

Compensation and wellness: a conflict for veterans' health

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Abstract

In Australia greater attention is being given to health determinants, and the dominance of treatment in health policy and budgets is giving away some ground to prevention, health promotion, rehabilitation and disability management. This creates a dilemma for compensation systems: should the inclusion criteria be broadened to match the new thinking or should a narrower definition of "disease, injury or death" be retained? This issue is explored in the context of war syndromes among veterans. While veterans experience symptoms more frequently and more severely than military and community controls, their patterns of symptoms are not unique. Current compensation and benefit programs can create iatrogenic effects. It is concluded that compensation systems should be kept as safety nets while resources are provided to improve the capacity of primary health care caregivers, community organisations and veterans with war syndromes and their families to better deal with these problems. Adapting compensation systems to promote wellness through self-management health partnerships is one way of directing resources to individuals and their families. Action research at the community level with veterans, their families, their organisations, primary health care organisations, policy makers and researchers would allow this sector to work out the best way to apply existing efficacious tools to these modern health problems.

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IN THIS PAPER it is argued that the broadening of the conceptualisation of health creates a dilemma for compensation systems. The paper is based on a presentation given at the Festschrift to honour Professor Ken Donald, Chairman of the Repatriation Medical Authority (RMA). The RMA's role is "to determine Statements of Principles (SOPs) for any disease, injury or death that could be related to military service, based on sound medical–scientific evidence. The SOPs state those factors which 'must' or 'must as a minimum' exist to cause a particular kind of disease, injury or death".¹

For compensation systems such as the one run by the Department of Veterans' Affairs and informed by the RMA, key questions are raised. Does the compensation system extend its inclusion criteria to match the broadening definition of health? Or does the compensation system retain a narrower definition of "disease, injury or death"?

The changing conceptualisation of health

The conceptual framework for "Australia's health 2006"² illustrates how "flesh is being put on the bones" of the World Health Organization's 1948 definition of health as "physical, mental and social well being".³ In addition to illness, disease and injury, health outcomes are described as including function, disability and subjective health and greater attention is given to health determinants in society today. "Australia's health" classifies health determinants as biomedical and genetic factors, health behaviours, socio-economic factors and environmental factors.

Internationally, the Global Burden of Disease project⁴ has famously progressed from comparing the burden of illness and injury in countries to comparing the burden of common health risk

War syndromes from 1900 to present

Disorder	Short-term	Long-term
Pre 1914	Wind contusion	Soldiers heart, irritable heart
First World War	Shell shock	Shell shock/ neurasthenia, effort syndrome
Second World War	Exhaustion, battle exhaustion, flying stress	Psychoneurosis, non-ulcer dyspepsia
Korean War	Combat exhaustion	Psychoneurosis, non-ulcer dyspepsia
Vietnam	Combat fatigue	Effects of Agent Orange, delayed stress response syndrome
Post 1980	Acute stress disorder, acute stress reaction, battle shock, combat stress reaction	Post-traumatic stress disorder, Gulf War Syndrome

Adapted from Edgar Jones 2006.⁷

factors. Furthermore, the RMA has received at least one application for the development of a statement of principle for a risk factor, specifically, blood pressure.

As well, the interventions of prevention, health promotion and rehabilitation are gaining ground on treatment which has traditionally dominated health policy and budgets. The description of health promotion first described in the Ottawa Charter in 1986 has matured, although the original parameters shown below have been strikingly stable over the past two decades as follows:

- Build healthy public policy — legislation, fiscal measures, taxation and organisational change undertaken in all sectors (with an emphasis on those other than health) to improve health and equity
- Create supportive environments — a socio-ecological approach to health, incorporating safe, stimulating, satisfying work and the protection of natural and built environments
- Strengthen community action — community empowerment and development

- Develop personal skills — another name for health education
- Re-orient health services — so that they give greater emphasis to health promotion.⁵

If wellbeing is having a sense of purpose, meaning and fulfilment, experiencing positive emotions, having resilience to deal with life's difficulties and belonging to a respectful community, plus physical health,⁶ then should veterans and others who are unwell be compensated? And if not, why not?

New understanding of war syndromes

Concurrent with changes in the notion of health and how wellness can be achieved, the understanding of war syndromes is changing, particularly following the extensive research undertaken on Gulf War Syndrome. Early in 2006 an edition of the *Philosophical Transactions of the Royal Society* attempted to draw together our understanding of Gulf War Syndrome after hundreds of millions of dollars of research generating thousands of papers. The editors concluded that although we have learned a great deal about the health of Gulf War Veterans and how to manage post-deployment physical and psychological health problems, there is no definitive answer to why Gulf War Syndrome exists.⁷

One paper⁸ took an historical perspective, pointing out that specific war syndromes have occurred with every major conflict, as shown in the Box.

The authors argued that the nature of the presentations reflected the prevailing medical interests at the time. For example “soldier's heart” and “irritable heart” occurred at the beginning of the 20th century when heart disease was a subject of mainstream medical focus. Syndromes featuring “dyspepsia” occurred in the middle of the century, and since 1980 mental health symptoms have predominated.

This paper also reported on a study in which 1456 cases of war syndrome which had been compensated in the United Kingdom from 1900 to the Korean War were compared with 400

compensated veterans from the Gulf War. A cluster analysis of symptoms showed that there was no difference in the patterning of symptoms between the two groups and that three groups of symptoms had predominated consistently in war syndromes throughout the 20th century: debility cluster ($n = 847$); somatic cluster ($n = 434$) and neuropsychiatric cluster ($n = 575$).⁸

Australian research into Gulf War Syndrome yielded similar results. Australian Gulf War veterans reported symptoms more frequently and more severely when compared with matched military personnel who did not deploy to this conflict. However, the pattern of symptoms was the same for the two groups, and featured: psychophysiological distress; cognitive distress and arthromuscular distress. In other words, veterans were found to have significant burden of illness, but not due to a specific Gulf War Syndrome.⁹

Writing in the special edition of the *Philosophical Transactions*, sociologist Durodié concluded “It may be that the search for a scientific or medical solution to this issue was misguided in the first place, for the Gulf War Syndrome, if there is such an entity, appears to have much in common with other ‘illnesses of modernity’, whose roots are more socially and culturally driven than what doctors would conventionally consider to be diseases”.¹⁰

New developments in the management of syndromes

Typically, the approach to the management of patients with syndromes is to undertake repeated investigations to exclude disease and then refer to a psychiatrist or psychologist. This was confirmed in qualitative research undertaken by the Centre for Military and Veterans’ Health (CMVH) with general practitioners working for Defence and the Department of Veterans’ Affairs.¹¹ However, this treatment is unlikely to be effective and may be iatrogenic.¹²

In a recent paper, Mayou et al called for a new approach to the definition of somatoform disorders in the Diagnostic and Statistical Manual of Mental Disorders Version V (DSM V).¹³ The

authors offered the following criticisms of the current classification:

- Terminology is unacceptable to patients
- Category is inherently dualistic
- Do not form a coherent category
- Incompatible with non-Western cultures
- Ambiguity in stated exclusion criteria
- Subcategories are unreliable
- Somatoform disorders lack clearly defined thresholds
- Causes confusion in disputes over medico-legal and insurance entitlements.¹³

New interventions for the management of syndromes such as war syndromes are emerging. These are based on the practitioner establishing a good rapport with patients, focussing on improving function rather than finding and curing a disease, and sharing responsibility for health with the patient while the practitioner adopts an expert support role. A randomised controlled trial that compared a new intervention to usual treatment for all patients with medically unexplained symptoms in an American health maintenance organisation showed significantly better results.¹⁴

Patients who had had medically unexplained symptoms for over six months, and with high utilisation rates, were randomly divided into the new treatment and traditional treatment groups. The new treatment, given by a nurse practitioner, comprised methods for establishing a good relationship, and interview methods for informing about and motivating health improvements. Specific disorders were managed as appropriate, including treatment with anti-depressants, reduction in medications, physical therapies and referral to mental health services. Depression scores, disability scores and satisfaction scores were significantly higher in the new treatment group.¹⁴

It is likely that a systematic literature review would reveal a number of efficacious interventions and tools which could be applied to these complex cases in primary care in Australia. For example, much has been learned in recent years from the self-management of chronic conditions. Fortunately, most chronic symptomatology presents similar challenges. Generic, community-based self-management training for patients, care-

givers and health practitioners has been effective for a diverse range of chronic symptoms and conditions including arthritis, diabetes, headache, back pain and chronic comorbidities, and could be extended to war syndromes. Furthermore, this management approach appears ready to be upstreamed to earlier intervention¹⁵ both clinically and within communities.

New service delivery mechanisms may be required for these new interventions. Veterans with war syndromes and their families, who are often the immediate caregivers, need resources to manage these problems. Adapting compensation systems so that they provide incentives for wellness through self-management partnerships would be one way of directing resources to individuals and their families.

In veterans health, the ex-servicemen's organisations such as the Returned and Services League and the Australian Peacekeepers and Peacemakers Veterans' Association could potentially play a substantial role. A study in progress in which a self-management intervention is being applied to the issue of substance abuse among veterans has found that veteran-led groups are effective,¹⁵ and consultative research which CMVH is currently undertaking suggests that the support provided by an informal group of veterans who participate in a gym program is a positive factor in dealing with post-deployment health problems.

The Centre for Military and Veterans' Health is proposing that action research adopting both a community development model and principles of self-management, in partnership with veteran organisations, primary care providers, policy makers and researchers is needed to determine how best to use the newer tools which have been shown to be efficacious.¹⁶ There is significant potential for e-health because "compared with individual visits and group-based programs, the Internet is far less expensive and has the potential to reach many more people ... Online disease self-management can be an effective delivery method for teaching patients the skills and self-confidence they need to take charge of their chronic disease care"¹⁷ and, potentially, medically unexplained symptoms.

Implications for compensation systems

One approach to compensation in the context of the broadening conceptualisation of health would be to say, "What the heck, let's extend compensation too". It is unlikely that many people in Australia would begrudge veterans compensation for not being well when, clearly, as a group, they carry a high burden of ill health following participation in war service or humanitarian assistance. However there is growing recognition that compensation itself may contribute to poorer health outcomes.^{18,19}

A recent large prospective cohort study which investigated compensation status and long-term outcomes after injury¹⁸ found that at 12 months after injury all patients remained below their pre-injury levels of physical health while the mental health scores of non-compensated patients were similar to their pre-injury level. Irrespective of injury pattern, injury severity, access to rehabilitation services and age, no-fault compensated patients were more likely to report comparatively greater levels of physical and mental disability at twelve months and were less likely to have returned to work. While further work remains to be done, there is a growing body of research indicative of compensation systems, as they are designed today, promoting illness.

Exploration is underway in many compensation systems in different sectors, including workers and motor accident compensation, and in different countries as to whether compensation systems can be changed to provide incentives for wellness. Across the different sectors there is scope to share operational costs for this development work which would provide benefits and compensation in relation to health, welfare and a multi-dimensional approach to veteran wellness along with their families.

Conclusions

As our conceptualisation of health broadens from injury and illness to include subjective health, function, wellness and risk factors it may be better for compensation systems to be viewed as

safety nets, and retain narrow definitions of health outcomes, eg, “disease, injury or death”. At the same time resources must be provided to improve the capacity of primary health care organisations and relevant community organisations to support people with medically unexplained symptoms and to promote wellness. Individuals with medically unexplained symptoms, and their families, need resources to manage these problems too. Adapting compensation systems so that they promote wellness through self-managed care may be one way of directing resources to individuals and their families. Action research at the community level with veterans, their families, their organisations, primary health care organisations, policy makers and researchers would allow this sector to work out the best way to apply existing efficacious tools to the needs and priorities of those who have medically unexplained symptoms, their caregivers, communities and health care providers.

Competing interests

The authors declare that they have no competing interests.

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