Executive summary

Part 1 Context

Chapter 1 Terms of reference and conduct of the Review

1. The Review of Military Compensation Arrangements was established in response to concerns expressed by the veteran and ex-service community. An examination of the legislation was also timely, as the *Military Rehabilitation and Compensation Act 2004* (MRCA) had been in operation for six years. The Review aimed to examine all aspects of the compensation system and the operation of the MRCA, including access to the system and the level of medical and financial care provided to military personnel and their families.

2. In 2009, a call for submissions to the Review resulted in 68 submissions, 52 of which were in the scope of the Review, and in June 2009 a six-member Steering Committee was appointed to conduct the Review. Serving and former members of the Australian Defence Force (ADF), their families, ex-service and other relevant organisations, other government agencies and members of the public were consulted.

Chapter 2 Historical overview

3. The Committee examined the evolution of military compensation arrangements in Australia. Since the First World War, successive governments have made it a high priority to provide compensation and related support to veterans and their dependants. Military compensation arrangements have evolved since that time in response to changing situations and a number of reviews. During the 1980s and early 1990s, significant changes were made in the standard of proof, pension eligibility, and compensation arrangements for peacetime service.

4. Legislation has included the *Australian Soldiers' Repatriation Act 1920* (later renamed the *Repatriation Act 1920*), *Veterans' Entitlements Act 1986* (VEA), *Safety, Rehabilitation and Compensation Act 1988* (SRCA), *Military Compensation Act 1994*, and the current MRCA. The MRCA covers defence service on or after 1 July 2004; the SRCA and VEA cover service before 1 July 2004. The MRCA is the first compensation legislation designed to cover the whole spectrum of military service, and it came into operation following an extensive examination of military compensation arrangements.

5. The current Review of Military Compensation Arrangements is the latest in a long line of reviews, inquiries and analyses of the compensation arrangements applying to military personnel and their dependants. Such attention demonstrates the sensitive and complex nature of this legislation and the importance given to it by governments.

Chapter 3 The Military Rehabilitation and Compensation Scheme

6. The Committee reviewed the current processes of military rehabilitation and compensation, along with historic and projected expenditure and liability estimates. The

ADF is the primary provider of medical treatment and rehabilitation to serving members. Following injury or disease, rehabilitation assistance may be requested by a treating medical officer, unit commander, the Military Rehabilitation and Compensation Commission (MRCC) or the member. For serving members, rehabilitation assessment is conducted under the ADF Rehabilitation Program (ADFRP) and a rehabilitation program may be recommended as a result.

7. The MRCC investigates claims for liability and accepts or rejects the claim. Before any compensation is payable, the MRCC conducts a needs assessment with the member to identify medical treatment, rehabilitation and compensation priorities. Compensation can include incapacity payments for lost income, payment for necessary attendant care or household services, or compensation for permanent impairment.

8. As at September 2010, the Department of Veterans' Affairs (DVA) had a total of 120,755 disability pensioners and 99,982 war widow(er)s under the VEA, compared to 4,798 active clients under the MRCA and 11,260 active clients under the SRCA (active clients are clients who have received benefits or services in the past two years).

9. Annually, DVA receives around 5,000 to 7,000 claims for initial liability under the SRCA and the MRCA (compared to around 17,000 primary claims for compensation under the VEA). There was a sharp decline in claims under the SRCA in 2005–06, after the enactment of the MRCA. Since 2007–08, initial liability claims under the SRCA have increased slightly and seem to have plateaued at around 3,500 claims per year. The 'tail' of SRCA claims is expected to continue for some time due to the lag between service related injury, disease or death and the lodgement of a claim for compensation.

10. The number of MRCA clients receiving permanent impairment compensation appears to have plateaued at around 1,000 clients per year. Despite a small decrease in 2008–09 compared to the previous financial year, the number of permanent impairment compensation payments continues to trend upwards. The number of SRCA permanent impairment clients decreased markedly in 2009–10, although the number of SRCA permanent impairment payments is decreasing more slowly.

11. MRCA incapacity payments and clients have been increasing quickly. SRCA clients and payments both increased slightly in 2009–10, at odds with the steady decline evident since the commencement of the MRCA. Although relatively stable up to 2008–09, both the total number of clients under both Acts and total payments increased significantly in 2009–10. It is difficult to know if this increase will continue.

12. Payments for medical and other services under the MRCA are growing quickly. Payments for medical and other services under the SRCA have been steadily declining since 2004–05, but increased again in 2009–10. The declining number of payments under the SRCA from 2004–05 to 2008–09 have more than offset the increasing number of payments under the MRCA, resulting in a steady decline in the total number of payments for medical and other services under both Acts during that period. Again, it is difficult to know if the significant increase in the total number of payments under the MRCA in 2009–10 will continue.

13. In 2009–10, total expenditure under the MRCA was $72.2 million — still less than half the total expenditure of $146 million for defence-related claims under the SRCA. Total 2009–10 expenditure under both Acts was $218.2 million (compared to $11.2 billion under the VEA). Total MRCA expenditure is expected to increase steadily in line with the claim trends, while SRCA expenditure should gradually tail off.

Chapter 4 Unique nature of military service

14. The Committee confirms the unique nature of military service and the requirement for a military-specific compensation scheme that recognises that military service is different from civilian employment. The Committee concluded that compensation arrangements separate from the civilian compensation arrangements should be continued.

15. Military compensation arrangements exist within the broader context of civilian occupational health and safety laws and systems, including workers' compensation legislation. While the MRCA needs to always have regard to the special features of military service, at the same time, the Act should be informed by community standards. The Committee recommends that the MRCC should review Australian workers' and international military compensation arrangements at least every five years to ensure that the MRCA remains contemporary.

Part 2 Operation of the Military Rehabilitation and Compensation Act

Chapter 5 Initial liability and the Statements of Principles

16. The Committee considered the application of the Statements of Principles (SoPs) system, which is used to determine liability for injuries, diseases and deaths under the MRCA and the VEA. SoPs are legislative instruments that define the factors to establish a connection between a medical condition and service in the ADF. They are determined by the Repatriation Medical Authority (RMA) according to 'sound medical–scientific evidence', and their aim is to provide an equitable, efficient, consistent and non-adversarial system of dealing with claims for liability. Under the SRCA, in contrast, causes of medical conditions are determined on a case-by-case basis using evidence provided by a specialist medical practitioner.

17. Some submissions to the Review recommended that there should be discretion not to use the SoPs for claims rejected under the MRCA where claims do not meet the relevant factor(s) in the SoP. This discretion would apply to claims that were in 'substantial compliance' with a SoP, or where other medical evidence, such as a specialist report, supported the claim. The Committee's view is that conferring such discretionary power on decision makers would undermine the SoP system's strengths of consistency and adherence to expert evidential judgement.

18. Discrepancies between the compensation coverage of the MRCA and the SRCA led some stakeholders to argue that the liability provisions of the MRCA should be more flexible. These concerns were raised in relation to medical conditions caused by ongoing wear and tear, such as chondromalacia patellae ('runner's knee'), for which the acceptance rate has been much higher under the SRCA than under the MRCA. The reason for this discrepancy does appear to be the requirement for the use of SoPs under the MRCA (but not under the SRCA); however, recent changes to the SoPs for this condition are likely to resolve the issue.

19. Diseases that have a temporal connection with service but not a causal connection were raised in some submissions. Under the MRCA, both a causal connection and a temporal connection must be established if the claim is to succeed. As a result, conditions

such as heart attacks are less likely to be accepted under the MRCA, because it is difficult to establish a causal connection with service. Heart attack is more likely to be accepted under the SRCA because of differences in the interpretation of injury and disease, and the liability provisions of that Act. While acknowledging the different outcomes between the SRCA and the MRCA, the Committee holds the view that the SoP regime under the MRCA should continue to require a disease process to have a causal relationship with service, not just a temporal relationship, before liability can be accepted for any condition that results from that disease process.

20. Currently, liability for an injury or disease related to a sporting activity undertaken away from the workplace is accepted under the MRCA only if that sporting activity is part of a formal training program designed by an ADF Physical Training Instructor. In light of developing case law on the liability provisions under both the VEA and the MRCA, the Committee's view is that the MRCC should review this policy to determine whether coverage for off-duty sporting activities should be broadened.

21. The MRCA sets out the circumstances under which the MRCC cannot accept liability for an injury, disease or death. These circumstances, which are known as the 'exclusion provisions', include injury or disease resulting from a member being under the influence of alcohol, seriously breaching discipline or self-inflicting harm. Some submissions to the Review expressed concern that some of the exclusion provisions were open to the decision makers' discretion. The Committee acknowledges this concern, but feels that the discretion within the current provisions allows each case to be assessed on its merits. The Committee also notes that there is case law clarifying the operation of exclusions, that discretion can often work in favour of the claimant, and that inappropriate application of an exclusion can be set aside on review. Although it is not aware of any case involving use of an exclusion to inappropriately deny liability for a particular injury, disease or death, the Committee considers that information technology systems should be improved to assist the MRCC in monitoring and reviewing the application of the exclusion provisions under the MRCA.

Chapter 6 Rehabilitation

22. The aim of rehabilitation is to maximise the potential for a person with a service injury or disease to return to their previous physical and psychological state, with the same social and vocational status. Rehabilitation programs, formulated by approved rehabilitation providers, can include medical, dental, psychiatric, in-patient and out-patient care; physical exercise and physiotherapy; psychosocial training and counselling; aids and appliances; and modifications to workplaces, homes and cars.

23. Defence provides rehabilitation to all full-time serving members though the ADF Rehabilitation Program (ADFRP), with no requirement to establish liability under any compensation scheme. There were 4,189 new referrals to the ADFRP in 2009–10. Of these, 925 were assessed as not requiring a rehabilitation program and resumed duties. On completion of rehabilitation programs, 2,405 members returned to normal or alternate duties.

24. For part-time Reservists and former members of the ADF, rehabilitation is provided by the MRCC; however, liability for the injury or disease must first be established under the MRCA or the SRCA. DVA also administers the Veterans' Vocational Rehabilitation Scheme (VVRS), which is available to former members of the ADF who are eligible under the VEA. In 2009–10, DVA opened 773 non-return to work

(NRTW; psychosocial) rehabilitation cases and 525 return to work (RTW; vocational) rehabilitation cases. Fifty-one per cent of RTW programs under the SRCA were successful; 63 per cent under the MRCA were successful; and 45 per cent under the VVRS were successful.

25. DVA has an active research program into its rehabilitation services, and some recent reviews and commissioned research have recommended that case management be improved and arrangements simplified across the relevant government agencies. The Committee recommends that this research continues, and that outcomes from the research are promptly reflected in revised policies and improved practices in the ADF and DVA.

26. A number of submissions to the Review related to vocational rehabilitation, including opportunities for tertiary training. Vocational rehabilitation programs are decided on a case-by-case basis, and may include tertiary training if appropriate for an individual; however, this may not be widely known. The Committee's view is that clients and providers would benefit from an improved understanding about MRCC policies on vocational rehabilitation. This could be achieved through more details and clarity in DVA referrals to providers, and through information in pamphlets and the DVA website, including examples of successful vocational programs undertaken by former ADF members.

27. The Committee identified a gap between the level of psychosocial rehabilitation that DVA delivers and what clients perceive is delivered. Psychosocial rehabilitation includes referral to community support services, basic skills training, lifestyle programs, attendant care services, drug and alcohol management programs, and household aids and appliances for daily living. The Committee believes that DVA should improve the information in its pamphlets and website on the availability of psychosocial rehabilitation, in addition to vocational rehabilitation. Performance reports for the MRCC should show the volume and outcomes for subcategories of psychosocial rehabilitation.

28. Early intervention improves the effectiveness of vocational rehabilitation. Some submissions and comments in public consultation indicated that the need to await the determination of liability can delay intervention. The Committee considered the feasibility of allowing entitlements to rehabilitation assessments and limited access to programs as soon as a claim is lodged for initial liability. Another option considered was to allow reimbursement of rehabilitation-related costs between the date of onset and the date of acceptance of liability. For cases in which claims are lodged some years after service, case coordinators could be able to offer a rehabilitation assessment without the need to await determination of liability. The Committee believes that the ADF and DVA should develop options to improve access to early intervention, and provide advice to the Government on such options.

29. The effectiveness of requiring people with mental health conditions to undergo rehabilitation programs has been raised as an issue of concern. However, the Committee received expert advice from the Technical Advisory Committee on Rehabilitation that participation in a rehabilitation program, including vocational rehabilitation, can benefit people with mental illness. MRCC policy is that people with mental health conditions should receive medical and psychiatric clearance before entering a vocational rehabilitation program. The Committee supports this aspect of the rehabilitation framework provided in the MRCA. The rehabilitation authority can suspend a member's right to compensation if the member refuses or fails to undertake a rehabilitation program, although these provisions are used sparingly.

30. ADF performance reports are not currently provided to the MRCC. The Committee believes that the ADFRP should provide performance reports on ADF rehabilitation assessments and program outcomes to assist the MRCC to fulfil its functions.

31. Lastly, the Committee recommends a long-term study of the effectiveness of rehabilitation arrangements within the ADF and DVA, reviewing the level of rehabilitation services and the link with incapacity payments. The study should cover at least 10 years, and should include mental health and physical injuries and the response by the ADF from the time of the first injury through transition to discharge and later experience in civilian life.

Chapter 7 Transition management

32. The Review considered the management of advice and assistance services for ADF members in the transition period from discharge from the ADF to re-entering civilian life. In 2009–10, there were approximately 530 medical discharges from the ADF and fewer than 4,000 discharges in total. Under the current arrangements, the DVA Transition Management Service (TMS) provides a voluntary service on referral from the ADF that supports members facing medical discharge. Legislation recognises that the ADF has a duty of care before discharge, and that post-discharge entitlements are governed by complex legislation administered by the DVA and other government agencies.

33. The Australian Defence Organisation (Defence) is developing a new model to support injured or ill ADF members throughout their career, including transition, under the Support for Wounded, Injured or Ill Project (SWIIP). The whole framework of transition support services is being re-examined as part of the SWIIP, and Defence plans to take full responsibility for transition management by 30 June 2011, depending on certain conditions being met.

34. Some submissions to the Review were critical of the current transition management services, citing a lack of coordination in management of the TMS among the agencies involved. In particular, guidelines for the appointment of case managers, their role and training are said to be unclear.

35. Recent reports and reviews on DVA and Defence operations have included specific comments on transition management. Two reviews recommended a ‘one-stop shop’ approach for transition support services, while others recommended joint responsibility between Defence and DVA. Defence and DVA continue to work collaboratively and aim to provide a seamless transition for members. Current joint initiatives include streamlining the separation health examination, continuing the DVA client liaison unit, referring clients to DVA case coordinators, conducting studies as part of the Lifecycle initiatives, continuing the Stepping Out program, and trialling a Keeping-In-Touch program. DVA and Defence continue to work with other agencies through the Interdepartmental Working Group to seek further opportunities to improve transition services.

36. To improve consistency and oversight of transition services under the tri-service management structure, the Committee recommends that responsibilities assigned to the Service Chiefs (particularly as rehabilitation authorities and appointers of transition case managers) be transferred to the Chief of the Defence Force.

37. Under the MRCA, the Service Chief is the rehabilitation authority for all full-time members, unless the member has been identified as being 'likely to be discharged from the ADF for medical reasons', when the MRCC is the rehabilitation authority. The timing of transfer of responsibility from Defence to the MRCC is currently stringently defined by Defence and does not currently consider individual needs or circumstances. The Committee recommends amendment of section 39 of the MRCA to allow more flexibility in the timing of the appointment of the MRCC as the rehabilitation authority, and of section 64 to allow more flexibility in the timing of the appointment of a transition advisory case manager.

38. No provision is currently made under section 64 of the MRCA for part-time Reservists to access transition advisory services. The Committee believes that this group has the right to be offered these services, and recommends that section 64 be amended to include part-time Reservists in the required group to be offered a transition advisory case manager. The Committee also recommends that the rehabilitation authority for part-time Reservists be amended in section 39 to designate the Chief of the Defence Force as rehabilitation authority, because the ADF has a duty of care as a responsible employer and can provide rehabilitation assessment and programs under the *Defence Act 1903* in advance of acceptance of MRCA liability, aiding early intervention.

39. Pension officer and advocacy services are provided by ex-service organisation (ESO) representatives trained under the DVA Training and Information Program (TIP), with funding from the DVA Building Excellence in Support and Training (BEST) program. ADF members have expressed concern over the variable levels of knowledge, skill and competence shown by these advocates in providing advice. A separate Review of DVA-funded ESO Advocacy and Welfare Services (TIP/BEST Review) has recently been completed and the Government has accepted all 45 recommendations. This follows previous reports that have recommended that ESO representatives and advocates who assist veterans should be paid, better trained, and accredited (Doogan Review), and that a second level of trained and accredited pension officers and advocates may be paid through a DVA-funded program (Dunt Review). The Committee recommends that ESO officers who will be in contact with ADF members should have a demonstrated understanding of the MRCA and rehabilitation programs. The accreditation programs being established for DVA staff could be extended to Defence and ESO officers who are in contact with compensation claimants, including Australian Army regional casualty assistance support officers.

40. A member in the ADFRP faced with medical discharge may have a number of different people assigned to them in various coordination or case-management roles, which may be confusing. The Committee believes the roles of these officers need to be explained more clearly, including on the Defence and DVA websites, so that the terminology is better understood by discharging members and staff.

41. SWIIP will monitor transition service performance and develop revised comprehensive transition advisory arrangements with agreed milestones, reporting mechanisms and a recommended model. So that the current oversight provided by the MRCC is not lost after this date, the Committee recommends that revised reporting arrangements after this date should include comprehensive monthly performance reports to the MRCC by Defence on transition services.

42. The Review received criticism of the dissemination and clarity of information on transition available on the Defence and DVA websites. The Committee recommends that

the Defence and DVA websites and transition information should be updated and refined to better meet the needs of ADF members planning their transition to civilian life.

Chapter 8 Permanent impairment compensation

43. Impairment is defined in section 5 of the MRCA as '… the loss, the loss of the use, or the damage or malfunction, of any part of the person's body, of any bodily system or function, or of any part of such a system or function'. Where liability for an injury or disease that results in permanent impairment has been accepted, the MRCA enables compensation to be paid as a periodic payment (generally, paid for life). Permanent impairment compensation payments are non-economic loss payments; that is, they are paid to compensate for pain, suffering, functional loss or dysfunction and the effects of the injury or disease on lifestyle. Functional loss and lifestyle effects are assessed using the *Guide to determining impairment and compensation* (known as GARP M).

44. The Committee discussed the arguments for and against the retention of different compensation levels for different types of service in the MRCA. Under the MRCA, different permanent impairment compensation amounts result for the same impairment rating depending on whether the service at the time is operational or peacetime. Generally, a higher permanent impairment compensation payment is made for operational service.

45. Many ESOs argue that compensation under the MRCA should be the same, regardless of the type of service rendered. Submissions on the issue centred on the argument that impairment has the same impact, regardless of what the service was at the time of injury. The principle of 'like compensation for like injury' is recognised in the development of all modern workers' compensation schemes. In addition, it can be argued that operational service is already financially recognised through the ADF deployment allowances. Conversely, the unique and high-risk nature of operational service compared to peacetime service can be seen to require a higher level of compensation. The Committee recommends that the existing permanent impairment compensation differential for warlike and non-warlike service (or operational service) as opposed to peacetime service be maintained.

46. The current compensation differential is payable for low levels of impairment but not severe impairment or death, and the Committee examined whether this should be revised so that the differential also applies to severe impairment and death.

47. The Committee had divided views on the application of the differential across differing levels of impairment. Committee members representing the Department of Finance and Deregulation, the Treasury, and the Department of Education, Employment and Workplace Relations support maintaining the status quo; Committee members representing DVA and Defence, as well as Mr Sutherland, supported the recommendation that higher rates of compensation for operational service should continue and be extended to the severely impaired and for death. It is estimated that 15–20 per cent of annual permanent impairment compensation expenditure relates to injuries from operational service, and that the proposed extension would have a cost of $1.15 million over four years.

48. The Committee discussed and confirmed the rationale for age-based lump sums under the MRCA. An eligible claimant may choose to convert all or part of a periodic permanent impairment payment into an age-based lump sum. Several submissions to the

Review raised the disadvantage caused to older recipients in not being eligible for the maximum lump sum. The Committee supports the retention of the current system because the lump sum is based on the periodic payments and is calculated on the total payments remaining to the member. If the member is unhappy with the lump sum calculation, they can choose to remain on the periodic payment.

49. The assessment of permanent impairment under the MRCA is based on whole person impairment methodology. That is, where multiple service-related conditions exist, the impairment resulting from all service-related conditions is not simply added but must be combined by applying a combined values formula, which ensures compensation cannot exceed 100 per cent of the whole person. The Committee recommends that the whole person impairment methodology continue under the MRCA.

50. The Committee examined the date of effect provisions for permanent impairment compensation. Weekly permanent impairment compensation under the MRCA becomes payable from either the date the claim for liability was lodged or the date that the claimant's condition(s) are found to have become permanent and stable, whichever is the later. The Committee has found inequities for claimants with multiple conditions where the conditions become stable at different points in time. The Committee recommends that permanent impairment compensation become payable on the basis of each individual accepted condition, rather than on the basis of all accepted conditions. The Committee confirms the stability requirement in the MRCA, but recommends that the increased use of interim compensation payments would alleviate concerns about delays created by the requirement.

51. Several submissions raised concerns relating to the limitations imposed by the MRCA on the pursuit and level of common law damages. If permanent impairment compensation is payable to a claimant under the MRCA, but the compensation has not yet been paid, the member may irrevocably choose to institute common law action against the Commonwealth or a potentially liable member for damages for non-economic loss. Under the MRCA, if a member institutes an action at common law, the court must not award damages of more than $110,000 for non-economic loss. In addition, the choice to pursue common law damages is only offered where permanent impairment compensation is payable. The Committee does not support any changes to these provisions and confirms that one of the objectives of the MRCA should be for statutory compensation to take precedent over the common law as the system for seeking non-economic loss compensation in respect of most, if not all, conditions related to defence service.

Chapter 9 Death benefit provisions

52. The MRCA recognises three classes of dependants who may be eligible for compensation in the event of the death of a member: wholly dependent partners, eligible young persons, and 'other' dependants. The Committee believes that the death benefit package provided by the MRCA is probably the most beneficial and comprehensive of any Australian compensation jurisdiction. Where a member's death is service related, his or her wholly dependent partner is currently eligible to receive a lifetime periodic payment, an additional death benefit (ADB), a Repatriation Health Card — For All Conditions (Gold Card), and a range of other benefits depending on his or her circumstances.

53. The Committee recommends simplifying the payment arrangements by combining the current age-based lump sum and the ADB to create a new combined lump

sum. This will make the compensation package simpler and easier to understand. It is proposed that the new lump sum payment be age based as with the existing lump sum and indexed in accordance with the Wage Price Index. The Committee also proposes that more flexibility be allowed in the choice between a pension and a lump sum to allow dependent partners to structure compensation to meet their financial priorities.

54. The Review examined whether the differential in permanent impairment payments between operational service and peacetime service should be extended to death benefits. Again, the Committee has divided views on this question. If the concept of a differential is accepted, the suggested differential of 10 per cent for higher impairment levels should also be considered for death benefits. Indicative estimates are that creating a 10 per cent differential for death benefits due to operational service would cost $2.85 million over four years. Committee members representing DVA and Defence, as well as Mr Sutherland, favour extension of a 10 per cent differential for operational service to the wholly dependent partner death benefit. Committee members representing the Department of Finance and Deregulation, the Treasury, and the Department of Education, Employment and Workplace Relations, favour maintaining the status quo.

55. Where the death of the member is not service related, the wholly dependent partner is entitled to compensation if the member was eligible for Special Rate Disability Pension (SRDP) or had 80 or more impairment points. The Committee proposed that the current lesser amount for this class of wholly dependent partner be maintained.

56. A number of submissions to the Review pointed out that the periodic payment to eligible young persons under the MRCA is below that of the SRCA. However, the SRCA does not provide the additional benefits of a separate lump sum payment, Gold Card or non-means tested education assistance to eligible young persons, as does the MRCA. The Committee recommends that the MRCA's current pension rate for an eligible young person should not be changed.

57. Several submissions argued that the requirement for a wholly dependent partner to be dependent on the deceased member for economic support is not relevant in contemporary society and is less beneficial than the previous arrangements under the VEA. Most, if not all, compensation jurisdictions in Australia require dependants to be deemed to be economically dependent before they can receive compensation for the death of a partner, and the MRCA supports this principle.

58. Some submissions also argued that former partners (including both divorced spouses and former de facto partners) should be compensated if they were economically dependent on the member at the time of death or while they have responsibility for the care of the deceased member's children. Currently, as the definition of a 'partner' in the MRCA does not include a former partner, a former partner is not entitled to compensation on the death of a member. This is so even if the former partner was wholly or partly economically dependent on the member at the time of death. The Committee recognises that situations could exist in which a former partner continues to be economically dependent on a member and believes that the MRCC should consider further the question of compensation for a former partner, and if necessary provide advice to the Australian Government.

59. The MRCA provides compensation for financial advice for the member or his or her family in a number of circumstances. On 1 July 2004, the amount payable for financial advice was set at $1,200. This amount has been indexed annually in line with the Consumer Price Index so that the current maximum is $1,503.83. The Committee

recommends that the existing compensation for the cost of financial advice should be increased to at least $2,400, taking into account pressures in the industry resulting in changes to fee structures. The cost of this increase would likely be under $50,000 over four years.

Chapter 10 Incapacity payments

60. Incapacity payments are economic loss compensation payments for the inability (or reduced ability) to work because of a service injury or illness. Incapacity payments are based on the difference between a person's normal earnings (NE) and their actual earnings (AE). The full difference between NE and AE is paid for 45 weeks after discharge; after this time, payments are made as a percentage (at least 75 per cent) of the person's NE and their AE (known as 'stepping down'). Payments may continue for as long as a person's AE are below their NE, or until they reach the age of 65 years.

61. The Review received a number of submissions relating to incapacity payments, all of which contended that the provisions be made more beneficial. However, the MRCA has a very high income replacement ratio in comparison with other compensation schemes, which may adversely affect some members' willingness to undergo vocational rehabilitation or desire to return to the civilian workforce.

62. Incapacity payments are based on pre-injury earnings adjusted over time. It is often argued that payments should be further adjusted over time to take account of career progression that is likely to have occurred if not for the injury (known as 'reasonable expectations'). Adjusting payments for 'reasonable expectations' is likely to involve speculation, be difficult to quantify for legislation, create inequity and inconsistency, and unreasonably increase Australian Government responsibilities and costs.

63. Significant administrative difficulties are involved in determining NE over time, due to the complexity of ADF pay scales and the more than 40 allowances that apply to incapacity payments. Determining incapacity payments is labour intensive and system support is inadequate. A more efficient method for calculating NE might be required; for example, consolidating allowances into one generic allowance or loading, or placing time limits on the application of allowances. Another option may be to convert long-term incapacity payment recipients to a statutory rate (either a flat rate, or taking account of rank) for the remainder of the time they are eligible.

64. The beneficial nature of the MRCA's incapacity payments may act as a disincentive for some former members to undertake rehabilitation with a view to obtaining alternative employment. While benefits should make up for what the former member loses through their incapacity to the extent practicable, there is also a need to recognise the link between return-to-work incentives and the level of income replacement.

65. As many of the issues raised in relation to incapacity payments under the MRCA also relate to the administration of incapacity payments in other state, territory and Commonwealth jurisdictions, as well as whole-of-government superannuation issues, the Committee recommends that a cross-agency working group investigate and advise the MRCC on issues relating to incapacity payments.

Chapter 11 Special Rate Disability Pension

66. A former member unable to work because of accepted disabilities may choose the SRDP in lieu of incapacity payments. Under the SRDP, they are paid an ongoing, tax-free amount for life. The SRDP rate is equivalent to the Special Rate of pension under the *Veterans' Entitlements Act 1986* (VEA; currently $1,092.90 per fortnight) and there are offsets for Commonwealth superannuation and permanent impairment compensation payments. The SRDP was built into the MRCA as a safety net payment.

67. There are significant differences between eligibility for the SRDP under the MRCA and eligibility for the Special Rate of pension. One key difference is that, under the MRCA, the former member must undergo a rehabilitation assessment before he or she can be eligible for SRDP. Before choosing the SRDP, a member must obtain financial advice from a suitably qualified financial adviser. Eligibility for SRDP attracts some additional benefits, irrespective of whether a former member chooses SRDP or incapacity payments.

68. There is no age limitation in the MRCA for SRDP eligibility. By contrast, additional conditions apply to the Special Rate of pension for applicants aged 65 years or over. It is unlikely that it was intended that the MRCA be less restrictive than the VEA in regard to remunerative work after age 65 years. The lack of employment history restrictions in the MRCA on SRDP applications after age 65 years should be addressed.

69. People who are eligible for the Special Rate of pension under the VEA or SRDP under the MRCA generally have access to equivalent benefits. One exception is that, under the VEA, a person who is eligible for the Special Rate of pension is automatically eligible for the invalidity service pension; however, a person who is SRDP eligible is not automatically eligible. The Committee recommends that SRDP-eligible former members should have automatic eligibility for invalidity service pension in the same manner as recipients of the Special Rate of pension under the VEA.

70. The commutation of a small amount of weekly compensation for incapacity into lump sum compensation under section 138 of the MRCA will result in a person becoming ineligible to make a choice to receive the SRDP, in circumstances where they would have otherwise been eligible. This is because section 199 of the MRCA requires a person to be receiving incapacity compensation at the time they are determined to be eligible for SRDP to be given the choice to receive SRDP. The Committee is not aware of any cases that have been affected by this situation.

71. Since the introduction of the MRCA in 2004, superannuation and taxation reforms have improved incentives for people to join, stay in and strive for greater rewards in the workforce, and to improve their standard of living in retirement. While tax offsets under superannuation schemes have changed since 2004, the superannuation offset against the SRDP has remained unchanged, with the result that the SRDP is now more advantageous than in July 2004. The setting of a single rate of offset as an adjustment to the SRDP does not result in an equitable outcome. Given the policy intention to reduce taxation for low and middle income earners and provide employment incentives, no change is recommended in the offset until the age of 60 years. The Committee recommends that, after the age of 60 years, the offset should be increased to 70 cents in the dollar to take account of reduced taxation on superannuation benefits after that age.

72. The Committee recommends maintenance of the current approach to not pay SRDP during a person's imprisonment, consistent with the non-payment of incapacity payments in this situation.

73. There are 22 former members who have become eligible for the SRDP since 1 July 2004. As at December 2010, only two had elected, or had indicated they will elect, to take the SRDP. This is thought to be because increases in remuneration levels in the ADF since 2004 have flowed on to incapacity payments, making the SRDP less attractive. In addition, changes in recent years to income tax thresholds and marginal rates have had a beneficial impact on recipients of incapacity payments.

74. With this low rate of uptake, and since the SRDP is designed as a safety net and is unique in modern Australian compensation legislation, the Review has considered its ongoing relevance. The Committee believes that the SRDP may still be of relevance to injured part-time Reservists and those approaching retirement. All aspects of the SRDP including its relevance, eligibility criteria and the effectiveness of rehabilitation should be evaluated as more data become available after a further five years.

Chapter 12 Military superannuation and related compensation issues

75. Most current serving ADF members contribute to the Military Superannuation and Benefits Scheme (MSBS), with some longer serving members remaining with the Defence Force Retirement and Death Benefits Scheme (DFRDB). Incapacity compensation payments and the SRDP under the MRCA are offset by the value of Commonwealth contributions towards superannuation benefits, under the principle that the Australian Government should not make duplicate income maintenance payments to the same person through both superannuation and compensation.

76. Submissions to the Review from ESOs argue that superannuation should not be offset against compensation, as members have paid for their superannuation benefits through their own contributions. The Committee does not support this view, as only the Commonwealth contribution to superannuation payments is offset, not the member's own contributions. If a member received benefits from the MSBS and the MRCA without offset, they could potentially have an income over 175.5 per cent of pre-discharge salary for the first 12 months, and 150.5 per cent until retirement age. The Committee recommends that the offset of incapacity payments and the SRDP by the Commonwealth-funded superannuation received by the member should continue. As at 30 June 2010, half of MRCA incapacity payees out of a total of 748 recipients were in receipt of superannuation payments that offset their compensation.

77. Under the MRCA, only Commonwealth superannuation contributions are offset, not those from private employers. The principle of the Commonwealth not duplicating compensation and superannuation is not applicable for corporations that are not Commonwealth funded. However, this is seen by some as discriminatory against former Commonwealth employees, as the NE and AE calculations for incapacity payments do not take into account superannuation payments from private employers, and the scheme is therefore more beneficial for these members than those receiving only Commonwealth superannuation.

78. The definition of Commonwealth-funded superannuation schemes includes licensed corporations, meaning that contributions to a part-time Reservist's superannuation scheme by a licensed corporation would be offset under the MRCA. The

Committee recommends that the MRCA definition of Commonwealth superannuation scheme should be amended to exclude licensed corporations, except Commonwealth licensed authorities.

79. Under the MRCA, superannuation offsets for incapacity payments apply to former ADF members only. In some circumstances, a current member may receive both Commonwealth superannuation and an incapacity payment, thereby duplicating Commonwealth payments. The Committee recommends the MRCA be amended to apply superannuation offsetting against incapacity payments for current members receiving Commonwealth superannuation, as well as former members.

80. The Review also examined several submissions relating to why the Commonwealth does not pay contributions to superannuation, or compensate for lost superannuation contributions, for people on incapacity payments who are unable to work because of their compensable conditions. The Committee recommends that this issue be considered as part of a cross-agency working group on incapacity payments recommended in Chapter 10.

81. The Review did not examine superannuation legislation or administration in depth, but did note the complexities of administration of invalidity and death benefits. One submission criticised the lack of cooperation between agencies in the administration of death benefits. The Committee recommends that the scope for streamlining the administration of superannuation and compensation invalidity and death benefits be further considered across government.

Chapter 13 Ancillary benefits

82. The Review examined the provision of compensation for household services and attendant care under the MRCA. The MRCA provides that the Commonwealth will meet the cost of services that are reasonably required by the person as a result of an accepted injury or disease, up to a maximum weekly amount.

83. Two submissions to the Review raised the issue of compensation for household and attendant care services provided by a spouse, particularly where a spouse experiences loss of income due to these services. The MRCA does currently allow for the payment for household and attendant care services provided by a spouse or member of the person's household in certain circumstances. However, this does not seem to be well documented in current policies or procedures. The Committee recommends that the MRCC develop guidelines on when household services and attendant care compensation can be paid to the spouse or ANother household member under the MRCA.

84. On enactment of the MRCA, Treatment Principles were made that set out the circumstances in which, and conditions subject to which, treatment may be provided to holders of Repatriation Health Cards. The MRCA Treatment Principles were modelled closely on the VEA Treatment Principles.

85. The Treatment Principles provide for a MRCA Home Care program, similar to the VEA Veterans' Home Care program, which provides personal care, domestic assistance, home and garden maintenance, and respite care. However, there is an overlap in the types of services that can be provided under the program and the household services and attendant care that can be compensated under the MRCA.

86. The Committee recommends that dual entitlements to household and attendant care services be removed.

87. Public consultations for the Review highlighted concerns at the monetary cap on household and attendant care services in regard to tetraplegic clients. Clients or their families arrange their own services and costs vary considerably between regions in Australia. The alternative proposed in discussions was for a statutory limit of hours, rather than a monetary amount. The Committee considers that these services are highly exceptional in the overall client base and individual case management would be more appropriate. DVA has an Exceptional Case Unit that oversees the funding and services provided to very high-dependency cases. The Committee recommends no change to the monetary cap.

Chapter 14 Treatment provisions

88. The MRCA allows the MRCC to provide treatment to a serving member, where liability for compensation has been accepted and the member's Service Chief requests the MRCC to provide treatment. In all other cases, full-time serving members are provided with treatment for injuries or diseases under the *Defence Act 1903*.

89. The Committee examined the treatment pathways available. For former members of the ADF, part-time Reservists and cadets, an MRCC delegate carries out a needs assessment upon acceptance of liability or when a person claims compensation, and determines whether the claimant should follow Treatment Pathway 1 or Treatment Pathway 2. Treatment Pathway 1 provides reimbursement for the cost of treatment that was reasonable for the person to obtain in the circumstances. It is intended as the pathway for short-term conditions. Treatment Pathway 2 is intended for chronic and permanent conditions, and Repatriation Health Cards are issued to provide access to treatment. Claimants who have over 60 impairment points or are eligible for SRDP have an automatic entitlement to a Gold Card, and the MRCA also provides a Gold Card to wholly dependent partners and eligible young persons.

90. As at December 2010, 36 per cent (1,685) of former members receiving treatment under the MRCA were on Treatment Pathway 1, and 64 per cent (2,786 former members) were on Treatment Pathway 2.

91. It is MRCC policy to encourage its delegates to use Treatment Pathway 2 wherever practical. The Committee believes that proper use of the needs assessment should provide for short-term or resolved cases to remain on a reimbursement system and for those with long-term needs to be issued with a Repatriation Health Card. The Committee recommends that the MRCC should conduct ongoing quality assurance reviews or team leaders' analysis of decisions to retain people on Treatment Pathway 1. The reasons behind these decisions should be ascertained and codified to allow ongoing analysis.

92. It has been suggested that the system could be simplified by abolishing the two pathways, and moving all eligible people to the card system on discharge or on acceptance of liability, as in the VEA system. However, the VEA system itself allows reimbursements of certain medical expenses; that is, for the period from the onset of the condition or injury (or three months before the claim, whichever is the later) until the Repatriation Health Card is issued. The Committee believes there are insufficient data

available to determine this question at this stage and it should be reviewed again in three years time, when further data will be available for analysis.

93. A person with both VEA and MRCA entitlements may have cards from both systems. The Committee recommends that the MRCC review the need to issue multiple treatment cards and, if necessary, seek legislative change for greater simplicity. For example, those with pre-existing VEA conditions or cards could be issued only with a MRCA card.

Chapter 15 Administration

94. The administration of SRCA claims for ADF personnel was transferred from the Department of Defence to the DVA in December 1999. With the commencement of the MRCA on 1 July 2004, the MRCC was established within the Veterans' Affairs portfolio. Its role is to oversee all military compensation matters under the SRCA and the MRCA, while Defence retained responsibility for healthcare and rehabilitation for serving members. Since 2004, DVA has assessed liability claims for more than 26,000 clients, made permanent impairment payments to more than 10,000 clients, and made incapacity payments to more than 21,000 clients under the SRCA and MRCA.

95. The DVA organisational structure is a national management model. From 1 July 2010, responsibility for rehabilitation and compensation claims processing staff was transferred to the Deputy Commissioners in each state and territory, and performance management was localised. Liability staff work in multidisciplinary teams with knowledge across all three Acts (the MRCA, the SRCA and the VEA), in an effort to address complexities arising where claimants have eligibility under multiple Acts. A risk-based model has been developed to prioritise claims and direct resources, and national management allows workloads to be moved between offices as the need arises. While submissions from ESOs expressed the preference for processing of claims, reconsiderations and reviews to take place in the claimant's home state, this is not favoured by the Committee, as it limits flexibility in applying staff resources to fluctuating workloads in different locations.

96. Submissions to the Review voiced concern about the time taken to process claims (TTTP), staff administration and quality of decisions. These issues have been the subject of internal audit reviews, and the Review examined the audit findings and management commitments to resolve the issues raised.

97. Performance statistics on compensation and rehabilitation workloads are collated monthly and reported quarterly to the DVA Executive Management Group and the MRCC.

98. DVA conducts a quality assurance program of all administrative functions, including MRCA operations. The key performance indicator (KPI) for each subprogram is expressed as a critical error rate, which is the proportion of cases that have at least one oversight or error of detail, and does not translate to the same percentage of cases with an incorrect outcome. DVA has now instituted a check of 5 per cent of MRCA casework each month over five key areas: liability, rehabilitation, incapacity payments, permanent impairment compensation and accounts payable. The results are compiled and feedback is provided to the MRCC and to the claims processing teams. These show improvements in accuracy in 2009–10 compared to 2008–09 in liability, permanent impairment compensation and rehabilitation work. Other error checks introduced include a 100 per

cent peer review technical check for permanent impairment compensation and team leader checks of at least 5 per cent of cases before a decision is finalised.

99. The TTTP target for initial liability and permanent impairment is 120 days to complete both stages. The average TTTP for initial liability reached 188 days in 2006–07 under the MRCA; however, the times taken are now trending down. Since 2006-07, initial liability claims in process for greater than 12 months were most often 2 to 3 per cent of cases, and were highest in 2006–07 at 5 per cent.

100. Comparisons are often made with the TTTP targets for Comcare claims processing, which are 10–20 days for injury (achieved 14 days in 2009–10) and 37–47 days for disease (achieved 49 days in 2009–10). However, there are a number of important differences that make this comparison invalid. Comcare only starts to record processing times once all evidence required to make a decision has been provided, whereas DVA begins recording its processing times once the claim is received. The average time from injury to a Comcare claim is approximately 110 days, compared with the SRCA and MRCA average of 16 years. In addition, the availability of timely evidence endorsed by the employer assists prompt processing for Comcare, whereas DVA usually needs to obtain archived records from Defence and conduct its own investigation. The MRCA TTTP for permanent impairment claims are adversely affected by the requirement for the condition to be stable before permanent impairment is assessed and the six-month period claimants are given to choose whether to accept compensation as a periodic payments or lump sum (or combination).

101. Needs assessments are completed once liability is determined. The timing of completion of a needs assessment is important for resolution of a member's priority needs. Therefore, the Committee recommends that a KPI should be developed for the time taken from the acceptance of liability to the dispatch of the needs assessment to the client.

102. DVA has sought to address client dissatisfaction with TTTP and other aspects of client liaison, particularly from the younger group of clients, in a number of ways. DVA has improved the coordination of case management and has appointed case coordinators for complex claims as per the recommendations of the Dunt Review. Staff training programs have been conducted to improve the client service culture. Processing times have reduced significantly since 2006–07 as a result of these initiatives.

103. The Committee believes that concerns outlined in submissions regarding the staffing and processing of claims are largely addressed by recommendations from an external review of business processes, an external audit of information technology systems and an internal audit of quality decision making, and supports DVA's efforts to implement the agreed actions as soon as possible.

Chapter 16 Claims

104. The Review received several submissions on issues relating to making claims. Several submissions criticised the volume of paperwork required, and one submission claimed that the onus is on the claimant to provide information that is often held by the ADF. Another proposed that the MRCC obtain all relevant information from Defence and provide this to the claimant with an opportunity to respond or to provide additional supporting information. The Committee believes that early determination of the claim is

best served by claimants providing all reasonably available evidence with their primary claim.

105. Some submissions criticised the 28 days allowed in the MRCA for a claimant to respond to a request for further information held or obtainable by them. The MRCC ensures that this is not applied in circumstances where it would be unreasonable, and no evidence was provided to the Review to show that the MRCC is being unreasonable in this matter.

106. The MRCA claim form combines many details that make it more complicated than may be necessary for all claims. DVA has trialled a Single Claim Form to simplify the claim process and reduce the form length. However, the Committee believes that a modular approach may be suitable for the claims process, where the initial claim form would seek only the information necessary to decide on initial liability and conduct a needs assessment. Other claims, such as permanent impairment compensation, could be submitted either separately or at the same time as the initial claim.

107. In addition, the Committee believes that a modified claim form should be considered for serving ADF members, or those claiming at the time of discharge, who have only served after 1 July 2004. These members will be entirely covered under the MRCA, and the ADF should provide the necessary information.

108. The average time from injury to a Comcare claim is approximately 110 days, compared to the combined MRCA and SRCA average of 16 years and median of 12 years. The average MRCA lag time between injury and claim is increasing. The Committee believes that the MRCC should establish a KPI to measure the time lag between injury and report or claim. Defence should report this annually to monitor the effectiveness of efforts to reduce the time lag, and the information should be included in the MRCC annual report.

109. There are no formal requirements in the VEA or the MRCA to report an incident or injury or lodge a claim within a certain time; however, the SRCA requires notification of an injury as soon as practicable. In the United Kingdom, claims must be made within five years of injury, with some exceptions. The Committee does not believe that this would be practical in Australia, and believes that issues with lag time should be addressed by Defence practice and MRCC monitoring.

110. Several submissions were critical of the time taken to access Defence records to support a claim. DVA and Defence have been aware of the need to address these delays for some time. Since 2006, the Single Access Mechanism initiative has channelled all requests for DVA access to Defence records through teams at DVA and Defence, in an effort to reduce timeframes and duplicate requests. Most requests for service and medical information are processed in fewer than 20 days, but requests for research and confirmation of leave take more than 30 days to process. The Committee believes that a KPI could be set and monitored by the MRCC, and reported in the MRCC annual report, but that the claimant should provide this information with the initial claim whenever possible.

Chapter 17 Reconsideration and review

111. With the introduction of the MRCA in 2004, the decision was made to provide parallel appeal pathways: review by the Veterans' Review Board (VRB); or

reconsideration by the MRCC delegate. This provides a choice between consideration by a non-judicial body (the VRB) and a path that provides reconsideration by another delegate, which may lead more quickly to the Administrative Appeals Tribunal (AAT). Both paths lead to review by the Veterans' Appeals Division of the AAT.

112. The Committee examined the issues around the parallel appeal pathways raised by several submissions to the Review. The VRB path can be seen as a lengthy and daunting process and, therefore, some claimants seek MRCC reconsideration, only then realising the irrevocability of the decision and the fact that legal aid will not be available at the MRCC or at the AAT, other than for claims relating to operational service. Confusion also arises from the different time limits applying for lodgement of applications and for subsequent actions in the two paths. For example, applications for MRCC reconsideration must be lodged within 30 days and subsequent review by the AAT must be within 60 days, and applications for VRB review must be lodged within 12 months and subsequent review by the AAT must be within 3 months.

113. The main suggestions from the submissions were that the appeals process be simplified by removing the MRCC pathway and directing all appeals to the VRB; and that legal aid be available for all appeals. The Committee recommends a single appeal path should be established that includes internal reconsideration, the VRB and then the AAT. The Committee believes that this will achieve more timely reviews at a lower cost. However, the Committee also believes that significant alterations to the current VRB process are required, including the introduction of active case management and improvements to timeliness for MRCA reviews by the VRB.

114. Case management and case conferences will help to ensure that the process is fully understood by the applicant, the issues are well defined, and all relevant evidence is identified and sought as early as possible so that the hearings can proceed without any unnecessary delay. In advance of the adoption of a single path, a formal service level agreement between the MRCC and the VRB should be negotiated to define a comprehensive case conference process within current legislation.

115. The Committee believes that reconsideration by the MRCC should be the first step in the review process. This would help ensure the quality of decisions that are considered by the VRB and reduce VRB workloads and costs.

116. Given the significance of the changes involved in moving to one pathway, alterations will need to be introduced incrementally. The Committee recognises that there are many significant issues that would need to be worked through in consultation with all stakeholders. A model for reform, business case and change management plan for implementation of incremental and legislative change would need to be developed. Incremental change could begin with negotiated changes between the DVA and the VRB. There will be up-front costs in recruitment, training and systems needs. Implementation of a single path would also require the current position in relation to costs and legal aid to be rethought. For legal aid coverage to be extended to a broader group, the federal Attorney-General would need to take up this matter with his state counterparts.

117. Where liability has been rejected by the MRCC but is subsequently accepted by the VRB, there is rarely sufficient material on file to enable the VRB to determine compensation, as the matters would not have been investigated by the MRCC. As the VRB currently has no power to remit a matter to the MRCC to determine compensation, it must, upon accepting liability, adjourn the hearing. The Committee believes the VRB

should be provided with explicit powers to remit a matter to the MRCC for needs assessment and compensation.

Chapter 18 Governance arrangements

118. Administration and governance of the MRCA is shared between Defence (the employer) and DVA (the scheme administrator). Three recommendations about governance from the Tanzer Review in 1999 were agreed to by the government of the day, but were not implemented when the MRCA was enacted. The current Review examined why these recommendations were not adopted.

119. The Tanzer Review proposed that the ADF should not be covered under the occupational health and safety (OHS) legislation of the time, but should be covered under the MRCA, or that ADF-specific OHS legislation be enacted. Since OHS legislation is different to compensation legislation, and there are moves towards harmonising OHS legislation across jurisdictions by 2012, the Tanzer Review no longer has relevance or benefit to Defence. The Committee recommends that the current arrangements continue.

120. The Tanzer Review also proposed that the Minister for Defence should be responsible for the MRCA. The government at the time changed this to the Minister for Veterans' Affairs, since military compensation is core business for DVA, but not for Defence. The Committee recommends that the Minister for Veterans' Affairs continue to be responsible for the MRCA.

121. In addressing funding and ministerial responsibility, the Tanzer Review believed that Defence should introduce a premium, payable to the Department of Finance and Deregulation. This has not been pursued by Defence or DVA, although the Australian Government Actuary has been calculating a notional premium for military compensation since the 1990s. The MRCA is funded on the basis of emerging costs, with its expenditure appropriated from the Budget.

122. The Committee is sympathetic to making the costs of military compensation more visible, but believes that a premium-based model is not appropriate for the ADF. There are difficulties in capturing compensation data, concern about commanders' ability to adjust their unit's activities in response to rising OHS costs, and a lengthy time required to know whether the calculation made was correct. The Committee recognises that the absence of an effective price signal is a barrier to understanding the dollar cost of service-related deaths, injuries and illnesses in the ADF.

123. Military compensation costs play a minor role in improving ADF OHS performance. Peacetime activities are covered under the same OHS regulations as civilians, with some exceptions, and peacetime service makes up the bulk of both claims and costs under the MRCA. This may change as the MRCA matures or operational tempo increases.

124. A more integrated approach to OHS and military compensation is required from DVA and Defence. The two organisations have different responsibilities but common goals, and a collaborative approach is needed to improve effectiveness and accountability. The Committee recommends that the two agencies should jointly determine the most appropriate future arrangements for operation of the MRCA, rather than revising the existing Memorandum of Understanding, which has little practical application.

125. Accurate and timely management information sharing is central to this approach. A system that is integrated with Defence's OHS and health information management systems would improve efficiency for both agencies. DVA claims assessors could interrogate Defence incident data and access medical and payroll information data directly. This could significantly reduce the time taken to process many claims. The Committee believes that Defence and DVA should devote greater effort and resources to developing and implementing more integrated systems.

126. The MRCC membership consists of three members of the Repatriation Commission, a member nominated by the Minister administering the SRCA (currently the nominee is the Chief Executive Officer of Comcare), and a member nominated by the Minister for Defence (currently an ADF member at the two star rank level, the Head of People Capability). The Committee believes that the addition of another member to represent Defence has significant potential benefits and should be considered.

Part 3 Legislative schemes that govern military compensation before the Military Rehabilitation and Compensation Act and anomalies that exist

Chapter 19 Compensation offsetting between the Veterans' Entitlements Act and the Safety, Rehabilitation and Compensation Act

127. The Committee examined offsetting arrangements between the VEA and the SRCA. This matter has been the subject of widespread criticism and concern in the veteran community for some years.

128. Offsetting occurs because certain claimants have dual eligibility and are able to claim compensation under both the VEA (pension) and the SRCA (permanent impairment lump sum payments and incapacity payments). Dual eligibility dates from 1972, when ADF members on peacetime service became eligible to claim under the two compensation schemes. The enactment of the MRCA from 1 July 2004 ceased the practice of dual eligibility for all forms of service from that date. However, dual eligibility continues for service before 1 July 2004. A key principle of offsetting is that dual eligibility should not result in claimants receiving benefits greater in value than the more generous of the benefits available under either the SRCA or the VEA for the same incapacity or death.

129. Out of 120,755 disability pensioners (as at September 2010), almost 9,000 (7 per cent) have their disability pension offset. In addition, 370 war widow(er)s have had their war widow(er)'s pension offset. The average disability pension offset is approximately $87.00 per fortnight. The average war widow(er)'s pension offset is approximately $313.00 per fortnight. These total approximately $25 million per year.

130. Offsetting is the process of reducing one compensation payment in recognition of another compensation payment for the same incapacity or death, so that a claimant does not receive double compensation. Offsetting typically occurs when a claimant receives a pension under the VEA and subsequently elects to receive a SRCA lump sum payment for the same incapacity or death. The legislation that governs the offsetting arrangements requires that the lump sum be converted to give a fortnightly payment equivalent. This conversion uses factors provided by the Australian Government Actuary, which take account of the claimant's age. The fortnightly VEA pension is then reduced for the life of

the claimant by an amount initially equal to the fortnightly equivalent (this amount increases in line with the Consumer Price Index).

131. Submissions to the Review did not take issue with the principle underlying offsetting, but were critical of the methodology. Claimants argued that offsetting should cease once the original amount has been repaid or, alternatively, upon claimants attaining their actuarial age. In 2003, these issues were the subject of a specific inquiry by the Senate Foreign Affairs, Defence and Trade Legislation Committee. The Senate Committee did not recommend changing the offsetting arrangements, noting that the introduction of the MRCA would cease dual eligibility for future service and thus the problem would eventually cease to exist.

132. The Committee examined the current actuarial model used for offsetting calculation and three alternatives: a modified actuarial model; a loan model; and ceasing the offset when the lump sum is 'paid back'. Any changes to existing military compensation offsetting arrangements would need to be considered from a whole-of-government perspective, since offsetting calculations based on an actuarial model are not confined to military compensation.

133. In the actuarial model, the total dollar amount offset against a claimant's pension over his or her lifetime usually exceeds the lump sum amount. This feature can result in perceived inequities. However, on average, the cost to the Commonwealth of providing the lump sum benefits is equal in value to the savings arising by offsetting the pensions.

134. To remain cost neutral to the Commonwealth, the modified actuarial model would result in a higher offset than the current approach, but the offset would cease when claimants reach their actuarial age (life expectancy). However, the higher offset would be unlikely to gain claimants' support.

135. In the loan model, when the offsetting process commences, the relevant part of the pension would be set to zero (fully offset); and when the loan is fully repaid, including an appropriate allowance for interest, the disability pension would be restored to full value for the rest of the claimant's life. The loan model would cost the Commonwealth 5–10 per cent more than the actuarial model. In addition, the 2003 Senate Inquiry concluded there were too many complexities associated with this model.

136. By ceasing the offset when the lump sum is 'paid back', the offset effectively becomes a non-interest loan. This approach has the benefit of being simple to understand, but it violates the key principle of offsetting mentioned earlier. Since this approach ignores the time value of money, claimants with dual eligibility would be able to receive benefits of greater value than under either the SRCA or VEA individually.

137. The Committee believes that these alternative models are complex and not cost effective, and recommends that existing offsetting arrangements be maintained. The Committee also recommends that the Repatriation Commission further explore the concept of giving claimants a choice, at the date any offset is determined under the VEA, to pay back the actuarial value of the lump sum previously received under the SRCA.

138. Since the complexities of the current offsetting arrangements make information difficult for many claimants to fully understand, it is important that the advice given to potential claimants is comprehensive, accurate and clear. The Committee recommends that the Department of Veterans' Affairs continue its efforts to improve advice to clients

regarding the effect that offsetting provisions will have on their compensation entitlements.

Chapter 20 Ceasing new claims under the Safety, Rehabilitation and Compensation Act

139. The MRCA was enacted in 2004 to overcome the complexities and confusion created by the parallel and combined operation of two separate compensation Acts for military service, the VEA and the SRCA. There continues to be complexity and confusion arising from the interaction of the three Acts (five Acts, if the 1930 Act and the 1971 Act subsumed into the SRCA are also considered). Most liability claims under the MRCA are determined quickly and dealt with simply. Claims that give rise to concerns are often complicated by previous conditions accepted under one or two other Acts. The effect of continuing to accept claims under the SRCA and the VEA for service before 1 July 2004 means that claims under those Acts will not be exhausted for possibly 60 years or even longer.

140. The Committee examined the possibility of reducing legislative complexity by ceasing future claims under the SRCA and treating them as claims under the MRCA. While the Committee's discussion focused on the movement of SRCA claims to be treated as MRCA claims, the Committee noted similar considerations might also be made for VEA claims in the future. Transitioning future SRCA claims to the MRCA would reduce complexity, confusion among stakeholders and some administration. Exact benefits under the MRCA and SRCA depend on individual circumstances; however, most would receive a higher benefit under the MRCA. The Australian Government's future military compensation liability could therefore be expected to increase substantially over time as a consequence of transitioning the SRCA into the MRCA. There may also be a perceived inequity where late claimants come under the MRCA, which is, in certain respects, more beneficial than the SRCA, so these claimants would be at an advantage by not lodging their claims sooner. There is potential for this to lead to demands that all old SRCA claims should be reassessed under the MRCA.

141. However, not all future SRCA recipients would be better off if assessed under the MRCA. The application of the MRCA's whole person impairment assessment, and the use of the SoPs and the *Guide to determining impairment and compensation* (GARP M) assessment tool, can lessen the amount of compensation for some claimants or deny eligibility altogether to some others. This may reduce, to some degree, the costs associated with transitioning new claims under the SRCA to the MRCA. However, it could lead to arguments by claimants for a choice as to which legislation they wish to be covered by, or litigation by claimants arguing they have been denied their rights.

142. Therefore, the Committee recommends that the current transition approach be maintained and that no action be taken to cease future claims under the SRCA by treating them as claims under the MRCA.

Chapter 21 Aggravations of conditions accepted under the Veterans' Entitlements Act related to service rendered after 1 July 2004

143. When the MRCA was enacted, the intention was not to interfere with compensation entitlements of VEA beneficiaries. Transitional provisions contained in the

Military Rehabilitation and Compensation (Consequential and Transitional Provisions) Act 2004 (CTPA) clarify the interaction between the MRCA, the VEA and the SRCA.

144. Claims for aggravation of a condition compensated under the VEA (where the aggravation occurred as a result of service rendered on or after 1 July 2004) require the claimant to make a choice under section 12 of the CTPA (known as a section 12 election). Claimants can either:

- make an application for increase (AFI) under the VEA for the aggravation. This means that both the underlying condition and the aggravated component will be pensionable under the VEA; or
- claim under the MRCA for acceptance of liability for the aggravation. This means that the underlying condition will remain pensionable under the VEA, while the aggravated component may be compensated under the MRCA.

145. The election process is an exception to the general date of injury approach adopted under the MRCA transitional provisions, but it ensures that the MRCA does not interfere with the entitlements of VEA beneficiaries. The election process is complex and can cause confusion and anxiety for claimants, and administrative burden for DVA. Most claimants elect to proceed with an AFI under the VEA, rather than claim under the MRCA. The Committee also identified a number of issues, in addition to those raised in submissions, relating to the difficulties in the administration of section 12 elections.

146. One approach to address these issues is that all aggravations of VEA conditions caused by service on or after 1 July 2004 could be compensated under the MRCA. This would be in line with the date of injury approach and the approach to aggravations of conditions previously accepted under the SRCA. However, the Committee does not prefer this option, as it may prevent some claimants from being eligible for an above General Rate of Pension or Repatriation Health Card — For All Conditions (Gold Card) under the VEA, and some claimants may have liability for the aggravation rejected under the MRCA.

147. An alternative approach is to remove the election process and stipulate that all aggravations of a VEA condition that relate to service can only be compensated under the VEA, regardless of when that service occurred. This option is an exception to the date of injury approach, but is more in line with the principle that enactment of the MRCA would not interfere with VEA entitlements. The Committee therefore recommends that the election provisions be removed and replaced with provisions stipulating that all aggravations of VEA conditions relating to service on or after 1 July 2004 must be the subject of an AFI under the VEA, and cannot be claimed under the MRCA.

Chapter 22 Transitional permanent impairment claims

148. Chapter 25 of GARP M sets out the method to be used where a person already has a condition accepted under the VEA and/or the SRCA, and suffers a further condition that is to be assessed for permanent impairment compensation under the MRCA. The legal authority for this process is provided in section 13 of the CTPA. The process involves:

- assessing the VEA or SRCA and the MRCA condition(s) using GARP M as at the current date and combining them according to GARP M to derive a total impairment rating;
- using the total impairment rating to determine a gross MRCA amount; and

- offsetting this gross amount by any compensation payment(s) under the VEA or SRCA.

149. The purpose of this method is to guarantee that impairment suffered as a result of previous VEA and/or SRCA conditions will be counted towards eligibility thresholds under the MRCA. Secondly, the method ensures that the whole person impairment methodology is applied across all three Acts. However, the method is complex and not easily understood by claimants, and was the subject of a number of submissions to the Review.

150. Submissions argued that the methodology is only about cutting costs and is detrimental to members, and suggested that claimants should be compensated for each individual injury. Ex-Service Organisation Round Table representatives requested no offsetting at all under Chapter 25 of GARP M. The Committee does not support this position, since removing consideration of previous conditions under the VEA or SRCA completely would not be in accordance with the intent of the whole person impairment methodology of MRCA. Total compensation under all three Acts should not exceed the maximum compensation intended to be paid by the Commonwealth for a person's defence service under the MRCA. Compensation should therefore remain capped at the maximum permanent impairment compensation payment under the MRCA.

151. However, the Committee found that the methodology used to calculate permanent impairment compensation for the MRCA condition under GARP M may result in a lower or higher net MRCA permanent impairment compensation payment than expected (when considered in light of the impairment points suffered as a result of the MRCA conditions), or no payment. This may occur because of differences in assessment methodologies and the calculation of compensation under the three Acts, and changes in VEA or SRCA conditions over time.

152. The Committee investigated whether the method of offsetting should be amended. The Committee was divided in opinion:

- Committee members from DVA and the Australian Defence Organisation, and Mr Peter Sutherland, believe that the current method is inappropriate because members who suffer an increase in whole person impairment as a result of new MRCA conditions may not receive additional compensation for that increased permanent impairment. They believe that the low or nil outcomes produced by the current method could not have been foreseen and were not intended at the time the MRCA was introduced.
- Committee members from the Department of Finance and Deregulation, the Treasury and the Department of Education, Employment and Workplace Relations believe that the current method is appropriate because it ensures that compensation outcomes for transitional claimants and MRCA-only claimants with the same levels of whole person impairment are equalised to the extent possible under the MRCA.

153. The Committee recommends that the Government consider these two views. The Committee also recommends that there be an education campaign in conjunction with ex-service organisations to facilitate greater understanding of the arrangements and ensure claimants are aware of the effect that these provisions may have on their compensation.

154. As an appendix to this chapter, an alternative method of offsetting is presented that, for the purposes of calculating the amount of compensation payable for the new impairment level, the SRCA or VEA conditions be treated as if they were being

compensated under the MRCA. It addresses the reasons for low or nil outcomes by ensuring that like is offset against like, while still meeting the policy principles of whole person impairment.

155. The alternative method would, if adopted, increase administered expenditure by approximately $25.5 million over four years, assuming any pre-existing cases where the claimant will be better off are not prevented from seeking a reassessment. Approximately 700 cases considered before 1 December 2010 have had the current method applied, and around 250 transitional permanent impairment claims can be expected per year, with that number increasing slowly.

Chapter 23 Other perceived anomalies

156. The MRCA is based on the SRCA structure. It includes rehabilitation benefits, and economic loss or non-economic loss compensation, with additions from the VEA, where this is beneficial and not anomalous. The VEA is pension based and has general healthcare benefits. Differences in benefits between the schemes have arisen because of the history of each of the Acts, and some differences in rates or circumstances in which a benefit is payable should be expected. The Committee considered several perceived anomalies between the MRCA, VEA and SRCA that were raised in submissions and during consultation. These relate to the following payments:

- household services and attendant care under the VEA;
- motor vehicle compensation scheme under the MRCA;
- lump sum payments for VEA recipients;
- telephone allowances;
- private vehicle travel expenses;
- funeral benefits;
- fortnightly payments for eligible young persons;
- education allowances for eligible young persons;
- impairment points and eligibility criteria for certain benefits, such as the Repatriation Health Card — For All Conditions (Gold Card); and
- automatic grant of death benefits for dependants of prisoners of war.

157. While it is not unusual for beneficiaries under one piece of legislation to compare similar benefits available under a different piece of legislation and argue for those that are more beneficial, the Committee concluded that, in all the above cases, the differences in these benefits are not unintended or anomalous. The Committee therefore recommends that no change is necessary to adjust benefits between the applicable Acts.

Part 4 Level of medical and financial care provided to Australian Defence Force personnel injured during peacetime service

Chapter 24 Treatment cards for Safety, Rehabilitation and Compensation Act clients

158. Defence-related claims under the SRCA can include medical expenses reasonably required for the compensable condition. This usually occurs through reimbursement of costs, and occasionally by direct billing. The Review received a number of submissions relating to healthcare provisions under the SRCA, including proposals to issue Repatriation Health Cards to ADF claimants under the SRCA.

159. Introducing Repatriation Health Cards would bring the SRCA in line with provisions under the VEA and the MRCA. However, this will mean that access to certain types of treatment, such as remedial massage or gym programs, will be more limited than under the current SRCA provisions. A co-contribution for pharmaceuticals will also be payable.

160. Many amounts payable under the DVA fee schedule are significantly lower than those under the SRCA, such as standard general practitioner consultations and most specialist consultations. This may lead to provider dissatisfaction, and medical and allied health provider groups, including the Australian Medical Association, should be consulted as part of the development of the expanded card system.

161. Advantages of Repatriation Health Cards — For Specific Conditions (White Card) for SRCA clients include:

- the convenience of not paying upfront and waiting for reimbursement;
- consistency in provisions across the VEA, SRCA and MRCA;
- greater control and monitoring of treatment and pharmaceuticals; and
- administration and departmental savings.

162. The SRCA has a steady volume of between 5,000 and 6,000 treatment claimants per year. Given that the SRCA has been closed for service rendered after 1 July 2004, it is assumed that most of these claimants will be suffering long-term or chronic conditions. The average annual cost per claimant is around $4,364 per year. As at September 2010, there were 50,137 White Card holders under the VEA and MRCA, with an average expenditure of $1,700 per cardholder. This figure may be slightly skewed towards a higher cost, given that the VEA treatment population will be, on average, older than the SRCA treatment population and therefore accessing health care more often.

163. The Committee therefore recommends that White Cards be issued to defence-related claimants under the SRCA. Provision of cards should be subject to a needs assessment showing long-term treatment needs. The current reimbursement arrangements for the treatment of short-term conditions should be retained. The Committee also recommends that the DVA fee schedule be adopted for treatment provided to defence-related claimants under the SRCA, and that the supplement payment for pharmaceuticals be extended to SRCA clients with Repatriation Health Cards.

Chapter 25 Non-liability health cover for certain conditions

164. Non-liability health cover is available under subsection 85(2) of the VEA for the treatment of pulmonary tuberculosis (TB), malignancies and post-traumatic stress disorder (PTSD). Determinations made under section 88A provide further non-liability health cover for other psychiatric conditions, such as anxiety disorder. Both these provisions also apply to members who have rendered operational service after 1 July 2004 where they do not have the condition accepted under the MRCA. Members who entered the ADF after 1994 and have peacetime service only are not eligible for non-liability health cover.

165. One submission to the Review argued for treatment of malignancies for all members, regardless of service type. Comments at public consultation meetings concerned the lack of automatic coverage for treatment of psychiatric disorders and malignancies for members with only peacetime service; comments were particularly strong about psychiatric conditions.

166. Treatment coverage for TB now has limited application, with a very small volume of claims made under the MRCA. Extending non-liability health cover for TB for all modern-day peacetime service is not considered necessary. Similarly, the low numbers of claims for malignancies under the MRCA to date indicate that there is not a substantial need to extend non-liability health cover to all peacetime former members covered under the MRCA. The Committee considered whether a subgroup of members should be defined for this purpose, using full-time status or length of service, but concluded that any extension could not be justified.

167. Current VEA non-liability health cover includes treatment for anxiety, depressive disorders and PTSD. These disorders represent 73 per cent of claims under the MRCA for psychiatric conditions; other claims are for conditions not included in VEA non-liability health cover (including acute stress disorder, adjustment disorder, bipolar disorder, panic disorder, personality disorder and schizophrenia). Recent reviews have drawn attention to the need for improvements in the care of all members and former members with mental health conditions.

168. As at 31 December 2010, there had been 683 claims from ADF members with peacetime service only for psychiatric conditions covered under the VEA non-liability treatment provisions; of those, 363 claims were rejected. DVA has estimated that the cost of providing non-liability treatment for this group would be approximately $6 million over four years. However, there may also be offsets to Government costs through non-use of Medicare arrangements that are not included in this estimate.

169. The Committee was divided in its view on whether the MRCA should be used to extend non-liability treatment for psychiatric conditions to former members of the ADF with peacetime service only.

170. Committee members representing DVA and the Australian Defence Organisation, and Mr Peter Sutherland believe that non-liability health cover for all psychiatric disorders should be provided under the MRCA for former ADF members and part-time Reservists who have served after 1 July 2004. These Committee members also believe that this is consistent with the thrust of recommendations of recent reviews including the suicide study by Professor David Dunt, which drew particular attention to members' needs around the period of transition to discharge and did not limit consideration to those who had operational service.

171. The Committee members representing the Department of Finance and Deregulation, the Treasury and the Department of Education, Employment and Workplace Relations believe the MRCA (or *Safety, Rehabilitation and Compensation Act 1988*) is not an appropriate vehicle to extend non-liability health cover for all psychiatric disorders to former ADF members and part-time Reservists with peacetime service only. In principle, compensation schemes should only deal with cases where liability is established.

172. These members recommend that Defence and DVA gather further evidence to establish both the benefit and need for additional psychiatric care for this group separate to the existing general health services. If need and benefit are established, then options could be explored to deliver such health coverage outside of compensation legislation and presented to the Australian Government.

Part 5 Implications of an Australian Defence Force compassionate payment scheme for non-dependents

Chapter 26 Compassionate payment scheme

173. The question of whether or not to introduce an ADF compassionate payment scheme was referred to the Review by the then Minister for Defence Science and Personnel and the then Prime Minister in 2008. The purpose of such a scheme would be to provide compassionate payments to the non-dependent parents (and other close family members) of ADF members who die while serving. Occasionally the government grants payments for grief or pain and suffering resulting from the loss of an ADF member, on a case-by-case basis.

174. Public emotion generated by a death of an ADF member can be accompanied by concern about the adequacy of the compensation and support provided to bereaved family members, particularly in circumstances where the ADF is at fault, or perceived to be at fault. Arguments for the introduction of a compassionate payment scheme for non-dependent family members include eliminating or reducing the potential for these matters to be politicised, and providing a clear and consistent way of providing support.

175. Consistent with other workers' compensation legislation, the MRCA does not pay compensation to parents or other family members unless they can establish they were financially dependent on the deceased. Common law in Australia does not generally provide compensation for grief or bereavement arising from the wrongful death of a close family member.

176. Implementing a military compassionate payment scheme would clearly go further than any other Australian workers' compensation scheme and would extend the notion of compassionate payment well beyond its present statutory scope. It would be difficult to design a scheme that would seem fair to all families, be relatively simple to understand and administer, entail minimal costs, and provide minimal potential for flow-on effects to other legislation.

177. The Committee concluded that, if such a scheme was introduced, it would have the potential to create more problems than it would solve. However, it recommends that Defence continue to consider the circumstances of individual cases under the current

arrangements as there may be grounds for the Australian Government to make payments in certain limited circumstances.

Part 6 Suitability of access to military compensation schemes for members of the Australian Federal Police who have been deployed overseas

Chapter 27 Coverage for Australian Federal Police

178. The current Australian Government gave a 2007 election commitment to consider the appropriateness of compensating Australian Federal Police (AFP) members for conditions arising from high-risk overseas missions through military compensation arrangements. This consideration forms part of the Review.

179. As Australian Government employees, AFP members are covered by the SRCA including when deployed, posted or working overseas. AFP members deployed with Peacekeeping Forces were eligible for benefits under the VEA until the enactment of the MRCA, and some on high-risk missions continued to be eligible. However, VEA coverage effectively ceased for the AFP when the previous government announced in 2006 its intention that AFP members with eligible overseas service would be compensated under new arrangements comparable to the provisions of the MRCA. It was intended that these arrangements would be included in an enhanced SRCA. However, while work on amendments to the SRCA commenced in 2006, technical difficulties halted the work and the requisite legislation has not been drafted. The AFP has recently introduced interim compensation arrangements for members posted to Afghanistan, Timor Leste and Papua New Guinea.

180. When the MRCA replaced the VEA in 2004, coverage for AFP members was intentionally not carried over into the new legislation, as the MRCA was designed to be a military-specific scheme and to take account of the special characteristics of military service. The Committee believes that bringing the AFP into the MRCA would run counter to the commitments given to ADF members and the ex-service community in promoting acceptance of the MRCA on the basis it was specifically for military personnel.

181. The Committee also believes that the work performed by the AFP and the ADF while on overseas operations is not the same, nor is the role of the two organisations always integrated. Bringing the AFP into the MRCA would necessitate not insignificant technical amendments to the legislation, and give rise to considerable complexity and anomalies in administration.

182. For these reasons, the Committee recommends that AFP members not be given access to the MRCA.

Part 7 Miscellaneous Issues

Chapter 28 Life insurance in the context of military compensation

183. The issue of life insurance for ADF members is outside the Review's terms of reference. Defence brought the issue to the Review in response to ADF members being

denied life insurance coverage, or having existing policies suspended, due to war exclusion clauses. This is a significant problem for Reservists on continuous full-time service, especially health professionals, where MRCA benefits for injury or death may not be sufficient to cover loss of business income.

184. Life insurance is a personal decision for ADF members, based on their individual financial circumstances. Defence provides financial assistance in the form of an allowance to reimburse ADF members for the additional coverage they need to purchase above the normal cost of a life insurance policy. It is difficult to see how life insurance could be integrated into the MRCA without radical change to the legislation and support from a wide range of stakeholders.

185. Compulsory insurance would also convey the impression that the MRCA is inadequate and life insurance is a necessary substitute for military compensation. In reality, compensation under MRCA is sufficient for the vast majority of ADF members, particularly when combined with the death and disability benefits provided by military superannuation schemes.

186. The Committee recommends that Defence and DVA jointly undertake a comprehensive communication strategy, aimed at educating serving ADF members on the full range of financial benefits provided under the MRCA and military superannuation.

187. Defence has elected to pursue this matter separately from the Review process, with several options under consideration before a recommendation is made to the Australian Government.

Chapter 29 Reconsideration of compensation-related recommendations from the Review of Veterans' Entitlements

188. A reconsideration of unimplemented recommendations from the Clarke Review of Veterans' Entitlements referred 22 recommendations on compensation issues to the current Review. These relate to the disability compensation structure, the private health insurance allowance, Extreme Disablement Adjustment (EDA), one-time election for SRCA or VEA, and rehabilitation.

189. The Clarke Review proposed a new disability compensation structure with different levels of compensation up to and after retirement age that varied according to family composition. Several elements of this disability structure have been included in the MRCA. The introduction of the MRCA and increases to VEA disability and war widow(er)'s pension rates have substantially improved the situation for former ADF members and families compared to the benefits available at the time of the Clarke Review. There is, therefore, no need to reconsider the revised disability structure arising from recommendations 76–79 of the Clarke Review.

190. Submissions to the Clarke Review advocated extending Gold Card eligibility to families of veterans. The Clarke Review rejected this concept, but recommended a private health insurance allowance for Special Rate of pension and EDA veterans. The DVA does not provide this allowance for any client group; families have access to health care through Medicare and the Australian Government's private health insurance premium subsidy. The needs identified in the Clarke Review have been addressed through higher Special Rate and EDA pensions, the introduction of the Defence Force Income Support Allowance and increases in income support pensions. The Committee does not

recommend introducing a tax-free allowance to assist Special Rate and EDA pension families with children who decide to take out private health insurance cover (Clarke Review recommendations 72 and 89).

191. Clarke recommendations 88 and 90 outline revised benefits for EDA veterans, including a Goods and Services Tax (GST) rebate for motor vehicle parts and services, and a 'more targeted' range of benefits for people older than 65 years who have 70 impairment points and six lifestyle factors. Considering the full range of benefits currently available to EDA veterans and increases in the rates of disability and income support pensions since 2003, Clarke's recommendations would actually reduce family income for this group. GST exemption for motor vehicle parts is available to all members of the general community who have lost the use of one or more limbs, so some EDA veterans may already be covered. For those who do not qualify for the general exemption, the VEA and MRCA provide motor vehicle compensation and assistance schemes. The Committee, therefore, does not recommend adjusting the benefits structure or seeking GST exemptions for EDA recipients or former members suffering the equivalent levels of impairment and lifestyle under the MRCA (Clarke Review recommendations 88–90).

192. Recommendation 92 of the Clarke Review called for veterans with dual entitlements under the VEA and SRCA to be allowed a one-time election, which would restrict them to receiving benefits under one Act of their choice. The Committee considers that this could prove disadvantageous to an individual if their circumstances change. Dual entitlements under the VEA and SRCA for injuries or disease arising from service after 1 July 2004 have been discontinued through the MRCA and the CTPA.

193. The Clarke Review made a number of recommendations relating to rehabilitation. The place of rehabilitation in military compensation administration is now firmly based and well entrenched in practice, and a number of recommendations for improvement in this area are made in the current Review. DVA's main effort on rehabilitation is through the MRCA service delivery stream, but there is a risk that people with VEA eligibility may not have the opportunity to participate in the programs relevant to their age and quality of life expectations. The Committee recommends that DVA, the Repatriation Commission and MRCC review the Veterans' Vocational Rehabilitation Scheme (VVRS) to improve rehabilitation options for those who have VEA eligibility and are younger than 50 years.

194. The MRCA contains many of the interlocking disability benefits and rehabilitation programs proposed by the Clarke Review. They are also evident in the principles and protocols for rehabilitation established by DVA in consultation with the Ex-Service Organisation Working Group (ESOWG) for implementing the MRCA. The gaps identified mainly relate to younger veterans who may still benefit from rehabilitation. The Committee recommends that no further action be taken on the recommendations of the Clarke Review that were referred to this Review.

Chapter 30 Suitability of access to military compensation schemes for non-members

195. Section 8 of the MRCA provides specified civilians, who support the ADF but do not have access to other worker's compensation schemes, access to the benefits of military compensation.

196. The SRCA provides cover to Australian Government employees in a variety of occupations and locations around the world. Extending the MRCA to an Australian Government employee already covered by the SRCA would mean that the claimant could choose which Act is the most beneficial, a contradiction given that dual eligibility ceased for ADF members with the introduction of the MRCA. This also applies to civilians covered under state and territory workers' compensation arrangements.

197. The Committee believes that military compensation should generally be restricted to ADF members. Extending coverage to employees covered by other schemes would conflict with one of the major reasons for enacting the MRCA, to remove dual eligibility.

198. However, the position of civilians who are not employees and who do not have compensation coverage can be clearly distinguished from those employees covered by the SRCA and other compensation schemes, and it is necessary to continue to provide them with cover under section 8 of the MRCA.

199. The Committee recommends that civilians in this category should only be provided with access to the MRCA in circumstances where they are:

- integrated with the ADF in an area of operations;
- employed and subject to military command and control; and
- subject to the relevant provisions of the *Defence Force Discipline Act 1982*.

200. The Committee also recommends that members undergoing career transition assistance and personnel holding honorary ranks should be defined under the Act as 'members' to ensure their continued coverage under the MRCA.