Veterans' Legislation Reform

Simplify and Harmonise

[redacted] 1 April 2023

The words simplify and harmonise appear dozens of time in the Royal Commissions interim report into veteran suicide, the Collins dictionary defines;

Harmonise as, to be in harmony; accord; agree**,** and

Simplify as, to make less complicated, clearer, or easier.

The question I have is, will the simplification and harmonisation result in a legislation which continues to remain fully beneficial, and will it continue to put veterans and veterans families first? or will "simplify and harmonise" be little more than a camouflage net under which changes will be made only to make decision making easier and less accountable, by depriving Veterans of a right to natural justice and impinging on the individuals entitlement to accrued right?

I am not legally qualified, so I will not go into any lengthy argument or explanation as to what I believe to be an accrued right, but I will be taking close notice to any change in legislation that leaves any veteran financially or procedurally worse off, and I include any potential widowed partner or children!

Harmonise

Harmonisation in relation to legislative change is a nice fluffy and convenient word, but it conflicts with the accrued right of those that have served during a particular period, or periods of service, and the reality is that accrued right will demand harmonisation can only occur in instances where a person will never be worse off.

By way of an example consider household services, MRCA can provide up to $532.11 per week, DRCA $512.17 (why the difference?), and VEA provides up to 15 hours per year of home and garden maintenance services. Likewise there are also significant differences in funeral allowances, and illogical differences in travel allowance to medical appointments.

If harmonisation is going to truly be reflected in the new or altered legislation then the "grass is greener" consideration must be reduced to the point whereby, to as practically possible all veterans receive the greater or better entitlement and/or benefit. For example the funeral and HHS allowance of MRCA must also be available to DRCA and VEA recipients, and the VEA/MRCA Gold Card must cross to those with DRCA entitlement.

Additionally there are non-monetary consideration where a legislative process is beneficial, the prime example being SRCA(D) s14.

SAFETY, REHABILITATION AND COMPENSATION **(DEFENCE-RELATED CLAIMS)** ACT 1988 - SECT 14

Compensation for injuries

(1) Subject to this Part, the Commonwealth is liable to pay compensation in accordance with this Act in respect of an injury suffered by an employee if the injury results in death, incapacity for work, or impairment.

(2) Compensation is not payable in respect of an injury that is intentionally self-inflicted.

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

Compare this with MRCA or VEA and the SRCA(D) provides considerably greater latitude to the Veteran. Logic would suggest that if true harmonisation were to place where Veterans were not disadvantaged the DRCA legislation is the section which must find its way into the new legislation or amended MRCA. And if its good enough for Veterans moving forward to find SRCA(D) s14, then surely VEA s70 must follow.

The VEA s137 process requires the Secretary DVA to provide the Veteran Applicant with the "relevant evidence", whereas AAT s37 (the process DVA are considering introducing into VEA s137) requires the Decision Making Commission to provide the AAT with the "relevant documents", before the AAT passes them to the Applicant. Despite being recently provided an opportunity to obtain a statutory interpretation in the Federal Court, at this time there is no statutory definition for "evidence", and bearing in mind decision makers can refer to "evidence or other material", "evidence" must mean something other than all documents.

However, perhaps if a mathematical equation were applied it would look something like this… **evidence = all documents – other material**. But again, and reinforcing the point, at the date this was written there is not statutory definition on "evidence", so why even consider change?

Under the MRCA the legislation allows for a claim to be investigated and decided by the same person, this was cut from the SRCA where it may have worked because there was no lay interim merit review process such as the VRB and SRCA matter would be expected to decided very quickly because claimants may need an income and hospitalisation or expensive treatment (neither of these are issues for serving members of the ADF. Whereas VEA s17 provides for a delegate of the Secretary to investigate, and VEA s19 allows for a delegate of the Commission to decide the claim or application.

Notwithstanding the VEA process eliminates any possible or potential issues surrounding actual or perceived bias it also simplifies, there is considerable sensibility, and even monetary savings if the VEA process is carried into the new or altered legislation, these include;

1. A person need only be trained to be an investigator or as decision maker, they do not need to be trained to do both. If for example it takes 6 weeks to train a person to investigate a claim and 4 weeks to make a determination the Department loses 10 weeks of training when a person leave the Department, whereas training I person to investigate and a second to decide you only lose 6 or 4 weeks respectively,

2. A person will become a specialist in investigating or deciding, if they are not burdened with a secondary role they will become more proficient as either an investigator or decision maker,
3. It may be that investigators can be trained to specialise in particular injuries or diseases, one delegate might specialise in dental, another in spinal and another in brain injuries, reasonable it can be expected they would learn from previous matters they have investigated and it might result in them having such proficient that they do not need to go to medical advisors. The documents and evidence that are passed on to the Commission (VEA s17(3)) would become increasingly refined in relevance and quality.
4. Likewise it may be that some decision makers develop a greater understanding or proficiency in deciding particular diseases or injuries,
5. There is nothing in the legislation that would appear to prevent medically qualified people from conducting, or being part of a team that investigates,
6. Noting VEA s17(1) states, "**The Secretary shall cause an investigation to be made…**", this would suggest that it would not be unlawful for a team approach in relation to the s17 investigation,
7. Officers entrusted with making determinations can be paid a lesser amount than investigators, which would result in savings, and
8. Proficient decision makers are likely to be the future source of investigators.

If the legislation it to be truly harmonised the better entitlement under any of the 3 existing acts must be provided to those with entitlement under the other 2 acts, even in instances where a Veteran has single Act entitlement.

Simplify

Simplification must also consider accrued right, if simplification removes or lessens even the smallest of entitlement, then it must be contra to the accrued right privilege.

The purest way to simplify the Act is to excise or remove elements that contribute to complexity, or are, or maybe unnecessary. To that end I would suggest legislation surrounding the Veterans Review Board (including SMRC) and the Statement of Principles could be easily excised, and it needs remembering **the SRCA (and later SRCA(D)) functions perfectly well without either since 1988**.

The Veterans Review Board

The Tribunals Amalgamation Act 2015 merged many review functions such as the Social Security Appeals Tribunal and the Migration Review Tribunal and Refugee Review Tribunal into the Administrative Appeals Tribunal, there is no reason why the VRB cannot also be amalgamated into the AAT Act, or the replacement to the AAT Act in the exact same manner.

It is noteworthy that about a seven years ago the VEA was amended, and a number of functions such as alternative disputes resolution were cut and paste from the AAT Act into

the role of the VRB. There is now almost full and complete duplication, and duplication would seem to be a waste of resources.

Not including the obvious costs issues surrounding duplication, there are a number of distinct and clear advantages with merging the functions of the VRB into the AAT, including:

1. Time saved, the time used by the applicant to seek a review by the Board and for the Board to review a decision of the commission is saved if the Board is done away with;
2. Decisions of the Commissions will be exposed directly to the AAT person giving expert and opinion guidelines, this means the Commission will now need obtain evidence that meet the requirement of the guidelines when making adverse determinations. Advice from medical advisors does not meet the requirements of the AAT guidelines;
   (It should be noted there would be no impingement on approving a claim on the basis of information provided by an advisor in instances where a claim or application is approved, because the Veteran would not be adversely effected, a requirement to take a matter to the AAT)
3. Eliminate the propensity of the members of the VRB (especially the Military member) to inadvertently or otherwise act as witness/hearsay witness. The military member had a function pre internet and social media, and when they were part of the primary decision making process under the Repatriation Act. But with modern communication a Veteran Applicant is more than likely going to be able to find a witness to support his claim, and if they can't the beneficial nature of VEA s119(1)(h)(i) & (ii) applies;
4. The VRB consist of 3 members, AAT decisions are made by 1 person, and that person generally has a very high level of practical and functional legal knowledge;
5. The AAT can issue practice directions in relation to the composition of relevant documents under AATs37 because the Commission is a party to the review, the VRB cannot issue practice directions in relation to how evidence is prepared for VEA s137(1)(a) because the Secretary is not a party to the review;
6. The AAT Act requires the President of the AAT to be a Federal Court Judge, there is no statute requirement for Principle Member of the VRB to even have a law degree, which may account for the VRB having issuing illegal practice directions in the past; and
7. Subject to conditions, the AAT Act allows for questions of law to be put to a Court, the same provision does not exist under the VEA.

My perception is the Department/Commissions view the VRB as a convenient procedural safeguard, how else have 70% of matters going before the VRB being found in favour of the VRB been rationalised as acceptable? The VRB allows poor, lazy or wrong decisions to be made in the first instant and in the full knowledge that if the veteran seeks review VRB will correct them without any repercussions, and if review is not sought the Commonwealth benefits as it saves money.

Without the VRB the same decision will be exposed to high quality legal minds and refined processes of the AAT, who are accountable to an external entity, the Attorney General's office. And it is unlikely the AAT and Attorney General will put up with 70% of the 3,000 matters that are currently being found in favour of the applicant that go for review at the VRB, being corrected in a similar manner at the AAT.

The Department/Commission (Clients Benefit Division) knowns a refusal by the primary decision maker under the "reverse criminal standard" effectively shifts the onus of proof from one whereby the Commission is obliged to prove the injury or disease is not related to service, to one where the Applicant has to prove the primary decision is wrong or unjust.

What seems to have been forgotten is the Board was originally introduced as a very simple and rudimentary review instrument, not a full blown replica of the AAT complete with outreach and ADR. In fact the original intent at one point in time is all refused claims were going to be mandatorily put to the VRB, and it is possible that the original 137(1)(a) process was probably intended to function or substitute for the hearing rule process which is not applied under VEA or MRCA.

Although it is recognised and commendable that the Board objectives are to be fair, just, economical, informal and quick (VEA s133A), this is a simple and exact cut and paste of AAT s2A, and it beggars belief that a process which is duplicated can be either "economical or quick". There is no function of the AAT that is not duplicated by the VRB, and the AAT provides an advantage that allows the Applicant to be represented by a lawyer should they so wish. The Veteran Applicant is deprived of legal representation at the Board by virtue of VEA s147(2)(a).

Statement of Principles

My broad concerns relating to the SoP process are detailed in my submission to the Royal Commission, The Unfairness of the Statement of Principles (see attached).

Again it needs remembering that the VEA operated perfectly well without the SoP's for the better part of a decade before change was deemed necessary on the basis of the single Federal Court Bushell judgement. Overnight the political will changed the VEA to one where existing beneficial VEA processes was unfairly weighted against the favour of the Veteran Applicant/Claimant.

What seems to have been conveniently overlooked is from the introduction of the War Pensions Act 1914 (Cth) through to the consequences of Bushell the Veterans Act was designed to be beneficial to that Veteran that volunteered to put their life before country.

It defies logic and common sense that you can have a fair process under a beneficial Act, a stroke of a pen in 1994 and the Australian Parliament erased a large element of the beneficial Act, and the so called benefit went from the veteran to the people.

Without being overly repetitive you will need to read my submission to the Royal Commission in full to understand my argument for no SoP's, but it's worth simply considering the following quotes.

> THE RMA DECIDES THE FACTORS FOR INCLUSION IN THE REASONABLE HYPOTHESIS SOP. WE THEN HAVE TO SET A DOSE FOR EACH FACTOR. **THIS IS WHERE WE HAVE ENORMOUS TROUBLE BECAUSE MOST OF THE EPIDEMIOLOGICAL LITERATURE WAS NEVER ASSEMBLED AND WRITTEN FOR THE PURPOSE REPATRIATION MEDICAL AUTHORITY & DEPARTMENT OF VETERANS' AFFAIRS THAT WE ARE NOW USING IT.** IT WAS WRITTEN FOR ALL SORTS OF PURPOSES: PUBLIC HEALTH, ADVANCEMENT OF PEOPLE'S CAREERS; ALL SORTS OF REASONS. **BUT IT WAS NOT WRITTEN SPECIFICALLY TO BE USED FOR THIS SORT OF SOCIAL PURPOSE.**"
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> Professor Ken Donald
> (Inaugural) Chairman of the Repatriation Medical Authority
> DVA & ESO forum held in response to recommendations of the Pearce Report
> 9 November, 1998

> "I HAVE HAD TO CONSIDER WHETHER THE SOP SYSTEM IS MORE EQUITABLE, ETC, THAN THE PREVIOUS SYSTEM, **NOT WHETHER OVERALL IT IS AN EQUITABLE, ETC, SYSTEM."**
>
> Dennis Pearce
> Emeritus Professor Australian National University
> Review of the Repatriation Medical Authority and the Specialist Medical Review Council
> 20 October 1997

> THE RULES EXPRESSLY PROVIDED THAT THE JUDGE WOULD MAKE THE THRESHOLD DETERMINATION REGARDING WHETHER CERTAIN SCIENTIFIC KNOWLEDGE WOULD INDEED ASSIST THE TRIER OF FACT IN THE MANNER CONTEMPLATED BY RULE 702. "**THIS ENTAILS A PRELIMINARY ASSESSMENT OF WHETHER THE REASONING OR METHODOLOGY UNDERLYING THE TESTIMONY IS SCIENTIFICALLY VALID AND OF WHETHER THAT REASONING OR METHODOLOGY PROPERLY CAN BE APPLIED TO THE FACTS IN ISSUE**."
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> Daubert v. Merrell Dow Pharmaceuticals, Inc. (1993)

> 3.7.1 **WE NOTE THAT THE REPATRIATION COMMISSION HAS DEVELOPED A SERIES OF STATEMENTS OF PRINCIPLE DESIGNED TO SET OUT MEDICAL MATTERS SUCH AS AETIOLOGY AND HYPOTHESES (VEA S138(2)(A)).** THESE ARE USED TO GUIDE DECISION MAKERS AND AIM TO IMPROVE CONSISTENCY IN APPLYING THE STANDARD OF PROOF.
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> 3.7.2 AS IT STANDS, THESE STATEMENTS HAVE NO LEGISLATIVE AUTHORITY AND ARE NOT BINDING ON DECISION MAKERS, INCLUDING APPEAL BODIES. CONSEQUENTLY EACH TIME A CLAIM IS LODGED, VEXED

MEDICAL QUESTIONS ARE DECIDED IN AN INAPPROPRIATE FORUM, OFTEN RESULTING IN INCONSISTENT DECISIONS. THERE IS NEITHER CERTAINTY NOT FAIRNESS IN SUCH A PROCESS.

3.7 Statements of Principle **A FAIR GO,** the Report on compensation for veterans and war widows **(The Baume Report)**

"WE SAY THAT THE CARE OF THE RETURNED SOLDIER IS ONE OF THE FUNCTIONS OF THE COMMONWEALTH GOVERNMENT. OUR SOLDIERS FIGHT NOT FOR QUEENSLAND, NEW SOUTH WALES, OR TASMANIA, BUT FOR AUSTRALIA. THEY ARE ENLISTED UNDER THE COMMONWEALTH BANNER. THEY GO OUT TO FIGHT OUR BATTLES. WE SAY TO THEM: 'WHEN YOU COME BACK WE WILL LOOK AFTER YOU' … THE SOLDIERS WILL SAY TO THE COMMONWEALTH GOVERNMENT: 'YOU MADE US A PROMISE. WE LOOK TO YOU TO CARRY IT OUT."
Prime Minister, the Right Honourable William Morris (Billy) Hughes KC, MP (Lloyd and Rees, p 69).

It is also worth recognising DVA own observations a few years after the SoP's were implemented from the 1997 Review of the Repatriation Medical Authority and the Specialist Medical Review Council, "**DVA estimates that, taking into account all levels of decision-making, the acceptance rate post-1994 is very little different from that under the previous regime**".

Food for thought

Traumatic Brain Injury: An Overview of Epidemiology, Pathophysiology, and Medical Management by Allison Capizzi, Jean Woo and Monica Verduzco-Gutierrez **2020**. This PubMed paper has been cited 339 times, at the time this submission was made not one of the documents that site this paper have been considered by the RMA in creating the SoP. However every one of the papers meet the VEA definition of Sound Medical Scientific Evidence and can be used by the RMA to create or amend SoP and Factors without the permission of the author.

Conversely an entitled person can request a SoP be investigated, they can have the permission of the Author and the RMA can refuse to amend, and there is no merit review path.

Even with the permission of the papers authors, no matter how valuable it would be in supporting a Veterans views he or she is unable to present Traumatic Brain Injury: An Overview of Epidemiology, Pathophysiology, and Medical Management as evidence in advancing their claim for a brain injury at the Commission, Board AAT or Federal Court.

Given the above, the real question should be asked as to whether all the SoP's have done is introduce, or infected an unnecessary level of arguably grubby, time consuming and unlawful level of officialdom, which has done little, if anything to change the outcome of the decision and decision review that existed prior to 1994 other than removing a Veterans access to the Court in relation to the aetiology of a disease or injury.

The situation as in now stands demands the Decision maker ensures a Veteran Applicant does not meet any, in some case many dozens of factors to refuse a claim, a very costly process that under the beneficial nature requires information which conforms engaging an independent medical expert to provide opinion evidence which conforms to the AAT person giving expert and opinion evidence guidelines.

To demonstrate the absurdity of the SoP, the osteoarthritis SoP requires a person to have lifted 150,000 kg in increments of greater that 20 kg in less than 10 years. If they lift 149,999 kg the claim must be refused, if they lift 150,000 kg in 10 years and 1 day, the claim must be refused, and if 1 of the lifts were 19.999 kg the claim must be refused. Further no consideration is given to the height of the lift including overhead where a clean and jerk motion is used. And to top this off it was only a few years ago that the Reasonable Hypothesis SoP had a 25 kg minimum increment, and the Balance of Probability SoP had a 35 kg increment.

A far better alternative to excising the SoP process would to use it as a guide to the aetiology of a disease or injury as the Department does in DRCA matters, this is a process the "Repatriation Commission had developed to set out medical matters such as the aetiology and hypothesis" prior to the legislated SoP, and simple change of wording in the SoP along the lines of substituting "must" with "may" should be sufficient (Bruxism example below). This would oblige a decision maker to approve where a factor is met, but at the same time give latitude for a decision maker to approve a claim where a weight may be just shy of a factor, or where the Applicant has provided new or compelling evidence.

> At least one of the following factors ~~**must**~~ may as a minimum exist before it can be said that a reasonable hypothesis has been raised connecting bruxism or death from **bruxism** with the circumstances of a person's relevant service:

My own view is that primary or Commission determinations would in most cases be made on the guide document factors, much as they currently are with the legislated SoP, but the alteration in the wording would allow the Veteran to present new or compelling evidence to the Commission or merit review, and/or the Federal Court and High Court in the same manner as Bushell. If the Applicant were successful at Commission or the AAT, but especially the Federal Court then it would be reasonable to expect appropriate change could be made to the guide SoP.

As a side note it is worth recognising the issue on hand in Bushell. On 4 April 2022 the hypertension SoP and via 9(12) the "having a clinically significant disorder of mental health as specified at the time of the clinical onset of hypertension" and anxiety was listed in the SoP dictionary as a "clinically significant disorder of mental health".

In simple terms Mr Baume's "maverick" Dr Miller was proven to be correct, and all the "many other eminent and mainstream practitioners" that the Repatriation Commission presented to the High Court as witness which disagreed with Bushell, were wrong.

How many hypertension claims have been refused which would now be accepted, is unknown. However what is known is DVA have no process to identify that that would now have entitlements, and I have not identified any notification via social media or in the DVA

newspaper advising the Veteran community of the correction to the SoP, which is what in effect a change in the SoP is.

The second change that I would recommend would be to change "Sound Medical Scientific evidence" to "evidence", this would effectively make the SMRC redundant because it would open appeal pathways to both merit review and ADJR.

Other Considerations

Advancement of allowances for such entitlements as travel and HHS. It is only legislation which prevents the Department from paying allowances in advance. I would suggest altering the existing legislation to provide for advance payments, such as it does with electricity allowance.

An example might be that all veterans can opt into a paid in advance annual travel allowance, for example $500, if they do opt in they are paid $500 at the start of the calendar or financial year. If they go over the km rate for $500 it gets reconciled in bulk at the end of the year. If a Veteran doesn't get to $500 they effectively come out ahead, but the department wins as it doesn't have to administer dozens or hundreds of travel claims.

It maybe that this only applies once a Veteran meets a certain threshold, say Gold Card, or over 50% of the VEA general rate, or has a certain accepted conditions, or a specified number of accepted conditions.

In relation to HHS, where the veteran pays the HHS provider, it would be far simpler for a Veteran to be advanced 6 months of HHS, this would need to be reconciled before the next 6 months is advanced. The saving to the department comes by way of less administrative costs.

An extension provision be introduced in relation to appealing a decision to the Board under VEA s135(4). From my observation extension provisions seem to exist at almost every facet of administrative law, certainly it exists under ADJR and FOI, and perhaps most noticeably the AAT s29 (8) The time for making an application to the Tribunal for a review of a decision may be extended under subsection (7) although that time has expired.

As it stands this provision applies to DRCA, it seems only reasonable this carry through to how Veterans that have DRCA entitlement at the least are not disadvantaged in how they are dealt with in the future, and if harmonisation is going to be more than a word surely, given the putting veterans and veterans families first legislation, and "beneficial nature" ridding VEA and MRCA recipients, especially those with mental health and traumatic brain injuries of what appears to be an overly harsh demand seems not unreasonable.

VEA pays a pension from 3 months prior to the date of application, and presumably also reimburses for treatment for the same time frame, MRCA and DRCA does not. For many reasons Veterans will not make claims while serving. I believe a backdated window for reimbursement of medical treatment should be introduced in the new or amended Act.

Greater emphasis in the new or amended Act that there is no obligation on the Veteran to provided evidence when they make a claim or application to the point it becomes a requirement for DVA to make this clear on the application form. Many Veterans see it as a requirement to provide all the evidence necessary to support claims and applications, this causes great delays between when the Veteran becomes aware they have a disease or injury and when they make the claim. Greater emphasis could also be made on the point that there is nothing preventing a Veteran from providing evidence or additional evidence as it comes to hand.

As it stands the legislation advice as to how to seek review at the VRB and AAT, the same section of the Act should include a reference to ADJR.

Finally I note the Royal Commissions views in relation to the involvement of the Australian Law Reform Commission (ALRC), in that it, "would very likely delay legislative reform more than is warranted", I respectfully disagree While ALRC involvement may delay, the delay is warranted, the paramount consideration in relation to new or modified legislation must be that it provides natural justice, and in this regard the ALRC is the appropriate authority must be given the final say.

> A PERSON IS ENTITLED TO HAVE A FIRST INSTANCE BODY EXERCISE ITS JURISDICTION **LAWFULLY AND FAIRLY**, AND THE COURTS SHOULD NOT IGNORE INFRACTIONS. IF NOT CORRECTED, INJUSTICES MAY PERSIST AND RECUR IN THE CASE OF THOSE WHO SIMPLY ACCEPT THEM. THERE ARE THOSE WHO, FOR WANT OF FUNDS, COURAGE OR PATIENCE, WILL NOT CONTEST UNFAIR DECISIONS WHETHER BY APPEAL OR JUDICIAL REVIEW.
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> Macksville & District Hospital v Maze (1987)

In order for any new or amended legislation to be lawful and fair there will be an expectation from every Veterans that it has been constructed and scrutinised by an appropriately qualified and credentialed authority, and there would be few if any Veterans that would agree those that got us into the mess whereby we need a new or amended legislation have the appropriate skillsets.

As it stands decision makers do not apply hearing rule under any act and there is potential bias within the existing DRCA and MRCA, which is compounded by the prohibition on legal representation at the VRB, and it would be interesting at the least to have the views of the ALRC on the overall fairness of the SoP process before Veterans are subject to it under the new, or amended legislation.

At the very least I feel the ALRC, like every Veteran should have visibility on what is being proposed before it is enacted, even if it is distributed down to the lowest level of membership via the ESO system, and more broadly on social media. Any failure to do so will only demonstrate those entrusted with simplifying and harmonising are fearful full public disclose will unearth failings.