PHILIP PAYTON

More than The Last Shilling

REPATRIATION IN AUSTRALIA 1994–2018

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ACKNOWLEDGEMENTS

This is the second of two volumes I have researched and written for the Department of Veterans' Affairs (DVA), the first, entitled '*Repat': A concise history of repatriation in Australia,* having been published in 2018. In preparing both books, I am indebted to Ian Skinner—project mentor and facilitator—and to Veronica Hancock and Roger Winzenberg, co-chairs of the Repatriation Centenary publications subcommittee.

In preparing this book, *More than the last shilling* (whose title was first suggested by Ian Skinner), I have also benefited from the suggestions and advice of the reference group—comprising Tim Evans, Ian Gardner, Mark Kelly and Craig Orme—appointed to assist with the project. Their careful reading of earlier drafts has spared me from numerous errors and omissions, although I should add that I alone am responsible for any remaining errors, together with all opinions and interpretations. Special thanks are also due to Courtney Page-Allen, who skilfully steered this book through its production stages to publication, selecting excellent illustrations along the way, and to Carolyn Page for her perceptive editing.

Many others at DVA have helped in numerous ways, and here I should especially like to thank (in alphabetical order) Neil Bayles, Sara Biggs, Anasuya Datta, Liz Cosson, Rebecca Fleming, Samantha Gonzalez, Chevelle Grey, Charlotte Harper, Ian Hodges, Leesa Holyland, Tara Hughes, Eva Krstin, Matt McKeon, Heather MacDonald, Natasha Meston, Naomi Mulcahy, Estelle Muspratt, Katherine O'Keefe, Kate Pope, Rozana Popovic, Rodney Quinn, Lisa Shepherd and Jo Wagner.

Additionally, I should like to thank Melanie Oppenheimer, Graeme Woodrow and Peter Yule for their guidance and support. My wife Dee, as ever, has been a constant source of love and encouragement.

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ISBN 978-0-6482824-7-1

Published by the Department of Veterans' Affairs, 2019.

P03920

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Foreword

Australia's repatriation scheme, initiated in response to the First World War, has provided for returning service men and women for over a century. In the last quarter of that century, the repatriation system in Australia has undergone rapid and dynamic change. By 1994, the divestment of the old 'Repat' hospitals was already well advanced, most being absorbed into the individual state healthcare systems, with the Department of Veterans' Affairs (DVA) in consequence becoming a major purchaser (rather than provider) of healthcare for the nation's veterans.

These veterans—together with war widows/widowers and other dependents—were by now an 'ageing clientele', or so DVA imagined. Statistics appeared to suggest that, although the pool of veterans would steadily decrease in the years ahead, the demand for specialist healthcare for the elderly would rise markedly. New policies were put in place to meet this changing requirement, while DVA began to ponder its long-term future. Although the fast-dwindling 'first wave' of veterans from the First World War, together with the still substantial 'second wave' from the Second World War and post-1945 conflicts such as Korea, had been augmented by a 'third' from the Vietnam War, DVA considered that one day its work and that of the Repatriation Commission would be complete, the metaphorical 'last shilling' having been paid to the last veteran.

However, by the early years of the new millennium, it was already apparent that DVA's 'ageing clientele' assumptions had been awry. A succession of 'out of area' and regional operations, including peacekeeping commitments, had begun quietly in the 1980s but in the following decades grew in frequency and intensity. Cambodia, Rwanda, Somalia, East Timor, Bougainville, Solomon Islands, together with the Gulf War and operations in Afghanistan, Iraq and

elsewhere, ensured the almost continuous deployment of the Australian Defence Force (ADF) in a way that had not been experienced before.

A major consequence of this activity was the emergence of an unexpected ‘fourth wave’ of veterans, young men and women who brought with them a wide range of new issues and new expectations, prompting major new policy initiatives by DVA. At the same time, DVA acquired responsibilities for military compensation and rehabilitation, leading to the *Military Rehabilitation and Compensation Act 2004* and the creation of a new Military Rehabilitation and Compensation Commission to sit alongside the existing Repatriation Commission. Increasingly ‘veteran-centric’, DVA was now focussed firmly on the overall well-being of veterans, young and old, and by 2015 had embarked on a remarkable transformation journey to modernise infrastructure and processes and change the working culture within DVA.

Simultaneously, as the significant anniversaries of the First World War approached, DVA redoubled its Commemorations program, aiming to increase public awareness of the sacrifices made by Australian servicemen and servicewomen, including Indigenous Australians, now as well as in the past, and to involve the veteran and ex-service community itself in a wide range of commemorative events.

In this impressive book, *More than the last shilling*, Professor Philip Payton, distinguished historian and Navy veteran, brings alive the fascinating story of the repatriation system in Australia, from 1994 until its centenary in 2018. He builds upon an earlier volume, *The last shilling*, published in 1994, which told the repatriation story up until that date and carried a foreword by one of my predecessors as Governor-General, Bill Hayden AC (1989–1996). In this book, employing a wealth of primary material, much of it consulted for the very first time, Professor Payton has skilfully woven together important facts, key events and telling anecdotes to illuminate a story

that sheds new light on a vital aspect of Australia's most recent history. I commend this book to all Australians.

His Excellency General the Hon David Hurley AC DSC (Retd)
Governor-General of the Commonwealth of Australia

September 2019

1990 OR THEREABOUTS.
Repatriating the Last Man with the Last Shilling.

Introduction

In 1994, Clem Lloyd and Jacqui Rees published their monumental *The last shilling: A history of repatriation in Australia*. An exhaustive examination of repatriation from its embryonic Boer War and early First World War days, *The last shilling* traced the background to the all-important *Australian Soldiers' Repatriation Act 1917* and told the repatriation story in great detail up to the rebranding of the Department of Veterans' Affairs (DVA) in 1976 and beyond into the decade before the millennium.

Designed to mark the three-quarters of a century since the foundation of the Repatriation Commission and the Repatriation Department (forerunner of today's DVA), the book took its evocative title from a famous cartoon of the same name by the distinguished Australian pen-and-ink artist Stan Cross. Appearing in the veterans' paper *Smith's Weekly* on 19 July 1919, the cartoon featured a decidedly threadbare First World War veteran leaning on a crutch at a counter in the Repatriation Department. An equally ancient clerk on the other side of the counter solemnly hands the old soldier a single coin. The veteran salutes weakly in grateful acknowledgement of receipt of his due. The caption reads: '1990 or Thereabouts—Repatriating the Last Man with the Last Shilling'.[1]

As well as envisaging the longevity and durability of what was still, in 1919, a recent innovation—and a touching act of faith that Australia would be as good as its word in looking after its returned servicemen and servicewomen—the cartoon gave voice to the expectation, commonplace at the time, that sooner or later the repatriation system would wither away, its job done and the last shilling paid to the last veteran of the First World War.[2] Lloyd and Rees observed that as 'a piece of prophecy it was accurate enough', and that by 1990 only

about 2,400 Australian veterans of the First World War remained eligible for compensation under the repatriation system. However, they were quick to point out that the Second World War and other conflicts—none of which could have been envisaged in 1919 (except perhaps by the most astute observer of the Versailles Treaty)—had added to the 'pool of potentially eligible veterans estimated at 630,000 in 1990', ensuring that 'a substantial job remained to be done into the third millennium AD'.

Yet by the early 1990s, as Lloyd and Rees undertook research for their book, there was a prevailing view that, notwithstanding the relatively recent infusion of veterans from the Vietnam War, the work of the Repatriation Commission and the Department of Veterans' Affairs would one day be complete. The view from 1994, when Lloyd's and Rees' book was published, was that DVA and the repatriation system were faced with an increasingly ageing clientele, which would require new policies to meet this challenge—but would also encourage DVA to look elsewhere for new work to perpetuate its existence. The results of this twin belief were far-reaching. First of all, as DVA had discovered by the early years of the new millennium, the 'ageing clientele' assumption had been misconceived, with a new cohort (or 'wave') of younger veterans (including women) arriving, from recent operations, to change the way DVA would do business in the future. Secondly, in looking for new work, DVA found itself absorbing the task of military compensation and rehabilitation, again with profound implications for the future.

The title of this book, then—*More than the last shilling: Repatriation in Australia, 1994–2018*—is more than just a nod in the direction of its predecessor. It follows in the shadow cast by *The last shilling*, and completes the story of the final quarter-century of the repatriation system, up to its 100th anniversary in 2018. But, more importantly, it argues emphatically that the long winding-down of activity implicit in the Lloyd and Rees title was misplaced as an assumption, and that the years since 1994 have witnessed change, renewal and revitalisation—more than the 'last shilling'—to an extent that might not have been imagined a quarter of a century ago. Two Gulf Wars,

Afghanistan, and a plethora of other out-of-area and regional operations (including peacekeeping roles), have changed the military and thus repatriation landscape of twenty-first century Australia entirely.

In 1994, the Vietnam question rumbled on, to the obvious irritation of Lloyd and Rees, who wondered (amongst other things) whether the case against Agent Orange would ever be resolved. The Repatriation General Hospitals were in the process of being divested, mostly to state governments, as DVA shifted from being a major provider of health care to a major purchaser of health care. The still recent *Veterans' Entitlement Act 1986* (VEA) remained the yardstick by which the Repatriation Commission and DVA conducted their affairs: a legislative intervention which had attempted to tidy up the many inconsistencies and to provide greater certainty in the provision of various veterans' programs.[3] Moreover, according to Lloyd and Rees, the repatriation system in the early 1990s had emerged more or less unscathed from the governmental upheavals of the 1980s, where demands for 'smaller government' had almost everywhere put acute pressure on the welfare state. Public sentiment, they argued, had combined with political bipartisanship to ensure that DVA was cushioned from the debate and from its potential effects.[4]

However, if this assessment hinted at an almost comfortable stasis, then events would soon reveal new dynamics at work. Little more than a decade later, DVA would admit that its 'ageing clientele' analysis had been misconceived. More useful now was a model that envisaged successive and overlapping cohorts. An initial—and diminishing as well as ageing—'wave' of First World War veterans, widows and widowers had been augmented by a 'second wave' from the Second World War and subsequent postwar conflicts such as Korea, to which had been added the 'third wave' of the Vietnam War. Now, however, there was a new, hitherto unexpected, 'fourth wave' of much younger veterans from recent operations—women as well as men—with an array of new issues and expectations to which DVA would necessarily have to respond. Additionally, the *Military*

Rehabilitation and Compensation Act 2004, which applied to all current or former Australian Defence Force (ADF) members who had suffered injury or disease since 1 July 2004, added a new dimension to DVA's task in responding to the requirements of the 'fourth wave'. A new Military Rehabilitation and Compensation Commission (MRCC) complemented the existing Repatriation Commission, and rehabilitation took centre stage in DVA's repertoire of activities, leading (among other things) to a new 'veteran-centric' emphasis on veterans' mental health and overall wellbeing.

Alongside these developments was DVA's continued commitment to commemoration. Commemoration and memorialisation had acquired a particular Australian dimension after the First World War, when the sheer distance of battlefields and cemeteries half a world away had made it impossible for all but the wealthy few to visits the sites of the fallen. But times change, and by the turn of the millennium it was possible for far greater numbers (including veterans and their families) to routinely travel to far-flung places, sometimes as parts of 'missions' organised by DVA. At the same time, commemoration became correspondingly more sophisticated (and sometimes controversial)—culminating in the 100th Anniversary of the Gallipoli landings, the opening in 2018 of the Sir John Monash Centre at the Australian National Memorial at Villers-Bretonneux, and events to mark the centenary of the Armistice on 11 November 2018.

Meanwhile, DVA had embarked on what was nothing less than a root-and-branch transformation process, first mooted in 2015, with additional government funding to finance rapid modernisation of infrastructure and processes. Its aim was the reorientation of DVA and its culture away from being an essentially claims-processing organisation towards one that was client-focused and designed to ensure the overall wellbeing of the veteran during his or her lifecycle. It was an admirable ambition, much of which—including the innovative MyService online portal (https://www.dva.gov.au/myservice/#/)—had been achieved by the close of 2018, and showed how far the repatriation system in Australia had travelled in the quarter-century since 1994.

A RAAF Nursing Sister adjusts the litter strap of an Australian Army casualty as he is flown to Australia from Vietnam, 20 August 1965. The RAAF provided a regular Hercules courier from Richmond in NSW to Vietnam and evacuated casualties from Bien Hoa. *(AWM MAL-65-0083-03; photographer Derek Travers)*

[1] Clem Lloyd and Jacqui Rees, *The last shilling: A history of repatriation in Australia*, Melbourne University Press, Melbourne, 1994, p. 411.

[2] The ‘Last shilling’ reference is itself an allusion to Labor opposition leader Andrew Fisher’s promise in the summer of 1914 that, if war broke out, Australia would stand by Britain ‘to our last man and our last shilling’. See Philip Payton, *Australia in the Great War*, Robert Hale, London, 2015, p. 11.

[3] Lloyd & Rees, *The last shilling*, p. 406.

[4] Ibid., p. 419.

CHAPTER ONE
Vietnam revisited

Although Australia had withdrawn the last of its combat troops from Vietnam in March 1972, the consequences and ramifications of Australian involvement in the Vietnam War endured far longer than anyone might have imagined. For the Department of Veterans' Affairs (DVA), created out of the erstwhile Repatriation Department in October 1976, Vietnam was destined to remain a major preoccupation for decades to come. By the mid-1990s Vietnam-related issues had not disappeared, as some had expected, and indeed they were about to re-emerge with a vengeance.

Writing in 1994, Clem Lloyd and Jacqui Rees, in their panoramic history of repatriation, *The last shilling*, expressed surprise—even dismay—that, more than twenty years after Australia's participation in the Vietnam War had ended, the 'spirit of anguish and betrayal' expressed by many Vietnam veterans was still keenly felt. Moreover, the authors continued, this enduring sense of grievance had been heightened rather than diminished with the passage of the years, nurtured and 'coloured [by] the retrospective attitudes of many Australian veterans to their combat experience in the Vietnam War'.[5] As Lloyd and Rees explained, 'the retrospective impact of the Vietnam War gradually corroded the lives of an influential minority of those who fought it, forcing the Department of Veterans' Affairs into an adversary [sic] relationship with a significant part of its client group'.[6] As they observed, this had been 'one of the most traumatic and turbulent periods in its long history', a 'continuing bitter argument over the distinctive imprint of the Vietnam War on the physical and mental health of its veterans'.[7]

It was not only ‘combat experience’ that had embittered Vietnam veterans, according to Lloyd and Rees, but also ‘the perception that they had been denied a glorious homecoming’—a ‘hurt that lingered even after the healing and reconciliation symbolised in the great march of Vietnam veterans through Sydney to public acclamation in 1987’.[8] Although acknowledging that the Vietnam War had eventually become extremely unpopular and divisive in Australia, Lloyd and Rees considered that, in ‘the early days, there was overwhelming public support for Australian participation, and the returning battalions were welcomed with a patriotic fervour reminiscent of 1918–19 and 1945–46’.[9] To emphasise the point, and to make a comparison between the historical ‘reality’ of the Vietnam experience (as they understood it), and the divergent ‘later recollections’ of many veterans, they turned to Ian Gollings, one-time national secretary of the RSL.[10] Gollings had given his own opinion of the matter in the RSL *National Newsletter* in October 1987. ‘Much has been written about the supposed hostility with which Vietnam veterans were confronted on their return to Australia’, he said. Yet ‘in the main’, he insisted, ‘returning servicemen were welcomed home, particularly when they marched through capital cities on the return of major units. Only a few had been actually abused, physically or verbally, by protesters.’ As he put it, apparently isolated incidents ‘seemed in the intervening years to have escalated to major events involving most veterans’[11] and were now thought to have been commonplace.

It was an opinion with which Lloyd and Rees readily concurred, reflecting as it did the conventional wisdom of the time. From their perspective as historians, ‘there were no compelling reasons why the experience of Vietnam veterans should have been materially different from that of earlier wars’.[12] Although acknowledging that the risks to Australian servicemen and servicewomen in Vietnam were substantial (not least being the psychological pressures of asymmetrical warfare, with the constant threat of ambush and mines), the veterans had not been exposed to the ‘mincing machine’ of the trenches experienced in 1914–18, nor had they endured ‘the

sustained campaigning in extremes of climate and terrain characteristic of Korea and World War II'. Likewise, they had not suffered the psychological damage inflicted by 'the pervasive monotony of much garrison service in World War II', nor had they been incarcerated in appalling conditions, such as those experienced by survivors of the Japanese prisoner-of-war camps.[13]

Moreover, according to Lloyd and Rees, 'the homecomings of Vietnam veterans were more assured and propitious than those of veterans from earlier wars'.[14] The Vietnam veterans had returned to a prosperous Australia, with little of the economic hardship that had confronted returnees from earlier conflicts. Despite increasing controversy over Australia's involvement in Vietnam, there had never been any doubt that its veterans and their dependents would benefit from the full array of repatriation provisions, as bipartisan political commitment during the war had made plain. Indeed, 'the returning veterans had the benefit of a repatriation system [that had matured] over half a century into a generous and effective public policy instrument'—a system that was 'much more assured and sophisticated than it had been for any previous war'.[15] Veterans, by and large, had known how long they were likely to serve in Vietnam, and, it was explained, Australian forces in Vietnam had had 'an inestimable advantage' over their predecessors in earlier conflicts, in that they understood exactly what their entitlements would be when they went to war. In earlier wars, entitlements had been decided by public policy developments as the war progressed, with service members unaware of their pension rights and other possible benefits until the fighting was almost over, or even after they had returned home.

Australian troops parade through the streets of Brisbane on their return from Vietnam, 12 November 1970. *(NAA: A1500, K26968, 11651089)*

Improvements in casualty evacuation and medical provision had led to vastly superior treatment of the wounded or ill when compared with previous conflicts. Medical records were allegedly also much improved (fewer files had gone astray in Vietnam), while documentation of troop movements and deployments was by then extremely accurate. Not surprisingly, given this efficiency, Vietnam veterans were not slow to apply to DVA for benefits on their return to Australia: there was a high take-up of war-service homes, for example, and Vietnam veterans proved more likely than their Second World War predecessors to apply for disability pensions.[16]

The Vietnam Veterans Association of Australia (VVAA), formed in December 1979 to represent the interests of the returnees, had reckoned that up to 15,000 veterans had been seriously affected as a result of their deployment to Vietnam. Yet by 1990, according to DVA figures, fewer than 3,000 (approximately five per cent of the

60,000-plus Australians who had served in Vietnam) suffered chronic ill-health. About 9,000 Vietnam veterans held disability pensions, and around 5,000 received small pensions for such conditions as ‘minor stomach ulcers, mild deafness, less serious forms of solar skin cancer, and flat feet’.[17] Assessing the evidence, Lloyd and Rees concluded that, as 67 per cent of Vietnam veterans who applied for disability pensions had had one or more of their reported conditions accepted, ‘the claims of serious illness seem overstated’.[18] They accepted that more might be learned ‘about the aetiology of deaths, illness and injury from the Vietnam War as the veterans age, but by the early 1990s there was no evidence that the basic configurations would change significantly’.[19] Moreover, persistent claims by VVAA that the use of Agent Orange as a defoliant in Vietnam had been responsible for a wide range of conditions allegedly suffered by veterans had been dismissed in the Evatt Royal Commission in 1985. Taking their cue from Evatt’s findings—‘Agent Orange: Not Guilty’—Lloyd and Rees concluded in 1994 that the ‘case against Agent Orange remains unproven and it seems unlikely, although not impossible, that this will ever be reversed’.[20]

The case against Agent Orange had been rejected, and complaints about an indifferent homecoming and public hostility were now generally considered greatly exaggerated. Moreover, according to Lloyd and Rees, the war itself was thought to have been fought in more favourable conditions and in a more benign environment than earlier conflicts, and its risks and consequences managed more effectively. Yet despite all this, many Vietnam veterans continued to press their claims, often vociferously. Why was this?

To begin with, the experience of war in Vietnam was every bit as horrific as in earlier conflicts. By the time Lloyd and Rees were writing, there were already numerous published accounts of Australian participation in the Vietnam War, and over the next quarter of a century there would be countless more, many of them accurate, well-researched and reliable, including first-hand accounts. Comparisons with the First World War, or the Second, or the Korean,

or any other conflict in which Australia had been involved, turned out to be more difficult—even invidious—than some had cared to imagine. Vietnam had had its own terrors, as those who had experienced them made plain in often vivid testimony.

The Battle of Long Tan on 18 August 1966, for example—in what was a concerted attempt by North Vietnamese and Vietcong forces to destroy the Australian presence in Phuoc Tuy province, Australia's principal theatre of operations in Vietnam—was etched permanently in the consciousness of those who fought it.[21] In 2006, one veteran recalled the terrifying cacophony of sound that broke out as the battle commenced, a 'frightening roar that lasted for the rest of the day', admitting that 'I know I'll be haunted by it for the rest of my life'.[22] For another, it was the piercing 'shriek of the bugles . . . you'll always remember the bugles',[23] and for a third there was the appalling spectacle of Vietcong human-wave tactics: 'They were 100 metres from us, less than that ... they were chanting ... psyching themselves up ... you'd see them in lines ... then the bugle would go and they'd charge us and they'd walk through our artillery, which was just wiping them out'.[24] There was also the unbearable tension of close-contact combat: '*I've gotta get this fella*. I shot the bloke that was going to fire, another bloke went over to take his place and I shot him, and another went and I got him ... I'm still shaking now [in 2014] when I think about it'.[25] Letters written home in the aftermath of Long Tan had familiar echoes of earlier conflicts: 'It looked so hopeless and there were so many of them, but everyone who died, died like a man. You feel sorry for the ones killed but when you see them lying out there you thank God it's not you, I'll be glad when it's all over'.[26] A national service veteran (a 'nasho' in popular parlance), who had fought at Long Tan, recalled vividly in 2014 'what I can only describe as a slaughterhouse ... body parts and pieces of flesh ... actually row upon row of [enemy] bodies ... churned up by the artillery'.[27]

Crowds cheer Vietnam War veterans during the commemorative Welcome Home parade in Sydney, 4 October 1987. *(AWM PAIU1987/227/07; photographer Peter David West)*

Sapper Raymond Bellinger, one of a team of engineers which searched hundreds of metres of Viet Cong tunnels, emerges unscathed from the subterranean gloom, June 1966. *(AWM CUN/66/0523/VN' photographer William James Cunneen)*

Long Tan was not the only battle. Among the most nerve-wracking encounters with the enemy was penetration of Vietcong tunnel systems. ‘Have you ever snorkelled?’, asked one veteran: ‘You know the rasping sound when you breathe and you can hear nothing else? Well, that’s all you can hear when you’re in the tunnel. You can hear the air going down your airways and you can hear this thump, thump, thump as your heart beats ... It’s very hard to control your fear’.[28] Booby-traps, mines and chance close-quarter struggles with the enemy were constant dangers. ‘It was scary going down the tunnels’, agreed another veteran, ‘I was lowered down [by rope] with a torch in one hand and a bayonet and a pistol. You’ve only got two hands, so it was push the torch, fiddle on the ground with the bayonet, then push the torch, a metre at a time’.[29] Using such methods, the Australians were able to gather an extraordinary amount of equipment and intelligence, from secret documents to photographs of foreign advisers and target lists of military and political figures singled out for assassination. But it added a particularly hazardous and often terrifying dimension to Australian operations in Vietnam.

‘Opinions vary on whether the Vietnam experience was harder, easier or simply different from that of the World War I or World War II Digger’, observed the writer Patrick Lindsay.[30] Put another way, comparisons with earlier conflicts would always be fraught with difficulty, and were often unhelpful. It would also be a mistake to imagine that Vietnam veterans had had it easier than those who had fought in previous wars. Aspects of the Vietnam experience were as distinctive as they were horrific, to which was added a challenging climate and terrain—heat, humidity and thick, thorny tropical jungle, through which the Australians hacked their ways with machetes, together with swamps and marshes and frequent drenchings from tropical downpours.[31] Presenting historical material on its Anzac Portal website (https://anzacportal.dva.gov.au), DVA acknowledged in 2018 that ‘Vietnam was different’, and noted that the conflict had ‘lasted longer than previous wars in which Australians had fought’. Moreover, ‘it occurred at a time when societal changes, some

brought about by the war, meant that attitudes at the beginning of the war were very different to those at the end'.[32]

For those who had fought in the war, these 'societal' changes could be perplexing. To have the nature of the war underestimated or misunderstood at home was galling for many Vietnam veterans. So too were the apparently bewildering swings in both political judgement and public opinion that had occurred during the war. Robert Menzies had first committed Australian troops to Vietnam in support of America as a result of his adherence to the 'domino theory'—the belief that South-East Asian countries would fall one by one to the communist threat if it was not confronted militarily and defeated. Menzies' successor, Harold Holt, shared the same opinion and insisted that in 'the long run the threat to South Vietnam is a direct threat to Australia'.[33] Yet three weeks before Saigon finally fell to the Communist forces on 30 April 1975, Prime Minister Gough Whitlam announced that 'who rules in Saigon is not, and never has been, an ingredient in Australian security'.[34]

This seemingly fickle shift in political assessment was matched (as many veterans saw it) by mercurial swings in the public mood. Early uncritical support for Australian involvement in Vietnam had been mirrored in enthusiastic homecoming receptions for those who had returned home by sea in HMAS *Sydney*. But by 1969 public opinion had begun to fragment, with growing opposition to conscription (which had been introduced in an amendment of the *Defence Act* in 1965), complemented by hostility to the war itself and increasing disquiet about Australia's involvement. This sowed the seeds of resistance—the Vietnam moratorium movement—and led to large anti-war demonstrations across Australia. The moratorium march in Melbourne in May 1970, for example, attracted more than 10,000 people.[35] Overall, some 200,000 people participated in demonstrations in the major towns and cities of Australia. As DVA has explained: 'For Australia, the Vietnam War was the cause of the greatest social and political dissent since the conscription referendum of the First World War'.[36]

‘Caught in the middle of this conflict and bitterness’, as one Vietnam veteran put it, ‘were the soldiers who fought the war—many of them unwittingly’.[37] Many, not least the ‘nashos’, wondered now what they had been fighting for, and felt aggrieved by what they saw as a lack of respect and support at home. According to one observer writing in 1999, ‘the men and women who fought in Vietnam were, on their return, largely ignored by a society and abandoned by the government which ordered them to conduct its war’.[38] Another veteran, writing in 2002, recalled bitterly that, on his return to Australia in 1972, ‘I was advised not to wear uniform as the public hated the sight of us! We were “rapists, murderers and war mongers”’. Moreover, he claimed, the ‘unions had declared us “black” to such an extent that I had not received my parcels or mail during Christmas 1971 ... Thanks guys for all your support!’.[39] According to one senior officer:

Australian soldiers rush a wounded mate to a waiting helicopter for evacuation for medical treatment at the 1st Australian Field Hospital, Vung Tau, Vietnam, July 1970. (AWM WAR/70/0601/VN; photographer Peter Anthony Ward)

> When our Vietnam vets came back, they were put on the plane and while they were on it they were told to get into their civvy clothes. They arrived at midnight and were given a briefing: 'Don't talk about the war. It's a year out of your life. Forget about it. The public don't like it. The press don't like it. Don't talk about it'.[40]

Likewise, a female veteran remembered going to meet her cousin at the airport. 'They used to bring them in from Vietnam at midnight', she recalled: 'We're all standing there waiting for them to get off and they diverted the boys to the hangar to get changed into civvy clothes first'. As she explained, it 'was because they were frightened they'd be belted up: that's why they made them change. Those boys went straight off the plane, into civvies, onto trains or buses, back home'.[41]

It was certainly true that some came home to an uncertain welcome, and some felt ostracised by former friends and civilian colleagues. Others detected resistance when they joined—or attempted to join—RSL sub-branches, a source of dismay for those who wished to be embraced as 'diggers' and to claim common cause and fellowship with veterans of former conflicts. But if men sensed that they were not always accorded the dignity and status of 'veteran', then this was doubly so for women who had served in Vietnam. In 2012, in a report commissioned by DVA, Samantha Crompvoets identified a lack of 'authentic veteran identity' among women who had served in Vietnam.[42] Intriguingly, those women who were more likely to self-identify as veterans were those who had successfully pursued claims through DVA. Being 'accepted' in this official sense brought 'legitimate status as someone who had served their country', yet even these women were often subjected to repeated questioning by civilians (especially medical administrators) about their possession of Gold or White cards and access to veteran benefits.[43]

In a more general sense, women were not encouraged to think of themselves as Vietnam veterans, or were presented with stereotypical depictions to which they did not conform. One former

Air Force nurse, who had served in Vietnam, was asked if she felt like a veteran. ‘No, not really’, she answered, and when pressed admitted that, although she did not see herself as a veteran in the accepted sense, she nevertheless self-identified as ‘Someone who’s been to war’. When invited to explain the distinction, she added that ‘for some unknown reason, because I was on the medical side, it [veteran status] doesn’t seem to apply’.[44] This was despite Australian nurses being exposed to harrowing scenes in Vietnam: as one ex-Army nurse recalled, ‘the wounds were absolutely terrible. I mean we had chaps with both, with their hindquarters blown off and an arm missing and all that was left of them was one arm and the head’.[45] Another nurse, who likewise did not really consider herself a veteran—despite being an active member of the RSL and Legacy—complained that she was routinely addressed as ‘Mr’ in correspondence, evidence of a general assumption that Vietnam veterans must be male. ‘They’re going to have to raise their game’, she insisted, including DVA, which had often repeated the mistake: ‘I’ve raised it with the Deputy Commissioner in the past ... they’re going to have to change that mindset within DVA’. Agreement came from an ex-Army nurse who thought that ‘DVA are funny. The most recent time I went there, the young man just ... you know, he wasn’t prepared to accept that I was a Vietnam veteran, (a) because I’m female, and (b) because he obviously thought that I should be grey haired, with a walking cane, and a stoop’.[46] More philosophically, another former nurse explained that it took a very long time before she began thinking of herself as a veteran. Before that, ‘I was just a nurse who’d gone to Vietnam, whether that was because of the treatment we’ve got when we came back from Vietnam, I don’t know’.[47]

The ‘treatment’ that Vietnam veterans, women as well as men, had received on their return to Australia added to the abiding sense of grievance. So, too, did the perception that the Australian Defence Force (ADF) had been tardy and parsimonious in its award of medals and decorations for service in Vietnam. For example, there was resentment when the Australian government disallowed the

award of the South Vietnam Cross of Gallantry after Long Tan (following the longstanding protocol that serving members may not accept foreign medals), while others complained that the quota system then in place for the award of military decorations meant that some individuals went unrecognised while others received lesser awards than those for which they had been recommended. In 2008, an Australian parliamentary review of awards to Long Tan veterans led to limited upgrades, and in 2009 a further inquiry sanctioned one further individual award while ruling that no additional awards or upgrades would now be considered.[48] Nonetheless, D Company 6 RAR was awarded the Unit Citation for Gallantry in 2011, while in 2016 (coinciding with the fiftieth anniversary of the battle), further individual awards were approved by the Governor-General.

Meanwhile, it took until May 2018 for full recognition to be achieved for participants in the battles of Fire Support Bases Coral and Balmoral, the most costly Australian engagement in the Vietnam War, in which twenty-six Diggers were killed and ninety-nine wounded. In the immediate aftermath of the battles—the first time an all-arms brigade-size operation of some 3,000 men had taken place since the Second World War—only a handful of soldiers had received decorations for their actions. It took another fifty years for the award of a collective Unit Citation for Gallantry to some of the 'most forgotten heroes of Australia's Vietnam War', as the *Australian* newspaper dubbed them, after a concerted campaign for recognition by Vietnam veterans.[49]

It was not until January 2019, in recognition of their hazardous service, that DVA health Gold Cards were approved for former members of the Australian Civilian Surgical and Medical Teams who had been deployed to Vietnam under the aegis of the Southeast Asia Treaty Organisation (SEATO).[50]

To this were added the long-term psychological effects of service in Vietnam. After my release', admitted one veteran, 'it was indeed difficult to come to grips with "normal" life. Some people hardly wanted to know me, others were incessant with questions'. Then one

day, ‘I found what I thought to be the answer. I looked into the mirror and was horrified to see old, so sad and cynical eyes staring back ... The Army had made a good job of turning me into a soldier but failed to turn me back into a civvie’.[51] When the Battle of Long Tan was over, according to another Vietnam veteran, ‘there was no counselling or anything else ... there was never any debriefing of any nature that I recall, and we just got on with the war’. He added, tellingly, reflecting on the long hiatus of subsequent years, ‘Long Tan didn’t become a big thing until the 20th anniversary’.[52] Those who had lost close friends suffered especially. In 2006, one veteran remembered clearly how on the Long Tan battlefield he had found his dead ‘mates lying in an arc, facing outwards, with rifles still at the shoulder as if they were frozen in a drill and it needed only a touch to bring them to life again’.[53]

Then there were the nightmares and recurring dreams. In 2007, another veteran recounted the disturbing dream that had visited him night after night since the Battle of Long Tan more than forty years before: ‘all the blokes in the dream were all me friends, all me mates that were killed and I just said to them, “It’s only a dream and when I wake up you’ll wake up in the morning with me”’. Alas, he continued, ‘that dream has kept with me from Long Tan till now ... I still tell them that when I wake up that next morning, they’ll wake up with me. But they never do’.[54] For those who had gone underground in the labyrinth of Vietcong tunnels, there was a lingering claustrophobia, liable to be triggered at any time. ‘I was petrified’, admitted one veteran: ‘If I have to get under the house even today I’m scared. I had to get under my mother’s house recently after she died, and it brought it all back to me’.[55]

Not surprisingly, such psychological effects impacted upon the lives of Vietnam veterans’ families. According to one observer, in ‘an abstract way, the wives of many Vietnam veterans, while not veterans themselves, are, nevertheless, equally the victims of the Vietnam war’. There was, for example, the case of ‘Adele’ and ‘Gary’. Before going to Vietnam, Gary was ‘a soft caring man’. He

came back a different person: Adele reported that ‘he became hard and scornful, he drank heavily, and flew into a rage over nothing’. Their home was now run with ‘military precision’, and Gary became extremely jealous of Adele’s social life, his fury often descending into domestic violence. He also suffered recurrent nightmares, in which, among other things, he saluted in his sleep, sweated profusely, and counted out loud. It transpired that Gary had been caught in crossfire during the Battle of Fire Support Base Coral while bringing up ammunition to his unit. In his sleep, he was still counting out the rounds. Gary’s behaviour rubbed off onto his son, who inherited his father’s loathing of Asians, picking on Vietnamese children at school, using racist language and exclaiming inappropriately after the family car was involved in a minor collision: ‘Oh, no Dad—you’ve run into a Dim Sim Charlie’.[56]

Posttraumatic Stress Disorder (PTSD) was still imperfectly understood when Lloyd and Rees were writing in 1994. Initially known as ‘shell shock’, a somewhat pejorative term with intimations of weakness of character or lack of moral fibre, psychological problems had later been categorised as the less judgemental ‘combat stress’. In 1980, however, the American Psychiatric Association’s *Diagnostic and statistical manual of mental disorders* had acknowledged PTSD as a mainstream condition, accepting that veterans’ psychological problems were a ‘normal reaction’ to stressful episodes. Put another way, it was now recognised by the medical profession that it was the acute stress of war, rather than any predisposed mental or personality disorder, that was the principal cause of psychological illness in veterans. In 1982, the Vietnam Veterans’ Counselling Service (VVCS) had been established by DVA, initially in Adelaide with strong VVAA support and encouragement, and within two years it had expanded to eight centres across Australia—such was the demand for its services. Indeed, following early review and restructure in 1994, so successful was the service that, in 2007 (following a major assessment of Vietnam veterans’ health), it was relaunched and rebranded as the Veterans and Veterans Families Counselling Service (VVCS), with

fifteen centres across the country by 2010.[57] Nonetheless, it took time for attitudes to change in Australia, both in the military and in the civilian world, and as late as 2005 one supposedly informed observer (who should have known better) complained that some PTSD sufferers among Vietnam veterans were merely 'lazy, rorting malingerers [who] ... want pensions for being turned into drunks'.[58]

Yet attitudes did change, and as understanding of PTSD became more sophisticated (by 2012 it was recognised by DVA as a stand-alone condition), so a greater appreciation emerged of the inherent difficulties experienced by veterans as they tried to readjust to civilian life on leaving the ADF. A revealing case study published by DVA in 2009 was that of an Aboriginal veteran, Dave. As a child, Dave had routinely suffered racist abuse and discrimination, but had taken heart from the exploits of his role model, his uncle, who drove a mighty Garratt locomotive, 'the powerfullest steam engine in Australia', as Dave put it. Everyone, black and white, looked up to his uncle, and Dave was determined to follow in his footsteps, to achieve the same status and recognition. He became an engineer, not on the railways but in the Royal Australian Navy. He joined in 1965, and five months later sailed for Vietnam, serving in an escort ship accompanying the vessels ferrying troops to and fro. 'I loved the navy', he said. 'We were good and we were fit and we earned respect'.[59]

However, at Vung Tau, the South Vietnamese port where the Australians had established a logistical base, Dave was involved in a diving accident and 'I bloody nearly drowned'. He began to drink heavily after the incident, but stayed on in the Navy until 1993, after twenty-nine years' service. Yet he found it difficult to 'cut the umbilical cord', as he put it, and at the age of sixty-one in 2009 saw that his life still revolved 'around ex-servicemen, their families, welfare, pensions, community duties and all those sorts of things. Basically, I'm just wearing civilian clothing'.[60] Moreover, Dave recognised that, alongside the trauma of his diving accident, there were other psychological issues resulting from his service:

> You never get reprogrammed to be a civilian: we're taught 24/7 'Can do, can do'. The older we get the more difficult it becomes to maintain standards, whatever that standard may have been. We're saying, 'Can do, can do, she'll be right mate' until we drop but the thing is, it's not all right; we're not all right. We don't even know we're broken'.[61]

'My wife thought I'd be normal when I left the force', Dave continued, but 'my fuse is getting shorter'. After Vietnam and experiencing the exigencies of service life, he was increasingly irritated by the seemingly trivial concerns expressed by civilians about everyday issues of no importance. Similarly, he was incensed by trains that ran late, and despised, for their perceived lack of respect, the 'blokes going over my body with a little electronic device' at the airport 'Naturally, I drink to excess', he admitted, although his psychologist had at least helped him to understand his predicament, 'so that's pretty cool'.[62]

Patricia Ferguson, a nurse who had served in Vietnam, experienced similar feelings, 'and developed a real attitude problem' after her return to civilian life: 'I openly told patients and colleagues how empty, vain and superficial they were'. Asked later if she had suffered PTSD, she was intrigued by the suggestion and inquired how she might know. 'Well, Sister do you have flashbacks, nightmares, difficulty sleeping, get anxious, feel isolated, have outbursts of anger and don't trust people?'. 'God', she replied, 'you've just summed up seventeen years of my life'.[63] Patricia Ferguson was subsequently formally diagnosed with PTSD, and in 1992 became the first female Australian Vietnam veteran to be awarded a Total and Permanently Incapacitated (TPI) pension by DVA.

By now, DVA was increasingly alive to the implications of PTSD, and recognised that it needed to know more and do more. In April 1994, therefore, the department decided upon a new, comprehensive approach to the treatment of PTSD and comorbidity, to be based at the Repatriation General Hospital (RGH) Heidelberg in Melbourne.

This initiative was largely a result of liaison visits by DVA personnel to PTSD centres run by their veterans' affairs opposite numbers in the United States of America. They returned to Australia with the redoubled conviction that 'PTSD is initiated through exposure to extraordinary stressful life events', and was not a result of any underlying weakness of character or predisposing personality.[64] The condition and its associated comorbidities were summarised in a paper presented to the Repatriation Commission following their return from America. It was to be a significant advance in the treatment of Vietnam (and other) veterans:

> PTSD in veterans is complicated by significant psychiatric, medical and social problems. Seventy to eighty percent of veterans with PTSD have periods of alcohol or drug addiction following the onset of their illness ... Other psychiatric disorders complicating PTSD include depressive illness, panic attacks, social phobia and agoraphobia. Common medical problems among this population of veterans include hypertension, ischaemic heart disease, obstructive airways disease, sleep aopnea, diabetes and obesity. Social problems are common and include marital breakdown, family disruption, domestic violence and unemployment.[65]

Specifically:

> ... it is recognised that Vietnam veterans who developed PTSD did so at a very early stage of their adult development and suffered severe developmental arrest in their maturation ... [they had] inadequate life skills needed to manage conflict, anger, interpersonal relationships, marriage, parenting, use of drugs, goal setting, financial planning and social interaction.[66]

RGH Heidelberg was to be the study centre for PTSD, while residential workshops for veterans with PTSD were to be set up across Australia with the active cooperation of the Vietnam Veterans Counselling Service (VVCS), which would itself experience a 'culture change', embracing new approaches such as the adoption of a case-management model and the establishment of a research ethos.[67]

There would also be drug and alcohol abuse programs, to be integrated within the treatment plans, and specialised vocational rehabilitation services for veterans with PTSD would be established. Learning from the American experience, DVA envisaged that the first goal in the treatment of PTSD would be symptom reduction, mainly through medication. This treatment would be followed by symptom management, and through 'detox' procedures for alcohol and drug abuse. Group therapy would be used to reverse the arrest of maturation, and to assist with anger management and conflict resolution. Vocational rehabilitation would then help veterans to retrain and to re-enter the workforce with a new sense of purpose. Meanwhile, good therapeutic relationships would be established with veterans to allow monitoring and detection of early indications of relapse. With a slight hint of embarrassment, DVA noted that such a program had been in existence in the United States since 1980.[68]

As a result of these deliberations, in 1995, with the active support and encouragement of the veteran community, DVA established a new cooperative partnership, the National Centre for War-Related Posttraumatic Stress Disorder. Funded exclusively by DVA for five years, the new centre was founded in collaboration with the University of Melbourne and the Austin & Repatriation Medical Centre (of which RGH Heidelberg had become a part in 1995). So successful was the new centre in developing an integrated approach to treating PTSD and associated mental health issues that, in July 2000, DVA's financial support was extended for a further five years.[69] By now, DVA was fully aware that some 30% to 40% of Vietnam veterans could be expected to experience mental health problems during their lifetimes, compared with between 18% and 20% for the general population.[70] Later, as funding was attracted from other sources, and as the extent of PTSD in the wider non-veteran community became better understood, the centre broadened its remit, initially becoming the Australian Centre for Posttraumatic Mental Health (APMH), and then Phoenix Australia—its name implying an emphasis on recovery and rehabilitation.[71]

This broadening of approach was reflected in DVA's publication, in 2001, of *Towards better mental health for the veteran community*, a further indication of the extent to which PTSD and other mental health problems were now at the forefront of DVA's concerns. In December 2000, for example, DVA signalled its approval for the counselling and psychiatric assessment of *former* dependents (partners and children) of Vietnam veterans, extending provision to take account of divorce.[72] Then, in 2013, DVA commissioned researchers at the Australian Institute of Family Studies in Melbourne to investigate health and social issues specifically among the children of Vietnam veterans. The resulting report confirmed what anecdotal and other evidence had been suggesting for some years—that there was an intergenerational dimension to PTSD. The sons and daughters of Vietnam veterans, it was shown, were more likely than the national average to have experienced 'harsh parenting' as well as bullying at school, and were more likely to have learning difficulties.[73]

Recognising that the children of Vietnam veterans were likely to have suffered as a result of their parents' experiences and subsequent disabilities or behaviour—and were thus often disadvantaged compared with their peers, the Long Tan Bursary scheme had been introduced by DVA in 2001. Considered part of DVA's Veterans' Children Education Scheme, which provided support services and financial assistance to children of certain deceased or severely incapacitated veterans or members of the ADF (and which by June 2004 was benefiting over 5,000 children), the Long Tan Bursary was aimed specifically at the offspring of Vietnam veterans, aged up to twenty-five, who were in full-time tertiary education or planned to enrol shortly. Initially, thirty scholarships, worth $6,000 each, were offered annually.[74] By 2018, this had expanded to thirty-seven bursaries, worth $12,000 for each recipient and paid over three years, the scheme administered on behalf of DVA by the Australian Veterans' Children Assistance Trust.[75]

The first Long Tan Bursaries were awarded by DVA in February 2001. The application summaries revealed the (by now) all too familiar patterns of indifferent parenting and family breakdown. ‘In more recent years, the veteran (who suffers from PTSD) has been drinking more heavily and withdrawing from his family’, observed the assessment of one application. ‘He is a gambler and maintenance payments are sporadic’, noted another. ‘His aggressive, volatile and unpredictable behaviour has made home life difficult’, reported a third. And so it went on: ‘He is now a TPI and service pensioner, with a high alcohol intake’; he ‘is difficult to live with’.[76] As DVA observed, such an environment was hardly conducive to academic study, so that children of Vietnam veterans would benefit educationally from whatever support might be made available. But there was also a wider mental health issue to be addressed, as DVA acknowledged, not least as suicides were three times more prevalent among Vietnam veterans’ children than among the general population of comparable age.[77]

In November 2002 the VVCS national management team had proposed the development of a book designed specifically for the sons and daughters of Vietnam veterans. Approved by DVA in February 2003, the resultant volume was published in 2004. Entitled ‘“*— and the pine trees seemed greener after that”: Reflections by sons and daughters of Vietnam veterans’*, the book’s objectives were ‘to reduce sons’ and daughters’ sense of isolation and stigma, improve their mental-health literacy and improve their intentions towards help-seeking behaviours’.[78] The contributions were by the children themselves, and included remarkable and often moving testimonies. As one child admitted:

> It wasn’t until I was about 7 or 8 that I realised my father had a problem. We had just settled down after dinner, one of my dad’s mates arrived with a TV and a VCR. My brother and I had grown up without a TV so we were enraptured with the cartoon videos that he had brought with him and were eagerly awaiting the promised movie ‘Deer Hunter’ [about the Vietnam War]. To dad’s

> credit he made it about half way through the movie then to our absolute horror he turned into a gibbering mess.[79]

The intrusion of unexpected and disturbing televisual images into the heart of the domestic environment was a recurring theme. Another contributor recalled viewing the film *Forrest Gump* at home, part of which was set in Vietnam and involved the protagonist retrieving the body of his dead friend, Bubba, who has been killed in action, while also saving the lives of other members of his platoon. We 'all sat down to watch a movie, "Forrest Gump"', wrote the contributor, and 'when Forrest pulled Bubba out of the jungle dad vomited. No warning, he just up and vomited':

> Then, not even a month later we sat down to watch a documentary. Much to our horror one of the scenes at the end shows a door gunner returning fire at Vietcong targets as the camera panned around to show the gunner's face ... it was my dad. His words will stay with me always: 'I never wanted my kids to see that'. Then he started sobbing.[80]

Sudden exposure to the trauma of war in the family sitting-room was a shock for such unsuspecting children, especially when confronted by their parents' reactions as they relived their own terror. But for others, erratic parenting was a constant daily dread. 'When I was growing up, the Vietnam War was a dark shadow at the heart of my family', remembered one offspring, detailing a depressing routine that was acted out day after day. This contributor explained that their father worked on the family farm with his four brothers, and rarely came home until after dark:

> When his truck would pull up in our driveway my stomach would drop … Will he be drunk tonight? Will he be in a bad mood? As I got older, I recognised the pattern that rarely changed. He would become loud and aggressive, then slump into tears, back and forth from one extreme to the other ... I heard how his best friend got his head blown off, how he killed men with his bare hands, how Vietnamese were so evil. I saw my father melt down, time after time after time.[81]

Concern for the intergenerational dimension of PTSD was but one element of the growing research interest in this complex disorder. In November 1995, for example, DVA had indicated that in 1996 and beyond, key areas for which it was prepared to award research grants to institutions would include PTSD (with an emphasis on questions such as the effect of traumatic stress on memory and concentration) and alcohol abuse (for example, alcohol damage to the pancreas).[82] Significantly, however, by 1998 the list of priority areas for the award of grants under DVA's Health and Medical Research Program had expanded to include spina bifida.[83] During 1996, DVA had decided that, as a matter of principle, diagnosis of PTSD would henceforth be an automatic entitlement for treatment.[84] Among other things, this was seen as a considerable victory for Vietnam veteran campaigners. Now, however, the emergence of spina bifida as a research priority signalled a new twist in the Vietnam veterans' saga. Despite the dismissive attitude of the Evatt Royal Commission—which had concluded that there was no evidence of any connection between the use of Agent Orange and the conditions allegedly suffered by Vietnam veterans—the debate about the effects of defoliants had only intensified.

The VVAA had long argued that the spraying of herbicides and pesticides (notably Agent Orange, a defoliant used extensively by the Americans to destroy the jungle hiding places and concealed supply routes of the North Vietnamese and Vietcong) was the root cause of many veterans' ailments. The Association insisted that a wide range of cancers, together with nervous, digestive, skin and respiratory diseases, were all directly attributable to Agent Orange and other toxins. By 1994, evidence suggestive of such links, trickling through from America, could no longer be ignored, and in October 1994, the Minister for Veterans' Affairs, Con Sciacca, announced that 'I have a report ... that says there is sufficient evidence to create a causal link [between defoliant exposure and cancers]. I have given the veterans the benefit of the doubt and I am comfortable with that decision, very comfortable'.[85] Giving veterans the benefit of the doubt was tantamount to formal acknowledgement

of an at least possible link between Agent Orange and various types of cancers. It represented another victory for the VVAA. However, in the same breath as this admission, the Minister added hastily that 'It's a big progression from the decision I've made, a very big progression ... to go and then say Agent Orange or herbicides have caused birth defects in children. Anything I have read opposes that line'.[86]

This was despite an array of anecdotal and circumstantial 'evidence' and opinion that had built up over the years, before and after the Evatt Royal Commission, which had suggested the possibility of such a link. One veteran, for example, who had served in Vietnam with 1st Australian Field Hospital, was finally discharged from the Army on medical grounds, suffering from skin rashes and blackouts which his doctors thought might be the result of some toxic exposure but could not pin it down. Although the veteran's wife had given birth to a healthy child while he was in Vietnam, she miscarried twice after his return home.

Eventually she gave birth to a baby girl, Elizabeth, who suffered from two dislocated hips and spent eighteen months in splints. She also suffered from chronic asthma. A further daughter, born after Elizabeth, also had birth deformities. She was born without a thumb socket, and later developed serious respiratory difficulties. A further child, a boy, was born without sight in his left eye. Sadly, birth deformities were also present in the two children borne by Elizabeth as an adult. One developed chronic asthma, and the other had severe cranial deformities.[87] Although indisputably tragic and plain for all to see, this family's experience was not typical of that of Vietnam veterans, and medical science was unable to link these deeply unfortunate occurrences to service in Vietnam. Yet such reports continued.

Another Vietnam veteran, for example, reported that his wife's first baby, a girl, was stillborn. A second child, a boy, had breathing problems from birth. The third, also a boy, was born with club feet. Specialists, puzzled by this unfortunate run of events, wondered if

there was some congenital issue at play, but the veteran insisted that no-one in his or his wife's family had ever experienced such difficulties. As he concluded: 'I hope the matter of Agent Orange can be cleared up one way or the other very soon'.[88]

Again, the American experience proved pivotal in informing and motivating DVA. In March 1996, DVA noted that a recent report from the National Academy of Sciences in the United States had linked Agent Orange with some birth defects—especially incidences of spina bifida—in the children of American Vietnam veterans. Following extensive discussion with ex-service organisations, especially the VVAA, DVA decided that it was time to act. A hotline was established to keep veterans and their families informed of the issues as they developed and, on 27 March 1996, a press release announced to the Australian public that Agent Orange was again on the agenda, and that the Australian government, through DVA, would now be continuing research into the effects of defoliants. Among other things, it would be investigating the postulated link between Australian veterans' exposure to defoliants and the incidence of spina bifida in their offspring.[89] Bruce Scott, Minister for Veterans' Affairs in the recently-elected Howard government, reported on 28 March that he had instructed DVA, through the Repatriation Commission, to conduct a 'speedy review' of all the evidence, so that 'the government can determine a just response'.[90]

'VVAA felt vindicated', according to one report, while John Methven, VVAA's president, hailed the breakthrough as a significant success: 'It has totally opened up a new field'.[91] Indeed it had. To begin with, in April 1997 DVA published *Mortality of Vietnam veterans: The Veteran Cohort Study*, which presented some alarming findings. There was 'evidence of excess mortality among Vietnam veterans compared with the rest of the Australian male population', it reported.[92] Deaths from lung cancer were 30% higher than the national average, while deaths from head, neck and prostate cancers were 50% higher. Suicide rates were some 14% to 21% higher. Yet these conditions had been self-reported, rather than

objectively assessed, so the findings had to be treated with some caution.

In the following year, 1998, DVA published its exhaustive report *Morbidity of Vietnam veterans: A study of the health of Australia's Vietnam veteran community*. Drawing upon 40,030 veterans' responses (an astonishingly high response rate), the results were revelatory and extremely disturbing. Some 25% of veterans reported that they had been diagnosed with cancer since their first day in Vietnam, and at least 30% reported mental health issues such as anxiety disorders and depression. The cancer rates were between three and ten times the national rates (depending on the condition). Congenital abnormalities in Vietnam veterans' children were three to eleven times the normal rate—spina bifida in their children was ten times the national average, and missing body parts in children were even higher. Women who had served in Vietnam (aid workers and ADF and civilian nurses) also reported higher rates of cancer, heart disease and birth complications.[93] Supplements to the study were published subsequently (that on the suicide of Vietnam veterans' children in 2000, that on adrenal gland cancer, leukaemia and non-Hodgkin lymphoma in 2001), with the intention of investigating specific aspects in greater depth.

Likewise, it was recognised that Agent Orange—generally referred to as a generic term covering all defoliants—in reality represented only 66% of the herbicides sprayed on South Vietnam by the United States Air Force during the war. There were in fact fifteen types of defoliant employed—Agents Purple, Green, White, Blue and Orange (I and II)—together with dinoxol, trinoxol, bromacil, diquat, tandex, monuron, diuron and dalapon. To this was added the six different kinds of insecticide used to exterminate malaria-carrying mosquitos.[94] There were painstaking attempts to try to isolate each of these different chemicals and assess their various effects on the human body, although only a small proportion of the chemicals was actually contaminated by dioxins. In January 2001, for example, DVA considered a report from the University of Sydney on Agent White and its supposed role in birth defects. It was noted that, in American

studies, there was ‘limited or suggestive evidence of an association between exposure to herbicides used in Vietnam and the development of spina bifida in the children of those exposed’. The Sydney university research team had been surprised to learn that the exact composition of Agent White was now unknown, and in experiments the Sydney team had to use Tordon 75D as an approximation. It was soon demonstrated that Tordon 75D had ‘toxicological effects’, and laboratory tests had led to birth defects in rats as well as the destruction of male rat testes.[95]

Private David Llewelyn of 1st Battalion, The Royal Australian Regiment (1 RAR) farewells his wife Josy before boarding HMAS Sydney, *bound for service in Vietnam in March 1968*
(AWM CUN/68/0123/EC; photographer William James Cunneen)

Similarly, it was acknowledged in a discussion of the supposed link between ‘exposure to herbicides and four types of Leukaemia’, that Royal Australian Navy warships operating in South Vietnamese waters may have unwittingly been exposed to toxins. In 2002, DVA sponsored a study by the National Research Centre for Environmental Toxicology into the potable water available onboard Australian warships operating off Vietnam. It was hypothesised that the estuarine water preferentially used in making drinking water in ships was likely to have been contaminated with herbicides and dioxins that had run off from areas that had been sprayed. The study, which reported in early 2004, found that the method of producing drinking water on board the vessels did not remove—and potentially may well have concentrated—any dioxins present in the source water. Hence, it concluded, ‘it is possible that service personnel on board such ships were exposed to harmful levels of dioxins’.[96] As a result of this finding, Royal Australian Navy personnel who had served in these warships were now considered comparable to other Vietnam veterans who were able to make claims to DVA on the basis of exposure to toxins. Thus they were added to the list of potential claimants, joining those already identified as having legitimate cause of complaint—those who had rendered more than thirty days service in Vietnam; those who had regularly eaten fish, fish products, crustaceans, shellfish or meat from Vietnam; those who had regularly drunk water or eaten food cooked with water from Vietnam discoloured by sediment; those who had regularly inhaled herbicide fog or inhaled dust in a defoliated area in Vietnam; and those who had sprayed or decanted herbicides in Vietnam as an occupational requirement.[97]

Meanwhile, there were further DVA-sponsored studies of Vietnam veterans’ mortality. The first, in 1997 was followed swiftly by a second and, in 2005, the third appeared in what was to become a four-volume comprehensive investigation of Vietnam veterans’ health. The 2005 study had followed nearly 60,000 men (but no women) for a period of up to thirty-eight years. Its report indicated that, in some areas (circulatory diseases, respiratory diseases,

infectious diseases), Vietnam veterans had a lower-than-expected mortality when compared with the general population. However, in other areas, mortality was significantly higher, notably from prostate cancer (which was now reported as 29% of those diagnosed), diseases of the liver (27%), and alcoholic liver disease (48%). Neoplasms were examined in detail and, overall, mortality related to neoplasms was found to be 6% higher. Specifically, lung cancer was 18% higher, and cancers of the head and neck 33% to 44% higher.[98]

There were also some interesting inter-service contrasts. On the whole, the mortality of Navy personnel who had served in Vietnam was not significantly different to that of the general population. But there were some important exceptions. Mortality from cancer generally was 19% higher than expected. Lung cancer was 39% higher, melanoma 56% higher, and mesothelioma (most commonly affecting the lungs) 150% higher. The overall mortality of Army Vietnam veterans was 7% lower than expected when compared with the national population, but again there were significant variations. Eye cancer, for example, was 240% higher, cancers of the head and neck 39% to 49% higher, lung cancer 13% higher, and cancer of the pancreas 30% higher. Mortality of Air Force Vietnam veterans was 9% lower than the expected mortality in the general population (and in some areas significantly so—13% lower for circulatory diseases and 36% lower for respiratory diseases). Although the report did not dwell on varying levels of exposure, the study inferred that differences between the services reflected their different operational roles in Vietnam. The study also observed that the generally favourable mortality rates (notwithstanding the significant exceptions) reflected the 'healthy worker effect', with service personnel being fitter than the national average at the time of service.[99]

The 2005 study also included some revealing perceptions of service during the Vietnam War. Particularly insightful were reports from veterans who had served in HMAS *Sydney*, the ageing Majestic class aircraft carrier that, in the early 1960s, had been refitted as an amphibious troop transport. Between 1965 and 1972, HMAS *Sydney*

had undertaken twenty-four voyages to Vietnam in this role, amounting to twenty-five operational visits to Vung Tau and earning the ship its unflattering nickname, the 'Vung Tau Ferry'.[100] Heat within the ship had been at times almost unbearable, it was claimed, one veteran recalling that 'the main galley ... we took the thermometer there one day and the temperature went up to 150 [degrees Fahrenheit]'. Another reported that there was no protection from the fierce sun—no hats and no sunscreen—and it was alleged that a fine white powder, thought by observers to be asbestos fibres, pervaded the ship. It was noted that, in HMAS *Sydney*, asbestos curtains had been used to isolate parts of the hangar as a fire precaution measure. The hangar doubled as a cinema, and on film nights, when the curtains were drawn back, the projectionist had had to wait for the dust to settle before the movie could be shown. It was also alleged that the ship was infested with cockroaches, despite frequent fumigation. According to one veteran, there 'was one bloke I can remember and he said I'm going to sleep in the mess. I said "the cockies will annoy you", and he said, "no, I'll sleep on this table" ... I had to give him a shake in the morning, and he had cockroaches all over him, up his nose, in his ears'.[101]

The 2005 study had been a male-only exercise. Female Vietnam veterans, as we have seen, often struggled to see themselves as 'veterans' in the conventional sense, and some perceived a continuing marginalisation. In 2012, one female veteran, a sixty-two year-old former Army nurse who had served in Vietnam, criticised DVA for what she felt was its male-centric bias: 'they forget there is [sic] women'. As she put it, 'the women have done the same as men ... and even if there is less women than men you still need to have that support ... there shouldn't be any distinction between the two of them, it should be equality. It should always be equality; it's supposed to be an equal population now'.[102] Likewise, a sixty-three-year-old ex-Air Force nurse, another Vietnam veteran, reckoned that ex-servicewomen were routinely overlooked. 'Being a woman, there's that attitude there [in DVA] and I think I've had to fight doubly hard. I've seen other people [men] you know, just mixing with other

Vietnam Veterans and ... in a blink of an eye they have their Gold Card or their TPI pension or whatever, and I think hang on'.[103] However, another ex-Air Force nurse, a Vietnam veteran who was sixty-nine in 2012, considered that DVA had by now embraced female veterans and had begun to understand their particular health and welfare needs. 'I would never survive if I hadn't been a TPI', she admitted. 'I've had four lots of back surgery ... I've just had a knee replacement, and I've got to have another knee replacement ... they call me the bionic bird'. As she concluded, 'I've got an implant to straighten my back ... oh, gosh, without the [Department of] Veterans' Affairs, I would be in big trouble'.[104]

In fact, DVA had been working towards a more inclusive outlook and policy for some time, not only paying closer attention to the needs of female veterans but also, as we have seen, including the families of Vietnam veterans in its purview—a trend that could be traced back at least as far as the restructuring of the Vietnam Veterans Counselling Service (VVCS) as the Veterans and Veterans Families Counselling Service (VVCS) in 2007. In 2007, DVA had also established a Family Studies Program, designed to perpetuate the family focus in its research agenda, and this led directly to the four-volume *Vietnam Veterans Family Study*, published by DVA in 2014. Anticipating the report, DVA in November 2013 announced that it would be 'the most significant research program ever undertaken into ... the physical, mental and social health of Australia's [Vietnam] veterans and their families'.[105] Hailed on publication as 'a ground-breaking intergenerational study', this work moved beyond the plethora of specific micro-reports and the wealth of incidental and anecdotal evidence accumulated over time to offer a comprehensive, scientific analysis designed to 'answer the question of whether the service of men in the Vietnam War had adverse effects on the physical, mental and social health of their sons and daughters'. The answer, it transpired, was an unequivocal 'Yes'.[106]

The 2014 study found that there were statistically significant differences between the offspring of Vietnam veterans and the

comparable peer group from the general population in most of the measures for mental health, especially depression, anxiety, PTSD, suicidal thoughts, suicidal plans or suicidal actions.[107] Alongside the quantitative data, the study presented an array of qualitative research based on extensive interviews with children, which confirmed behaviours and outcomes observed in earlier work. 'Dad gets very angry, frightened', reported one interviewee: he 'cannot handle easy, simple everyday things—like parking at a shopping centre'.[108] There were other (by now) familiar responses. 'One day Dad came to pick me up from Mum and my step-dad's home', explained another offspring, 'I was just chattering like a regular teenager and he went from happy and friendly to crazy in an instant. He yelled at me to shut up and ranted about how I talk a lot ... I don't think he has any idea how hurtful that is'.[109] The study found that the grown-up offspring of Vietnam veterans were more likely than the comparable peer group to have had more than one marriage or to be in a de facto relationship, and were less likely to have a university degree. But there were no significant differences in stability of employment (the number of jobs held), homelessness, criminal convictions or being the victims of criminal violence. The offspring were, however, more likely to report financial stress.[110]

Importantly, the study also indicated that, by 2014, many Vietnam veterans had availed themselves of the help offered by DVA and other organisations, notably the RSL, and as a result, the children felt, the veterans' mental health showed definite signs of improvement. As one of the interviewees reported, his/her father had retired 'a couple of years ago ... and he ... got into the RSL. They sent him to different groups and counselling and did different things for him, and now he is a bit more open about it. I think they applied for [Department of] Veterans' Affairs services. Since he has been involved with the veterans, he has been so much better'.[111] At the same time, the offspring themselves found that support from DVA greatly improved their own lives. As one noted: 'That was really good because I had a good relationship with the guy who was doing the counselling ... it worked for me because I felt I was talking to a peer. I

had maybe a dozen sessions and worked through a lot of that anger and pain and angst that I had developed'.[112]

In terms of physical health, the 2014 study identified only three measures out of sixteen that showed significant differences from the comparator population, and these were all (as the study noted) areas where psychological factors may have played a part: skin conditions (which were often a product of service in tropical conditions), migraines and sleep disturbance.[113] Moreover, and perhaps controversially, the study also found that there were no statistically significant differences in areas relating to a mother's history of pregnancy—problems conceiving, miscarriage, stillbirth, babies born with spina bifida, and babies born with a cleft lip or palate. This was an important result, as it appeared to fly in the face of many earlier assumptions. As the study recognised, these unfortunate 'outcomes have previously been considered as being a possible link with fathers' exposure to herbicides and pesticides (including dioxin used in Agent Orange)'. But, as the study hastened to explain, the fact that there were no significant differences apparent in these areas might possibly be a function of the statistical rigour employed in the analysis. Put another way, the 'Main Survey did not ... have the very large sample sizes that would be needed to assess the possible impact of deployment on comparatively rare outcomes such as spina bifida and cleft lip or palate in children'.[114] This inability to pronounce definitively on the effects of Agent Orange on Vietnam veterans' offspring would be disappointing to some, although the study was absolutely clear that negative health outcomes in these children 'are related to the father's psychological experiences during the war rather than the exposure to toxins'.[115]

The exposure of the veterans themselves to Agent Orange and other toxins was a different matter. Back in 1994, Vietnam veterans had been shocked to find (in their estimation at least) that Part IV of volume three *Medicine at war* of the official history *A nation at war: Australian politics, society and diplomacy during the Vietnam War 1965–1975* was little more than a synopsis of what they considered

the flawed Evatt Royal Commission report.[116] By 2014, however, the general atmosphere—as well as scientific understanding of the subject—had shifted to such an extent that the Australian War Memorial could announce that it intended to commission a new single-volume history of the health and medical problems experienced by Vietnam veterans, especially as they related to Agent Orange and other toxins.[117] This initiative was part of a wider mellowing in society that had been detected in the 2014 Vietnam Veterans Family Study, whose conclusions stand now as testament to how times had changed, mostly for the better, since the 1970s:

> More than four decades on, Vietnam veterans have become senior members of the Australian community. That period has seen many changes in attitudes towards the war and towards its veterans. The formation of organisations dedicated to advocating the needs of Vietnam veterans, the establishment of VVCS in 1982, the Sydney Welcome Home parade in 1987, and the opening of the Vietnam Forces National Memorial in Canberra in 1992 were important steps that marked a progress towards acceptance and recognition—a progress urged by the veterans themselves and by their families. The broader community has come to acknowledge and respect Vietnam veterans as witness to, not perpetrators of, a terrible war.[118]

Certainly, the landscape for both DVA and the Vietnam veterans themselves had changed considerably since the days when Clem Lloyd and Jacqui Rees were writing in 1994, although the lingering suspicion of DVA's motives and practices had by no means disappeared entirely, as we shall see in the Epilogue.[119]

Veterans of the Battle of El Alamein share wartime stories with a member of the ADF Federation Guard at the El Alamein War Cemetery in Egypt. *(Dept of Defence 20121020adf8144078_456; photographer CPL Christopher Dickson)*

5 Lloyd and Rees, *The last shilling*, p. 355.
6 Ibid., p. 356.
7 Ibid., pp. 358–9.
8 Ibid.
9 Ibid., pp. 355–6.
10 Ibid., p. 355.
11 Ian Gollings, *RSL National Newsletter*, October 1987, cited in Lloyd and Rees, *The last shilling*, p. 355.
12 Lloyd and Rees, *The last shilling*, p. 355.
13 Ibid., p. 356.
14 Ibid.
15 Ibid.
16 Ibid., p. 357.
17 Ibid.
18 Ibid.
19 Ibid., p. 378.
20 Ibid.
21 See David W Cameron, *The Battle of Long Tan: Australia's four hours of hell in Vietnam*, Penguin, Melbourne, 2016.
22 Alan Parr, *Memories of Vietnam*, Nemingha (NSW), 2006, p. 46, cited in Cameron, *The Battle of Long Tan*, p. 122.
23 Bill Akell interview, 7 June 2015, in Cameron, *The Battle of Long Tan*, p. 239.
24 Len Vine interview, 15 May 2015, in Cameron, *The Battle of Long Tan*, p. 239.
25 Ibid., p. 261.
26 Letter from Alan Parr to his parents, 21 August 1966, cited in Cameron, *The Battle of Long Tan*, p. 289.
27 Mark Dapin, *The nashos' war: Australia's national servicemen and Vietnam*, Viking, Melbourne, 2014, p. 144, cited in Cameron, *The Battle of Long Tan*, p. 307.
28 Patrick Lindsay, *The spirit of the digger*, Harper Collins, Sydney, 2011, p. 254.
29 Ibid., p. 256.
30 Ibid., p. 270.
31 Cameron, *The Battle of Long Tan*, p. 40.
32 https://anzacportal.dva.gov.au/history/conflicts/australia-and-vietnam-war/resources, accessed 7 June 2018.
33 Cited in Allan Gingell, *Fear of abandonment: Australia in the world since 1942*, La Trobe University Press, Melbourne, 2017, p. 72.
34 Cited in Gingell, *Fear of abandonment*, p. 107.
35 Caroline Holbrook, *Anzac: The unauthorised biography*, NewSouth Publishing, Sydney, 2014, p. 120.
36 https://anzacportal.dva.gov.au/history/conflicts/australia-and-vietnam-war/australia-and-vietnam-war/vietnam-war, accessed 11 June 2018.

[37] Ambrose Crowe, *The battle after the war: The story of Australia's Vietnam veterans*, Allen & Unwin, St Leonards (NSW), 1999, pp. ix–x.

[38] Ibid., p. x.

[39] Cited in Amanda Laugesen (ed.), *Diggerspeak: The language of Australians at war*, Oxford University Press, Melbourne, 2005, pp. 158–9.

[40] Lindsay, *The spirit of the digger*, p. 242.

[41] Moya Sayer-Jones, *Beyond the call: Stories from veterans and their families*, Department of Veterans' Affairs, Canberra, 2009, pp. 53–4.

[42] Minutes of the Military Rehabilitation and Compensation Commission [MMRCC] 161/2012/S, 2 November 2012, Findings from the Report 'The health and wellbeing of female Vietnam and contemporary veterans'; Samantha Crompvoets, *The health and wellbeing of female Vietnam and contemporary veterans*, Australian National University, Canberra, June 2012.

[43] Crompvoets, *The health and wellbeing*, p. v, p. 23.

[44] Ibid., p. 27.

[45] Ibid., p. 11.

[46] Ibid., p. 29.

[47] Ibid., p. 28.

[48] Cameron, *The Battle of Long Tan*, p. 347.

[49] *Australian*, 15 May 2018.

[50] DVA Media Release, 14 February 2019.

[51] Laugesen, *Diggerspeak*, p. 51.

[52] Graham Smith interview, 26 May 2015, in Cameron, *The Battle of Long Tan*, pp. 348–9.

[53] LE McAuley, *The Battle of Long Tan: The legend of Anzac upheld*, Hutchinson, Melbourne, 1986, p. 132, cited in Cameron, *The Battle of Long Tan*, p. 307.

[54] M Caulfield, *The Vietnam year: From the jungle to the Australian suburbs*, Hachette Australia, Sydney, 2007, p. 333, cited in Cameron, *The Battle of Long Tan*, p. 352.

[55] Lindsay, *The spirit of the digger*, p. 258.

[56] Crowe, *The battle after the war*, p. 37.

[57] DVA *Annual report*, 2009–10, p. 180.

[58] Attributed to an anonymous Defence Department official who did not wish to be identified: see Paul Ham, *Vietnam: The Australian war*, Harper Collins, Melbourne, 2017, p. 635.

[59] Sayer-Jones, *Beyond the call*, p. 22.

[60] Ibid., p. 27.

[61] Ibid.

[62] Ibid., pp. 22–7.

[63] Crowe, *The battle after the war*, p. 124.

[64] Minutes of the Repatriation Commission [MRC] CM4692, 13 April 1994, A proposed new approach to treatment of post-traumatic stress disorder and co-morbidity.

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[86] Ibid.

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[88] bid., p. 104.

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[91] Crowe *The battle after the war*, p. 146.

[92] *Mortality of Vietnam veterans: The Veteran Cohort Study*, Department of Veterans' Affairs, Canberra, 1997, pp. 12–13.

[93] *Morbidity of Vietnam Veterans: A study of the health of Australia's Vietnam veteran community*, Department of Veterans' Affairs, Canberra, 1998; see also Ham, *Vietnam: the Australian war*, pp. 626–7.

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[98] MRC CM5857, 14 March 2006, Third Vietnam Veterans' Mortality Report, 2005.

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[106] DVA, *Vietnam Veterans Family Study:* 4 *vols: Volume 1: Introduction and summary of Vietnam veteran's families*, Canberra, 2014, p. iii and p. 33.

[107] Ibid., p. 9.

[108] Ibid., p. 27.

[109] Ibid., p. 28.

[110] Ibid., p. 10.

[111] Ibid., p. 30.

[112] Ibid., p. 31.

[113] Ibid., p. 10

[114] Ibid.

[115] Ibid., p. 23.

[116] Crowe, *The battle after the war*, pp. 183–3.

[117] *Sydney Morning Herald*, 1 May 2014.

[118] DVA, *Vietnam Veterans Family Study: Volume 1*, p. 31.

[119] The debate about the 'myths' and 'reality' of the Vietnam War continued unabated: see, for example, Mark Dapin, *Australia's Vietnam: Myth vs history*, NewSouth Publishing, Sydney, 2019.

Chapter 2
An ageing clientele?

Although the Vietnam War had brought a new 'third wave' of Australian veterans, these men and women—and, in some cases, widows and widowers—were by the mid-1990s already entering middle-age. Their concerns, and the way they expressed them, often varied markedly from those of earlier generations of veterans. Yet in other respects, the 'third wave' was by now merging with veterans of the 'first' (the First World War) and the 'second' (the Second World War and subsequent conflicts in the 1950s and 1960s), to create what the Department of Veterans' Affairs imagined to be essentially an 'ageing clientele'. The statistics appeared to bear this out. In 1995, some 39.2 per cent of veterans were aged 75 years and over. By 2000, this figure was expected to have increased to 68.1 per cent, so that 'a high demand for health and aged care services will continue into the next century'—this despite there being a projected decrease in the actual number of veterans, due to deaths in the ageing population.[120]

Accordingly, in 1994–95 the Repatriation Commission expressed its belief that 'the ageing of the veteran population means there have to be changes to traditional approaches'.[121] There would be significant policy as well as structural and practical implications. For example, the Commission considered that 'the ageing of veterans has important implications for veterans' entitlements' and that 'institutional arrangements, care in the home and treatment of chronic conditions should assume greater prominence—with some adjustments to the more traditional approaches to entitlements'.[122] There was little doubt, it seemed, that in the years ahead DVA would

need to tailor its activities to suit the needs of this ageing veteran population. But there were other considerations too.

There was concern, for example, about 'the likely impact of the ageing veteran population on ex-service organisations' with which DVA routinely cooperated—especially in the projected decline in the number of volunteers from these organisations who could be trained to assist with veterans' claims. As these volunteers themselves aged, the Commission explained, so the efficiency and quality of their contribution might well decline. Moreover, the 'volume of claims is increasing while the number of able veterans is declining'.[123] By 1997, according to DVA, there were some 2,500 ex-service organisation volunteers and paid 'Advocates' who had trained variously as pension officers, welfare officers, case officers and appeal advocates, and together they assisted in the preparation of over 70,000 claims and appeals. The department acknowledged that such support was vital in achieving just entitlements to compensation, income support and care. Any appreciable decline in the number of volunteers, or in the quality of their work, would, it was emphasised, inevitably impact on the level of service provided by DVA.

A further demographic change consequent upon the ageing of DVA's clientele, was the likely growth of the widows and widowers population, which would have policy and practical implications. As DVA explained, 'War Widow(ers)s are increasing and are expected to equal veterans by 2008'.[124] Likewise, ageing would have a direct impact upon the nature of pharmaceutical provision. In June 1999, for example, the Repatriation Commission agreed to the listing under Repatriation Pharmaceutical Benefits of both Aricept, an (expensive) treatment for Alzheimer's disease, and Viagra, an effective treatment for some types of erectile dysfunction. Both drugs were seen as significantly improving the quality of life of elderly veterans. In the case of Viagra, it was estimated that the increased cost of provision ($4.1 million per annum) would be offset to a degree by an annual saving of $0.7 million as the use of Caverject injections

decreased.[125] It was emphasised, however, that Viagra would be supplied under section 85(2) of the *Veterans' Entitlements Act 1986*, so that 'eligibility for Viagra [would] be limited to veterans with impotence which is directly related to an accepted disability (war-caused or service-related)'.[126]

DVA's final divestment of its remaining major repatriation institutions—to state health systems in the cases of Repatriation General Hospital (RGH) Heidelberg (Melbourne) and RGH Daw Park (Adelaide) and to the private sector in the case of RGH Greenslopes (Brisbane)—released resources which would now be deployed elsewhere. Put simply, DVA had, by 1995, shifted from being a leading provider of health care to a major purchaser—a change of direction which would allow greater flexibility in determining new priorities and new directions as its clientele aged. As the Repatriation Commission explained, this divestment 'has freed the Commission to be more active in the development of aged care policies for veterans, war widows and widowers'.[127] Among other things, it allowed greater and more equitable access to a larger range of public and private hospitals. This especially advantaged rural, regional and remote veterans who previously had no easy access to RGH facilities.

Repatriation General Hospital (RGH) Greenslopes, Brisbane, was offered to the Queensland state government as part of the Department of Veterans' Affairs divestment policy but was eventually acquired by the private healthcare provider Ramsay Hospital Holdings, the handover taking place on 6 January 1995. *(Greenslopes Repat Hospital 001)*

However, this divestment had been a complex process, and in the mid-1990s its myriad ramifications were still being felt across the department. In June 1994, agreement in principle had been reached between the Commonwealth and Victorian Governments on the integration of RGH Heidelberg within the state public hospital system, with formal transfer being achieved on 1 January 1995. Likewise, negotiations between DVA and the South Australian Health Commission had led to the integration of RGH Daw Park into the South Australian public health system on 9 March 1995. In

Queensland, the state government had advised in February 1994 that it did not require RGH Greenslopes as part of its public health system. As a result, a private operator was sought through an intensive tendering process, with the aim of negotiating the sale of the hospital and guaranteeing its future. The successful tenderer was Ramsay Hospital Holdings, which had also recently acquired RGH Hollywood (Perth) in Western Australia, with the handover of RGH Greenslopes occurring on 6 January 1995.[128] In the interim, DVA had managed to decrease public community patients at Greenslopes to zero by 31 December 1994, while maintaining private community patients until the point of sale.[129]

As the Repatriation General Hospitals passed to state or private ownership, so veterans in each state became eligible for inclusion in the Repatriation Private Patient Scheme (RPPS). Attractively designed booklets were produced in each state to show how the new scheme would operate.[130] As DVA explained, the RPPS introduced new elements of choice and flexibility into the system, a distinct advantage in an ageing veteran population, enabling 'veterans and war widows, the majority of whom are elderly, to obtain hospital treatment closer to their homes, rather than having to travel to a repatriation general hospital'.[131] The RPPS had already been operating smoothly in Tasmania since its introduction there on 1 July 1992, and, according to DVA, indications 'received through the Tasmanian Treatment Monitoring Scheme are that the ex-service community is happy with the Scheme'.[132]

This experience was soon replicated across Australia. In 1995 it was reported that, since the integration of RGH Concord (Sydney) within the New South Wales state health system in 1993, veterans had increasingly 'taken advantage of better options for local hospital treatment'. Indeed, veteran usage at RGH Concord had fallen to about 33 per cent of occupied beds, the NSW Treatment Monitoring Committee noting that in its first year of operation, the RPPS in New South Wales had received a relatively small number of complaints, and that the complaint rate had fallen by half by 1994–95. Likewise,

in Western Australia the RPPS had been ‘well received by veterans, war widows/widowers and [health] providers’ following the sale of RGH Hollywood on 24 February 1994. In its new guise as Hollywood Private Hospital, the facility had seen a rise in public usage, while waiting times for elective surgery ‘have been effectively eliminated’. In Queensland, meanwhile, some 68,000 veterans and war widows entitled to repatriation health care had gained access to RPPS in January 1995, with the recently privatised Greenslopes Private Hospital continuing to ‘provide a high level of services’. RPPS had come into operation in Victoria in January 1995 and in South Australia in March of that year, and early indications were ‘that the Scheme has been generally well received in both states’.[133] Two decades later, however, there was growing concern that in some states special access procedures for veterans in these hospitals had been eroded, or that veterans with acute needs (especially in mental health areas) were being passed on to other facilities, only being welcomed back for rehabilitation treatments but not while they remained acutely unwell.[134]

The introduction of the Repatriation Private Patient Scheme (RPPS) had proved remarkably successful, at least initially. But in several other respects, divestment of the Repatriation General Hospitals had left webs of complexity yet to be resolved. One was the future of Lady Davidson Hospital, in 1995 the only Repatriation institution remaining directly under DVA management. An auxiliary hospital located at Turramurra in north-east Sydney’s Upper North Shore, Lady Davidson provided veterans and war widows/widowers with ‘slow stream’ and post-operative rehabilitation, particularly for post-stroke and traumatic brain injury cases, together with cancer and palliative care.[135] Such provision was seen as vital to DVA’s long-term commitment to its ageing clientele, and the Repatriation Commission was concerned that this focus and the accompanying high level of specialist care offered at Lady Davidson Hospital should remain undiminished during and after the divestment process. A review in 1990–91 had suggested that some veterans treated at Lady Davidson would benefit from access to services in their local

areas, and discussions with the New South Wales State Government about the hospital's future had begun in 1993. These talks were given renewed impetus in 1995, as the divestment program reached its conclusion, with DVA committing to the continuing provision of 120 beds and 230 staff at Lady Davidson from 1 March 1996 until the hospital's anticipated integration within the New South Wales health system.[136] Detailed consideration was also given to the purchase of specialist care provision in other parts of the state for those veterans living beyond the Sydney catchment area.[137] The eventual solution, however, was the privatisation of Lady Davidson in 1997, when it was acquired by Australian Hospital Care Ltd (AHX). Thereafter, the hospital developed swiftly to become the largest private teaching rehabilitation centre in Australia by 2018, with 115 beds for both veterans and private patients.[138]

Other divestment complexities included the transfer of assets at the repatriation wards at Queen Victoria Hospital, Picton, to the New South Wales Government, and those at Wacol, Brisbane, to the Queensland Government.[139] There was also the question of the Red Cross presence at Greenslopes. Historically, DVA had supported a variety of Red Cross activities at Greenslopes, and the Red Cross expressed a 'strong desire' that this should continue after the hospital had passed into private hands. The Repatriation Commission agreed, pledging to continue financial support for the provision of bed-to-bed delivery of books (including large print) at an annual cost of $25,000, together with a handicraft service, including bed-to-bed provision of materials plus instruction at a cost of $9,700 per annum.[140] These were relatively small amounts but they represented a significant commitment to the Red Cross relationship and were important gestures of goodwill. Similarly, DVA had arranged the transfer of 'surplus' land at RGH Heidelberg, ahead of divestment, for the development of a new hostel by the RSL and the War Veterans' Home Trust of Victoria (WVHT). Likewise, the Repatriation Commission had also approved the disposal of the old Anzac Hostel at Brighton (North Road), Victoria, in support of the RSL and WVHT initiative.[141]

In South Australia, DVA continued its support of the War Veterans' Home at Myrtle Bank, Adelaide, whose major building program first proposed in the late 1990s was partly underwritten by the department. As historian Brian Dickey has observed, the 'key for the Home was the willingness of the Department of Veterans' Affairs to make a substantial capital contribution to the Home's rebuilding budget'.[142] Set against the current climate of divestment, and in the light of the *Aged Care Act*, passed in October 1997 by the new Howard government, which placed a great deal more emphasis on the requirement for agencies and institutions to raise their own capital funds for building projects, such DVA assistance might well have raised eyebrows. Indeed, according to Dickey, it 'might be said that this [DVA support] contravened the new government's policy', although he was swift to add that the money was not a grant as such (as would have been made under the erstwhile *Aged Persons Homes or Hostels Acts*), but rather 'a gift from DVA to one of its longstanding clients, serving the veterans of Australia'.[143] The department offered $1.7m for the first phase of development at Myrtle Bank, with the promise of more to come if the home's board could agree a coherent plan. Building work commenced in 1999, leading to the opening of phase one (Kapyong wing, named after a battle fought during the Korean War) in February 2000, with phases two, three and four completed in due course. By 2005 there were approximately 100 residents (men and women) at the new-look Myrtle Bank.

As Brian Dickey stressed, writing in 2005, the 'days of old men's hostels have long gone', Myrtle Bank having been transformed (with DVA help) into a modern fully equipped care facility, meeting government expectations and achieving 'adherence to the standards laid down by the now-independent Standards and Accreditation Agency'.[144] Although Myrtle Bank could 'now expect little outside grant money from such agencies as DVA or the Department of Health and Ageing',[145] it nonetheless remained under the purview of DVA as the department introduced a 'casemix' analysis plan to monitor the standards of care provided to its veterans in all public

and private health-care facilities.[146] Put simply, casemix analysis provided the health-care industry (including DVA) with a consistent method of classifying types of patients treated in a health-care facility, and was useful in determining the relationship between health-care activity and costs.[147]

One of the consequences of divestment was the necessity for new arrangements for DVA-sponsored medical research. Hitherto, research had been carried out 'in house' at the Repatriation General Hospitals (RGHs) by their staff specialists and by university research personnel holding appointments at the RGHs. In future, however, as the Repatriation Commission explained in November 1995, advertisements would be placed annually inviting applications for research grants, with a DVA Research Grants Evaluation Committee established to oversee this competitive process, including the allocation of awards.[148] One of the advantages of this new scheme was that it allowed DVA increased flexibility in determining which areas of research it wished to prioritise. (For 1998, for example, priority areas for research grants included dementia, prostate cancer, PTSD and spina bifida.)[149] It was a model that was to serve DVA well for many years, being reviewed favourably in 2008 and not fundamentally overhauled until 2013, in what was by then a very different research climate.[150]

Again, there were complications, notably at Greenslopes Private Hospital (as it had become), where an agreement between DVA and the University of Queensland to support teaching and research activities at the hospital was terminated in early 2004. DVA, which had provided 50 per cent of the staff salaries, agreed to pay 50 per cent of the voluntary redundancy packages negotiated as part of the termination.[151] Meanwhile, in a separate initiative, DVA and the Defence Department had, in the previous year, cooperated in the establishment of a Centre for Military and Veterans' Health at the University of Queensland.[152] But it was an arrangement that did not last—DVA having committed $1 million per year to the initiative, and

Defence only offering half-a-dozen personnel and no supporting funding.[153]

As DVA moved to become a major purchaser (rather than provider) of health care, so new issues of procurement came to the fore. By September 1995, for example, new procedures were in place for the purchase and delivery of chiropractic and osteopathic services in the post-divestment environment.[154] Likewise, in October 2003, DVA listed the items approved for purchase to support its new rehabilitation appliances program—everything from alarm systems, stationary exercise bicycles, personal computers, finger-pricking devices, guide dogs, hearing aids, stair-lifts, renal dialysis machines and wheelchairs, to wigs, shower-seats and tap-turners.[155] This provision was later formalised as DVA's Rehabilitation Appliances Program.[156]

Part of the rationale for the divestment of the RGHs had been financial savings and cost efficiencies, although DVA remained alive to the need to keep procurement spending strictly under control in the new regime. More than two decades after divestment had been achieved, DVA in June 2016 could still worry that the 'biggest risk associated with any procurement process for private hospitals is the possibility that negotiations will stall or become protracted, with the potential threat that provision may cease'. Moreover, 'there are risks that some entities may seek unreasonable fee increases, including using policy changes as an opportunity to increase fees'.[157] For example, in 2012 one provider, having tendered a substantial increase, gave DVA only two days' notice that scheduled procedures for veterans would be cancelled if its demands were not met. This was indeed a considerable risk, as the 'single largest area of health cost for DVA is hospital expenditure'.[158] By 2015–16, DVA was spending $1.53 billion per annum on hospital services, with over $804 million going to private hospitals which, in turn, were accessed by some 67,000 DVA clients.

Alongside the divestment of the RGHs, was the phased transfer to the states and territories of DVA's Artificial Limbs Scheme (ALS) and

Repatriation and Artificial Limb and Appliance Centres (RALACs). The transfer had been first mooted in 1990, its implementation heralded by the decision in February 1994 to close the Melbourne RALAC, including the sale of its footwear assets and the land on which the centre was situated.[159] The state government formally assumed responsibility for ALS in Victoria on 1 December 1994. An identical formula was followed in Queensland, with the redundant Brisbane RALAC also closed, while RALA sub-centres in Townsville, Darwin and Canberra were transferred to their respective state and territory governments. Transfer of the RALAC and the ALS in South Australia was an integral part of the RGH divestment process, achieved in March 1995.[160] Subsequently, transfer agreements were reached with the remaining state governments, with the partial exception of Tasmania.

Inevitably, divestment led to structural changes within DVA as the organisation reacted to the new conditions. AS DVA explained, one 'of the challenges facing the department is the requirement to meet the needs of the veteran community in the years ahead, following the largely completed institutional divestment program'. To meet this challenge, 'the Department [has] decided to restructure its Central Office and move to a modified program structure'. The most significant changes were to DVA's Program 1, formerly entitled 'Benefits' but now refocused as 'Compensation'; Program 2, previously 'Health' but now 'Health Care and Services'; and its 'Treatment Management' activity, now renamed 'Aged Care' to reflect the new emphasis. The department's former 'Programs' became 'Divisions', while the Central Office became the 'National Office'.[161] Transition to the new arrangement began in March 1995. Streamlining meant that fewer staff were required, and—although most employees were accommodated within the new structure—there were 75 voluntary redundancies.[162]

This restructuring and the shifts in service provision were matched by advances in administrative efficiency. For example, the introduction of DVA's new Compensation Claims Processing System

in 1995–96 was reckoned to have resulted in a 30 per cent productivity increase. Soon after, the Pension Information Processing System was also introduced, and likewise deemed a successful exercise in efficiency. Information technology, the growth of the internet, and digitisation offered further opportunities for managerial innovation, which DVA was not slow to embrace. As early as 1992, DVA had outsourced its information and communications technology infrastructure to Ferntree Computer Corporation, being one of the first Australian Government agencies to do so, and in 1997, post-divestment and after restructuring, DVA negotiated a new contract with IBM. By 1997–98, all DVA personal computers were enabled for internet access, to be followed soon after by a trial period of electronic forms lodgement and the establishment of information technology links to the Department of Finance and Comsuper. In 1998–99, the DVA intranet was established and DVA Factsheets online (with some 300 individual items) was launched. By 2000–01, all DVA forms were available on the internet.[163]

As DVA noted, the ‘enhanced data analysis’ enabled by the digital marshalling of information had also facilitated the establishment of an ‘eBusiness environment’. Here, ‘rigorous data analysis has aided the purchasing work being undertaken in the health care area’, equipping DVA for its role in the post-divestment era. In particular, the new methods of assessing health purchase requirements had greatly assisted ‘the program of veteran partnering contracts with private hospitals’.[164] Thereafter, digitisation continued apace and, by late 2014, it was possible for veterans to lodge their claims online, and for them to notify online changes in their income or assets and alterations in their bank account details.[165]

Recognising it had become ‘a major stakeholder in the field of aged care’, DVA focused now on policies and services ‘specifically designed to meet the special needs of older veterans and their dependents’.[166] In June 1995, the department released As Time Goes By: Continuing the Commitment, an aged care policy for the

veteran community. An important objective now was for the development of services to enable veterans and widows/widowers to live in their own homes for as long as practicable. Closer links were forged with organisations such as the Arthritis Foundation and Diabetes Australia, and publications such as *Dementia education notes for community nurses*, and videos on subjects like incontinence management and wound management complemented education programs to support carers. Home maintenance advice was introduced, including a Veterans' Home Maintenance Helpline, launched in April 1995, which offered a 24-hour home emergency service and referral to tradespeople.[167] There were leaflets on *Preventing fire, electrical and gas accidents* and on keeping abreast of *You and your pension*. In cooperation with the Pharmaceutical Society of Australia, 'Being MediWise' self-help cards were introduced to assist veterans in maintaining proper management of their medications.[168] This was later extended in the Veterans MATES Program, set up in June 2004 and designed to encourage best practice in veterans' medication management, particularly in chronic diseases and complex medication regimes.[169]

This self-help ethos was crystallised in the launch of DVA's Veterans' Home Care program in January 2001, which aimed to keep veterans and widows/widowers living independently in their own homes. In the year to 30 June 2002, 44,043 veterans, widows and widowers had already been assessed under the terms of the new program, and more than $51.9 million had been paid for services to support these applicants. At the same time, DVA launched the Choose Health! strategy, designed to guide the planning, implementation and evaluation of health promotion programs for the next half-decade.[170] Again, the emphasis was on encouraging individual members of the veteran community to take responsibility for their own health.[171] Similar in intention was the Men's Health Peer Education (MHPE) program, which had begun as a pilot in Tasmania in 1999—intended initially to help Vietnam veterans share responsibility for their own health and wellbeing. DVA provided training for volunteers from the veteran community, covering a range of topics such as social

participation, sleep, mental health and illness prevention. The program was rolled out nationally in 2001, and so

successful was it that, by 2017, there were more than 200 active volunteers across Australia, including several women who engaged with the wives and partners of veterans to improve men's health. A twice-yearly MHPE magazine (with a distribution of about 15,000 copies per issue) and other periodic newsletters kept participants up-to-date, their tone and content becoming increasingly gender-neutral as DVA later evolved the MHPE program to explicitly include female veterans.[172]

The DVA Gold Card entitles the holder to Department of Veterans' Affairs funding for services for all clinically necessary healthcare needs, and all health conditions, whether they are related to war service or not.

Alongside the commitment to self-help was the aim of keeping veterans in employment for as long as possible. In May 1995, for example, the Repatriation Commission gave in-principle agreement to the establishment of a permanent Vocational Rehabilitation Scheme. As an incentive to participate, it was explained that those veterans who took part in the scheme and subsequently remained in employment until retirement, would automatically return to the highest level of disability pension that they were receiving prior to the commencement of their vocational rehabilitation.[173] In this way, veterans with disabilities could be successfully returned to the workforce—an important contribution to their wellbeing and self-esteem—while being assured of an adequate pension and associated support from DVA in old age.

One significant outcome of the 1995 DVA restructuring was the implementation in January 1996 of a simplified system of entitlement cards. Hitherto, there had been four categories of card, with cards issued to eligible veterans and their dependents according to their levels of entitlement. Thus, for example, the Specific Treatment Entitlement Card (STEC) reflected entitlement to health-care services for all disabilities accepted as service-related, as well as for pulmonary tuberculosis and malignant neoplasia. In contrast, the Service Pensioner Benefits Card (SPBC) had given entitlement to most health-care services except pharmaceuticals, nursing home and transport for non-inpatient care. There were also the Dependent Treatment Entitlement Card (DTEC) and the Personal Treatment Entitlement Card (PTEC), both with specific entitlements. Under the new system, this unwieldy and somewhat complicated provision (with its intensely bureaucratic nomenclature) was replaced by a simpler arrangement with just two categories of card. The Gold Card replaced the current SPBC, DTEC and PTEC cards and were issued accordingly, while what became known as the White Card later replaced the STEC.[174] As DVA itself reflected: 'Simplification of treatment entitlement will reduce confusion among veterans, war widows/widowers and their dependents, and will be considerably easier to administer for providers of health services and for the Department'.[175] Subsequent reviews of the card scheme expanded Gold Card entitlements and provision, and an Orange Card was introduced to allow holders (British Commonwealth and Allied veterans with qualifying service from either World War, aged over seventy, and resident in Australia for more than ten years) access to pharmaceuticals and dressings.[176]

Unfortunately, but perhaps not surprisingly, in a small number of cases cards were issued in error to non-entitled individuals. In January 1999, for example, Gold Card entitlement was extended to 'Australian Mariners of World War II', resulting in a new rush of applications. As these were being processed, about thirty incorrect decisions were made, and DVA found itself in the unpalatable position of having to recall those cards issued by mistake.[177]

Moreover, as applications for Gold Cards increased, so did the number of contentious cases. In 2001, for example, a Gold Card application was received from a woman who had served in coastal waters off Western Australia during the Second World War, where she had been employed in the dangerous role of target signaller during naval gunnery trials. However, as DVA observed, qualifying service under the *Veterans' Entitlement Act 1986* (VEA) required evidence of engagement in operations against the enemy while exposed to danger from the hostile forces of the enemy. Although the applicant's wartime service was undoubtedly hazardous, she was not at any time under threat from hostile forces of the enemy, nor was she engaged directly in operations against the enemy. Consequently, her application for a Gold Card was refused.[178]

A perhaps less complex case considered by DVA resulted in confirmation that Royal Navy personnel on loan to the Royal Australian Navy during the Second World War and subsequent operations could not be considered to have been members of the Australian Defence Force, and were therefore ineligible for benefits under the VEA.[179] More complicated was an application for a Gold Card in 2005 that claimed eligibility under 'Special Mission' status. As the Repatriation Commission noted at the time, a Special Mission was 'a mission that ... was of special assistance to the Commonwealth [of Australia] in the prosecution of a war to which the Act [VEA] applies'. Such status was conferred on members of philanthropic organisations operating in war zones—the Australian Red Cross, YMCA, YWCA, Salvation Army and the Australian Comforts Fund—and on specific individuals, including ABC personnel in the field, Department of Home Security personnel (camoufleurs attached to the Royal Australian Air Force), telegraphists attached to the Royal Australian Navy, and canteen employees in HMA Ships. In this particular case, the applicant had been an employee of the Post-Master General's Department, and had served in the SS *Mernoo* when it was involved, he claimed, in laying an anti-submarine screen around Auckland in 1942. After due consideration, it was decided that the applicant was ineligible

because the *Mernoo* was not a commissioned warship, and was manned solely by merchant seamen.

It was, however, difficult to maintain consistency and parity in decision-making, and there was an ever-present danger of creating unwarranted precedents. In February 2009, the Repatriation Commission reviewed some recent erroneous decisions. One applicant who had successfully applied for a Gold Card (and a disability pension) had been told that he had 'qualifying' service as a civilian in SS *Mernoo*. Another, who had also served in the *Mernoo*, was a member of the Post-Master General's staff and had participated in cable laying between Papua New Guinea and Australia during the Second World War. Remarkably, in 2006, the Veterans' Review Board (the independent tribunal existing to review DVA deliberations) had set aside a DVA delegate's earlier decision that the cable-layer was not a veteran and now accepted his claim on the grounds that he suffered from a war-caused injury. Additionally, the Repatriation Commission discovered, several Royal Navy personnel on loan to the Royal Australian Navy, serving in the aircraft carrier HMAS *Sydney* during the Korean War, had successfully obtained Gold Cards as they now lived in Australia, despite the earlier determination that they were not eligible.[180]

The continued instances of incorrectly determined cases under the VEA remained a cause of some anxiety and, in January 2012, the Repatriation Commission reviewed a range of options for dealing with erroneous decisions. It selected two options, to be applied variously depending on the case in hand. One option was to advise the individual concerned of their incorrect eligibility and to cease the incorrectly granted benefits, at the same time advising them that any detriment could be addressed through the CDDA Scheme (the Compensation for Detriment Caused by Defective Administration Scheme) or through Act of Grace payments by the government. This option was to be applied where an earlier decision was outside the law, or where the law was silent, but in any case where the decision now contravened current policy. The second option was to consider each case on its merits, and to take no action in specific cases

where an error had been identified but had nevertheless been reviewed positively in the past.[181]

Both options displayed considerable sympathy for the position of the veteran who was incorrectly but unwittingly in receipt of benefits for which he or she was not entitled. Despite the apparently rigorous application of eligibility criteria, there was sometimes room for giving the benefit of the doubt. In January 2004, for example, the Repatriation Commission reviewed its guidelines for the consideration of claims. The VEA had set out two standards of proof in determining claims for a pension or benefit—'reasonable satisfaction' and 'beyond reasonable doubt'—with 'reasonable satisfaction' meaning that the decision-maker must be satisfied that it is *more likely than not* that a certain fact existed. For example, if a veteran made a statement about an occurrence on active service during the Second World War, and the statement appeared credible, then this should be taken as sufficient evidence. As the Commission explained, this is 'because it may be unreasonable to expect a veteran or the department to locate witnesses to the event who can corroborate the veteran's evidence, given the lapse of time since it occurred'. Similarly, a veteran might make a statement concerning the receipt of medical treatment for an injury he (or she) had suffered during a particular military action. Again, if the statement appeared credible, then the decision should be in favour of the claimant, even if no record existed, because 'it is common knowledge that the exigencies of the service were such that full records of all treatment were not always made'.[182] The same logic should be applied, it was added, to statements by widows about events that their late husbands may once have described.

The interpretation and application of these standards of proof was not without complication, however, being shaped over the years by a variety of reports, reviews and developing case law. For example, as early as 1992, the High Court had pondered the meaning of 'reasonable hypothesis', as it related to veterans with operational service, in the important case of *Bushell v Repatriation Commission*. The Court concluded that a 'reasonable hypothesis' standard of

proof would be satisfied where a single, responsible medical practitioner, eminent in the field, acting within the scope of his or her expertise, supported a connection between the veteran's condition and their service. The effect of this decision was a substantial rise in claims acceptance rates.[183] Later, in 1996–97, the Australian National Audit Office (ANAO) report *Compensation pensions to veterans and war widows* identified inconsistencies in decision-making, and recommended a fundamental review of veterans' compensation, focusing particularly on the acceptance of claims involving a tenuous link between a veteran's service and his or her condition.[184]

The ANAO report had also prompted the government to establish the Veterans' Compensation Review Committee, headed by Peter Baume, which produced *A fair go: Report on compensation for veterans and war widows* (the 'Baume Report') in March 1994. The Baume Report considered the repatriation compensation system through the lens of 'fairness', and recommended that the standard of proof for operational service no longer be based on the so-called 'reverse criminal' onus but rather on the legally tried and tested civil standard, with the benefit of the doubt always being exercised in favour of the veteran. The report also recommended that an expert medical committee be established.[185] The government responded to issues identified in the Baume Report by announcing initiatives in the 1994–95 Budget. These included the establishment of a Repatriation Medical Authority (RMA), whose purpose was to determine relationships between medical conditions and service based on sound medical-scientific evidence, issued in the form of 'Statements of Principle'. RMA determinations could, in turn, be reviewed by the Specialist Medical Review Council, which had also been created in the 1994–95 Budget.[186]

In February 2009, the Repatriation Commission received a submission from DVA's Policy and Development Division (evidently following some lively discussion), recommending that the Commission should not alter current eligibility requirements for the

VEA War Widow's Pension, which limited eligibility to those who were in a relationship with the veteran at the time of his (or her) death. After due consideration, it was agreed that existing processes were sufficient, but that those ineligible claimants who could demonstrate 'exceptional circumstances' could seek support through Act of Grace arrangements. For example, it was explained, DVA might reasonably support requests for compensation through Act of Grace payments for divorced spouses of former prisoners of war (POWs) where the cause of marital breakdown was 'war-caused behaviour', such as 'domestic abuse and violence resulting from war-caused psychiatric conditions'.[187]

However, the Repatriation Commission also acknowledged the enduring strength of the opinion, first articulated in 1914 and upheld ever since, that a veteran's widow was only entitled to a War Widow's Pension if the veteran's death was related to his war-related injuries and had occurred while she remained a dependent of that veteran. It was a position that had been examined and duly confirmed in both the 1994 Baume Report and the 2003 *Report of the Review of Veterans' Entitlements* (the 'Clarke Review'). In other words, any 'special circumstances' attracting Act of Grace payments would indeed need to be truly exceptional.[188]

To demonstrate the complexity of the matter, the Repatriation Commission cited the case of 'Mrs M'. She had married her husband in 1947. He had been one of the few survivors of the notorious Sandakan Death March in occupied North Borneo in 1944 while a prisoner of the Japanese. Following his repatriation to Australia and subsequent marriage, he became psychologically unstable and was often violent. He and Mrs M were divorced in 1958, and in 1961 he committed suicide. Mrs M was granted Act of Grace payments on the grounds that she had only divorced her husband as a result of his war-caused condition, which had accounted for his violence towards her and their children. DVA, it was pointed out, had not supported the decision to award Act of Grace payments to Mrs M but, 'after a considerable amount of lobbying', the Minister at the time had made a recommendation for acceptance. A further example

was that of ‘Mrs W’, who had married in 1949. Her husband had been a POW at Changi, in Singapore, for four years. He later became violent and threatened to murder his wife, and was subsequently sent to prison. He died in 1984. Mrs W made an application for Act of Grace payments, which was rejected as the circumstances were not deemed to be sufficiently ‘special’.[189]

In examining the multiplicity of special cases of all types that came before the Repatriation Commission and DVA, it was emphasised that, as a policy, the Commission was committed to ‘the widening of access to repatriation health benefits to all veterans as opportunity permits’.[190] Sometimes, as we have seen, there could be difficulty in determining who exactly was a ‘veteran’ under the meaning of the VEA, and who was not. One distinctly unusual case was that of Mr Sancho de Silva and Mr Celestino dos Anjos, who had both served in Portuguese East Timor during the Second World War, and who in April 2010 were awarded posthumous recognition as former members of the Australian Defence Force who had rendered continuous full-time service. It transpired that both had served with the Services Reconnaissance Department SRD/Z Special Unit of the Australian Military Forces in Timor between 1943 and 1945. They had been evacuated by submarine in August 1943 and taken to Darwin, subsequently being settled in rural New South Wales. However, both were keen to fight the Japanese, and volunteered to return to East Timor. De Silva was subsequently captured and was a POW in Dili until 1945. He died in March 1997 of heart failure. Dos Anjos also survived the Second World War but was later killed by Indonesian soldiers in East Timor on 22 September 1983.

These ‘posthumous veterans’, it was noted, had both held the rank of sergeant and had worn Australian Army uniform, the latter proving critical in determining their status.[191] Their preferential treatment, albeit belated, contrasted strongly with the experience of their fellow countryman, Casimiro Augusto Paiva, who was serving in the Portuguese Army in East Timor at the time of the Japanese invasion. Like de Silva and dos Anjos, Paiva linked up with Australian special

forces infiltrated into East Timor, and was subsequently sent to an intelligence school in Cairns before returning to Timor to continue the fight. Following his enlistment with the Australians, he had been 'told … that from then on in the future I was like an Australian soldier', just as de Silva and dos Anjos had been.[192] However, Paiva was still technically a member of the Portuguese Army and, as Portugal was neutral during the Second World War, he was soon sent back to Australia where, to his dismay, he was interned as an alien in camps at Graythorne, Holdsworthy and, finally, Taura, before being released in August 1944 and going to live in Singleton, New South Wales. There would be no later discussion of possible Australian veteran status, indicating again the difficulty in achieving parity of esteem and equality of treatment.

However, the ability of DVA to recognise injustice and to modify its position over time—especially in the light of new rulings or advances in medical science—was also apparent. Such was the case of Flight Lieutenant Graham David Woodrow. A navigator in the Royal Australian Air Force, David Woodrow (as he was known) had trained in Canada, where he was attached to the Royal Canadian Airforce, and was subsequently attached to the Royal Air Force in Britain where he flew in the elite Pathfinder Squadrons of Bomber Command during the Second World War, navigating Halifax and Lancaster aircraft. Prior to demobilisation, he returned home to Brisbane, where he was discharged in September 1945. More than thirty years later, in January 1978, DVA wrote to the Royal Australian Air Force requesting details of Woodrow's service record, as the 'department is considering an application lodged for Repatriation benefits'. The Air Force replied on 20 February, noting that David Woodrow had been attached to the Royal Air Force from December 1943 until May 1945, and opining that there might be grounds for 'a charge against the Imperial [sic] Government if, and only if, his disability is found to have arisen from an occurrence happening between 14.12.43 to 23.5.45'.[193] In other words, if Woodrow could be shown to be suffering from a disability, then any benefit or compensation was the responsibility of the British.

By the mid-1980s, however, the responsibility of home governments for benefits due to their veterans who had been routinely attached to British Commonwealth forces overseas during the Second World War, was now increasingly accepted. (Royal Navy personnel serving with the Royal Australian Navy, for example, were recognised as the responsibility of the United Kingdom). Moreover, Posttraumatic Stress Disorder [PTSD] was only now beginning to be understood, prompting a more sympathetic (or at least more insightful) appreciation of those who were suffering from this condition. Flight Lieutenant Woodrow's 'disability' was now recognised as PTSD, a result of his experiences during the Second World War. The unrelieved stress of nightly bombing raids over Germany and northern France was exacerbated by a horrific 'occurrence' on the night of Wednesday 23 February 1944. That night David Woodrow was on leave in Brighton, Sussex, and had been out for the evening with friends. As the four of them returned home, they were caught in a bombing raid. One of the group—a young woman called Doris Williams, of whom David Woodrow was especially fond—was hit in the head by shards of glass from a shop frontage shattered in the blast, and Woodrow was with Doris's father when she died soon after.[194] The recognition and support provided by DVA, more than forty years later, was appreciated by David Woodrow for the rest of his life.[195]

Indigenous members of the Australian Defence Force – Private Leonard Lamilami from Croker Island, Private Peter Round from Darwin Squadron (centre) and Private Lloyd Braybon from Tiwi Islands – participate in a training activity in the countryside near the Aboriginal community of Oenpelli in the Northern Territory. (Dept of Defence 20080825adf8243523_280)

As part of its strategy to reach out to hitherto unidentified veterans, the Repatriation Commission in April 1999 expressed concern that a 'significant number' of Aboriginal and Torres Strait Islander veterans were unknown to the department and had not accessed DVA services.[196] An Indigenous Veterans Forum was set up in June 1998, consisting of eight Indigenous veterans plus DVA representatives, and had met in Darwin—reporting that many Aboriginal and Torres Strait Islanders were not accessing entitlements because of lack of opportunity. According to the forum, there was 'a strong tradition of service by Aboriginal and Torres Strait

Islanders in the military but they were never identified [in the record] on the basis of race or cultural background'. As a result, DVA had little knowledge of the demographic profiles of Indigenous veterans and scant understanding of 'their circumstances or cultural issues', which affected the department's ability to deliver the desired high level of service. Moreover, Indigenous veterans were 'generally of the view that their life expectancy and war service places them in a category of higher risk of premature death than any other sector of the community'.[197]

It was a chastening wake-up call for DVA, and there was more to come. Many Aboriginal and Torres Strait Islander veterans spoke fondly of their experiences as serving members of the Australian Defence Forces. 'For them', the forum reported, 'their status as a serviceman or servicewoman was based on equality, giving a sense of freedom, respect and pride not previously experienced'. Yet on leaving the services, 'any accumulated status and sense of equality was lost to many as they integrated back into their own communities', where they were confronted by sub-standard housing, poor health care, and few employment prospects.[198] In response, DVA reiterated that it could not identify Aboriginal and Torres Strait Islanders from service records but listed a number of its current initiatives: it had provided a grant to enable the Gippsland and East Gippsland Aboriginal Co-operative in Victoria to purchase a hostel respite bus, and had supported and participated in an Aboriginal Men's Healthy Living Camp in Western Australia, which had focused on smoking, alcohol and drug issues. It was liaising with Tangentyere Council to provide information on DVA services to veterans in the Alice Springs area of the Northern Territory, and was providing financial assistance, along with the Queensland State Government, to establish a podiatry clinic on Thursday Island to assist aged and diabetic veterans living there. Additionally, the department was compiling a booklet on DVA services adapted for Torres Strait Island readers, for distribution in the region.

As DVA recognised, these projects, welcome and worthwhile as they were, hardly touched the underlying needs of Indigenous veterans

and their communities. Accordingly, during 1999, DVA began to develop a strategy for improving access to veterans' entitlements for the estimated 3,000 Aboriginal and Torres Strait Islander veterans and their dependants. A communications strategy *You Served Your Country* was launched, with posters, brochures and booklets distributed to Indigenous communities. Indigenous veterans were added as a special needs group in DVA's rural and remote areas policy initiative, and a number of Indigenous veterans received training as veteran Advocates under the Training and Information Program (TIP) (a forerunner of the later Advocacy Training and Development Program [ADTP]), while the Men's Health Peer Education Program (MHPE) attracted a number of Indigenous volunteers. At the same time, over 200 DVA staff received cross-cultural training, to enable them to deal more effectively with Indigenous communities. Most importantly, DVA helped form an Aboriginal and Torres Strait Islander Veterans' and Services Association. By 2005, DVA was planning to invite Indigenous representatives to many of its major forums, and was pursuing closer links with other government agencies supporting Indigenous Australians.[199]

Trainee Ethel Abrym at 1st Combat Engineer Regiment's training facility during a visit by the Army Indigenous Development Program to Robertson Barracks in November 2017. (Dept of Defence 20171106adf8521052_053; CFN Priyantha Malavi Arachchi)

In 2006, DVA reviewed and updated its Indigenous strategy: in particular, endorsing new directions for the period 2010 to 2015.

There was to be a new network of Indigenous Veteran Liaison Officers, designed to facilitate more active engagement with veterans and to increase Indigenous affairs awareness among DVA staff. Similarly, there were plans to identify and develop community champions from within the Indigenous veteran community, together with a more proactive outreach commemoration program which would increase recognition, across Australia, of Aboriginal and Torres Strait Islander veterans' contribution to the nation.[200] Meanwhile, in 2009 DVA had funded the first phase of an Indigenous Veterans' Contribution Project at the Australian National University, a critical literature review of publications in the public domain detailing Indigenous contribution to the defence of the nation. By 2013, the project had expanded to a second phase, designed now to furnish a detailed study of the 'relatively neglected but significant contribution' made by Indigenous people from the Boer War to the present.[201]

In contemplating its own Indigenous veterans' strategy, DVA compared notes with its New Zealand equivalent, Veterans Affairs NZ, to see what lessons might be learned. It was not quite a question of comparing like with like as—in contrast to Australia's DVA—Veterans Affairs NZ was only concerned with injuries and disabilities arising from operational deployments. Nonetheless, the findings were perhaps surprising, with DVA discovering that there was 'no evidence to suggest that Maori service personnel were treated differently to their Pakeha (non-Maori) colleagues during and after their Defence service'. Moreover, 'there are no separate initiatives in place to commemorate the service and sacrifice of Maori Defence force personnel, [and] no additional services are in place to support these personnel'. DVA did not pause to consider the possibly contrasting place of Maoris in the New Zealand polity and society but concluded, rather perfunctorily 'that there are no relevant experiences in dealing with Maori veterans that could be beneficial to DVA's Indigenous Veterans' Strategy'.[202] The experience of Australia's Aboriginal and Torres Strait Islander veterans was, apparently, unique.

Among its 'second wave' of ageing clientele, DVA had also become increasingly aware of Korean War veterans as a distinct cohort—perhaps a result of the attention attracted by the later Vietnam War veterans, and possibly also because of anecdotal evidence suggesting some commonality of symptoms among those who had served in Korea. By the close of 2000, the Repatriation Commission had accepted recommendations for the establishment of a cancer incidence study for Korean War veterans, designed to investigate the period 1982 to 1999, and especially to 'examine the carcinogenic effects of possible exposures in Korea'.[203] There was a range of issues that might warrant scrutiny, it was thought, from asbestos in warships to benzene in aviation fuel. By early 2002, indeed, the scope of the Korean study had expanded to include the full spectrum of veterans' health, in addition to its existing research on mortality and cancer.[204]

An initial report, *Cancer Incidence Study: Australian veterans of the Korean War*, was published in December 2003, followed by *Mortality Study 2003: Australian veterans of the Korean War*, which appeared in 2004. In July 2005, the concluding report *Health Study 2005: Australian veterans of the Korean War* was published. Some 17,866 service members had been deployed to the Korean War as part of the British Commonwealth contingent in support of the United Nations. Of these, 7,525 male veterans had been included in the health study. The 58 female Korean War veterans were not included, partly because of their small numbers but also, it was argued, because 'health patterns in men and women can be quite different'.[205]

The findings were remarkable. Some five decades after the conflict, veterans were 'experiencing significant excess in several measures of psychological ill-health, poor life satisfaction and quality of life, and excess medical conditions and hospitalization compared with a group of similarly aged men [who were] resident in Australia during the Korean War'.[206] The study also noted an excess of alcohol use and smoking among the veterans, with PSTD, anxiety and

depression elevated to five or six times that of the comparison group. These findings complemented those of the earlier reports, which had indicated an excess of cancers, including melanoma, and excess mortality associated with cancer; respiratory diseases; digestive diseases; and diseases of the circulatory system including ischaemic heart disease and stroke. It was also noted that those veterans who had seen the most combat exhibited the worst characteristics across a range of conditions, while other ranks fared worse than officers. The veterans themselves had expressed satisfaction that the government had now recognised their particular service and sacrifice. All Korean War veterans were, perhaps not surprisingly, in receipt of repatriation Gold Cards.

A further discrete group of Australian veterans to receive particular attention were those participants in British nuclear tests in Australia during the period 1952 to 1960. Veteran and environmental groups had been raising concerns for several years, ranging from the treatment of contaminated land to the possible effects of exposure to radiation on Indigenous populations in the locality. Among these concerns was the impact on servicemen who had participated in the tests. In 2006, a report entitled *Australian Participants in British Nuclear Tests in Australia 1952–60, Dosimetry, Mortality and Cancer Incidence Study* was published by DVA. The report indicated that the majority of Australian military participants in the nuclear tests had been exposed to less than 1 mSv of additional radiation (the equivalent of one CT scan per year). Additionally, and perhaps controversially, it was argued that this estimated dose of radiation did not correlate with an elevated incidence of cancer among participants—a conclusion that was strongly disputed by elements of the veteran community.[207] Nonetheless, an *Australian Participants in British Nuclear Tests (Treatment) Act 2006* shortly received Royal Assent, the legislative instruments in pursuance of the Act providing for non-liability treatment of, as well as testing for, malignant neoplasia (cancer) for eligible veterans. This was one outcome of deliberations following the Clarke Report, when it was decided that former Defence personnel involved in the British nuclear tests be

given full access to disability pensions and health-care benefits under the VEA.[208] However, a similar recommendation in the Clarke Report—that service with the British Commonwealth Occupation Force (BCOF) in Japan in the aftermath of the Second World War should likewise attract benefits under the VEA—was not accepted.[209]

Another group that DVA considered 'unique' [sic] was the so-called Deseal/Reseal Group—the Royal Australian Air Force veterans who had worked on one or more of four formal fuel tank maintenance programs for the F-111 strike aircraft between about 1977 and 2000. Following an RAAF Board of Inquiry, DVA observed that this group was averaging ten disabilities per claim submitted, compared with the general veteran population average of 3.2 disabilities per claim—a disparity that warranted 'extensive investigation'.[210] Successive studies in 2003, 2004 and 2009 culminated in a final report in 2016, which showed that there was a statistically significant higher incidence of three types of cancer among the group—non-Hodgkin lymphoma, lung cancer and eye cancer—although it urged caution in how these results were interpreted, given the small numbers concerned and the lack of any objective measure of exposure.[211] Nevertheless, Deseal/Reseal remained a contentious issue, not least because only participants in the four formal programs were acknowledged and given access to special tax-free ex-gratia payments, lifetime health care for some thirty-one conditions (including all malignant neoplasms), and compensation under F-111-specific rules. Others who had done almost identical work on the aircraft while in the United States, or who had done identical work on other aircraft types (but not involving use of any of two specific solvents, SR 51 and SR 51A) were never formally acknowledged.[212]

Despite (or perhaps because of) the number of these 'special cases' requiring specialist attention, in the years after Vietnam DVA had begun to contemplate its long-term future. During the 1990s and into the new millennium, a new conventional wisdom had emerged, one which imagined that someday the department and the Repatriation

Commission would quietly wither away, as their workload declined and disappeared with the ageing and final passing of both the older and more recent generations of veterans and their dependents.[213] In DVA's annual report for 2001–02, Neil Johnston, President of the Repatriation Commission and Secretary of DVA, had pointed to the likely impact of 'emerging demographic trends'.[214] For example, he estimated that the number of income support service pensioners would decline by 16 per cent over the following half-decade, despite an expected increase in the number of Vietnam veterans becoming eligible as they turned sixty years of age; while disability compensation claims were also beginning to decline. There would, in the short-term, be an increase in the number of widows and widowers, but these too would ultimately decline and disappear.

It was an argument strangely reminiscent of 1918, when it had been assumed that the Repatriation Commission and its department would eventually become redundant, their task complete. Of course, the outbreak of the Second World War and subsequent postwar conflicts soon exposed the folly of this assumption, as a new 'second wave' of veterans and their dependents emerged, followed by a 'third wave' from Vietnam. Yet Neil Johnston's analysis appeared fair, based as it was on current forecasts drawn from the available statistics. However, even as the argument was being articulated, so evidence was accumulating of an emergent 'fourth wave' already in the making, which would culminate in Australia's (as-yet unanticipated) long-term commitments in Afghanistan and Iraq. Nonetheless, the conventional wisdom endured, for the moment at least, and by the turn of the millennium DVA was actively looking for new business as it pondered its future.[215]

In 1999, for example, DVA's purview had been significantly enhanced when it assumed responsibility for the Military Compensation and Rehabilitation Scheme, which was transferred from the Department of Defence.[216] This proved to be the prelude to the Military Rehabilitation and Compensation Act 2004 (MRCA) which, over the next decade, would operate simultaneously with the

growth of the new ‘fourth wave’ of veterans. It would, through a newly-constituted Military Rehabilitation and Compensation Commission, provide rehabilitation, compensation and other benefits for both current and former members of the Australian Defence Force (ADF) (including reservists and cadets) who had suffered an injury or disease due to service after 1 July 2004. Likewise, it would provide benefits and support for the dependants of members whose deaths were a result of an injury or disease due to service after the same date.[217] And, unlike the old VEA, which lacked any sustained focus on rehabilitation, rehabilitation would be at the heart of the new MRCA.

Private Lee Bailey of 5/7 Royal Australian Regiment is greeted by local children while on patrol near a small village on the outskirts of As Samawah in Al Murhanna province, Iraq.
(Dept of Defence 20050516adf8239682_097; photographer Neil Ruskin)

[120] DVA, *Annual report* 1994–95, p. 69.

[121] Ibid., p. 14.

[122] Ibid., p. 11.

[123] Minutes of the Repatriation Commission [MRC] CM 5027, 28 January 1999, Formal Evaluation of the Training Information Program and the Claims Assistance Grant Scheme.

[124] Ibid.

[125] MRC CM 5051, 25 June 1999, The Repatriation Pharmaceutical Benefits Scheme, and 19 August 1999, The Estimated Cost of Listing Viagra on the Repatriation Pharmaceutical Benefits Scheme for War Caused Impotence.

[126] MRC CM 5067, 28 September 1999, Supply of Viagra (Sildenafil) for Veterans with Erectile Dysfunction (Impotence) under Section 85(2) of the *Veterans Entitlement Act 1986*.

[127] DVA, *Annual report* 1994–95, p. 4.

[128] Ibid., p. 12.

[129] MRC CM 4688, 7 March 1994, Downsizing Greenslopes Repatriation Hospital by Gradually Decreasing Public Community Patients.

[130] Philip Payton, '*Repat': A concise history of repatriation in Australia*, Department of Veterans' Affairs, Canberra, 2018, p. 86.

[131] DVA, *Annual report* 1994–95, p. 23.

[132] Ibid., p. 12.

[133] Ibid., pp. 12–3.

[134] I am indebted to Ian R Gardner, former Chief Health Officer, Department of Veterans' Affairs, for this insight.

[135] Ibid., p. 13.

[136] MRC CM 4807, 27 October 1995, Lady Davidson Hospital, Turramurra—Operating Capacity.

[137] MRC CM 4859, 24 September 1996, Future of Lady Davidson Hospital.

[138] www.ladydavidsonprivatehospital.com.au/about, accessed 30 October 2018; www.warmemorialregister.nsw.gov.au/content/lady-davidson-hospital-war-memorial, accessed 30 October 2018.

[139] MRC CM 4695, 4 May 1994, Future of Repatriation Wards at Queen Victoria Hospital, Picton; MRC CM 4696, 4 May 1994, Future of the Repatriation Wards at Wacol, Brisbane.

[140] MRC CM 4799, 20 May 1994, Sale of RGH Greenslopes.

[141] MRC CM 4678, 3 February 1995, Amend Legislation to allow Disposal of Anzac Hostel; 18 October 1994, Transfer of Land at RGH Heidelberg to the RSL War Veterans' Trust of Victoria for Hostel Development.

[142] Brian Dickey, *The war veterans home Myrtle Bank 1915–2005*, War Veterans Home Myrtle Bank, Adelaide, 2005, p. 59.

[143] Ibid.

[144] Ibid., p. 65.

[145] Ibid., p. 67.

[146] MRC CM 4879, 19 December 1996, Establishment of a Casemix Strategic Plan.

[147] https://ncc.uow.edu.au/casemix/aboutcasemix/index.html, accessed 31 October 2018.

[148] MRC CM 4798, 28 November 1995, Establishment of DVA Research Grants Evaluation Committee.
[149] MRC CM 4866, 25 October 1996, Health and Medical Research Program.
[150] Minutes of the Military Rehabilitation and Compensation Commission [MMRCC] 11/2013, 7 February 2013, Future Strategic Direction for Research in DVA.
[151] MRC CM 5558, 19 March 2004, Cessation of Agreement between DVA and the University of Queensland for Teaching and Research Activities at Greenslopes Private Hospital—Redundancy Costs.
[152] MRC CM 5502, 17 September 2003, Establishment of Centre for Military and Veterans' Health.
[153] I am indebted to Ian R Gardner for this insight.
[154] MRC CM 4782, 9 August 1995, Implementation of Chiropractic and Osteopathic Services.
[155] MRC CM 5509, 14 October 2003, Rehabilitation Appliances Program (RAP) Schedule and National Guidelines.
[156] https://www.dva.gov.au/factsheet-hsv107-rehabilitation-appliances-program, accessed 28 February 2019.
[157] MMRCC 8/2016, 3 March 2016, Private Hospitals—Update following Exposure Draft and Endorsement of Procurement Process.
[158] MMRCC 32/2016, 29 September 2016, Private Hospital Services Procurement Update.
[159] MRC CM 4687, 28 February 1994, Closure of Melbourne Repatriation Artificial Limb and Appliance Centre.
[160] DVA, *Annual report* 1994–95, p. 13.
[161] Ibid., pp. 17–8.
[162] Ibid., p. 19.
[163] Payton, '*Repat'*, p. 84.
[164] DVA, *Annual report* 2001–02, pp. xiii–xvi.
[165] MRC CM 7078, 3 July 2014, Electronic Lodgement Via the Internet.
[166] DVA, *Annual report* 1994–95, p. 11.
[167] Ibid., p. 9.
[168] Payton, '*Repat'*, p. 180 and pp. 186–7.
[169] MMRC 39/2009/S, 28 August 2009, Veterans' MATES Program Progress and Continuation.
[170] MRC CM 5844, 12 December 2005, Review of Choose Health! A Health Promotion Strategic Plan for the Veteran Community.
[171] DVA, *Annual report* 2001–02, pp. 28–9.
[172] Briefing document produced by Naomi Mulcahy, Project Officer Mental and Social Health Program, Sydney Office DVA; *Men's health and peer education*, vol. 10, no. 1, March 2011; https://www.dva.gov.au/health-and-wellbeing/wellbeing/mens-health-peer-education, accessed 28 February 2019.
[173] MRC CM 4759, 3 May 1995, Vocational Rehabilitation Scheme.
[174] DVA, *Annual report* 1994–95, p. 69.
[175] bid., p. 14.

[176] For current entitlements, see DVA Fact Sheets HSV60 (Gold Card), HSV61 (White Card) and HSV69 (Orange Card).
[177] MRC CM 5037, 21 April 1999, Decision to Rescind Qualifying Service Decisions and Withdraw Incorrectly Issued Gold Cards.
[178] MRC CM 5200, 3 April 2001, Qualifying Service Policy.
[179] MRC CM 5580, 11 May 2004, Members of the Royal Navy on loan to the Royal Australian Navy—Eligibility for VEA Entitlements.
[180] MRC CC 6196, 17 February 2009, Incorrect Determinations Made Under the *Veterans' Entitlements Act 1986*.
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[199] MRC CM 5774, 12 July 2005, Indigenous Veterans' Issues; MMRCC 42/2005/S, 24 August 2005, Indigenous Veterans' Issues.
[200] MMRCC 21/2013/S, 22 February 2013, Indigenous Veterans' Strategy.
[201] MMRCC 40/2013, 28 March 2013, Australian National University and Australian Research Council Linkages for Indigenous Veterans Contribution Project.
[202] MMRCC 21/2013/S, 22 February 2013, Indigenous Veterans' Strategy.
[203] MRC CM 5165, 6 December 2000, Research into the Health of Korean War Veterans.

[204] MRC CM 5299, 21 February 2002, Proposed Korean Health Study Pilot.

[205] MRC CM 5772, 12 July 2005, Health Study 2005: Australian Veterans of the Korean War.

[206] Ibid.

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[211] https://www.dva.gov.au/benefits-and-payments/fl-ll-fuel-tank-maintenance/inquiries-and-studies/studies#fourth, accessed 7 November 2018.

[212] I am indebted to Ian R. Gardner for this insight.

[213] Personal communication, Veronica Hancock, Assistant Secretary Health and Community Services Policy, DVA Canberra office meeting, 24 October 2017; interview with Neil Bayles, Assistant Secretary, Portfolio, Program and Assurance, DVA Canberra office, 26 October 2017.

[214] DVA, *Annual report* 2001–02, pp. xiii–xvi.

[215] Interview with Neil Bayles, 26 October 2017.

[216] Interview with Neil Bayles, 26 October 2017.

[217] *Military Rehabilitation and Compensation Act* (MRCA), www.dva.gov.au/benefits-and-payments/compensation/military-rehabilitation-and-compensation-act-mrca, accessed 1 November 2017; DVA, *Annual report* 2012–2013, p. 30.

Chapter 3
New wave, new issues

In early 2012, the Repatriation Commission looked back over the decade or so since the turn of the millennium, and observed that during this period 'there has been a significant change in the nature and intensity of military operations and there are also emerging, significant changes in the profile of our client groups'.[218] It was a profound change in outlook, and an admission that the simplistic 'ageing clientele' model—with an expectation that the Commission and DVA would one day wither away—was no longer tenable.

Indeed, the Commission was by now fully aware that DVA was reaching out simultaneously to several different veteran cohorts, each with its particular health risks and needs arising from the nature of its military experiences, its life trajectories and family circumstances, and its varying expectations of service delivery. There was, somewhat belatedly perhaps, recognition that any analysis of veterans' needs should focus henceforth on what were described as 'three broad cohorts'. The initial 'first wave' of veterans and their dependants from the First World War now having passed on, this left extant the 'second wave' of (by now) elderly veterans from the Second World War and from postwar conflicts such as Korea, together with the 'third wave' (from Vietnam)—some of whom were entering aged care. But now there was an acknowledgement that a 'fourth wave', consisting of 'contemporary veterans and peacekeepers' (as the Commission described them), had emerged strongly over the previous decades, bringing with it a host of new issues and expectations which would continue to demand DVA's close attention in the years ahead.[219] The department, it seemed,

was here to stay, while its ‘ageing clientele’ had been joined suddenly by a largely unexpected wave of much younger servicemen and servicewomen.

Evidence of the ‘fourth wave’ had been accumulating since the early 1990s but, for the most part, it had been slow to catch the close attention of DVA, especially as there was often a significant time lapse from the date of an individual’s injury or discharge until the time a claim was lodged. Increasingly under financial pressure as governments responded to an (assumed) inexorable decline in the number of veterans and their dependents, DVA had worked to achieve greater administrative efficiency in response to its ‘ageing clientele’ problem. First mooted in 2005, the department had launched its internal ‘One DVA’ program, a process designed to identify and rectify inefficiencies across the DVA system—in particular the duplication and variation that existed in state offices where management decisions were not routinely reported to Canberra. ‘One DVA’ aimed to achieve greater coordination between the localities, and to develop national consistency. A new management structure was introduced to meet these aims. However, while greater efficiencies were indeed made and new levels of consistency achieved, the restructuring created its own difficulties. There was the not-inconsiderable challenge of managing geographically disparate teams across the localities, line-managers in Canberra creating ‘virtual teams’ which communicated principally by video conferencing. Significantly, the Deputy Commissioners in each state found themselves effectively disenfranchised, their roles and authority severely curtailed by the centralising of control in Canberra.[220]

More to the point, all this restructuring had occurred against the background of the sudden emergence of the hitherto unexpected ‘fourth wave’, as Australia became increasingly involved in new commitments overseas. Responding to the disconcertingly steep increase in veteran demand, DVA reacted by refashioning the role of the Deputy Commissioners as the department’s ‘front line’ and ‘hands on’ authority in each state, restoring their status and providing

a means of meeting the new challenges. It was a timely initiative. Increasingly articulate, linked through social media, and often predisposed to create their own networks and veterans' groups, the new generation of young veterans (and their dependants, and in some cases, widows) was sharply different from that which had gone before.[221]

In the aftermath of Vietnam, there had been those who had supposed that the Australian public (and politicians) would be reluctant to commit Australian forces to overseas operations in future.[222] Yet times change, and with the passage of the years much of the popular ire and indignation of the later Vietnam era had dissipated, its critics turning to other concerns. As one observer wrote in 2007, the 'anti-war protesters and draft resisters are quieter now—installed in careers, enjoying their grandchildren or pursuing new causes: climate change, Africa, AIDS'.[223] Moreover, despite the enduring trauma suffered by Vietnam veterans and their dependents, it soon became apparent that Australian politicians and public opinion were prepared, in certain circumstances, to support external military operations, especially in humanitarian roles or where Australia's vital interests were seen to be at stake. In this way, Australia was to emerge in the years ahead as a strong contributor to the security of the Asia-Pacific region, while also acting 'out of area' when deemed necessary to do so. Certain commitments, notably in Afghanistan and Iraq, proved deeply controversial (although perhaps not to the extent of Vietnam). But the broad principle of legitimate operational deployment overseas in defence of national interests had been firmly established in Australia by the turn of the millennium.

This trend had been observable since at least the late 1980s. Australian troops had already served as part of the Commonwealth force monitoring the ceasefire in the lead-up to elections in Rhodesia (Zimbabwe) in 1980 and, in 1982, Australian units had participated in the Multinational Force & Observer mission in Sinai. Others were deployed to Iran in 1988–90 as part of the United Nations (UN) Iran-

Iraq Military Observer Group. Australians also formed elements of the peacekeeping UN Transition Assistance Group in Namibia in 1989–90, and were part of the UN Mission for the Referendum in Western Sahara in 1991. By now a clear pattern of external engagement was apparent.

More substantially, in 1990–91 Australia participated in what became known as the first Gulf War, committing some 1,800 Australian Defence Force personnel and several Royal Australian Navy warships to the UN-backed coalition formed to oust Iraq from its illegal occupation of Kuwait. This was the first major evidence of a new wave of veterans in the making, and would have profound consequences for DVA in the medium and long term, as it sought to investigate and manage the array of health issues that emerged from the conflict. The Gulf War deployment was followed shortly by a succession of new overseas commitments. Australians assisted in the UN peacekeeping operations in Cambodia in 1992–93, contributing some 1,200 personnel.[224] Similar numbers served under UN auspices in Somalia in 1992–94, and an Australian medical contingent was deployed to Rwanda in 1993–96 in support of the UN. Closer to home, and more controversially, Australia became involved in the Bougainville situation, and in 1997 joined the New Zealand-led Truce Monitoring Group (the other members being Fiji and Vanuatu), which was designed to support the ceasefire between Bougainville separatists and the Papua New Guinea Government. Later, in 2014, Australian forces led the effort to rid Bougainville of unexploded ordnance. The Solomon Islands had also hosted Australian peacekeepers, when the Australian-led Regional Assistance Mission to the Solomon Islands was deployed in 2003.

Prominent among these regional operations was that in East Timor (Timor-Leste, as it became in 2002), a former Portuguese colony that had resisted incorporation into Indonesia. A UN-sponsored referendum in August 1999 indicated that some 80 per cent of the population did not wish East Timor to become an Indonesian province. Accordingly, the UN established a transitional authority to administer East Timor as it prepared for independence, with security

provided by an Australian-led International Force East Timor (INTERFET). Australia won international applause for its leadership of INTERFET and for its humanitarian effort, which included bringing the market in the capital Dili back to life and helping to construct a sustainable health-care system for the new country. Remarkably, the East Timor Reconstruction Project lasted approximately 16 weeks, compared with a World Bank expectation of an average of 15 months for this type of activity.[225] This successful humanitarian role was also popular with the Australian public, which acknowledged that the Australian Defence Force had been a 'force for good' in the Asia-Pacific region.

Warrant Officer Class 2 Pip Iseppi, Regimental Sergeant Major (RSM) of 1 Joint Support Unit (1JSU) on patrol during INTERFET in East Timor, January 2000. *(Dept of Defence V00_018_28; photographer CPL Patrina Malone)*

More controversial was Australian involvement in the NATO-sponsored International Security Assistance Force (ISAF) in Afghanistan, where, from late 2001, Australia deployed substantial forces (some 26,000 all-told) to engage in counterinsurgency operations and to advise the Afghan National Army in the southern

province of Uruzgan. This Australian involvement had its detractors at home—but supporters of the intervention could note that, by the early twenty-first century, such operations had come to define the current role of the Australian armed forces. As one observer put it, the task of 'stabilising threatened political systems and working with struggling nations to defend [themselves] against a return to instability and suffering has become a routine activity for the modern Australian Defence Force. An obvious example is Afghanistan'.[226] Afghanistan had also produced the first recipient of the Victoria Cross for Australia—the first time the medal had been awarded in the post-Imperial honours system—awarded to Trooper Mark Donaldson for conspicuous gallantry on 2 September 2008 after his patrol in Uruzgan Province was ambushed by a numerically superior and well-entrenched enemy.[227] But unfortunately Afghanistan had also proved extremely costly in human terms. It was Australia's longest war, with 43 ADF personnel killed in action and a further 261 physically injured.[228] Sergeant Andrew Russell was the first Australian to die in Afghanistan, when the vehicle in which he was travelling ran over a suspected mine on 16 February 2002.[229]

Especially controversial was Australian participation in the second Gulf (or more commonly, Iraq) War in 2003. Here the Australian contribution was larger than in the first Gulf War, including, for example, no fewer than a total of 500 Special Forces deployed over time. At sea, the Royal Australian Navy played an important role in the northern Arabian Gulf, including the assault on the Al Faw peninsula, where HMAS *Anzac* was in the gun-line bombarding the Iraqi coast in support of an amphibious landing by the UK's 3 Commando Brigade. HMAS *Kanimbla* performed a variety of tasks, from boarding suspicious vessels to preventing mine-laying in the Gulf. In the air, fourteen F/A-18 Hornet fighters were among the assets committed by the Royal Australian Air Force. After the initial combat phase, Australian forces remained in Iraq, helping to train the reconstituted Iraqi armed forces and providing security for international civilian reconstruction workers and air traffic control at Baghdad airport for six months. By now, the Australians had

acquired an enviable reputation as arguably ‘the best trainers in the world’ and, in 2014, Australia further enhanced its role (and its presence) in Iraq with the commencement of Operation OKRA, a special operations task group deployed specifically to assist in training the Iraqi Army, with substantial support provided by the Royal Australian Air Force.[230]

In this way, the Australian Defence Force was more or less constantly engaged in overseas theatres of operation as the old millennium drew to a close and the new one dawned. Although DVA was slow in waking-up to the resultant ‘fourth wave’ of veterans, the implications were already there for those who cared to see. One early consequence was the potential blurring of the definitions of ‘warlike’ and ‘non-warlike’ service. Clear distinction between the two was critical in deciding compensation and benefits under the *Veterans Entitlement Act 1986* (VEA), but the complex nature of recent and current operations—especially peacekeeping roles—caused some uncertainty and prompted calls for clarification.[231]

Accordingly, in August 1995, the Repatriation Commission reiterated the definitions of ‘warlike’ and ‘non-warlike’ service, and emphasised the differences between the two. ‘Warlike’ service, it was explained, existed (most obviously) where there was a declared state of war. But the term also encompassed combat operations against an armed adversary, even where no formal declaration of hostilities had been made. Moreover, ‘warlike’ service could also include peace *enforcement* in support of diplomatic efforts, usually under UN auspices, where belligerents might not accept intervention to restore peace. ‘Non-warlike’ service, by contrast, included operations short of ‘warlike’ but where there was inherent risk. Examples of such hazardous operations included mine clearance, weapons inspection and destruction, and aid to the civil power. Significantly, in view of recent and current operations, ‘non-warlike’ service was also deemed to include peacekeeping where there was no power of enforcement, together with the deployment of military observers (for

example, to monitor ceasefires) and the provision of humanitarian relief.[232]

Lieutenant Colonel Chris Smith is briefed by a section commander during a joint Australian Army-Afghan National Army operation to clear insurgent-held compounds in the Tangi Vally in Uruzgan province, southern Afghanistan. (Dept of Defence 20110907adf8114832_071; photographer ABIS Jo Dilorenzo)

The emergent 'fourth wave' was also responsible for prompting entirely new areas of inquiry and for precipitating new dimensions of veteran support. Australian participation in the 1991–92 Gulf War, for example, had raised a number of important issues relating to both the distinctive nature of military operations in the Gulf and the symptoms later exhibited by the war's veterans. In 2003, DVA published the *Gulf War Health Study*, investigating such concerns as the impact on Australian servicemen and servicewomen of depleted uranium shells, presumed proximity to chemical and biological weapons, and the effects of smoke from burning oil installations. In contrast to the essentially reactive studies of Vietnam and Korean veterans, this was the first-ever comprehensively planned health study of a group of Australian veterans involved in a single theatre of war, and was undertaken by a team of specialists from Monash University, the University of Western Australia, and the University of Melbourne.[233] Especially noticeable—as in the case of Vietnam veterans, and later in debates over homelessness, suicide and incarceration—was the influence of the American experience. For example, although very few Australians had participated in the land battle (most had served at sea in warships, with different exposures), discussion of 'Gulf War Syndrome' in Australia drew heavily on the experience of the 100,000-plus United States land forces.

Nonetheless, the *Gulf War Health Study* indicated clearly that Gulf War veterans were more likely, compared with those from comparable military units not involved in the conflict, to report symptoms of suspected illness. As the Repatriation Commission put it, 'ADF personnel deployed to the Gulf War have poorer physical and psychological health, poorer quality of life, greater use of DVA health services and greater use of pharmaceuticals relative to the comparison group of ADF personnel who did not deploy to the Gulf'.[234] Typical conditions included PTSD, chronic fatigue, irritable bowel syndrome, alcohol disorder, and what was termed

‘multisymptom’ illness (the latter apparent in 26 to 29 per cent of Gulf War veterans, compared with 16 to 18 per cent in the comparator group). Those deployed during the actual combat phase of the war were more likely to display a range of symptoms, as were servicemen and servicewomen of lower rank. Alongside deployment-related stressors, potential deleterious influences ranged from the number of vaccinations received by a serviceman or woman to the effects of pyridostigmine bromide (NAPS) tablets and pesticide exposure, together with possible exposure to depleted uranium dusts. But, as the Commission cautioned, ‘overlap between these exposures limits the certainty with which any one exposure can conclusively be linked to any one health outcome’.[235]

This diagnostic uncertainty was combined with greater focus on what was now designated chronic multisymptom illness (CMI), together with an assessment of CMI’s apparent relationship to so-called Gulf War Syndrome. The latter term, originating in America, had passed into popular parlance shortly after the Gulf War, largely through widespread media usage, and was often employed in non-specialist circles as a loose approximation to CMI. In an effort to provide clarification, in March 2015 the Repatriation Commission declared emphatically that ‘Gulf War syndrome is not an identifiable disease’; it also explained that ‘Chronic Multisymptom Illness (CMI) as categorised in the available scientific literature does not warrant designation as a disease’ in its own right either.[236] Rather, CMI was a collection of potentially inter-related conditions now recognised officially by the Repatriation Medical Authority (RMA), the specialist body of practitioners ‘eminent in the field of medical science’ which had been established in 1994 to deliberate authoritatively on disease causation.[237] Where the RMA led, the Repatriation Commission followed, basing its opinion (and decisions) on RMA’s scientific evaluation of the medical evidence.

The RMA considered that the complex mix of health outcomes that could signal the existence of CMI might arise from ‘living or working in a hostile or life-threatening environment for a period of at least one

month in the six months before the clinical onset of chronic multisymptom illness'. More specifically, according to RMA, CMI could be said to exist in those cases which met the criteria laid down in RMA's own statement of principles.[238] Firstly, any particular case would need to exhibit one or more current symptoms from two of three diagnostic categories identified by RMA, with at least one symptom in those categories being rated as 'severe'. The first category was fatigue, the second mood-cognition (for example, feeling depressed; difficulty remembering or concentrating; feeling anxious; trouble finding words; difficulty sleeping), and the third musculoskeletal (symptoms such as muscle pain, joint pain and joint stiffness). At the same time, it was explained, the collection of symptoms relied upon to make a diagnosis should be of sufficient extent to result in 'severe disruption of social and occupational functioning', and must have persisted for at least six consecutive months. Finally, it was emphasised that any or all of these symptoms should not be better explained by another medical or psychiatric condition.[239] It was perhaps not surprising that (as of March 2015), DVA had received only one compensation claim potentially attributable to CMI (and which was deemed likely to fail)—nor that the Gulf War Veterans' Association had asked for the criteria to be reviewed.

A RAAF Wing Commander gestures to his maintenance team before taking off in his F/A-18 Hornet on its final combat mission over the skies of Iraq. *(Dept of Defence JPAU27APRO3WG10)*

By now, however, a further study was already well advanced, its publication imminent. Data for what was entitled the *Australian Gulf War Veterans' Follow Up Health Study* had been collected during 2011–2013, approximately ten years after the original baseline study, by the Centre for Occupational and Environmental Health at Monash University. The *Follow Up* study was designed to build upon the 2003 study, and was a longitudinal cohort study of the physical, psychological, and social health and military-related exposures (for example, to burning oil fumes) of Gulf War veterans, including a parallel examination of a comparison group also drawn from the ADF.[240] Published in 2015, this new study investigated those health outcomes that had been in excess in the 2003 baseline (such as PTSD, gastrointestinal disorders, alcohol disorders, and chronic fatigue), noting any changes in the prevalence of these health outcomes since the baseline study. It also observed the pattern of persistence or new incidence of these health outcomes, as well as the existence of some additional adverse symptoms—such as sleep disturbance and musculoskeletal disorders—that had not been

assessed in 2003. Likewise, there was discussion of current levels of general wellbeing, social functioning, and quality of life, together with an assessment of the association between deployment-related exposures during the Gulf War and any health outcomes.[241]

The *Follow Up* study found that, since the 2003 baseline, individual symptoms were more likely to have persisted in Gulf War veterans, compared with the comparison group, while individual new symptoms previously absent at baseline—but observed during the Follow Up—were also more likely. Across a range of indicators—chronic fatigue, musculoskeletal disorders, pain, adverse reproductive outcomes, sleeping patterns, respiratory health, neuropathic symptoms, PTSD, alcohol disorder, depression and psychological health—the Gulf War veterans were more likely to present symptoms than were those in the comparison group, sometimes significantly so. However, in terms of traumatic life events—financial difficulties, homelessness, imprisonment—the Gulf War veterans showed no difference from the comparison group, and general measures of life satisfaction were also similar between the two study groups. Where difference did exist, it was in poorer quality of life relating to physical and psychological health, and the maintenance of personal relationships. Moreover, relative to the comparison group, Gulf War veterans had a significantly increased rate of lodging disability claims with DVA, including an increased likelihood of having at least one claim accepted, as well as an increased likelihood of having been issued a Gold Card.[242]

The *Follow Up* report also sought to investigate more closely the impact of specific exposures during the Gulf War. In the 2003 baseline study, exposure assessment had been based largely on each veteran's self-reported experiences—from dust storms and burning oil wells to vaccinations and anti-malaria tablets—but the *Follow Up* study identified additional sources of evidence (such as military Reports of Proceedings [RoPs] and ships' logs and ships' medical journals) to supplement the self-reported information, as well as documenting the patterns of exposures reported across each ship's company or other units deployed to the Gulf. This expanded

methodology served to confirm the general exposures identified in the 2003 baseline study, so that during the *Follow Up* study, several 'Gulf War deployment characteristics and exposures were [again] associated with a number of adverse health outcomes'.[243] Interestingly, morbidity and cancer incidence among Gulf War veterans did not vary significantly from the comparison group or from the same-aged Australian male population as a whole. There was, however, a 'five-fold increase in brain cancer observed in Gulf War veterans relative to the comparison group [that] was not statistically significant [as it was] based on less than five cases, but warrants further monitoring'.[244]

The latter observation was typical of the report's exhaustive attention to detail, but added little to the overall assessment, as there were no known occupational or service-related exposures proven to cause brain cancer.

The *Follow Up* analysis echoed the Repatriation Commission's insistence that it was intrinsically difficult to link any one exposure conclusively to any one health outcome, because of the complex overlapping of reported exposures. However, the study was emphatic that various health outcomes could coalesce in contributing to chronic multisymptom illness, and among the study's recommendations was a call for 'greater recognition in Australia of Gulf War-related multisymptom illness'.[245] It was a recommendation repeated in the more extensive Summary report of the *Follow Up* study, which concluded that 'the finding of a persisting excess of multisymptom illness in the Australian Gulf War veteran group provides further support for the US Institute of Medicine's 2010 judgement that the weight of the scientific studies provides "sufficient evidence of an association" between deployment to the Gulf War and multisymptom illness'.[246]

Among the implications for DVA policy and programs identified by the *Follow Up* study, was the importance of the 'effective detection and management of existing chronic conditions in Gulf War veterans such as multisymptom illness, chronic fatigue syndrome, irritable

bowel syndrome, PTSD and alcohol disorder'.[247] As well as shifting chronic multisymptom illness from the margins to the mainstream, the *Follow Up* study had the effect of reinforcing in the public mind—as well as within DVA and in the medical and veteran communities—the distinctive characteristics of the Gulf War itself and the resultant mix of physical and psychological health outcomes experienced by its veterans. These distinctive qualities were further emphasised when it became apparent that Gulf War veterans had an increased risk of suffering PTSD and generalised anxiety disorder, compared even with Australian Afghanistan and Iraq War veterans.[248]

The *Gulf War Health Study* and subsequent *Follow Up* had dealt with the veterans themselves. By contrast, the *Timor-Leste Family Study*, commissioned by DVA and undertaken by the Centre for Military and Veterans' Health (CMVH) at the University of Queensland, was designed to determine what, if any, physical, mental or social health impacts were observable in the families of service members who had been deployed to Timor-Leste. Additionally, the study sought to identify any risk or necessary protective factors associated with any health impact.[249]

Overall, the study found that there was no significant difference between the families of those who had deployed and a comparable group which had not deployed. However, it was noted that, if an 'ADF member [who had deployed to Timor-Leste] had poor mental health, their partner was more likely to also report poor mental health. This in turn had negative consequences for affected children'. Moreover, partners 'were twice as likely to report that their children had behavioural difficulties if the family had experienced two or more deployments'.[250] It was also apparent that there were perceived barriers to seeking care, such as the imagined likely expense; difficulty in getting time off work; and not knowing where to turn for help (notwithstanding the wide spread of DVA promotional literature). A further worrying discovery was that a full 10 per cent of partners self-reported domestic abuse. Typically, these partners described

their relationships as comprising ‘a lot of tension’, and reported that arguments were only resolved ‘with great difficulty’.[251]

More generally, families of ‘fourth wave’ veterans experienced a range of deleterious effects resulting from the particular nature of veterans’ service in the 1990s and the new millennium. A wealth of qualitative and anecdotal evidence soon emerged, to provide penetrating insights into the characteristics of this ‘fourth wave’ experience. ‘Jane’, the subject of one DVA case study, reported that her husband ‘Ben’ (not his real name) was changed almost beyond recognition by his deployment to Rwanda. ‘When I first met him, Ben was completely different to how he is now’, Jane explained in 2009. Their wedding plans had had to be put on hold as a result of the deployment, an initial cause of irritation and resentment, and when Ben returned home six months later, ‘the minute he stepped foot back in the door, I knew he had a problem’. For the next couple of years, ‘Ben was trying to hold it together but there was an escalation in his symptoms. Anxiety, depression, flashbacks, dreams, social withdrawal, incredible night sweats, all those things’.[252] Ben was still serving at that stage, and proved reluctant to seek help, despite Jane’s encouragement, for fear that it would impact on his career.

Ben was an Army photographer, and Jane had hoped that this ‘might save him from what he saw: that standing behind the camera might make him a bit more detached. But obviously it didn’t’. There was a video ‘where bullets are flying over the top of his head’, and ‘there were always things happening, you know. Like fourteen-year-old kids walking around with AK 47 weapons in Rwanda, pointing them at you and laughing. Or the minefields where you are taking a photo, taking a photo, step back, look around, just missed it’.[253] As Jane went on to explain:

> It took him months to show me the photos from Rwanda. I didn’t ask, I was waiting for him to be ready. One day, he just brought them out and said, ‘That’s the photos’. And to sit there and keep my face blank and go through them without getting upset or throwing them away or screaming ... it was the hardest thing I’ve

> ever done. And that's just photos, that's me just looking at them. Not taking them, not being there, not the smells or the atmosphere of seeing every day what people can do to each other. It gave me an understanding that was so helpful. I've got the photos now and they're hidden: they're put away.[254]

After Rwanda, Ben was deployed to Timor-Leste. 'Ben'll tell you East Timor was a walk in the park compared with Rwanda; that's what he'll say'. But Jane was not so sure that was the case. 'The operational rules for peacekeepers are to stand and watch and clean up afterwards', she said, a situation that inevitably took its toll. Besides, Ben had been in Timor-Leste for more than half of Jane's pregnancy, and he returned home just in time for the birth of their first child, and 'that was when things started to go really pear shaped'. But, she added, 'while he was definitely worse when he came back it's always hard to know ... was it Timor? Was it the baby? And for me, my focus had changed now because suddenly I've got a child and so maybe I'm not as supportive'. There was 'lots of arguing' and 'increasing rage', and eventually Jane gave Ben an ultimatum: 'That's it. So either you go and sort yourself out or I am going to pack my bags and leave'.[255] The ultimatum worked. Through the Army, Ben was seen by a psychologist, and was diagnosed with PTSD. He was discharged as TPI [totally and permanently incapacitated] in 2002. Thereafter, he was seen regularly by a psychologist, and was supported by DVA's Veterans' and Veterans' Families Counselling Service (VVCS). He was also on medication for anxiety and depression. Together, this made the situation tolerable and kept the family together, although there would always be those friends and neighbours who, despite the efforts of VVCS, could not understand Ben's continuing mood swings and emotional outbursts ... 'so what's the problem? Christ, get over it mate, Get a life'.[256]

As Ben's experience had shown, multiple deployments to varying operational theatres in relatively quick succession could have a cumulative effect on the young servicemen and servicewomen of the

‘fourth wave’. Such was the case of ‘Bell’. Her father had cautioned her against joining the Army—‘What about the wars?’—but Bell had countered that ‘Australia hasn’t gone anywhere since Vietnam, don’t worry about it’. (Her analysis was not strictly correct, as there had been a number of overseas deployments by the time she joined-up, albeit not on the scale of Vietnam.) Nonetheless, aged 19, Bell joined the ADF: ‘Six months later I was in East Timor when the big conflict occurred in ’99. It was mind-boggling. Everyone was unprepared for it and I was so young and so new and I’d never left Australia before’. She found herself in an extremely threatening environment. ‘We were peacekeepers’, she explained, ‘but we were deployed under war-like circumstances. It was a very fine line between peace enforcing and peace keeping, especially in the beginning. How do I explain it? You carry a fully loaded weapon at all times. There’s always ... two people together. There’s a whole kind of armed defence around everything’.[257]

Bell was in the Ammunition Platoon, which meant keeping the ammunition safe (in often non-ideal conditions) and issuing it as required. The platoon also took charge of confiscated weapons. ‘We had shipping containers lined up in our compound just chockers full of militia contraband’, she recalled. ‘Really horrific, brutal homemade weaponry’. The close proximity of rockets, grenades and bullets, together with the ugly assortment of improvised weapons, was highly stressful, as was the responsibility of monitoring and accounting for this array of ordnance. ‘But’, she confessed, ‘it was kind of boring too. You’re on alert, the “enemy’s” out the gates, but you’re sitting in the same spot day after day. It’s ordinary and huge, both at the same time’.[258]

This sense of surreal unreality was heightened when Bell returned after her six-month deployment, ‘when you’re also trying to merge in again with everybody back home.’ As she put it:

> It’s hard. You’ve been with these poor people in this Third World country who don’t have anything; who’ve lost everything and it makes you want to appreciate the things you have ... But when

> you come home, it feels like people are naïve or totally out of touch with what's really going on ... you get impatient. It drove me round the bend to hear Australians complain about their life, particularly older people. It just drove me bonkers and I thought, 'You've got no idea what life is like for other people'.[259]

Being surrounded by these seemingly dozy and uncomprehending civilians could be unbearable:

> The frustration level can be so high at times—you go to the shops and you get so annoyed with people dawdling along and behaving like wombats. Then you have a beer with a mate who was in East Timor with you and you go, 'Jeez. I hate going to the shops: I hate the crowds'. And you find out it's been the same for them. And then, I'd drink more beer and so it goes on.[260]

Similarly, Bell discovered that family and friends had no idea either. 'Nobody', she complained, 'knows how disconnected you feel. They assume that you're the nineteen-year-old you were when you left home. They assume a lot of stuff and so much of it is wrong'. However, Bell was focused on her ambition to become an Army photographer, and this gave her a positive aim in life. She was promoted and appointed to the Public Relations Service, 'which was just phenomenal; it's the best job in the defence force. You deploy around the world, chasing soldiers, taking photographs, telling people what it's really like'. In her new guise, Bell found herself almost constantly deployed: 'Over the next four years I went back to Timor once and to places like Bougainville and the Solomon Islands. And then on Boxing Day 2004, I got a call from the boss'.[261]

It transpired that Bell was to be deployed immediately to Indonesia as part of Australia's humanitarian response to the huge tsunami that had devastated much of the Indian Ocean littoral. She was sent to Banda Aceh, capital of Aceh province on the island of Sumatra, flying in a RAAF C130 Hercules transport aircraft. Strapped to the open door of the 'Herc', her camera at the ready as the plane flew at low level, Bell suddenly became aware that the crystal-clear water below had turned 'to chaos'. The sea was dark now, and full of

debris. ‘You can see trees and bodies in the trees and this is still the ocean’, she recalled: the ‘bodies are face down in the water, their arms and legs splayed out like they’re a frog on a cutting table’.[262] Having landed at an airfield, Bell was given an impromptu lift into town, standing up in the back of a ute so as to be able to use her camera:

> We drove past the mass graves and the bodies, mostly wrapped in sheets, bloating on the side of the road and the bulldozers rolling the bodies forward into ditches and the terrible smell was everywhere ... I get the camera ready and we turn a corner and there’s piles of bodies: smaller kids, bigger kids and they’re trying to sort them out and there are adults, possibly relatives, looking amongst them.[263]

Bell was in Banda Aceh for a fortnight, but to her it felt like months, such was the intensity of the experience. By now she had decided to leave the service to pursue a civilian career in graphic design, and before her discharge her boss insisted she see a psychologist. But the ‘session with the psych was just a tick and flick affair’, said Bell, and she was disappointed that she did not have the opportunity to talk about her disturbing experiences:

> I would have told him that on the plane home, somebody gave me a steak for a meal and I just lost it. Like I saw burnt kids straight away, smelt them, the whole bit like a flashback. It’s not abnormal to have vivid reminders after a big trauma, I know, but I think it’s probably a good sign that maybe some follow-up could help. I went ahead with my discharge and looking back, this was not such a clever idea. I should have delayed and stayed in the army for six months just to process the trauma in a familiar environment. I was losing a big piece of my identity and struggling with a trauma. All at once. It might be that Aceh on its own was enough ... But it’s also possible Timor set me up for it and Aceh was the straw that broke the camel’s back.[264]

There were nightmares, depression, edginess, numbness, aggression, and arguments with her partner, ‘Kerry’. The graphic

design course was not going well—Bell found the young students silly and irresponsible (in the Army ‘you don’t wander in late; you respect your teacher, you don’t use your mobile in class, you don’t rock out when you feel like it’)—and concluded that: ‘People are f… ing stupid ... they have no idea’.[265] However, almost a year after leaving the Army, Bell was referred to DVA’s VVCS, which proved ‘instrumental in helping me process the experiences in Aceh and put it in a positive place’. Formal counselling followed, together with a diagnosis of PTSD, and eventually Bell came to understand that her time in Aceh had been a ‘phenomenal experience: the best and the worst experience of my life. The worst because it’s impacted on other people like Kerry. The best because there’s much to learn from it’.[266] Bell got her university degree, and came to a more balanced assessment of what was important to her in life. But she remained convinced that more needed to be done to educate families about the nature of military life and its impact on those who serve and have served. There was, she felt, an enormous disconnect between service in the ADF and mainstream civilian life in early twenty-first century Australia, and that more should be done to address this gap, particularly for young veterans attempting to reintegrate into civil society.

Another candid insight into this new ‘fourth wave’ generation of veterans was provided in the autobiographical memoir penned by James Prascevic, an Australian soldier who had served in Timor-Leste, Iraq and Afghanistan before sustaining serious injuries during parachute training, after which he had been discharged unfit from the Army.[267] Close friends had been killed in action, and he had witnessed distressing scenes during active service overseas. Forced to abandon his chosen career, Prascevic experienced feelings of worthlessness and low self-esteem, punctuated by uncontrollable outbursts of anger, together with a pervading sense of guilt. All this propelled him into a spiral of decline, involving heavy drinking, the breakdown of his marriage, and attempted suicide. He listed his darkest thoughts: ‘I hate myself’—‘I feel insignificant’—‘I feel that I have failed in life’—‘Why did I survive when others didn’t?’—‘I feel I

am getting in everyone's way'—'I feel like my career with the Army was worthless'—'I hate when I see people doing things that I cannot do, e.g. running'.[268] Diagnosed with depression and PTSD, James Prasevic attended a residential PTSD course along with other former ADF personnel, which resulted in a 'feeling that a huge weight had been lifted off my shoulders', an improvement that was sustained through the continued support of his psychologist, psychiatrist and GP, as well as his own commitment to seeking help.[269]

Among the self-help tools that James Prasevic had found especially useful, was a DVD *You're not in the forces now*, produced by VVCS. Launched initially as the Vietnam Veterans' Counselling Service in 1982, with its first centre in Adelaide, within two years the VVCS had expanded to eight centres located across Australia. In 2006, against the background of the new array of demands from the emergent 'fourth wave' of veterans, the service was rebranded and relaunched as the Veterans' and Veterans' Families Counselling Service (also abbreviated as VVCS). By 2010, there were fifteen centres across Australia, with counselling services available to veterans of all conflicts, along with their families and current serving members of the defence forces. Vietnam veterans had been among the initial generation of counsellors, and the tradition of employing serving and ex-serving men and women remained a key strength within VVCS. Steve Dunning, for example, a veteran and counsellor, had been in the military for over forty years, first as an Army regular and then as a Navy Reservist. After half-a-dozen years, he had begun training as a social worker at Repatriation General Hospital (RGH) Daw Park in Adelaide, and it was there that his enthusiasm for VVCS first took off. During his lengthy career, Steve Dunning undertook multiple operational deployments, including Afghanistan. 'I was there', he explained, 'when we experienced two significant "green on blue" incidents where rogue Afghan soldiers killed and wounded a number of ADF personnel'. As a staff officer in the Headquarters Joint Staff Force 633, he was involved in the initial reporting of the incidents through to the repatriation back to Australia of those killed and wounded—the latter for specialist medical care. As he reflected, his

intimate involvement in current operational environments created an empathy with serving members and recent veterans, as well as their families. As he put it, ‘I felt that with my background and experience I could have a significant impact in helping people ... I thought I could offer another insight and level of expertise to VVCS, my colleagues and our clients’.[270]

For veterans like James Prasevic, ‘Bell’ and ‘Ben’, VVCS was a lifeline. A 24-hour telephone counselling service was complemented now by an outreach program which allowed veterans and their families to receive counselling wherever they might be in Australia. This program arranged for private counsellors to provide services in remote areas where there was no ready access to VVCS centres.[271] Advances in information technology also allowed access to VVCS counselling in regions where, previously, local counselling was problematic or non-existent. In August 2014, DVA launched its VVCS Facebook page, which was used by VVCS to interact with veterans and their families who were active on Facebook. As might be expected, the initiative proved especially popular with the ‘fourth wave’ of younger veterans, and in its first eleven months of operation the VVCS Facebook Page had attracted over 3,000 followers, and was estimated to have reached upwards of 60,000 ex-service community members. As well as allowing VVCS to interact with veterans and their families, the VVCS Facebook page provided information on services and client eligibility, at the same time alerting veterans to forthcoming programs and promoting general mental health literacy. However, out-of-hours monitoring and moderation was soon identified as an issue and, following an approach to market, this was outsourced to an external provider. By April 2015, only one individual had been blocked for repeated breaches of VVCS social media policy, but with several defamatory posts having been removed, the Repatriation Commission stressed the importance of out-of-hours monitoring ‘as an efficient way to manage the liability inherent in a mental health counselling agency being involved in a relatively uncontrolled social media space, such as Facebook’.[272] More generally, as DVA aimed to achieve greater

standardisation, rationalisation and consolidation, at first under its 'One DVA' initiative, and then as a part of general policy development, so it attempted to become ever more 'veteran-centric' in its efforts, especially in response to the demands of 'fourth wave' veterans who expected 'joined-up' action as a matter of course. Closer integration of claims-processing across DVA's various services was one area of endeavour. Another was the drive to move client services as close as possible to the veterans themselves, at the same time bringing client-related information together to establish what was described now as a 'whole client view'.[273]

A major development in this regard was DVA's Coordinated Veterans' Care [CVC] Program, a team-based hands-on program designed to increase support for those Gold Card holders with one or more targeted chronic conditions or complex needs who might be vulnerable to unplanned hospital admissions.[274] The experience of 'Michael', an Indigenous ex-Army veteran suffering from diabetes and PTSD, provided an insight into the program's operation. After leaving the ADF, Michael had become isolated from his family and friends and had relationship problems. Assessed as being at high risk of unplanned hospital admissions, his GP at his local Family Medical Centre drew Michael's attention to DVA's CVC program, explaining how his care could be better coordinated and how he could be supported to achieve improved health outcomes. 'Before CVC, Michael stayed in bed all day', it was reported. 'He was isolated, depressed, anxious and very ill and at risk of going to hospital from his poorly controlled diabetes and medications'. However, thanks to the program 'he has progressed to the point where he is out and about and even exercising a little. He has had no unplanned hospitalisations from his conditions and is more careful about taking his medications. He cooks his own meals and has now reconnected with his family'. At the Medical Centre, his care team was led by his GP and CVC nurse coordinator, and included an Aboriginal health worker, diabetes educator, mental health worker, and podiatrist. Key to the success of Michael's management plan was the marshalling of all relevant information in one place. As the

Medical Centre reported, ‘having the notes all here at the practice, managed and coordinated, has been invaluable to the improvements we have seen in Michael’s condition’.[275]

Among the new initiatives designed to assist reintegration back into civilian life was The Right Mix, an alcohol management plan launched by DVA in 2001, in conjunction with the ex-service and veteran community, which was designed to help individuals achieve a balance between responsible alcohol consumption and a healthy lifestyle. Later, an interactive website was developed to encourage ‘hands-on’ investigation and self-management. Another DVA initiative, At Ease, introduced in 2007, focused on mental health issues: its website explained that it was not unusual to experience sadness, distress or anger after a military deployment. Moreover, the program—aimed at veterans, serving members of the ADF, and their families—gave advice on recognising such symptoms and seeking timely help and treatment.[276]

A further evolution of the At Ease program, aimed specifically at the ‘fourth wave’ of veterans, was the launch of its new web portal in 2013, providing a self-help website tool for post-discharge men and women. The experiences of one (anonymous) ex-serviceman offer an insight into the program in action, demonstrating the difficulties often encountered by veterans of recent conflicts, and highlighting changes in the ways veterans could access help and support. ‘It wasn’t the combat’, emphasised DVA’s informant. ‘Combat and taking action was what I was trained for. My problem was the way of life over there. It is just so different. Life is cheap. Women and children are abused, sold or killed so easily and I couldn’t do anything about it ... having to stand on the sidelines made me feel helpless and guilty’. Moreover, he continued, after return from deployment he still felt always on his guard, and it took him a long time to stop reacting to loud noises, and a quite a while to get ‘used to feeling safe again in Sydney traffic’. There was also difficulty at home. ‘I felt like I had changed but my family had stood still and now I was out of step’, he explained: ‘I couldn’t tell my wife. I wanted to protect her and the kids from the bad stuff I had seen. They thought I

was a hero, not realising how guilty I felt'. He started to shut them out, wondering whether he even wanted to live with them anymore, and spent solitary hours surfing the net to avoid having to do anything with the family.[277]

However, it was on the web that he discovered some YouTube videos about other recently returned veterans, and soon realised that he was not alone in his feelings of despair. There was even a link to the DVA At Ease website. Here he learned that his experiences were not unusual, and, moreover, that he could do something about them. There was advice on recognising the signs of mental illness, and a guide to resources for taking action. He tried using some of the self-help tools on At Ease, which he admitted he found hard work at first, but which soon started to help. There were fewer arguments at home, he talked to his wife, and then went to see his GP who referred him to a psychologist. The 'psych ... really opened my eyes', he explained, making 'me feel safe to talk about my sense of failure and guilt'. DVA was paying for the treatment, 'and I didn't have to make a compensation claim'. Most importantly, 'I am talking to my wife and kids—not about the bad stuff, but how I am feeling. It has made such a difference'.[278]

The emergence of the new 'fourth wave' of veterans was matched by the increasingly diverse roles played by women in Australian society, not least in the armed forces. Indeed, with approximately 14 per cent of the ADF made up of women (in 2012 an average of 345 females served on overseas operations at any one time), and with the Force's recruiment policy actively seeking to increase the number of serving women, female veterans were becoming an increasing proportion of DVA's 'fourth wave' clients. More than 11,000 veterans with one or more health conditions were women, and in 2012–2013 DVA and the Defence Department established the ADF Service Steering Committee to inform both departments on the specific needs of women.[279] By 2012 it was anticipated that women would soon be able to occupy any role in defence, including special forces, diving and infantry roles, subject to meeting physical and intellectual

requirements. As DVA put it, historically ‘in times of war women were the ones left behind. It is the same today—when their partners and husbands leave for active duty thousands of women take on a dual parenting role, often juggling that with a job and other family responsibilities’. Now, however, times were changing: ‘we are now entering a time when men are also taking on the responsibilities associated with staying behind and more women take an active role in the defence forces’. DVA was ‘prepared to adapt to a changing client base and welcomes the challenge of continuing to provide excellent support to all ex-service personnel, both men and women’.[280]

Able Seaman Shonelle Watkins, a medic onboard HMAS Newcastle, *participates in a replenishment at sea (RAS) operation in the northern Arabian Gulf off the Iraqi coast. (Dept of Defence 2005089cpa8267338_025; CPL Cameron Jamieson)*

A major study published by DVA in 2012, based on research conducted at the Australian National University, led by Dr Samantha Crompvoets, found that, overall, women ‘highly value their careers in the ADF and are empowered by the skills and opportunity it affords

them'.[281] But this was despite the prevalence of traumatic experiences and, in some cases, exposure to bullying, sexual harassment and abuse. Informed by in-depth interviews with 60 female veterans, together with 30 other stakeholders in the female health and wellbeing arena, the Crompvoets study had been commissioned by DVA in 2009. It built on earlier work by Crompvoets and other research teams, which collectively had identified a 'new generation of women veterans'.[282] In her 2012 study, Crompvoets went on to investigate the experiences of women who had been deployed from the Vietnam era onwards, including to Rwanda, the Gulf War, Cambodia, Timor-Leste, Bougainville, the Solomon Islands, Afghanistan and Iraq, as well as those who had served more generally in the ADF.

The study revealed the wide-ranging diversity of exposure to operational scenarios experienced by women since the 1990s. One interviewee, for example, an Army medic aged 52, had had multiple deployments during her time in the ADF, including to Africa and Cambodia. In the latter, one of her roles was to visit communications outposts (known as 'Charlie Tangos') along the Cambodia-Thai border, manned by Australians and other UN peacekeepers. The visits were by UN helicopter, with a Canadian pilot. It was varied and exciting work: 'We'd go to a place ... a Charlie Tango and we'd get out and see who was there ... And all the kids would come around. And it was actually a bit dangerous because all the kids would run out, get onto the [helicopter] skids and we had to get them away'. On one occasion, however, approaching another Charlie Tango at low level, they came under fire from unseen assailants: 'We took a bullet. A steel-capped bullet between the pilot and my head ... it was a really loud sound. It was absolutely really loud. I don't know, it's just like in such a small helicopter, just this big like explosion sound'. The bullet had damaged the helicopter's control system, and oil was leaking everywhere. The pilot broadcast 'Mayday, mayday, mayday', and 'in between saying mayday he goes, "They're fucking shooting at us; they're fucking shooting at us ... I can't believe it"'. Fortunately, the pilot managed to land his crippled aircraft, and, instinctively,

following her School of Infantry combat training, the female medic swiftly exited the helicopter, taking cover behind a log as she cocked her weapon and put her finger on the trigger, following the much practised drill: ‘You’ve got to go down, crawl, you know, look up, aim, observe ... even though I’m a nurse I could remember those things about what the R.S.M. [Regimental Sergeant Major] was telling me’.[283]

The hostile forces that had brought down the UN helicopter were not identified, notwithstanding the gruelling debrief experienced by the female medic at a nearby Dutch marine base. Trying to account for the incident, the marine ‘was really, really, really persistent ... he pushed and pushed and pushed me and he didn’t let me go until I burst into tears. And it was really horrible. I was really angry with him because then I had problems thinking, “Oh, fuck, I nearly got killed”’. She was also extremely angry with herself, as before she had always considered herself a strong person. There were sleepless nights, and then the strange experience of returning home: ‘So we came through and then we had our parade and got our medals and then 24 hours I’m back at Yarralumla here in Canberra, mowing the lawn as if nothing had happened. As if nothing had happened’.[284]

Three members of HMAS Warramunga's *ship's company farewell family and friends prior to departure from Australia for a six-month deployment in the Arabian Gulf.* *(Dept of Defence 20060831ran8297357_160084; ABPH Nadia Monteith)*

Action in the face of an (unknown) enemy and robust questioning during debrief both contributed to a sense of trauma and anxiety. For others, it was the sheer horror of what they had to cope with that left an unfading imprint on their lives, the 'things [that] are etched in your head and your heart forever'.[285] A 46-year-old ADF nurse, with multiple deployments in Africa and the Middle East, where she worked in military resuscitation units, had decided to record her experiences for professional purposes, photographing patients with the intention of using these illustrations in educational presentations later on. But they soon became harrowing reminders of what had been experienced, revealing (as Crompvoets put it) 'the normalisation of the acute trauma she was repeatedly exposed to' and demonstrating 'what nursing in contemporary conflict zones involves, the potential impact on mental health and the critical need of appropriate services to assist women like her to make sense of these experiences'.[286] The nurse showed the photographs to the study interviewer:

> That's one of the civilians. This is a gunshot wound. He was an Iraqi. What they do is they got to come to us and to make it more humane for them to die in a nice setting. We still have to put like a monitor on them. He's dead now. What I couldn't accept or what was very difficult was that when they came to us they were already in a body bag. This is a body bag so you know that they are going to die, they have pretty much carked it anyway. So they're in a body bag and we keep them warm.[287]

The photographs were extremely graphic records in their own right but they also had the effect of precipitating a wave of disturbingly intimate recollections:

> And what was horrible was that when they got shot it is very foggy, very wet and all the brain matter falls out. You usually have a bluey [blanket] under there to catch it all. So many other times that when you are holding their head up to try ... because their head is heavy, if you don't have any help you are trying to put this bluey under and cover them up with a bandage. A lot of brain matter falls and it used to fall on my shoes, and you'd often go home and you would have brain matter on your shoes. We didn't get to take the shoes home [to Australia] we could get rid of them in Kuwait. That was horrible.[288]

Alongside the traumatic exposures of overseas deployment, there were specific challenges for female veterans. Motherhood was a significant area. To the practical and emotional difficulties, especially for single mothers, of leaving young children at home, there was the additional burden of having to deal with sick, starving, injured or neglected children when on deployment.[289] Supportive partners and parents at home made a big difference, and some schools were especially helpful. 'Everybody at school was fantastic', recalled one Army female veteran. 'The support, everybody knew what was happening, the children had a map of Bougainville in their room, and when I talked about sending postcards and letters home, they'd take them to school, I sent emails to the teachers'.[290] But a supportive environment did not necessarily make everything easier. One female

ADF veteran recalled that, about to deploy to Solomon Islands, she had had to give up breastfeeding her young son: ‘I actually weaned him the day I got on the plane. So I gave him his last feed and I knew that was going to be his last feed. And I’m telling him this is your last feed now. I was in tears. I was a mess. It was hard’.[291]

The rapid expansion of female employment in the ADF, especially in those ‘other occupations’ beyond the traditional health-care areas, was for some serving men an intrusion into what was a male domain. ‘On my first day my boss said to me “women don’t belong at sea; they don’t belong in the Navy”’. This was the experience of a young female rating, deployed overseas in a warship for the first time. It was a shocking moment, although she admitted that during her seven years in the Navy, attitudes had changed rapidly. ‘I saw a massive turnaround’, she reported, the ‘old school’ of diehards gradually retiring and younger male recruits proving readier to accept women as colleagues. Besides, now ‘you’ve got so many female Chiefs [Chief Petty Officers] and POs [Petty Officers] and so they can reinforce that it’s OK for women’.[292]

Nonetheless, extreme forms of sexual harassment remained. ‘You’re constantly fighting it off’, explained another young female Navy veteran. She remembered particularly a ‘runashore’ when their ship was visiting Townsville in Queensland. Many of the sailors went to a local pub, where it happened to be ‘topless night’: ‘I can’t remember if the Captain was there. But I know that all the Chiefs and the Warrant Officers and that from the ... Department were there’. There were just three female sailors, the informant and her friend, plus a ‘leader’ [Leading Hand] who had been in the Navy for some time, as her higher rank denoted. ‘And she’s one of the boys ... I think she’d basically been brainwashed, and she just acted like they did ... she was just wanting to get up there and get her top off’. The male ratings encouraged the informant’s friend to follow likewise: ‘“Yeah, you should get out there. You’d win”. You know, because, you know, she’s got big boobs’. As the informant reflected: ‘There’s no respect whatever’. Moreover, she added, the many courses about diversity and gender equality that ADF personnel were required to attend,

seemed to count for little: ‘As I say, you get a ship pull into Townsville, and there’s topless night at the local pub. And you know, and all of a sudden, all those courses go out of the window’.[293]

There were also cases of actual sexual assault, in the Army and Air Force as well as the Navy, where ‘they’d walk past and push you against the wall and grab your boobs and stuff like that, like it was very physical and awful’.[294] As one respondent explained, such behaviour made her ‘Very wary of males, totally. I know it did nothing for ... my intimacy with males. I know with my first marriage I didn’t like him ... my ex-husband coming up behind me and giving me a hug because that’s exactly what would be going on, but you’d get groped at the same time’.[295]

For many of these women, as Crompvoets discovered, their service careers had left them with serious psychological issues, and not all knew where to turn for help. The experience of one interviewee was an insight into the difficulties some female veterans had encountered. She had begun attending some ‘TPI courses with DVA’ but was ambivalent about their value, especially as they seemed to be dominated by Vietnam veterans in their 60s. She had also sought the advice and assistance of accredited Advocates, those whose training had been funded by DVA to enable them to make a veteran’s case, but they too seemed attuned to the ‘ageing clientele’ and were unsure how best to represent her interests, being young and female. ‘Older men’ appeared to be prioritised, ‘and there wasn’t a lot of women’.[296] A 27-year-old Navy veteran explained that she had approached DVA, and as a result had been assessed as 65 per cent incapacitated. ‘But I never mentioned a word about what I’ve told you [the interviewer; about sexual trauma] ... what I said was still true but it wasn’t the real reason’. For the system to work effectively, she argued, both claimants and DVA assessors had to be comfortable and up-front in dealing with sensitive issues such as sexual trauma. As she put it, ‘I think they need to be able to sit down and say look, to DVA or people doing claims, like people can’t be

afraid to hear [about sexual trauma], you know that's the biggest thing for me'.[297]

Others were even more ambivalent, and some extremely vague. Asked if she had ever contacted DVA, one 29-year-old female Navy veteran gave a disarmingly honest answer: 'I guess I don't really know and I haven't really investigated my entitlements from doing my Gulf trip and that's something I guess I'll find out when I need to'.[298] Another respondent was at even more of a loss. Asked about DVA, she answered: 'I don't know. Do they even know you exist? Fucked if I know ... it's not something I've actually thought about ... I've never contacted them, don't even know what they supply'.[299] By contrast, another female veteran explained that she had been awarded 'Hundred per cent disability on the back injury' as a result of her approach to DVA. But, despite this positive outcome and her clear understanding of DVA procedures, it had not been a happy journey. She alleged that all the details of her physical injuries had been somehow removed from her medical records, making it infinitely more difficult to fight her case: 'Six years it took me to get my Gold Card'.[300]

More generally, the 2012 study concluded that there were significant shortcomings in DVA's ability to deal with the new surge in female veterans. There was a perceived lack of support services developed specifically for or targeted at female veterans. There was a dearth of appropriate information on female-specific issues, including maternal separation, reproductive and gynaecological health, domestic violence, military sexual trauma, and lesbian, transgender and same-sex-attracted women.[301] (In 2004, the Repatriation Commission had decided that 'gender reassignment surgery is not considered as clinically necessary, and will therefore not be funded under the Commission's Health Care Arrangements', although the ADF went on to fund more than ten of these sex-change operations).[302] In response to the report, the Military Rehabilitation and Compensation Commission protested strongly that VVCS 'offers a range of services to assist male and female veterans and their families to work through

emotional and psychological issues arising from military service', including 'referral to specialised female health services'. But the Commission also promised that the forthcoming 2013 DVA Mental Health Strategy would highlight the unique experience of female veterans.[303]

An ADF veteran receives retraining and work placement support to transition to civilian life after service, June 2012. *(DVA 20120619_MF ... 0581)*

[218] Minutes of the Repatriation Commission [MRC] CM 6636, 30 January 2012, Future Mental Health Policy Work.

[219] Ibid.

[220] Interview with Neil Bayles, 26 October 2017.

[221] Ibid.

[222] For example, the *Sydney Morning Herald*, 3 April 1972, published a survey indicating that although two-thirds of respondents continued to support some form of national service to the armed forces, fewer than one-quarter considered that conscripts should ever be sent overseas again. See also Dapin, *The nashos' war*, p. 412.

[223] Ham, *Vietnam: The Australian war*, p. 664.

[224] MRC CM 4677, 3 February 1994, Termination for Operational service in Cambodia.

[225] Andrew Blyth, 'Entrepreneurship for post-conflict reconstruction', in Tom Frame (ed.), *The long road: Australia's train, advise and assist missions*, NewSouth Publishing, Sydney, 2017, p. 322.

[226] Tom Frame, 'The long road to peace and prosperity', in Frame (ed.), *The long road*, p. 2.

[227] Department of Veterans' Affairs (DVA), *Annual report* 2009–10, p. 73.

[228] *Australian*, 25 April 2019.

[229] https://www.abc.net.au/news/2014-07-03/defence-releases-name-of-soldier-who-died-in-afghanistan/5569196, accessed 7 May 2019; https://web.archive.org/web/20101011194257/http://defence.gov.au/vale/sgt_russell/sgt_russell.htm, accessed 7 May 2019.

[230] Frame, 'The long road to peace and prosperity', p. 4. The assessment of Australian training qualities was made by United States Vice President Joe Biden.

[231] MRC CM 4784, 9 August 1995, Warlike and Non-Warlike Service.

[232] Ibid. A perhaps more common way of distinguishing between 'warlike' and 'non-warlike' in a UN context is to cite the UN's own distinctions elucidated in its *Charter*, 'Resolutions under Chapter VI' indicating resolutions that are to be achieved through negotiation, arbitration and conciliation (i.e. 'non-warlike') and 'Resolutions under Chapter VII' which require nations to comply with the terms of a resolution in response to threats to peace, breaches of the peace and acts of aggression (i.e. 'warlike'). I am grateful to Craig Orme for this clarification.

[233] www.dva.au/health-and-wellbeing/research-and-development/health-studies/gulf-war-veterans-health-study, accessed 8 September 2017.

[234] MRC CM 7148, 4 December 2014, Update on the Australian Gulf War Veterans' Health Study Follow-up.

[235] Ibid.

[236] MRC CM 7154 and Minutes of the Military Rehabilitation and Compensation Commission [MMRCC] 149/2014, 4 March 2015, Commissions' Submission to Specialist Review Council (the Council) of Chronic Multisymptom Illness and Gulf War Syndrome.

[237] www.rma.gov.au, accessed 26 November 2018.

[238] Repatriation Medical Authority Paper no. 56 of 2014, cited in MRC CM 7154 and MRCC 149/2014, March 2015, Commissions' Submission to Specialist Review Council (the Council) of Chronic Multisymptom Illness and Gulf War Syndrome.

239 Ibid.
240 MRC CM 7176 and MRCC 31/2015, 8 April 2015, Release of Australian Gulf War Veterans' Study Follow Up.
241 Ibid., Annex: Australian Gulf War Veterans' Follow Up Health Study: Executive summary report 2015, pp. 1–2.
242 Ibid., pp. 2–7.
243 Ibid., p. 8.
244 Ibid., p. 10.
245 Ibid., p. 11.
246 Ibid., Summary report, p. 15.
247 Ibid., Executive Summary Report, p. 11.
248 Summary report: Systematic reviews of psychological disorders, multisymptom illness and chronic fatigue syndrome in veterans deployed to the Gulf War, Afghanistan or Iraq, 2015; see https://www.dva.gov.au/health-and-wellbeing/research-and-development/health-studies/systematic-reviews-psychological, accessed 30 November 2018.
249 MRCC 67/2013, 16 May 2013, Utilisation of Timor-Leste Family Study (TLFS) Findings.
250 Ibid.
251 Ibid.
252 Sayer-Jones, *Beyond the call*, p. 7.
253 Ibid., pp. 7–8.
254 Ibid., p. 8.
255 Ibid.
256 Ibid., p. 10.
257 Ibid., p. 29.
258 Ibid.
259 Ibid.
260 Ibid., pp. 29–30.
261 Ibid., p. 30.
262 Ibid., p. 34.
263 Ibid.
264 Ibid., p. 36.
265 Ibid.
266 Ibid., p. 38.
267 James Prascevic, *Returned soldier: My battles: Timor, Iraq, Afghanistan, depression and post traumatic stress disorder*, Melbourne Books, Melbourne, 2014.
268 Ibid., p. 203.
269 Ibid., p. 262.
270 DVA, *Annual report* 2012–13, p. 68.
271 DVA, *Annual report* 2009–10, p. 180.
272 MRC CM 7179 and MMRCC 35/2015/S, 16 April 2015, Procurement: Veterans' and Veterans' Counselling Service (VVCS) After-Hours Crisis Line.
273 DVA, *Annual report* 2007–08, p. 4.

[274] www.dva.gov.au/providers/provider.programs/coodinated-veterans-care, accessed 12 September 2017.
[275] DVA, *Annual report* 2012–13, p. 104.
[276] http://at-ease.dva.gov.au, accessed 6 November 2017.
[277] DVA, *Annual report* 2012–13, p. 89.
[278] DVA, *Annual report* 2012–13, p. 89.
[279] DVA *Annual report* 2012–13, p. 9.
[280] DVA *Annual report* 2010–11, p. 148.
[281] MRCC 161/2012/S, 2 November 2012, Findings from the report *The health and wellbeing of female Vietnam and contemporary veterans*.
[282] Samantha Crompvoets, 'The health and wellbeing of female veterans: A review of the literature', *Journal of Military and Veterans' Health*, vol. 19, no. 2, 2011, pp. 25–31; AE Street, Dawne Vogt & Lissa Dutra, 'A new generation of women veterans: Stressors faced by women deployed to Iraq and Afghanistan', *Clinical Psychology Review*, vol. 29, no. 8, 2009, pp. 685–684.
[283] MMRCC 161/2012/S, 2 November 2012, Findings from the report 'The health and wellbeing of female Vietnam and contemporary veterans'; Annex: Dr Samantha Crompvoets, *The health and wellbeing of female Vietnam and contemporary veterans—final report*, June 2012, pp. 23–24.
[284] Ibid., p. 24.
[285] Ibid., p. 17.
[286] Ibid., p. 18.
[287] Ibid.
[288] Ibid.
[289] Ibid., p. 31.
[290] Ibid., p. 33.
[291] Ibid., p. 35.
[292] Ibid., p. 37.
[293] Ibid., pp. 40–1.
[294] Ibid., p. 42.
[295] Ibid., p. 39.
[296] Ibid., p. 62.
[297] Ibid., p. 60.
[298] Ibid.
[299] Ibid., p. 59.
[300] Ibid., p. 58.
[301] MMRC 161/2012/S, 2 November 2012, Findings from the Report 'The health and wellbeing of female Vietnam and contemporary veterans'.
[302] MRC CM 5559, 30 March 2004, Gender Reassignment.
[303] MMRC 161/2012/S, 2 November 2012, Findings from the Report 'The health and wellbeing of female Vietnam and contemporary veterans'.

Chapter 4
Military rehabilitation and compensation

During 1999, the Department of Veterans' Affairs assumed responsibility for the Military Compensation and Rehabilitation Scheme (MCRS). The Department of Defence, under whose aegis it had been managed previously, was pleased to be relieved of a complex task, while DVA, worrying about its long-term viability as its clientele aged, was more than happy to take on the additional work.[304] Although the *Veterans' Entitlements Act 1986* (VEA), had little to say about rehabilitation (compensation being its primary concern, with rehabilitation handled by the Veterans' Vocational Rehabilitation Service),[305] DVA's forerunner, the Repatriation Department, had had a long history of managing rehabilitation going back to 1918, so acquisition of the Scheme by DVA seemed appropriate as well as desirable.

However, as soon became apparent, the administration of the MCRS alongside the provisions of VEA was by no means straightforward. As Neil Johnston, then Secretary of DVA, explained at a seminar hosted by the Australian Institute of Administrative Law (AIAL) in Canberra in August 2004, the MCRS was based on the *Safety, Rehabilitation and Compensation Act* 1988.[306] Put simply, peacetime service in the ADF had been covered by the MRCS, while warlike and non-warlike (operational) service was covered by both MCRS and VEA. As a result, some servicemen and servicewomen enjoyed dual eligibility for benefits under both schemes. This complexity had actually been exacerbated in April 1994, when the *Military Compensation Act 1994* tinkered with the Scheme, introducing dual eligibility between VEA and MRCS for ADF members on operational,

peacekeeping or hazardous service while removing dual eligibility for those on peacetime service. Thus, for example, from 1994 members on peacetime service were to be covered by only the MRCS—with the exception of those who had enlisted before May 1986 and served on continuous full-time service for three years or more, or who had enlisted after May 1986 and served until April 1994.[307]

A recipe for uncertainty and confusion, and with the potential for inequitable treatment of individuals, these 'dual arrangements' (as Johnston described them) 'have been complicated to administer, difficult for serving and veteran members to understand and have led to a degree of anomaly in the way they enable members to select benefits between the two schemes'.[308] Yet the possibility of establishing a single scheme for military compensation and rehabilitation had been discussed on and off for many years. In 1975, for example, Justice Toose, in his wide-ranging review of what was then the Repatriation Department, had recommended the establishment of a single scheme with a single supporting legislative framework. In 2004 the Clarke Report had reviewed the repatriation system, focusing on perceived anomalies, recommending the extension of VEA benefits to further groups of veterans, and advocating the creation of an integrated and comprehensive rehabilitation program. (Of its 109 recommendations, most were accepted by the government.)

In that sense, DVA's acquisition of MCRS was a step in the right direction, for it brought both existing schemes within the purview of one department. However, two unfortunate incidents proved the real catalysts for change. Firstly, a training accident in the Northern Territory in 1995 resulted in a young soldier becoming a quadriplegic. He was married with three young children and did not own his own house. Despite his having dual entitlement under VEA and MCRS, there was, as Johnston admitted, 'a view that the available payments were not adequate to his needs'.[309]

Then, in the following year, on the evening of 12 June 1996, there was a catastrophic collision of two Black Hawk helicopters during a

Special Air Service (SAS) Regiment and Army Aviation Corps training operation at the High Range Training Area near Townsville in Queensland. In all, six Black Hawk helicopters, in two rows of three aircraft flying abreast, were performing a practice assault on a hilltop position, in a training scenario designed to simulate counter-terrorist operations as realistically as possible—including the use of live ammunition. The fatal manoeuvre, performed at around 6 pm, occurred when aircrew were using night vision goggles (NVGs) for visual clues. NVGs impair vision by reducing the field of view to approximately 40 degrees, less than half that of normal vision; reducing the contrast of the terrain; and making depth perception more difficult. During the final stages of approach to the target area, the lead aircraft (far left, front row) and the aircraft to its immediate right collided in flight, the main rotor blades of the lead aircraft slicing through the aft section of the second. Both Black Hawk helicopters fell to the ground, and were consumed by fire.[310]

Black Hawk helicopters lift off on a sortie to bring in Australian troops for an INTERFET insertion into Balibo, East Timor, in October 1999. *(Dept of Defence V9902001; photographer WO2 Al Green)*

The graphic details were reported extensively across the news media, prompting widespread public concern, especially when it became apparent that eighteen ADF members—fifteen from the SAS and three from 5th Aviation Regiment—had been killed in what was Australia's worst peacetime military aviation disaster. A further ten servicemen had suffered serious injury. The Black Hawk accident also focused public and political attention on the differences in military compensation benefits that applied to ADF members killed or injured in the same incident or circumstances. In the Black Hawk case, varying dates of enlistment and differences in service history meant that there were significant differences in entitlement, with some individuals having dual entitlement under VEA and MRCS as a result of previous service. There were also deep concerns about the adequacy of benefits available overall in a peacetime service context. As a result, an interdepartmental inquiry into compensation for ADF members was established, and in 1998 the government decided to use a Defence Determination under the *Defence Act 1903* to provide supplementary benefits to assist in cases of severe injury and to support widows.[311]

Although this mechanism ensured an adequate level of benefits—as well as ironing out any discrepancies arising from varying eligibility—it was only an interim measure. In May 1998, therefore, Noel Tanzer AC, a past Secretary of DVA, was asked by the government to undertake a review, with the aim of proposing a single compensation and rehabilitation scheme. The Tanzer Review, as it was known, was presented to the government in March 1999 and, as expected, it recommended legislation for a single scheme for military service. It was a seminal moment. Following extensive consultation within the government, a draft framework for such legislation was distributed for comment, including by the ex-service community. During 2001, with the 'in-principle' support of both the Defence and ex-service communities, it was announced publicly that new legislation was being developed. A consultative Ex-Service Organisation (ESO) working party was set up in March 2002, initially representing nine major organisations and later incorporating a further two groups. It

met on more than ten occasions, chaired by the President of the Repatriation Commission, with detailed papers submitted by the ESOs as part of the process. A draft bill was circulated in June 2003, followed by a further consultative period, and a revised bill was presented to Parliament in December of that year. Following passage in the House of Representatives, where it attracted bipartisan support, the bill was subject to further scrutiny and public consultation by the Senate Committee for Foreign Affairs, Defence and Trade Legislation. After the adoption of several amendments recommended by the Senate Committee, the legislation was passed finally on 1 April 2004 as the *Military Rehabilitation and Compensation Act 2004*. The new Act came into operation on 1 July 2004, and would apply to all current and former ADF members (including reservists and cadets) who had suffered an injury or disease on or since that date.[312]

Following the recommendations of the Tanzer Review, a principal aim of the new Act was to 'provide legislation more appropriate to current and future conditions of military service'.[313] This appeared tailor-made for the new 'fourth wave' of veterans, of which DVA was just becoming aware, as well as timely recognition that the ADF was by now involved in a disparate range of operations overseas which were in many ways distinctly different from what had gone before. At the same time, as Neil Johnston emphasised, since 'the new legislation applies equally to current serving personnel as well as veterans it is appropriate that it gives emphasis to rehabilitation and return to work where possible'.[314] Indeed, the priority given to the term 'Rehabilitation' within the new Act's title (MRCA)—as opposed to the erstwhile MCRS—was an indication of the salience of rehabilitation within the new legislation. 'What is significant', claimed Johnston, 'is that it [the MRCA] provides for a needs assessment and rehabilitation, if appropriate, for any ... claims that can be related to military service'.[315]

The aim of rehabilitation, according to the new Act, was 'to maximise the potential to restore a person who has an impairment, or an

incapacity for service or work, as a result of a service injury or disease to at least the same physical and psychological state, and at least the same social, vocational and educational status, as he or she had before the injury or disease'.[316] Importantly, such an individual could only be considered for rehabilitation once the newly-constituted Military Rehabilitation and Compensation Commission (MRCC) had accepted liability for his or her injury or disease. Established under section 361 of the *Military Rehabilitation and Compensation Act 2004*, the MRCC, thus empowered, was given responsibility for all such determinations under the Act relating to the acceptance of liability for service-related conditions, the payment of compensation, and the provision of treatment and rehabilitation. Like the Repatriation Commission, the MRCC was allocated no staff of its own but relied on support provided by DVA. Similarly, the dual role of President of the Repatriation Commission and Secretary of DVA was extended to include the role of Chair of the MRCC. This further enhanced the cohesion between the two Commissions and DVA, and reinforced the new focus on rehabilitation.[317]

The MRCC met on 24 May, 21 June and 28 June 2004 to prepare for implementation of the new scheme. By 30 June 2004, 34 submissions had been considered by the MRCC, including important foundation documents such as protocols and principles on rehabilitation and needs assessment and provision of treatment. The MRCC recognised that much of this was new. Not only was there a 'different terminology' but there were also 'legislative differences', and some concepts such as 'Prisoner of War' (POW) did not feature in the new scheme. Likewise, there were no references to 'Vietnam Veterans' or to 'Gulf War service', for both groups of veterans would continue to be considered under the VEA. There were other complexities, such as the issue of Gold Cards, which would continue to be issued within the provisions of the VEA (whose 'treatment principles' were legislative instruments providing the basis for treatments under other Acts) rather than MRCA.[318]

The MRCC also recognised at the outset that it would need a clear communications strategy to inform the Defence and veteran communities, together with the wider public, of the benefits of the new scheme. The Commission recalled that, following the Black Hawk disaster in 1996, there had been ‘a significant amount of negative publicity regarding the level of support provided to ADF members and their families in the event of serious injury or death’. It was important now to stress the positive nature of the new scheme, especially the opportunities for rehabilitation and the increased amounts of financial support available to ADF members, reservists and cadets in the event of service-related injury or illness. Existing members receiving benefits under VEA would not be affected, it was emphasised, although those whose injury or illness was aggravated after 1 July 2004 would then fall under the new scheme.[319]

In applying the principles and protocols guiding rehabilitation, the MRCC was empowered to engage specialists with suitable qualifications or relevant expertise to assess an individual’s capacity for vocational, social or educational rehabilitation, and where appropriate to provide guidance on the type of program the individual should follow. Significantly, if an individual failed to undertake a rehabilitation assessment or program without reasonable excuse, the MRCC could decide to suspend his or her right to compensation (but not to treatment for the injury or illness). The MRCC acknowledged that any such rehabilitation would need to be coordinated, integrated and adequately resourced to achieve effective outcomes. Similarly, incapacity payments would be payable whilst a person was undertaking a rehabilitation program—he or she being deemed unfit for work during that period. Vocational training and education would be provided in the expectation that a person would eventually return to the workforce at a level to which they had previously been accustomed. Should an assessment determine that education or training to a higher level (including tertiary) was required in order to regain this level, then such a program would be considered if it was thought to be cost-effective, although there was no legislated absolute right to post-secondary vocational training. Social

rehabilitation, meanwhile, aimed to restore or maximise an individual's function in society by providing appropriate behavioural and basic training skills for living and participating in the community. Generally, a rehabilitation program might include any one (or more) of a range of provisions, from medical, dental, psychiatric and hospital services, to physical training and exercise, physiotherapy, occupational therapy, counselling, drug and alcohol management, psycho-social training, skills training, and further or higher education and training.[320]

One of the main objectives of rehabilitation was to enable an individual to re-join the work force. Here, 'rehabilitation' extended to actively helping an individual to find suitable employment in the civilian workplace (assuming, of course, that he or she was not a full-time member of the ADF returning to service after rehabilitation). In its report for 2005–06, the MRCC conceded that it is 'still early days in terms of being able to assess the effectiveness of the rehabilitation provisions'.[321] But it also noted that a 'taskforce has been set up in DVA to examine a range of information strategies with a focus on clients under 45'. Here was recognition of the emergent 'fourth wave' of younger veterans—although the 'ageing clientele' perspective was not yet overtaken by the pace of events. In a commentary on what was essentially a transitional moment for DVA, the MRCC noted that it had 'closely monitored DVA's move during 2005–06 to a ... new *oneDVA* structure organised along functional lines, which will allow the department to rescale its operations over time as its workload and resources are reduced'. As the MRCC sought to explain, 'DVA's new approach to its business has been made necessary by the accelerating decline in veteran numbers, as the World War II veteran and war widow/widower population becomes smaller'. Yet, recognising that a fundamental shift was by now already occurring (and of which MRCA was indeed a part), the Commission added that the 'MRCC supports the department's efforts to ensure that it is able to maintain and enhance its services to younger members under the MRCA', including 'strategies to address the complexity of legislative provisions for younger clients'.[322]

Launched formally as the ‘Younger Veterans’ Taskforce’ in February 2006, DVA’s new taskforce set about marshalling and analysing all available data to identify emerging issues and needs, and to provide a coordination point for current and future younger-veteran initiatives. This work was supported and informed by the National Younger Veterans’ Consultative Forum, and by the Younger Veterans’ Consultative Forums that had also been set up in several states.[323] Before long, the MRCC and DVA were able to point to a string of success stories involving the rehabilitation of young ‘fourth wave’ veterans. There was, for example, the case of Luke, a 19-year-old Reservist who had sustained a knee injury during his initial recruit training, for which he successfully claimed compensation under the MRCA. He was medically discharged from the ADF, and was unfit for work for some six months following surgery. During this time, he received full incapacity payments and financial cover for all medical treatment.[324]

Luke’s civilian employment prior to his injury had been as a general labourer, working under contract. It was clear now that he could not return to this type of work, and a rehabilitation assessment was duly organised. Carried out by a rehabilitation provider in consultation with Luke and his doctor, the assessment indicated that he was suitable to undertake a rehabilitation program leading to potential employment as a Trades Assistant, Luke’s preferred career path. A rehabilitation plan was approved, including physiotherapy, supervised physical conditioning and a gym program. Subsequently, Luke was able to undertake a nine-week fully-funded work trial, arranged for him at a motor vehicle dealership close to his home. A worksite suitability assessment (including recommendations for safe handling and safe lifting instructions for Luke) was implemented, and funding was approved for Luke’s purchase of an appropriate tool kit for use as a mechanic. After completing his trial period, Luke took up a full-time employment opportunity with the dealership, achieving what his case manager considered ‘a very successful and durable outcome’.[325]

A very different case was that of Ken. His father had been a chef, and so was his brother. Ken's great ambition was to follow in the family tradition, and he planned to join the ADF as a cook/chef. However, after he had joined up, he discovered that he had severe contact dermatitis, from which he suffered so badly that he was medically discharged in 2005, at the age of 22. He successfully lodged compensation claims for both his skin condition and a musculoskeletal injury, and undertook a rehabilitation assessment. Ken elected to be discharged in his home state of South Australia, and his case files were handed over to DVA's Adelaide office for further management. He was soon enrolled on a local TAFE course to give him 'front of house' skills to complement his existing knowledge and experience. At the same time, he was receiving other benefits, including a lump sum payment in respect of his permanent impairment; incapacity payments from the date of his discharge (which would continue until he obtained work); study materials; job-seeking assistance; and medical treatment. Following his TAFE course, Ken had several employment opportunities to choose from, and took up a position in hospitality overseas.[326]

Different again was the case of John. He was injured in a motor-cycle accident while on duty when he was 21 years old, and as a result suffered paraplegia. He successfully claimed compensation under the MRCA, beginning the transition from ADF to civilian life in December 2006 and being finally discharged in March 2007. John's assessed rehabilitation needs focused on improving fitness, and on enhancing his mobility and independence through vehicle and household modifications, all of which were arranged and paid for as part of his rehabilitation program. He was also in receipt of full incapacity payments, a permanent impairment lump sum, and payment for all medical treatment, with medical and financial entitlements under the MRCA continuing as needed. After successful vocational training and work trials, John found full-time civilian employment.[327]

Peter, a 20-year-old soldier, was injured during recruit training when a tree branch fell on his head. He successfully claimed

compensation, and was discharged medically unfit from the ADF in 2004. His subsequent rehabilitation assessment identified cognitive deficits that needed to be addressed. Following extensive counselling, Peter decided that he would like to retrain as a fitness instructor. As part of his rehabilitation program, he successfully completed a Master Trainer's course during 2006. He later underwent surgery, followed by further counselling. After his convalescence, he undertook a work trial and then completed a small business course, leading to his successful transition to the workforce as a fully qualified personal trainer. During this time, Peter had received full incapacity payments, a permanent impairment lump sum, and payment for all medical treatment.[328]

Ben Aldridge, a 23-year-old East Timor veteran, became a quadriplegic after a service-related accident and, following four months of intensive rehabilitation, he was at last able to move into his new home in Perth. There to welcome him was his team of DVA rehabilitation coordinators and care providers. His new accommodation had been customised with additional living aids and equipment provided by DVA, including a customised scooter, transfer hoist, automated door, and customised gym equipment. As DVA observed at the time: 'Ben is not one to let his disability slow him down and he has given several inspirational talks to other disabled young people. He is waiting on the results of a driving assessment and is contemplating tertiary education. If he decides to take that path, DVA will be there to assist'.[329]

Curtis McGrath, a Sapper in the Australian Army, was three months into a six-month tour of duty in Afghanistan when he lost both legs to an improvised explosive device (IED) in Uruzgan Province in August 2012. He was casualty evacuated to the United States Landstuhl Medical Centre in Germany, spending three days in intensive care and several weeks undergoing surgery in preparation for the long flight home to Australia. From Germany, Curtis was flown, along with his medical team, to Brisbane. While in hospital there, he was contacted by a DVA adviser who explained his eligibility for benefits and services. As DVA noted at the time: 'Curtis is one example of an

increasing trend of a currently serving [ADF] members who is also a client of DVA. His story highlights the coming together of support and assistance offered to ADF personnel by both Defence and DVA'. For example, it was explained, 'Curtis' prosthetics and some home modifications were supplied by Defence, but additional home modifications were provided by DVA under legislation covering DVA clients'. Additionally, DVA 'managed the processing of Curtis's lost deployment allowances and the provision of a modified vehicle under the Motor Vehicle Compensation Scheme'. Much of this was facilitated through the On Base Advisory Service (OBAS), a service introduced in 2011 that situated DVA advisers (part-time as well as full-time) on a number of Defence bases. Curtis's OBAS adviser also arranged his rehabilitation activities, including hydrotherapy, allowing him to 'feel that the whole process has been managed in a holistic way'.[330]

DVA's engagement with the increasing number of younger women veterans, was demonstrated in the case of Emily, 'a promising young Army recruit'. At 18 years of age, Emily had been involved in an accident that caused severe damage to her arm. 'After the accident', she recalled, 'I felt like I couldn't even move my hand'. Sadly, Emily was now unable to pursue her chosen military career. But with DVA's assistance, she received the support and rehabilitation that she needed, working with an approved rehabilitation provider to develop a comprehensive management plan to meet her specific requirements. This, it was reported, was an example of the client-centric 'holistic approach DVA now takes', where rehabilitation providers 'coordinate referrals to doctors and therapists and arrange for services to be delivered, keeping their clients involved in every step of the process'. Thus 'Emily's journey with DVA began with intensive hand therapy (a functional restoration program to regain mobility in her hand), psychological counselling and a vocational assessment. Her tailored exercise program was designed to allow the damaged nerve in her arm to eventually grow back'. Exploring career options with her vocational adviser, Emily realised that 'the only thing besides being in the Army that I wanted to do was

cooking'. Accordingly, with DVA support, she enrolled in a Certificate Three course in commercial cookery, a first step to her subsequent apprenticeship at a boutique chocolate store and café.[331]

Reflecting on such cases, the MRCC observed in 2009–10 that in 'recent times, DVA has shifted its focus from compensation to rehabilitation'. Echoing the letter and spirit of the 2004 Act, it explained that: 'We now aim to restore an injured person to at least the same physical, psychological, social, vocational and educational status as they had prior to their injury so they can achieve long-lasting, whole-of-person outcomes and a better quality of life'.[332] Yet compensation remained a vital and integral part of the benefits available under the 2004 Act, complementing and indeed enabling rehabilitation programs, such as those described in the case studies above.

At its foundation, the MRCC grappled with its *Guide to determining impairment and compensation*, taking care to assimilate the detail and understand the provisions. It worked through the differing levels of impairment—'negligible impairment', 'malignant conditions', 'intermittent impairment' (fits, for example), 'activities of daily living' (locomotion, personal hygiene, dressing, eating), 'disfigurement'—and studied the conditions and nature of impairment in its very different forms. There were cardiorespiratory impairment; hypertension and non-cardiac vascular conditions; impairment of spine and limbs; and emotional and behavioural impairment—the latter described as 'manifest distress' where examples 'include preoccupation, manic behaviour, inappropriate actions, restless pacing, nervous sweating, tremor, bursts of anger, pressured speech, perseveration, inability to follow a conversation, vocalisations during nightmares, compulsive or excessive drinking and compulsive gambling'. There were neurological impairment; gastrointestinal impairment; hearing impairment; visual impairment; renal and urinary tract function; sexual function (reproduction and breasts); skin impairment; and endocrine and haemopoietic impairment.[333]

As the MRCC noted, individual impairment ratings had been apportioned to each of these conditions (and their levels of severity). When a person had submitted a claim for compensation under the 2004 Act, each of their reported impairments would be assessed carefully, and 'after impairment ratings have been calculated for all accepted conditions they must be combined to a single value known as the combined impairment rating'.[334] Inevitably, there were complexities, such as 'partially contributing impairment', when 'impairment is not due solely to the effects of accepted conditions', and 'lifestyle effects' (a 'disadvantage, resulting from an accepted condition that limits or prevents the fulfilment of a role that is normal for a veteran of the same age without the accepted condition'), for which points were awarded.[335] There were also differentials for 'warlike and non-warlike service' and 'peacetime service', which needed to be factored into the compensation payable to a person under Part 2 of the Act. There were hypothetical examples, employing fictional servicemen and servicewomen, to show how all this would work. For instance:

> Petty Officer Andrews is 28 when she applies for compensation. It is determined that she has incapacity caused by an injury on non-warlike service. She is assessed as having an impairment rating of 15 and 1 lifestyle point. From the table [in Chapter 18 of the Guide to Determining Impairment and Compensation] the factor for her injury is 155. The maximum payment ... is $245.82 per week. When this amount is factored she is entitled to $38.10 per week ... indexed on 1 July'.[336]

A more complicated case was that of Captain Brown: 'Captain Brown has two conditions, a gastro-intestinal condition (A) resulting from warlike service assessed as 20 impairment points and a spinal injury (B) resulting from peacetime service assessed as 30 impairment points. The lifestyle rating is 4. The combined impairment (C) is 44'. As a comparison, it was explained that if both conditions had resulted from warlike service, the compensation factor would be 0.478. Likewise, if both of Captain Brown's conditions had occurred

during peacetime service, the compensation factor would be 0.268. However, as his conditions had resulted from warlike service (A) and peacetime service (B), the weighted average was 0.352. The maximum compensation payable was $245.82, and when the factor was applied, it indicated Captain Brown's entitlement of $86.53 per week. In a further comparison, it was noted that if Captain Brown's gastro-intestinal condition had arisen from peacetime service and the spinal condition from warlike service, then, with the same impairment and lifestyle ratings, the final compensation factor would have been 0.294, with payment of $96.85 per week.[337]

It was also noted that compensation for permanent impairment could be made as a periodic payment (normally weekly) or as a lump sum. However, the 'lump sum payable to a person must not exceed that worked out by reference to the conversion of a lump sum of a periodic payment payable to a male aged 30 years'. Moreover, it was admitted, 'separate advice will be needed for females. Due to their longer life expectancy, the age up to which the maximum payment is limited will be higher than for males'.[338] Alongside such considerations, there was also now an Education and Training Scheme, aimed specifically at any 'Eligible Young Person', aged under 16, or 16 or more but under 25, and in full-time education, who was a dependant of a service member or former member eligible for a Special Rate Disability Pension (SRDP). The scheme also applied to any similarly 'Eligible Young Person' who was dependant on a service member immediately before the member's death, where the MRCC had already accepted liability for the member's death or where the deceased member was eligible for SDRP.[339] (SDRP was an ongoing payment that in certain circumstances could be made to an eligible member instead of incapacity payments.)[340]

An early challenge for the new MRCA, and thus for the MRCC and its intimate relationship with DVA, was the crash of a Royal Australian Navy Sea King helicopter on 2 April 2005. This incident, the MRCC admitted, was 'the first real test of the MRCA system'.[341] Flying from the warship HMAS *Kanimbla*, the helicopter had been

providing humanitarian aid to survivors of a recent earthquake on the Indonesian island of Nias, off the west coast of Sumatra. Eleven military personnel were onboard, including four aircrew and seven members of the ADF Joint Medical Element, when the Sea King crashed during its approach to a landing zone at Amandraya, on Nias Island, an accident later shown to have been caused by the failure of the aircraft's flight control system. Nine of those onboard were killed, the remaining two injured. Although, in the initial aftermath of the accident, there was some lack of coordination between the Defence and DVA communications teams, DVA had already appointed a single point of contact for families (a lesson learned from an incident in HMAS *Westralia* in 1998), which proved a significant asset. Early claims for death benefits for five members were received from partners and eligible children. These were accepted, resulting in lump sum payments to two Eligible Young Persons, and in ongoing periodic and additional death benefit lump sum payments to five partners of the deceased. Two further claims from persons claiming to be other dependants were also received. One was rejected, and the other referred for more extensive assessment. Two claims for injury from the surviving members were also received and accepted, and, reviewing the situation in August 2005, the MRCC anticipated the possibility of further claims in the future.[342]

The MRCA had seemingly passed its first major test but, perhaps inevitably, as new issues arose and new claims were examined, so critics (especially among ex-service organisations) emerged to point to what they considered to be gaps, loopholes, inconsistencies, anomalies or plain unfairness. One awkward question was the status of peacetime training by the Special Air Service (SAS) Regiment. In 2009, ten former members of the SAS Counter Terrorist/Special Recovery Group (CT/SRG) had made submissions, requesting that their peacetime service be categorised as 'non-warlike (hazardous)', and that they be granted eligibility for commensurate compensation and awarded appropriate medallic recognition. The Defence Department, having extensively examined the case in the light of

both legislation and policy, advised that SASR training did not satisfy the definition of ‘non-warlike service’—a conclusion that was duly echoed by the MRCC. Explaining this position, it was pointed out that ‘non-warlike’ scenarios involved rules of engagement which allowed for the use of minimum force in self-defence, to protect personnel and property against hostile or belligerent elements. Peacetime training, however realistic and however hazardous, did not encompass this. But the MRCC went on to recognise that the ‘issue is very emotive due to the high injury and casualty rate of SASR members in training’, and noted that submissions from the ten former members had seen the award of the Australian Service Medal (ASM) with the clasp ‘Special Ops’ to Navy Submariners (but not to SASR CT/SRG members), as an anomaly.[343] Tellingly, in most SAS cemeteries in Australia, those killed in training or in preparation for operations outnumbered those who had died on actual operations[344]

A Sea King helicopter flies the Australian White Ensign over HMAS Kanimbla *as the warship returns to Sydney from the northern Arabian Gulf, April 2003. (Dept of Defence Niue20030411-16)*

Meanwhile, a further tragedy had deeply affected public and political opinion. Sergeant Brett Till had been killed in action in Afghanistan, when disarming an improvised explosive device. His widow, Breeanna Till, heavily pregnant at the time, soon found herself in straightened circumstances. She was in receipt of $305 a week compensation from DVA (her late husband's salary had been $905 per week), and was faced with the prospect of having to move out of her Defence Housing Authority home six months after Sergeant Till's death.[345] Her predicament attracted widespread media coverage, and prompted an internal DVA investigation which showed again that 'fourth wave' widows and dependents often had very different needs compared with older cohorts. As DVA put it, the requirements of this group 'differ from the traditional cohort' of veterans' families 'due to fundamental differences in circumstances'.[346] Approving a new set of guiding principles to support contemporary widows, widowers and dependents, the MRCC broadened the scope of assistance offered, to include areas such as transport, respite, home maintenance, meals, health treatment, vocational assessment, and help with the costs of running a household.[347]

In the lead-up to the 2007 Federal Election, DVA had agreed to undertake a review of the MRCA, given the concerns expressed by some ex-service organisations. The review was conducted between mid-2009 and February 2011 by an interdepartmental steering committee chaired by Ian Campbell in his capacity as both Chair of the MRCC and Secretary of DVA. The final report was released in March 2011. Some 48 individuals and organisations provided written feedback, and generally the review was well received. There were 108 recommendations, of which the government accepted 94 (either in full or in part), pledging $17.4 million over four years to implement the resultant package. Among the changes was a revision of the methodology used to calculate permanent impairment compensation. Access to medical treatment was to be streamlined, and there would be an increase in the amount of compensation that could be paid for financial and legal advice in relation to certain choices that an individual might be required to make under the

MRCA. There were improved benefits for families of current and former ADF members, such as increased flexibility for future wholly dependent partners in the way in which they received compensation following the death of an ADF member or former member. This allowed them to convert part of their periodic compensation to a lump sum, rather than the existing choice between an ongoing periodic payment or conversion of the whole amount to an age-based lump sum. There was also a one-off increase to the rate of pension payable to eligible children following the death of an ADF member or former member. More generally, access to rehabilitation and compensation benefits for current and former ADF members was simplified. There would be routine reviews of individual rehabilitation and compensation arrangements, to ensure that the health and wellbeing of members and former members was maximised, and improvements in the education and training opportunities on offer would also be made.[348]

In the aftermath of the review, there were changes to DVA's research agenda. As the MRCC observed in February 2013, 'DVA's research model and … priorities have not been reconsidered since 2008'. Now that a fourth wave of veterans was increasingly apparent, and 'with emerging issues of DVA post-Afghanistan; the new service models and rehabilitation changes; the Centre for Military and Veterans' Health contract coming to an end [in December 2013 after a frustrating period in which the Department for Defence failed to inform potential participating universities of its precise requirement]; and the need to strengthen research relationships with universities, the Department of Defence and other agencies, it is time to review DVA's research model'.[349] It was explained that a new research strategy would be launched during 2013, to be reviewed regularly thereafter, beginning in 2017. The new strategy, it was intimated, would reflect 'four flagship programs' established as the focus for DVA research effort in the future. There would be longitudinal research projects based on deployment studies such the Military Health Outcomes Program—Defence (Mil-HOP) data series. Additionally, there would be predictive modelling, making better use

of DVA data and other existing databases with a veteran or Defence indicator, together with further families studies, building on the existing Timor-Leste and Vietnam Veteran Family Studies, and what was labelled ‘interventions’—research on services and programs including rehabilitation, primary care and clinical care.

As the changes to the MRCA were implemented after 2011, so the difficult issue of prioritising the consideration of compensation claims became more complex. In February 2013, DVA reviewed and accepted the new Priority Guidance provided by the MRCC. Priority One would be high-profile cases including deaths and injuries (such as those occurring on deployment or in a major accident), followed by cases of death or imminent death which were not high-profile, but where bereaved dependents would be left without immediate financial support. Next on the list were mental health cases, where there was a risk of self-harm or harm to others. This was followed by instances of immediate or imminent financial hardship (for example, those of medically discharged ADF members, especially those with minimal accrued ADF entitlements, such as recruits and officer cadets, and reservists who may have been incapacitated for their civilian employment). There were further priority categories, ranging from those cases where it was considered that delay would be detrimental to the wellbeing of an individual, to claims returned from the Veterans’ Review Board which now needed to be expedited. Bottom of the list, controversially perhaps, were claims from those over 90 years old.[350]

In amongst such considerations were day-to-day issues requiring decisions and interventions. In February 2013, for example, the MRCC adjudicated in the case of an Afghanistan war widow who herself suffered ‘major health issues’. Provision was made for monthly garden maintenance of two hours duration to assist with weeding and tidying, together with fortnightly lawn mowing services, with an additional allowance for ‘a human hair wig including maintenance’.[351] Occasionally there were errors to be rectified, when decisions or interventions made for the best possible reasons

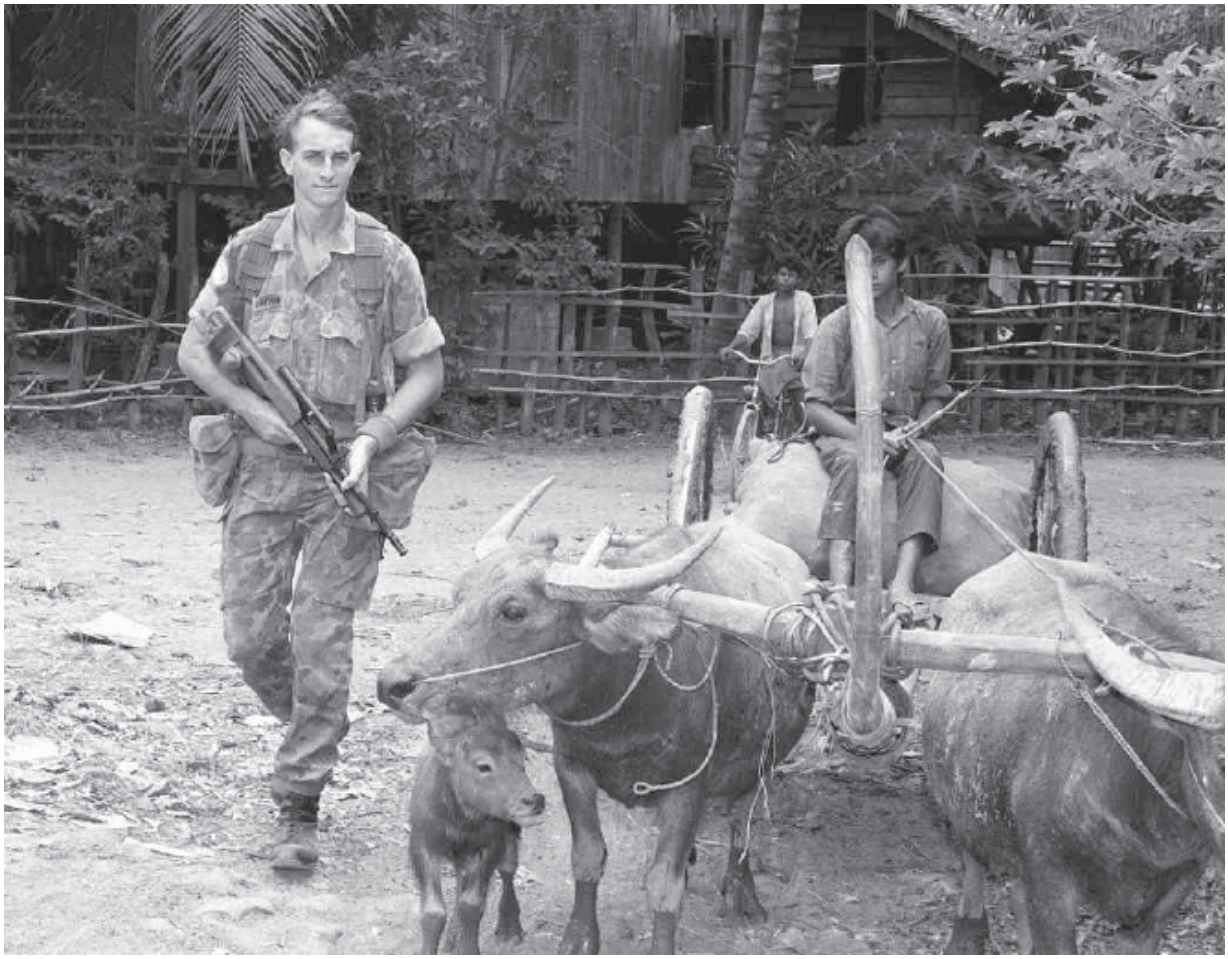
were shown to be contrary to prescribed procedures or best practice.[352]

The focus on rehabilitation under the MRCA, confirmed in the 2011 review, had led to a growing emphasis on mental health. In many ways, mental health care was seen as the key to reintegrating individuals into civil society or finding roles for them in the workplace. But, as DVA had observed in 2010, getting ex-service men and women to admit to mental health issues was notoriously difficult. 'For many reasons (including personality, military culture, deployment experiences, and adjustment to civilian life)', it was explained, 'veterans may be reluctant to acknowledge or report psychological problems. They may have poor mental health literacy, may avoid treatment, and can be hard to engage when they do present'. Moreover, many veterans had 'developed unhelpful strategies for managing distressing emotions, often channelling them into anger or aggression or covering them with substance misuse'. When consulting their GPs, they often presented physical health complaints that masked concerns about psychological issues.[353]

DVA also recognised a symbiotic relationship between mental health problems and homelessness, in May 2016 explaining that, in addition to homeless individuals, there were others in the ex-service and veterans' community who were exposed to 'housing stress' of one sort or another. Some experienced difficulty in obtaining and maintaining affordable and appropriate housing. Others had problems with budgeting and money management. Problematic alcohol and drug abuse prevented some from finding satisfactory accommodation, while others suffered from social isolation, marginalisation and exclusion, making it difficult to access services to obtain assistance. Exposure to violence and abuse was likewise inhibiting.[354]

Some had difficulty in making the transition from the military environment to civilian life. Such was the case of Andrew, a 39-year-old veteran living in transitional (homeless) accommodation in Melbourne. As his case notes recorded:

Andrew joined the Army when he was just 17 years and served for five years, including overseas service in Cambodia. Andrew witnessed a fellow serving member [from another UN national contingent] being killed by an unexploded shell. Andrew was traumatised by this, and despite encouragement from senior officers, Andrew decided to leave the military and was discharged. Following discharge Andrew felt 'lost and alone' and the relationship with his family broke down. He missed the structure of the Army and tried to re-join. When he attended the [recruiting] appointment he was told that he would have to undertake six months in the Army Reserves prior to re-joining the military full-time.[355]



Private 'Stretch' Boreham patrols through the village of Stoung, Cambodia, in 1993 as part of Australia's contribution to the United Nations peacekeeping operation. *(Dept of Defence CAMUN93_134_01; photographer CPL Al Green)*

Andrew reacted badly to this news, and angrily decided not to re-join the Army. No longer on speaking terms with his family, he moved to Melbourne, where he ended up in a homeless shelter and subsequently became involved in criminal activity, violence and illicit drug use. Over the next fifteen years, he lived in various homeless shelters, as well as sleeping rough and spending time in prison. He did manage to access some welfare services, including meals programs and material aid services. But his health deteriorated. He contracted hepatitis C and was on methadone to address his drug addiction. Tragically, despite having contacted DVA, Andrew convinced himself that he was not eligible for DVA support, partly because he had not served long enough but also because he was himself not physically injured during his deployment.

A further insight into the mindset and experience of a homeless veteran, was provided by Marty, aged 49, who was now living in his car. He had joined the Army when he was 17, enlisting for 15 months. He was medically discharged, however, and later received a pension. Subsequently, he faced the challenges of alcohol and gambling addiction, but was able to access a range of medical and mental health assistance. Marty lived initially with his family on discharge, and then in several different private and public housing properties, before becoming homeless. Looking back, Marty considered that he should have been given re-training when he left the Army, and ought to have had more assistance in developing life skills. He also thought that ex-service organisations should do more. Ostensibly, they understood veterans' issues and the veteran's point of view. But, Marty felt, in reality they were more interested in socialising than doing anything for people like him.[356]

Such feelings of exclusion and powerlessness could lead to suicidal thoughts, although it was considered that suicide within the military and veteran populations was less than that for society as a whole (despite a higher-than-average incidence of suicidal thoughts), as indicated in the 2010 ADF Mental Health Prevalence and Wellbeing Study, *Towards Better Mental Health for the Veteran Community.*[357] Released in 2001, the study had elaborated DVA's overall mental

health policy framework for the period to 2012, including provision for suicide prevention (which it designated 'Operation Life').[358] Thereafter, a new ten-year framework was introduced for the period 2013–2023, in which suicide was recognised 'as a national issue affecting all areas of society'.[359] But this was within the broad context of the increasing 'prevalence of mental health conditions within the ex-service population'.[360] Here, as the new framework explained, an 'increase in military operations over the last decade or so has resulted in a new cohort of contemporary veterans'. This 'new cohort' (the fourth wave) shared many of the military experiences of previous generations but also had different needs, compared with its predecessors. There was the impact of multiple deployments or deploying in smaller contingents or as individuals—unlike the larger formations of earlier times. To this was added the extended periods away from family during operations or training; the impact of new technologies on treatments and interventions (including telemedicine); different levels of expectation regarding care and service; the significant potential working life for many members post-discharge; and the rapidly changing role of women in the ADF.[361]

In 2015, DVA published its *Mental and Social Health Action Plan 2015 and 2016*, a distillation of the ten-year framework strategy launched in 2013 and a guide to current practice and policy. As DVA explained, it continued to expand its own understanding of contemporary mental health issues and their effects on veterans' lives and their families, 'including homelessness and suicide', a process which required the department to 'continue to adapt and enhance our policies and programmes [sic] to ensure we're delivering evidence-based, best practice services and support to the community'.[362] In early 2015, for example, DVA commissioned the Australian Institute of Health and Welfare (AIHW) to undertake research to provide more sophisticated information on the numbers and rates of suicides in the serving and former ADF population—a project that would range widely across military superannuation data, State Coroners' records and the National Death Index.[363]

Two years later, while the AIHW was still deliberating, the Senate Foreign Affairs, Defence and Trade References Committee tabled its report, *The constant battle: Suicide by veterans*, in Parliament. The Committee made twenty-four recommendations, most of which were accepted by the government, which now committed $31 million to new activities aimed at supporting the mental health of ADF members and their families. Notable initiatives included an annual health assessment for ex-serving ADF members for the first five years after discharge.[364] One of the submissions made to the Senate inquiry was provided by John and Karen Bird, the parents of Rifleman Jesse Bird. Joining the Army in 2007, Jesse had been deployed to Afghanistan during Operation Slipper in 2009. He was discharged voluntarily in 2012, suffering from physical injuries, deteriorating mental health and PTSD. He experienced difficulty in transitioning from service to civilian life, and also had financial problems. Jesse ended his life in 2017, and this tragic loss made media headlines. His death prompted a review conducted by DVA and the Department of Defence, resulting in an admission by Veterans' Affairs Minister Dan Tehan that DVA 'either did not or could not provide the support or proactive engagement that Jesse needed'.[365] The Bird Review made 19 recommendations aimed at improving service provision for veterans, all of which were accepted by the government.[366]

In 2018, in its publication *National suicide monitoring of serving and ex-serving Australian Defence personnel: 2018 update*, the AIHW outlined the findings of the research commissioned by DVA in 2015. This showed that, in 2014–2016, suicide rates among ex-serving men aged under 30 were 2.2 times that of Australian men the same age. Suicide rates among men serving full time or in the reserves were actually lower than rates for Australian men generally, as conventional wisdom and earlier research had suggested. Compared with all Australian men, however, the age-adjusted rate of suicide over the period from 2002 to 2016 was 18% higher for ex-serving men. In other words, suicide in the veteran community was a greater

problem than had been recognised hitherto, especially among young men.[367]

Early intervention was now seen as critical in tackling both suicide and homelessness, and indeed in managing mental health as a whole. Thus, the new mental health policy framework strategy was underpinned by three principles: prevention, recovery and optimisation. 'Prevention', it was explained, aimed to reduce the onset and prevalence of mental health conditions. This required not only early intervention but also the effective application of treatment and other services to prevent or minimise the many potential negative impacts associated with a mental health condition. 'Recovery' recognised that, despite attempts at prevention, some DVA clients would experience mental health–related issues or illness, requiring treatment, interventions or management. Importantly, recovery went beyond the traditional notion of 'cure', and was designed to create opportunities for individuals to live personally fulfilling and meaningful lives, even with the continuing presence of adverse mental health symptoms. 'Optimisation', meanwhile, aimed to maximise individual mental health and quality of life, assisting individuals to realise their capacity by maintaining and improving their physical and mental fitness. Here the goal was to reach the highest attainable level of mental health and general wellbeing.[368]

As DVA emphasised, government funding for veteran mental health treatment was demand-driven, and not capped or restrained by budgetary considerations. The aim was to ensure that resources were ready and available to meet client needs as soon as these became apparent—with support ranging from online mental health information, GP services, psychologist and social work services, specialist psychiatric services, pharmaceuticals, trauma recovery programs for PTSD, and inpatient and outpatient hospital treatment. Additionally, there was continued funding for the Veterans and Veterans Families Counselling Service (VVCS) (rebranded now as 'Open Arms—Veterans and Families Counselling') for the delivery of free and confidential support, nationwide, to veterans and

families.[369] And complementary to mental health was social health. As well as preventing illness where possible, DVA sought to foster social connectedness and to enhance general wellbeing. Here the objectives included improved self-awareness and healthy behaviour, increasing participation in decision-making, and greater involvement in positive lifestyle activities.[370]

Reviewing its mental health provisions, DVA emphasised that 'We need to support our older cohorts as they transition through their lives, while providing younger veterans with access to effective rehabilitation programs so that they can successfully return to the ADF or transition to new careers if they leave the military'. Significantly, for both older cohorts and the younger fourth wave, DVA added, 'Validation of service and sacrifice is essential to the mental health and wellbeing of all veterans'. The Centenary of Anzac, it was noted, marked 100 years since the Gallipoli landings and Australia's participation in the First World War. But 2015 also marked the completion of Operation Slipper in Afghanistan, an event which was commemorated by a welcome-home parade honouring the men and women who had served there. Recognition had also been given to Indigenous veterans through commemorative services and NAIDOC [National Aborigines and Islanders Day Observance Committee] events. As DVA concluded, these 'and many other commemorative activities provide important support to our veteran and ex-service communities'.[371]

A member of Australia's Federation Guard resting on arms as part of the catafalque party during the Anzac Day dawn service at the Australian National Memorial at Villers-

Bretonneux in France, April 2018. *(Dept of Defence 20180425adf8581277_107; photographer LSIS Jake Badior)*

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[304] Interview with Neil Bayles, Assistant Secretary Portfolio, Program and Assurance, DVA Canberra office, 26 October 2017.

[305] Minutes of the Repatriation Commission [MRC] CM6860, 7 February 2013, Review of Military Compensation Arrangements—Veterans' Vocational Rehabilitation Service (VVRS). N.B. in 2013 VVRS was renamed Veterans' Vocational Rehabilitation Scheme.

[306] Neil Johnston, 'Legislation for the rehabilitation and compensation scheme', paper presented at the AIAL Seminar AIAL Forum no. 43, Canberra, 18 August 2004.

[307] DVA, *Review of military compensation arrangements, February 2011: Volume one: Overview*, Canberra, 2011, p. 70.

[308] Johnston, 'Legislation', p. 19.

[309] Ibid.

[310] Wing Commander Ken Roberts (Chief Engineer, RAAF Richmond) and Dr Graham Clark (Principal Research Scientist, DSTO Aeronautical and Maritime Research Laboratories, Melbourne), 'The 1996 Black Hawke accident—the technical investigation', presented at IAC99 International Aerospace Congress, Adelaide, September 1999, pp. 1–2.

[311] Johnston, 'Legislation', p. 19; DVA, *Review of Military Compensation Arrangements*, pp. 70–1.

[312] Johnston, 'Legislation', p. 20; DVA, *Review of Military Compensation Arrangements*, p. 71.

[313] Johnston, 'Legislation', p. 20.

[314] Ibid., pp. 20–1.

[315] Ibid., p. 21.

[316] Section 38 of the Act, cited in Johnston, 'Legislation', p. 27.

[317] DVA, *Annual report* 2003–04, pp. 18–19

[318] Minutes of the Military Rehabilitation and Compensation Commission [MMRCC] 1/2004, 24 May 2004, New Military Rehabilitation and Compensation Scheme.

[319] MMRC 30 July 2004, Communications Strategy.

[320] Johnston, 'Legislation', pp. 27–31.

[321] MRCC, *Annual report*, 2005–06, p. 3. In 2005–2006 and 2006–2007, the MRCC *Annual report* was published by DVA as a stand-alone volume. Thereafter, it was integrated into the main DVA *Annual report* (and paginated accordingly).

[322] MRCC, *Annual report* 2005–06, p. 4.

[323] MRCC, *Annual report* 2006–07, p. 4.

[324] MRCC, *Annual report* 2005–06, p. 10

[325] MRCC, *Annual report* 2005–06, p. 10

[326] MRCC, *Annual report* 2005–06, p. 16.

[327] MRCC, *Annual report* 2006–07, p. 19.

[328] MRCC, *Annual report* 2006–07, p. 17.

[329] DVA, *Annual report* 2007–08, p. 29.

[330] DVA, *Annual report* 2012–13, p. 37.

[331] DVA, *Annual report* 2010–11, p. 112.
[332] DVA, *Annual report* 2009–10, p. 51.
[333] MMRCC Instrument no. 9 of 2005, 26 May 2005, Guide to Determining Impairment and Compensation.
[334] MMRCC Instrument no. 9 of 2005, 26 May 2005, Guide to Determining Impairment and Compensation (see especially Chapter 18 Combined Values Chart).
[335] MMRCC Instrument no. 9 of 2005, 26 May 2005, Guide to Determining Impairment and Compensation.
[336] MMRCC Instrument no. 9 of 2005, 26 May 2005, Guide to Determining Impairment and Compensation.
[337] MMRCC Instrument no. 9 of 2005, 26 May 2005, Guide to Determining Impairment and Compensation.
[338] MMRCC Item 1,24 May 2004, New Military Rehabilitation and Compensation Scheme.
[339] MMRCC 6/2004, 24 May 2004, Scheme to Provide Education and Training.
[340] *https://www.dva.gov.au/benefits-and-payments/compensation/military-rehabilitation-and-compensation-act-mrca*, accessed 8 August 2018.
[341] MMRC 54/2005, 24 August 2005, Operation of the MRCA over the First Year.
[342] MMRC 54/2005, 24 August 2005, Operation of the MRCA over the First Year.
[343] MMRC 53/2009/S, 30 September 2009, Peacetime Training by the Special Air Service Regiment.
[344] I am grateful to Ian R Gardner for this observation.
[345] *Daily Telegraph*, 26 September 2009.
[346] DVA Businessline, Subject: Guiding Principles for the Provision of Support to Contemporary Widow/ers and Dependants, Attachment A, 13 September 2012, p. 3.
[347] Ibid., pp. 9–15.
[348] https://www.dva.gov.au/consulation-and-grants/review-military-compensation-arrangements/government-response-review#top, accessed 8 August 2018; see also DVA, *Review of military compensation arrangements*.
[349] MMRCC 11/2013, 7 February 2013, Future Strategic Direction for Research in DVA.
[350] MRC CM6851, 7 February 2013, Support for Wounded Injured or Ill Program (SWIIP) Recommendations—Defence Criteria for Priority Consideration of Compensation Claims.
[351] MMRCC Instrument 2013/MRCC16, 7 February 2013, Services to Support a Contemporary Widow.
[352] MRC CM7257, 5 May 2016, Consideration of Community Nursing Services for two DVA Clients.
[353] MRC CM6343, 16 April 2010, Extension of Operation Life.
[354] MRC CM7253, 5 May 2016, Future Directions of the Crisis Assistance Program.
[355] MRC CM7253, 5 May 2016, Future Directions of the Crisis Assistance Program.
[356] MRC CM7253, 5 May 2016, Future Directions of the Crisis Assistance Program.
[357] MMRCC 46/2017, 3 November 2017, Health and Wellbeing Updates and Outcomes,
[358] MRC CM6633, 30 January 2012, Future Mental Health Policy Work.
[359] DVA, *Mental and Social Health Action Plan 2015 and 2016*, Canberra, 2015, p. 11, commenting on DVA, *Veteran Mental Health Strategy: A ten-year framework 2013–2023*,

Canberra, 2013.

[360] Ibid.

[361] DVA, *Veteran Mental Health Strategy*, p. 4.

[362] DVA, *Mental and Social Health Action Plan 2015 and 2016*, Canberra, p. 17.

[363] MMRCC 46/2017, 3 November 2017, Health and Wellbeing Update and Outcomes.

[364] Australian Government Response to the Foreign Affairs, Defence and Trade Committee Report, The constant battle: Suicide by Veterans, October 2017

[365] Ministerial statement in response to Foreign Affairs, Defence and Trade Committee's Report on the Inquiry into suicide by veterans and ex-service personnel, 24 October 2017, http://minister.dva.gov.au/media_releases/2017/oct/va144.htm, accessed 7 May 2019

[366] Bird Review recommendations, Department of Veterans' Affairs, Department of Defence, https://www.dva.gov.au/consultation-and-grants/reviews/government-reports/bird-review-recommendations, accessed 7 May 2019

[367] Australian Institute of Health and Welfare, *Australia's health 2018*, Australia's health series no. 16, AUS 221, Canberra, 2018, Chapter 5.6: Veterans, p. 6.

[368] DVA, *Mental and Social Health Action Plan 2015 and 2016*, p. 11.

[369] Ibid., p. 6.

[370] Ibid., p. 13.

[371] Ibid., p. 7.

Chapter Five
Commemoration

Amidst all the changes, many of them dramatic, that had occurred within DVA in the quarter-century between 1994 and 2018, there appeared to be at least one constant—commemoration. As we shall see, this period had brought innovation, new policy directions, and sometimes criticism and controversy, in this field of DVA activity too. Commemoration, it turned out, could be as complex a subject as any other facing the department.

After the First World War, each of the combatant nations had sought to remember those who had fought, and especially those who had died. From individual graves to vast towering monuments, sombre and often moving memorials to the sacrifice of millions appeared across the old battlefields and in the homelands of those who had fought. But perhaps more than any other nation, Australia (along with New Zealand) had wholeheartedly embraced the principle of commemoration after the First World War—principally as a means of addressing the seemingly impossible distance between the Antipodes and the battlefields and cemeteries of Europe and the Middle East. In this, as in other areas, Australia endured 'the tyranny of distance', as Geoffrey Blainey has dubbed it, and then (as now) commemoration became the nation's response.[372]

Most Australians at home had no alternative but to live with the unpalatable truth that husbands, fathers, sons and brothers, lay in graves half a world away, in places so remote that they could never be visited. To help assuage their sense of loss and grief, the Australian government produced a pamphlet, *Where the Australians rest*, which illustrated the overseas cemeteries, showing well-kept,

orderly rows of graves in beautiful garden settings, serene and peaceful places that allowed the bereaved to imagine their loved ones lying quietly and safely. At Gallipoli, according to one observer in 1926, the cemeteries and memorials presented an 'ordered God's acre which is a picture of rest and peace'.[373] The names of all Australians 'missing' in France—those with no known grave who had been swallowed up in the vastness of the battlefield—were inscribed on the Australian National Memorial at Villers-Bretonneux, with those missing in Belgium at Ypres also appearing on the Menin Gate memorial.

For a tiny minority of Australians—the wealthy—there was at least the possibility of going on a 'pilgrimage' (as it was often described) to the Western Front or Gallipoli, the first organised tour (in 1929) attracting eighty-six men and women at the astronomical cost of £250 per head. They found themselves representing the aspirations of all bereaved Australians, and their ship, the SS *Baradine*, carried artificial sprigs of wattle, purchased by the bereaved at home, to be placed on the deceaseds' graves.[374] It would be very many years before more than just the privileged few could afford to actually make such a journey and, until those more democratic times arrived, 'pilgrimage' remained a distant dream for most people. In the meantime, commemoration developed apace at home. State memorials, such as Kings Park in Perth and the Shrine of Remembrance in Melbourne, were erected, while the Australian War Memorial (or Museum, as it was designated originally) was located in Canberra in 1941, having been housed temporarily in Melbourne and Sydney beforehand.[375]

This distinctly Australian approach to commemoration, established in the years after the First World War and nurtured thereafter, had become firmly established in the repertoire of DVA activities by the closing decades of the twentieth century. This was enhanced by the inclusion of the Office of Australian War Graves (OAWG) within the DVA portfolio, the department assuming responsibility for more than 19,000 war graves in Australia, Papua New Guinea, the Solomon

Islands and Norfolk Island, and a further 3,300 names of war dead commemorated on memorials. Additionally, there were Australian war graves at Ambon in Indonesia, and in numerous graves in Australia in more than 900 civilian cemeteries. Adelaide River Cemetery, south of Darwin, was the most visited in Australia; the largest military cemetery in Australia was Rookwood in western Sydney.

Like other areas of DVA activity, OAWG could on occasion be the subject of criticism and controversy. Alongside anxiety that cemeteries or individual graves in locations overseas might be subject to neglect or desecration, there were changing aspirations. Most notable had been growing opposition to the principle, laid down explicitly in the First World War, of interring Australians where they had fallen—with next-of-kin and relatives of those killed in Vietnam now demanding the right to bury their dead at accessible locations within Australia. Subsequently, the remains of most Australians who had died in Vietnam were returned to Australia at government expense for burial according to their families' wishes, setting a precedent for all future conflicts and operations overseas.[376]

On 12 November 2018, Australian Army pallbearers carry the coffin of a First World War Australian soldier at Queant Road Cemetery, Buissy, northern France, at a ceremony to inter the recently identified remains of two servicemen—Lance Corporal James (Lennox) Leonard Rolls and Private Hedley Roy Macbeth. (Dept of Defence 20181112adf8555536_665; photographer LS Nadav Harel)

However, one remarkable and unexpected event was the discovery of a mass grave of Australian and British war dead, buried by the Germans after the Battle of Fromelles on 19–20 July 1916. In 2002, an amateur historian, Lambis Englezos, had drawn attention to the possible site and, in 2008, archaeological investigation confirmed the mass grave's existence.[377] Subsequently, 250 Australian and British soldiers were interred with full military honours in individual graves at the new Fromelles (Pheasant Wood) Commonwealth War Graves Cemetery. The cemetery was formally dedicated on 19 July 2010. Two years later, on 20 July 2012, a further nine bodies were interred at Fromelles, continuing the First World War tradition that Australians from that conflict were buried where they fell.[378]

By marked contrast, and in accordance with the new protocol, the repatriation of the remains of Australian servicemen killed in Vietnam

had been pursued conscientiously. In 2009, shortly after the remains of the last six Australians missing in action were discovered and returned home, DVA ran a feature on the six individuals in its annual report, describing the fate of each man.[379] Later, in May 2015, the Australian government extended an offer of repatriation to the families of thirty-five Australians interred in the Terendak Military Cemetery in Malaysia and the single remaining Vietnam War casualty interred in the Kranji War Cemetery Military Annex in Singapore. In all, thirty-three families accepted the offer. The resulting repatriation was led by the OAWG, working closely with other agencies, with the governments of Malaysia and Singapore, and with the funeral directors InvoCare Australia. On 2 June 2016, 180 family members gathered at the RAAF base at Richmond in New South Wales to welcome home their loved ones. Susan May, one of those who had waited at Richmond, was the daughter of the late Corporal Robert Bowtell. She looked back over the recent months, when the repatriation arrangements were being made, as 'a time of reflection, remembrance, understanding and acceptance of 50 years passed', thankful that she and her family had taken up the offer 'to return our much revered and loved father and husband' and to have him 'back home and close at hand'.[380]

By then, DVA's commemorative program, growing steadily since the mid-1990s, was fully developed, an array of anniversaries from both world wars and other conflicts prompting growing public (and scholarly) interest in Australia's military history. The 50th anniversary, in 1995, of the end of the Second World War, for example, was marked by DVA's *Australia Remembers 1945–1995* commemorative program, culminating in national ceremonies held in Brisbane on 15 August 1995 to remember the 50th anniversary of victory in the Pacific. In June 1995, as part of the program, some 900 ex-servicewomen took part in a commemorative ceremony at the Adelaide River War Cemetery, south of Darwin—an indication that female veterans (alongside widows, wives and partners) would play a prominent part in such events in the years ahead.[381] Overall, some $9 million dollars had been allocated by the government for

commemorative events, large and small, in all states and territories across Australia. Additionally, as a gesture to former Australian prisoners of war (POWs)—many of whom had suffered terribly in Japanese camps—Prime Minister Paul Keating (who took a keen interest in POW issues as his uncle, William, had died during the notorious Sandakan-Ranau death march in Borneo in 1945), together with Minister for Veterans' Affairs, Con Sciacca, announced that the 'Federal Cabinet has agreed to exempt Australian ex-prisoners of war who are receiving nursing home care from the cost of nursing home resident contributions'.[382] The statement was timed to coincide with the fiftieth anniversary of the cessation of hostilities in the Pacific.

Alongside the numerous activities within Australia, there were also 'commemorative missions' overseas—affectionately called 'pilgrimages' by their participants—organised by DVA as part of the *Australian Remembers 1945–1995* program, with veterans journeying to Papua New Guinea, Borneo, Singapore and other places where Australians had fought during the Second World War. In the 1995 mission to Papua New Guinea, for instance, there were visits to three war cemeteries and battlefield memorials, with a judicious realignment of headstones in the Port Moresby (Bomana) War Cemetery having been completed ahead of the event.[383] A new departure for DVA, commemorative missions were to become an increasingly important feature of the department's engagement with the veteran community, at a time when DVA was looking to diversify its activity in response to what it imagined to be an 'ageing clientele'.

Commemorative missions, as they were known, had begun officially in 1990, with a high-profile pilgrimage to mark the 75th anniversary of the Gallipoli campaign, a collaborative effort by several veterans' organisations, including the RSL, with funding and other support (including medical) provided by DVA and the Department of Defence. Five years on, and commemorative missions had become a DVA responsibility, the department organising the 80th anniversary visit to Gallipoli in 1995. By June 2013, less than twenty years later,

DVA had managed more than 30 such commemorative missions, with others already planned for the years ahead. Significant anniversaries were now routinely marked in this way, typically involving missions to major battlefields and locations overseas, with commemorative services, receptions and other functions and events.[384]

In contrast to the 'pilgrimages' made in the aftermath of the First World War, where the bereaved naturally took precedence, these new commemorative missions were designed primarily with the veterans in mind. There had been earlier independently organised veterans' pilgrimages (for those who could afford to pay), notably 'Operation Amiens', as it was dubbed, to the Western Front in 1986. But, as historian Bruce Scates has argued, 1986 signalled the end of these self-managed veterans' pilgrimages, at least for the First World War survivors. Thereafter, as Scates explained, some of these First World War veterans would indeed make their way back to the old battlefields, but they would do so 'as honoured guests of a touring government entourage'—journeys that now seemed 'more a matter of public relations, diplomacy and a nation's belated thanks rather than a truly soldiers' pilgrimage'. Besides, he added wryly, 'now that there were so few left, the government was prepared to pay for them'.[385] In the commemorative mission to Gallipoli in 1990, fifty-two of the original Anzacs joined the entourage, the youngest 93 years old and the oldest 104.[386]

However, as Bruce Scates admitted, although Operation Amiens might have been 'the end of an era',[387] the passing of the First World War generation was matched by the emergence of later cohorts of veterans, anxious now to accept the government's largesse where possible, and to return to the sites 'heavy with memories of long ago', as one veteran put it.[388] Although undertaken to commemorate significant anniversaries in Australia's military history or to dedicate Australian memorials overseas, commemorative missions were also about veterans themselves, and often had a major impact on those who participated. Dr Graeme Killer, DVA's then Principal Medical

Adviser, had accompanied many of these missions and observed that ‘in some ways it changes their lives, they’re different people. If you see them at the beginning of the mission and then you see them at the end, they’re changed men and women’.[389]

The Department of Veterans’ Affairs invited a number of veterans of the Burma-Thailand railway construction to attend the opening of the Hellfire Pass Memorial Museum in April 1998. *(DVA Veterans at Hellfire Pass)*

Commemoration had the effect of recognising, honouring and legitimising the sacrifice of such men and women, as Graeme Killer explained: ‘We don’t want veterans to think that they’ve been on a campaign and they haven’t helped the country or the world’.[390] But more than this, missions provided rare opportunities for veterans to talk openly and sometimes emotionally about their experiences—something that they might have found difficult in everyday and commonplace situations at home. Moreover, the missions offered an opportunity to visit the sites of earlier trauma, and to contemplate those who had served and not returned. As one veteran confided after his visit to the Hellfire Pass Memorial Museum in Thailand,

opened in April 1998: ‘I can go home now content; I’ve said my goodbyes’.[391]

Bruce Scates, who conducted a questionnaire-based survey of over 700 Australians (and quite a few New Zealanders) who had attended the Gallipoli Anzac Day commemorative service in 2000, revealed a yet more complex set of reactions among veterans of Australia’s recent conflicts. On the anniversary of the landing, a new Anzac Commemorative Site was dedicated within the new Gallipoli International Peace Park, with orders of service and a commemorative booklet provided by DVA.[392] It was a solemn occasion. Garry, a participant in the service and one of the 19,000 national servicemen conscripted to serve in Vietnam, found the Gallipoli visit intensely moving, as he confided to Scates in his questionnaire response—equating and comparing the events of 1915 with his own experiences of warfare. As Garry admitted, ‘I cried all day’, adding ‘I think visiting Gallipoli was a very personal experience and not always easy to explain to people who have not fought in a war. I was in Vietnam in 1967’.[393]

Greg (who had served in Vietnam for over a year, where his armoured squadron suffered heavy casualties) found his visit to Gallipoli in 2000 a life-changing event. Previously he had shared much of the anger and disillusion felt by other Vietnam veterans. ‘On return from Vietnam I was very bitter and never attended Anzac Day services’, he said. ‘I felt the people [of] Australia were ungrateful for what servicemen did ... Because of the politics of the war they took it out on the ... vets ... The RSL was not user-friendly and told us it was not a real war, only a police [action]’.[394] The unveiling of the Vietnam Memorial in Canberra in 1992 had begun a slow process of personal reconciliation (he and his old Army mates had decided to ‘stop punishing ourselves’)—but it was the visit to Gallipoli that really ‘changed’ him. Greg had found himself drinking late into the evening at a café at Eceabat with a group of young backpackers from Australia. To his delight, they turned out to be as interested in his war as they were in the events of 1915. He described the ‘pleasure of

being able to communicate with such young interested people', a moment when 'the young can sit down with vets and ask all sorts of questions, and sometimes very searching questions, and get, on occasions, very emotional responses'.[395] It was, Greg admitted, a turning point in his life.

As Bruce Scates had also discovered, alongside the backpackers and Vietnam veterans at Gallipoli in 2000, there were others who had seen action or who had engaged in peacekeeping operations in Korea, Malaysia, the Gulf, East Timor and Africa. Additionally, there was a sprinkling of Army Reserve and officer cadets from the ADF, who described themselves as 'training for war', even if they 'hadn't actually been in one'.[396] These included young female recruits, one (Michelle) explaining: 'We are ... soldiers this is our "Haj"'.[397] Each, from their different generations, and with their varying backgrounds and experiences, found something at Gallipoli that resonated, enabling them to put their personal stories into a context that gave wider meaning to their existence. Many pondered the pity of war, but no-one felt that commemoration—the physical act of mission or pilgrimage, or the erection and dedication of memorials—was in any way tantamount to the glorification of war.

Yet commemoration did have its critics, even among the veteran community. Prominent among these was James Brown, a former Australian Army officer who had commanded a cavalry troop in Iraq, served on the Australian taskforce headquarters in Baghdad, and was attached to special forces in Afghanistan. He complained, controversially, that today 'Australians spend a lot more time looking after dead warriors than those who are alive. We focus on a cult of remembrance'.[398] He argued that the money spent on commemoration would be better spent on the veterans themselves. In fact, however, despite the increasing prominence of commemoration and its frequent appearance in the public eye (the 'public relations' dimension detected by Scates), the cost of commemorative activities represented a relatively modest proportion of DVA annual expenditure. In 2016–2017, for example, the total

DVA budget was $12.1 billion. Of this amount, $6.4 billion was allocated to Compensation and Support, $5.3 billion was spent on Health and Wellbeing, with $383.4 million going to Enabling Services (including staff salaries) and Commemoration receiving $47.2 million (which included allocations for the Office of Australian War Graves and for the production of educational resources).[399] Commemoration, it turned out, consumed a relatively small proportion of DVA funds and personnel-hours.

Despite the criticism sometimes levelled at commemorative activities, visits and missions offered some of the best avenues for veteran engagement and participation, and accounted for their continuing popularity, both with DVA commemorative planners and the veterans themselves. In December 1994, therefore, work began on the Memorial Project at Kokoda in Papua New Guinea, designed to commemorate the Kokoda Campaign of 1942—fought from the initial Japanese invasion of 29 July that year until the Australian victory on 2 November.[400] Australian forces sustained nearly 1,700 casualties (including more than 600 dead) during the battle for the Kokoda Track, fought in the Owen Stanley Ranges northeast of Port Moresby. The people of Papua New Guinea had also suffered significantly but had played a major role in carrying forward supplies and ammunition, as well assisting in the evacuation of casualties. The Memorial Project was first mooted by Prime Minister Paul Keating during a visit to Papua New Guinea (PNG) in 1992, and the resultant memorial complex (consisting of a war museum, hikers' guesthouse, hospital, and an airport terminal) was constructed by the Australian government in partnership with Rotary Australia Community Service and with the assistance of the people of Ora Province, Papua New Guinea. The facilities were opened by Prime Minister Keating and Sir Julius Chan, Prime Minister of Papua New Guinea, on 16 September 1995, when an extension of the project was also announced, to include the renovation of the roads and water reticulation system in Kokoda village and the landscaping of grounds at the new Kokoda Memorial Hospital.[401]

The Kokoda Memorial Project demonstrated several key elements of current government strategy. The project provided a physical focus for future missions, ensured a supporting infrastructure for visitors as well as for the local population—and negotiated a partnership with a major non-government agency to deliver a significant international aid initiative. The project was also indicative of the extent to which senior Australian politicians were now committed to commemoration as a policy, and wished to be associated with it personally. Bob Hawke, who had enthusiastically endorsed the provision of financial and logistical support to veterans for the commemorative mission to Gallipoli in 1990, was perhaps the first to embrace commemoration wholeheartedly. As Prime Minister, Hawke participated in the 1990 mission—partly because (as his speechwriter Graham Freudenberg put it), it would 'break the conservative monopoly on the interpretation of Australian military history', but also because he believed that commemoration reflected 'that commitment to Australia, which defines and alone defines what it is to be an Australian'.[402]

Although Hawke's successor as Prime Minister, Paul Keating, did not share his erstwhile leader's enthusiasm for Gallipoli, he nonetheless embraced commemoration of a different sort, preferring to focus on the Second World War and the role of Australians in the Asia-Pacific region. He had demonstrated a particular sympathy for those who had been POWs in the Japanese camps, and had actively promoted the Kokoda Memorial Project as a means of asserting Kokoda's significance in Australian history—hoping that it would eventually replace Gallipoli as the nation's principal object of commemoration.[403] This was a controversial aspiration, and drew criticism from some Second World War veterans and others who objected that concentrating too closely on Kokoda would come at the expense of other important campaigns in other theatres during the war. It was no coincidence, perhaps, that DVA was at pains to point to recent renovation work at the 9th Australian Division Memorial at El Alamein War Cemetery in north Africa, and at the 6th Australian Division (Stavromenos) Memorial on Crete. Closer to home, as DVA

explained, the Sandakan Memorial Park, an RSL initiative, had recently been constructed near the wartime POW camp at Sandakan in the state of Sabah, Malaysia, and was in July 1995 the subject of an official DVA mission.[404] The Memorial was formally dedicated in 1999.

Nonetheless, Keating's emphasis on Kokoda had the effect of keeping the Kokoda Campaign firmly in the public eye. The Kokoda Track itself, soon made safe and accessible for hikers, opened in 2001 and at the end of 2002 a trekkers' hut, complete with twelve bunk beds, was constructed at Isurava to provide shelter for walkers from the sometime tempestuous weather of the Owen Stanley Range. The completion of the Track was a prelude to the dedication of the new Isurava Memorial on 14 August 2002, unveiled by the Australian Prime Minister John Howard and the Prime Minister of Papua New Guinea, Sir Michael Somare, to mark the 60th anniversary of the series of gallant actions fought by the Australians in the vicinity of Isuvara village during August 1942. Conceived as a commemoration of all Australians and Papua New Guineans who had fought in the Kokoda Campaign, including those who had died, the dedication of the Isuvara Memorial was part of a wider DVA commemorative mission, which included Kokoda veterans. A striking feature of the new memorial was its four flanking Australian black granite pillars, each inscribed with a single word—COURAGE, ENDURANCE, MATESHIP, SACRIFICE—to reflect the values and qualities of those who had fought along the Kokoda Track. [405]

Paul Keating's particular concern for the commemoration of POWs was reflected in the opening of the Hellfire Pass Memorial Museum in Thailand in April 1998. Built and maintained by the Australian government, and dedicated to all Allied POWs and Asian labourers who had suffered and died at Hellfire Pass and elsewhere in the Asia-Pacific region during the Second World War, the museum was Keating's brainchild. He had visited Hellfire Pass (Konyu Cutting on the notorious Burma-Thailand railway) for the Anzac Day ceremony held there in 1994, when a portion of Sir Edward 'Weary' Dunlop's

ashes were interred at the site, and he had been profoundly moved by the occasion. ‘Weary’ Dunlop had been commanding officer of prisoners as the surgeon at the Japanese POW hospital at Tarsau in Thailand, which handled POWs working on the railway. Like many other POWs, he had been tortured and threatened with execution but had returned safely to Australia, where he had involved himself in repatriation affairs. Garnering cross-party support in Australia, and with the approval of the Thai government, Keating allocated $1.6 million for the construction of the museum, which was located on high ground just above Hellfire Pass. On 24 April 1998, the complex was officially dedicated by the then Prime Minister, John Howard, accompanied by the Minister for Veterans’ Affairs and by former POWs and their families.[406]

Paul Keating’s personal commitment had also raised the public profile of commemoration in Australia. Commemoration was further enhanced in 1997 when the Governor-General, at Prime Minister John Howard’s instigation, signed a proclamation to renew the nation’s pledge of remembrance, to remember afresh all those who had fought and died in the First World War and in subsequent conflicts. The pledge called for the observance of one minute’s silence on Remembrance Day, marking the eleventh hour of the eleventh day of the eleventh month in 1918, when the guns at last fell silent on the Western Front. As John Howard explained, such observance ‘would encourage remembrance of the sacrifice for those who died or otherwise suffered in Australia’s cause’, and he hoped that ‘in schools and workplaces, in cities and in the bush, Australians will stop, just for a moment, to consider what was lost to us’.[407]

The centrepiece of the interpretive centre at the Hellfire Pass Memorial Museum is a giant sculpture, conceived by Courtney Page-Allen and commissioned by the Department of Veterans' Affairs, which compares the amount of rock that a prisoner of war was required to quarry or carry each day with the amount of rice he would receive as a ration from his Japanese captors. *(DVA Hellfire Pass – IMG_2316)*

In the following year, four First World War veterans joined a mission to France for the 80th anniversary of the Armistice, at which they were awarded the French Legion of Honour. Earlier, on 4 July 1998, the Australian Corps Memorial Park at Le Hamel had been unveiled by both the Minister for Veterans' Affairs and the Minister of Defence, commemorating the short but significant battle fought there by the Australians, as the tide had begun to turn on the Western Front. The park was designed to act as a focal point for visitors to the 1918 battlefields, consisting of a walking track past a series of interpretive panels, together with a central commemorative area—the main feature of which was a wall of Australian black granite etched with a large Rising Sun badge. The original trench captured by the Australians was preserved as an integral part of the memorial. On the previous day, 5 July, the Australian Memorial Park at Fromelles had also been opened officially. Marking the Battle of Fromelles in July 1916, the memorial's central feature was a sculpture entitled

‘Cobbers’, erected on a cairn made from remnants of an old German fortification.[408]

Among this burgeoning repertoire of commemorative events, was the mission to Vietnam on Long Tan Day (18 August 1996) and the dedication of the Australian Nurses National Memorial in Canberra in 1999.[409] Taking stock of all these initiatives as the end of the millennium approached, DVA launched its Their Service—Our Heritage program, designed to coordinate the plethora of commemorative activities at home and overseas, and to present them as a coherent and inter-linked series of events. As DVA explained, the program consisted of five inter-related elements: national days of remembrance, memorials, significant events, education and community awareness. The aim now was ‘to promote the ongoing recognition of Australia’s servicemen and women and their contribution to the nation during the past [twentieth] century’, and to support ‘a range of initiatives and projects leading to a growing understanding of Australia’s wartime heritage and the service of its veterans’.[410]

Hot on the heels of Their Service—Our Heritage came what DVA announced as a ‘Refocussing’ of commemorative programs ‘post-Centenary of Federation’. This was designed to extend the scope of the programs by focusing more closing on ‘the service and sacrifice of Australians in more recent conflicts and peace operations since 1947’. In particular, DVA acknowledged ‘the importance of recording veterans’ experiences in a structured, accessible format’, citing its *Australians at War* Film Archive initiative (a world-class collection of 2,000 filmed interviews with veterans from all conflicts) and the use of multimedia technology to make Australia’s wartime history more ‘understandable to the wider community, particularly young Australians’. But while shifting at least some of its attention to post-1947 operations, DVA made clear that it was not about to abandon its longstanding commitment to earlier conflicts. Far from it: the web sites *Visit Gallipoli* and *Australians at War* continued to be developed, and a new web site about Australia’s involvement in the

Second World War had just begun. In all these areas, DVA stressed, it had 'worked closely with educators to focus on resource materials that meet the need of teachers and students'.[411]

Marshalling details of all recent activities under the 'Refocussing' umbrella, DVA, in its annual report for 2002–03, presented an almost bewildering array of events, most of which centred on veteran participation. In July 2002, for example, DVA arranged for seven of the 10 remaining HMAS *Armidale* survivors to attend the opening of an exhibition 'A Cruel Sea: The Sinking of HMAS *Armidale*'—a series of drawings by Jan Senberg, at the Australian War Memorial. There were missions to the Kokoda Track, and to Egypt, where nine veterans and an ex-servicewoman/widow attended international ceremonies commemorating the 60th anniversary of the Battle of El Alamein. A commemorative booklet, *El Alamein Egypt: October-November 1942* was produced by DVA to mark the event. Similarly, missions to Papua New Guinea resulted in two commemorative booklets, *Milne Bay 1942* and *Battle of the Beachheads 1942–43*, to coincide with the visits. DVA also arranged for four veterans from HMAS *Yarra* (II) to attend the commissioning ceremony of HMAS *Yarra* (IV), a Minehunter Class ship, the same party then attending the commissioning of HMAS *Rankine*, the latest Collins Class submarine.[412]

DVA explained that 'Refocussing' also covered 'Preserving our wartime heritage', including the provision of discretionary grants (generally up to a maximum of $4,000 in 2002–2003) to local government authorities and community and ex-service organisations for the restoration or updating of community memorials or the establishment of new ones. National projects supported by DVA included the rededication of the Australian Vietnam National Memorial in Canberra on 5 October 2002, and enhancements to the National Memorial of the Royal Australian Air Force, also in Canberra, which was rededicated on 1 November 2002, with a booklet *Royal Australian Air Force: Artworks from the collection of the Australian War Memorial* published to mark the occasion. In

South Australia, DVA had also sponsored an extremely successful museums project, *Sharing Their Legacy*, working with the History Trust of SA in 2001–02; in 2003 it supported the state's annual State History Conference in Renmark, as well as organising a collection management workshop for ex-service groups in the Riverland area. The department had also supported a Museums Conference in Perth in 2003, and was working up a new project with the Queensland Museum. Similar sponsorship provided $15,000 to the National Foundation for Australian Women to design and implement the Australian Women at War element of their Australian Women's Archive web site. Similarly, DVA had given financial support to the publication of *Malaria frontline: Australian Army research during World War II*, a book by Dr Tony Sweeney, and helped organise its launch at the Australian War Memorial.[413]

Overseas, Remembrance Day 2003 saw the dedication of the new Australian War Memorial in Hyde Park, London, by Her Majesty the Queen. The memorial's principal architect, Peter Tonkin, wrote that the 'form chosen for the Memorial reflects the sweep of the Australian landscape, the breadth and generosity of our people, the openness that we believe should characterise our culture'.[414] The grey and green of the Australian granite used in the Memorial evoked the subtle colours of the bush. Prime Minister John Howard, present at the dedication—along with a mission of Second World War veterans—explained that the memorial was 'a lasting tribute to those Australians who lost their lives in defending those values which are the foundation of the democracy and freedom shared and cherished by Australia and the United Kingdom', adding that it would become the focal point for Anzac Day services in London from 2004.[415]

Alongside this 'Refocussing', with its intimate engagement with national life at all levels, was a growing recognition of the important contribution of Indigenous Australians to the nation's military heritage, and of the need to do more to commemorate its significance. In 2000, for example, DVA arranged for a group of

Torres Strait Islander veterans to attend the Remembrance Day service at the Australian War Memorial as guests of honour.[416] In the same year, the MLC Tower in Canberra, then DVA's national office, was renamed the Lovett Tower. This change in nomenclature reflected the extraordinary service of the Lovett family, but was also a wider salute to the role played in Australia's military history by Aboriginal and Torres Strait Islander veterans. The Lovett family, members of the Gunditjmara people in Victoria, was seen to exemplify this contribution. As DVA reported, the Lovetts' distinguished service record began when five sons of Hannah and James Lovett enlisted in the First World War, seeing action on the Western Front and then in Palestine. Each of the sons returned home safely to Australia and, remarkably, four of them volunteered for service in the Second World War, along with several women from the family who served in the Women's Auxiliary Air Force. As before, all returned home safely. In all, some twenty members of the Lovett family served in the Australian armed forces, from the Somme during the First World War to East Timor in more recent times, and several continued to serve in the ADF.[417]

There was also what historians Noah Riseman and Richard Trembath described as 'a new surge in memorials dedicated to Aboriginal and Torres Strait Islander service'.[418] Examples included the Narungga War Memorial at Point Pearce in South Australia (1999), the Thursday Island War Memorial (2001) commemorating the Torres Islander Light Infantry Battalion, and the poignant Anzac Day 2000 rededication of the memorial (originally erected in 1937) commemorating Cape Barren Islanders from Tasmania who fought in the First World War. In Perth, Aboriginal Vietnam veteran John Schnaars founded the Honouring Indigenous War Graves organisation, and overseas there were similar attempts to honour the graves and memorials of Indigenous Australians.[419] At the dawn service at the Australian National Memorial at Villers-Bretonneux in April 2011, for example, DVA paid tribute to Private Francis Alban Varcoe, a Ngarrindjeri man from Point McLeay Mission Station (now Raukkan) near the Coorong in South Australia, who was killed in

action on 5 May 1917 at the Second Battle of Bullecourt, less than a month after having been taken on 27th Battalion's strength. He has no known grave.[420]

During Reconciliation Week 2006 (29 May—4 June), the RSL organised a commemorative service at the Shrine of Remembrance in Melbourne where, as the *Sun Herald* newspaper noted, the 'Aboriginal flag was raised for the first time ... to honour Indigenous servicemen and women'. The initiative was the suggestion of Dot Peters, an Elder of the Healesville Indigenous Community in Victoria. As she explained to the *Sun Herald*, Indigenous servicemen and servicewomen in the two world wars 'couldn't vote but they died for their country, and I've always thought something should be done for them ... I love my country and I think what our boys and other Australians did for us, and we need to remember that no matter what culture we are'.[421]

Encouraged by her success, Dot Peters wrote to the Minister for Defence (who passed the letter on to the Minister for Veterans' Affairs, Bruce Billson), describing the recent Melbourne initiative and requesting that it be replicated across Australia during Reconciliation Week 2007. 'My Dad fought in the Second World War', Dot Peters explained: 'He served in the 2/2nd Pioneer Battalion in the Middle East. On his way home he was taken prisoner at Java and later died on the Burma Railway'.[422] She continued:

> Like thousands of our Aboriginal young men who fought for our freedom, Dad was not able to vote ... Last year I approached our local RSL and invited them to become involved during Reconciliation Week. The result was that for that week when the Ode was spoken, a didgeridoo played in the background. … This led to a service at the Shrine of Remembrance in Melbourne. It was a nice service and good to see our flag raised there for the first time.[423]

Dot Peters went on to explain her 'hope that during Reconciliation Week next year [2007], this ceremony will occur all over Australia'.

As she put it:

> Along with all Australians our Aboriginal men and women fought (and many died) for us all, so that we can live in peace and live our lives as we choose. This is a privilege all of us should cherish, guard and honour always. To honour our [Indigenous] service men and women with a service at every Shrine and RSL to include the didgeridoo playing with the Ode, would be a dream come true. Could this happen?[424]

It could. Having obtained the support of the RSL and Legacy, and after consulting the Aboriginal and Torres Strait Islander Veterans' Association, the Minster responded to Dot Peters' moving and persuasive request, explaining that arrangements would be made for DVA to host commemorative events, on the lines she had suggested, in each capital city in 2007.[425] In the end, only Darwin and Hobart were unable to participate.

As appreciation of the contributions of Indigenous peoples became more nuanced and sophisticated, so the decision was made to explicitly honour the vital role played by the people of Papua New Guinea in supporting Australian operations against the Japanese during the Second World War. This was in the form of the 'Fuzzy Wuzzy Angels' commemorative medallion, the nomenclature reflecting the term of endearment commonplace among Australians who had fought in Papua New Guinea—many of whom owed their lives to the local population. The award was announced at a joint press conference on 28 April 2009 by Prime Minister Kevin Rudd and Sir Michael Somare, Prime Minister of Papua New Guinea, with two Fuzzy Wuzzy Angels and two Australian veterans of the Second World War in attendance. DVA worked with the Royal Australian Mint and other government agencies to produce the medallion and determine eligibility criteria.[426]

Mirroring the spirit of 'Refocussing', the 50th Anniversary of the Korean War armistice was commemorated prominently with ceremonies in both Australia and Korea on 27 July 2003. Three veterans and a war widow were selected to accompany the Minister

for Veterans' Affairs to the international ceremonies in Korea. Earlier, in April 2000 the Australian National Korean War Memorial had been dedicated on Anzac Parade in Canberra, becoming the focus of subsequent commemorative activities in Australia, while a new travelling exhibition—*Out in the Cold: Australia's Involvement in the Korean War—was* launched by the Australian War Memorial, with commemorative postage stamps produced by Australia Post. Following the interest engendered by the 50th Anniversary of the Korean armistice, there were subsequent DVA missions to Korea in 2011 and 2013, and again in 2016 when eight veterans returned to the battlefields to commemorate the 65th anniversaries of the battles of Kapyong and Maryang San.[427]

Inevitably, the 60th anniversary of the end of the Second World War in 2005 was another major event commemorated across the nation and beyond, culminating in a spectacular Salute to the Veterans in Canberra on 13–15 August 2005, with an air display over Lake Burley Griffin led by a vintage Mustang aircraft, followed by other demonstrations by the Navy, Army and Air Force. There were receptions and commemorative events across Australia—in Perth, Adelaide, Darwin, Melbourne, Hobart, Sydney, Brisbane and elsewhere—and, in Townsville, the weekend commenced with the arrival of a 'troop train' carrying 160 veterans, wives and war widows. Remarkably, some 80,000 local residents lined the streets to cheer these 'Living Heroes' as the 'troops' marched past. [428] Overseas, there were further missions to Hawaii, Papua New Guinea, Singapore and Thailand.

However, notwithstanding the 'Refocussing' imperative, across Australia attention was already turning to the 100th anniversary of the First World War, now suddenly on the horizon, and especially to the centenary of the Anzac landings at Gallipoli. Indeed, in 2000 DVA had noted a 'resurgence of interest' over the past decade in Anzac Day and other commemorative events, as well as increasing numbers attending the Dawn Service at Gallipoli itself. In response, the OAWG had constructed a new Anzac Commemorative Site

within the International Peace Park at Gallipoli, able to accommodate large crowds, which was dedicated on Anzac Day 2000 in the presence of the Prime Minister of Australia, John Howard, and the Prime Minister of New Zealand, Helen Clark, together with Australia's Minister for Veterans' Affairs and representatives of the Turkish and British governments.[429] Two years later, in 2002, Neil Johnston, President of the Repatriation Commission and Secretary of DVA, reflected that the 'passing of Australia's last Gallipoli veteran, Alec Campbell ... [has] prompted enormous public interest, highlighting the community's continuing strong interest in our wartime heritage'.[430]

The broadcast of the landmark ABC documentary series *Australians at war* during 2001 had also done much to heighten this interest. Commissioned by the Australian government through DVA and produced by the Sydney-based company 'Beyond Productions'. *Australians at war* consisted of eight 55-minute television programs, detailing Australian involvement in overseas conflicts from the Boer War to the 1990s. As well as telling the stories of Australians in all major conflicts—in both world wars, Korea, the Malayan Emergency, the Indonesian Confrontation, Vietnam, the Gulf—the programs also examined the impact of those wars on Australian society. In the final program of the series, there was discussion of the significance of commemoration and memorialisation and, as the ABC put it, the 'strong resurgence of interest in the Anzac tradition and its values among today's Australians'. However, the analysis was by no means uncritical. The ABC observed that the concluding program 'provocatively raises the recurring question that confronts us every Anzac Day—what have we done with the peace that has been won for us'? As the documentary-makers well understood, the growing popular interest in Anzac Day and its enthusiastic commemoration at home and abroad had also posed questions about the purpose, relevance and legacy of Anzac Day in the new millennium. 'Australia now has a significant international profile and reputation as a successful "peacekeeping" contributor', continued the ABC commentary, as if probing for an answer to the question it had itself

raised: ‘Not only is this something we do well; it seems an entirely appropriate direction for our fighting sons and daughters of Anzac’.[431]

Australians at war received four major awards during 2001–02, including a Logie, signalling the widespread applause that the series had attracted. However, not everyone was as easily convinced as to the continuing appropriateness of Anzac Day commemoration, especially in its early twenty-first century guise. To begin with, there were those—notably James Brown, the former Australian Army officer—who considered that the Anzac tradition cast a ‘long shadow’ over today’s servicemen and servicewomen, not least on Anzac Day ‘when our myth-making paints glory and honour so thickly on those in the military that it almost suffocates them’.[432] Brown’s sense of distance—between himself, as a recently returned veteran, and what he saw as a wider, uncomprehending public-at-large steeped in ‘Anzackery’[433] (as critics described it)—mirrored the general sense of disconnection (even alienation) experienced by many ex-service men and women as they returned to civilian life. And yet, as we have seen, commemoration—including participation in Anzac Day events and in missions to former battlefields—had had a profoundly healing effect for many of these veterans, especially over time, as they reflected on their experiences with the benefit of hindsight and after long contemplation.

As DVA had recognised, commemorative events were also important opportunities for veterans’ widows and widowers to participate in individual acts of remembrance (often moments of great personal significance) as they came to terms with their loss. The 90th anniversary Anzac Day at Gallipoli, for example, had been an opportunity for Norma Whitfield, National President of the War Widows’ Guild of Australia, to travel to the peninsula as part of a group of ten national leaders of major ex-service organisations. Mrs Whitfield was the widow of a Second World War veteran, and her father had fought at Gallipoli where he was seriously wounded—shot in the mouth and bayoneted in the arm. As DVA reported, the visit

‘was especially memorable for Mrs Whitfield as she reflected on the courage and sacrifice of her late father and his comrades-in-arms’.[434]

In the end, even James Brown was pleased that Anzac Day had endured, and he concluded that it was really a question of degree:

> I’m glad that Anzac Day has been restored from the wilt of the 1970s, when military service was something Australians seemed ashamed of and we neglected to honour those who served on our behalf. But just as it was possible to neglect Anzac Day, it is now possible to overcorrect and create a jingoistic commemoration that does little to help the way we think about war or to stitch veterans back into the society from which they came.[435]

Others agreed that the marking of Anzac Day was often one-sided. Writing in 2015, historians Bruce Scates, Rebecca Wheatley and Laura James observed that there ‘has been no shortage of heroic stories over the course of the Anzac Centenary: stories of courage and sacrifice, fortitude, and endurance, mateship and resolve’. But they recognised a profound need ‘for other stories as well—the stories too often marginalised in favour of nation-building narratives’.[436] Here they offered a different kind of commemoration, one which ‘widens the ambit of remembrance, beyond our blinkered vision of 1914–1918 to the broken years that lay beyond’.[437] Collecting together the experiences of those killed in war and also those who survived—among them ‘the gassed, the crippled, the insane’—Scates, Wheatley and James compiled their *World War One: A history in 100 stories*. Among the stories was that of four-year-old Isabella Wilkinson, murdered (along with her mother) by her father, a failed soldier-settler and veteran of Passchendaele, who afterwards slit his own throat. It was a violent and also desperately sad story which sat uncomfortably, perhaps, within the wider mood of the Anzac Centenary. But Bruce Scates and his co-authors recognised its significance, dedicating their book to Isabella and

insisting that Anzac commemoration 'is a time to gauge the cost of war for our entire community'.[438]

To these critiques of Anzac commemoration were added more fundamental objections. The Anzac myth had long been deconstructed (for example, in EM Andrews' *The Anzac illusion* in 1993), and some feminists, such as historian Patricia Grimshaw, had expressed discomfort at the very idea of men (who were subsequently 'richly rewarded' for their pains by the repatriation system) 'giving birth' to the Australian nation at Gallipoli. [439] As the 100th anniversary of the First World War and the Anzac landings drew ever closer, so such voices became more insistent. In 2010, historians Marilyn Lake and Henry Reynolds (with Mark McKenna and Joy Damousi) confessed that they were 'deeply concerned about many aspects of the Anzac resurgence', and warned against 'the relentless militarisation of our history', complaining that 'the commemoration of war and understanding of our national history have been confused and conflated'.[440] They were alarmed by the increasing number of books, newspaper articles, television documentaries and electronic media devoted to the history of war. As they explained:

> Political leaders of all persuasions, government departments led by the Department of Veterans' Affairs, national institutions such as the Australian War Memorial, mass media, opinion makers, publishers and schools in every state and territory now either actively fund or promote the commemoration of Australians at war, whether at Gallipoli, Fromelles or Kokoda, in Korea and Vietnam, not just on special days, but throughout the year.[441]

Marilyn Lake, the lead contributor to the polemic *What's wrong with Anzac?*, was especially critical of Anzac Day as currently practised. It had 'long since ceased to be a day of solemn remembrance', she considered. Now, instead, it had become 'a festive event, celebrated by backpackers wrapped in flags, playing rock music and proclaiming their national identity on the distant shores of Turkey'.[442] Her principal complaint, however, was directed at the 'torrent of

curriculum materials sent to primary and secondary schools by the Department of Veterans' Affairs'.[443] Schoolchildren had become 'conceptualised as the inheritors of the Anzac spirit and its traditions', and were 'bombarded' with military history material, part of a 'vast pedagogical enterprise of the DVA'. She asked pointedly whether 'it is the job of the federal Department of Veterans' Affairs to prescribe schoolchildren's understanding of national history' and feared that '[h]istory has been appropriated in Australia for militaristic purposes and comprehensively rewritten in the process'.[444] Trawling through DVA annual reports, she traced the growth of this presumed project from the mid-1990s. She noted that DVA had held workshops for teachers, and revealed that 'educators at the DVA have found partners in universities as well as museums and schools', identifying the National Centre for Australian Studies at Monash University as an especially enthusiastic collaborator.[445]

Yet, in presenting her analysis, Marilyn Lake had not considered the agency and critical skills of school teachers and college lecturers, and had underestimated their ability to use DVA material in ways that might challenge students and enable young people to develop their own critical faculties and independent thought. The sheer diversity of material produced by DVA provided a resource base from which teachers could pick and choose, flexible enough to allow teachers to use it creatively in a number of classroom situations, should they so wish. The dynamic quality of this material was widely recognised and, in 2008 for instance, the DVA resource *Australian women at war* won the coveted Australian Teachers of Media (ATOM) award for Best Educational Multimodal Production.[446] In the same year, continuing this focus, DVA published an illustrated volume, *Australian women and war*, by historian Melanie Oppenheimer; as a follow-up, the department's calendar for 2009 dwelt on the theme of women at war, with 'a particular focus on the groundbreaking nature of women's service in the Second World War', depicting servicewomen and civilians in a variety of roles, including munitions work, nursing, firefighting, agriculture, aircraft maintenance and fundraising.[447]

But Lake was correct in noting the expansion of DVA educational material since the mid- 1990s. She was also right to point to the increased sophistication of its content, presentation and multiplicity of media. In 1999–2000, for example, under the aegis of the Their Service—Our Heritage program, DVA launched its 'Anzac Day kit' to all primary and secondary schools, together with Scouts and Guides associations and both the YMCA and the YWCA. The kit included activity sheets suitable for classroom exercises, posters, postcards, information about obtaining Australian War Memorial's 'Memorial Boxes' (containing uniforms and artefacts from different eras for students to examine), and a guide to the Simpson Prize and the National History Challenge, competitions which children were encouraged to enter. Launched in tandem with the school kit was a new website, developed in conjunction with the New South Wales Board of Studies, which discussed the recent Anzac Commemorative Site as well as presenting 'an environmental view of Gallipoli and other educational resources'.[448]

Taken together, such resources were dovetailed to link with national curriculum objectives, mainly in areas such as studies of society, the environment and history. In 2001, for example, DVA produced its Remembrance Day resource, *We remember*, which was distributed to all 7,500 primary schools across Australia. It contained a 'big book' Remembrance Day story, together with teachers' guides and student activities. Similarly, the Anzac Day 2002 education resource *Defence of Australia* included material on Australia's involvement in the Second World War, covering events such as the fall of Singapore, the bombing of Darwin, the midget submarine raid on Sydney, and battles in Papua New Guinea during 1942. The *Buzz for Kids*, a school newspaper, was produced, featuring articles such as '*A* look at the Lovetts' (about the celebrated Aboriginal family of that name) and 'Women in war—not just nurses'.[449] At the same time, DVA organised a continuing biannual direct mail outreach program to a wide range of non-school audiences as part of its commemoration community engagement activity.

Subsequently, under the 'Refocussing' imperative, 'educational initiatives for young people' were redoubled. *Time to remember: Understanding Australia's experiences in war and peacekeeping*, an education resource for lower and middle primary school students, was distributed to all primary schools in 2003. Meanwhile, an Anzac Day information pack was sent to secondary schools, containing a CD with music for commemoration ceremonies, along with information about Anzac Day school activities, the Valuing our Veterans program and education programs offered by the Australian War Memorial. There was also increased engagement with the teaching profession itself. The December 2002 edition of *Teaching History*, the journal of the History Teachers' Association of New South Wales, focused on Australia at war and was sponsored by DVA under its commemoration program. Likewise, presentations and displays were given at the History Teachers' Association of Australia's national conference in Sydney in October 2002.[450]

DVA's publishing program continued apace: in March 2007 the department completed its 17-part series 'Australians in the Pacific War' with the release of *Australian prisoners of war: 1941–1945*, and the second and third booklets in the five-part 'Australians on the Western Front' series also appeared.[451] Several major volumes were published during 2007 and 2008, including *The battles of Fire Support Bases Coral/Balmoral, Vietnam 1968*, released to commemorate the 40th anniversary of those battles; an updated edition of the DVA history of the Sandakan death marches *Sandakan 1942–1945;* and a new book, *Australian Light Horse*, written to commemorate the 90th anniversary of the Battle of Beersheba. The latter was designed to be the first in a new series 'Australians in World War I', which would include books on the Australian Flying Corps, the Royal Australian Navy, the Gallipoli campaign, and the experiences of Australians on the home front.[452] For primary school children, DVA in association with the Australian War Memorial, produced the highly acclaimed *M is for mates: Animals in wartime from Ajax to Zep*, which in 2010 was shortlisted for the prestigious Eve Pownall award by the Children's Book Council of Australia.[453]

Two further books were distributed to schools in 2010, both developed around the theme of love in wartime Australia. *Forever yours—Stories of wartime love and romance* contained ten true stories of love found, broken or lost against the background of war. *We'll meet again* was the accompanying guide for secondary teachers, investigating the impact of wartime romance against the social norms of the day. According to DVA, the two volumes 'have been warmly received in schools by teachers of both history and English'.[454]

There was also a growing commitment to electronic media. The website Australia's War 1939–1945 was launched in February 2004, for example, and in the following year DVA enhanced a number of its existing websites while announcing new sites dealing with the Western Front, Vietnam and post-Second World War South-East Asian conflicts.[455] The popularity of these and other commemorative websites was impressive, and in 2010 DVA reported that these sites continued to attract significant numbers. Some 22,516 people had visited the Gallipoli and the Anzacs website 295,925 times during the year, viewing 1,020,825 pages. Even more astonishing, 123,716 people had visited the Australians on the Western Front website; 158,525 had visited Australia's War 1939–1945; and 186,064 had visited Australia and the Vietnam War.[456] This sustained activity culminated in 2012–13 in the creation of the Anzac Portal, a wide-ranging online educational and community resource, designed to provide a vast array of material for teaching and research, including historical articles and publications, veterans' stories and interviews, and digital exhibitions, together with curriculum units written by teachers.[457]

One of the most intriguing features of the Anzac Portal was an online 'debate' between commentators on the Anzac tradition—historical figures as well as today's observers. Among the latter were the former Prime Ministers, Paul Keating and John Howard, and the historian Joan Beaumont. Selecting extracts from the public statements of these prominent individuals, the Anzac Portal sought

to present contrasting views of the Anzac tradition, setting them in a framework that allowed students to discuss and compare the competing opinions. For Paul Keating, the 'truth is that Gallipoli was shocking for us. Dragged into service by the imperial government in an ill-conceived and poorly executed campaign, we were cut to ribbons and dispatched'. Moreover, Keating added, 'none of it [was] in the defence of Australia. Without seeking to simplify the then bonds of empire and the implicit sense of obligation, or to diminish the bravery of our own men, we still go on as though the nation was born again or even was redeemed there'. It was, he concluded, an 'utter and complete nonsense … I have never been to Gallipoli and I never will'.[458]

In marked contrast to Keating's analysis, John Howard, speaking at Gallipoli, considered that at Anzac Cove 'the first sons of a young nation ... forged a legend whose grip on us grows tighter with each passing year ... Here they won a compelling place in the Australian story. Today we remember the 50,000 Australians who served in the Gallipoli campaign. And the more than 26,000 who fell or were wounded here'.[459] Joan Beaumont, offering an historian's perspective, argued that today the Anzac legend was 'primarily, about values and ways of imagining the national identity. These values ... are currently courage, endurance, sacrifice and mateship'. However, as she explained, these were not 'exactly the values that the original Anzacs embraced', being 'often staunch British imperialists [who] prided themselves on being effective killers—something we tend to forget today when soldiers are often depicted as victims of catastrophe and trauma'. And yet, she concluded, 'these values [courage, endurance, sacrifice, mateship] are arguably those which Australian society needs to affirm in the 21st century when, for all our materialism and rampant individualism, we still need at least some individuals to volunteer to subordinate their personal interests to the collective good'. As she put it, 'Anzac, in this sense, can validate not only the men and women of the Australian Defence Force who are the direct heirs of the legend of Gallipoli, but also the service of police officers, civil defence forces and fire fighters'.[460]

In offering these competing perspectives, DVA was acknowledging the complexity of the Anzac tradition, including its potential for sometimes heated controversy, and was concerned that students and the wider community should have access to contrasting points of view and given the tools to examine them. This, in turn, reflected a broader determination that the Anzac Centenary should be an opportunity—in the words of the Anzac Centenary Advisory Board set-up for the purpose—to encourage the active 'participation of individuals and communities', for 'community involvement in the Centenary is critical to its success'.[461] The Advisory Board had been established by the Australian Government in July 2011, on the advice of the earlier National Commission on the Commemoration of the Anzac Centenary (whose Commissioners included former Prime Ministers Malcolm Fraser and Bob Hawke), its aim being to provide strategic advice and recommendations on the planning and implementation of Anzac Centenary initiatives, not only for the centenary of the Gallipoli campaign itself but for the entire period 1914–1918. Part of the Advisory Board's task was to work closely with DVA to develop 'an encompassing, accessible and appropriate program of commemorative events and activities over the centenary period 2014–18'.[462]

Among the recommendations published by the Advisory Board in March 2013 (all of which were accepted by the government), were those relating to 'Education and Research' and 'Commemoration'. Among the former were a travelling exhibition, designed to be the 'flagship' of the Anzac Centenary; the digitisation of a sample of the repatriation records of servicemen and servicewomen from the First World War; greater emphasis on the roles of women, Indigenous Australians, and Australians from diverse cultural and linguistic backgrounds; and completion of the Australian Remembrance Trail, a partnership with local authorities and communities in France and Belgium to mark the service of Australians on the Western Front during the First World War. Among the commemorative events recommended by the Advisory Board, was a special Hands of Friendship ceremony at Gallipoli between former adversaries, to

involve New Zealand as well as Turkey as the host country.[463] An Anzac Centenary Fund, which attracted significant corporate and public donations, supported a range of major projects across Australia, from the Flame of Remembrance at the Cenotaph in Hobart to the redevelopment of Anzac Square in Brisbane. Likewise, an Anzac Centenary Local Grants program allocated $125,000 to each Federal MP to support community commemorative initiatives, from the publication of books about particular localities during the First World War to restoration of honour boards in memorial halls.[464]

By 2014–15, DVA could report that, since the Anzac Centenary period had formally commenced on 4 August 2014, after more than four years of consultation and planning, 'significant progress had been made'.[465] Among projects already completed were the opening of the National Anzac Centre in Albany, Western Australia, where the Albany Convoy commemorative event was held, marking the departure from Albany, in 1914, of the first Australian troops for the Middle East (and with the surprising news, for many Australians today, that Japan had provided a significant element of the Naval escort) . A major initiative was the Joint Historical and Archaeological Survey of the 'Anzac Area' of the Gallipoli peninsula, conducted by experts from Australia, New Zealand and Turkey, and which culminated in the authoritative book *Anzac battlefield: A Gallipoli landscape of war and memory*, published in 2016, which was gifted by DVA to every public, university and school library across Australia.[466]

Meanwhile, DVA had been working systematically towards the commemoration of the 100th anniversary of the Dawn Landing at Gallipoli. Recognising that demand from Australians to attend the Dawn Service on Anzac Day 2015 would be unprecedented, DVA departed from its usual practice and held ballots to determine the allocation of passes. In all, 10,043 people attended the Dawn Service and the New Zealand service at Chunuk Bair. The Prime Ministers of Australia and New Zealand, Tony Abbott and John Key, were in attendance, along with the Ministers for Veterans' Affairs

from both countries—Michael Ronaldson and Craig Foss—and Prince Charles and Prince Harry. The ABC and other networks televised the events and broadcast them to Australia and across the world.

The Australian government had also invited the widows of ten Australian First World War veterans to attend the 2015 commemoration at Gallipoli. As DVA reported, these 'remarkable women, each accompanied by a carer, were active participants in the day's commemorative activities'.[467] At the Dawn Service, Mrs Niki Alldritt, whose late husband Robert (Bob) Gregory Alldritt had served at Gallipoli, laid a wreath on behalf of all war widows. Similarly, at the service at Lone Pine, Mrs Ann Beasley (accompanied by her son), whose late husband Frank Beasley who had fought at the battle of Lone Pine, laid a wreath on behalf of the war widows. Reviewing the day's events, DVA concluded modestly that the department 'conducted a solemn and dignified ceremony for the 100th anniversary'.[468] Later in the year, to coincide with the 100th anniversary of the battle of Lone Pine, DVA jointly hosted the world premiere of the acclaimed *Gallipoli Symphony*, a composition ten years in the making by leading Australian, New Zealand and Turkish musicians, at the Hagia Irene inside the Topkapi Palace in Istanbul. The Australian premiere, again hosted jointly by DVA, was at the Queensland Performing Arts Centre in Brisbane on 24 November 2015.[469]

An Australian Defence Force bugler sounds the Last Post at a ceremony at the Lone Pine Memorial to the Missing to commemorate the hundredth anniversary of the Gallipoli campaign, Anzac Day 2015. *(DVA GLP_2015_99)*

Less than three years later, coinciding with the dawn service marking the hundredth anniversary of the battle of Villers-Bretonneux, came the opening of the Sir John Monash Centre, at the Australian National Memorial at Villers-Bretonneux in France, situated at the hub of the Australian Remembrance Trail linking First World War sites of significance to Australia on the former Western Front, including museums, battlefields, memorials and cemeteries. Some critics had argued that Australia's intense focus on Villers-Bretonneux had long obscured the contributions of other nations, especially France (including its colonial troops), to the significant Allied victory there in April 1918, and historian Romain Fathi saw Villers-Bretonneux as the epicentre of what he (and others) considered an exaggerated Australian military identity created in northern France.[470] Nonetheless, the Australian National Memorial

at Villers-Bretonneux was selected unreservedly for the high-point of the Australian Government's Anzac Centenary program.

The impressive interior of the interactive multimedia interpretive area in the St John Monash Centre at the Australian National Memorial at Villers-Bretonneux, opened in 2018. *(20180418 SJMC_DX_10598)*

Designed as the enduring legacy of the Anzac Centenary program, the new Sir John Monash Centre was intended to engage and educate current and future generations about the Australians who fought on the Western Front. At the Centre's heart was a large multimedia interpretative area, with a 360-degree theatre, where visitors were invited to immerse themselves in a sometimes confronting experience as they connected with the real-life stories of Australian men and women, allowing them to reflect on the emotional as well as historical significance of war on the Western Front. It was a far cry from the quiet, contemplative memorials of earlier times, but responded to contemporary twenty-first century

demands for multimedia interpretation and lived interactive experience.[471]

In the introduction to the book published by DVA to describe the new Sir John Monash Centre, it was observed that: 'In a war that was much bigger than our small nation, they were our people. And it is through their eyes, that we might begin to understand the broader context of the Great War in which they fought'.[472] It was, perhaps, a sentiment that might also stand for the wider purpose of DVA's commemorative program: to place Australia's experience of war in its global setting, a story often involving vast distances; to promote understanding of that experience among the widest possible public; and to honour the veteran community itself. It was a sentiment at the heart of the series of individual commemorative services held at Albany, Lone Pine, Fromelles, Pozieres, Polygon Wood, Beersheba and Hamel during the Anzac Centenary program; it was evident, too, at the centenary Anzac Day services at Gallipoli and Villers-Bretonnuex, as well as in the solemn commemorative events in Australia and overseas on Remembrance Day 2018, marking a hundred years to the hour since the guns fell silent in the First World War.

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[433] www.anu.edu/news/all-news/words-watch-anzackery, accessed 3 March 2019; defined as 'the use and promotion of the Anzac legend, especially in ways seen to be excessive or misguided', and thought originally to have been coined by historian Geoffrey Searle.

[434] DVA, *Annual report*, 2004–2005, p. 132.

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[464] Examples of such publication include: Don Longo (ed.), '*The ties that bind': Southern Yorke Peninsula and the Great War, 1914–1919: The war diary and letters of Private Sidney Peter King, of Koolywurtie, South Australia*, Ardrossan RSL Sub-Branch Inc., Ardrossan, 2015; and Jan Lokan (ed.), *WW1 Anzacs of the Fleurieu Peninsula: Stories from pioneer families*, Fleurieu Peninsula Family History Group, Christies Beach North, 2016.
[465] DVA, *Annual report* 2014–15, p. 104.
[466] Antonio Sagona, 'An archaeology of the Anzac battlefield', *Humanities Australia*, vol. 6, 2015, pp. 34–46; Antonio Sagona, Mithat Atabay, C.J. Mackie, Ian McGibbon and Richard Reid, *Anzac battlefield: A Gallipoli landscape of war and memory*, Cambridge University Press, Cambridge, 2016.
[467] Ibid., p. 110.
[468] Ibid.
[469] DVA, *Annual report* 2015–16, p. 87.
[470] Romain Fathi, *Our corner of the Somme: Australia at Villers-Bretonneux*, Cambridge University Press, Cambridge, 2019.
[471] In April 2019 the Commonwealth War Graves Commission noted that quiet, neatly trimmed cemeteries and serene gardens of remembrance were no longer enough to engage with a public that wanted more (see Adelaide *Advertiser*, 11 April 2019). Meanwhile, in the UK the multimedia heritage interpretation organisation *ATS Heritage* worked with a wide range of leading cultural and heritage sites of international significance, including

military sites such as Bletchley Park, the Royal Hospital Chelsea (home of the 'Chelsea Pensioner' veterans), and the Culloden Battlefield Visitor Centre, to help 'deliver extraordinary on-site visitor experiences' (ats-heritage.co.uk. accessed 11 April 2019).

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Epilogue
Transformation and beyond

Since the early 2000s, DVA had been expressing its determination to become more ‘veteran-centric’, to put ‘veterans first’, and to place veterans firmly at the centre of all its activities.[473] However, it was increasingly obvious to both DVA and the veterans themselves that reality did not always match aspirations. Despite the plethora of recent initiatives and numerous success stories, many in the veteran community considered DVA to be still too adversarial, too slow, even unresponsive, and the younger ‘fourth wave’ of veterans especially was not shy about expressing its frustrations with what it saw as an overly bureaucratic system. As the Facebook page of the Australian Gulf War Veterans ex-service organisation put it: ‘It’s time to speak up and tell Veterans Affairs we deserve better’.[474]

On occasion, such criticism burst into the public eye. An autobiographical memoir by Jacqui Lambie—Senator for Tasmania from 2014 to 2017 and re-elected in 2019—was published in 2018 and received widespread publicity. In it, she described her ten-year career in the Army, and her subsequent relationship with DVA, including a six-year legal wrangle with the department. In her interpretation of events, she ‘had lost the battle with the Department of Veterans’ Affairs (DVA)—they won, they had beat me’.[475] In later encounters with DVA she was more successful, but never deviated from her view (‘a saying within the veterans’ community’) that ‘the method DVA uses against veterans is conveyed in three simple words: delay, deny, die’.[476] Eventually, she decided that ‘the only way I could do anything about what veterans are put through at the hands of DVA was to become a politician’.[477] As a Senator, she

called for a Royal Commission into DVA, and won the backing of some elements of the veteran community.[478] The Vietnam Veterans' Federation of Australia, for example, acknowledged 'Senator Lambie's leadership in this area', and commended her efforts to the Senate Foreign Affairs Defence and Trade References Committee.[479]

The Commonwealth Ombudsman also publicly expressed concerns, voicing disquiet in July 2018 about the number of health checks mentally ill veterans were being asked to take by DVA—the process sometimes delaying their compensation claims for more than a year. At the same time, the Ombudsman noted that some veterans were struggling to find medical providers who would accept DVA scheduled fees, leaving veterans potentially out of pocket if they had to pay additional amounts up-front. Indeed, DVA had explained that, while it had the discretion to pay above the scheduled rate, it could only do so in exceptional circumstances. Based on 710 complaints received in the preceding five years, the Ombudsman reported that the most common problems related to pensions, access to health-care services, incapacity benefits, offsetting of payments and pensions, and service delivery problems. In response, DVA readily acknowledged difficulties in a number of the issues highlighted by the Ombudsman, and emphasised that it was now undertaking a root-and-branch reform 'to put veterans and families first by transforming business processes and culture, improving service options and information and redeveloping outdated ICT systems'.[480] This, in a nutshell, was an outline of the 'transformation' journey upon which DVA was already embarked.

Although the older generation of veterans generally felt well supported, younger veterans were not so sure. It was increasingly apparent that DVA's infrastructure and administrative processes had become ever more complicated and outdated, hindering rather than helping moves to become more veteran-centric. For example, by 2017 DVA had over 200 separate contact telephone numbers, with the onus on the veteran to know which one to call to access the

service he or she required. It was often difficult for veterans to seek help when they needed it; it took a long time to make a claim, and an equally long time to receive an answer. DVA's information and communication technology (ICT) systems were nearing end-of-life, no longer supported by providers and incompatible with the latest operating systems. Indeed, some ICT systems were older than the clients they served! Additionally, DVA's culture had become more risk-averse, with individuals reluctant to make decisions that might be incorrect or unwittingly set precedents, or that could be interpreted as over-generous or an unwarranted demand on the public purse.[481] It was also painfully obvious to DVA that it 'knew' only one in five veterans, and was failing to reach a full 80% of veterans in the community—individuals only becoming 'known' once they had submitted a claim. Remarkably, the Australian Defence Force was unable to inform DVA when an individual enlisted or when they left the services, the responsibility for making contact resting firmly with the veteran.

As part of its Veteran Centric Reform (VCR) program, the Department of Veterans' Affairs launched its first trial 'information point', at Australia Post's Woden outlet in Canberra, in 2017, designed to increase awareness in the community of services available for veterans and their families. *(DVA 20171208_DVA_IS_VCR_Aus_Post_323)*

Accordingly, DVA launched its entirely new program of Veteran Centric Reform (VCR) as an integral part of its radical transformation process, first mooted in 2015 by Minister for Veterans' Affairs Stuart Robert and DVA Secretary Simon Lewis. In the 2016–17 Budget, the Australian Government announced DVA's First Pass Business Case for VCR, agreeing an investment of $24.8 million to develop a Second Pass Business Case—effectively a roadmap for future change. The latter was duly approved in the 2017–18 Budget, unlocking $166.6 million to finance what was hailed as the most comprehensive plan ever conceived to overhaul DVA, a significant turning point in DVA history and a testament to the persuasive advocacy of Minister Dan Tehan and his predecessor. The core mission of DVA, however, would not change: to continue to support those who serve or have served in defence of Australia, and to commemorate their service and sacrifice.

DVA began by initiating the digitisation of veterans' files, part of an ongoing streamlining of administrative processes, as well as consulting with ex-service organisations about proposed developments. Telephony consolidation also began, with 109 inbound phone numbers decommissioned by November 2017, the first step in achieving just a single 1800 VETERAN phone line by 2019. Moreover, it was planned that the new DVA telephone system would be supported by voice-recognition technology, call-queuing capability and a postcall survey option to allow clients to comment on the service and so contribute to ongoing improvements. At the same time, DVA's website was being comprehensively redesigned, making it easier for both clients and providers to find the information they might be looking for, with re-launch of the site scheduled for 2019.[482]

Significantly, the all-important new MyService online facility was now launched as the digital 'front door' for compensation clients, enabling the average time taken to process claims (during the trial) to be

reduced from 109 days to thirty-one days.[483] In some instances, indeed, with DVA's streamlining of conditions, straight-through processing and decision-ready claims, by the summer of 2018 the time taken to process some claims via MyService could be even less than 24 hours. In its initial trial period, in early 2017, only those ADF members who had enlisted after 30 June 2004 were able to use MyService, but in subsequent months access was expanded rapidly, so that by the end of 2018, well over 40,000 veterans and their families were registered for DVA's new digital 'front door'.[484] Using MyService was remarkably simple: having registered, a client could swiftly prove his or her identity, and then, having electronically accessed his or her service history, was 'in real time' able to have some conditions related to that service accepted straight away. Based on a person's service history, up to 40 conditions could be claimed where a link to service was accepted without any further investigation by DVA—substantially reducing process time and making the experience significantly less stressful for the claimant. Moreover, all MyService users now automatically had access to a digital health card so that, for instance, a claim for free mental health treatment took only three 'clicks' to activate.[485] The latter was a very significant expansion of non-liability health care for all mental health conditions, without needing to link a specific condition to service history. It represented the latest broadening of the longstanding 'non-liability principle', the mechanism which allowed current and former members of the ADF with certain types of service to receive treatment—without having to prove that these were caused by their service—for specified medical conditions (such as cancer, tuberculosis, alcohol and substance abuse, and PTSD).[486]

Despite the apparent simplicity, the speed of decision-making, and the evident popularity of MyService, some parts of the veteran community were suspicious of the new process. The Vietnam Veterans' Federation of Australia (VVFA), for example, thought the 'DVA online portal a dangerous tool'. As it explained, while 'speeding up of the present unsatisfactory tardiness in determining veterans' compensation claims is welcome, there are "traps for young players"

for veterans completing online claims, unassisted by a trained Advocate'. In short, VVFA asserted, 'a veteran filling out the on-line forms without help from a trained Advocate, then just leaving it up to DVA to adjudicate, is allowing DVA to be both Advocate and adjudicator—not a good idea ... it is a sad fact that the goodwill of DVA cannot be relied upon'.[487] This commentary was accompanied by a cartoon showing smug DVA staff barely concealing their contempt and incredulity as they peruse a MyService application on their office PC. 'You won't believe what this guy has put in his claim!' snorts one staffer. 'What a jumble' exclaims his colleague, and another confirms that 'This will be quick and easy to reject'. With an eye to performance indicators and departmental metrics, another opines that 'A few more like this one will quickly push up our completed decisions numbers', another colleague adding 'That'll please the boss'.[488]

In the light of such wariness, DVA sought to bring the 'transformation' process closer to the veterans and veterans' family community in a series of grassroots 'client engagement workshops' and 'policy forums'. During May 2018, for example, DVA held hospital admission workshops in Canberra, Brisbane and Adelaide. The aim was for DVA to better understand the hospitalisation experience from the client perspective, as well as assisting the development of the DVA patient experience survey. In all, 58 DVA clients participated in the workshops, all of whom had experienced a recent DVA-funded hospital admission. The 'door-opening' authority of the Gold Card (which paid medical practitioners significantly above the going Medicare Benefits Scheme rates), was highly valued by all participants—'There's no doubt that the DVA Card opens doors that would not otherwise be open'—'What DVA has done for us with the Gold Card has been tremendous'—'I'm constantly amazed at how much the Gold Card is respected'—although there were some clients who were not yet fully aware of their entitlements under the Gold Card scheme. One participant had been told that s/he needed to monitor his/her blood pressure using a machine that cost nearly $200: 'I was saving up, weeks had gone by

when I ran into another veteran and he said “DVA will get that for you”. My doctor knew nothing about it. I did get it, but eight weeks later. I had no idea it was available’. Additionally, there were complaints about families not being kept informed of progress while a veteran was in hospital for an operation, about haphazard medication management, about indifferent communication between various medical professionals, and about payment systems. ‘I went through [a medical procedure] in Sydney’, explained one workshop participant, ‘I didn’t bother claiming it because the process was so convoluted. When you’ve got all the stress and trauma in front of you, you just need to focus on the treatment you’re getting’.[489]

Workshop participants also expressed ideas for improving the hospitalisation experience. Some shared positive experiences as exemplars of good practice. ‘I needed a walking stick’, explained one veteran, ‘so they rang DVA and I got the stick. It was waiting for me when I got home, leaning against the door’. Another veteran had ‘had a hip replacement and the OT [Occupational Therapist] checked my furniture: that there were no trip hazards, did I need ramps or handles or steps. They checked out the entire house to make sure it was fit. I thought that was excellent. I didn’t have to ask for it, it was part of the deal’. But there were shortcomings to be addressed —‘You can tell the factsheets are written by public servants. The language!’—‘When I got my Gold Card it came in an ordinary envelope. Your Virgin Frequent Flyer card comes with more information’—‘I had an appointment with my specialist. I walked in and they said, “We’re not doing DVA anymore because they don’t pay, goodbye”. They didn’t even ring us up’. Proactive support by DVA was especially prized and much appreciated. ‘The DVA nurse is worth 11 out of 10’, commented one participant: ‘She is really good. When she comes around, she listens and asks, “Is there anything I can do for you”’. Another veteran recalled that a ‘DVA guy used to visit me. Just to make sure that you feel that you are part of DVA. That’s really important’. Overall, participants had thought the workshops worthwhile (and suggested they should become annual events), and were especially glad of the opportunity to relate their

personal stories to DVA directly. As one veteran put it: ‘We’re their customers. One criticism that people have is that DVA staff don’t have empathy and this [workshop] is something they can do to help with that perception’.

Likewise, the Female Veterans and Veterans’ Families Policy Forum, held over two days in Canberra in June 2018, was another opportunity for DVA to engage more closely with its clientele as part of the transformation process. Building upon earlier forums in 2017, this policy forum ranged across a variety of areas, from veterans’ information and communications preferences to the idea of a Female Veteran Champion. There was, for example, a general feeling that the current DVA website was overwhelming for new clients, and that, in redesigning the website, a section aimed specifically at those approaching DVA for the first time would be extremely beneficial. There was also a feeling that too many images used in DVA communications depicted male Army veterans, wearing medals, and it was argued that imagery should become more inclusive and reflect the diversity of veterans and their families. As one policy forum critic put it: ‘What about the females? What if I don’t have medals? What if I haven’t been deployed? There was a lot of stereotyping and a lack of diversity in the visuals on the website and the posters’. There was also a call for more imaginative innovation: ‘We would love an online chat option on the website. So there’s someone there and we can just ask a quick question’.[490]

Interestingly, the policy forum was ambivalent (like some parts of the wider veteran community) about the creation of a single Female Veteran Champion, and argued instead for a Defence Women and Families Council, ideally facilitated by DVA, a mechanism for tabling, discussing and progressing key issues concerning female veterans and defence veterans’ families, to share information, and to help shape the creation and implementation of new policy. There was also much interest in the potential options for rebranding the Veterans’ and Veterans’ Families Counselling Service (VVCS), following the recent expansions of eligibility for VVCS access, and for group programs available to veterans and their families.

(Subsequently, after further consultation, the service was renamed ‘Open Arms—Veterans and Families Counselling). There was, for example, considerable discussion of the suggested ‘resilience training’ for veterans’ families proposed at an earlier forum. Such training might range from acquiring skills to manage stress to reducing anxiety through cognitive behavioural training, although there were those who found the term ‘resilience training’ inappropriate, perhaps with negative connotations for some veterans and their families. As one participant put it: ‘Resilience personalises the responsibility on the individual and sets them up to fail. It compounds feelings of isolation’.[491]

The Female Veterans and Veterans’ Families Policy Forum was established to build a strong network of female veterans. One initiative was to support the ‘By the Left’ campaign to encourage female veterans to march together in major centres across the country on Anzac Day 2017, as depicted here, designed to raise awareness of the contribution of women to the Australian Defence Force. (DVA 20171027_DVA_IS_Female_Vets_052)

Meanwhile, DVA made further progress with the transformation project. Significantly, newly implemented protocols allowed for the registration with DVA of all who joined or left the Australian Defence

Force, although there still remained an estimated 600,000 potentially entitled veterans in Australia who were ‘unknown’ to DVA because they had never submit ted a claim. At the same time, new links to ADF health data helped DVA to better understand the type of support veterans might need—the eventual aim being comprehensive knowledge of everyone who was serving or had served, and the identification of connections between service history and individual situations, especially for those ‘at risk’. There were those, however, not least the Productivity Commission (the Australian Government’s independent research and advisory body), who felt that DVA had by now taken on too much of the role that properly belonged to the Department of Defence—the logical outcome, perhaps, of the developments put in train by the *Military Rehabilitation and Compensation Act 2004.*

As the Productivity Commission put it, a ‘unique aspect of the current veteran support system is that Defence (the employer) bears no financial responsibility for the cost of compensation, rehabilitation, transition services or medical treatment for service-related injuries and illnesses once a member leaves the service’.[492] Instead, continued the Productivity Commission, ‘DVA picks up the tab. The Australian government should recognise that Defence has primary responsibility for the wellbeing of discharging Australian Defence Force members, and this responsibility may extend beyond the date of discharge’.[493] The Productivity Commission also called for simplifications in the compensation system (arguing for the elimination of the differentials between ‘warlike’, ‘non-warlike’ and ‘peacetime’ service), and recommended that schemes for rehabilitation and compensation should be focused on what the *Australian* newspaper called ‘the new face of veterans: those typically in their 20s and 30s, who have a full life outside of military service ahead of them’.[494] Ultimately, beyond the current transformation process, the Productivity Commission envisaged DVA metamorphosing into a Veterans Services Commission, with policy oversight shifting to the Department for Defence.

There were those, of course, who insisted that veterans would always want their own dedicated department.[495] But all that remained for the future to consider. For now, the transformation process continued apace, with Liz Cosson, the first-ever female Secretary of DVA, reporting enthusiastically that, for 'veterans and their families, and for all of us at DVA, 2018 has been a watershed year'. As she explained: 'We entered the second year of our transformation, introducing a range of initiatives that put veterans and their families first. Through collaboration and engagement we reached out to more than 2,100 members of the veteran community to redesign the future of DVA'.[496] Alongside the improvements in electronic communications—telephony, MyService, a new website in the making—there was also an expansion of DVA's physical network to make the department more accessible for veterans who prefer to deal face-to-face.

More generally, there was now a greater determination within DVA to understand the veteran 'ecosystem', in all its diversity, from the veteran's perspective—and this commitment was at heart of transformation. To begin with, it was argued, the complexity of the transition from service to civilian life required a more nuanced appreciation. Individuals underwent significant and often unsettling changes in personal identity as they undertook the transition, but in leaving the ADF they sought (and deserved) continuing recognition for their service. Multiple influences affected a veteran's wellbeing and lifecycle—health (mental as well as physical), family, accommodation, employment, income, relocation, ex-service organisations, interaction with DVA and other governmental agencies—and it was the task of the transformation process to engage energetically with each of these areas. It was a vision that encompassed all these 'domains of veteran wellbeing', as DVA described them, aiming to ensure for veterans and their families a healthy, productive and engaging life, with 'dignity to the last'.[497] It was a noble aspiration.

The Female Veterans and Veterans' Family Policy Forum seeks to develop solutions to the complex challenges faced by female veterans and veterans' families. Discussion topics range from health issues and impact of service life on families, to ways to support those in the veteran community experiencing domestic violence. (DVA 20180605_DVA_IS_FEMALE_Veterans_Forum_032)

473 See DVA, *Annual report* 2007–08, p. 4.

474 Facebook page, Australian Gulf War Veterans, accessed 8 November 2017.

475 Jacqui Lambie, *Rebel with a cause: You can't keep a bloody Lambie down—my story from soldier to senator and beyond,* Allen & Unwin, Sydney, 2018, p. 163. In the United States, as Ian R Gardner has pointed out to me, the usual version of this statement is: 'Delay, Deny and Hope that you Die'.

476 Ibid.

477 Ibid., p. 216.

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479 Vietnam Veterans' Federation of Australia Inc., letter to Committee Secretary, Senate Foreign Affairs Defence and Trade References Committee, 8 August 2017. I am indebted to Peter Yule for drawing my attention to this correspondence.

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[491] Ibid., pp. 16.

[492] *Australian,* 14 December 2018.

[493] Ibid.

[494] Ibid.

[495] *Yorke Peninsula Country Times, 5 February 2019.*

[496] https://www.dva.gov.au/about-dva-publications/vetaffairs/vol-34-no4-2018/news-department, accessed 25 January 2019.

[497] For detailed discussions on the transformation process, I am indebted to my meeting with Chevelle Grey, 24 October 2017; interview with Matt McKeon, VCR Transformation Project Management Office Lead, 24 October 2017; interview with Kate Pope, First Assistant Secretary Transformation and Engagement, 26 February 2017; interview with Liz Cosson, Deputy Secretary (now Secretary), and Craig Orme, Deputy President, 26 October 2017.

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The Australian

Men's Health Peer Education Magazine

The Sun Herald

The Sydney Morning Herald

Vetaffairs

MINISTERS

FOR REPATRIATION

Senator Edward Millen	1917–1920
Arthur Rogers A/g	1920–1921
Senator Edward Millen	1922–1923
No minister*	1923–1929
Frank Anstey, MP	1929–1931
John McNeill, MP	1931–1932
Charles Hawker, MP	1932
Sir Charles Marr, MP, KCVO, DSO, MC	1932–1934
Billy Hughes, MP, CH, KC	1934–1935
Joseph Lyons, MP, CH	1935
Billy Hughes, MP, CH, KC	1936–1937
Senator Harry Foll	1937–1939
Sir Eric Harrison, MP, KCMG, KCVO	1939–1940
Geoffrey Street, MP, MC	1940
Senator Sir Philip McBride, KCMG	1940
Senator George McLeay	1940–1941
Senator Herbert Collet, CMG, DSO, VD	1941
Charles Frost, MP	1941–1946
Claude Barnard, MP	1946–1949
Senator Sir Walter Cooper, MBE	1949–1960
Frederick Osborne, MP, CMG, DSC and Bar, VRD	1960–1961
Sir Reginald Swartz, MP, KBE, MBE	1961–1964
Senator Colin McKellar	1964–1969
Mac Holten, MP, CMG	1969–1972
Lance Barnard, MP, AO	1972
Senator Reg Bishop, AP	1972–1974

FOR REPATRIATION AND COMPENSATION

Senator John Wheeldon	1974–1975
Senator Don Chipp, AO	1975

FOR REPATRIATION

Kevin Newman, MP, AO	1975–1976

FOR VETERANS' AFFAIRS

Peter Durack, MP, QC	1976
Sir Vic Garland, MP, KBE	1977–1978
Evan Adermann, MP, AO	1978–1980
Senator Tony Messner, AM	1980–1983
Senator Arthur Gietzelt, AO	1983–1987
Ben Humphreys MP, AM	1987–1993
Senator John Faulkner	1993–1994
Con Sciacca, MP, AO	1994–1996
Bruce Scott, MP	1996–2001
Danna Vale, MP	2001–2004
De-Anne Kelly, MP	2004–2006
Bruce Billson, MP	2006–2007
Alan Griffin, MP	2007–2010
Warren Snowdon, MP	2010–2013
Senator Michael Ronaldson	2013–2015
Stuart Robert, MP	2015–2016
Dan Tehan, MP	2016–2017
Michael McCormack, MP	2017–2018
Darren Chester, MP	2018–

*Prime Minister Stanley Bruce chose not to have a Minister for Repatriation.

In some ministries, the portfolio of Repatriation was held jointly with another portfolio (usually Health) but there was no portfolio for Repatriation during the period 1923 to 1929; instead there were two 'ministers-in-charge' of the portfolio.

The Rt Hon. Sir Earle Page, GCMG, CH, MP (1923–1925) and Sir Neville Howse, VC, KCB, KCMG, (1925–1929)

DEPARTMENTAL EXECUTIVES

SECRETARY OF REPATRIATION/VETERANS AFFAIRS PRESIDENT* REPATRIATION COMMISSION CHAIR MILITARY REHABILITATION AND COMPENSATION COMMISSION**

Sir Nicholas Lockyer*** CBE, ISO	1917–1918
David Gilbert***	1918–1920
Senator Edward Millen (ex-officio)	1918–1920
Lt Col J M Semmens, OBE, VD	1921–1935
Sir Norman Mighell, CMG	1935–1941
John Webster (acting)	1941–1945
Major General Sir George Wootten, KBE, CB, DSO, ED	1945–1958
Brigadier Sir Frederick Chilton, CBE, DSO	1958–1970
Sir Richard Kingsland, CBE, DFC	1970–1981
Derek Volker, AO	1981–1986
Noel Tanzer, AC	1986–1989
Lionel Woodward, AO	1989–1994
Dr Allan Hawke, AC	1994–1996
Dr Neil Johnston, AO	1996–2004
Mark Sullivan, AO	2004–2008
Ian Campbell, AO, PSM	2008–2013
Simon Lewis, AO, PSM	2013–2018
Liz Cosson, AM, CSC	2018–

*Referred to as ‘Chairman’ until 1970

** From 2004

***Referred to as ‘Comptroller’

DEPUTY PRESIDENTS*, REPATRIATION COMMISSION MEMBERS, MILITARY

REHABILITATION AND COMPENSATION COMMISSION**

Heatley Gascoigne-Roy, DCM, OBE	1953–1959
Alfred Gould, OBE	1960–1963
Ralph Hurman, OBE	1963–1968
James Greenwood, OBE	1968–1974
Ron Kelly, AM	1975–1983
Jocelyn McGirr	1984–1989
Keith Lyon	1990–1999
Ian Campbell, AO, PSM	1999–2005
Ed Killesteyn, PSM	2005–2009
Shane Carmody	2009–2014
Craig Orme, DSC, AM, CSC	2014–

*Referred to as ‘Deputy Chairman’ until 1970

** From 2004

Note: It appears that prior to 1953 various state-based arrangements were in place before the position of National Deputy Chairman was established.

REPATRIATION COMMISSIONERS MEMBERS, MILITARY REHABILITATION AND COMPENSATION COMMISSION*

James Neagle	1956–1962
Charles Costello	1962–1976
Keith Medbury, OBE	1976–1981
Major General Alan Morrison, AO, DSO, MBE	1981–1989
Rear Admiral Neil Ralph, AO	1989–1995
Major General Arthur Fittock, AO	1995–1997
Major General Paul Stevens, AO	1997–2003
Rear Admiral Simon Harrington, AM	2003–2007
Brigadier William (Bill) Rolfe, AO	2007–2010
Major General Mark Kelly, AO, DSC	2010–2019
Don Spinks, AM	2019–

*From 2004

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