CHAPTER THIRTY

DISABILITY COMPENSATION: CURRENT ARRANGEMENTS AND A NEW STRUCTURE

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INTRODUCTION

30.1 Preceding chapters in this Report examine recommendations made in earlier independent reviews, claims of erosion in benefits and the adequacy of current disability compensation payments. The Committee has concluded from its examination of the issues raised in those chapters that a new approach to disability compensation is necessary.

30.2 This chapter summarises the Committee's conclusions and proposes a disability compensation structure based on modern principles of compensation. The Committee believes that this structure would provide disability compensation to Australia's veterans that is comparable to community standards. At the same time, it would meet the changing needs of disabled veterans and their families over time and would provide access to an appropriate scheme of rehabilitation.

SUMMARY OF CURRENT COMPENSATION PROVISIONS

Disability Pension

30.3 Once an injury or disease has been accepted as either war or defence related under the *Veterans' Entitlements Act 1986* (VEA) the level of incapacity

and compensation to be paid as disability pension is assessed by the Repatriation Commission or its delegates. This assessment is made using the Guide to the Assessment of Rates of Veterans' Pensions (GARP).

30.4 The GARP sets out a methodology for measuring the extent of permanent medical impairment and the effects on a veteran's lifestyle caused by accepted disabilities. It also provides rules for converting this measurement to a degree of incapacity, expressed as a percentage of the general rate pension. A disability pension may be paid at between 10 and 100 per cent of the general rate.

30.5 Where this degree of incapacity reaches or exceeds 70 per cent, further tests are applied to determine if the accepted disabilities alone preclude the veteran from working. A special rate of pension, commonly referred to as the totally and permanently incapacitated (TPI) pension, may be paid if a veteran is unable to work more than eight hours per week. If a veteran is unable to work for more than 20 hours per week, an intermediate rate of pension set between the general rate and the special rate is paid.

30.6 Rates of disability pensions are indexed twice yearly to reflect movements in the Consumer Price Index (CPI). Adjustments for CPI result in pension increases in March and September each year.

Medical Treatment and Health Care

30.7 Medical treatment, health care and rehabilitation associated with accepted disabilities are provided to a veteran at Commonwealth expense. A veteran can also receive treatment for malignant neoplasia, pulmonary tuberculosis and posttraumatic stress disorder, regardless of whether these conditions are service related. Eligibility provisions extend health care cover at two levels, either specifically for accepted disabilities, or for all disabilities and conditions. War widows and orphans can also receive health care for all conditions at Commonwealth expense.

30.8 If a veteran dies as a result of accepted disabilities, a war widow's pension and/or a dependent orphan's pension may be payable. These pensions are paid at fixed rates and are not subject to any income or assets test. Once granted, the war widow's pension continues for life, while the dependent orphan's pension normally ceases at 16 years of age.

Vocational Rehabilitation

30.9 Vocational rehabilitation is provided under the Veterans' Vocational Rehabilitation Scheme (VVRS), which was introduced in May 1998. The Scheme assists veterans, including those about to leave the Australian Defence Force

(ADF), to find or continue in suitable paid employment. It provides an income safety net for veterans, in receipt of pensions under sections 23 or 24 of the VEA, or the invalidity service pension, who wish to engage in suitable paid employment. Participation in the scheme is voluntary.

DISABILITY COMPENSATION ISSUES RAISED IN SUBMISSIONS

30.10 Disability compensation related issues raised in submissions are detailed in Chapter 26. Among the general themes identified were concerns about the adequacy of the special rate pension, particularly for those veterans with families. In many submissions, these concerns were linked with the perception that the pension's value had eroded over time because of inappropriate benchmarking and indexation.

30.11 Other submissions raised concerns about income support pensions being inappropriately provided to veterans in order to supplement inadequate disability compensation payments. This supplementation was also identified as having an impact on veterans with families. Means testing of family income and subsequent reduction of income support pensions create a substantial disincentive for the veteran or his partner to work. Another cause of concern was the reduction in income support received by those veterans who receive their income support through the social security system.

30.12 A further concern raised in submissions was the limited amount of compensation available to a veteran's partner and children. This was claimed to be particularly evident where a partner is the veteran's primary carer or suffers considerable personal disadvantage because of the veteran's accepted disabilities.

30.13 Other issues raised were:

- the perceived inadequacy of benefits provided to war widows and the significant drop in household income when a TPI veteran dies;
- disparity in the levels of compensation received by older veterans in receipt of the special rate disability pension and those who receive the extreme disablement adjustment (EDA):
- pharmaceutical benefits co-payments made by veterans; and
- the current level of the funeral benefit.

EROSION, ADEQUACY AND STRUCTURE OF BENEFITS

Erosion of Benefits

30.14 As indicated in Chapter 29, the Committee found no evidence of significant erosion in the total compensation available to TPI veterans. The Committee concluded that a combination of the special rate benefit and maximum rate service pension is near to, or in some cases above, post-tax Male Total Average Weekly Earnings (MTAWE), a position maintained over many years.

Adequacy

30.15 In framing its conclusion on erosion of benefits (see Chapter 29), the Committee also noted that MTAWE is a generous measure of average earnings across the Australian workforce. Accordingly, this benchmark could be seen as representing an adequate income level for average Australians.

30.16 Impressions gained by the Committee during public consultations suggest that pension adequacy is mainly an issue for veterans with family responsibilities.

Structure

30.17 The Committee formed the opinion that the inherent inequities of the VEA disability compensation system arise largely from the use of income support pensions to supplement compensation payments.

Means Testing

30.18 The Committee agrees that an above general rate disability compensation structure containing a means-tested income support element is a significant disincentive for a disabled veteran or partner to work and to supplement family income. It is desirable, where practicable, that compensation not be the sole income of a disabled veteran and his family. A veteran who is receiving compensation for a reduced capacity to work should be encouraged and supported to earn income within the assessed capability. The veteran's partner should also be encouraged to work.

Disability Pension Regarded as Income

30.19 The Committee's conclusion in Chapter 29, that the current level of total compensation benefit granted to a special rate veteran is broadly adequate over a lifetime, was based on that level of benefit being available to a veteran with qualifying service. However, a veteran without qualifying service receives a

lower level of compensation for the same degree of disability because of the difference in treatment of the disability pension between the veterans' and the social security income support components.

30.20 The Committee holds strongly to the view that fairness and equity dictate equal compensation for veterans suffering the same level of disability. In this context, the Committee found that the way qualifying service eligibility is applied in means-testing arrangements results in veterans with the same level of disability receiving different levels of benefit.

Lack of Distinction between Compensation Elements

30.21 The Committee faced substantial difficulty when assessing disability compensation adequacy because the VEA does not make a clear distinction between disability compensation elements, particularly those in the benefit provided to a veteran who is unable to work.

30.22 Two earlier independent reviews of the repatriation disability compensation system (Toose 1975, Baume 1994) also expressed concern at the lack of appropriate criteria on which to base assessments of the adequacy of compensation benefits. Both stressed an urgent need for legislation that sets out a clear distinction between the elements of disability compensation payments.

Rehabilitation

30.23 In addition to concerns about the lack of defined standards to measure the appropriateness of compensation benefits, the Committee is concerned that the VEA does not articulate the need for a linkage between rehabilitation and compensation. Chapter 31 further discusses rehabilitation.

Pension Nomenclature

30.24 Part of Chapter 31 sets out the Committee's concerns about the use of the term 'totally and permanently incapacitated'. In that chapter, the Committee has recommended that this term be removed from the VEA. Other than this change, the Committee sees no need to alter the current nomenclature of disability pensions. Other terminology, such as 'special rate' and 'intermediate rate', are well known and are consistent with the structure recommended by the Committee.

Need for Restructuring

30.25 The Committee concludes that, despite the generally adequate nature of its quantum, the current special rate package is not structured in a way that meets the changing lifetime needs of recipients and their families. At the same

time, the Committee believes that this and other inadequacies, such as the lack of clear distinction between compensation elements, should be addressed by restructuring the VEA disability compensation system.

A NEW DISABILITY COMPENSATION BENEFIT STRUCTURE

Objectives of the Structure

30.26 The Committee proposes a new disability compensation structure that would provide:

- appropriate levels of economic and non-economic loss compensation;
- clear distinction between these compensation elements;
- benefit levels appropriate to a veteran's changing needs over his lifetime;
- obligation for a veteran to undertake medical, social and vocational rehabilitation, if such rehabilitation is possible; and
- a wider range of benefits for a veteran's family.

Distinction between Compensation Elements

30.27 The Committee believes that a new structure of disability compensation benefits should follow the recommendations of Toose and Baume regarding distinction between compensation elements for non-economic and economic loss. Each of these elements should have its own distinct characteristics, following established principles in workers' compensation schemes.

30.28 Appropriate levels of economic loss compensation would replace current income support payments, such as the invalidity service pension, the associated partner service pension and the social security disability support pension.

Non-economic Loss

30.29 Under the new structure proposed by the Committee, compensation for non-economic loss would be inviolable, in that it would not be subject to taxation or means testing, or assessed as income for other VEA or SSA benefits, including income support and rent assistance. Compensation paid to veterans would be based on an assessment of pain and suffering made under GARP and paid for life at a percentage of the general rate. The Committee considers that the general rate, as part of a package of benefits, is appropriate at its present level.

Economic Loss

30.30 Compensation for economic loss would be paid in the form of an income substitute during the normal working life of a veteran and, in reduced form, as a superannuation substitute after that time. It would be taxable, or paid net of normal tax (not including any otherwise applicable rebates, including the pensioner and low-income aged person tax offsets). A portion of it would be subject to income testing up to a limit equal to the single rate of the service pension. Payments received for similar purposes, including invalidity superannuation, would be offset dollar for dollar against a veteran's economic loss compensation.

30.31 The gross level (that is, before tax) of compensation for loss of income would be paid at 75 per cent of MTAWE to a veteran who is assessed as being unable to work more than eight hours per week, or 37.5 per cent of MTAWE if the veteran cannot work more than 20 hours per week.

30.32 It is the Committee's view that a veteran who is capable of working, given suitable rehabilitation, should do so at a level commensurate with his assessed work capacity. Provision of economic loss compensation would be subject to a veteran's participation in a rehabilitation program and where practicable, undertaking reasonable employment. Following rehabilitation and reskilling, this may include employment in a new occupation.

Normal Retirement Age

30.33 In workers' compensation schemes, economic compensation normally ceases when the recipient reaches normal retirement age. After that time, the recipient can claim a means-tested social security age pension. The Committee considers that the proposed compensation structure should aim to produce a similar outcome.

30.34 However, a veteran who has been paid compensation for economic loss has not, in the main, had the opportunity to contribute to a superannuation scheme or to accumulate other assets from earned income. The proposed scheme therefore makes provision for a veteran who has been paid compensation for economic loss to continue to receive an element of that compensation (10 per cent of MTAWE, paid as a gross amount) after reaching normal retirement age. Although this amount, like the age service and social security age pension, would be taxable, the Committee recognises that the majority of recipients would not be liable to pay tax.

Indexation

30.35 As payment for personal loss, non-economic loss compensation would be adjusted twice yearly to reflect increases in the CPI and maintain its purchasing power. As an income substitute, economic loss compensation would be adjusted twice yearly to reflect increases in MTAWE and preserve its relation to community income standards.

Means Testing

30.36 The Committee believes that some component of economic loss compensation should be means tested to ensure that a veteran receives those benefits that are ancillary to the means-tested income support pension and to link the compensation to needs, as is appropriate in a publicly funded system of support. In deciding an appropriate amount for means testing, the Committee has kept in mind that the proposed structure does not differentiate between single and married veterans when assessing the level of economic loss compensation. In this context, the Committee considers that the means-tested component should be an amount equivalent to the maximum rate of the single service pension.

30.37 As mentioned in paragraph 30.32, an incentive for a veteran under 65 years of age to work up to the limits consistent with his condition (eight hours per week for a special rate veteran or 20 hours per week for an intermediate rate veteran) would be provided in the form of an earnings concession equivalent to MTAWE income at that limit. In other words, a veteran under 65 years of age would be able to earn up to one fifth (if a special rate pensioner) or one half (if an intermediate rate pensioner) of MTAWE without impact on the means-tested element of his economic loss compensation. The earnings concession would be separate to the basic income 'free area' for the single service pension, which would apply in assessment of the means-tested component of the economic loss compensation.

Offsetting

30.38 The Committee supports the principle that a person should not be compensated twice for the same disability. Where a veteran is provided with workers' compensation, invalidity superannuation or other disability insurance benefits, any compensation provided under the VEA for the same disability would be reduced first on a dollar-for-dollar basis. This would be consistent with offsetting arrangements in workers' compensation schemes.

Income Support

30.39 Income support, subject to the income and assets tests, under either the repatriation or social security system would not be available to a veteran in receipt of economic loss compensation until normal retirement age. In other words, the service or social security pensions would not be available to a veteran or partner under age pension age if the veteran receives economic loss compensation under the new structure. A veteran and/or partner could claim income support at the normal age pension age. The continuing payment of non-economic loss compensation would be disregarded as income for any form of income support, including rent assistance.

Rehabilitation

30.40 The Committee is firmly of the view that a properly structured rehabilitation scheme is an essential ingredient in any modern system of compensation for injury, especially if a person is to be compensated for an inability to work. The absence of appropriate rehabilitation arrangements discourages veterans from recovering or testing their capacity to work in new fields. Additionally, the VEA currently restricts the range of employment options that may be considered in determining a veteran's capacity for employment.

30.41 The Committee recognises that there is an obligation on the Government to provide the necessary rehabilitation services to assist veterans to remain in, or return to, active involvement in work and community life, to the extent possible given their injuries or disabilities.

30.42 Chapter 31 of this Report sets out a proposed policy framework for the creation of a comprehensive, universally applicable scheme of rehabilitation for veterans. An integral element of this scheme, in common with workers' compensation, is that the provision of economic loss compensation would be subject to the veteran's participation in a rehabilitation program. The Committee also proposes in Chapter 31 that a veteran's capacity to undertake remunerative work should be assessed under a broader set of rules than those that currently exist.

30.43 An initial grant of economic loss compensation would take the form of a rehabilitation allowance where the veteran's conditions are amenable to rehabilitation. Payment of this allowance would be subject to the veteran's participation in a medical, social and/or vocational rehabilitation program if rehabilitation is feasible. There would be a consequent obligation on the veteran to undertake training and to re-enter the workforce if vocational rehabilitation is considered possible. Continued payment of any economic loss compensation would depend on the veteran's meeting his rehabilitation obligations.

Benefits for Families

Reduced Means Testing

30.44 Under the Committee's proposed structure, access to income support payments for disabled veterans of normal working age who cannot work would be removed and replaced with economic loss compensation. The means-tested portion of this economic loss compensation would be assessed on the combined incomes or assets of the veteran and his partner in order to avoid income transfer between them. However, the partner's income from employment would be disregarded in this assessment.

30.45 Such a structure would greatly help families, because a veteran's partner would be able to supplement the family income by working, without reducing the veteran's payments. A veteran would also be encouraged to work, up to a limit, without suffering a benefit reduction. This matter is discussed above in paragraph 30.37.

Carer's Allowance

30.46 The Committee recognises that the partner of a veteran under 65 years of age may be unable to work because of a need to care for the veteran full time. In this case, a non-taxed and non means-tested VEA carer's allowance of $150 per fortnight, adjusted annually to movements in the CPI, would be available in lieu of the lower-rate social security carer's allowance. Once granted, payment of this allowance would continue past the veteran's normal retirement age.

Increased Family Income

30.47 A veteran without qualifying service who transfers to the new structure would receive substantially increased benefits, to the immediate advantage of his family. This is because, under the new structure, a veteran without qualifying service would receive the same economic loss compensation payment as a veteran with qualifying service.

Non-economic Loss

30.48 The Committee also recognises that the families of disabled veterans suffer non-economic loss. In particular, the partner of a disabled veteran can suffer significant degradation of lifestyle because of the veteran's inability to work more than eight hours per week. This degradation is manifested in varying degrees of social isolation because of the need to care for the veteran, stress and anxiety related to the veteran's condition, and increased responsibility for family wellbeing.

30.49 The partner of a veteran unable to work more than eight hours per week would receive non-economic loss compensation at the rate of 75 per cent of that received by the veteran during the veteran's normal working life. This rate would reduce to 25 per cent at the veteran's normal retirement age. If a veteran can work more than eight hours but less than 20 hours per week, the partner would receive 37.5 per cent of the veteran's non-economic loss compensation, reducing to 12.5 per cent at the veteran's normal retirement age.

30.50 The child of a disabled veteran also suffers disadvantage because of the veteran's inability to work. A disabled veteran may be unable to provide a child with the usual parental support and encouragement, reducing the child's social, educational and vocational expectations. The Committee recognises that educational and vocational expectations are addressed by the Veterans' Children Education Scheme. However, it also recognises that a child's personal and social development may depend on family expectations, a factor in many cases related to income. A child aged under 16 years, or up to 25 years if undertaking full-time education, would receive non-economic loss compensation at the rate of either:

- 20 per cent of that received by a veteran unable to work more than eight hours per week; or
- 10 per cent of that received by a veteran unable to work more than twenty hours per week.

30.51 This benefit would assist a veteran's family by providing additional income.

Orphans

30.52 The orphan of a veteran whose death was service related would receive the orphan's pension at the rate of 50 per cent of that received by the veteran at the time of death or 100 per cent if both parents are deceased. This benefit would continue up to 16 years of age, or 25 years of age if the child is undertaking full-time education.

Other Family Issues

Private Health Insurance

30.53 Chapter 22 deals with the issue of health care costs for the families of veterans who hold the Repatriation Health Card — For All Conditions (Gold Card). In that chapter, the Committee concludes that subsidising the cost of private health care insurance is justified in certain cases.

30.54 Because some veterans receive health care at Commonwealth expense for all conditions, private health insurance for the veteran's spouse and children bought at the family rate duplicates the cost of the veteran's health cover. A subsidy approximating the difference between single-rate and family-rate health insurance (around $1300 per year) would be made available to special rate veterans with dependent children and who choose to take out private health insurance.

Housing

30.55 The Committee understands that many veterans who are unable to work because of their accepted disabilities may have difficulty in maintaining housing loan repayments. These veterans could be in danger of losing their homes and a greater part of the equity they have accumulated if they are unable to renegotiate loans. The Committee is also aware that lending agencies are reluctant to extend housing loan facilities to a veteran being compensated for inability to work. In the time available, it has not been possible for the Committee to examine all the implications in this very complex issue. However, the Committee recommends that the Government consider measures to assist veterans who face housing difficulties. These measures could include negotiation with lending agencies at industry level on behalf of veterans to ensure that loss of the family home does not exacerbate the pressures faced by the veteran who is unable to work due to service-related incapacity.

Tertiary-level Education

30.56 One of the concerns raised with the Committee was the limited ability of some veterans to support their children through tertiary education. Although the proposed structure provides compensation to some dependent children undertaking full-time education, the Committee recognises that in some cases this assistance will not be sufficient.

30.57 The Committee is aware that some additional tertiary education assistance is available to the children of Vietnam veterans, for example through the Long Tan Bursary Scheme. The Committee believes that there are grounds for providing additional assistance through this scheme, or creating a similar scheme to assist children of other veterans. The Committee recommends that the Government consider this matter.

Disability Pension Not to be Regarded as Income

30.58 Chapter 29 discusses the inequities that occur in the disability compensation payments to veterans as a result of the different treatment of these payments as income between the veterans' and the social security income

support systems. As a principle, veterans should receive like compensation for like degree of incapacity, regardless of the nature of the service, qualifying or non-qualifying. This principle is reflected in the proposed disability compensation structure in that economic loss compensation replaces income support payments for veterans under normal retirement age. Also, the non-economic loss compensation paid under the new structure would not affect the economic loss compensation payable to the veteran before age 65 years or the income support payments made to him on or after age 65 years.

30.59 The Committee believes that this principle is one that has common application to all disability compensation payments, under both the current and proposed VEA schemes. It should therefore apply to all VEA disability compensation payments, including those received by veterans who do not transfer to the new structure. In the Committee's view, disability compensation payments under either scheme should not be assessed as income in any means tests applied under the VEA or the social security system. This would have the effect of resolving a particular anomaly, in that disability pensions are currently exempted fully for the assessment of the service pension, but are counted as income in the assessment of rent assistance paid in addition to the service pension.

Level of Compensation for EDA Veterans

30.60 A summary of the submissions received by the Committee from EDA veterans is contained in Chapter 26 of this Report. In essence, submissions argued for parity between the EDA and the special rate disability pension. In support of the claim for parity, submissions claimed that the disability of EDA veterans greatly exceeded that of special rate veterans and that many had reduced working lives. In addition, many EDA veterans claim that they were entitled to claim the special rate pension before turning 65 years of age, but were not informed of their rights or were in the process of having their disabilities accepted as war-caused.

30.61 The Committee believes that these claims result mainly from the design and administration of the current scheme and do not relate directly to the appropriateness or otherwise of the current eligibility provisions for the EDA or to the level of benefit provided.

30.62 The perceived anomaly between the EDA and the special rate of disability pension arises from the latter providing an inappropriate level of benefit after normal retirement age. This perceived anomaly would be removed by the disability compensation structure proposed in this chapter. Under the proposed structure, there would be very little difference in pension outcomes between veterans with or without economic loss compensation on turning 65

years of age. In addition, veterans without qualifying service would be able to receive increased social security benefits because the disability pension would not be treated as income.

30.63 The Committee considers that 100 per cent of the general rate is an appropriate maximum for non-economic loss compensation under the proposed structure. It is therefore inappropriate to compensate an extremely disabled veteran by providing a general rate adjustment. The needs of such a veteran would be better met through a range of targeted benefits. Accordingly, the Committee recommends that the EDA not be included in the proposed structure as a distinct level of non-economic loss compensation. The Committee believes that the EDA should not be provided in future to veterans who are under 65 years of age at the date of amending legislation, but that the special benefits described hereunder be provided to veterans who become extremely disabled in the future because of their accepted disabilities.

Future Extremely Disabled Veterans

30.64 The Committee sees value in a package of assistance for future extremely disabled veterans who would not be in receipt of economic loss compensation at either the intermediate or the special rate because of age and would not be eligible to claim the current EDA under transitional arrangements. This package would be targeted at the veteran's lifestyle needs. These veterans would continue to receive disability pension at 100 per cent of the general rate and the Gold Card.

30.65 A veteran in receipt of disability compensation at the special rate has access to a Goods and Services Tax (GST) exemption on motor cars and parts and a GST rebate on motorcycles and parts in recognition of the his physical impairment and need for mobility. The Committee recognises that an extremely disabled veteran has similar or greater needs, based on his higher rate of impairment, than does a special rate veteran. A similar benefit, in the form of a rebate on motor vehicles and parts, would also be available to an extremely disabled veteran.

30.66 The Committee also recognises the importance to veterans of their personal independence and their wish to live in their own homes for as long as possible. An extremely disabled veteran living in his own home may be incapable of performing even minor day-to-day household tasks because of his disabilities. In many cases, such a veteran relies totally on personal care and home maintenance services provided through the Veterans' Home Care scheme. This scheme requires the veteran to make co-payments and only provides a limited range of home maintenance. In recognition of this reliance, an extremely disabled veteran would receive a means-tested home care allowance of $150 per

fortnight, adjusted annually to increases in the CPI, while he continues to live at home.

30.67 Because an extremely disabled veteran receives health care at Commonwealth expense for all conditions, private health insurance for the veteran's spouse and children acquired at the family rate duplicates the cost of the veteran's health cover. The same subsidy as that available to special rate veterans (see paragraphs 30.53 and 30.54) would be available to a future extremely disabled veteran with dependent children who chooses to take out private health insurance.

Existing EDA Recipients

30.68 All veterans in receipt of the EDA would retain their current entitlements. Those veterans aged 65 years and over at the date of effect of any amending legislation would retain their eligibility to claim the current EDA. Veterans in these two groups would also receive two additional benefits:

- access to the GST rebate on motor vehicles and parts (see paragraph 30.65); and
- the private health insurance subsidy (see paragraphs 30.53 and 30.54).

30.69 However, they would not be entitled to the home care allowance provided to future extremely disabled veterans who would not be entitled to the 50 per cent of general rate EDA.

TRANSITION ARRANGEMENTS

30.70 The Committee recognises that any transition to a new disability compensation structure should ensure that existing beneficiaries, that is, those who are special and intermediate rate pensioners, are not disadvantaged. As the proposed structure is based on a redistribution of benefits between veterans above and below normal retirement age, the Committee believes that transition to the new scheme for special and intermediate rate pensioners should be:

- obligatory for existing beneficiaries under 50 years of age; and
- voluntary for existing beneficiaries 50 years of age and over.

30.71 The Committee has calculated that, under the proposed structure, a special or intermediate rate veteran under 50 years of age would receive total lifetime benefits at least comparable to those provided under current arrangements. In most cases, this benefit would be significantly greater, particularly for the younger veteran with a family.

30.72 While total lifetime benefits may be reduced for veterans aged 50 years or more, the Committee recognises that many may wish to receive higher levels of compensation and family benefits before normal retirement age. The Committee concludes that an option to transfer to the proposed structure should be available to these veterans.

30.73 Given this option, the Committee believes that an existing special or intermediate rate pensioner 50 years of age or over should be given comprehensive advice on the implications of an election to the new structure, and adequate time to consider his position.

30.74 The new structure would also apply to all new grants of the special or intermediate rate, regardless of the recipient's age at the time the rate is granted.

30.75 The Committee proposes that the benefits of the new structure of special and intermediate rates, including the carer's allowance and the private health insurance subsidy, would generally be available only to a veteran and his family if the veteran transfers to the new structure or receives a grant of economic loss compensation under the new arrangements. An exception to this would be that the extended bereavement payment, recommended by the Committee for widows of veterans in receipt of the special rate at the time of the veteran's death, would be available to all such widows.

30.76 Existing disability compensation conditions, including indexation arrangements, would continue for those beneficiaries who choose not to transfer. However, some of those who choose not to transfer will benefit from the changes, such as the disability pension no longer being regarded as income for all VEA and social security benefits.

30.77 The EDA would not be a feature of the new structure for veterans under 65 years of age at the date of the new legislation. However, a more targeted range of benefits would be available to them. Existing EDA veterans and those aged 65 or more at the date of new legislation who meet the EDA criteria would be entitled to additional benefits (see paragraph 30.68).

30.78 A veteran currently receiving disability compensation up to 100 per cent of the general rate would be unaffected by the proposed structure.

OUTCOMES

30.79 The proposed structure addresses the shortcomings of current arrangements and provides a more rational and equitable basis for the payment of disability compensation to veterans. Australia's veterans would receive disability compensation more in line with modern workers' compensation systems. In practical terms, the proposed structure would mean redistribution of

a veteran's economic compensation to that period of the veteran's life during which it is most needed.

30.80 There would be an increased range of targeted benefits for veterans with families, including partner and child non-economic loss compensation and a carer's payment. In addition, a veteran's partner would be able to earn extra income without reducing the family's benefit. This greatly increases the value to a veteran's family of rewards for work.

30.81 Removing dependence on social security benefits from above general rate disability compensation would also remove inappropriate benefit reductions where a veteran does not have qualifying service. This would provide substantial increases to many such veterans who are receiving disability compensation.

30.82 An increase in base compensation rates would be available to a single special rate veteran under normal retirement age. A smaller increase in these base rates would be available to a partnered veteran. However, many additional benefits would be provided for those veterans with families. The total package of family benefits would represent a significant improvement on current levels.

30.83 The large gap between special and intermediate rates in the current disability compensation structure would also be addressed. An intermediate rate veteran would receive significant benefit increases, combined with the incentive to work part time without benefit reduction. For example, the intermediate rate veteran working around 10 hours per week at average earnings could receive total income above that received by a special rate veteran. Currently, the intermediate rate veteran is likely to receive significantly less than a special rate veteran because of the present rate structure, and any earnings received reduce the income support payable. Therefore, he suffers a strong disincentive to work additional hours.

30.84 While benefits for special rate and intermediate rate veterans would be reduced after a veteran's normal retirement age, the total available benefit would still be generous. The benefit would include non-economic loss compensation, a reduced economic loss compensation payment corresponding to superannuation for those veterans who had a restricted working life, and continuing eligibility for either the service pension or the age pension.

30.85 Details of this comprehensive and innovative structure are set out in Appendix 16.

ECONOMIC EFFECTS

30.86 The proposed disability compensation structure would bring forward benefits for veterans who are under normal retirement age. This would produce an initial cost shift as disability compensation becomes better targeted to those in most need.

30.87 Veterans under 50 years of age and their families would generally receive a greater quantum of lifetime benefits than that provided under existing disability compensation arrangements, and these benefits would be available earlier. Although the proposed structure would provide a lesser quantum of lifetime benefits to some veterans currently 50 years of age or more, many of those veterans might choose to receive higher benefits before normal retirement age and lower benefits thereafter. This cost shift would result in increased program costs in earlier years, reducing as the current beneficiary population, predominantly in their fifties, reaches normal retirement age.

30.88 Some expenditure growth will also occur through additional benefits for families and the removal of disability compensation from the VEA rent assistance test and the social security income test.

30.89 The Committee has not costed the proposed rehabilitation programs because these could be set at a number of levels that would need to be determined as the schemes are developed and tested. However, the costs of these programs are likely to be offset over time as rehabilitated veterans become less dependent on economic compensation.

30.90 Estimated Budget costs of the initiatives in the proposed structure and transition structure over four years are provided and discussed in Appendix 12.

OTHER ISSUES

War Widows

30.91 In reviewing the level of payments to war widows, the Committee notes that, while there is no clear benchmark for the level of these payments, a war widow in receipt of the income support supplement (ISS) may receive about 30 per cent more than a social security age or disability support pensioner (this differential is less if the social security pensioner is receiving rent assistance). Recipients of a war widow's pension also receive the significant benefit of a Gold Card. The Committee cannot find justification to increase the war widow's pension beyond its current level.

30.92 At the same time, the Committee notes that a war widow in receipt of an ISS does not receive additional rent assistance. It recognises that war widows

renting in the private market are among the most needy in the Australian community and regards this situation as inequitable. The Committee recommends that rent assistance in its present form be provided in addition to the existing war widow's pension and ISS**.**

30.93 Submissions made to the Committee also raised the inability of Australian war widows living overseas to claim the ISS because of current VEA provisions. The Committee believes that there is some strength to the argument presented to it that these widows are Department of Veterans' Affairs (DVA) clients who are in needy circumstances and through illness or financial circumstances are unable to travel to and reside in Australia to claim the ISS. Their ties to Australia are established by their VEA entitlements and the ISS is an essential component of the war widow's compensatory package. The Committee notes the longstanding government policy that VEA or SSA income support claimants must be present in, or resident in Australia. Subject to the operation of this longstanding policy, the Committee recommends that Australian war widows living overseas be able claim ISS.

30.94 The Committee recognises that the exemption of war widows living overseas from these provisions might create a demand for an exemption for disability pensioners who live overseas in similar circumstances and are unable to claim the service pension. The Committee did not receive any submissions on this matter and did not examine it. Consequently, the Committee is unable to make any recommendation on this matter.

30.95 The Committee is concerned that the former domestic allowance component of war widow's pension has been frozen for many years. The Committee feels that, in order to maintain the current adequacy of the war widow's pension, this component (currently $25.00 per fortnight) should be folded into the war widow's pension and indexed in the same manner as the rest of the benefit.

30.96 Beyond this, the Committee feels there is a need to provide an increased level of bereavement payments to certain widows. In the proposed structure, a war widow may suffer short-term disadvantage arising from reduced income following the death before normal retirement age of a veteran who was in receipt of the special rate. The Committee considers that this war widow would need some time to adjust to a reduced level of disposable domestic income. It is in this context that the proposed structure provides a transitional benefit to these war widows for six months after the veteran's death.

30.97 The proposed amount of the transitional benefit would be a fortnightly payment equal to 50 per cent of maximum rate economic loss compensation (net of tax) for seven fortnights after the veteran's death, reducing to 25 per cent for a further six fortnights. This benefit would be subject to the veteran and partner

having satisfied the means test for payment of income support payments immediately before the veteran's death, had income support pensions been payable. The benefit would be paid in addition to the normal bereavement payment of non-economic loss compensation (100 per cent of the general rate).

30.98 This benefit would also be available to the widow of a special rate veteran who did not transfer to the new structure and would normally be entitled to an income support bereavement payment of seven fortnights of the veteran's married rate of service pension. However, in this case, with the new bereavement payment based on economic loss compensation, the normal income support bereavement payment would not be available.

Pharmaceutical Benefits Co-payment

30.99 Some submissions to the Committee recommended that a veteran in receipt of the disability pension be provided with exemption from the pharmaceutical co-payment.

30.100 Veteran disability pensioners and war widows are required to make a contribution towards the cost of their prescriptions until they have reached a safety net limit, after which free pharmaceuticals are provided. This is consistent with a 1991 government decision that there be a patient co-payment by all Australians who receive subsidised pharmaceuticals. However, all entitled veterans and war widows receive a pharmaceutical allowance to partly offset these expenses. This leaves a small gap between the co-payment and the pharmaceutical allowance, currently a maximum of $36.40 per calendar year, before the safety net applies. The gap encourages a more thoughtful and responsible use of medication.

30.101 Eligible veterans, war widows and dependants have access to the Repatriation Pharmaceutical Benefits Scheme, which offers a wider range of drugs and other selected medical items than is available to the general community under the Pharmaceutical Benefits Scheme. Additionally, DVA may approve the prescribing of unscheduled pharmaceuticals where appropriate clinical justification is provided to support the application.

30.102 In these circumstances, the Committee believes that the present arrangements are appropriate.

Funeral Benefit

30.103 Under the provisions of the VEA, a funeral benefit may be granted towards the funeral expenses incurred on the death of prescribed veterans. In 1984, the maximum amount of this benefit was $550; it remained at that level

until 2000, when the maximum payment was raised to $572 under the Government's GST adjustment policy.

30.104 Submissions to the Committee sought an increase in the level of the VEA funeral benefit and the indexation of any revised amount. The Committee has some sympathy with this view. The Committee understands that a very basic cremation or burial today costs $3000–4000. Given that the death of a prescribed veteran is accepted as being caused in total or in part by accepted disabilities, the Committee considers that a more realistic contribution to the cost would be up to $1000.

Dual Eligibility under the VEA and the *Safety, Rehabilitation and Compensation Act 1988*

30.105 The Committee was made aware that many veterans have eligibility to claim disability compensation under both the VEA and the *Safety, Rehabilitation and Compensation Act 1988* (SRCA). This dual eligibility was defined in the review of the Military Compensation Scheme (Department of Defence 1999) as:

> Having an entitlement to claim benefits under both the VEA and the SRCA for an injury or illness that arises out of or in the course of ADF service. It does not mean being compensated for the same injury/illness twice. Claimants are required to make two separate claims and where the benefits are for the same injury/illness under different Acts, offsetting arrangements apply.

30.106 This situation permits some veterans to access, simultaneously, different benefit components of each Act. The result is that these veterans are able, with some restraints, to construct a package of benefits to suit their individual circumstances. In many cases, this results in a veteran receiving a higher level of benefit than would be possible under the provisions of one Act alone.

30.107 A veteran with conditions accepted under both the VEA and SRCA may elect to receive SRCA incapacity benefits but retain Gold Card entitlement under the VEA, which provides cover for all health care costs rather than only those arising from the accepted condition. The veteran would also be able to receive special rate payments on reaching 65 years of age, at which point SRCA incapacity payments cease.

30.108 A veteran may also choose, in certain circumstances, to maximise income by receiving SRCA incapacity benefits, VEA special rate payments at a reduced rate and the invalidity service pension.

30.109 The Committee finds these outcomes to be over generous compared to those available to members of the veteran community without dual eligibility. While the Government has stated that it proposes to remove dual eligibility for

future service under proposed new military compensation arrangements, dual eligibility would nevertheless remain for past service.

30.110 The Committee recommends that a veteran who has entitlement to claim disability compensation under both the VEA and the SRCA, but has not yet made a claim, be required to make a one-time election at the time of his first claim. This election would indicate the legislation under which the veteran wishes to be compensated, at that time and in the future.

Access to Lump Sum Payments in Compensation for Permanent Disabilities

30.111 Some ex-service submissions sought access to varying levels of lump sum payments to provide veterans with the capacity to meet substantial capital costs, such as house purchases. The Committee notes the opposition to this proposal from some ex-service organisations, based on previous experiences in which lump sum compensation payments made under other arrangements were exhausted quickly, with the result that the recipients became reliant on welfare payments. The Committee also notes that there would be significant budgetary implications in meeting lump sum compensatory payments, particularly when these might not be used to accumulate capital and might result in recipients seeking welfare assistance later, having given up the security of continuing payments.

30.112 The Committee was unable to explore this issue in detail in the available time. However, while noting the differing views within the veteran community about lump sum payments and the significant budgetary implications of making lump sums available, the Committee considers that the Government might wish to examine this issue further.

RECOMMENDATIONS

A New Disability Compensation Structure

The Committee recommends that:

- the Government accept that the principles of disability compensation on which the proposed structure is based are sound and appropriate for Australia's disabled veterans;
- following this acceptance, the Government adopt and implement the proposed structure as soon as practicable, given its beneficial nature for veterans and their families;
- the Government adopt the proposed transitional arrangements; and
- as enhancements to the new structure, the Government consider how additional assistance can be provided to veterans who experience housing difficulties in maintaining housing equity and to children of veterans who wish to undertake tertiary education.

Disability Pension to be Disregarded as Income

The Committee recommends that the Government no longer regard the VEA disability pension, paid under either the current or proposed structure, as income for any VEA and social security income support payments or benefits.

Other Matters

War Widows

The Committee recommends that:

- the current non-indexed component of the war widow's pension be no longer separately identified;
- the current non-indexed component of the war widow's pension is indexed in the same way as the main benefit;
- an extended bereavement payment be made available to the widow of a veteran in receipt of the special rate disability pension at the time of the veteran's death;

- rent assistance be provided in addition to the existing war widow's pension and income support supplement; and
- war widows living overseas be able to claim the income support supplement.

Extreme Disablement Adjustment

The Committee recommends that:

- the EDA not be included in the proposed disability compensation structure;
- all veterans 65 years of age and over at the date of introduction of the new structure retain the right to claim EDA;
- all existing EDA veterans retain their current entitlements;
- all veterans in receipt of EDA now and in the future have access to a GST rebate on motor vehicles and parts; and
- EDA veterans receive a private health insurance subsidy if they have dependent children and choose to take out private health insurance.

Extremely Disabled Veterans

The Committee recommends that a veteran who is aged under 65 years at the date of introduction of the new structure and who, after reaching that age, is assessed under GARP as having 70 disability points and a lifestyle rating of six, not be granted EDA but instead receive a benefit package including:

- the disability pension at 100 per cent of the general rate;
- access to a GST rebate on motor vehicles and parts;
- a fortnightly means-tested home care allowance of $150 while living in his own home;
- a private health insurance subsidy if he has dependent children and chooses to take out private health insurance; and
- the Repatriation Health Card — For All Conditions (Gold Card).

Funeral Benefit

The Committee recommends that the maximum funeral benefit be increased to $1000.

Eligibility for Disability Compensation under both the VEA and the SRCA

The Committee recommends that the Government require of a veteran with dual entitlement a one-time election, which would restrict the veteran to receiving benefits under either the VEA or the SRCA at that time and in the future, if he has not already made a claim under either Act.

CHAPTER THIRTY ONE

REHABILITATION

31

INTRODUCTION

31.1 The Committee's terms of reference required it to consider the extent to which the medical, social and vocational rehabilitation needs of disability pensioners are being adequately met and to recommend improvements to address identified deficiencies.

31.2 Some veterans re-enter civilian life smoothly following their service and sustain successful working and family lives with little or no need for special assistance.

31.3 The Committee recognises that, unfortunately, some others will live with a legacy of medical and social problems and have limited working lives because of their service-related disabilities. These veterans generally require rehabilitation to restore them to their highest possible level of function.

Definition of Rehabilitation

31.4 The Australasian Faculty of Rehabilitation Medicine (AFRM 2002) defines rehabilitation as:

> the combined and coordinated use of medical, social, educational and vocation measures for training or retraining the individual to the highest possible level of function.

31.5 The Committee accepts this definition and believes that it contains the critical elements of rehabilitation, about which the Committee will be commenting in this chapter.

Description of Rehabilitation

31.6 The parts of rehabilitation are:

- Medical rehabilitation — the restoration of physical and mental function following injury or incident. This may involve medical or health-related intervention from time to time to assist veterans to improve, minimise or cope with their service-related disabilities.
- Social rehabilitation — the restoration of effective functioning in the community or re-integration of an individual into societal activities and interpersonal contact. This may include adjusting to the demands of family, community and employment.
- Vocational rehabilitation — the restoration of effective functioning in employment. The aim of this is to assist veterans to secure and hold paid civilian employment.

31.7 There is frequently a blurred demarcation between treatment (medical correction or intervention to address the effects of an injury or disease) and medical rehabilitation, which normally follows treatment.

Objective of Rehabilitation

31.8 The Committee accepts that the objective of rehabilitation should be to restore veterans to their optimal level of function, commensurate with their service-related disabilities in order to provide them with better quality of life, maximised vocational outcomes and reduced dependency on financial disability compensation.

31.9 The Committee notes that, in some cases, the highest level of function possible through rehabilitation might not meet the individual veteran's hopes. For example, paid employment will not be a realistic outcome for some. However, other aspects of rehabilitation may bring significant benefits for veterans and their families.

Committee's Approach to its Review of Rehabilitation

31.10 The Committee has examined the rehabilitation issues raised in submissions and at meetings with veterans. It has consulted widely and referred to previous reports that have addressed rehabilitation for veterans: the Toose Report (Toose 1975, pp. 43–5), the Auditor-General's Report (Auditor-General 1993, p. xxii), the Baume Report (Baume 1994, p. 91–104) and the Tanzer Report (Department of Defence 1999).

Rehabilitation within Australian Workers' Compensation Schemes

31.11 Compulsory participation in suitable rehabilitation is an integral part of most contemporary Australian workers' compensation schemes, including Commonwealth and state employees' schemes.

Benefits of Rehabilitation

31.12 Rehabilitation has benefits both for the injured person or employee, and the employer or source of compensation. For the individual, rehabilitation can help restore his levels of function, evidenced by:

- higher levels of self-esteem and confidence;
- a more stable and secure family life;
- improved social and life skills;
- better employment prospects;
- improved quality of life;
- retention or restoration of earning capacity;
- greater independence; and
- prevention of complications, deterioration or the development of other illnesses or conditions.

31.13 For the employer or other compensation source, and society generally, the benefits can be:

- reduced long-term costs of compensation, including health care;
- restoration of the individual's value to society, the economy and family; and
- restoration of the person as a productive employee, so that there is no loss of expertise and knowledge to his employer.

Rehabilitation Medicine

31.14 Rehabilitation medicine is a specialty that arose in response to the needs of those injured in war. The Australasian Faculty of Rehabilitation Medicine, a faculty of the Royal Australasian College of Physicians, trains, accredits and supports medical practitioners in the management of disabilities arising from illness and injury. Consultants in rehabilitation medicine:

- have had advanced training in the comprehensive management of disability;

- have a sound background in clinical medical skills, knowledge and attitudes;
- are experienced and trained in those aspects of medicine, surgery, community medicine and the psychological and social impacts of illness that relate to the assessment, management and prevention of disability;
- have the ability to organise and administer a comprehensive rehabilitation service;
- work in close collaboration with medical colleagues, allied health professionals and others to develop rehabilitation programs and regularly review rehabilitation goals; and
- see the disabled or handicapped person's problems as a challenge (AFRM 2002).

Rehabilitation within the Repatriation System

31.15 The mandate for the provision of health care and treatment to veterans is set out under Part V of the *Veterans' Entitlements Act 1986* (VEA). Consistent with the observations made in the Report of the Major Review of the Health Program of the Department of Veterans' Affairs (DVA) undertaken during the late 1980s (DVA, n.d., p. 25), this Committee accepts that medical and social rehabilitation is part of treatment. The power for the Commission to provide vocational rehabilitation is in Part VI(A) of the VEA.

31.16 Rehabilitation is closely related to, and for veterans may involve:

- resettlement/re-establishment — a process of assisting members of the Defence Forces to re-assimilate into civilian life, including employment;
- retraining — activities designed to re-educate and re-skill an individual;
- occupational health and safety — activities designed to ensure a safe working environment;
- prevention of further injury or disease through early identification of injury or disease and early intervention; and
- health promotion — activities designed to encourage individuals to adopt healthy lifestyles.

VETERANS' NEEDS

31.17 Veterans receiving disability compensation payments from DVA, particularly at the higher levels, often have more than one disability.

31.18 Veterans suffer from a range of physical disabilities. The major disabilities tend to be chronic diseases, often of the respiratory and cardiovascular systems, disabilities of the sensory organs (including hearing loss), and musculoskeletal problems.

31.19 Mental health conditions remain a significant problem for veterans. A principal finding of the major Australian study into the health of Vietnam veterans, the Vietnam Veterans Health (Morbidity) Study, was that Vietnam veterans are three times more likely to report their health as poor than the general community. Those surveyed indicated a high and consistent experience of mental health conditions that included panic attacks, anxiety disorder, depression and posttraumatic stress disorder (PTSD) (DVA 1998b, vol. 1, pp. 4–5). Prevalence of these conditions is reflected in the high numbers of Vietnam veterans receiving disability payments at the special rate.

31.20 The number of veterans accepted for mental health-related compensation claims has increased by an average of 25 per cent per year over the past 10 years. Claims for PTSD and, to a lesser extent, alcohol dependence, have accounted for most of the increase (DVA 2001f, pp. 6–7).

31.21 PTSD is a major disability among veterans, although it is not diagnosed to the same extent amongst older veterans as amongst the younger. Depression and anxiety states are also prevalent. There is commonly a link between alcohol dependence, alcohol abuse and other mental health disorders, especially PTSD.[178]

31.22 Alcohol dependence and abuse are serious problems because of their impact on veterans and their families. In 1997–98, veterans with alcohol dependence as an accepted mental health disability had the highest total treatment costs — on average 50 per cent greater than the average treated veteran with a disability (Pica Pica and Buckingham and Associates 2002).

31.23 Self-reported rates for alcohol or substance abuse are about 36 per cent among Vietnam veterans (DVA 1998b, p. 32). Many veterans point to their experience in the military as a source of their attitude and behaviour towards alcohol misuse (DVA 2001e).

31.24 An analysis for DVA by CRS Australia during 2002 showed that, among veterans participating in the Veterans' Vocational Rehabilitation Scheme (VVRS), medical conditions experienced were primarily psychological/PTSD and/or musculoskeletal injuries and degradation. Barriers to progression to a return to work identified by CRS Australia included:

[178] The level of co-morbidity presented here is likely to be an underestimate, as it is based on diagnosable conditions accepted as war-related disabilities and does not reflect treatment data in which veterans may be treated for alcohol problems that are not part of their accepted disabilities.

- length of time unemployed;
- lack of familiarity with, or lack of experience in, job seeking and job targeting;
- outdated work skills;
- attitude to, and experience in, a multiskilled work environment; and
- difficulties managing work and life stressors.

31.25 Social isolation has been identified by DVA as a cause of concern for some veterans of all ages. A significant difference between the composition of the World War II and subsequent veteran groups is that World War II units were often demobilised in a manner different from those of later conflicts, so that World War II veterans were better able to establish local support mechanisms on return home. In addition, for a significant number of Vietnam veterans, the traditional support provided to earlier veterans by the Returned & Services League of Australia (RSL) has not been attractive because of the inhospitable reception some experienced in local branches of the organisation on their return from the war. These factors appear to have made it more difficult for Vietnam veterans and those of subsequent warlike and non-warlike deployments to establish supportive networks.

31.26 Difficulties arise for young veterans who are classified as totally and permanently incapacitated (TPI) following the determination of compensation claims. It is likely that veterans who are young and unemployed will not seek social engagement and will consequently become socially isolated.

SUBMISSIONS FROM VETERANS CONCERNING REHABILITATION

31.27 In its research, the Committee has become aware that the major ex-service organisations (ESOs) recognise the value of well-focused rehabilitation when it is combined with appropriate monetary compensation to minimise the financial impact of service-related disabilities.

31.28 Most major ESOs of which the Committee is aware have pointed to deficiencies in rehabilitation services under the VEA. The submission provided at the Committee's request by the Australian Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women[179] encapsulated the concerns of the veteran community.

31.29 Rehabilitation was directly mentioned in 14 submissions. Two submissions in particular, from the Vietnam Veterans Association of Australia

[179] Submission 1265c.

(VVAA)[180] and the Australian Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women, explored in depth the issues relating to rehabilitation. These two submissions were particularly useful to the Committee in its deliberations.

Vietnam Veterans Association of Australia

31.30 The VVAA proposed a two-tier scheme of rehabilitation to be administered by DVA with eligibility as it currently applies.

Tier 1

31.31 Under the proposal, Tier 1 participation would be required for veterans between the ages of 19 and 50 years and receiving 70 per cent general rate disability pension or higher.

31.32 Participation would be for a specific period nominated by a medical specialist or specialists. This would follow an assessment of the veteran's capacity to undertake vocational rehabilitation, by a person qualified and specialising in vocational and rehabilitation training.

31.33 The Association proposed that, on completion of the nominated period, the suitability of the veteran for work would be compulsorily re-assessed by a medical specialist appropriate to the veteran's condition. After re-assessment, the veteran might continue in the scheme for another set period. Alternatively, the veteran could be declared TPI and unable to work more than eight hours per week. In that event, the individual would revert to the special rate payment or to the intermediate rate payment, if assessed as being able to work up to eight or 20 hours per week, respectively.

31.34 Training under the scheme could include tertiary education institutions, Technical and Further Education (TAFE) colleges, and apprenticeships or on-the-job training. Under the proposal, postgraduate degrees would be included in the VVRS. The proposed training should be agreed to by the veteran.

31.35 The Association recommended that the training assessment should be appealable. All training would be at government expense, including Higher Education Contribution Scheme (HECS) and any other charges.

31.36 The special rate payment would continue during training, but be redesignated as a rehabilitation and vocational payment.

[180] Submission 1267.

31.37 Following the completion of vocational and other rehabilitation training, the veteran would, if necessary, be assisted through the scheme to obtain employment.

31.38 Upon gaining suitable work, the veteran would be paid at the special rate (which could be designated as the rehabilitation and vocational payment) for six months. All special rate payments and benefits would cease after six months, unless the veteran were receiving income below the special rate, in which case the Association proposes that the Commonwealth make up the difference.

31.39 Additionally, compensation may still be paid at between 70 and 100 per cent general rate.

31.40 A safety net of seven years was proposed, in case the veteran becomes unable to work for any reason and needs to revert to the special rate. The Association proposed that, if the safety net provisions were activated and the veteran undertook further employment, the veteran would only be able to access the remaining portion of the six-month period of co-payment and the seven-year safety net provision.

31.41 After seven years, the veteran would be declared fit for employment. However, if the veteran met the criteria in s.24 of the VEA before reaching age 65 years, a new claim could be made for the special rate.

Tier 2

31.42 Tier 2 of the scheme was proposed for veterans over the age of 50 years. The Association recommended that the existing arrangements for vocational and rehabilitation training under VVRS should apply, with the significant difference that vocational training would be extended to cover training in community volunteer programs.

31.43 The Association considered that many special rate recipients are isolated from community activity and involvement because of feelings of worthlessness and loss of self-esteem due to their disabilities. The proposal would give those veterans who are unlikely to return to the paid workforce an opportunity to raise their self-esteem, contribute to the community, and lead a healthier and more active lifestyle.

General

31.44 In presenting this submission to the Committee, the VVAA argued that there is a need for incentives to encourage veterans to transfer from the special rate to the proposed rehabilitation allowance.

31.45 The Association's view was that veterans need to be medically and financially looked after, but that there is also a level of personal responsibility.

31.46 In its presentation to the Committee, the Association stated its view that those who cannot get back to work should not be compelled. It also mentioned to the Committee that classifying an individual in his twenties as TPI might deter that person from fulfilling his potential.

31.47 In presenting the submission to the Committee, the VVAA representatives made the following additional points:

- certain individuals may be 'damaged' by being assessed as TPI;
- social and medical rehabilitation are both useful;
- social rehabilitation should be undertaken before vocational rehabilitation;
- the element of compulsion in Tier 1 is critical;
- Tier 2 veterans may be assessed, but only after the grant of the special rate, when they are secure financially and psychologically;
- there is no incentive where there is no compulsion;
- PTSD sufferers can learn to deal with their condition and cope through Vietnam Veterans Counselling Service (VVCS) counselling and programs; and
- it must be recognised that some veterans are beyond the point where they can be rehabilitated.

Australian Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women

31.48 The Australian Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women provided a detailed submission to the Committee concerning rehabilitation.

31.49 The Federation recommended that the Government develop and implement a rehabilitation model that is integrated with the pension and treatment process and that assists veterans to fulfil their physical, emotional and developmental potential.

Perceived Deficiencies in the Current Arrangements

31.50 The Federation believed that the current arrangements need attention in two fundamental areas:

- early intervention to identify veterans who would benefit from participation in one or more of the rehabilitation processes; and

- the adoption of a more holistic approach to rehabilitation.

Timing of Rehabilitation

31.51 Current arrangements are not considered by the Federation to focus on rehabilitation as an integral component of the disability compensation scheme, in contrast to the situation for serving members of the Australian Defence Force (ADF). The Federation noted, however, that rehabilitation is an option that veterans may choose to pursue under the VVRS.

31.52 The Federation noted that TPIs are not generally identified as possible participants in rehabilitation processes until they have been classified. It considered that, in most instances, this means that the potential effectiveness of the programs has therefore been significantly reduced.

31.53 The Federation believes that the Government should adopt a 'case management' process for TPIs, so that their health and employment situations can be monitored from the first onset of their conditions. They can then be given the appropriate support to help minimise the impact of their conditions.

31.54 For example, the Federation considered that vocational rehabilitation would be more effective and easier if possible problems were identified while the veteran was still in employment. It saw this process as a continuation of the philosophy that has been applied in recent years to serving members, whereby members of the ADF undergo counselling when they return from overseas deployments to identify and deal with any issues that arise from their deployment.

31.55 The Federation recommended that regular comprehensive assessments should be part of the standard annual 'medical'. This would identify problems and enable them to be treated before they become chronic. With this in mind, the Federation further recommended that psychiatric counselling be a part of ADF discharge procedures.

31.56 The Federation felt that, when veterans leave the service, the rehabilitation process loses focus and is more concerned with the lodgment and determination of claims.

31.57 Regular and focused assessments of both serving and former members would have the advantage of identifying a range of health, social and vocational issues that might be affecting a veteran.

Holistic Approach

31.58 The Federation believed that the fundamental deficiency in the current rehabilitation structure is that it is reactive, rather than proactive. It is an optional 'add-on' to the pension and treatment processes.

31.59 Officers with the appropriate professional skills and training should be recommending programs and development opportunities to veterans, to help them realise their full potential.

31.60 The programs should be tailored to satisfy the particular needs of veterans and should not be limited by the pursuit of narrowly focused outcomes. The VVRS excludes those veterans who want to undertake some further education or rehabilitation simply as a form self-improvement or development.

31.61 The Federation submitted that:

- there is currently no single program administered by any state or Commonwealth Government agency that addresses the full range of the rehabilitation elements mentioned in the terms of reference; and
- vocational rehabilitation through the Military Compensation Scheme and the VVRS is premised on retaining the member in employment or returning the member to employment.

Incentives for Rehabilitation

31.62 An important and difficult question for the Federation, when dealing with the issue of rehabilitation, was incentive. Its view was that that most of the target group would be TPIs who have spent a significant part of their lives coping with their disabilities, and struggling with a complex and adversarial assessment system to have their medical conditions accepted.

31.63 The Federation considered that, when veterans have completed the claims determination process, they are often in their weakest physical and emotional condition. Consequently, they are not ready to begin a return journey. In addition, the Federation felt that many TPIs had reached middle age or later, with their financial and social framework at best depleted and in many cases destroyed. They were unlikely to be able to retrieve their situation, regardless of rehabilitation.

Rehabilitation for TPIs

31.64 The Federation felt that there is an underlying assumption in submissions from DVA and the Department of Defence that a TPI can be fully rehabilitated and return to full-time work.

31.65 The Federation stated that the real issue is to determine the processes that can be applied to make the lives of TPIs and their families happier and more purposeful. Its view was that, within a TPI's psychological and physical limitations, his life may be improved by appropriate assistance to undertake education or development. A purposeful and happy life might also be achieved

by contact with civilian stimulus groups, perhaps under the guidance of a DVA community adviser.

Medical Rehabilitation

31.66 The Federation felt that medical rehabilitation should be a relatively straightforward matter, determined by the specific condition for which the TPI is treated.

Impacts on Families

31.67 The Federation considered that the impact on the spouse/partner and children of living with and caring for a TPI with PTSD has not been seriously addressed, but must be if the total rehabilitation of the TPI is to be achieved.

Socialisation Rehabilitation

31.68 The Federation considered that the most obvious area for improving the quality of the lives of TPIs is in reducing social isolation. It acknowledged that, in the DVA context, the initial rehabilitative emphasis on socialisation is made through programs, such as DVA's Lifestyle Management Programs, that build on the service-created relationships and common experience of veterans. The Federation considered that these have been successful and that wider TPI participation should be encouraged.

31.69 The Federation considered that veterans' self-help programs should be promoted and encouraged, and that these types of initiatives are very important because they are conceived and driven by the veterans themselves and are more likely to target veterans' needs.

31.70 The Federation view was that the socialisation process must also take a wider focus and seek to encourage veterans beyond predominantly ex-service oriented programs, and involve them and their families in community programs.

Vocational Rehabilitation

31.71 The Federation considered that the essential element in vocational rehabilitation is re-skilling. Its view was that the conditions that cause veterans to be TPI continue, and that it is unreasonable to believe that such veterans can be integrated back into the workforce without re-skilling. The Federation argued strongly that it is crucial that the age and suitability of the TPI for re-skilling be carefully considered in order to avoid a cruel and pointless exercise.

31.72 Further, the Federation argued that, even with appropriate medical and vocational rehabilitation, only a very small number of current TPIs are

potentially able to return to full-time employment because they are often unattractive to employers. Suggestions to overcome this included returning preferred employment status to veterans for certain public sector positions.

31.73 The Federation's view was that, for the overwhelming majority of TPIs, vocational training should focus on achieving self-esteem, happiness and lifestyle improvement.

31.74 Whatever approach was to be pursued, the Federation considered it crucial that families be rehabilitated first. Any work incentives provided to TPIs must be carefully planned and focused on getting them to work no more than eight hours per week. Furthermore, any remuneration should be free from assessment or penalty.

Australian Peacekeepers and Peacemakers Association

31.75 The submission of the Australian Peacekeepers and Peacemakers Association[181] concentrated on the problems of younger TPI veterans, particularly their inability to accumulate wealth or pursue a career.

31.76 The Association recommended:

- creation of a 'younger veteran career incentive scheme' that helps younger veterans gain qualifications and prospective employment, is not time restrictive, does not restrict veterans' income from VEA benefits, is Commonwealth funded, and provides the younger veteran with self-esteem and personal pride;
- allowing younger veterans who are unable to function in employment to return to the special rate disability pension with no detriment; and
- a wealth-creation educational program for younger veterans, to give them incentives to fund their own retirement and to allow them to independently and 'actively plan for life after 65 (off the service pension)'.

The Australian Gulf War Veterans Association

31.77 The submission of the Australian Gulf War Veterans Association[182] concentrated on the difficulties experienced by younger TPI veterans. It pointed out that younger special rate recipients also have severely truncated working lives. This disadvantages them in providing for their family (sometimes more than one family) and in accumulating wealth for their later years. The Association recommended that:

[181] Submission 1264.
[182] Submission 1266.

- the VVRS be made available to all TPI pensioners on a voluntary basis, under the medical supervision of their treating specialists;
- younger veterans, specifically, be able to undertake undergraduate tertiary studies as part of this scheme, knowing that their TPI pensions are fully protected should they fail to retrain and secure long-term employment; and
- annual gym membership be made available to all veterans upon application, provided a rate of, say, 52 visits per year is maintained.

31.78 The submission also proposes that younger veterans be able to access the VVCS Heart Health Program.

SHORT HISTORY OF REPATRIATION REHABILITATION

31.79 Although rehabilitation '… is a relatively recent concern of workers' compensation schemes in the general Australian community' (HWCA 1986, p. 44), the repatriation system has, intermittently since its inception, provided resettlement, retraining and rehabilitation for returned service personnel.

31.80 Various schemes have provided vocational assistance to veterans and serving members since World War II. By the early 1970s, special veterans' schemes had been largely absorbed into those available to the general community. Consequently, most Vietnam veterans had little access to appropriate rehabilitation on their return to Australia.

31.81 In 1992, the Auditor-General (1993, p. x) reported to Parliament that the DVA Compensation Subprogram was 'not well geared to handling the complex issues arising from claims for psychiatric conditions, which are the most significant factor affecting disability pension increases for Vietnam veterans. The report commented on the urgent need for rehabilitation facilities for Vietnam veterans suffering PTSD.

31.82 It also commented that 'the structure of compensation payments often results in a conflict between the desire for improvement in veterans' psychiatric conditions and related functional disabilities and the risk of loss of pension.' The report recommended a fundamental review that would address the findings, including:

- the need for a more effective policy on post-acute long-term rehabilitation facilities for veterans suffering PTSD;
- the diagnosis and assessment of psychiatric conditions; and
- the disincentive aspects of the then current disability pension structure (Auditor-General 1993, p. 56).

31.83 Subsequently, the Hon Professor Peter Baume chaired the Veterans' Compensation Review Committee. The Baume Report was presented to the Government in 1994, and identified a number of significant problems in veterans' rehabilitation (Baume 1994, p. 95), including:

- a perceived lack of social rehabilitation and targeted medical rehabilitation, particularly psychological help for younger veterans with substance-abuse problems;
- a lack of incentives encouraging return to paid work or a 'normal' life; and
- strong incentives to remain ill and 'move up' the disability pension scale towards the TPI pension.

31.84 The Baume Report made a number of recommendations about veterans' rehabilitation for action by DVA (Baume 1994, p. 103).

HOW NEEDS ARE BEING MET SINCE THE BAUME REPORT

31.85 DVA's responses to the recommendations of the Baume Report have brought about a significant improvement in the rehabilitation services available to veterans. The following section deals with relevant services that have since been implemented within DVA and the Department of Defence.

Department of Defence

31.86 The activities of the Department of Defence in the rehabilitation of members and ex-members have impacts on the effectiveness of DVA's efforts to provide rehabilitation services.

31.87 The Department of Defence and the ADF continue to provide resettlement programs, mainly in the form of seminars and advice, for members being discharged.

Military Compensation Scheme and the *Safety, Rehabilitation and Compensation Act 1988*

31.88 Some veterans receive rehabilitation under two quite different arrangements: the repatriation system, and the Military Compensation Scheme (MCS), administered by the Military Compensation and Rehabilitation Service (MCRS), which operates under the *Safety, Rehabilitation and Compensation Act 1988* (SRCA). Some veterans receive entitlements under one of the schemes, while some receive benefits under both. The assessment of rehabilitation needs is an integral part of the process of claiming compensation under the SRCA.

31.89 The main aim of the MCRS is to return the member or former member to civilian employment. The Service also aims to restore the highest possible level of function of a person following a compensable injury or illness. The MCRS provides medical, occupational/vocational and social rehabilitation to achieve these aims. It also provides rehabilitation on a more limited scale to help veterans make lifestyle changes following service-related injuries or illnesses. This can include, but is not limited to, attendant care, household services, alterations to buildings or vehicles, provision of aids and appliances, and non-vocational training.

31.90 For some former members, vocational rehabilitation is not possible. MCRS provides medical and social rehabilitation in these cases.

31.91 The 1999 Tanzer Report (Department of Defence 1999, p. 50) found that:

> For discharged ADF members with compensable injuries or illnesses, the MCRS has a well established system for providing occupational rehabilitation and DVA has introduced similar arrangements. For serving members, however, the ability of the MCRS and DVA to offer occupational rehabilitation is restricted by the lack of coordination between the ADF Health Services, ADF Units and the compensation administration agencies in Defence and the DVA.

Proposed New Military Compensation Scheme

31.92 The Department of Defence provided advice to the Committee about a new compensation scheme that the Department is developing for the ADF. This is discussed in Chapter 7.

Defence Links Project

31.93 The Defence Links Project is a joint DVA and Department of Defence initiative to improve services to ADF members and veterans by identifying common business areas between these agencies and by making better use of their resources. Activities under the initiative have included the transfer of the MCRS to DVA administration in 1999, the creation of a Medical Advisory Panel to examine clinical issues relating to ADF deployments, and the establishment of the Transition Management Service.

31.94 The Transition Management Service provides advice and support to ADF members who are in the process of making the transition to civilian life following discharge on invalidity grounds. DVA delivers the services, which are funded by the Department of Defence.

31.95 As part of the Defence Links Project, the Government has recently announced that it is exploring the possibility of establishing a new Centre for

Military and Veterans' Health (CMVH). The main objective will be for the CMVH to provide a cost-effective national base of expertise in military health to maintain and improve the health, fitness and deployability of the ADF. At the time of writing, DVA and the Department of Defence were in the final stages of evaluating tenders from academic institutions.

Medical Rehabilitation

31.96 The distinction between medical and social rehabilitation is not precise. Some of the initiatives mentioned under the heading of medical rehabilitation contain social rehabilitation aspects, and vice versa.

31.97 DVA provides an extensive range of professional medical rehabilitation services to veterans.

Treatment Programs for Veterans Suffering from PTSD

31.98 Hospital-based treatment programs for veterans with PTSD began in 1994–95. There are approximately 18 programs across the country that provide mainly inpatient services. DVA also funds treatment for veterans with PTSD through residential, day hospital, outpatient, and regional outreach programs.

31.99 Research by the Australian Centre for Posttraumatic Mental Health (ACPMH) showed positive effects for the PTSD treatment programs implemented in recent years. The programs compare well to similar ones overseas. DVA is funding fewer inpatient treatment programs because of findings that show greater effectiveness for outpatient, regional and residential treatment programs.

Australian Centre for Posttraumatic Mental Health

31.100 The ACPMH is a collaborative venture between DVA, the ADF and the University of Melbourne. The mission of the Centre is 'to achieve significant improvements in the recognition, prevention and treatment of mental health problems in veterans and currently serving personnel' (ACPMH 2001a). The Centre has a key role in the development and quality assurance of PTSD treatment programs across Australia. ACPMH has:

- applied a standardised process to evaluate the clinical effectiveness of these programs;
- shown that the positive effects of the treatment programs compare well to the results of similar programs in other countries;
- trained and educated significant numbers of clinicians in the recognition and management of PTSD;

- become a focal point for traumatic stress research; and
- collaborated with the ADF to help ensure that veterans of the future are better protected from the psychological sequelae of military service and receive prompt, effective treatment when required.

Vietnam Veterans Counselling Service

31.101 The mission of the VVCS is to improve the quality of life of veterans, their families and dependants, through services that promote and maintain health, wellbeing, independence and community integration.

31.102 Since the Baume Report, the Service has been expanded and group programs have been implemented to address the perceived lack of social rehabilitation for veterans and their families.

31.103 The VVCS currently provides:

- counselling;
- group programs (e.g. PTSD support groups, stress and anger management groups);
- local contact and support for veterans and their families, including those in rural and remote areas;
- community development activities;
- health promotion; and
- information and education.

DVA Mental Health Policy

31.104 In 2001, for the first time, DVA developed a mental health policy and strategic directions statement (DVA 2001f). The strategic directions set out in the policy are:

- developing a more comprehensive approach, incorporating prevention, early intervention, treatment and rehabilitation, with a greater emphasis on community-based models of care;
- responding to specific needs of alcohol abuse, the aged population and rural-based veterans and families;
- becoming a more active and informed purchaser of mental health services; and
- strengthening partnerships with key stakeholders in mental health care, including the Department of Defence, and improving the participation of consumers in decisions about mental health care.

31.105 DVA has begun to implement a number of programs in accordance with the identified strategic directions. A description follows of some of the major activities and services provided.

Alcohol Management

31.106 DVA established the Alcohol Management Project with the primary aim of reducing the harm caused by alcohol misuse, with added attention to its misuse in combination with other substances (e.g. nicotine and prescription drugs).

31.107 Veterans can access treatment through a general practitioner, psychiatrist, psychologist or social worker. Most VVCS centres address alcohol management strategies in both counselling and group programs. Specific alcohol detoxification, treatment and rehabilitation programs exist in some locations. Most treatment and rehabilitation programs provide support for both abstinence and controlled drinking approaches.

31.108 DVA state offices, depending on the availability of resources, respond to requests from veterans, service providers and ESOs seeking assessment for both alcohol-related disability pension applications and for treatment. DVA has also examined methods of rehabilitating veterans with drug and alcohol problems both through specific programs for veterans, and by assisting veterans to participate in proven community programs.

31.109 Although the PTSD treatment programs do not aim to treat alcohol disorders as such, data from the 12-month follow-up of about 1000 veterans suggests that 46 per cent improved on both PTSD and alcohol, 25 per cent improved on PTSD but not alcohol, 14 per cent improved on alcohol and not PTSD, and 15 per cent improved on neither.[183]

31.110 The ACPMH is working closely with the DVA Alcohol Management Project to establish the protocols and clinical practice guidelines for treatment of alcohol problems and dependence. Joint work between the Centre and the Department of Defence is progressing.

Pathways to Care Research — Access to Services for Veterans Recently Compensated for a Mental Health Condition

31.111 A review by DVA of services used by veterans with a mental health disability indicated that up to 40 per cent were not receiving mental health care funded through DVA. World War II veterans who have recently been accepted

[183] Information supplied by ACPMH, 2001.

as having war-related mental health conditions have the lowest treatment rates (DVA 2001f, pp. 6–7).

31.112 The ACPMH began a study this year on the pathways to care used or not used by these veterans. The study will include all age groups, and veterans in metropolitan and rural areas. The final report, expected by March 2003, should help DVA to understand:

- which mental health services are accessed by veterans with accepted mental health disabilities;
- how veterans came to access those services (i.e. the pathways to health care they followed); and
- where veterans have not received mental health services, the reasons why they have not done so.

Social Rehabilitation

31.113 DVA-supported social rehabilitation programs include VVCS lifestyle management programs, self-help activities and health promotion activities. In addition, DVA encourages many initiatives that are independent of the Department and provide appropriate models of social rehabilitation. These include the work of the unit associations and the Vet Centres in Victoria, which act as a valuable source of social engagement.

31.114 A more detailed description follows of social rehabilitation activities undertaken by the VVCS and through DVA Veteran and Community Grants.

Vietnam Veterans Counselling Service

31.115 The VVCS has supplemented its counselling focus with a lifestyle management approach. This recognises that many problems experienced by veterans result either from war trauma or their lifestyle (e.g. poor diet, smoking, alcohol abuse and lack of exercise).

31.116 Lifestyle management programs generally aim to:

> maintain and where possible improve the quality of life of the participants. Specifically, the objectives … are to provide information on the principles of a healthier lifestyle, to enhance beliefs and attitudes that a person can be an agent of change in their own life, to provide strategies for creating a healthier personal lifestyle and to promote skills in linking and relating to family and others. (Devilly 2002, pp. 1119–34)

31.117 The VVCS Heart Health Program also has a medical rehabilitation component.

DVA Veteran and Community Grants

31.118 Veteran and Community Grants administered by DVA aim to maintain and improve the independence and quality of life of members of the veteran community through activities that sustain and/or enhance wellbeing. The grants recognise health promotion as a major priority of DVA's strategy to provide effective support to the veteran community.

31.119 Grants promote health issues and healthy lifestyles, reduce social isolation and encourage involvement in community activities. The intention is to assist and encourage the development of projects that will become financially viable and sustainable. Grant funds are not provided for recurrent or ongoing financial assistance. For example, funding is not available for wages or salary payments for any staff, except in the case of a one-off establishment grant for a short period, or for volunteer services (DVA 2002h).

31.120 The Committee became aware of two social rehabilitation programs run by Vietnam veteran groups that seem to have been very successful in assisting Vietnam veterans with PTSD and receiving special rate payments. The programs are Connect-a-Vet, which operates on the Gold Coast, and a similar program, the Veterans Support Group (North), which operates in Launceston. Seeding funding for the programs was provided by Veteran and Community Grants. Both programs are fairly typical of a number of projects supported by DVA that enable veterans, for instance those of the Vietnam War, to assist older veterans who may need companionship or assistance to remain in their homes. Veterans give voluntary service in a variety of social support activities. Community engagement, together with appropriate support and training, is directed at raising the level of self-esteem and self-worth amongst the younger veteran volunteers through their own provision of practical support services to other veterans and war widows and through their work within the general community. Tasks such as home visiting, assisting with shopping, outings, transport and social activities are carried out by the volunteer group. The evaluation of the Connect-a-Vet project found that, in addition to achieving its specified aims, the physical fitness of the volunteers had improved.

31.121 Members of the Veterans Support Group (North) benefit not only from their own involvement in activities similar to those of the Connect-a-Vet project, but also from a local support group for their partners, which also received seed funding from Veteran and Community Grants. The group enables partners to deal with issues relevant to them in understanding the impact of the veterans' conditions on their families and in having healthy lifestyles; it also helps them to engage in social activities.

31.122 In Victoria, a number of ESOs have collaborated to create cooperative veterans' centres. With DVA assistance, this cooperative model has begun to

spread to other states. One example is the assistance provided recently by DVA to the Mackay Veterans Support Group to refurbish and equip two houses that are to be used as a drop-in centre. The program has also received assistance from the Queensland Government, the local council and other organisations that will use the centre. The centre will be a place in which support and guidance can be provided to veterans and their families in the Mackay region. The anticipated benefits of the project include reducing the social isolation of members of the veteran community and helping veterans to lead a healthier lifestyle. The facility will also provide private areas for visiting community service providers and a time-out facility for veterans and their partners.

Vocational Rehabilitation

Veterans' Vocational Rehabilitation Scheme

31.123 The VVRS, which is administered by DVA, was introduced in 1998 after a pilot program and extensive consultations with ESOs.

31.124 The objectives of the VVRS are to assist veterans to find, or continue in, suitable paid employment, with particular emphasis on:

- facilitating the transition from service in the ADF to suitable paid civilian employment;
- assisting those veterans whose jobs are in jeopardy to retain suitable paid employment ('jobs in jeopardy assistance'); and
- in conjunction with Part V1A of the Act, providing an income safety net for certain veterans receiving intermediate and special rate disability pensions, or the invalidity service pension, who wish to engage in suitable employment.

31.125 The principles of the VVRS are:

- participation is voluntary;
- a rehabilitation plan is to be approved only if the veteran has undergone an assessment of rehabilitation capability by a suitably qualified person;
- rehabilitation services are to be provided only in accordance with an approved plan that has been developed and agreed with the veteran;
- rehabilitation services are to be provided only if the Repatriation Commission is satisfied that these services will result in a suitable paid employment outcome;
- rehabilitation services are to be approved according to principles of cost-effectiveness and will generally be the minimum necessary to achieve a suitable paid employment outcome;

- there are no penalties for withdrawal from or failure to complete an approved program, although rehabilitation services may be discontinued in such circumstances; and
- rehabilitation services are not to be provided concurrently with another vocational rehabilitation program.[184]

31.126 Participation in the VVRS is free. Injury or an accepted disability is not a prerequisite for participation.

31.127 The VVRS has a legislated safety net that guarantees that DVA pensioners who find work through the Scheme will not receive less income than they would have without that employment. Veterans who receive payments at the special rate (TPI) or intermediate rate and the invalidity service pension are guaranteed that:

- If paid work ceases at any time or for any reason, including retrenchment, retirement, or ill health, special rate or intermediate rate pensions are automatically restored in full. Invalidity service pension restoration is subject to the income and assets test.
- Income from disability pension and earnings will never be less than the disability pension that would otherwise be payable. (DVA 2002d)

31.128 CRS Australia provides the specialised vocational rehabilitation services for the VVRS.

31.129 The Repatriation Commission's advice to the Committee included that:

- the achievement of fifty TPIs in sustained employment could be considered significant; and
- the program can link up with other programs such the VVCS, Defence Links and the DVA Mental Health Plan.

31.130 At the time of preparing this Report, the Repatriation Commissioner, Major-General Paul Stevens AO, was the convenor of a working party of ex-service and DVA representatives. The terms of reference of the working party are to:

- consider the parameters and structure of the VVRS, with a view to ensuring its attractiveness to veterans;
- identify strategies to market the VVRS effectively (e.g. to veterans who are newly compensated, or have jobs in jeopardy, or do not have contact with the DVA or ESOs); and
- consider other issues in the support of veterans if required.

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[184] *Instrument No. 5 of 1997, Veterans' Vocational Rehabilitation Scheme*, Repatriation Commission, *Veterans' Entitlements Act 1986.*

31.131 The working party will soon present its recommendations to the Commission. At the time of writing, a paper drafted by the party was with the ex-service members for endorsement before presentation to the Commission.

ADEQUACY OF THE CURRENT ARRANGEMENTS

31.132 The Committee accepts that the objective of rehabilitation should be to restore veterans to their optimal level of function, commensurate with their service-related disabilities, in order to provide them with better quality of life, maximised vocational outcomes and reduced dependency on financial disability compensation.

31.133 There is widespread support amongst the veteran community for suitable rehabilitation linked to appropriate financial compensation. This is consistent with the Committee's understanding of the policy principles of the new Military Compensation Scheme, which include the intention to emphasise effective injury management through treatment, rehabilitation, return to work and compensation for residual capacity.[185] The Committee considers it extremely important that veterans be involved in activities to develop rehabilitation, and finds the work DVA is doing in consulting with veterans, for example the participation of ESOs and DVA in the VVRS working party, very positive.

31.134 The Committee notes that many of the issues raised by ESOs and individuals in their submissions and meetings with the Committee are being addressed, but believes that significant issues have been neglected and require attention.

31.135 The rehabilitation needs of disability pensioners are being only partially met. The Committee heard cases of veterans 'hitting the wall' and having social problems, which included being unable to sustain employment. Such a crisis is unpredictable and can occur many years after the event that caused it. It is an indicator that current rehabilitation processes are inadequate.

31.136 Veterans are not well served by the current arrangements, which, as outlined below, encourage dependency on disability compensation support payments. The number of veterans classified as TPI following their service also demonstrates a clear need for improvements in the rehabilitation services available to them.

31.137 The number of recent disability compensation claims for mental health conditions following deployments to East Timor raises serious questions about the effectiveness of the measures undertaken by the Department of Defence to

[185] Submission 2339, Department of Defence.

prepare members for warlike and non-warlike deployments, to support them while on those deployments and to assist them following their return to Australia.

31.138 The inadequacies of the current arrangements are:

- the lack of a policy framework for rehabilitation through the repatriation system;
- the lack of early rehabilitation intervention;
- the focus on seeking pensions to the exclusion of restoring functioning;
- the lack of coordinated programs of medical, social and vocational rehabilitation;
- the lack of expertise in rehabilitation medicine;
- the voluntary nature of the existing systems;
- the extent of the incentives for rehabilitation;
- the lack of evaluation data on many DVA rehabilitation programs; and
- poor knowledge within the veteran community of available rehabilitation.

Policy Framework for Rehabilitation

31.139 Rehabilitation may involve a sophisticated combination of medical, social and vocational programs. Although a range of rehabilitation programs is provided to veterans, the programs are not provided within a coherent policy framework. The result is that some needs are not identified or met at all and some needs are only partially met.

Early Rehabilitation for Veterans

31.140 It is recognised in Australia that 'rehabilitation is most effective when measures towards it are undertaken swiftly' (Luntz 1975). Submissions from ESOs have endorsed this view.

31.141 Where possible, it would be preferable that rehabilitation occur before discharge and as part of the transition management, so that there is a continuation on moving to DVA of the rehabilitation commenced while in the ADF, rather than after a move into a new system.

Delays in the ADF in Reporting Disabilities and Seeking Treatment

31.142 The medical treatment and rehabilitation that veterans receive while they are in the ADF has an impact on the effectiveness of their rehabilitation.

Unwillingness to report injuries and illnesses within the ADF is a concern because it may adversely affect the rehabilitation prospects of veterans and the efficiency of the ADF, and should be further addressed as a matter of priority.

31.143 The Acting Head of Defence Personnel reported to the Joint Standing Committee on Foreign Affairs, Defence and Trade in 2002 that ADF statistics show that members tend not to report injuries as early as they would in civilian employment.[186] This is often due to members' reluctance to disclose conditions that could lead to reduced career opportunities, or the fear of medical discharge and consequent loss of employment.

31.144 Additionally, there is evidence that, in parts of the ADF, 'there is still a stigma attached to seeing a psych'. The Department of Defence is currently drafting an instruction on mandating psychological screening. Members are not routinely screened when they leave the ADF unless they are members of the SAS.[187] Members who have been on operational service can access the VVCS without advising the Department of Defence, as the use of the service is entirely confidential.[188]

31.145 The Committee notes the work that is currently being done within the ADF to promote the early reporting of illnesses and injuries. It considers that further work is necessary within the ADF as a matter of priority.

Post-deployment Assistance

31.146 There is some evidence of difficulty in providing coordinated post-deployment support to individuals drawn from specialist areas of the ADF.[189] The Navy has noted that, while members returning to Navy units after deployment tend to be fairly well looked after, some of those who do not return to their units are not being monitored as well. The Navy is addressing this issue.[190]

31.147 The ADF has analysed psychological screening data on all its members deployed operationally between January 1999 and March 2001. The indications from the data are that the psychological health of deployed personnel is quite robust and is better than that of the general community (Deans 2002, p. 1).

31.148 The Committee has been advised by DVA that, by June 2002, the Department had received, from ADF members deployed to East Timor,

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[186] Parliament of Australia, Joint Standing Committee on Foreign Affairs, Defence and Trade, *Transition Management in the Australian Defence Force*, < www.aph.gov.au/hansard/joint/commttee/j5642.pdf, FADT 12.
[187] *Ibid*., FADT 14.
[188] *Ibid*., FADT 14.
[189] *Ibid*., FADT 24.
[190] *Ibid*., FADT 30.

approximately 90 compensation claims under the VEA and a similar number under the SRCA citing PTSD. Some of these claims may be from the same members.

31.149 The level of compensation claims lodged from veterans who have been deployed to East Timor raises serious concerns about the effectiveness of preventative mental health measures and the management of veterans' health following deployments. With the Department of Defence, DVA should investigate the causes of the apparent disparity between the number of claims for compensation due to PTSD and the results of ADF screening data on the psychological health of deployed personnel. This investigation should include an examination of the support members received before, during and after the deployment and the bases of the claims.

Transition Management

31.150 There is evidence that, for some injured members of the Navy, the transition management process may not be working as effectively as possible. Consequently, some members may be experiencing delays between ceasing useful employment in the ADF and being assisted by DVA.[191]

31.151 Effective handover of personnel between the ADF and DVA systems is improving as a result of the implementation of the Transition Management Service for veterans who are being discharged on invalidity grounds.

31.152 Some veterans only report their service-related disabilities after discharge and compensation claims are sometimes not made until then. The Committee considers that there is value in examining the extension of the Transition Management Service to all discharging veterans.

Impediments to Early Intervention within the Repatriation System

31.153 DVA has not acted on a critical recommendation of the Baume Report that it examine means of assessing and monitoring health rehabilitation as veterans' requirements change, particularly at the time of assessment for benefits or increases.

31.154 With the exception of some programs, such as the VVRS and those delivered by the VVCS, which do not require prior determination of compensation claims, rehabilitation is considered only after disability claims have been assessed. This relies on the veteran initiating the rehabilitation

[191] *Ibid.*, FADT 64.

process and inappropriately presumes a level of knowledge on the part of veterans about rehabilitation.

31.155 To achieve the best results for veterans, it is too late to leave rehabilitation until they have reached a particular level of disability compensation, as has been suggested by some ESO representatives.

31.156 Diagnosis of mental health disorders, such as PTSD, can be difficult. Veterans need to be able to receive early diagnosis of their conditions so that they receive early and appropriate treatment. Although DVA has medical advisers who are involved in the examination of some compensation claims, it does not have specialist mental health advisers.

Focus on Seeking Pensions to the Exclusion of Restoring Function

Lack of Assessments of Capacity for Rehabilitation

31.157 The repatriation compensation assessment process continues to focus on degrees of impairment, with the sole purpose of determining the extent of financial compensation to be provided. There is no assessment of rehabilitation needs, consistent with modern workers' compensation principles, when veterans apply for benefits or increases to their levels of disability compensation.

31.158 Additionally, from the information provided to the Committee, it is evident that some of the problems identified in the Baume Report still exist, particularly the incentives to remain ill and 'move up' the disability pension structure.

31.159 The Committee has considerable concern about the culture of 'going for a TPI' that is promoted by some ESOs and, unintentionally, by DVA in its training of pension and welfare representatives. The Committee considers that this approach may have been encouraged by the lack of suitable rehabilitation. There is evidence that this emphasis is changing.

31.160 The Committee considers that the rise in numbers of recipients of higher levels of disability compensation payments reflects DVA's success in encouraging those veterans who have legitimate service-related conditions to claim.

31.161 There is little evidence to show that veterans have been better off as a result of pursuing disability pension compensation payments when they might have been able to continue working, even if for less than full-time hours. Indeed, the experience of the Vietnam veterans, and the comments the Committee has received from ESOs and the Commission, indicate that the opposite has been the case for some.

Legislative Restriction of the Consideration of Veterans' Capacity to Undertake Remunerative Work.

31.162 Section 28 of the VEA deals with determinations made under s.23(1)(b) and s.24(1)(b) of a veteran's capacity to undertake remunerative employment. It states that, in making this determination:

> [T]he Commission shall have regard to the following matters only:
>
> (a) the vocational, trade and professional skills, qualifications and experience of the veteran;
>
> (b) the kinds of remunerative work which a person with the skills, qualifications and experience referred to in paragraph (a) might reasonably undertake; and
>
> (c) the degree to which the physical or mental impairment of the veteran as a result of the injury or disease, or both, has reduced his or her capacity to undertake the kinds of remunerative work referred to in paragraph (b).

31.163 The full bench of the Federal Court has confirmed that the three matters set out in paragraphs (a)–(c) above 'should alone be taken into account in deciding whether a veteran is incapable of undertaking remunerative work' (Creyke and Sutherland 2000, p. 238).

31.164 Therefore, s.28 limits the range of employment options that can be considered in determining a veteran's capacity for employment. Successful rehabilitation, which may include re-skilling, may broaden the range of suitable employment options open to a veteran. Section 28 might have an undesirable effect of restricting rehabilitation options that can be considered at the time eligibility for economic loss compensation is being determined.

31.165 The Government should amend s.28 of the VEA so that that a broader range of employment options, including those that a veteran might reasonably undertake if given suitable rehabilitation and re-skilling, may be considered in the assessment of a veteran's capacity to undertake remunerative work for the purposes of s.23(1)(b) and s.24(1B)(b) of the VEA.

Terms in the Disability Compensation Structure

31.166 In order to be eligible for the special rate pension, a veteran must have been blinded, be tubercular, or be totally and permanently incapacitated (TPI) (i.e. unable to work more than eight hours a week as a result of accepted disabilities alone).

31.167 There are three major problems with the continuing use of 'TPI' in the language of repatriation. First, it is inaccurate. To qualify, a veteran must have a *permanent* incapacity. The incapacity does not, however, have to be *total*, and in

many cases it is not. The advice to the Committee from the Repatriation Commission concerning the successful return to paid employment of a small number of TPIs demonstrates the inaccuracy of the classification, at least for some veterans. Second, the concept originated at a time when the Australian workforce was vastly different, with the majority of returning soldiers earning a living by means of manual work. Clearly, this is no longer the case. Third, there is a growing body of evidence to suggest that the classification of an individual as TPI can have negative effects, particularly in terms of psychological well-being, by continually reinforcing an essentially negative concept, almost to the extent of identifying a person by his disabled status. This militates against the person's recovery and return to a 'normal' lifestyle.

31.168 The term 'totally and permanently incapacitated' should be removed from the vocabulary of the repatriation system and replaced with 'special rate'. As a minimum, s.24 of the VEA should be amended to remove the word 'totally'.

Lack of Coordinated Medical, Social and Vocational Rehabilitation Programs

31.169 The repatriation system suffers from a lack of coordination among providers, particularly for veterans with complex and chronic conditions. Consequently, medical, social and vocational rehabilitation needs are not determined or met in a coordinated way. This may have a negative impact on the overall benefit of treatment and rehabilitation.

31.170 The Repatriation Commission has advised the Committee that it may be worth revisiting case management as a means of integrating treatment, lifestyle management and other rehabilitative interventions, particularly for veterans who have been newly compensated. The Committee considers that an approach facilitating coordination among providers of rehabilitation services, particularly for veterans with complex and chronic conditions, is highly desirable.

Medical Rehabilitation

The Heart Health Program

31.171 The Committee heard many favourable comments about the Heart Health Program available to veterans of the Vietnam War, and also heard requests for it to be extended to other veterans. The benefits gained by Vietnam veterans participating in the program demonstrate the potential for improvements in the health of other veterans. The Committee considers that the program has important health and social benefits for participants and that these benefits should not be limited to Vietnam veterans. A limited extension to other

veterans who have a professionally assessed need for the program and who receive disability compensation at the special rate is warranted.

31.172 The Committee also received submissions seeking an extension of the period of assistance provided under the program. The Committee is aware that, at the conclusion of their participation, some veterans approached gyms and negotiated extensions of their programs at their own cost and at reduced rates. The Committee considers that the current arrangements for Vietnam veterans, which assist them to take responsibility for their health by establishing a healthy lifestyle, are appropriate.

Rehabilitation and Mental Health

31.173 DVA should continue to explore rehabilitation options for veterans with service-related mental health conditions. The ACPMH and professionals in rehabilitation medicine should be used in this process.

31.174 The Department should undertake further controlled investigations into the inclusion of spouses in the treatment of veterans and the utility of lifestyle-management courses as a first step in the treatment of trauma-related problems within the veteran community.

Social Rehabilitation

31.175 The Committee has seen ample evidence that DVA provides many effective programs of social rehabilitation. These need to be promoted and expanded.

31.176 The Committee heard many favourable comments about DVA's socially focused programs, for example the VVCS lifestyle management programs and the projects funded through DVA Veteran and Community Grants, which are available to all veterans.

31.177 Some outwardly focused programs supported by Veteran and Community Grants have been evaluated as being particularly beneficial in raising participants' self-esteem, reducing their social isolation, improving their health and facilitating involvement in general community activities. Schemes such as the Veterans Support Group (North) and Connect-A-Vet, while small, could provide a model for similar schemes in other locations. The Committee believes that DVA should seek to expand structured social rehabilitation programs that have been positively evaluated, in local communities. Crucial requirements for the success of such programs seem to be that they:

- are owned by the veterans involved;
- are voluntary, with a clear philosophy of not trying to do too much;

- have a few key personnel, who are enthusiastic and skilled in interpersonal communication, to coordinate and drive the groups;
- promote participants helping each other;
- provide a welcoming and understanding environment;
- have a democratic and non-structured management approach within the group;
- provide opportunities for veterans to meet and talk freely about their feelings and experiences;
- provide a supportive environment that helps some veterans address problems related to their disabilities; and
- undertake productive activities that give feelings of self-worth and contribute to society.

31.178 Such schemes may need some initial seed funding and limited ongoing support (e.g. advice from community development officers).

31.179 Even if voluntary activity is unrelated to paid employment, the gains from it are immense. Placement in volunteer work should be seen as a suitable rehabilitation outcome for veterans for whom paid employment is unrealistic.

31.180 It is best that DVA continue to help establish the programs and that the veterans take over responsibility for operating and maintaining the groups. If DVA staff are too heavily involved, the dangers are that the benefits to the veterans (e.g. pride in the success of the projects) will be reduced and that the staff may come to be seen as an essential part of the programs.

31.181 As social rehabilitation is often a prerequisite for any successful vocational rehabilitation, such programs might enable some veterans to participate in vocational rehabilitation.

31.182 The Committee acknowledges the valuable work done by DVA as a result of its participation with ex-service and community organisations through mechanisms such as Veteran and Community Grants. The Committee considers that community service organisations, such as Lions Clubs and Rotary International, present opportunities that need exploration to encourage veterans to become further involved in activities that are future-focused and outward looking.

31.183 Although the Committee has heard criticism from veterans of the temporary nature of seeding grants under the Veteran and Community Grants program, it has received evidence that the need for programs to become self-supporting has on occasions been a source of pride amongst veterans (e.g. the successful Veterans Support Group (North), which undertakes similar functions

to Connect-a-Vet). The Committee considers that the temporary, seeding nature of Veteran and Community Grants is appropriate.

31.184 Distance causes difficulties that prevent the establishment of supportive networks for veterans returning from warlike and non-warlike deployments. Assistance is needed to provide a mechanism that veterans can use to keep in touch with other members from deployments in which they participated.

31.185 Some veterans may require social rehabilitation that is not vocationally focused and therefore is not available under the VVRS. The necessary assistance may not be provided by group programs or through the services of the VVCS. For example, a veteran may seek to re-enter employment under the VVRS and may, in conjunction with the service provider, determine that this is not an appropriate outcome. Other veterans may seek social rehabilitation that requires some skill development before they participate in voluntary activities (an example might be a veteran who wants to acquire some public speaking skill before participating in a community group). There is currently no mechanism to provide assistance that is not vocationally focused.

Lifestyle Management Programs

31.186 Although lifestyle management programs are mainly socially oriented, some of their elements could be defined as medical rehabilitation, such as those that promote health and education to prevent deterioration of disabilities. A study to assess the effect on a veteran group of a residential lifestyle course attended by a number of the veterans' partners found small-to-moderate effects for veterans and generally larger effects for partners. The researcher considered that the results warranted further controlled investigation into the inclusion of spouses in the treatment of veterans and the utility of lifestyle-management courses as a first step in the treatment of trauma-related problems within the veteran community (Devilly 2002).

Vocational Rehabilitation

31.187 Acting on the recommendation of the Baume Report that it develop a vocational rehabilitation package, DVA has developed and implemented the Veterans' Vocational Rehabilitation Scheme (VVRS), which was evaluated during 1999–2000. The evaluation found widespread support and acceptance of the Scheme and a perception that it fulfilled important personal, social and political roles for the stakeholders. Although VVRS is a small scheme, further evidence of its usefulness was provided by the Repatriation Commission's advice that the Scheme had contributed to the return of approximately 50 special rate recipients to sustained employment of six months or more. The Committee

considered it significant that, according to the Commission's advice, most of these veterans were in their fifties.

31.188 The Committee considers that the objectives of the VVRS (to assist veterans to find or continue in suitable employment) are appropriate.

31.189 However, some veterans have criticised the principle of the VVRS that states that 'rehabilitation services are to be provided only if the Commission is satisfied that these services will result in a suitable paid employment outcome'. The Committee considers that the current principle is likely to restrict the vocational rehabilitation opportunities for some veterans and should be amended.

31.190 A further principle of the VVRS criticised by veterans is that 'rehabilitation services are to be approved according to principles of cost-effectiveness and will generally be the minimum necessary to achieve a suitable paid employment outcome'. Some veterans feel that DVA should be providing whatever assistance is necessary to help them reach their optimal level of work, commensurate with their disabilities. The VVRS has supported some veterans through formalised training, including tertiary education, following a professional assessment of rehabilitation needs.

31.191 The Committee considers that, as a principle of repatriation rehabilitation, critical assistance that will help a veteran obtain or hold employment should be provided. It considers that an appropriate level of support is provided to veterans under the existing principles.

31.192 The Committee endorses the current principles of the VVRS with the exception of the principle stating that 'rehabilitation services are to be provided only if the Commission is satisfied that these services will result in a suitable paid employment outcome'. This should be amended to enable rehabilitation services 'to be provided to veterans if the Commission is satisfied that these services *are likely to* result in a suitable paid employment outcome'. It is impossible to guarantee that participants in the VVRS will obtain or retain employment following vocational rehabilitation, and this change to the wording would acknowledge that. More importantly, it would provide opportunities for veterans who are keen to work and have a likelihood of employment following assistance, but are excluded by the current requirement.

31.193 The numbers undertaking VVRS programs appear to be very small. This is particularly so when these numbers are compared to the number of new special rate payments that are granted each year, most of which are for veterans of normal working age.

31.194 Most assistance under the Scheme has been to help veterans find employment. In a minority of cases, veterans were assisted to hold employment they were at risk of losing.

31.195 The Committee considers that there is potential to assist more veterans before they lose their employment, although this ability is restricted because of the inadequacies mentioned earlier. However, DVA has mechanisms (e.g. the VVCS) that should be able to aid the early identification and rehabilitation of veterans who are starting to fail in employment. Additionally, the VVRS services that help veterans hold employment that is under threat should be actively promoted through mainstream media and the ex-service community.

31.196 The truth of the view, common in parts of the veteran community, that mental health disabilities such as PTSD necessarily lead to a loss of employment, has not been tested. The Committee considers that veterans would benefit from research in this area.

31.197 Most Vietnam veterans are in the 50–60 year age range, and some hold the view that it is difficult, if not impossible, to work after age 55. The evidence does not support this view, as many Vietnam veterans successfully continue full-time or part-time employment beyond the age of 55.

31.198 The Committee recognises that, if veterans apply for pension increases or approach the repatriation system at 50 years of age, it is generally going to be more difficult to help them to stay in, or re-enter, full-time employment than it would be with younger members. Within the general community, the workforce participation of people in this age group is diminishing (Kelley and Frenzel-Zagorska 2002, p. 9).

31.199 However, if veterans of any age are in suitable employment, it would be preferable, both for them and the public purse, that they be assisted to keep working, even if their hours are reduced and compensatory payments are necessary to supplement their earnings.

31.200 The Committee sees behavioural disadvantages to having an age at which veterans are presumed to be unemployable. Consequently, it does not recommend the imposition of an upper age limit, after which rehabilitation assessments would disregard veterans' ability to stay in the workforce.

31.201 During the Review, the Committee was impressed by the number of ESO representatives, many of whom had a legacy of severe, service-related disabilities and were in or past their fifties, who carried heavy workloads in their organisations. The Committee noted that, with appropriate understanding of their situation (e.g. allowing them to work at their own pace), they were able to contribute very positively. The Department should seek out employers who are sympathetic to the situations of veterans with limited ability to work full

time or regular hours. This approach should be accompanied by an educational program to help employers understand the effects of war-related trauma on employment.

Rehabilitation Medicine Expertise within DVA

31.202 Although the Committee saw evidence that veterans are receiving effective rehabilitation in some areas, there is a lack of specialist rehabilitation expertise within DVA that militates against successful rehabilitation. DVA should acquire this expertise.

Voluntary Nature of Repatriation Rehabilitation

31.203 In Australia, following accidents and injuries in the workplace, injured workers are usually obliged to cooperate with return-to-work and rehabilitation programs that meet their needs and relate to suitable employment (HWCA 1997, p. 33).

31.204 Under the existing arrangements, participation by veterans in medical, social and vocational rehabilitation is voluntary and most often initiated by the veteran. The current arrangements encourage veterans who are in danger of falling out of work to seek pensions first and then voluntarily explore rehabilitation. The Committee believes that there is a need for DVA to remedy this urgently because of the serious consequences for veterans, their families, the community and Commonwealth expenditure of not doing so.

Extent of Incentives for Rehabilitation

31.205 Particular disincentives to vocational rehabilitation within the repatriation system include the lack of any impact of non-participation in suitable rehabilitation on levels of benefits, and the fear of loss of entitlements and financial security if rehabilitation is commenced or is successful.

31.206 Veterans with dual eligibility under the VEA and SRCA have often been attracted by the higher financial benefits of the VEA, with voluntary rehabilitation, compared to the lesser financial benefits and compulsory rehabilitation of the SRCA. Consequently, veterans have pursued the path to a TPI.

31.207 Veterans re-entering employment through the VVRS have a guarantee of not being worse off because of their participation. However, the effect of marginal tax rates and the interface of different income tests is such that veterans in lower-paid positions may see little, if any, financial benefit for their efforts. The Department should consider improving the financial incentives affecting veterans who obtain relatively low-paid employment through the

VVRS, by providing more generous reduction rates of the disability compensation and the service pensions (s.115D and s.115H of the VEA).

Lack of Evaluation of Many DVA Rehabilitation Programs

31.208 There is a lack of evidence of a comprehensive, outcomes-focused approach to the evaluation of the rehabilitation programs conducted by DVA. Although DVA evaluates some programs, the Committee has been hampered in its considerations by the lack of evaluative data about some programs.

31.209 For example, although most VVCS centres address alcohol management strategies, VVCS does not have consolidated outcome data available to demonstrate the effectiveness of its alcohol treatment regime. There are no protocols, guidelines or treatment evaluation systems currently available to DVA state offices that would allow them to assess alcohol management programs offered by treatment providers. However, the ACPMH is working closely with the Alcohol Management Project to establish the protocols and clinical practice guidelines for treatment of alcohol problems and dependence.

Lack of Knowledge of Available Rehabilitation within the Veteran Community and amongst DVA Staff

31.210 Not all veterans who might need and want rehabilitation are aware of the available services, how to access them or how they interact with disability compensation benefits. The Committee is concerned that some veterans who need assistance to enter or hold civilian employment might not be aware of the VVRS. The Committee has also been advised that some DVA staff who deal with veterans have a similar lack of knowledge, particularly about vocational rehabilitation.

31.211 The Committee is encouraged by ESOs' willingness to actively promote the VVRS. However, media promotion of the VVRS has been limited, and the significant number of veterans who are not members of ESOs may be largely unaware of the range of the Scheme.

31.212 DVA promotes rehabilitation amongst the ESOs, and should continue to do so vigorously, so that rehabilitation is seen as a benefit in the same way as disability compensation.

31.213 The Committee considers that the services provided by the VVCS are of significant rehabilitative value and should be part of a compulsory system of rehabilitation.

31.214 However, because of the exclusive title of the VVCS, veterans of conflicts other than the Vietnam War might not realise that many VVCS services are available to them and their families; others might be hesitant about

approaching the Service. These matters were also raised by some ESO representatives.

ASSOCIATED ISSUES

Prevention

31.215 During the Committee's research, it has been impressed by the importance that experts place on prevention. While prevention is not strictly a function of DVA compensation, it should be recognised that some consequent costs for service are the claims that are made on DVA. Thus DVA, with the Department of Defence, should pay particular attention to developing policies that assist and improve the prevention and early treatment of service-related disabilities.

31.216 As a matter of high priority, the Department of Defence needs to benchmark, against international best practice, its procedures for protecting the long-term mental health of servicemen and servicewomen as they prepare for, undertake and make the transition from warlike and non-warlike deployments. This should include an examination of the role of commanders, senior non-commissioned officers (NCOs) and members' families over these periods.

Vocational Assistance for Partners

31.217 The Committee has heard from partners and widows that there is a need to assist those who may have had a caring role and provide them with some form of vocational assistance to re-enter the workforce. The Committee notes the Government's announcement that war widows and partners of service pensioners will be able to use the full range of Job Network services. This should provide the level of assistance that these people need in order to find work. Consequently, the Committee does not believe that additional assistance will be necessary.

THE WAY AHEAD

31.218 The examination of rehabilitation services conducted by this Committee shows that many veterans who suffer from service-related disabilities that require and would be amenable to rehabilitation are not being well served by the current repatriation compensation arrangements. Many veterans are not receiving the rehabilitation they need to restore them to the optimal level of function commensurate with their service-related disabilities. Consequently,

they are not realising their full potential following the onset of their disabilities. This has heavy costs for the veterans affected, their families and the nation.

31.219 The Committee considers that the compensation arrangements for veterans should be comparable to those enjoyed by other Australian workers and should include an element of generosity in recognition of the veterans' service to the nation. Most Australian workers' compensation schemes seek to minimise the social and financial impact of work-related disabilities through financial compensation and rehabilitation to assist employees to return to work. Under these arrangements, employers are obliged to provide financial compensation (Chapter 30 of this Report outlines the Committee's proposed arrangements for financial compensation) and supply effective rehabilitation. Employees have an obligation to participate in return-to-work and rehabilitation programs that meet their needs and relate to suitable employment.

31.220 In contrast, the repatriation compensation system is heavily oriented towards providing financial compensation for life and medical treatment. It provides relatively little rehabilitation and few incentives to work, reducing veterans' capacity to accumulate assets, including superannuation that would help them enjoy a comfortable retirement.

31.221 The Committee's view is that DVA should pursue its efforts to provide and promote rehabilitation services with the same vigour that it applies to the other elements of disability compensation. This would lead to better outcomes for veterans, their families and the community by improving the veterans' quality of life, maximising their vocational outcomes and reducing their dependency on financial disability compensation.

31.222 Early and appropriate rehabilitation following injury or illness would minimise the consequences of service-related disabilities for veterans, their families and the nation by contributing to the restoration of veterans' functions. Veterans who are capable of working, given suitable rehabilitation, should do so at a level commensurate with their assessed work capacity.

31.223 The Committee considers that, in the ideal system, a veteran's needs for medical treatment, rehabilitation and financial compensation would be jointly assessed shortly after the veteran suffers a service-related disability. The assessment would be triggered by the veteran lodging a claim for compensation. This should occur, where possible, before discharge (for some veterans, as part of the transition management process) so that rehabilitation begun in the ADF can continue under DVA without interruption.

31.224 The determination of medical, social and vocational rehabilitation needs could be conducted by a rehabilitation professional. Where the disability is a mental health condition, the advice of an appropriate mental health professional

could be obtained in the course of the determination of the pension claim and would be critical in determining rehabilitation needs and capacity. This would not delay the determination of the disability compensation pension claim.

31.225 Comprehensive rehabilitation assessments and services will not be warranted in all cases (e.g. they would be inappropriate for minor illnesses). There is a need for DVA to develop, with professional guidance, and implement a list of disabilities that would normally be likely to require rehabilitation and would be amenable to it.

31.226 If the veteran is assessed as having a service-related condition that requires, and is amenable to, rehabilitation, an appropriate professional would develop a rehabilitation plan in consultation with the veteran. This would include an assessment of the veteran's rehabilitation needs and his capacity to undertake rehabilitation. It would list the rehabilitation services that would be provided and the period covered by the plan. Rehabilitation services would be provided only if DVA were satisfied that they were likely to result in an improvement in the veteran's medical, social or vocational status. The extent of rehabilitation services provided would take into account the likely benefits to the veteran and the cost involved. For veterans suffering complex disabilities requiring a range of treatment and rehabilitation services from different providers, the plan should also outline the coordination arrangements for services.

31.227 Ideally, treatment and rehabilitation would begin while veterans are still in the ADF and, where appropriate, continue without interruption when they are discharged. Progress during rehabilitation would be monitored by an appropriate professional in consultation with the veteran and DVA. The plan would be adjusted to deal with illness during rehabilitation or to help the veteran overcome other problems during the process.

31.228 A rehabilitation allowance equal to the economic loss component of compensation payable for disability would be payable during rehabilitation. Although the Committee has received submissions recommending the payment of a rehabilitation allowance for a fixed period, it considers that it is not practical to prescribe such a period because the needs of individual veterans will vary. Whether the allowance is paid for a longer or shorter period would be subject to a professional assessment of the veteran's capacity for, and likelihood of, obtaining employment after rehabilitation. Disability compensation for non-economic loss would be unaffected by rehabilitation.

31.229 Once DVA has implemented a suitable system of rehabilitation assessments and coordinated rehabilitation, veterans applying for disability compensation would be obliged to participate in that rehabilitation. Access to

permanent disability compensation should depend on this participation. Rehabilitation should remain voluntary until a suitable system is implemented.

31.230 There would be no penalties for withdrawal from, or failure to complete, the rehabilitation program, if this occurs because of factors outside the veteran's control. However, rehabilitation services and economic loss compensation could be discontinued if a veteran, without reasonable cause, fails to comply with or participate in an important element of the approved plan.

31.231 The Committee notes that there are many current disability pensioners who would also benefit from access to appropriate rehabilitation. Although rehabilitation for these veterans might not be vocationally focused, it could help them deal more effectively with the long-term effects of war-caused trauma, such as mental health problems and social isolation.

RECOMMENDATIONS

Key Recommendations

Principles

The Committee recommends that the major principles of repatriation rehabilitation be that:

- the aim of rehabilitation is to restore veterans to their optimal level of function commensurate with their service-related disabilities in order to provide them with better quality of life, maximised vocational outcomes and reduced dependency on financial disability compensation;
- veterans' participation in rehabilitation assessments and, where appropriate, rehabilitation programs is an integral, obligatory part of the disability compensation provided under the repatriation system; and
- DVA has a responsibility to provide suitable and comprehensive rehabilitation to veterans who require it as a result of service-related disabilities.

Rehabilitation Program

The Committee recommends that:

- DVA, as a matter of priority, provide the resources to establish a suitable program of rehabilitation within a policy framework for the assessment of rehabilitation needs and the coordinated delivery of medical, social and vocational rehabilitation to veterans with service-related disabilities; and
- DVA pursue its efforts to provide rehabilitation services to veterans and promote them to DVA staff with the same vigour that it applies to educating the veteran community and DVA staff about the other elements of disability compensation.

Policy Framework

The Committee recommends that the rehabilitation policy framework focus on:

- the principles of repatriation rehabilitation articulated above;
- factors within the Department of Defence that affect veterans' rehabilitation;
- early rehabilitation in conjunction with the disability payment assessment process;
- the role of experts in rehabilitation in the compensation assessment and rehabilitation processes;
- addressing the range of younger and older veterans' service-related mental and physical disabilities likely to require rehabilitation;
- coordination among providers of rehabilitation services, particularly for veterans with complex and chronic conditions;
- incentives for rehabilitation;
- evaluation strategies for rehabilitation programs;
- the obligations of veterans to participate in rehabilitation;
- the appeal rights of veterans in the assessment and rehabilitation processes;
- the frequency of reviews of individual veterans' rehabilitation programs; and
- the promotion of rehabilitation.

The development of a policy framework should follow an investigation of best practice in rehabilitation. Experts in rehabilitation medicine (e.g. Fellows of the Australasian Faculty of Rehabilitation Medicine) should be used in this process.

Recommendations for Implementation

General Arrangements for New and Existing Beneficiaries

The Committee recommends that:

- the recommendations in this chapter, if accepted by the Government, be implemented in concert with the Committee's recommendations for a new disability compensation structure; and
- the recommendations, with the exception of those in the following section, 'Arrangements for Rehabilitation – Proposed Disability Compensation Structure', apply to all veterans whether or not they transfer to the new disability compensation structure.

Arrangements for Rehabilitation — Proposed Disability Compensation Structure

The Committee recommends that:

- Should the Government implement the disability pensions structure recommended by the Committee in Chapter 30, the following complementary rehabilitation arrangements should be implemented at the same time for the veterans who will receive payments under that system. These arrangements, described below, should be consistent with the other recommendations in this chapter.
- Continued payment of the economic loss component of disability compensation payments should be subject to participation in rehabilitation. This requirement is based on the assumption that suitable rehabilitation assessments and services will be available.
- Safety net arrangements should provide full payment of benefits during periods of rehabilitation. The desirability of specifying a period for which safety net arrangements should be provided should be investigated by DVA.

- Veterans undertaking rehabilitation under the proposed disability payments structure should continue to receive payment for non-economic loss, together with a rehabilitation allowance to meet their economic needs. The rehabilitation allowance should be the same as, and in lieu of, the economic loss compensation.
- While the rehabilitation allowance is paid, rehabilitation needs should be professionally assessed. Further, a rehabilitation plan should be developed that would help the veteran to recover from, improve, minimise or cope with the accepted disabilities. This action should not be required before the assessment of the veteran's eligibility for disability compensation. However, the assessment and rehabilitation should occur quickly, to be of greatest benefit to the veteran.
- The rehabilitation program, agreed with the veteran, should be reviewed as necessary. DVA should use experts in rehabilitation medicine to establish appropriate guidelines.

Staged Implementation

The Committee recommends that to best manage the introduction of a rehabilitation regime, priority should be given to veterans who are identified by appropriate experts as having service-related disabilities causing the greatest need for rehabilitation and who are also the most likely to derive significant benefits from rehabilitation. It appears to the Committee that veterans already receiving disability compensation for accepted mental health conditions would be a priority group.

Supplementary Recommendations

The Committee recommends that:

- the Government consider the implementation suggestions provided by the Committee in the sections, 'The Adequacy of the Current Arrangements' and 'The Way Ahead' in this chapter;
- the VVCS be a part of the compulsory rehabilitation system; and
- the Department give the service a more inclusive name, such as the Veterans' Counselling Service.