

Compensation in the Australian Defence Force

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Introduction

This article follows previous papers by the author, regarding occupational and environmental medicine in the Australian Defence Force (ADF).¹ They assert that high rates of workplace illness and injury indicate the need to improve the management of hazards associated with ADF workplaces, with better emphasis on prevention. They also advocated that the ADF's health services should be premised on an occupational and environmental health paradigm, which would require reassessing the fundamental inputs to capability for both Joint Health Command (JHC), and Defence's Work Health and Safety branch.

The papers argue that such a reassessment could lead to a holistic and sustainable workforce-based health service delivery model by 2030. This timeframe is based on the current state of the ADF's occupational and environmental health services, and the small number of civilian specialist practitioners within the Australasian Faculty of Occupational and Environmental Medicine. These considerations suggest that a mature health delivery model would take 10–15 years' sustained effort with respect to occupational and environmental physicians alone.

This article expands on these papers, with respect to facilitating the compensation of ADF personnel for their Service-related illness and injuries.

Civilian worker's compensation

Civilian worker's compensation claims in Australia are subject to multiple federal, state and territory jurisdictions. Collating their data is not straightforward; for example, Safe Work Australia states that during 2012–13, Australia had 10.599 million employees,² while the Australian Bureau of Statistics' Work-related Injuries Survey infers there were 12.367 million employees.³

The Work-related Injuries Survey indicated that during this time, an estimated 531 800 workers (4.3%) experienced a work-related incident. 348 600 of these workers did not receive compensation, either

because no application was made, or the application was rejected.⁴ Of the remaining 183 200 workers, Safe Work Australia showed that 117 815 were for serious worker's compensation claims (requiring a work absence of one working week or more), or approximately 11 claims per 1000 employees.⁵

The median time off work was 5.2 working weeks for male and 6 working weeks for female employees. The agriculture, forestry and fishing industry had the highest civilian serious claim incidence rate (21 per 1000 employees), followed by the transport, postal & warehousing industry (19.1 per 1000 employees).

Employees working as labourers had the highest serious claim incidence rate of all civilian occupations (27 per 1000 employees), followed by machinery operators and drivers (24.4 per 1000 employees).

The most common causes of serious claims were manual handling accidents (33%), followed by slips, trips and falls (22%). The most commonly injured part of the body was the back (22%), while other common locations were hands, fingers and thumbs (13%), shoulders (10%) and knees (9%).

Despite comprising 52% of the total civilian workforce, 63% of serious workers' compensation claims were by male employees. Musculoskeletal injuries made up 90% of these claims, while another 6% were for mental health disorders.

Although there is no equivalent 'serious claim incidence rate' for Defence members, the nature of the ADF workforce and its workplaces, as previously described by the author,⁶ suggests that it would be comparable to – and in fact, almost certainly significantly exceed – the maximal civilian industrial and occupational rates.

Safe Work Australia indicates that the median cost⁷ of these civilian claims in 2011–12⁸ was \$8 900.⁹ The Work-related Injuries Survey showed that the total economic cost was estimated to be \$61.8 billion (4.1% of GDP),¹⁰ or \$5 000 to \$5 800 per Australian civilian employee.

ADF compensation legislation

The ADF is not responsible for determining compensation entitlements for either current or ex-Service personnel; this is a Department of Veterans' Affairs (DVA) responsibility. Determining eligibility is complex, as it may depend on up to three separate pieces of legislation.

Veteran's Entitlements Act (VEA).¹¹ The VEA covers wartime Service and certain operational deployments, as well as certain peacetime Service between 7 December 1972 and 30 June 2004. For peacetime Service eligibility, a Defence member who had not completed a qualifying period of three years' Service prior to 7 April 1994 is not covered, unless they were medically discharged.¹² Eligible personnel may receive:

- a disability pension, if a disability is accepted as having been caused or aggravated during an eligible period of Service
- a service pension at age 60 if they have Qualifying Service, whereby they were allotted to, and have served in, an operational area or warlike service area
- a White Repatriation Health Card for one or more medical conditions deemed to be Service-related, or a Gold Repatriation Health Card that provides treatment for all medical conditions, including those that are not Service-related.

Safety, Rehabilitation and Compensation (Defence-Related Claims) Act 1988 (SRCA).¹³ The SRCA provides rehabilitation as well as compensation coverage, for injuries and diseases suffered as a result of peacetime and peacekeeping Service up to, and including, 30 June 2004, and operational Service between 7 April 1994 and 30 June 2004. These personnel may be eligible for:

- a lump sum compensation benefit, if they are permanently impaired
- weekly compensation benefits, if they are unable to work because of an accepted injury, disease or illness
- DVA payment of all medical, hospital, pharmaceutical and other treatment costs that they may reasonably require due to their compensable injury, disease or illness
- some additional rehabilitation services in specific circumstances where they have an accepted claim for a Service-related injury. These entitlements are limited to the provision of household services, aids and modifications and attendant care. The

household services may include house cleaning, laundry, ironing, gardening and lawn mowing. The attendant care services may be provided for the essential and regular personal care of the injured member

- help with the cost of vocational retraining to help Reserve and ex-Service members return to the work force, or with other forms of rehabilitation to help them cope with the effects of their injury, disease or illness.

Military Rehabilitation and Compensation Act 2004 (MRCA).¹⁴ The MRCA provides rehabilitation as well as compensation coverage for all Permanent, Reserve and other entitled personnel, who served on or after 1 July 2004.¹⁵ MRCA benefits may include:

- vocational and other rehabilitation services
- choice of periodic payments or lump sum compensation or a combination of both for permanent impairment (non-economic loss)
- incapacity benefits, which are periodic payments of compensation for economic loss due to incapacity for Service or work
- choice of a Special Rate Disability Pension (SRDP) 'safety net' payment for life or incapacity payments up to age 65 (conditions apply)
- vehicle modifications or assistance with the cost of a vehicle under the Motor Vehicle Scheme
- compensation for household services
- compensation for attendant (personal) care services
- telephone allowance (conditions apply)
- compensation for dependants in the event of a member's death (conditions apply)
- funeral benefits
- bereavement payments
- assistance with the cost of financial advice obtained in relation to certain permanent impairment, SRDP and death benefit choices
- DVA White or Gold Cards in certain cases or otherwise payment of reasonable treatment costs related to accepted medical conditions for those who are not eligible for a White or Gold Card
- pharmaceutical allowance
- travel and accommodation costs associated with medical appointments for treatment and rehabilitation assessments and programs.

Compensation Entitlements. Which Act(s) apply when claiming for compensation, and the benefits that may be received, depend on the:

- date of the injury or illness (for SRCA and MRCA purposes), and/or
- period of service that the injury or disease relates to (for VEA purposes).

Additionally, the Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Act 2017 (DRCA)¹⁶ replicates the current SRCA entitlements for current and ex-Service ADF members, with eligibility being determined by the Minister for Veterans' Affairs rather than the Minister for Employment. The DRCA does not affect VEA or MRCA eligibility or entitlements.

Finally, in accordance with its Non-Liability Health Care provisions, ADF members with even one-day's Service can get immediate ongoing treatment from DVA for up to five mental health conditions.¹⁷ The purpose of these provisions is to ensure the member's safety, without the delays inherent to assessing their eligibility.

Repatriation Medical Authority

The Repatriation Medical Authority was established in accordance with the VEA, as an independent statutory authority responsible to the Minister for Veterans' Affairs. It comprises five renowned practitioners in the field of medical science. Their role is to determine Statements of Principles (SoPs) for any disease, injury or death related to military service, based on sound medical-scientific evidence. The SoPs state the factors that 'must' or 'must as a minimum' exist to cause the particular disease, injury or death.¹⁸

Each condition determined by the RMA has two SoPs that list the factors relating the condition to ADF service. These SoPs are based on two separate legal standards as to the weighting of the medical evidence. The more generous SoP is based on the 'reasonable hypothesis' standard, which is applicable to current and ex-Service ADF members with operational or warlike service. The marginally less generous SoP is based on the 'balance of probabilities standard', which generally applies to claims where the veteran or ADF member does not have operational service.¹⁹

Specialist Medical Review Council

The Specialist Medical Review Council (SMRC) was also established in accordance with the VEA, as another independent statutory authority responsible

to the Minister for Veterans' Affairs. Its role is to review RMA determinations on request from an eligible person or organisation. It comprises a pool of medical practitioners and scientists appointed as Councillors by the Minister. The Specialist Medical Review Council Convener select three to five Councillors to conduct each review as required, based on the relevance of their expertise.²⁰

ADF Veterans

The author has previously noted that in 2015, Australia had approximately 339 000 veterans, including 150 200 with peacetime-only Service.²¹ Of the total, 61.4% were receiving health care services from DVA for Service-related conditions, costing \$5.525 billion in 2014-15. If the cost was borne (and funded) by Defence rather than DVA, it would constitute 15.9% of a recalculated Defence budget, compared to around 9.5% of GDP in health costs for the entire Australian population.²²

A striking characteristic of ADF Service, therefore pertains to the high treatment cost of Service-related medical conditions (even for personnel with peacetime-only Service), despite high recruiting and retention health standards.²³

Furthermore, these figures exclude another \$3.22 billion spent by DVA on non-health disability services and compensation.²⁴ To this end, 96 493 people received a VEA disability pension in 2015; while another 4 291 people received a weekly incapacity payment and an additional 18 537 received one-off permanent impairment payments per the SRCA or MRCA.²⁵

This means that, of approximately 440 000 current and ex-serving ADF members,²⁶ approximately 270 per 1000 received some form of compensation payment for at least one Service-related medical condition. This is at least 20 times the average civilian serious claim incidence rate, and 10 times the highest civilian serious claim incidence rate, by both industry and occupation.

The size of the total DVA budget also means that the per capita cost of treatment, disability services and compensation for these 440 000 current and ex-Serving ADF members is \$19 875, which is up to four times the median civilian Safe Work Australia and Work-related Injuries Survey rate. This figure is consistent with the estimated average cost of \$22 700 per gold card, and \$2600 per White Card in 2015-16.²⁷

Notwithstanding the differences between Defence and civilian compensation entitlements, these

Table 1: 15 most frequently claimed conditions under the VEA in 2014–15

Disability	Claims accepted	Acceptance rate	Claims rejected	Total claims
Osteoarthritis	1 623	76%	514	2 137
Sensorineural hearing loss	1 372	99%	14	1 386
Tinnitus	1 307	98%	26	1 333
Lumbar spondylosis	930	84%	181	1 111
Solar keratosis	640	99%	9	649
Post-traumatic stress disorder	472	76%	151	623
Non-melanotic skin cancer	533	99%	7	540
Depressive disorder	270	56%	211	481
Alcohol use disorder	218	55%	176	394
Hypertension	100	31%	219	319
Cervical spondylosis	82	28%	211	293
Ischaemic heart disease	154	53%	139	293
Acquired cataract	223	100%	1	224
Rotator cuff syndrome	70	32%	150	220
Chronic bronchitis	124	60%	84	208
Totals	8 118	79%	2 093	10 211

figures are consistent with the previous assertion that ADF workplace injury rates and per capita costs are comparable to – and almost certainly significantly exceed – the aforementioned maximal civilian industrial and occupational rates, even for ADF members who have not deployed.

Medical conditions

Table 1 lists the 15 most frequently claimed conditions under the VEA (based on the RMA SoPs) in 2015. These made up 61.5% of all conditions claimed under the VEA.

Table 1 suggests that, generally consistent with the author's original article,²⁸ at least 22% of all VEA claims were for musculoskeletal conditions, while at least another 9% were for mental health issues (including alcohol abuse). Other conditions, for which a relatively straightforward relationship to ADF employment exists, include hearing disorders secondary to workplace noise (16%), skin disorders secondary to sun exposure (7%), and a small number of eye disorders secondary to ultraviolet-light exposure (e.g. arc welding).

However, Table 1 also indicates that lifestyle-related conditions such as hypertension, ischaemic heart disease and chronic bronchitis (much of which can be attributed to smoking), make up only 5%

of all claims, 53% of which were rejected as non-Service-related. This suggests that the focus by JHC on healthy lifestyle promotion (per the College of General Practitioner's 'Red Book'²⁹), at the expense of workplace illness and injury prevention, is generally misplaced, especially if 36% of Permanent ADF members serve for less than five years (6.25%) of their estimated 80-year lifespan.³⁰

Compensation and the ADF's health services

The author has previously noted that the ADF appears unique in that unlike other employers, its health services provide employee healthcare without ascertaining whether their clinical presentations are work-related.³¹ For example, JHC clinical records routinely document patient details such as their Service and rank but not their rate (Navy), corps (Army) or mustering (Air Force) that indicate the jobs they perform.

Furthermore, JHC at present does not collect or report work-related illness/injury data, or record lost time or restricted duties, or identify the ensuing health care costs.³² Although some – but by no means all – of this information is provided via Defence's Work Health and Safety Compensation and Reporting (WHSCAR) System, a recent study indicates that only 11 to 19 percent of all Army Reserve and

Regular work-related injuries and illnesses are being reported.³³ It seems likely that WHSCAR reporting by the other Services would be comparable.

Collecting this baseline health information at the point of treatment is essential, not only for monitoring the effectiveness of the ADF's occupational and environmental health services, or to account for the healthcare costs incurred by JHC, or to account for the compensation and veteran health care costs incurred by DVA, but documenting the work-relatedness – and therefore compensation eligibility – of each member's illness or injury in the first place.

A previous article noted that JHC does not include occupational and environmental physicians as part of its multidisciplinary rehabilitation teams, despite anecdotal evidence suggesting that only 20-40% of ADF clinical presentations are for (generally non-compensable) conditions typically seen in an equivalent Australian civilian population. It also referred to the limitations of general practitioners with respect to medical fitness-for-work certification managing long-term work absence, work disability and unemployment and balancing the needs of commanders against those of their patients.³⁴

However, the previous article also noted that occupational and environmental physicians have skills and expertise that can complement general practitioners, with respect to facilitating compensation as intrinsic to providing primary healthcare for the ADF workforce. Perhaps more importantly, they can also facilitate local command compliance with the Work, Health and Safety Act 2011, thereby preventing compensable workplace illness and injury in the first place.

In summary, facilitating each ADF member's future compensation entitlements by considering the work-relatedness of their illness or injury at the time of presentation, is clearly intrinsic to their overall healthcare. However, at present it is not recognised as such from a clinical management perspective, with respect to the fundamental inputs to capability for either JHC's garrison health services, or for the Defence Work Health and Safety branch.

Conclusion

With ADF personnel arguably exposed to the most diverse range of occupational and environmental hazards of any Australian workforce, high rates of preventable workplace illness and injury indicate the need to improve the management of occupational and environmental health hazards, with added emphasis on prevention above treatment.

This suggests that the ADF's health services should be premised on an occupational and environmental health paradigm, with revised fundamental inputs to capability that would lead to a genuinely holistic and sustainable workforce-based ADF health service delivery model by 2030.

This paradigm would entail Defence medical officers who accept the requirement to facilitate the compensation entitlements of ill and injured ADF personnel, as intrinsic to providing primary healthcare for a workforce. This specifically refers to the timely and accurate documentation of the work-relatedness of every ADF patient presentation.

It also entails occupational and environmental physicians who can help prevent high rates of compensable workplace illnesses and injuries (potentially up to 20 times the average civilian rate), by facilitating local command compliance with the Work Health and Safety Act.

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Disclaimer

The views expressed in this article are the author's and do not reflect those of the RAN or any of the other organisations mentioned.

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- 5 Safe Work Australia explains that the definition used for the term 'serious worker's compensation claims' is: 'A workers' compensation claim for an incapacity requiring an absence from work of one working week or more, lodged in the reference year, and accepted for compensation by the jurisdiction by the date the data are extracted for publication.
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- 7 Safe Work Australia explains that, because a small number of uncharacteristically long absences or high payments can skew the average (mean), median payment and median time lost from work of serious workers' compensation claims approximate to a 'typical' claim.
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Workplace- and sports-related injuries are not recorded separately, which precludes differentiating work- versus sports-related treatment costs or Lost Time Injury Frequency Rates' and
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