act 2004,
No. 52, 2004
Compiled July 2009.
(CTPA Table to MRCA 2004).

Serial	Reference	Item Description	Matter of Contention.	Remarks.
001	Part 2 Application of the MRCA to certain injuries, diseases, deaths, losses and damage. S7, Part 2 Application of the MRCA to certain injuries, diseases, deaths, losses and damage.**"**	S7(1) Note: After the commencement date, benefits stop being provided under the VEA and SRCA for such injuries, diseases and deaths (see section 9A of the VEA and s4AA of the SRCA).	Interpretations point of this note suggests that all payments, compensation, income support, treatment and pharmaceuticals cease on the commencement date from VEA and SRCA. If a veteran is in receipt of any Income or dependant upon income from the VEA and/or SRCA entitlements, how will the veteran maintain the standard of living whilst the process of MRCA for PI and IP? It is well known that the MRCA system is slow and cumbersome.	Further interpretation required or explanatory notice, however this Note will be of detriment to the veteran, particularly if he or she are compensated for differing conditions, along with the reliance of such compensation income. As a result of this situation, the veterans' previous income from VEA and\or SRCA, the period in between of MRCA acceptance to payment of PI and IP, places the veteran in a financial hardship in terms of regular income, as the veteran will not be receiving benefits under MRCA until the completion of the investigation process.
002	Part 2, s7(2)	Note 1: After the commencement date, benefits stop being provided under the VEA and the SRCA for such aggravations and material	Interpretations point of this note suggests that all payments, compensation, income support, treatment and pharmaceuticals cease on the commencement date from VEA and SRCA.	Further interpretation required or explanatory notice, however this Note will be of detriment to the veteran, particularly if he or she are compensated for differing conditions, along with the reliance of such compensation income.

		contributions (s9A VEA & s4AA SRCA).	If a veteran is in receipt of any Income or dependant upon income from the VEA and/or SRCA entitlements, how will the veteran maintain the standard of living whilst the process of MRCA for PI and IP? It is well known that the MRCA system is slow and cumbersome.	As a result of this situation, the veterans' previous income from VEA and\or SRCA, the period in between of MRCA acceptance to payment of PI and IP, places the veteran in a financial hardship in terms of regular income, as the veteran will not be receiving benefits under MRCA until the completion of the investigation process.
003	Part 2, s7(2), Application of the MRCA to certain injuries, diseases, deaths, losses and damage.	Note 2: The MRCA does not apply to an aggravation or material contribution if a person instead applies under s15 of the VEA for an increase in pension because of the aggravation or the material contribution (see s9 of the CTPA).	Interpretations point of this note suggests that all payments, compensation, income support, treatment and pharmaceuticals cease on the commencement date from VEA and SRCA. If a veteran is in receipt of any Income or dependant upon income from the VEA and/or SRCA entitlements, how will the veteran maintain the standard of living whilst the process of MRCA for PI and IP? It is well known that the MRCA system is slow and cumbersome.	Further interpretation required or explanatory notice, however this Note will be of detriment to the veteran, particularly if he or she are compensated for differing conditions, along with the reliance of such compensation income. As a result of this situation, the veterans' previous income from VEA and\or SRCA, the period in between of MRCA acceptance to payment of PI and IP, places the veteran in a financial hardship in terms of regular income, as the veteran will not be receiving benefits under MRCA until the completion of the investigation process.

004	Part 2, s8(1), Application of the MRCA to injuries, diseases and deaths etc. caused by certain treatment.	Note: After the commencement date, benefits stop being provided under the VEA and SRCA for such injuries, diseases and deaths (see s9A VEA & ss6A(2) SRCA.	Interpretations point of this note suggests that all payments, compensation, income support, treatment and pharmaceuticals cease on the commencement date from VEA and SRCA. If a veteran is in receipt of any Income or dependant upon income from the VEA and/or SRCA entitlements, how will the veteran maintain the standard of living whilst the process of MRCA for PI and IP? It is well known that the MRCA system is slow and cumbersome.	Further interpretation required or explanatory notice, however this Note will be of detriment to the veteran, particularly if he or she are compensated for differing conditions, along with the reliance of such compensation income. As a result of this situation, the veterans' previous income from VEA and\or SRCA, the period in between of MRCA acceptance to payment of PI and IP, places the veteran in a financial hardship in terms of regular income, as the veteran will not be receiving benefits under MRCA until the completion of the investigation process.
005	Part 2, s8(2)	Note 1: After the commencement date, benefits stop being provided under the VEA & SRCA for such aggravations and material contributions (see s9A VEA and ss6A(2A) SRCA).	Interpretations point of this note suggests that all payments, compensation, income support, treatment and pharmaceuticals cease on the commencement date from VEA and SRCA. If a veteran is in receipt of any Income or dependant upon income from the VEA and/or SRCA entitlements, how will the veteran maintain the standard of living whilst the process of MRCA for PI	Further interpretation required or explanatory notice, however this Note will be of detriment to the veteran, particularly if he or she are compensated for differing conditions, along with the reliance of such compensation income. As a result of this situation, the veterans' previous income from VEA and\or SRCA, the period in between of MRCA acceptance to payment of PI and IP, places the veteran in a financial hardship in terms of regular income, as the veteran

			and IP? It is well known that the MRCA system is slow and cumbersome.	will not be receiving benefits under MRCA until the completion of the investigation process.
006	Part 2, s8(2)	Note 2: The MRCA does not apply to an aggravation or material contribution if a person instead applies under s15 of the VEA for an increase in a pension because of the aggravation or material contribution (see s9 MRCA).	Interpretations point of this note suggests that all payments, compensation, income support, treatment and pharmaceuticals cease on the commencement date from VEA and SRCA. If a veteran is in receipt of any Income or dependant upon income from the VEA and/or SRCA entitlements, how will the veteran maintain the standard of living whilst the process of MRCA for PI and IP? It is well known that the MRCA system is slow and cumbersome.	Further interpretation required or explanatory notice, however this Note will be of detriment to the veteran, particularly if he or she are compensated for differing conditions, along with the reliance of such compensation income. As a result of this situation, the veterans' previous income from VEA and\or SRCA, the period in between of MRCA acceptance to payment of PI and IP, places the veteran in a financial hardship in terms of regular income, as the veteran will not be receiving benefits under MRCA until the completion of the investigation process.
007	Part 2, s11, Application of the MRCA to loss or damage to medical aids.	Note: After the commencement date, benefits stop being provided under the SRCA for such loss and damage (see s15A SRCA).	Interpretations point of this note suggests that all payments, compensation, income support, treatment and pharmaceuticals cease on the commencement date from VEA and SRCA. If a veteran is in receipt of any Income or dependant upon income from the VEA and/or SRCA	Further interpretation required or explanatory notice, however this Note will be of detriment to the veteran, particularly if he or she are compensated for differing conditions, along with the reliance of such compensation income. As a result of this situation, the veterans' previous income from VEA and\or SRCA, the period in between of MRCA

			entitlements, how will the veteran maintain the standard of living whilst the process of MRCA for PI and IP? It is well known that the MRCA system is slow and cumbersome.	acceptance to payment of PI and IP, places the veteran in a financial hardship in terms of regular income, as the veteran will not be receiving benefits under MRCA until the completion of the investigation process.
008	Part 4 – Other transitional Provisions, s15 No Dual Entitlement for Similar Benefits.	*No dual entitlement for injuries and diseases.*	The contention is that veterans who have accepted conditions, which are separate medical conditions under individual Acts, will have their compensation NEL offset. The practice previously existed prior to 1 Jul 2004 that a veteran could claim a specific disease, for example: psych condition under VEA and muscular-skeletal (back) under SRCA. Both separate injuries without offsetting provisions.	As noted, the principle behind compensation offsetting is that a person should not be compensated twice for the same incapacity. Therefore, there has been a disadvantage approach undertaken in this transitional arrangement, which requires rectification to allow for separate conditions accepted under the different Acts to not be offset against each condition. This therefore follows the principle behind compensation offsetting and is not disadvantageous to the veteran.
009	Part 4 - Transferring superannuation amounts, s16, Item 2.	The superannuation pension amount mentioned in s136 MRCA, is taken to the same as the weekly superannuation amount in SRCA s21(3) - found to be s20.	In using the formula in subsection (3) to calculate an amount of compensation for an employee who retired before the day on which item 22 of Schedule 1 to the *Safety, Rehabilitation and Compensation and Other Legislation Amendment Act 2007* commenced, use "SC" instead of "5% of the employee's normal	Superannuation Contributions, which reduces the IP by a further 5% from dollar for dollar offsetting of superannuation or income to IP amount is not consistent with modern compensation philosophy. Revoke this Item.

			weekly earnings". For this purpose: ***SC*** means the amount of superannuation contributions that the employee would have been required to pay in that week if he or she were still contributing to the superannuation scheme. Therefore, s20A(3), is the amount of compensation minus [superannuation amount plus 5% of the employee's normal weekly earnings.]	
010	Part 4, Transferring superannuation amounts, s16, Item 3.	The superannuation amount in s136 MRCA, is taken the same as this SCRA amount of weekly superannuation lump sum benefit mentioned in s21 SRCA. (Lump Sum superannuation).	SRCA s21(3), is the Amount of compensation minus [Interest on the superannuation lump plus 5% of the employee's normal weekly earnings].	Superannuation Contributions, which reduces the IP by a further 5%, from 009, is not consistent with modern compensation philosophy. Revoke this Item.
011	Part 4, Transferring superannuation amounts, s16, Item 4.	The superannuation amount in s136 MRCA, is taken the same as this SCRA amount of weekly superannuation lump sum benefit mentioned in s21A SRCA. (Lump Sum and with weekly pension superannuation).	In this section SRCA 21A(3), is the amount of compensation minus [superannuation amount in relation to the pension plus weekly interest on the lump sum plus 5% of employee's normal weekly earnings].	Superannuation Contributions, which reduces the IP by dollar for dollar superannuation, plus 5% Superannuation Contribution, plus weekly interest on the lump sum of the Superannuation. This is not consistent, nor a fair arrangement for a veteran to be placed into. Severe reduction in this case of a combination of both superannuation Lump Sum and weekly pension is reduced by three factors). Revoke this item.

012	Part 4, s18 Rehabilitation under the MRCA for persons undergoing rehabilitation under the VEA or SRCA.	Within s18(2), the person's rehabilitation authority may determine that the old program stops being provided under the VEA or the SRCA.	In this case, the veteran will not undergo an old program (under VEA or SRCA), of which there may be a continual and consistent program that assists the veterans' rehabilitative goals.	This situation may prevent a detrimental decision, given the TTTP of the MRCG to process Needs Assessments and OT assessments. This may cause an upheaval if the rehabilitation program is assisting the veteran in achieving his/her rehabilitative goals. Further interpretation required.
013	Part 4, s18(4).	If the approved program provider incorporates all or part of the old program, then the Commonwealth must pay all unpaid costs incurred in respect of the old program.	This may cause the veteran to pay upfront for various rehabilitation program(s), during the decision period to process such claims.	That this situation, the Commonwealth continues to pay for the old program rehabilitation until the commencement of the new program under MRCA.
014	Part 4, s24(3). Regulations may provide for transitional etc, issues.	Without limiting s24(1), the regulations may provide; (a) that persons who are entitled to compensation under the MRCA cease to be entitled to a similar benefit under the VEA or the SRCA.	Under s24(1)(a) CTPA, it is inferred that the Commonwealth will immediately cease compensation under MRCA. It is also contended that if the VEA or the SRCA provides for a beneficial approach to a veteran that it remains extant.	The situation within s24(1)(a), suggests that cessation of compensation under MRCA if VEA or SRCA provides a similar benefit. It is felt that if eligible under MRCA, that the eligibility remains extant, unless there is a benefit to the veteran to retain an entitlement under the VEA or SRCA.
015	All CTPA Schedules.	Schedules 1-4	Amendments to the SRCA and VEA.	That subject to the points raised in this submission that subsequent amended is made within Schedules 1-4 of CTPA.

Michael Finnerty
Advocate to the AAT and VRB

24 July 2008
Revised 11 August 2008

WRIGHT'S CASE

DVA is now applying Wright's case to all claims concerning veterans under 65 seeking the Special Rate and Intermediate Rate. Under Wright a veteran must have **ceased work entirely in the employment they were undertaking prior to their claim. The 8 hours,** mentioned in s.24 (1) (b), can only apply to **a different kind of work.**

John Blasic has advised that over 20 claims have been refused based on Wright since late May.

Much of what is summarised below is attributable to Craig Colborne, Barrister at Law, who delivered a paper canvassing the issues in Wright at the 2006 Veterans' Law Conference in July of that year.

In recent times DVA in Melbourne has been applying, what it contends is a precedent, from Wright v Repatriation Commission (2005) 114 FCR302.

The decision in Wright follows decisions in Carter v Repatriation (2001) FCA 992 and Haskard v Repatriation Commission (2002) 126 FCR 1.

Both Haskard and Carter concerned claims for Special Rate by veterans over 65. In the judgements of both these cases the court raised the proposition that any claimant seeking the Special Rate must be ***prevented from continuing to undertake remunerative work that the veteran was undertaking*** to qualify as set out in s.24. In Haskard, Hill J stated that a literal interpretation of this provision was that a veteran was precluded from working at all in that specific line of work. He or she must have ceased that work completely. He went on to propose that ***work aggregating more than 8 hours,*** referred to in the preceding provision, s.24, can only apply to a different kind of remunerative work.

Having previously noted that these two cases involved veterans over 65 at the time they made their claims, it is accepted that s.24 (2A) applies and this is the case. However, the provisions are, in effect, identical to those in s.24 (1) dealing with veterans under 65. In addition they are identical with those provisions in s.23 dealing with both groups of veterans but apply to the Intermediate Rate.

It is clearly absurd to imagine that the Parliament's intention in regard to the provisions dealing with s.23 would render a veteran ineligible for the Intermediate Rate, having satisfied all other provisions, unless he or she was engaged in a different kind of work. Such an interpretation would mean that an

unskilled veteran, only capable of unskilled work, would never qualify for Intermediate Rate. This would clearly be discriminatory. The same applies to the Special Rate.

As the language of s.24 is identical to s.23 it is reasonable to imagine that the Parliament did not contemplate that a veteran seeking the Special Rate or Intermediate Rate would have to have ceased work entirely in the kind of work that was being undertaken prior to making a claim. Similarly the inclusion the provision that a veteran could work up to 8 hours is unlikely to have the narrow and implausible application as that proposed in Haskard. In both cases the veteran has been rendered incapable of working fulltime due to their accepted disabilities. The legislation was put in place, through s.23 ands.24, to compensate the veteran for loss of earnings.

Work, for the purposes of the VEA has been clearly defined over time as to mean any remunerative work that a veteran could do subject to the limitations imposed by s.28. It is nonsense to distinguish work as has been done in Haskard.

The language of s.24 (1) (b) and (1) (c) is, on a strictly literal interpretation, somewhat ambiguous but does not warrant the interpretation canvassed in Haskard.

Before addressing Wright it is important to discuss what was decided in Carter and Haskard to see to what extent each decision binds decision makers.

It is established law that decisions of superior courts bind all decision makers below, but only in so far as the facts in future cases are precisely similar to that decision. If the facts of a future case can be distinguished from those in the earlier decision, the precedent does not apply.

Carter was decided on the basis that the veteran failed to be continuously employed for 10 years as required by s.24 (2A) (g). This decision is consequently not binding on future decisions where the type or extent of work is an issue.

Haskard related to a Veteran who was over 65 when he made his claim and the decision was based on s.24 (2A). The precedent in this case, at best, only applies to similar veterans.

In Wright the case concerned a veteran who was under 65 at the time he made his claim and therefore was required to satisfy the provisions of s.24 (1).

In Wright's case Tamberlin J found on the basis that Wright had failed the "alone test". The judge went on to comment that had Wright relied on the fact that he was working less than 8 hours in ongoing remunerative employment, he would have failed based on the decision in Haskard. Having decided the case on another basis these comments do not form part of the reason for decision and are therefore not binding.

Where a case has significantly altered the way the VEA is construed, DVA has issued a Departmental Advisory as was the case with Delideo, Keeley, Kattenberg and Stoddard. Though Wright was decided

in 2005 there appears to be none for this case. It is also significant that these issues were publicly raised in the presence of DVA senior lawyers at the 2006 law conference mentioned above. It is also clear that Bruce Topperwien holds the same view as Hill J in Haskard and has supported this in a paper titled Recent Court Cases presented to pension officers and representatives in Melbourne 01/09/05 and later in Verbosity.

He was recently contacted by email in regard whether an advisory for Wright had been issued. As yet he has not responded.

Craig Colborne was also contacted and he was gracious enough to respond. His email is attached and provides further weight to the absurdity of applying Wright.

Aside from all the technical arguments the most compelling reason for asserting that the imposition of the so called Wright precedent is wrong is that its application is an affront to substantial justice.

In Roncevich v Repatriation Commission [2005] HCA 40 at p.53 the High Court supported the benevolent nature of the VEA. Noting that the Commission bound to act according to the substantial justice and the substantial merits of the case as set out in s.119. It is incomprehensible to reconcile the application of the principle DVA claims to have arisen from Wright with anything resembling justice.

To compel a veteran, incapacitated through service, to cease all work in their pre claim field and find something different is beyond belief on too many grounds to canvass here. However it does raise a number of interesting questions about s.115 and vocational rehabilitation.

Psychiatrists from the PTSD unit at the Repatriation Hospital and counsellors from the VVFCS have actively encouraged veterans suffering from war caused psychiatric illnesses to maintain some level of engagement with work.

It is of great concern that DVA would apply Wright in light of what has been raised above without any consultation with the Veteran community.

(Email from Craig Colborne not available, however this case has been submitted to the PMAC for further investigation).

AUSTRALIAN PEACEKEEPER & PEACEMAKER VETERANS' ASSOCIATION
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20th June 2009

COMCARE,
P.O. Box 9975,
CANBERRA, ACT, 2601

Subject: APPVA Submission for the Permanent Impairment Guide Edition 2.

Introduction.

1. The purpose of this submission is to articulate areas of the presented Permanent Impairment Guide Edition 2 (PIG 2), by COMCARE, on Monday 30th May 2005 in Canberra.

2. It was noted at the forum that no feedback had been provided to ESOs and was therefore not available at the forum. We request that the feedback and COMCARE responses are available to all participating ESOs.

3. As you would be well aware, the Safety Rehabilitation & Compensation Act 1988 (SRCA) is articulated with the introduction of the Military Compensation and Rehabilitation Scheme 1994 (MCRS). We highlight that the service of an Australian Defence Force (ADF) member holds special circumstances within the ESO Community and indeed with the Federal Government. The approach, since 1918, has always been the "Beneficial Approach" for all current and former Service men and women (Veterans). Members of the ADF work and train in very hazardous circumstances that are dangerous and unique to the task of War-fighting.

4. It is with the Beneficial Approach in mind that we provide this submission to COMCARE, as we believe special consideration must be afforded to veterans and serving ADF members by the Federal Government, and indeed COMCARE.

10% Whole Person Impairment.

5. We submit that the PIG 2 has had a significant change in comparison to the 1st Edition (PIG 1) from 1988. As was stated by Dr Dwight Dowda, consideration toward modern medical advances have necessitated in changes to the PIG. In addition, it is also noted that ambiguity in the PIG 1 has caused a significant impact to the Government in compensating veterans in Permanent Impairment payments (PI).

6. It is with the consideration of the necessary changes to the PIG 2, derived from the American Medical Association (AMA) 5th Edition, that we believe that the threshold of 10% Whole Person Impairment (WPI) is removed from the SRCA, accommodating a fairer compensation payment system.

7. The reason for this proposal is to provide compensation to veterans of any WPI percentage of the current maximum amount. It was noted that a number of veterans would not have been able to receive PI under PIG2, of which we submit that this is due to (in some cases – particularly Musculoskeletal conditions), that veterans would be unable to secure adequate compensation, for the potential of job loss.

8. The PI would be beneficial to a veteran, particularly if they are being medically discharged for the claimed condition(s), in order to prepare for life outside of the ADF. We believe if a veteran is able to say, gain 13% WPI, then the veteran should be eligible for such payment to the full WPI that he/she has been assessed. Therefore 13% of the SRCA Maximum amount for Lump Sum compensation (PI).

9. In addition to the above, we also submit that combined values (Combined Values Table (CVT)), of say a veteran who gains 8% WPI for Lumbar Spine and 18% for Thoracic Spine conditions would be equal to 25% WPI, which is beneficial to the veteran to be paid the full 25% of the maximum amount.

Table 1.1.3 – Activities of Daily Living.

10. We submit that Table 1.1.3 is used as a reference guide for Medico-Legal Assessors as a referral note on all Tables throughout the PIG2. This is ensuring an adequate Objective assessment of the veteran, and prevents ambiguous decisions of claims. Therefore, also perhaps saving the Government substantial amounts of money in either the Review process or hearings before the Administrative Appeals Tribunal (AAT).

Disability.

11. Although Dr Dowda explained that compensation is composed of Medical Impairment and Disability, and that the Disability is covered under Part B (Non-Economic Loss (NEL)), we submit that Part B covers only the Pain, Suffering and Social areas of a given medical condition. The loss of function of the body part is not highlighted within the PIG2.

12. An example of this is say, the Bicep of an arm is impaired to a degree, with NEL assessment, and we feel that the loss of function of the body part is not adequately considered.

13. A suggestion would be to further investigate the Veteran Entitlement Act 1986 (VEA), Guide to Assessment of Rate of Pensions number Five (GARP V), which also includes loss of function for a range of medical conditions.

Notation of Changes and Amendments to the Revised Edition.

14. For the purposes of comparative analysis, it is suggested that all changes or amendments that are made to the current Draft PIG 2 is notated, so that ESOs are able to track these amendments.

Sunset/Grandfather Clause.

15. In order to ensure continuity of the beneficial approach, we support the consideration of COMCARE for a Sunset Clause. This being a Clause placed into the SRCA providing the benefit of ADF members who may place their claims some years later. As was stated by you, ADF members are averaging 10 years latency period for claims. We suggest, in order not to invoke widespread panic and fear within the ADF and veteran communities that members may lose their employment due to submitting these claims, that they provided a 10 year latency period under the SRCA.

16. The ideal latency period is from 1 Jan 2006 to 1 Jan 2016 (10 years). Those assessments of claims placed by veterans are compared with both PIG 1 and PIG2, with the benefit of either Guide that allows the higher WPI compensation to be the selected Guide for SRCA Delegates.

17. We recognise that this may provide confusion to assessing doctors; however, we believe that the beneficial approach must be retained for the veteran.

Chapter 11 – The Reproductive System.

18. Referring to 11.1 (Male Reproductive System), we submit that the age of men in the 40-65 year group be reviewed, as men in their 40's and even early 50's are fathering children in today's society. This would be particular to those who have separated and started a new family, or those who have married or partnered late in life.

Summary.

19. In summary, we believe that the SRCA needs to appropriately accommodate the implementation of PIG 2. In saying this, we believe that the removal of the WPI threshold of 10% would provide adequate compensation opportunities to veterans. In addition, we want to see the "Beneficial Approach" retained by the Federal Government for veterans who are eligible for compensation under the SRCA.

Recommendations.

20. The Australian Peacekeeper & Peacemaker Veterans' Association (APPVA), strongly recommends the following to COMCARE for review, consideration and implementation into the revised edition of PIG 2:

a. That the threshold of 10% WPI is removed and that no threshold is Legislated;

b. That reference to Table 1.1.3 is notated on all Tables throughout the PIG 2;

c. That the disability component of compensation is investigated by COMCARE with comparative analysis made of the GARP V of the VEA;

d. That notation of changes and/or amendments are provided in the Revised Draft of PIG 2; and

e. That the “Sunset” or “Grandfather” Clause is added to the SRCA for 10 years latency of current or former members of the ADF, of which a comparison of WPI is made to both PIG 1 and PIG 2 and the higher or beneficial payment is provided to the veteran;

f. That Chapter 11.1, Male Reproductive System, accommodates men in the age group of 40-55 year old, without detriment.

Your Sincerely,

(Signed)

P.A. Copeland, OAM, JP,
National President

The Australian Peacekeeper & Peacemaker Veterans' Association

Offsetting aspects of the *Veterans' Entitlement Act 1986* and the *Military Compensation & Rehabilitation Scheme (MCRS).*

1. The Australian Peacekeeper & Peacemaker Veterans' Association (APPVA) has Training Information Program (TIP) qualified Advocates, Pension and Welfare Advocates; with a focus on the Military Compensation Rehabilitation Scheme (MCRS), Veteran Entitlement Act 1986 (VEA), and The Military Rehabilitation Compensation Act 2004 (MRCA). Our main focus is to assist veterans and their families, in providing a veteran entitlement assistance and welfare network. The APPVA is also a Key Ex-Service Organisation (ESO) and a focal point of contact for serving and ex-serving ADF and AFP personnel, Peacekeepers, Peacemakers (Peace Enforcement (warlike service)), Gulf War, Afghanistan and Iraq War veterans.

Aim.

2. The aim of this paper is to convince the Military Rehabilitation and Compensation Review Committee to have the VEA & SRCA amended, in order to provide a fair, just and equitable compensation offsetting provision to all veterans.

Compensation Offsetting ("***Double Dipping")* – MCRS Incapacity Payments.**

3. The experience of our VEA and MCRS Case Officers has been to say the least very confusing, when trying to advise a young veteran of the offsetting procedures and calculations. Currently a veteran under our clientele is only receiving the Special Rate (Totally & Permanently Incapacitated – normally $752 p. f.), of only $38.00 per week, as he is in receipt of MCRS Incapacity Payments (IP) ($628 before Tax p. f.), and Defence Force Retirement & Death Benefit Fund Class B pension of approximately $1,008 before tax p. f. The total income is $1,674 per fortnight. Some may say this is a really good outcome. However what has occurred is that the veteran has now been pushed into a higher tax bracket by accepting MCRS IP, along with VEA TPI. The veteran was medically discharged from the Royal Australian Navy (RAN) in 1997 and subsequently qualified for the DFRDB Class B pension (30-60% of disability under the DFRDB Act). The MCRS IP and DFRDB Class B pensions are both counted as taxable incomes and the veteran is placed into the income tax stream of $42,536, with a tax-free benefit of $986 from his reduced TPI pension. The veteran is then liable for the 30% Income Tax Bracket.

4. After discussions with the staff of the Incapacity Section of MCRS in Melbourne, it was soon discovered that there is an apparent flow-on from Superannuation to MCRS then lastly onto VEA Pension. The information provided by the Incapacity Section was that the DFRDB is deducted as income for MCRS purposes; in order to satisfy the maximum limit of income a veteran may receive for MCRS IP purposes. When calculating the MCRS IP portion a further 5% (Military Superannuation Benefit Scheme (MSBS)), or 5.5% for DFRDB pension recipients, in order to offset the MCRS IP, as though the veteran was continuing to contribute to either schemes. Then lastly, the VEA Pension, no matter the status (TPI, EDA, TTI, Intermediate or General Rates), receives only the minimal payment to cover the total package so that he or she does not exceed the income limits for MCRS purposes.

5. The relevance of this case highlights the following areas:

a. The veteran is not aware of this provision, before he or she is committed to MCRS IP, although they are given the MCRS IP total, they are not given the full break-down of the calculations made, to make an educated decision.

b. The veteran should not be made to offset 5% (MSBS), or 5.5% DFRDB, as though they are continuing the contribution toward their superannuation, as they had done so whilst serving and because of their incapacity are in receipt of the Invalidity pension that they previously paid for.

c. The "Flow-on" effect that was described in paragraph 7 should be reversed. Therefore the full benefit of the veterans' Tax-Free TPI Pension is made payable, along with DFRDB, then the MCRS IP being the last added payment covering the difference, instead of the VEA Pension. It is obvious that the Government Actuarial Department has placed this system, in order to obtain some return in the form of taxation from the veteran, leaving the veteran disadvantaged from the full benefit of the Special, Intermediate or General Rates of VEA Tax-free pension.

Compensation Offsetting – MCRS Lump Sum Payments with VEA Pension.

6. Most claims handled by the APPA that have MCRS Lump Sum (aka Permanent Impairment) payments, have seen the veteran firstly lose up to $1,600 from the Lump Sum **and** have their VEA Pension Reduced. In all cases, the veteran is not made fully aware of the circumstances of the offset offer made to them. To highlight this point, most loaning institutions in Australia are required to show the intended Loan recipient a schedule of costs and payment rates – particularly when taking out a home loan. The schedule of costs displays to the recipient the approximate amount of the repayment value over a number of years. In many cases the Loan recipient is able to pay the Principle loan amount without penalty. They also have an educated offer made to them, showing the amount that they will need to payback in principle and interest.

7. Whilst not trying to provide the FADT Committee with a lesson in Housing loans, we emphasise that our Younger Veterans do not receive a detailed schedule of costs, along with CPI increases and how much they are required to pay-back the Lump Sum Compensation payment made toward them.

8. One case story is of a 25 year-old veteran who was severely injured in a Motor Vehicle Accident, whilst participating on Exercise Kangaroo 1989 (K89). As a result of the injuries he received in total approximately $60,000 for various injuries, along with a VEA Pension at the General Rate in 1994, at the age of 25. He also served on Operational Service in Cambodia and later in his life was diagnosed with Post Traumatic Stress Disorder (1999), which severely incapacitated him. The veteran is now in receipt of the TPI pension, but at a reduced rate. Not only did he lose approximately $4,500 from his MCRS PI value, he is now required to pay $87.00 per fortnight (after the latest CPI increase), out of his TPI pension to cover the PI that was made in 1994. In total the subject veteran will pay back to the Commonwealth $127,452 for a $60,000 Compensation Lump Payment – given that he lives until 82 years of age.

9. Another case story is of a 33 year-old ADF soldier, who suffered Bilateral Instability of the Knees & Depressive Disorder, including (later) Skeletal Back Strain as a result of military parachuting. The ex-soldier was Medically Discharged in 1996. He was overpaid the amount of approximately $11, 000, an error made by MCRS, in which the then Director of Military

Compensation & Rehabilitation (Department of Defence), refused to a non-repayment waiver to the soldier, in which he was forced to repay the $11,000 amount. He subsequently was awarded in total $56,101.48, (repaying $68,000), under Section 24 of *the SRCA* and $21,187.64, under section 27 of the *SRCA* for Non-Economic Loss (NEL). It has been confirmed by MCRS that the ex-soldier is not in receipt of MCRS IP; however he is in receipt of the DFRDB Class A pension (approx $1,000 p. f.), and has a Compensation Limitation under Division 4, of Part IV of the *VEA 1986*, of over **$650 p. f**. from his TPI pension, therefore leaving him with only approximately $94.00 of his TPI Special Rate pension.

10. The ex-soldier was aged 28 years of age at the time of the determinations (1997). Therefore if his life expectancy is to be around say, 82 years old, he will effectively return his debt to the Commonwealth a massive total of **$912,600**. One would suggest that this is far in excess of his Lump Sum repayment or Compensation Limitation.

11. The veterans' cases in paragraphs 11 and 12, is typical of many Younger Veterans who believe that taking the Lump Sum will be better than not at all. The average housing Principle does not rise with CPI, and is certainly easily paid off at the price that it was borrowed. This is contrast to Commonwealth Compensation as not only is the veteran paying in excess of that amount back, with a reduced pension amount in the first place, but the veteran is also paying as the CPI rises.

Department of Finance.

12. Upon investigation for the actuarial documentation and calculations made to arrive at the compensation of PI payments and VEA Pensions, it appears that not many departments within the DVA – MCRS or VEA are very familiar with the calculations. It has been suggested that the Department of Finance would be able to provide answers to these questions. However, upon investigation with the Department of Finance as to which department calculates and arrives at the figures offered to veterans, they say it is a responsibility of DVA. Therefore, causing a great deal of confusion as to whom, where and how the calculations for offsetting are made.

Legislation/Acts (Superannuation versus Compensation).

13. Notwithstanding the above in paragraph 13, the *Veterans' Entitlement Act 1986*, attempts to describe how the calculations are made within *Part IIIC – Compensation Recovery*. The interpretation of the calculations within *Part IIIC* are not easily understood and requires Government Actuary to calculate the Ordinary Income Free Area (OIFA), Maximum Basic Rate (MBR), rate of Pharmaceutical Allowance (RPA). Having read through *Part IIIC*, it would be easy to ask how the calculations are arrived for discounting 5% - 5.5% to be inclusive of COM super contributions, the discounted PI Payment and the amount of compensable pension that is subtracted from the veterans' VEA Pension.

14. Due to the provisions of Division 4 of Part IV of the *VEA 1986*, (*pension and other compensation),* "it is no possible to receive benefits from two (2) Departments or compensating bodies for the one condition". Looking at the *Safety Rehabilitation and Compensation Act (SRCA 1988),* and the *Military Compensation and Rehabilitation Scheme Act (MCRS 1992)* – enacted in 1994, refers to "*The Principal Act*" (*VEA 1986)*, in particular *Division 5A (VEA 1986)– Effect of certain compensation payments on rates of pension*, also produces a complex description, however is explained in calculations terms under *Section 30C (10) (VEA 1986) Lump sum compensation payment*, where the calculation offered is Pension to be reduced over Total Pensions Payable times by the Total Compensation payable. Where does COM super come into these calculations with regard to compensation?

15. Throughout the MCRS Act, the reference to the *"Principle Act" (VEA 1986)* is largely referred to discuss pension offsetting. In this case it appears that the *VEA 1986* may not be cognisant of the changes in Military Compensation from its operation on 7 April 1994. *The Principle Act* describes compensation paid when a veteran receives a pension in respect of incapacity from war-caused injury or war-caused disease or both, is to have these payments taken into account in assessing the rate of pension offered. This is highlighted in *Part II Pension other than Service Pensions for veterans and their dependants, Rates of pensions payable to dependant of a deceased veteran (s) 26 (VEA 1986), Reduction in rate of pension in certain cases*.

Summary.

16. This paper has highlighted a system of compensation that is very disadvantageous to the veterans of the Australian Defence Force. In particular is the reduction value in MCRS Lump Sum payments and the recovery of Lump Sum payment through the VEA pensions. It is very evident that the veteran is virtually paying for his or her Lump Sum Compensation, with CPI and interest – to the point where they are paying double the amount received. It is also evident that an accurate breakdown of offsetting is not disclosed to the veteran concerned – therefore the veterans in many cases are potentially making decisions, without adequate information provided to them by DVA or MCRS.

17. The *VEA 1986* requires amendment to accommodate the MCRS, with regard to recovery and reduced pensions, (Compensation Limitation), to make the MCRS and VEA compensation systems equitable and fair to those who selflessly served Australia

Recommendations.

18. The following recommendations are made:

a. That the practice of offsetting 5%-5.5% for potential COM super contributions ceases.

b. That the Government provide the intended recipient of an MCRS Lump Sum and VEA pension, with a complete cost schedule, including the rate of payback, along with the potential CPI increases.

c. That the Government amend *the VEA 1986*, to make the act fair and equitable, with adequate compensation, without penalty to be afforded to Australia's veterans.

d. That the calculations made for veterans in receipt of IP, VEA Pensions and COMSUPER Pensions are given the opportunity for the full value of the VEA Pension – therefore tax-free income, in replacement of the MCRS IP, effectively providing the veteran with a higher tax-free income, with a lower taxable income.