3 The Military Rehabilitation and Compensation Scheme

Chapter summary

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

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.

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 *Veterans' Entitlements Act 1986* (VEA), compared to 4,798 active clients under the *Military Rehabilitation and Compensation Act 2004* (MRCA) and 11,260 active clients under the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) (active clients are clients who have received benefits or services in the past two years).

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.

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.

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 under the MRCA increased significantly in 2009–10. It is difficult to know if this increase will continue.

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 in 2009–10 will continue.

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. The 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.

Introduction

3.1 This chapter describes the processes of today's Military Rehabilitation and Compensation Scheme, and outlines the client and payment trends, along with historic and projected expenditure and liability estimates. Military compensation arrangements must be seen as a continuum and need to be linked closely between the Australian Defence Organisation (Defence) and the Department of Veterans' Affairs (DVA).

3.2 As at December 2010, DVA had a total of 120,755 disability pensioners and 99,982 war widow(er)s under the *Veterans' Entitlement Act 1986* (VEA), compared to 4,798 active clients under the MRCA and 11,260 active clients under the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) (active clients are clients who have received benefits or services in the past two years).

Background

3.3 The *Military Rehabilitation and Compensation Act 2004* (MRCA) covers Defence service on or after 1 July 2004. The *Safety, Rehabilitation and Compensation Act 1988* (SRCA) and the *Veterans' Entitlements Act 1986* (VEA) cover service before 1 July 2004. Due to the MRCA's relatively short history, data for defence-related compensation under the SRCA have been included to provide a fuller picture post-2004.

3.4 As discussed in the previous chapter, the enactment of the *Military Compensation Act 1994* extended SRCA coverage to claims related to operational service (it had previously only applied to defence-related claims for peacetime service). The MRCA covers the same kinds of service that were covered by the SRCA after 1994. Furthermore, the benefit structure of the MRCA is aligned with the SRCA.

3.5 Detailed VEA data have not been included in this chapter. This is because eligibility under the VEA is limited to specific kinds of service, and the VEA has a different benefit structure from the SRCA and the MRCA. Furthermore, date of injury or disease is not recorded in the system for VEA claims, so it is difficult to ensure that VEA claims data are being compared for the same period as SRCA claims data. VEA expenditure is approximately $12 billion per year. The number of VEA beneficiaries is expected to halve over the next 10 years.

Kinds of service under the Military Rehabilitation and Compensation Act

3.6 The MRCA replicated the VEA system of classifying service, introduced in 1997, and recognises three types of defence service — peacetime, non-warlike and warlike

service.[1] Service is peacetime service by default unless it is determined by the Minister for Defence to be non-warlike or warlike service (see Appendix C for determinations under paragraphs 6(1)(a) and (b) of the MRCA, as at 1 October 2010).

3.7 Warlike operations are those military activities where the application of force is authorised to pursue specific military objectives, and there is an expectation of casualties.[2]

3.8 Non-warlike operations are those military activities where there is a risk associated with the assigned tasks and where the application of force is limited to self defence, but fall short of warlike operations. Casualties could occur but are not expected.[3]

3.9 The risk of harm from the enemy or dissident elements is a requirement for both warlike service and non-warlike service.

3.10 Under the MRCA, benefits payable for warlike service and non-warlike service are the same. For the sake of simplicity, this report will often refer to warlike and non-warlike service as 'operational service', a term that has no technical meaning under the MRCA, but is used to jointly describe the two types of service under previous legislation.

Occupational health, safety, rehabilitation and compensation in the Australian Defence Force

3.11 Within the Department of Defence, the Defence People Strategies and Policy Group is responsible for the development of policy for occupational health, safety, rehabilitation and compensation for the Australian Defence Force (ADF). The Vice Chief of the Defence Force is a member of the Safety, Rehabilitation and Compensation Commission (SRCC) and represents the interests of members and former members of the ADF. The SRCC oversees the administration of the *Occupational Health and Safety Act 1991* for members of the ADF.

3.12 Each of the Defence Services is responsible for implementing personnel management procedures. Each is responsible for reviewing a member's continued suitability for employment in the ADF and their reallocation or retraining, where possible. Such decisions are made in consultation with the member, the member's Commander and ADF health providers.

3.13 ADF commanders are responsible for the health and welfare of ADF members under their command. This includes efficient administration of long-term casualties, provision of adequate and timely rehabilitation, assignment of appropriate duties, ongoing support for the member and their family, assistance with the administrative requirement for the lodgement of compensation claims, and liaison with support agencies to ensure the best outcomes for the member.

[1] Section 6 of the MRCA.
[2] R Creyke & P Sutherland, *Veterans' Entitlements Law*, 2nd edition, Federation Press, 2008, p. 25.
[3] Creyke & Sutherland, op cit.

Incident report and rehabilitation referral

3.14 The ADF is the primary provider of medical treatment and rehabilitation to serving members of the ADF, with each Service Chief acting as the rehabilitation authority under the MRCA.

3.15 Where a serving member sustains an injury or contracts a disease, the member's supervisor will complete and submit an incident report.[4] These reports are recorded on the Defence system and are available for review by policy makers, Service Commanders and, on request, Military Rehabilitation and Compensation Commission (MRCC) claims assessors.

3.16 Rehabilitation assistance may be requested by a treating medical officer, the member's commander, the MRCC or the member.[5] A local ADF rehabilitation coordinator will arrange a rehabilitation assessment under the ADF Rehabilitation Program (ADFRP). A rehabilitation program may be recommended as a result of the rehabilitation assessment.

3.17 The senior medical officer of the base, establishment or area assigns an ADF medical practitioner to be the clinical case manager — the principal coordinator of the member's medical care and the point of contact for liaison with the allocated rehabilitation coordinator. The clinical case manager will provide medical guidelines for the serving member's rehabilitation and ensure that unit medical records accurately reflect the total plan of management.

3.18 Rehabilitation coordinators are appointed to manage the return to work (vocational rehabilitation) of all ADF members, regardless of their compensation status.

3.19 Rehabilitation providers must be approved Comcare program providers. If a member refuses to undertake a rehabilitation assessment or program, the rehabilitation authority can suspend the member's right to compensation until the member undertakes the program.[6] This does not affect the right to treatment or compensation for treatment.

[4] AC563, Defence OHS Incident Report.
[5] The originator completes a PM546, Request for Rehabilitation Assessment.
[6] Section 52 of the MRCA.

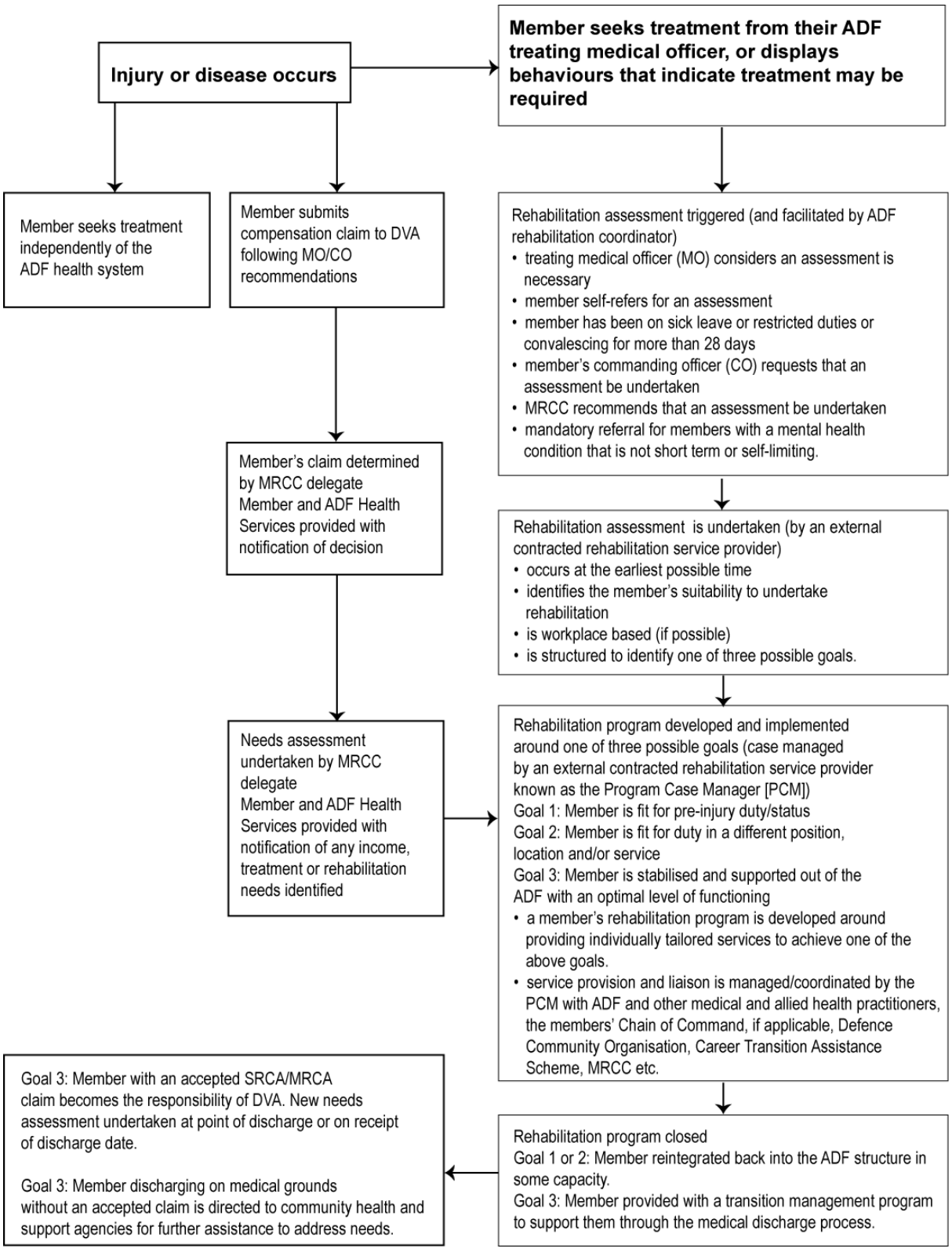

Figure 3.1 The Australian Defence Force Rehabilitation Program case management pathway

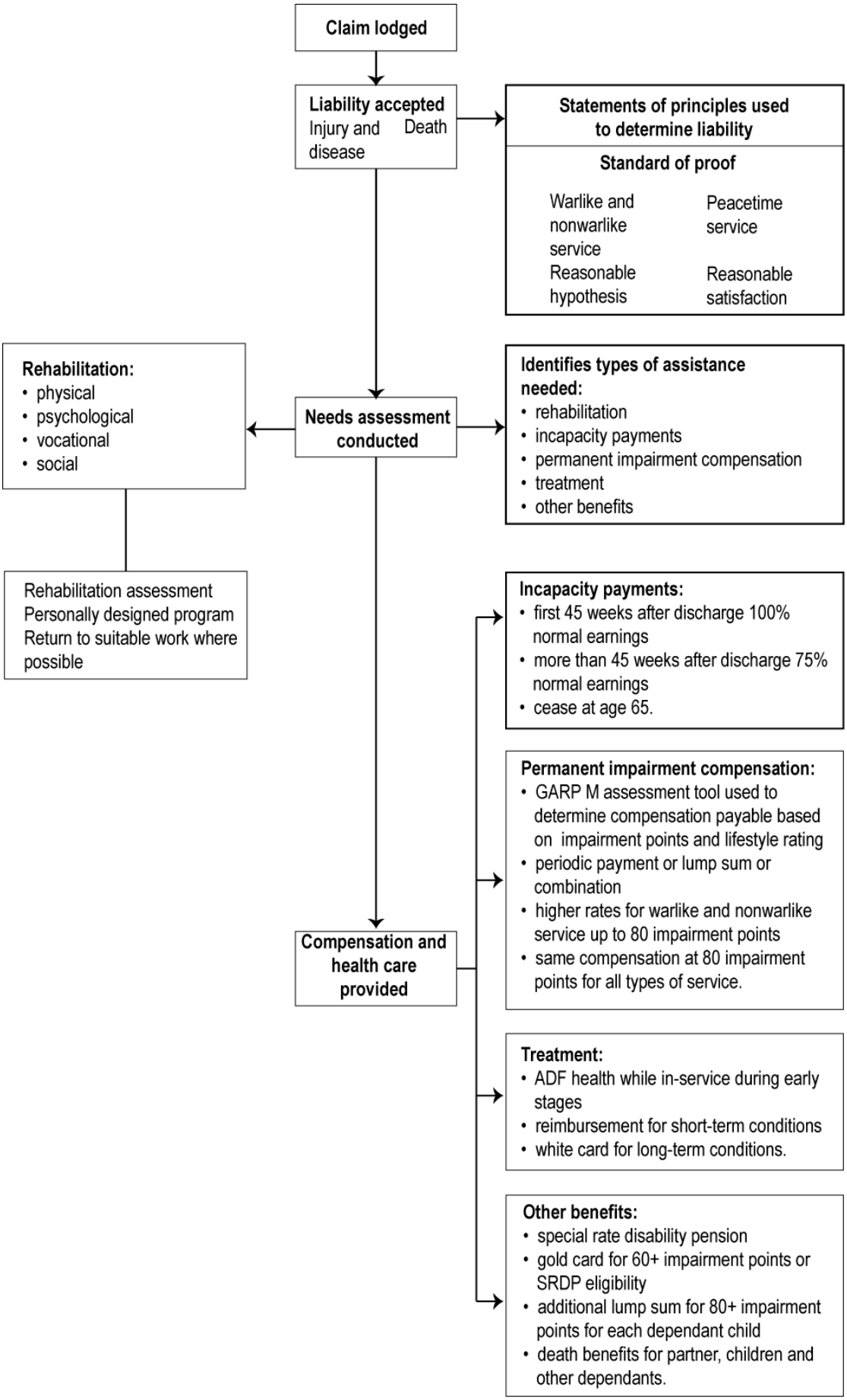

Figure 3.2 Military Rehabilitation and Compensation Act claims process

Initial liability

3.20 The member may contact DVA for information about possible compensation for a service-related injury or disease. Once a claim is lodged, DVA will acknowledge receipt and provide a copy to Defence. This documentation is retained by Joint Health Command and placed on the member's unit medical record.

3.21 A delegate of the MRCC within DVA investigates the claim for liability, including service details, diagnosis and causation. Generally, all the evidence required by the MRCC delegate will be available on the member's unit medical record and the incident report provided with the claim or sought by the delegate from Defence. The delegate may require other evidence; for example, a specialist medical report or witness statements.

3.22 For most conditions, there is a Statement of Principles (SoP) that the MRCC delegate must use to determine liability. The delegate will either determine that the member's injury or disease is a service injury or service disease and accept the claim for liability, or reject the claim for liability.

3.23 DVA provides a copy of the MRCC delegate's determination to the member's Service Chief. This documentation is retained by Joint Health Command and placed on the member's unit medical record.

3.24 The determination letter will outline the member's reconsideration and review options if he or she is unhappy with the decision of the delegate. The member may request an internal reconsideration within three months of receiving the original determination, or apply to the Veterans' Review Board (VRB) for a review within 12 months of receiving the original determination. The member's Service Chief may request that the MRCC reconsider its decision, or the MRCC may have a different delegate undertake its own reconsideration. The member can also appeal to the Administrative Appeals Tribunal (AAT) if not satisfied with the first level of appeal.

Needs assessment

3.25 Before any compensation is payable, a delegate of the MRCC will undertake a needs assessment with the member. During the needs assessment, the delegate will attempt to identify the priorities for rehabilitation, medical treatment and compensation needs that the member may have.

3.26 The MRCC delegate will summarise the findings of the needs assessment process and report these back to the member and the ADFRP. This document will confirm activities currently being undertaken and highlight any additional issues that may need to be addressed by the ADFRP or through DVA, such as the provision of aids and appliances, household assistance or attendant care.

3.27 The member may also claim for incapacity payments for any pay-related allowances included in their normal earnings that were lost as a result of the service injury or service disease; for example, any lost deployment allowance if the service injury or service disease resulted in the member's return to Australia before the expected unit end date of a deployment. It is the responsibility of Defence to provide the MRCC with

details about any pay-related allowances included in normal earnings that the member would have been receiving if not for the accepted injury or disease.

3.28 A claim for permanent impairment compensation may be discussed, but may need to be deferred until the member's condition has stabilised.

Transition to civilian life

3.29 While Defence has responsibility for providing medical treatment for all conditions for serving members, this responsibility may be transferred to the MRCC before discharge, after considering any advice from Defence.

3.30 The ADFRP aims to support the member in returning to his or her pre-condition duties or alternative duties. However, if a member is unable to return to normal or alternate duties during rehabilitation, they will be assisted in making the transition out of the ADF. The discharging member will be assigned a transition case manager through a referral process via the ADFRP. DVA provides a transition service for members undertaking medical discharge to advise on future compensation and treatment arrangements. Defence and DVA have agreed to extend this service until 30 June 2011 while a 'whole of life' medical, rehabilitation, compensation and transition framework is developed for ADF members.

3.31 Once the member has been identified as likely to discharge, responsibility for their rehabilitation transfers from the ADFRP to a DVA rehabilitation case manager on behalf of the MRCC. The member's existing rehabilitation provider will continue to manage the member's rehabilitation after discharge, if appropriate and practical.

3.32 As soon as possible after the member has been identified for discharge, a new needs assessment should be undertaken. Any change in the member's circumstances may require a new rehabilitation program or an adjustment to the range of services and activities required by the member, especially if their discharge involves relocation.

Incapacity payments

3.33 Incapacity payments compensate the member for lost income. If a rehabilitation program is no longer being undertaken, the member will be required to provide a medical certificate or other evidence of incapacity for service or work.

3.34 Through the transition process the member should contact ComSuper regarding any invalidity benefits payable under a Commonwealth superannuation scheme, such as the Military Superannuation and Benefits Scheme (MSBS). MRCA incapacity payments are offset on a dollar-for-dollar basis by the Commonwealth-funded portion of any Commonwealth superannuation the member receives. The maximum incapacity payment for a member who does not return to work is the difference between normal earnings and actual earnings for the first 45 weeks after discharge. After 45 weeks, normal earnings are reduced to 75 per cent. If a former member returns to work, this percentage increases in correlation to normal weekly hours worked during a week. Incapacity payments are payable for the duration of the incapacity or until age 65.

Treatment, household services and attendant care

3.35 After discharge, access to treatment at cost to the MRCC will be arranged either through reimbursement (for short-term conditions) or a Repatriation Health Card – For Specific Conditions (White Card). The MRCC delegate will arrange this as part of the needs assessment.

3.36 As noted above, during any needs assessment process, the member's eligibility for compensation for attendant care (essential and regular personal care services such as mobility assistance, personal hygiene, grooming, dressing and feeding) or household services (services required for the proper running and maintenance of a household such as cooking, cleaning, laundry and gardening) will also be considered. These benefits can be provided while the member is still serving.

Permanent impairment compensation

3.37 The member may wish to claim for permanent impairment compensation, either while serving or after separation. A copy of the claim for permanent impairment compensation will be provided to the member's Service Chief if they are still serving. This documentation is retained by Joint Health Command and placed on the member's unit medical record.

3.38 The MRCC delegate will arrange an appointment with an occupational physician or a specialist for a permanent impairment assessment. If the impairment is not yet stable, the delegate will generally defer a final decision. In some circumstances, interim permanent impairment compensation will be considered.

3.39 Once the injury or disease is determined as permanent and stable, the delegate will determine the member's impairment points using an assessment guide (the *Guide to determining impairment and compensation*, known as GARP M). The weekly permanent impairment compensation is then determined. An advice letter will outline the member's reconsideration and review options if they are unhappy with the delegate's decision.

3.40 DVA provides a copy of the delegate's determination to the member's Service Chief if he or she is still serving. This documentation is retained by Joint Health Command and placed on the member's unit medical record.

3.41 Before payment commences, the member will be provided with a choice between accepting the permanent impairment compensation payment or pursuing damages for non-economic loss under a common law action against the Commonwealth or another party. The choice to pursue common law action means that no future permanent impairment compensation is available under the MRCA for that condition. If the member chooses the permanent impairment compensation payment, he or she may also elect within six months to convert part or all (depending on the level of impairment suffered) of the weekly payment to an age-based lump sum.

Other benefits

3.42 If the impairment suffered by the member is assessed at 60 or more impairment points and they are no longer serving, they will be issued a Repatriation Health Card —

For All Conditions (Gold Card), which provides access to medical treatment for all conditions.

3.43 If the member is eligible for the maximum permanent impairment compensation payment, they will also be eligible for an additional lump sum for each of his or her dependent children.

3.44 Once a member is discharged, he or she may become eligible for the Special Rate Disability Pension (SRDP) when designated criteria around incapacity for work, permanent impairment and unsuitability for vocational rehabilitation are met. If a former member is determined to be eligible for the SRDP, he or she will be given a choice between incapacity payments and the SRDP. The SRDP is a safety net payment, and it will be financially advantageous for the former member to remain on his or her incapacity payments. However, once eligible for the SRDP, a member will receive a Gold Card and his or her dependent children will receive education assistance.

Claims lodged after separation from the Australian Defence Force

3.45 The most common variation in the process outlined above occurs where a claim for liability is lodged by a former member after he or she has separated from the ADF. This may occur for a number of reasons.

3.46 One major reason is that a disease may manifest itself years after a former member has separated from the ADF. For example, exposure to asbestos in the Royal Australian Navy in the 1970s may not result in a diagnosis of asbestosis until many years later.

3.47 Additionally, the Committee was informed by current ADF members at consultations held on Defence bases that ADF members are often reluctant to reveal the existence of a health condition while serving, due to concern that such a disclosure would affect their deployability or capacity to undertake certain duties.

3.48 Where a claim is lodged after separation from the ADF, DVA will carry sole responsibility for the administration of rehabilitation and compensation provided to the former member.

3.49 Establishing liability becomes more difficult with the passage of time between the service related to the condition and the lodgement of the claim. Evidence to support the claim can become more problematic.

Benefits under the Veterans' Entitlements Act

3.50 The compensation provisions of the SRCA (as it relates to defence service) and the VEA have been closed off for injuries, disease and deaths related to service rendered on or after 1 July 2004. However, service rendered on or after 1 July 2004 may attract eligibility for a number of non-compensation benefits under the VEA that have not been closed off.

3.51 In particular, members with qualifying service (warlike service), whether before or after 1 July 2004, continue to be eligible for the income support provisions of the VEA

such as the service pension. Members with qualifying service also remain eligible for a Gold Card at age 70.

3.52 Members who have rendered operational service, either before or after 1 July 2004, continue to be eligible for non-liability health care for certain mental health conditions, malignant neoplasia and tuberculosis.

3.53 Appendix D provides a comparison of benefits for different kinds of service.

Transitional cases

3.54 The process outlined above is for a new claim under the MRCA. However, many claimants in the early years of the MRCA have had service resulting in eligibility to claim compensation under previous veterans' and military compensation legislation. The Committee acknowledges that, where a claimant under the MRCA has been receiving compensation under the VEA or the SRCA for an injury or disease related solely to service rendered before 1 July 2004, the process outlined above can become significantly more complex.

Systemic issues

3.55 Failures in personnel or operational management during service can affect performance and member outcomes later in the system. For example, failure of occupational health and safety can lead to incidents that cause injuries, and failure to report an incident can affect liability determinations downstream.

3.56 Similarly, failure to refer a member for a rehabilitation assessment can lead to a delay in return to work; failure to return to work can reduce a member's sense of health and wellbeing, as well as increase compensation costs.

Claim trends

3.57 Claim trends affect both the administrative requirements for DVA and future program outlays. Annually, DVA receives around 5,000 to 7,000 claims for initial liability under the SRCA and the MRCA (Table 3.1)

3.58 The data in Table 3.1 shows a sharp increase in liability claims under the MRCA in 2004-05 and 2005-06, which has plateaued in recent years. There was a corresponding sharp decline in liability claims under the SRCA in 2005–06, after the enactment of the MRCA. Since 2007–08, liability claims under the SRCA have increased slightly and seem to have plateaued at around 3,500 claims per year.

3.59 The 'tail' of SRCA claims is expected to continue for some time due to the lag between service related to an injury, disease or death and the lodgement of a claim for compensation.

3.60 The number of MRCA clients receiving permanent impairment compensation appears to have plateaued at around 1,000 clients per year (Table 3.2). 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.

3.61 MRCA incapacity payments and clients have been increasing quickly (Table 3.3). 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.

3.62 Payments for medical and other services under the MRCA are growing quickly (Table 3.4). 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, except in 2009-10 where there was a significant increase. Again, it is difficult to know if the significant increase in the total number of payments in 2009–10 will continue.

3.63 There is a considerable workload in processing account payments from medical and rehabilitation providers and other accounts. In 2009–10, a total of 12,365 MRCA accounts were paid, a 41 per cent increase on the previous year, and 106,202 SRCA accounts were paid (75 per cent within the target of 28 days), a 13 per cent increase.

Table 3.1 Number of initial liability claims and clients under the Military Rehabilitation and Compensation Act and the Safety, Rehabilitation and Compensation Act

		2004–05	2005–06	2006–07	2007–08	2008–09	2009–10
MRCA	Claims	688	1,798	2,572	2,709	3,282	2,948
	Clients	640	1,519	2,142	2,311	2,862	2,522
SRCA	Claims	5,510	3,659	3,170	3,469	3,728	3,451
	Clients	3,696	2,413	2,099	2,154	2,202	1,845
Total	Claims	6,198	5,457	5,742	6,178	7,010	6,399
	Clients	4,336	3,932	4,241	4,465	5,064	4,367

MRCA = *Military Rehabilitation and Compensation Act 2004*; SRCA = *Safety, Rehabilitation and Compensation Act 1988*

Table 3.2 Number of permanent impairment payments and clients under the Military Rehabilitation and Compensation Act and the Safety, Rehabilitation and Compensation Act

		2004–05	2005–06	2006–07	2007–08	2008–09	2009–10
MRCA	Payments	0	146	906	1,481	1,338	1,651
	Clients	6	53	368	990	1,046	977
SRCA	Payments	5,475	3,827	3,571	3,326	2,886	2,874
	Clients	1,759	1,332	1,142	1,233	978	842
Total	Payments	5,493	3,973	4,477	4,807	4,224	4,525
	Clients	1,765	1,385	1,510	2,223	2,024	1,819

MRCA = *Military Rehabilitation and Compensation Act 2004*; SRCA = *Safety, Rehabilitation and Compensation Act 1988*

Table 3.3 Number of incapacity payments and clients under the Military Rehabilitation and Compensation Act and the Safety, Rehabilitation and Compensation Act

		2004–05	2005–06	2006–07	2007–08	2008–09	2009–10
MRCA	Payments	167	856	3,892	8,963	13,443	20,372
	Clients	42	256	405	731	925	1,247
SRCA	Payments	70,752	70,733	66,742	63,071	58,801	61,587
	Clients	3,455	3,241	2,982	2,749	2,602	2,629
Total	Payments	70,919	71,589	70,634	72,034	72, 244	81,959
	Clients	3,497	3,497	3,387	3,480	3,527	3,876

MRCA = *Military Rehabilitation and Compensation Act 2004*; SRCA = *Safety, Rehabilitation and Compensation Act 1988*

Table 3.4 Number of payments for medical and other services under the Military Rehabilitation and Compensation Act and the Safety, Rehabilitation and Compensation Act

		2004–05	2005–06	2006–07	2007–08	2008–09	2009–10
MRCA	Payments	No data	No data	4,284	5,273	8,782	12,365
SRCA	Payments	112,165	108,290	104,882	100,771	94,340	106,202
Total		112,165	108,290	109,166	106,044	103,122	118,567

MRCA = *Military Rehabilitation and Compensation Act 2004*; SRCA = *Safety, Rehabilitation and Compensation Act 1988*

Most frequently claimed conditions and acceptance rates

3.64 In 2009–10, 3,284 liability claims were determined, representing around 6,000 conditions. (A claim can be for multiple conditions related to different aspects or incidents of military service.) Table 3.5 shows the 15 Statements of Principles (SoPs) most frequently used in MRCA decision making during the year.

Table 3.5 The 15 Statements of Principles most frequently used to decide claims under the Military Rehabilitation and Compensation Act in 2009–10

Statement of Principle	No. accepted	No. rejected	Total	Acceptance rate (%)
Acute sprain and acute strain	768	145	913	84
Fracture	326	61	387	84
Sensorineural hearing loss	177	72	249	71
Osteoarthrosis	163	82	245	67
Lumbar spondylosis	172	73	245	70
Internal derangement of the knee	151	64	215	70
Tinnitus	179	29	208	86
Depressive disorders	101	98	199	51
Chondromalacia patellae	101	85	186	54
Rotator cuff syndrome	147	27	174	84
Intervertebral disc prolapse	130	40	170	76
Dislocation	142	27	169	84
Shin splints	133	13	146	91
Post-traumatic stress disorder	114	29	143	80
Physical injury due to munitions discharge, and cuts, stabs, abrasions and lacerations	96	23	119	81
Total	2,900	868	3,768	77%

Expenditure

3.65 Total expenditure under the MRCA is still less than half the total expenditure for defence-related claims under the SRCA (Table 3.6). This is because the MRCA covers service only from 1 July 2004, whereas the SRCA applies to all claims before that date. In addition, the average lag time from date of injury in the ADF to date of claim is 17 years (with a median of 12 years).

3.66 Incapacity payments are the most significant expenditure under the SRCA (41.3 per cent; Table 3.7) and MRCA (39.7 per cent; Table 3.8). Permanent impairment compensation is the other significant expenditure (21.5 per cent under the SRCA; Table 3.7 and 39.4 per cent under the MRCA; Table 3.8). Because incapacity payments are ongoing, whereas permanent impairment compensation is generally paid as a lump sum, MRCA incapacity payment expenditure is expected to increase proportionately as more claimants use the scheme.

3.67 Total SRCA incapacity expenditure has remained relatively consistent since 2004–05 (Figure 3.3), although the amount of death benefits expenditure increased in 2009–10. This is expected to continue into forward estimate years, with incapacity payments trending downwards slightly from 2010–11. Permanent impairment payments under the SRCA are expected to decrease over the forward estimates.

3.68 Total MRCA expenditure is expected to increase steadily in line with the claim trends presented earlier in this chapter (Figure 3.4). Total expenditure for the MRCA and SRCA is shown in Figures 3.5 and 3.6.

Table 3.6 Actual expenditure for the Military Rehabilitation and Compensation Act and the Safety, Rehabilitation and Compensation Act in 2009–10

Act	$('000)
SRCA total	145,952
MRCA total	72,236
Combined total	218,188

MRCA = *Military Rehabilitation and Compensation Act 2004*; SRCA = *Safety, Rehabilitation and Compensation Act 1988*

Table 3.7 Actual expenditure for the Safety, Rehabilitation and Compensation Act in 2009–10

Benefit	$('000)	%
Permanent impairment	31,438	21.5
Benefits for eligible dependants	9,358	6.4
Incapacity payments	60,360	41.3
Medical examinations	3,306	2.3
Death payments	2,063	1.4
Medical services	20,514	14.1
Rehabilitation service	6,975	4.8
Other	11,938	8.2
Total	145,952	100.0

Table 3.8 Actual expenditure for the Military Rehabilitation and Compensation Act in 2009–10

Benefit	$('000)	%
Permanent impairment	28,467	39.4
Benefits for eligible dependants	1,699	2.3
Incapacity payments	28,673	39.7
Medical examinations	2,787	3.9
Medical services	5,756	8.0
Rehabilitation service	3,550	4.9
Other	1,304	1.8
Total	72,236	100.0

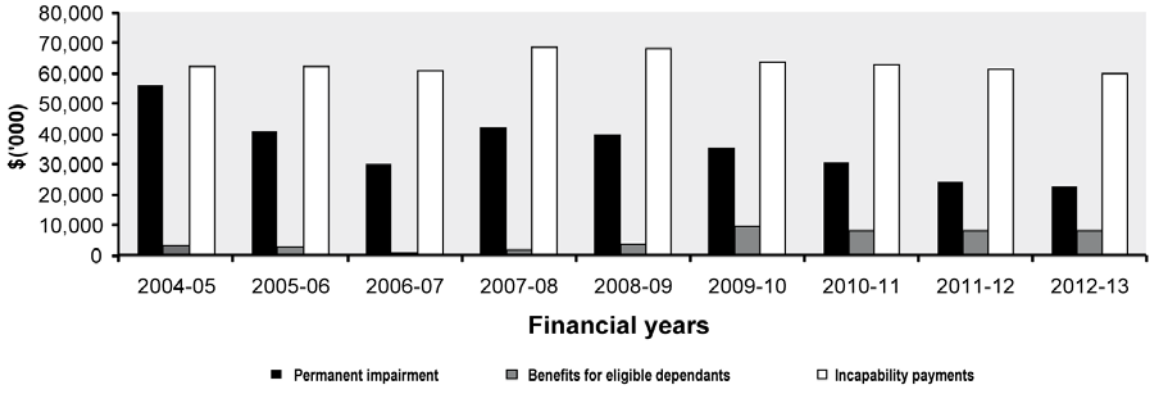

Figure 3.3 Safety, Rehabilitation and Compensation Act actual expenditure 2004–05 to 2009–10 and projected expenditure 2010–11 to 2012–13

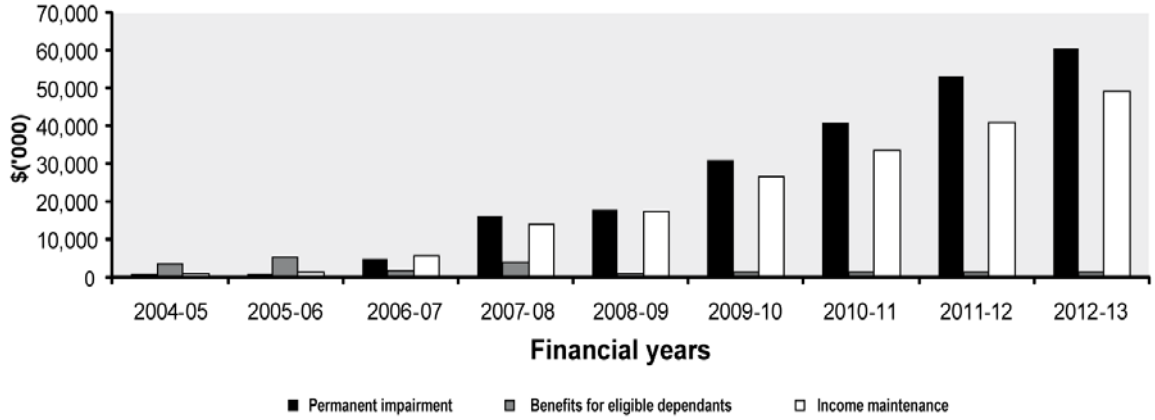

Figure 3.4 Military Rehabilitation and Compensation Act actual expenditure 2004–05 to 2009–10 and projected expenditure 2010–11 to 2012–13

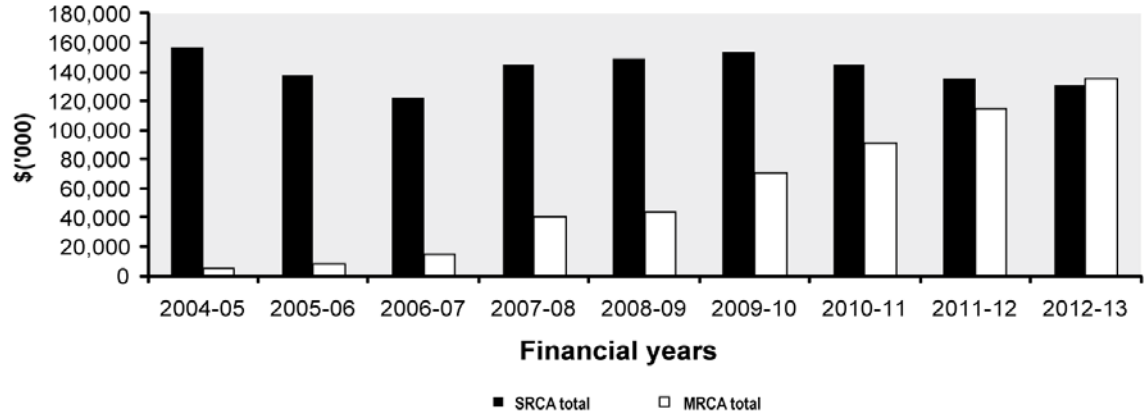

Figure 3.5 Total Safety, Rehabilitation and Compensation Act and Military Rehabilitation and Compensation Act actual expenditure 2004–05 to 2009–10 and projected expenditure 2010–11 to 2012–13

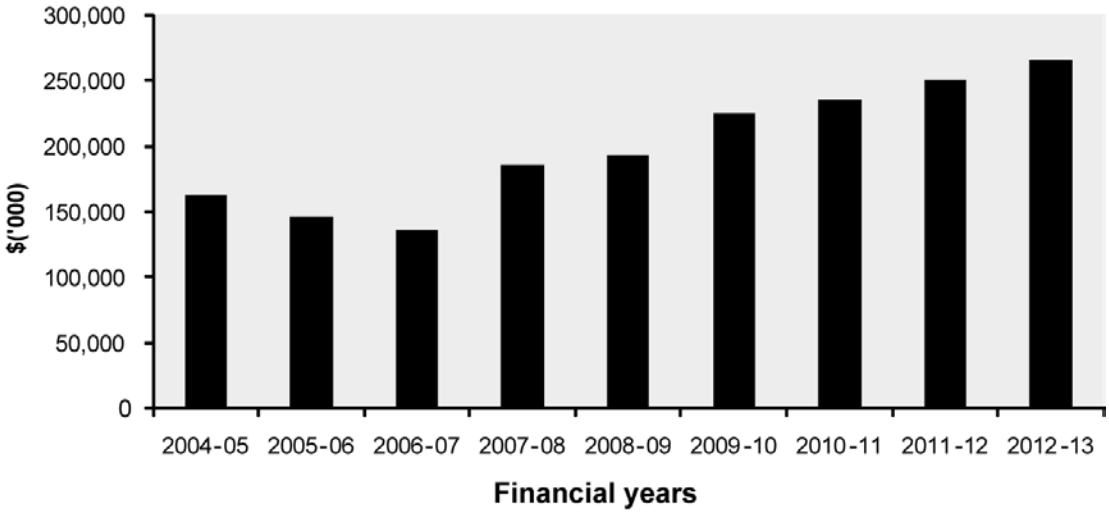

Figure 3.6 Combined Safety, Rehabilitation and Compensation Act and Military Rehabilitation and Compensation Act actual expenditure 2004–05 to 2009–10 and projected expenditure 2010–11 to 2012–13

Military Rehabilitation and Compensation Act and Safety, Rehabilitation and Compensation Act liability

3.69 The Australian Government Actuary produces estimates of the SRCA and MRCA liability for future years (Table 3.9). These figures become less assured as they estimate further into the future.

3.70 Liability in this context means the present value of all estimated future cash flows arising from claims attributed to service before the valuation date (in this case 30 June 2009). The estimates allow for the liability arising from claims attributable to service after the valuation date (e.g. the estimate for 2011 allows for the cost of claims attributable to 2009–10 and 2010–11 years). The value of the liability arising from a particular year is referred to as the notional premium for that year. The Australian Government Actuary has estimated the notional premium for 2009–10 to be $182 million.

Table 3.9 Safety, Rehabilitation and Compensation Act and Military Rehabilitation and Compensation Act liability estimates

	SRCA ($ billion)	MRCA ($ billion)	Total ($ billion)
2009	1.597	0.719	2.316
2010	1.546	0.881	2.427
2011	1.495	1.049	2.543
2012	1.445	1.222	2.667
2013	1.398	1.400	2.798
2014	1.353	1.586	2.939
2015	1.311	1.780	3.091
2016	1.270	1.984	3.254
2017	1.231	2.197	3.428
2018	1.193	2.421	3.614
2019	1.156	2.657	3.813

MRCA = *Military Rehabilitation and Compensation Act 2004*; SRCA = *Safety, Rehabilitation and Compensation Act 1988*

3.71 The SRCA liability is expected to reduce by about 28 per cent over the next decade (Table 3.9). Over the same period, the MRCA liability will more than treble and reach about two-and-a-half times the SRCA liability. It is estimated the MRCA liability will exceed the SRCA liability by 2013.

3.72 The liability figure is a notional estimate of future cash flows based on empirical data to date. The MRCA and SRCA schemes are funded on an emerging cost basis from the Consolidated Revenue Fund. The liability indicates the cash required in years well into the future and the liability figure for any one year does not require cash funding in that year. As the MRCA scheme is only six years old, the data on which the liability estimates are based reflect the early experience of the scheme. As the scheme matures, the claims and expenditure data on which the liability estimates are based will improve, providing a more reliable estimate. Annual changes in the liability estimates, as reported in the Portfolio Budget Statements for DVA, are likely to reduce as more claims experience data available each year builds better liability estimates.

3.73 It is worth noting that DVA's total departmental and administered annual budget for the VEA, SRCA and MRCA is approximately $12 billion per year. Defence's total annual budget is approximately $26 billion per year, including health costs.

Conclusions

3.74 The first part of this chapter introduced the military compensation scheme as a system, beginning with Defence and finishing with DVA, with significant overlap between the two departments at various points in the continuum. Failures at early parts in the system can affect performance at later parts in the system.

3.75 This chapter recognised that claims are often lodged under the military compensation scheme many years after discharge from the ADF, and that this can have an impact on the efficacy of the system, as evidence required to support a claim diminishes over time.

3.76 The second part of the chapter provided some data and commentary on payment and client trends, historic and projected expenditure, and liability estimates. Although these data are limited, they show a steady upward trend in both claims and expenditure under the MRCA over time. SRCA claims are not declining as steadily as might have been expected after 1 July 2004, while claims under the MRCA continue to grow.