HANDLING MEDICAL CONTENTIONS IN THE REPATRIATION SYSTEM

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Preamble

I don't think any of us are in any doubt about the immense impact of administrative law on the lives of a vast number of Australians. It also impacts on the day to day business of government through the review of decisions made in the administration of government programs and the interpretation and application of legislation implementing government policy.

Purpose

In the recent past there has been considerable debate about the provisions of the *Veterans' Entitlements Act 1986* (VEA). In particular, the December 1992 report by the Auditor-General into the Department of Veterans' Affairs (DVA's) compensation sub-program and the March 1994 Baume Committee report entitled *A Fair Go* both argued for changes to the "reasonable hypothesis" standard of proof. The major problem perceived was that elderly veterans were being granted pensions for conditions that were the normal consequence of the ageing process. Each report argued for radical changes to the eligibility criteria for disability pensions and war widows' pensions.

The Government rejected most of the recommendations because they would have led to major reductions in entitlements for veterans and widows. The Government did, however, decide that there should be some action to ensure that cases with no real merit should not succeed simply because of the very generous standard of proof applied in the repatriation jurisdiction. I shall deal with these changes in more detail a little later.

At this point, a brief history of the repatriation system may be useful.

Historical Background

The repatriation compensation system, or the "Repat" as it is more familiarly known among ex-service men and women, has a very special place in the Australian psyche. Set up during World War I, it has been the mechanism through which a grateful nation has endeavoured to meet its obligations to its veterans and their families. The Repatriation Commission was the body charged with administering the repatriation system.

It came to be agreed that repatriation the nation's moral debt - should include positive measures to assist returnees to re-establish themselves in civil life; ample pensions, re-training and medical care for the disabled; and monetary allowances for dependants (chiefly wives and children).

The Australian interpretation was, from the outset, significantly more generous than that adopted by other allied countries.

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In essence, the Australian repatriation system has been based on the following principles:

- national indebtedness to those who served;
- a duty to look after the dependants of those who died as a result of war;
- compensation and other benefits should be a right and not a welfare handout; and
- in cases of doubt, the doubt should be resolved in favour of the veteran.

The Commission was empowered to issue regulations and also sat as an entitlement and assessment determining body to adjudicate on claims by ex-service personnel. Exercising this quasi-judicial function made it a pioneer in the development of Australian administrative law.

While the structure was intended to ensure a sympathetic appraisal, the Repat's decisions and approach have not been without controversy. For example, in earlier years, pensions and medical treatment were withheld from those whose disability and illness were ruled to be caused by venereal disease contracted while on active service. In more recent times, Vietnam veterans claimed to have suffered severe, but unrecognised, impairment of health through exposure to Agent Orange and other chemicals. A further difficulty has flowed from the fact that the administrative law evolved by the Repat did not sit comfortably with administrative case law which evolved under Administrative Appeals Tribunal (AAT), Federal Court and High Court decisions. An expansive definition of the onus of proof as it related to claimed pensionable disabilities (*O'Brien's case 1985*) and much readier provision of legal aid to claimants raised the spectre of a nightmare escalation of costs in some minds.

The Repatriation Commission's role, functions and powers are set out in the VEA and it discharges its responsibilities through the Department.

DVA is, of course, bound by the terms of the VEA as interpreted by the relevant appeal bodies. This might seem to be a trite, almost trivial, observation, but it is an issue which has bedevilled the administration of the repatriation system almost since its inception. The complexity of the legislation and the flow-on effects from the interpretation and application of beneficial legislation to individual cases have created many problems. The emotion which naturally underpins the whole nature of the commitment and sacrifice by veterans often makes "fine" and sometimes legalistic decisions about pension matters seem inexplicable. Further complications arise in accommodating advances in medical knowledge and dealing with differences of opinion among medical experts.

These are not new issues. They have been at the very core of reviews and enquiries into the administration of the repatriation scheme over the past two decades - by the Toose Enquiry (1975), the Administrative Review Council (1983), the ANAO (in 1984 and 1992), the Veteran's Entitlements Act Monitoring Committee (May 1988) and various internal departmental reviews.

Legislative Setting

Before going further, an understanding of the basic legal tenets in the repatriation jurisdiction is necessary. As with most complex issues, there is a danger in endeavouring to simplify the concepts because this necessarily tends to gloss over the subtleties and nuances which can be critical to that understanding.

As mentioned earlier, claims for compensation for war or defence service-related disabilities are made on the Repatriation Commission. DVA is the administrative arm of the Commission and is controlled by the Secretary who is also President of the Repatriation Commission. The Commission has two other members, one of whom must be appointed from a list of nominees put forward by organisations representing veterans.

Veterans may apply to the Commission to have an injury or disease determined as being related to their service. Widow(er)s are entitled to a war widow(er)s pension when a veteran's death is related to their service. (There are some special categories of veterans whose widow(er)s automatically receive a war widow(er)s pension.) In considering a claim, the Commission must look at whether there is a causal link between the injury, disease or death and the particular circumstances of the veteran. In this context, the two important elements are the facts relating to the veteran's service and the contention which seeks to link those facts to the injury, disease or death.

The repatriation determining system consists of the primary level - where delegates of the Repatriation Commission consider and decide claims - the Veterans' Review Board (VRB) - a specialist independent review board - and the AAT.

Two standards of proof are provided under the VEA - one for veterans with operational service (eg service in "war like" circumstances) and one for veterans with non-operational service (eg service within Australia during World War II and peace time service post-1972).

The **standard of proof** required for a veteran with **non-operational service** is that the Commission must be **reasonably satisfied** of the connection between disability and service (that is, the civil standard of proof).

The **standard of proof** for a veteran with **operational service** is that the Commission must determine a claim in favour of the veteran unless it is satisfied **beyond reasonable doubt** that there is **no** sufficient ground for making that determination. Introduced into the VEA in 1977, this standard was interpreted between 1977 and 1982 as meaning no more in a compensation context than that the benefit of any ultimate doubt should be given to the veteran.

In 1981 (the *Law case*), however, the High Court found that the "beyond reasonable doubt" standard meant the same in repatriation law as it did in criminal law - that is, the reverse of the criminal standard of proof was to be applied. This standard of proof is unique to Australia's repatriation jurisdiction.

In the 1985 *O'Brien case*, the High Court went further, finding that a mere possibility was enough for a claim to succeed unless the Commission could be satisfied beyond reasonable doubt that the condition was not related to service. Even if there was no evidence, or if the evidence was neutral, the claim was to succeed. Hence, the onus of disproof was effectively placed on the Commission.

In response to the *O'Brien* decision, the Government amended the standard of proof to provide, in effect, that a claim should not be accepted unless the material raised a reasonable hypothesis, connecting the injury, disease or death to the veteran's service. (Annex A provides more detail on the "reasonable hypothesis".) Further significant amendments occurred in 1986, so that the Commission could be satisfied at the beyond reasonable doubt standard if no reasonable hypothesis of connection between

disability and service was raised after an analysis of all the material.

In *Bushell* (1992) and *Bymes* (1993), the High Court ruled on the meaning of the term "reasonable hypothesis". In effect, these decisions meant that a single responsible medical practitioner, speaking within the ambit of his or her expertise, (or a single expert eminent in the field) who supported a claim automatically satisfied the reasonable hypothesis standard of proof.

In the 1950s and 1960s the entitlement rate averaged about 54% over all levels of the determining system. For example, the acceptance rate was 46% in 1957-58, 57% in 1963-64 and 52% in 1966-67.

By the late 1970s, prior to the *Law* case, primary level acceptance rates were about 30%. Acceptance rates doubled and commenced to rise again after the *Bushell* case in 1992.

Changes in entitlement intake lag approximately one to two years behind changes in the acceptance rates, that is, when the acceptance rate rises, the claim intake rises soon afterwards. The intake increased significantly after the *Law* case.

Reasons for the Change in Acceptance Rates

As you might imagine, many claims lodged in the immediate post-war period were readily identifiable as being related to service. The nature of the diseases and injuries claimed and the proximity to service in terms of the time and onset of the conditions naturally assisted in the determination of those claims.

In a sense, the period in the mid-1970s might be characterised as marking a change from acceptance of the direct consequences of war to include the more indirect consequences. The best example of this involves smoking related conditions. Up until the *Law* and *O'Brien* decisions, claims for smoking related conditions were not generally accepted. But those decisions, together with developments in medical research led to smoking being linked to a wide range of conditions. The threshold question therefore became not so much the link between smoking and the condition claimed, but whether or not the commencement of, or increase in, smoking could be linked to service.

One does not need a "reasonable hypothesis" standard of proof to establish a causal link between smoking and a wide range of conditions like lung cancer and respiratory and heart disease. There have been numerous cases in the general law where that position has been accepted under the civil standard of proof. The significance of smoking-related conditions in the community and the fact that many of those conditions do not manifest themselves for many decades underlie the rise in acceptance rates. Given that many of these conditions are directly or closely associated with the cause of death of many veterans, the number of successful war widow claims has also increased.

While the "reasonable hypothesis" standard of proof has not really affected claims for those conditions which fall within what might be described as conventional medical and scientific opinion, it does have a significant impact on those which are at the margins. Currently, acceptance rates are around 70% at the primary level, rising to 76% after all rights of appeal have been exhausted. Over 95% of these acceptances relate to conditions which would be covered by mainstream medical and scientific opinion.

The Australian National Audit Office (ANAO) Report

The Australian National Audit Office Audit *Report No 8* of December 1992, (referred to above), found that:

- there was a lack of consistency in decision making at primary level and above;
- decisions of the AAT and the courts had rendered earlier amendments to the legislation in 1985 and 1986 largely ineffective;
- veterans were being compensated for disabilities suffered at no greater rate than the community generally; and
- far fetched claims were succeeding.

The Baume Report

As a result of the ANAO report, the Government set up the Veterans' Compensation Review Committee consisting of Professor Peter Baume (a Minister in a previous Government and Professor of Community Medicine at the University of NSW), Air Vice Marshall Richard Bomball and Ms Robyn Layton QC (a former Deputy President of the AAT with considerable experience in VEA matters) to look into the repatriation compensation system.

In its March 1994 report, the Baume Committee identified problems with the standard of proof and causation provisions in the VEA. It recommended:

- there should be a single standard of proof - the civil standard of balance of probabilities (or reasonable satisfaction) - for both operational and non-operational service;
- there should be an "equipoise" provision for veterans with operational service whereby they were given the benefit of any ultimate doubt. This is the reverse of the normal civil standard position where if the matter is in equipoise at the end of the day, the claimant loses. (Or, putting the positive equipoise provision in cricket parlance, "the batsman gets the benefit of the doubt"); and
- an expert medical committee should decide on generalised medical contentions. (An example might be whether malaria can lead to some generalised suppression of the immune system which leads to cancer in later life.)

Other problems

Departmental research conducted around the time the Government was considering the Baume Committee recommendations found inconsistency in primary level decision making between and within States.

The time taken to determine claims was also considered unsatisfactory. In 1984-85, primary level entitlement decisions took an average of 347 days while VRB decisions took a further 751 days.

These times are now 154 days and 414 days respectively. Despite these reductions we are still not satisfied with the time taken to process claims. They imply, for the 4,900 applications expected by the VRB this year, an average delay of 568 days (1 year 7 months) between lodgement of the initial claim and the outcome of the first appeal.

About 4% of entitlement cases are subsequently taken to the AAT. These take an average of 12 months to resolve while appeals to the Federal Court add a further 9 months. From initial receipt of a claim to a decision from the Federal Court, 3½ to 4 years may elapse.

Solutions

The Government's response was to:

- establish a Repatriation Medical Authority through legislative amendment;
- establish a Specialist Medical Review Council through legislative amendment; and
- introduce an "expert system" - the Compensation Claims Processing System.

Repatriation Medical Authority

The *Veterans' Affairs (1994-95 Budget Measures) Legislation Amendment Act 1994*, which received Royal Assent on 30 June 1994, introduced a number of new concepts and procedures into the VEA. In summary these are:

- in its approach to the concept of "reasonable hypothesis" the Government has sought to amplify the requirements before an hypothesis can be found to be reasonable so that an opinion held by a single medical practitioner that does not have sound medical-scientific support, will no longer be sufficient as the basis of a reasonable hypothesis;
- as part of the requirement that hypotheses have medical-scientific credibility and to ensure consistency in the determining of claims, decisions on the reasonableness of medical hypotheses are decided by an independent body of eminent medical practitioners and medical scientists known as the Repatriation Medical Authority (RMA). Purely medical causation issues are no longer decided by departmental delegates or, at review stages, by lawyers or laymen;
- the members of the RMA were appointed by the Minister for Veterans' Affairs in July 1994 after extensive consultation with the ex-service community. The Minister gave an undertaking that he would only appoint members of the RMA who were seen by all parties as entirely independent of the Repatriation Determining System. The five members of the Authority, Professors Donald, Raphael, Duggan, Heller and Kearsley are acknowledged as leaders in their respective professions;
- the legislation requires at least one member of the RMA to be a person who has at least 5 years experience in the field of epidemiology. Professor Donald, the Chairman of the Authority, is a specialist in pathology, Professor Raphael is a psychiatrist, Professor Duggan, a general physician, Professor Heller, an epidemiologist and Professor Kearsley, an oncologist. The Authority is able to call on a list of ministerially appointed consultants for further expert advice concerning any disease under their consideration;
- the RMA was given the power to determine from time to time those medical contentions that are based on sound medical-scientific evidence and that provide a relevant relationship between service and the disabilities claimed by applicants for pension and hence can form the basis for "reasonable hypotheses" and claims at the "reasonable satisfaction" standard;
- these changes are consistent with the decision in *Bushell* in which the High Court required the validity of the reasoning of all medical and scientific material to be examined;

- in effect, it is now necessary, before an hypothesis can be found to be reasonable or a claim determined at the reasonable satisfaction standard, for it to be based on sound evidence from the field of medical science: that is, for the medical contention to be accepted it needs to be based on medical-scientific acceptability;

- as an example, an hypothesis would not be able to be found reasonable if it were espoused by a medical practitioner whose views on the medical-scientific issues involved were speculative, fanciful, unsound, or undermined by the views of peers;

- on the other hand, full scientific proof will not be required for an hypothesis to be reasonable and more than a single hypothesis of causation in relation to a disease, injury or death can be reasonable;

- the RMA's determinations are issued in the form of a "Statement of Principle" based on sound medical-scientific evidence that will exclusively state what factors, when related to service, must exist to establish a causal connection between diseases, injuries or death and service. Statements of Principles (SOPs) prepared by the RMA will be disallowable legislative instruments;

- provision has been made to enable the RMA, where necessary, to consult with veterans and their organisations during the process of formulation of SOPs and for the SOPs to be open to review in light of subsequent research findings. Veterans and their representative organisations are able to initiate action by the Authority to formulate or review the contents of SOPs and may make written submissions to the RMA;

- so far the RMA has determined 60 SOPs. We estimate 400 SOPs will be determined by July 1995 and that this will cover some 80% of claims. A further 200 SOPs will be required to cover 95% of all conditions claimed. The RMA has also decided to carry out an investigation into the causes of cancer of the prostate. This will examine whether there is a causal link between smoking and the development of cancer of the prostate; and

- instead of waiting for the RMA to issue a SOP for every condition, we have decided to process and accept claims under the present Repatriation Commission guidelines, except where the RMA has announced an investigation (as is the case with cancer of the prostate).

We expect these changes to reduce the acceptance rate for entitlement claims over the whole determining system by one or two percentage points from 76% to 74% or 75%.

Specialist Medical Review Council

In the same Bill that established the RMA, a Specialist Medical Review Council (SMRC) was established to review the determinations of the RMA if so requested. This provision was added, with the Government's agreement, following debate about who would review the RMA's determinations even though these determinations were to be disallowable instruments. (A disallowable instrument is an instrument of delegated legislation such as regulations or other rules not made by Parliament itself, but which determine general principles of law. It must be tabled before both Houses of Parliament and can be disallowed by either House.)

The members of the SMRC will be appointed by the Minister for Veterans' Affairs on a part-time basis. One of the members will be appointed as Convenor. For the purposes of a review the SMRC must be constituted by at least three, but not more than five, members selected by the Convenor. The members will be selected from lists of nominees submitted by professional medical colleges or similar bodies.

When so requested, by a veteran, a widow, an ex-service organisation or the Repatriation Commission, the SMRC must carry out a review of all of the material that was available to the RMA when it made its determination on a SOP. The SMRC does not conduct a totally *de novo* review. It has regard to the material that was before the RMA, but it can also take into account new submissions in relation to that material. (If a person, having been unsuccessful at the primary level, decides to seek a review by the RMA or the SMRC of a SOP, it will also be necessary for him (or her) to lodge an appeal to the VRB in order to ensure that the maximum arrears of pension can be paid if the claim ultimately succeeds.)

It is important to recognise that the RMA and SMRC are legislative bodies - not administrative tribunals. They do not deal with individual cases, but make rules of general application. They do, however, permit veterans and their organisations to have a direct role in influencing this legislative process where that process may have a direct impact on their or their constituents' pension rights. This is certainly a novel approach to consultation in rule-making.

If the SMRC is of the view that there is sound medical-scientific evidence that was available to the RMA when it made its determination or decision that would justify the RMA in amending or determining a SOP, then the SMRC must make a written declaration. That declaration must state the SMRC's views and set out the supporting evidence and must either direct the RMA to amend or determine a SOP or otherwise remit the matter for consideration in accordance with any directions or recommendations of the SMRC.

On the other hand, if the SMRC considers that the RMA made its decision on other than sound medical-scientific evidence, then the SMRC must make a written declaration to that effect, giving reasons. The SMRC may include in the declaration any recommendation that it may wish to make about any future investigation that the RMA may carry out.

The RMA and SMRC approaches to deciding medical issues have been seen in some quarters as establishing a new system to replace the traditional mechanisms of tribunals and courts.

In this regard, it is worth noting the trend in the Workers' Compensation area for medical issues to be decided, not by courts and tribunals, but by specialist medical committees and for the findings of those committees to be conclusive and binding on courts and tribunals. This leaves only non-medical issues to be decided by the courts and tribunals.

Compensation Claims Processing System

The Compensation Claims Processing System (CCPS) initiative is intended to improve the consistency and speed of primary level decision making. It is a computer based "expert system" incorporating an extensive rule base (covering the SOPs) and requiring research and input by departmental claims assessors.

Claims assessors working in the CCPS environment draw on medical officers and senior assessors to assist them in exercising judgment and discretion in determining the course of action.

Where a claims assessor makes a decision to over ride the rule base, the case is automatically referred to a senior officer for validation of the decision made.

CCPS went live in March 1994 and was applied to a quarter of the intake of claims in Queensland Branch Office. It was progressively introduced in all other States and expanded to apply to all claims intake and became fully operational in September 1994. CCPS should:

- address the problems of ensuring inter-and intra-State consistency in decision-making in a large and dispersed department;
- reduce waiting lists of claims awaiting determination; and
- reduce the average time taken in determining claims.

Early indications are that delays in processing claims have been reduced as a result of the introduction of CCPS. During the September 1994 quarter about 2,400 entitlement claims were processed using CCPS, with an average time taken of about 86 days. This processing time was 168 days in the June quarter under the old system. It needs to be borne in mind that these 2,400 CCPS claims were mainly claims which can be easily accepted and there may be an increase in the CCPS times taken as the system starts to process a more normal flow of cases. Nevertheless, there are definite signs that CCPS is providing a better service in terms of consistency and the speed of decision-making.

As part of the introduction of both CCPS and the recent amendments setting up the RMA and SMRC, DVA has set up teams to determine the backlog of claims made under the previous system for determining claims. We are aiming within the next 3-4 months to reduce the outstanding number of claims to the lowest level they have been for more than ten years.

With the introduction of CCPS, the Department has put in place a completely new administrative support structure. The Repatriation Commission delegation to determine claims has been devolved to a lower classification level - from Senior Officer Grade C to Administrative Service Officer (ASO) Grade 5. The ASO 5 level met the Public Service work level standards for that type of activity. As part of the devolution, the new structure introduced the responsibility based processing concept with the ASO 5 claims assessor responsible for managing the claim from receipt to decision and advice to the claimant.

Once the new system is bedded-down we will be reviewing the consistency of decision-making throughout the country. My aim is to ensure equity of outcomes for claims by all veterans and war widows, wherever they may live in Australia.

As part of our ongoing process of upgrading our systems technology, we will be introducing better software and hardware platforms for the CCPS system. This will be an important element in my drive to introduce a new and strong quality-of-service culture in the Department of Veterans' Affairs.

Additionally, early in 1995 we will be carrying out reviews of cases at all levels in the system by using the powers in section 31 of the VEA where further evidence has come forward since the claim was last considered.

It is of interest that CCPS was named in a paper at a recent conference on innovative applications of artificial intelligence held by the American Association for Artificial Intelligence (AAAI). The paper was submitted by

Softlaw, the Australian firm which has written the CCPS software.

(Annex B deals in more detail with the ways in which the RMA, the SMRC and CCPS will deal with the expectations of clients.)

Other initiatives

In conjunction with these initiatives, we are taking other steps to assist the veteran community in preparing, presenting and arguing claims. A training and information program helps ex-service community advocates and welfare officers with the investigation and presentation of claims. A Veterans' Advice Network (VAN) is being established to assist veterans in suburban, rural and remote locations with information and access to health care and support services. Finally, in the 1994 budget the Government approved funding for medical opinions obtained by applicants in VRB appeals.

Problems Remaining

Although the amendments to the VEA introducing the RMA and SMRC should address some problems in the repatriation area, not all problems will be solved. Problems obviously remain in:

- the standard of proof to be applied in determining matters of fact other than medical contentions; and
- determining causation issues.

The majority of appeals are based on questions of fact, such as whether a veteran served in a particular area or whether certain events occurred during the time of his or her service rather than on questions of medical causation. All these rights of appeal remain and the existing standard of proof remains as the test for establishing whether a particular disease or injury is war caused.

A further problem is the excessive number of levels of *de novo* decision making. This is related to, but not the same as, the "proliferation of tribunals" which is part of the subject matter in the Administrative Review Council discussion paper entitled "Review of Commonwealth Merits Review Tribunals".

In the repatriation area there are now up to five levels of *de novo* decision making. These are:

- primary level decision making by DVA's delegates;
- internal review by DVA (in certain cases);
- VRB review;
- further pre-hearing review by DVA and "mediation" procedures by the AAT; and
- formal AAT review by way of hearing.

In addition to these appeal arrangements, veterans and war widow(er)s do, of course, have access to the Ombudsman. We have in place a system that facilitates ready access to case files by the Ombudsman. Where there is an active appeal under the above review arrangements the Ombudsman generally does not get involved.

The Minister has commissioned a review of the appeals process. The Commission will also be reviewing its policy on appeals and putting more effort into getting the decision right the first time - through training and the like.

Other critics have:

- commented on the erosion of the power of the Parliament by the judiciary which has no responsibility

for the fiscal implications of its decisions;

- questioned whether a bereaved widow of a veteran who subsequently died from smoking induced lung cancer is as much a war widow as the widow of someone killed during the war;
- said that the rort-ridden world of veterans' affairs history is one of political opportunism, popularism, political incompetence and inequity;
- argued that veterans have been conned and that the VEA amendments have effectively downgraded benefits (rather than redressed dodgy claims);
- claimed that the VEA amendments will impose the greatest administrative fiasco since inception of the Repat system, the net result of which will be that only some 17% of claims will succeed.

Some critics also believe it inappropriate that there is nothing to stop an applicant recommencing the process even without new evidence.

Financial Implications

The ANAO report was critical of the efficiency of DVA's approach to claims processing and the administrative cost of the appeals system.

The 1993-94 cost of administering the repatriation determining system is about $28m, comprising:

- $13.1m for the primary determining level
- $5.3m for the VRB
- $5.2m for the AAT
- $4.7m for Legal Aid for AAT cases

Introduction of the RMA is expected to save about $32m over the four year forward estimate period 1994-95 to 1997-98. These estimated savings enabled the Government to direct other assistance to veterans in the 1994-95 Budget, for example, the $20m package of assistance for Vietnam veterans.

Conclusion

The RMA and the SMRC will provide more certainty as to the reasonableness of medical hypotheses so that there will be much greater consistency on medical-scientific issues at all levels of the determining system.

Brennan J, in *Drake (1979)* stated:

> Inconsistency is not merely inelegant: it brings the process of deciding into disrepute, suggesting arbitrariness which is incompatible with commonly accepted notions of justice.

The thrust of these reforms is to achieve what has eluded us in the past. To provide a system which deals with claims from all veterans in a consistent and timely manner and to do this in a way which appropriately honours and recognises that these people are indeed special. They are our living national treasures.

ANNEX A

The "Reasonable Hypothesis"

This annex sets out a brief history of the "reasonable hypothesis" standard of proof.

The Full Federal Court case of *East* (1987) found that a reasonable hypothesis requires more than a possibility, not fanciful or unreal, consistent with the known facts even though not proved on the balance of probabilities.

In legislation such as the VEA, which is clearly intended to be generously beneficial, the *East* decision might be considered to represent a fair interpretation of the standard, so that proof is required at something less than the civil standard.

In *Bushell* (1992), however, the High Court gave a fresh interpretation to the reasonable hypothesis in saying that

> It would be an exceptional case in which it would be right for the AAT, forming its own view of competing medical theories, to hold an hypothesis of connection favouring entitlement to be unreasonable, when the hypothesis is supported by "a responsible medical practitioner, speaking within the ambit of his expertise.

The High Court added in *Bymes* (1993) that:

> It was not open to the [Administrative Appeals] Tribunal ... to say that the hypothesis relied on by the appellant was not reasonable because there was only a 20 to 1 chance of it being valid. A hypothesis within that degree of probability cannot as a matter of law be regarded as unreasonable ... .

(The medical expert's opinion in this case was that the possibility of connection between disability and service was "extremely unlikely" - "a twenty to one outsider". Hence the "20 to 1 chance" of the High Court's decision.)

The High Court went on to say that

> In some cases, the hypotheses may assume the occurrence of existence of a "fact". That itself does not make the hypothesis unreasonable.

ANNEX B

Client Expectations

DVA considers that appellants and citizens have legitimate expectations that, in bureaucratic decision-making there will be:

- procedural fairness;
- timeliness;
- consistency;
- "once and for all" resolution of the issues;
- guidance to decision-makers;
- economy (both for the individual and the taxpayer); and
- conformity with government policy.

It has been argued that in the repatriation jurisdiction only the first of these is being achieved on an ongoing and consistent basis, although the problems with the second are also due to delay by the applicant themselves.

The question arises whether a structure based on the court norms of hearings and representation, leading as it has to a more adversarial approach in a two tier system at the final level, is the best way to achieve the objectives of merits review. More of an inquisitorial or an administrative approach to decision-making and the law would seem to be required as part of addressing the major problems remaining. The Explanatory Memorandum to the recent VEA amendments pointed out that a major cause of difficulties with the previous determining system was that medical decisions were required to be taken by non-medical bodies. In *McIntyre* the AAT, in commenting on the nature of medical evidence and hypotheses put before it said:

> Such fanciful views, while bordering on an insult to the intelligence, do not advance the positions of ex-servicemen. Whilst recognising that our findings of the fact are final, whether right or wrong, ... the Tribunal is concerned that so much money is consumed in repeated and persistent attempts to persuade it that there is factual support for the hypotheses advanced in this matter. If weak minded Tribunals accept such material, this will only lead to increased money being spent on computer searches for papers and witnesses' expenses, while avoiding a review of the present legislation with its fictionalised method of determining war pension for veterans and their widows, who probably deserve them, for the service rendered, rather than for fanciful hypotheses advanced.

As I understand it, this hypothesis is based on the following, which I have tried to put in non-technical terms:

> Nitrates and nitrites are contained in canned food such as was eaten in quantity by troops in WW2. They were actually added to such foods (and others) as part of the preserving process. Nitrates/ nitrites ' are converted in the gut to nitrosamines some of which have been shown in animal studies to be carcinogenic. Various cancers (generally) of the stomach, bowel etc are then hypothesised to have resulted in humans from nitrates/nitrites. The counter argument is that nitrates/ nitrites occur naturally in a wide range of non-preserved foods (including fresh fruit and vegetables). As well, there are many different nitrosamines produced when the gut acts on nitrates/nitrites. It is not clear which of these are harmful. It is undeniable, however that manufacturers have reduced nitrates/nitrites in processed foods since concern has been expressed about the possibility that certain nitrosamines are carcinogens.

The particular hypothesis referred to in the *McIntyre* case was later accepted by the AAT in *McKnight* and *Taylor* but rejected in *Gorman* and *O'Brien*. In *Anderson* the two lay members of the Tribunal found that the hypothesis was reasonable, but the medical member did not.

In *Bushell's* case in the High Court, Mason CJ, Deane and McHugh JJ stated that the Commission is "bound" to have regard to "medical or scientific material opposing the material that supports the veterans' claim ... for the purpose of examining the validity of the reasoning which supports the claim that there is a connection between the incapacity or death and the service of a veteran".

The introduction of the Compensation Claims Processing system, together with the setting up of the RMA and SMRC, is expected to provide clients with a fairer and more consistent system for determining their claims.

FACTS OF CASES REFERRED TO IN PAPER

"Beyond Reasonable Doubt" Cases

Repatriation Commission v Law

(High Court decision 16 October 1981 against Commission)

The respondent was the widow of an ex-serviceman whose death was caused by carcinoma of the lung and myocardial infarction. She claimed a pension under the Repatriation Act 1920 on the basis that her husband had become a heavy smoker while a prisoner of war and this had caused the carcinoma. During the period in which he was a prisoner of war he underwent severe hardship and suffered from enteritis, bacterial dysentery, malaria, otitis externa, beriberi and hookworm. When he joined the Army he had not smoked cigarettes but by the time he was repatriated to Australia from a prisoner of war camp he had begun to smoke heavily. When discharged from the forces he was in a wretched physical condition and remained in poor health for the rest of his life. The AAT rejected her claim.

The *Law* case was a landmark decision which held that changes to legislation in 1977 had inserted a reverse criminal standard into the Act.

Repatriation Commission v O'Brien

(High Court decision 27 February 1985 against Commission - Brennan and Murphy JJ dissenting)

The respondent served in Australia with the RAAF between 1942 and 1946. During this period he suffered from essential hypertension which developed into anxiety neurosis as a result of stress suffered because he was separated from his wife due to his training and because he served only within Australia, contrary to his strong desire to serve overseas. The condition persisted after discharge. The AAT rejected the claim that the hypertension or anxiety neurosis were related to war service.

East v Repatriation Commission

(Full Federal Court decision 22 July 1987 for Commission)

The appellant was the widow of a former member of the RAAF who died from carcinomatosis and toxaemia due to hypernephroma of the left kidney. Mr East's service included overseas service in the Middle East. The veteran's hypernephroma, a condition of unknown aetiology, was first apparent in 1979. He died on 16 January 1983. In October 1982 he had made a claim for "medical treatment and pension". At the AAT, medical evidence was received from two witnesses. One of the medical experts identified three factors upon which he based an hypothesis of a causal connection between service and death: use of the anti malarial agent, stress and change of lifestyle and diet. This witness gave reasons for postulating a link between these factors and the development of the hypernephroma many years later.

The second medical witness disputed this hypothesis. He said that, despite extensive studies, the only established formal association between an environmental factor and the development of renal cancer was in the connection with smoking. For these, and other reasons, the second medical witness found that, upon present knowledge, there did not appear to be any environmental factor during Mr East's war service or later life which would predispose him to the development of any malignancy. In particular he saw no association with the later development of renal cancer.

The AAT affirmed the decision of the Veterans' Review Board to reject the claim.

Byrnes v Repatriation Commission

(High Court decision 15 September 1993 against Commission)

My Byrnes served in the Australian Army and the Royal Australian Navy. He claimed that his cervical and thorasic spondylosis were war-caused diseases and were the consequences of three incidents during his naval service.

The three incidents upon which Mr Byrnes based his claim were:

- ricked neck caused by diving into a shallow pool; later admitted to hospital with "cervical myositis";
- hit on back of the head by a piece of coal when ship rolled; and
- fell and hit head and shoulders on riveted bulkhead when on deck to get fresh air.

The first incident is the one most relied on. It appears that Mr Byrnes did not report it immediately and although he was kept in hospital for observation he was only treated with linament.

The medical witnesses for both the applicant and the Commission agreed with the medical hypothesis that a severe injury was necessary to lead to the development of spondylosis. The applicant's medical witness contended that the diving injury was sufficiently severe, whereas the Commission's specialist considered that there was no evidence to support this view and that the condition would have emerged at an earlier time had it been so. As the condition did not emerge for many years after war-service and appeared consistent with the effects of aging he considered that there was no material pointing to the hypothesis.

The AAT found that there was no evidence to show that any of the occurrences caused severe injury and that in the circumstances there was no more than a possibility of a relevant cause or connection. Hence a reasonable hypothesis had not been raised.

Bushell v Repatriation Commission

(High Court decision 7 October 1992 against Commission)

Mr Bushell was discharged from the RAAF in January 1946 because of "temperamental instability". In 1982 he applied for a service pension claiming 100% of the general rate of pension for incapacity in respect of anxiety state as being service related. The AAT rejected Mr Bushell's claim that he had an anxiety state, attributable to war service, which contributed to hypertension.

(Note: Both *O'Brien* and *Bushell* were, broadly speaking, stress and hypertension cases. Given that the legislation was changed to overcome the *O'Brien* decision, the AAT decision in *Bushell* should have been unremarkable and able to withstand challenge.)

As a comparison to the above "beyond reasonable doubt cases", particularly in comparison to the veterans' circumstances in *Law's* case which began it all, below is outlined a case that was determined on the civil standard of proof.

The case of Mr T

T was in the Citizen Military Forces (CMF) (not the AIF) for 7 months in 1940-41 during the second World War. During that time he was on one full camp of less than two and a half months. T did not leave Australia at any time. At the time T was in the CMF the Japanese had not entered the war and

the legislation in place did not allow the CMF to be sent overseas. T lodged a disability claim in 1990 when he was 74 years old. He claimed that the apprehension caused by his military service, the cheapness and the availability of cigarettes and peer pressure had caused him to commence smoking in 1940 during his full time military service and various diseases had resulted from his smoking. The AAT rejected his claim, which was however upheld by the Federal Court. This case emphasises how far the law has moved from the High Court decision in the *Law* case involving the beyond reasonable doubt standard.