Australian Government
Defence

Joint Standing Committee on Foreign Affairs, Defence and Trade—Defence Subcommittee

Inquiry into the Department of Defence Annual Report 2022–23

Department of Defence

Submission

February 2024

Contents

Assistance to Ukraine

Introduction

1. Australia is committed to supporting Ukraine's defence of its sovereignty and territory in the face of Russia's illegal and immoral invasion. Australia's objective, along with its partners, is to empower Ukraine to resolve this conflict on its own terms. In doing so, Australia demonstrates its commitment to upholding the rules-based international order.

2. Defence support for Ukraine is carefully balanced against other priorities, noting Defence's primary focus on the Indo-Pacific region and the ambitious objectives for Defence outlined in the Government's response to the Defence Strategic Review (DSR).

Operation KUDU

3. Operation KUDU is the overarching ADF operation in support of Ukraine. It comprises two elements:

    a. training of Ukrainian recruits in the United Kingdom (UK); and

    b. deployment of a Royal Australian Air Force (RAAF) E-7A Wedgetail early warning and control aircraft to Europe.

4. Since January 2023 the ADF has deployed four rotations of around 70 personnel to the UK to deliver training to Ukrainian 'citizen soldier' recruits. The training helps Ukrainian recruits gain the military skills required to defend their homeland, and has focused on basic infantry tactics for urban and wooded environments. Over 1,300 Ukrainian recruits have graduated from ADF-delivered training. This operation is part of a multinational program under the UK-led Operation INTERFLEX, which has seen more than 30,000 Ukrainian soldiers trained since June 2022.

5. On 14 December 2023 the Deputy Prime Minister announced an extension of Australia's commitment to the training program through to the end of 2024. The training has been expanded through the inclusion of a junior leadership program, at the request of Ukraine and the UK. This expansion has brought the number of ADF personnel deployed on each rotation to approximately 90, an increase of 20 from 2023.

6. In response to a request from the United States (US), Australia has deployed a RAAF E-7A Wedgetail aircraft to Germany for six months. Deployed in October 2023, the aircraft is integrated with Australia's partners, including the US and the North Atlantic Treaty Organisation (NATO), to provide early warning of threats against a gateway that is a vital supply line for humanitarian and military assistance to Ukraine.

7. The aircraft is operating from Ramstein Air Base, Germany. Up to 100 ADF personnel have deployed with the aircraft, comprising aircrew, maintenance, medical, logistics, and operational and administrative support personnel. ADF personnel or assets will not enter Ukraine throughout the deployment.

Materiel and financial contributions

8. Defence materiel and financial contributions to international funds make up the most significant form of support provided to Ukraine. Through Defence, Australia has provided approximately $730 million, including equipment from ADF stocks, equipment purchased from Australian defence industry and contributing funds through partners.

9. A range of equipment has been gifted from ADF stock, including:

    a. 120 Bushmaster protected mobility vehicles;

    b. six M777 155mm lightweight towed howitzers plus ammunition;

    c. 56 M113AS4 armoured vehicles and 14 special operations vehicles;

    d. 28 MAN 40M medium trucks and 14 trailers;

    e. de-mining equipment to help remove explosive ordnance littering the battlefield;

    f. anti-armour weapons and other weapons;

g. technology from Australian suppliers, including unmanned aerial systems, decoys and remote vehicles; and

h. 105mm and 155mm artillery ammunition.

10. Defence has assisted Australian defence industry to provide equipment to Ukraine through support for commercial arrangements, as well as directly procuring $52 million of equipment from industry, and providing 155mm artillery ammunition to Ukraine through a partnership with France.

11. At the onset of Russia's invasion, Australia provided $18 million to the UK's Ministry of Defence for the purchase and delivery of materiel to Ukraine; and $24.2 million to NATO's Ukraine Assistance Trust Fund to purchase and deliver fuel, medical supplies and non-lethal military equipment.

12. Defence acknowledges there is significant, sustained community interest and support for Ukraine. There is also strong interest in the type and extent of assistance Australia provides. This has included calls for additional support, including particular platforms and systems. Defence carefully assesses its assistance against Ukraine's needs and capabilities, and against potential impacts on ADF capability.

13. The Deputy Prime Minister has responded to two House of Representatives petitions to provide Ukraine with Hawkei vehicles, tanks and F/A-18 Hornet aircraft, outlining the approach on each.

Australian National Audit Office report

14. The Australian National Audit Office (ANAO) undertook an independent performance audit, *Australia's Provision of Military Assistance to Ukraine*, which was presented to Parliament on 29 June 2023.

15. The ANAO report underscored the extensive efforts Defence undertook to ensure that meaningful assistance to Ukraine is delivered promptly to best support Ukraine in defending itself.

16. The report noted that Defence moved quickly to identify appropriate options for providing military assistance to the Government of Ukraine for the Australian Government's consideration, and engaged effectively with relevant stakeholders in Australia and internationally.

17. The report did not make any recommendations. Two opportunities for improvement were identified, relating to Defence:

a. resolve, in consultation with the Department of Finance (Finance) and the Department of Foreign Affairs and Trade, issues identified in its administration of financial assistance grants provided by the Australian Government to assist the Government of Ukraine; and

b. review or evaluate its arrangements for the delivery of military assistance to the Government of Ukraine, to inform its approach to and implementation of any further assistance initiatives.

18. Defence welcomed the ANAO's constructive engagement, and has implemented the suggested opportunities for improvement by:

a. consulting with Finance to seek and receive a delegation from the Minister for Finance to the Secretary of Defence to enable the gifting of Defence property in support of Ukraine; and

b. establishing an internal consultation process to consider and implement current and future Ukraine gifting.

Defence Health System

Introduction

19. This section will describe the Defence Health System (DHS), garrison health services, and, considering the geostrategic environment as articulated in the DSR, the operational health services.

20. Health services are provided to approximately 60,000 permanent members of the ADF (Service Category 6 and 7) and 25,000 Reserve/Part time members of the ADF (Service Category 3 and 5). Members in Service Category 3 and receive health care in connection with their duties, such as when they are on exercise, deployed or undertaking full time service.

21. Defence manages a health system to enable the Defence mission, in accordance with the requirement of the Defence Regulation 2016, which provides (inter alia):

    The Commonwealth must arrange provision to a member of the Defence Force rendering continuous full time service of medical and dental treatment necessary to keep the member fit for the performance of the member's duties.[1]

22. This includes supporting ADF personnel and commanders in preventing, treating and rehabilitating illness and injury.

23. The DHS is described in health policy and in governance agreements with the Royal Australian Army (Army), the Royal Australian Navy (Navy) and the Royal Australian Air Force (Air Force) (the Services), Joint Operations Command (JOC) and other stakeholders. It represents a collaborative system of health consumers (Defence members), the Services, JOC, health providers and other stakeholders. Health care is delivered in multiple locations and contexts.

24. Defence administers the health system through Command instruments, committee charters and administrative policy, which is largely contained in the Defence Health Manual (DHM). The DHM broadly defines eligibility for health care as:

    1.6 For Defence members in Service Category 6 and 7 and those on Service Option C, Defence will normally fully fund the clinically relevant health services that are required to:

    a. *keep Defence members fit from a health perspective to perform their military duties;*
    b. *maintain or achieve the medical and physical standards required by the Military Personnel Policy Manual;*[2]
    c. *reduce the risk of deterioration of health of a Defence member while deployed;*
    d. *where possible, restore an ill or injured Defence member to a level of health enabling them to meet the inherent requirements for Defence service;*
    e. *provide treatment and rehabilitation for illness, injury or health conditions.*[3]

25. The health services provided to Defence members are at a minimum the same ones all Australians are eligible to receive through Medicare, the Pharmaceutical Benefits Scheme, Primary Health Networks and state and territory health departments, but are invariably greater in scope because of the higher requirement to maintain fitness for duty in the military context.

26. While the health service delivery model is appropriately primary care led, there is an occupational medicine component to all interactions between Defence members and their clinical providers that takes into account the complex needs of the individual and their employment in the military.

27. In addition to the day-to-day health needs of Defence members, when deployed on operations or exercises, health services are provided by embedded/deployed health practitioners in formed health units, or in collaboration with allies and partners, and detailed in the health support order for that

[1] Defence Regulation 2016, section 49 (1)
[2] Defence Military Personnel Policy Manual (MILPERSMAN)
[3] Defence Health Manual Vol 1 Part 4 Chapter 1: Eligibility for Defence Health Care

activity. This means that mission-focussed, highly responsive operational health care is provided when Defence members are deployed domestically and overseas.

28. The authority for health service delivery across the Defence Force, regardless of the chain of command in which health care may be provided, is a two star position: the Surgeon General of the ADF (SGADF). SGADF is also appointed Commander Joint Health (CJHLTH), responsible for the command of Joint Health Command (JHC) and command of health effects delivered in the Garrison environment. SGADF is also appointed as the Learning Management Authority for the purposes of training and education of ADF health professionals.

29. In addition to the direct delivery of clinical care JHC is accountable for:

    a. leading and coordinating strategic health effects;

    b. guiding investment within joint capability priorities;

    c. shaping health capability development;

    d. providing appropriate compliance, assurance and performance management oversight of Defence's health systems; and

    e. managing health initiatives and health research.

Description of the Defence Health System

Defence Health System Philosophy

30. The Commonwealth has regulatory responsibilities to provide necessary medical and dental care to Defence members. The Defence Health System (DHS) is the vehicle through which this is achieved.

31. Defence members are required to maintain medical and dental fitness to perform their military duties. To facilitate this, Defence provides a comprehensive range of health services with eligibility benchmarked with Australian community standards. Health care is provided to Defence members as a condition of service and members are not required to pay out of pocket expenses. The provision of appropriate and timely healthcare is prioritised based on the assessed clinical need and in some instances operational considerations, rather than cost.

32. Defence provides health care planning and treatment for all injuries and illnesses regardless of whether or not they are directly resulting from service in the ADF.

33. The DHS consists of a number of organisations within Defence, and links to the Australian civilian health system to form a network that provides care to Defence members within Australia and around the world.

Joint Health Command – Delivery of Garrison health services and health advice

34. JHC was established by a decision of the Chiefs of Services Committee in 2008 to provide strategic leadership of the DHS and to unify the delivery of garrison health services. It is a divisional-level organisation within the Military Personnel Organisation (MPO) of Defence People Group (DPG). As the steward of the DHS, JHC enables the Integrated Force to persistently support and sustain operations. In executing its mission, JHC has broad accountabilities beyond those expected of a civilian health service organisation. JHC also has developed relationships with allies and partners to support interoperability and the sharing of lessons learnt.

35. CJHLTH, Rear Admiral Sonya Bennett AM, is supported by four full-time one star ADF Officers and a Band 1 SES Officer. Recently, three part-time (Reserve) one star appointments were made as Principal Consultants to the Surgeon General. The Reserves are eminent professionals that will provide clinical, academic and technical advice on matters including military trauma, force protection, and mental health.

36. Garrison Health Branch within JHC is responsible for delivering garrison health services to the ADF. This is achieved through a headquarters in Canberra, eight regional Joint Health Units and 50 health facilities nationally.

Joint Health Command ADF / APS workforce

37. The JHC workforce is an integrated workforce comprising Defence members, APS employees and contractors. Table 1 shows the ADF (across Service Categories) and APS (including non-ongoing) workforce headcount as at 7 December 2023. The figures do not include contractors.

Table 1: ADF and APS workforce headcount by branch in JHC.

Branch	APS	ADF SERCAT 6/7	ADF SERCAT 5	ADF SERCAT 3	Total
Garrison Health	284	287	23	39	633
Health Business and Plans	52	3	1	4	60
Health Protection and Policy	43	12	21	18	94
Operational Health	28	42	23	13	106
Office of CJHLTH	9	8	4	3	24
TOTAL	***416***	***352***	***72***	***77***	***917***

Joint Operations Command – Deployed/operational health

38. JOC is a Group in Defence led by a three star Officer who commands ADF operations. Health staff in JOC, led by the Director Health (an O6 Medical Officer), develop Health Support Orders. Health Support Orders are used by Commander Joint Operations (CJOPS), who is responsible for commanding the health effect on deployed operations.

39. Planning for health services during operations requires detailed consideration of health intelligence, mission analysis, and development of a scheme of manoeuvre which may include allies and partners. Operational health doctrine is aligned with partners to achieve interoperability, including systems, for reporting casualties, and nomenclature of health facilities deployed in the theatre of operations.

40. Health personnel deployed on operations are almost always Force Assigned to JOC by the Services. There is a reliance on health professionals from the ADF Service Category 5 and 3 (Reserve/part-time) component, particularly specialist medical and nursing professionals. These professionals necessarily maintain their scope of clinical practice (credentialing, competency and currency) relevant to their discipline in the public health system or private practice and, in partnership with the civilian sector, are released for duty in the ADF when required.

41. Defence also maintains a small group of permanent force specialist medical practitioners to support very short notice requirements.

Navy, Army and Air Force – medical personnel and health units

42. The Navy, Army and Air Force raise, train and sustain health forces and provide formed health units to operations. In current doctrine, when deployed on named Defence operations health units are assigned, individually and collectively, to JOC under theatre command of CJOPS.

43. Each Service has a one star officer dual-hatted in a JHC appointment, and an O6 Officer designated as the Service Director of Health. These Officers provide Service-specific technical advice and leadership to, and on behalf of, their Service Chief.

44. There is considerable emphasis on integration of health effects such that they are the same by default, similar by exception and only different by necessity.

45. Health personnel posted to Service units are able to practice professionally in JHC facilities, and also frequently work in civilian facilities to maintain their professional skills and networks.

ADF uniformed health workforce

46. The ADF health workforce consists of around 1,941 Service Category 7 and 6 personnel (full-time) and 1,775 Service Category 5 and 3 personnel (Reserve/part-time). The majority of these individuals are posted to positions in the Services.

47. A detailed breakdown of the ADF workforce is available at Appendix 1: ADF Workforce – Service Category 7 and 6 – (Permanent) and Appendix 2: ADF Workforce – Service Category 5 and 3 (Reserve/Part time).

Mental health and wellbeing

48. Mental health and wellbeing is a key focus of the DHS. JHC provides best-practice mental health screening, prevention, diagnosis and treatment for Defence members through clinical service delivery to Defence members by mental health professionals in both Garrison, off-base and on operations.

49. JHC is also responsible for mental health policy development and providing mental health subject matter expert advice related to the management of Defence members. JHC works closely with the newly established Mental Health and Wellbeing Branch (MHWB) in DPG to ensure alignment with the wider Defence focus on general mental health and wellbeing, including Defence's suicide prevention program.

50. MHWB aim to enhance workforce performance, improve organisational resilience and support units and individuals from a predominately non-clinical perspective when needed. MHWB support JHC by developing and leveraging broader organisational workforce factors (i.e. policies, processes, people and programs) that contribute to individual and collective mental health and wellbeing.

Defence Health System governance and assurance

Overview

51. The approach to DHS assurance and by extension, assurance of health capability, requires a broad view of the systems complexity and of the levers available to govern it.

52. The ADF Health Select Committee (HSC) is accountable for the performance of the DHS. Co-chaired by the Chief of Personnel and Deputy Secretary Defence People, the HSC was established in 2021 as a select committee of the Defence People Committee, to bring together all Command elements and stakeholders (at the Band 2/two star level) to unify strategic decision making about the DHS. The HSC must be assured that the DHS is functioning as intended in order to enable military capability and prioritise the allocation of resources. The capstone document guiding health service planning and delivery is the ADF Health Strategy.

53. SGADF is responsible for maintenance of appropriate standards of patient care and safety in the delivery of health services – across the Defence enterprise – throughout the lifetime of the ADF member from recruitment to transition out of Defence. This accountability for clinical governance takes into account the different operating contexts including deployed, garrison and civilian partnerships.

54. JHC has developed a health assurance framework, based on the Fundamental Inputs to Capability (FIC). The health assurance framework continues to be further refined to measure the health system effect.

Joint Health Command governance structure

55. JHC has established a clinical and corporate governance framework, to provide safety and quality assurance to SGADF/CJHLTH. The hierarchy of this system includes:

    a. ADF Health Strategy. The ADF Health Strategy provides a roadmap to ensure Defence has the capability to meet the health needs of current and future warfighting, and of members as they transition to civilian life. The ADF Health Strategy enables Defence to build a ready, responsive and resilient Health System, with the agility to respond to the changing operational environment.

    b. Service Level Charter. The Health Service Level Charter guides the partnering arrangement between the Services, JOC and DPG, including communication, decision-making and workforce management. It is supported by the garrison health support arrangements, workforce business rules, relationship management and a performance management framework.

c. **Health policy framework.** ADF and JHC health policy supports the implementation of strategic Defence goals and provides guidance and direction as it applies to healthcare in Defence. Health policy instruments provide the authoritative statement of the principles, mandatory requirements and procedures for health services and support in the Defence context.

d. **Joint Health Command Executive Board**. The top-level governance committee of JHC, chaired by Commander Joint Health and reporting to the HSC.

e. **Organisational structure.** All persons working in the health system have a responsibility for the quality of care provided. Responsibilities are defined by position descriptions and duty statements, along with roles and responsibilities defined by committee membership and professional affiliations.

f. **Clinical Governance Committee structure.** Local, regional, operational and national level clinical governance committees oversee clinical governance initiatives and performance. At its peak, the ADF Health Quality and Safety Board.

g. **Performance Indicator Framework (PIF).** The Joint Health Command Performance Indicator Framework report was developed in 2012 and has transformed as Defence's approach to health informatics has matured. The PIF encourages comparison of performance in significant areas of health to stimulate quality improvement and is coordinated through clinical governance committees. It has transitioned to more robust reporting using data extracted from the electronic health record system to inform the services and identify areas for improvement.

h. **Communication Strategy.** A variety of communication methods are used, including the JHC and single Service health websites, to ensure ease of access to information, face-to-face communication with Health staff, use of electronic tools to receive and distribute information and use of formal communication templates to document and communicate relevant information effectively.

i. **Clinical components.** At the clinical level there are a suite of activities/systems that identify issues with clinical care. These include but are not limited to:

   i. peer support, supervision and review;

   ii. clinical audit (routine and ad hoc);

   iii. KPI monitoring and management;

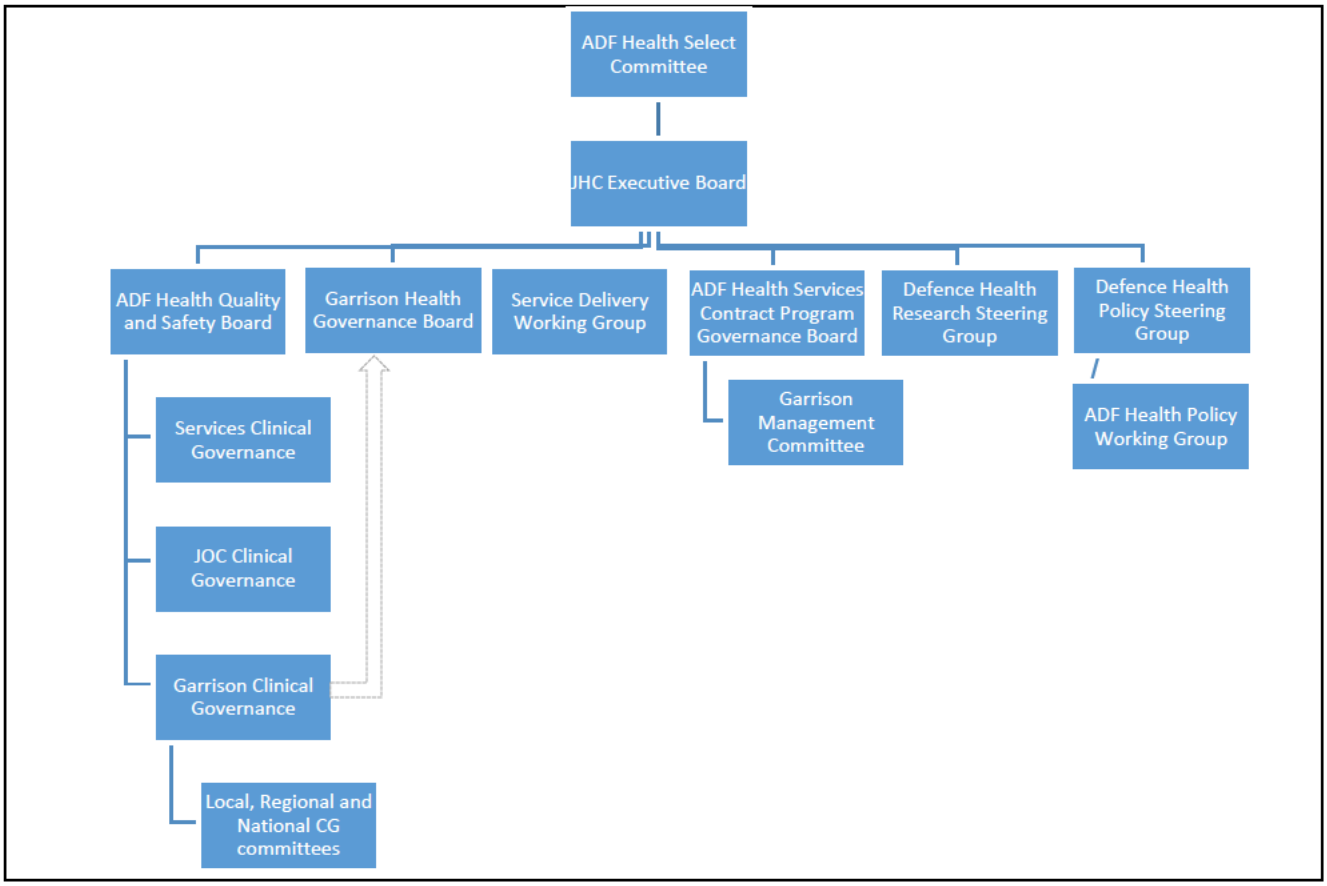
   iv. clinical incident and near miss reporting, monitoring and management including complaints and compliments;

   v. defined Severity Assessment Code incident management process; and

   vi. documentation of Quality Improvement and the outcomes achieved.

56. Figure 1 illustrates the committee architecture in JHC.

Figure 1: Committee Architecture within JHC Joint Health Command



Defence Force Recruiting – ADF health entry standards

57. Defence Force Recruiting Branch (DFR) is part of the MPO in DPG. DFR maintains a staff of health professionals who assure health policy standards for applicants proceeding through the recruitment process. The delivery of health assessments is conducted by the prime recruitment services contractor, Adecco, and their subcontractor, Sonic Healthcare.

58. Health policy standard are contained in the Defence health policy. The aim of the medical examination of candidates is to determine medical fitness for service in the ADF. There are medical conditions, which allow an individual to be physically fit in terms of their functional capacity for a particular workplace, but which do not satisfy the medical fitness requirements for ADF operational or training conditions. This distinction is important when assessing a candidate's suitability for military service. DFR adopts a principle-based decision-making approach encouraging contemporary medical evidence, risk based assessments, and the exercising of clinical acumen to make medical determinations at the earliest possible time rather than following the prescriptive standards on low risk medical conditions.

59. The medical aspects of processing candidates for entry into the ADF involve both administrative and clinical procedures. While the prescribed components of medical testing are mandated, the order in which they occur within the recruiting service delivery model can be amended. Determining the medical fitness of a candidate is done by conducting the following assessments:

a. Medical Health Questionnaire split into Part A and Part B;

b. Entry Level Medical Examination;

c. Pre-Enlistment Check; and

d. Medical Attestation Examination.

60. Each Service has unique medical requirements that need to be considered to assess a candidate's suitability (e.g. seagoing service, combatant duties, aviation environment).

61. The move to the space and cyber domains necessitated consideration of whether Defence's recruiting medical standards, as they apply to different military roles/occupations, remains fit-for-purpose. Considerable work has been done and updates to musculoskeletal and mental health standards have already been made. A case example of ongoing work is detailed below.

Case example: Medical Entry Requirements Reform Project

62. The Medical Entry Requirements Reform Project (the Project) is a recruitment initiative established under the DSR to address the 'workforce' recommendation that:

"options should be developed to change the policy and risk settings to improve the achievement of recruitment targets by 2024."

63. The Project is revising the ADF's medical entry standards to allow for increased opportunity to recruit from the general population based on nature of the role and environment employed in. The current recruiting medical standards are being reviewed based on a 'one size fits all' approach, with exceptions approved only through an individualised waiver process. The waiver system is in place to allow the entry of candidates who do not meet entry level medical standards but who may represent an acceptable risk to the ADF. Waivers are designed to provide some flexibility when dealing with medical standards to maximally benefit the candidate and the ADF. Irrespective of the waiver system the current medical assessment framework and policy does not allow for the diversity of current and expected job roles likely to be required to meet the intent of the DSR.

64. The reform will allow for a more occupationally-based approach to medical entry standards to be taken. Policy on assessment and acceptance of candidates will be based on endorsed Service-specific requirements, and will complement an occupationally based ADF workforce design.

65. This approach will establish medical standards in a stratified manner, in accordance with expected job role and individualised medical risk. It will facilitate appropriate and timely decisions being made by DFR without requiring individual waivers based on a single entry standard for all ADF personnel.

Garrison health

Defence health service delivery

66. The routine delivery of health services to Defence members both in Australia, and when posted overseas for non-operational roles is facilitated through a Garrison health system, which combines on-base and off-base services to provide holistic, end-to-end health care to Defence members.

67. Defence provides most primary health care from on-base Garrison health facilities located within close proximity to members, on Defence establishments across Australia. Garrison health facilities deliver a multidisciplinary health system that includes primary health care services such as preventive health, general practitioner, nursing, occupational medicine, dental, mental health, occupational and clinical psychology, pharmacy, physiotherapy, pathology specimen collection and occupational rehabilitation. In some areas, Garrison health also provides low-acuity inpatient care.

68. Garrison health centres provide a dedicated walk-in clinic for unscheduled care, known as 'sick parade' to ensure urgent or emergent healthcare is provided on the same day. This service is available in all Defence health centres and typically comprises a multidisciplinary team of health professionals. This approach promotes acute care planning and, when necessary, the commencement of clinical rehabilitation through early intervention and accelerated access to care.

69. Defence members can also access telephone-based triage and health advice, 24 hours a day, 7 days a week. This service is staffed by registered health professionals who can access Defence members' health records in real time.

70. Defence provides access to specialised services through an off-base contracted network of health providers. Off-base specialised services include medical and dental specialists; hospital admissions;

allied health services; optometry; imaging and radiology; and pathology. Garrison Health staff coordinate care, administration and record keeping to integrate on-base and off-base services.

71. In addition to the provision of routine healthcare the DHS enables the ADF to support and sustain operational capability through the health assurance of Defence members. This occupational aspect contextualises individual healthcare with command-focussed operational capability requirements. Occupational health services include:

    a. screening for specialist occupational groups in Defence such as aviators, divers and submariners;

    b. pre and post deployment screening; and

    c. advice to commanders and managers of Defence members on the impact of their health conditions on their service, including occupational restrictions.

72. Defence also delivers preventive screening to manage a range of occupational exposures (such as fuel, asbestos, industrial chemicals and noise).

Garrison health workforce composition

73. The Garrison health workforce is comprised of ADF, APS and Contracted Health Professionals (CHP). This workforce model enables multi-discipline healthcare across a national system.

74. ADF staff provide military health leadership, and the occupational and operational knowledge and experience which supports individual and organisational needs. ADF health staff employed within the Garrison health system develop and maintain their clinical, administration and logistics skills to support their health professional mastery when subsequently deployed on operational service.

75. APS Garrison health staff complement the ADF health workforce by providing stable and consistent care and clinical and corporate governance, within and across the Garrison system over the longer term. They provide the system continuity to as a balance to the ADF posting cycle or deployments.

76. The CHP workforce provides the consistent, reliable and stable clinical treatment platform upon which healthcare is delivered to all Defence members nationally. CHPs deliver the majority of frontline clinical services and transactional administration. With a headcount of around 1,355 the CHP make up approximately two-thirds of the Garrison health system workforce. The CHP workforce structure and composition can be altered under the provisions of the contract to meet changing service delivery requirements (such as short and long-term changes to the ADF dependency in a particular location).

77. The scenarios in Figure 2 show Defence member engagement with Garrison health over a 12 month period from October 2022 and September 2023 and on an average day.

Figure 2: Defence Member engagement with Garrison health

In the 12 months between October 2022 and September 2023, at Garrison health facilities, permanent Defence members:

- Attended 1.1 million walk-in and scheduled appointments.
- Had, on average, six walk-in or scheduled appointments with a Medical Officer.
- Had, on average, seven walk-in or scheduled appointments with a Nurse or Medic.

Of the permanent Defence members who accessed healthcare at Garrison Health facilities during this time:

- 82 per cent had at least one walk-in or scheduled appointment with a Medical Officer.
- 88 per cent had at least one walk-in or scheduled appointment with a Nurse or Medic.

On an average day Garrison Health:

- provides over 1,600 general practice services;
- initiates more than 500 specialist referrals;
- completes 1,900 individual pathology tests; and
- completes over 400 imaging services.

Deployable health

78. The ADF provides health support to joint, maritime, land and air forces conducting military operations. Support is required by day or night and under any climatic or topographic conditions. Health practitioners are often required to practice in the most austere circumstances, such as in the field, in tented or temporary facilities, ship sick bays or a variety of air platforms. The command arrangements and planning for such deployments have been described above. In all instances, health support to operations is planned and task-organised based on the unique circumstances of the operation, including host-nation and partner services that may be available and the requirements of the supported force. It takes into consideration risk due to numbers of personnel, geographic, topographic, climatic or operational factors, and limitations on casualty evacuation.

Roles of health care

79. The term 'role' is used in Western military doctrine and is described in NATO documents.[4] It relates to the stratification of tiers in which health support is organised, based on function, not facility type. Aligning nomenclature with key allies and partners is critical to interoperability.

80. Role 1 (R1) is integral to a ship, land-based unit or forward operating airbase. R1 provides basic primary health care, specialised first aid, triage, resuscitation, stabilisation and preparation for casualty evacuation. It provides routine sick parade and manages minor wounded, ill and injured personnel for immediate return to duty. R1 is also capable of basic occupational and environmental health advice to supplement measures taken by individuals and commanders. Depending on operational requirements, R1 facilities may be supplemented with limited casualty holding, basic primary dental care, basic laboratory testing, a psychological support team, underwater medicine support and/or aero-medical evacuation (AME) capability.

81. Role 2 (R2) provides extended primary health care and emergency healthcare services. In addition to R1 capability it receives and triages casualties, provides medical officer-led resuscitation and stabilisation, has limited casualty holding with nursing support, psychological first aid and triage of psychological casualties. In the land and air environment an R2 health facility also has basic imaging, a field laboratory and primary dental support. R2 generally has force health protection capabilities including disease outbreak investigation. It also has a health materiel capability and an administration capability for health records maintenance and casualty tracking. In the land environment R2 includes integrated pest management, vector control programs, and water, air, soil and chemical analysis.

82. R2 can be supplemented with a light surgery capability to provide surgery and basic post-operative care for short-term management of casualties until they are evacuated. Supplementation can also include aviation medicine, AME, additional inpatient nursing care, environmental health, medical imaging, pathology, pharmacy, operational stress management, and casualty evacuation coordination.

[4] NATO Logistics Handbook, Chapter 16: Medical Support

83. Role 2 Enhanced (R2E) deployable capability provides basic hospital care. It is designed for acute treatment, but not for lengthy subsequent treatment to full recovery. It is capable of basic secondary health care and provides:

    a. damage control resuscitation, damage control surgery and primary surgery (trauma and orthopaedic);

    b. surgical and medical intensive care;

    c. medium and low dependency beds with nursing support;

    d. rotary wing AME with trauma retrieval teams;

    e. allied health services, including pharmacy, pathology, physiotherapy, blood services and advanced diagnostic imaging;

    f. extended primary medical and dental care;

    g. occupational and environmental health support;

    h. operational mental health support and force extraction psychological;

    i. screening; and

    j. health materiel and health administration.

84. R2E capabilities are scalable and modular. Typically, R2E can provide a capability ranging from one to two resuscitation bays, one to four operating theatres, two to eight intensive care beds, and up to sixty ward beds. The R2E can be supplemented with specialist modules as required. An R2E health facility may be deployed as a small hospital or secondary health care hub.

85. While the ADF does not presently deploy complete Role 3 and above capabilities, a number of specialists capable of working in coalition facilities at this level serve, mostly in the Service Category 5 and 3 workforce (Reserve/part-time). Many of these individuals have deployed on coalition operations in recent years.

Deployable Health Capability Project (Joint Project 2060 Phase 3)

86. Joint Project 2060 Phase 3 (JP 2060-3) is a transformative project to update deployable health capability to provide modern, deployable, scalable systems and equipment for combat health services delivered by Army and Air Force, across a 15-year lifespan. At its centre is a complete renewal of health equipment from forward care through to theatre level hospital care, including training systems to support our health professionals as they perform their duties.

87. In September 2020 two contracts for the provision of JP 2060-3, one for acquisition and one for sustainment, were awarded to Saab Australia. The contracts are valued at approximately $370 million (GST inclusive). Initial Materiel Release (IMR) was achieved in May 2023 and Final Operational Capability (FOC) is expected to be achieved in 2025. Defence intends to bring Navy into the sustainment contract after FOC in 2025 with the aim of maximising commonality of materiel support where prudent to do so.

88. Under the contracts Saab has established a deployable health capability support centre, as a contractor-furnished facility in the vicinity of Amberley, to support the Defence deployable health capability. The facility will provide warehousing, maintenance, training and supply support to the new deployable health capability.

Innovation, science and technology

89. JHC and the Defence Science and Technology Group (DSTG) are leading collaboration for health innovation, science and technology (IS&T) through engagement with stakeholders including academia and industry. IS&T is a critical and asymmetric enabler to manage critical gaps and deliver health networks that can deliver persistent support and sustainment for operations.

90. Consideration will be given to fit-for-purpose delivery mechanisms, including whole-of-government and international opportunities; and identify potential funding options and transition-into-service pathways.

The Australian Defence Force Health Services Contract

Overview

91. Under the ADF Health Services Contract (the Contract), Bupa Pty Ltd (Bupa) is contracted to provide clinical health services to current Defence members. The purpose of the Contract is to deliver a suite of health services to members of the ADF to maintain an acceptable level of health, fitness and wellbeing. Services include:

    a. an integrated contracted health professional workforce (CHP);

    b. access to medical advice, triage and referrals (including providing mental health risk assessments) 24 hours a day, seven days a week;

    c. access to a broad range of specialised services;

    d. an appointment and booking system and/or service;

    e. imaging and radiology services;

    f. pathology services; and

    g. occupational rehabilitation services.

92. Through the Contract Defence provides access to a range of specialised services off-base. Where required access to specialised services may be provided by alternate means such as on-base clinics using a fly-in fly-out arrangement, for example, dermatology services. This supports access to services in geographically isolated areas or where there is no 'local' access to these service. Telehealth is also an option where clinically appropriate.

93. As at December 2023 approximately 1,355 CHPs and support staff were providing services on-base.

94. The Contract has mechanisms to manage a surge in demand for health support. For example the:

    a. 2019–20 black summer bushfires which saw an additional 3,500 hours of un-rostered health professional hours delivered in support of Operation Bushfire Assist; and

    b. COVID-19 pandemic which saw the release of contracted health professionals to assist vaccination delivery teams in aged care facilities and support Defence quarantine and testing activities.

95. The contract with Bupa is for an initial period of six years (2019–20 to 2024–25), and a maximum of 10 years from the operative date.

96. The current expiry date for the Contract is 30 June.

Performance Management Framework

97. The Contract has a robust Performance Management Framework (PMF) designed to measure and assess Bupa's achievement and performance against its contractual requirements. Bupa's achieved performance against the PMF to date demonstrates there are opportunities for improvement.

98. The PMF has been in effect since the Contract operational date (1 July 2019). The PMF sets out:

    a. Performance measures. Performance measures are detailed in Appendix 3.

    b. Performance payments. Bupa's entitlement to performance payments is subject to its performance against the KPIs in the Contract. For example, Enterprise KPI (EKPI) incentive payments and retention of At Risk amounts against achievement of Contract KPI (CKPI) fill rates.

    c. Performance reporting. For example a quarterly Contract Status Report is provided by Bupa and addresses broad performance against contract outcomes, not just what is detailed in the PMF.

    d. Performance reviews and assessments. Performance Assessment Reviews commenced in December 2023 to ensure improved monitoring of service delivered, performance outcomes, management of shortfalls, and to consider factors reported in the Contract Status Report, including problems, opportunities and risks.

99. A review of the PMF undertaken by Ernst and Young (EY) in 2021 found the framework was fit-for-purpose though complex. EY suggested changes could be made to the PMF to ensure it effectively supports achievement of Defence outcomes and promotes the right behaviours for a long term, collaborative and transparent approach to delivering the Services.

100. The ANAO Auditor-General's Report No 24 2022-23 found Defence has a fit-for-purpose performance management framework in the contract, however implementation is partly effective. Defence, in consultation with Bupa, has completed review of the PMF; executive agreement and sign off is anticipated by March 2024.

Case Study: The integrated contract health practitioner workforce

101. The Commonwealth continues to partner with Bupa and its subcontractors to identify and implement improvement initiatives aimed at ensuring Defence CHP staffing requirements are met. A number of factors have contributed to the challenges of meeting the Defence health contracted workforce requirements including:

    a. national workforce shortages across the health care sector; and

    b. longer term effects of COVID-19, which include, for example, the contractor's ability to secure a back-up workforce to fill vacancies within Defence health facilities on an ongoing basis.

102. The Commonwealth supports and monitors Bupa's initiatives to meet CHP fill requirements. These include:

    a. a weekly review of national position fill rate including identification of clinical and service delivery risks. This contributes to greater accuracy and integrity of risk mitigation;

    b. Bupa's simplified recruitment process, which contributes to a smoother transition for newly employed professionals joining the Defence health workforce within Defence health facilities;

    c. identification of perceived recruitment gaps to assist in providing more targeted recruitment advertising;

    d. the engagement of third party employment agencies;

    e. improving communications between all Defence stakeholders and Bupa to ensure efficient and effective workforce management;

    f. site visits to health facilities to support region-specific understanding of the issues that may be affecting day-to-day service delivery; and

    g. a review of position descriptions to identify elements of their roles that could be amended to improve recruitment opportunities, while ensuring the quality and professional credentialing requirements under the Contract continue to be met.

103. During 2022-23 and start of 2023-24 (July 2022 to October 2023) the fill rate outcomes, while indicating a marginal improvement, remain mostly below contracted requirements. As at December 2023 Bupa has been requested to provide two remediation plans to address these gaps in performance.

The Auditor-General's report No 24 of 2022-23

104. The ANAO released Auditor-General's Report No 24 of 2022-23 on 23 May 2023 as part of an ongoing program of work to examine aspects of the Department of Defence's contract management and administration.[5]

105. The objective of the audit was to assess whether Defence is managing the ADF Health Services Contract to achieve efficient and effective delivery of the contracted services. The ANAO's key findings focussed on contract governance arrangements, performance monitoring, evaluation and reporting, and cost and service delivery efficiencies of the Contract.

[5] Defence's Management of the Delivery of Health Services to the Australian Defence Force | Australian National Audit Office (ANAO)

106. The Report concluded that:

    a. *Defence's management of the ADF health services contract to achieve efficient and effective delivery of the contracted services is partly effective.*

    b. *Defence has developed largely fit for purpose contract governance arrangements, however the implementation of contracted requirements is partly effective.*

    c. *Defence has a fit for purpose performance management framework in the contract, however implementation is partly effective and Defence has not managed the contract to ensure that the full suite of performance measures, and all review and assessment processes, have been fully implemented in line with contract requirements.*

    d. *Performance measurement and assessment arrangements are not fully functioning and Defence is not well placed to provide assurance that services are being delivered effectively against the contracted requirements. Key arrangements and initiatives to drive and monitor benefits realisation have not been fully implemented and Defence is not able to demonstrate that the expected cost and service delivery efficiencies under the contract have been realised.*

107. The Report made four recommendations and identified one area for improvement. All were accepted by Defence:

    a. ***Recommendation 1**. Defence will ensure all record keeping requirements are complied with.*

    b. ***Recommendation 2**. Defence will develop and implement an assessment and authorisation framework and update existing standard operating procedures to ensure further oversight of the handling of contract change proposals.*

    c. ***Recommendation 3**. Defence notes the recommendation aligns with a current body of work to streamline the accreditation process. Defence advises the assessment of the system in question relating to the audit has been completed and the delegate has accepted the residual risk. This recommendation and associated reporting is being managed by CIOG.*

    d. ***Recommendation 4**. Defence will establish a project team to implement the benefits realisation management plan and will establish appropriate governance arrangements to monitor and report on benefits realisation.*

    e. ***Area for Improvement** Defence review its arrangements for seeking assurance that the controls and mitigation activities identified to manage risk, and reported in the risk register, have been implemented and are effective.*

108. Work is underway to address the recommendations and a Management Action Plan (MAP) has been created in accordance with ANAO requirements.

109. The JHC Executive Board is the governance mechanism for tracking and reporting on the implementation of activities against the Report and ongoing benefits realisation of the Contract. Implementation is currently on-track. Recommendations 1 (Record Keeping), 2 (Contract Change Assessment and Authorisation Framework) and 3 (Benefits Management Plan) are expected to be fully implemented by the end of Quarter 3 2023-24.

Enablers to the Defence Health System

Health information—The Defence Health System

110. Defence members' clinical information is captured and stored in the Defence eHealth System (DeHS). DeHS is an enterprise-level electronic Health record that combines medical, dental and mental health records. It is concurrently accessible by the multi-disciplinary healthcare team, in accordance with privacy requirements.

111. Clinicians access DeHS to support the delivery of care to Defence members, in any location, subject to appropriate access controls. Information can be captured during a consultation or through documents

uploaded at a later time (such as after receipt and assessment of external specialist reports, medical imaging and pathology reports, and other test results).

112. This current system does present challenges as it uses legacy software that is becoming difficult to support, presenting the risk of platform stability issues. It cannot readily exchange information with other Commonwealth agencies, has limited deployed capability, and has no functionality for managing inpatient care, emergency triage or first responder health activities.

Member access to health records

113. Defence members have a right to request access, or seek correction to, their health information held by Defence that relates to them. In accordance with good medical practice, clinical information is shared with serving members during the clinical consultation to facilitate shared decision making. Members may request a copy of all or part of their health record.

Joint Project 2060 Phase 4 – Health Knowledge Management

114. Joint Project 2060 Phase 4 (JP2060-4) aims to deliver an enterprise ICT Health Knowledge Management (HKM) system that records, stores, aggregates and analyses health information for the ADF population. The new system will comprise:

    a. specialist electronic health (eHealth) software to support the delivery of multi-disciplinary primary and occupational care, and emergency and hospital care in the garrison and deployed environments; and

    b. reporting and analytics software to enable clinical governance, business intelligence and advanced analytics for the ADF, and efficient and effective health command and control.

115. The project is led by JCG; delivered by Defence Digital Group (DDG); with JHC as the primary user.

116. The contract was executed with Leidos Australia Pty Ltd in December 2021. The whole-of-life cost is approximately $800 million (including contingency, acquisition and sustainment). FOC is anticipated by 2026.

117. The benefits of the new system include:

    a. A more intuitive user interface, meeting the needs of clinicians for a contemporary, familiar, and responsive platform.

    b. An integrated, secure and future-focused Defence health system to better support Defence's delivery of health services.

    c. Defence members will be more informed and involved in their health care.

    d. Support for an integrated pharmaceutical dispensing capability as well as deployed hospital and casualty evacuation care.

    e. Integration with national e-Health Infrastructure operated by the Australian Digital Health Agency. This will enable the system to interface with the Australian Immunisation Register and other eHealth technologies to provide effective health care delivery to Defence members.

    f. Facilitation of sharing of ADF member claims data with both the Department of Veterans' Affairs and the Commonwealth Superannuation Corporation.

Pharmacy and medical consumables

118. Defence is required to supply Medical and Dental Consumables & Pharmaceuticals (MDC&P) to sustain the health requirements of the ADF across the spectrum of operations and in Garrison health where medical consumables are required.

119. Defence provides health materiel for use by health practitioners practicing within and from Defence health facilities. Health practitioners are required to comply with Defence policy on health materiel, whether the health support is provided in Garrison, deployable or deployed health facilities. This

includes a prohibition on local procurement of health materiel without the approval of JHC or Capability Acquisition and Sustainment Group (CASG).

Infrastructure

120. JHC has developed a Strategic Infrastructure Plan that considers requirements over a ten-year period.

121. Since 2012 JHC has progressed the rationalisation of smaller, low capacity health delivery points, with the associated workforce and other health assets consolidated into larger, centralised ADF health facilities. This has enabled more effective delivery of clinical health services. Much of this rationalisation has already been completed, however a number of facility upgrades and new builds are yet to occur.

122. JHC has recently delivered eight new and four refurbished health facilities under a major estate project "Garrison Health Facility Upgrade project – J0105". An additional new facility is currently under construction at RAAF Darwin and will be completed in mid-2024.

123. JHC recently undertook an analysis of all remaining health facilities with a focus on compliance and condition audits. The purpose of the review was to prioritise facilities for future replacement or refurbishment. This will inform potential future development including opportunities for consolidation of the existing 49 health facilities, pending allocation of resources and appropriate decision authority.

Strategy and policy

The ADF Health Strategy

124. The ADF Health Strategy was approved by the Chief of the Defence Force (CDF) in 2021 and reviewed in 2022 resulting in some layout improvements. The Strategy has two leading Pillars, Force Optimisation and Operational Health Capability, with five supporting Pillars (trusted mission partner, smarter service delivery, a whole-of-life focus, health system insights and integration). The strategy supports the Defence mission, Defence Corporate Plan and Defence Planning Guidance. Seven key enablers are integral to supporting the achievement of the Strategy.

125. The Strategy guides the DHS to contribute to the Defence mission through innovation, agility, scalability, resilience, adaptability and as a learning organisation.

126. The ADF Health Select Committee (HSC) provides oversight of the ADF Health Strategy. It has tasked the establishment of a single Defence Action Plan that identifies activities contributing to the realisation of

Defence Health Policy – Defence Health Manual

127. A comprehensive suite of Defence health policies known as the Defence Health Manual (DHM) support delivery, governance and assurance of health care in Defence. These policies are developed through a robust committee process involving key stakeholders in Defence (including those external to Health) before being authorised for publication. As far as reasonably practical, Defence health policy is based on existing Australian standards and best practice guidelines. The SGADF is the policy owner for health policy.

128. Defence health policy is developed, co-ordinated and maintained through the Directorate of Defence Health Policy in JHC.

129. The Defence Health Policy Steering Group (DHPSG) is the senior health policy committee in Defence, and is accountable to SGADF. It is chaired by the Deputy Surgeon General. The DHPSG is responsible for endorsing policy proposals; providing guidance and direction to stakeholders and policy writers; ensuring policy instruments provide authoritative statements of desired outcomes, principles, accountabilities, and procedures; and providing advice to SGADF on draft policy. It is supported by the Defence Health Policy Working Group (DHPWG).

130. The DHM consists of three volumes, with over 280 discrete policy documents.

    a. Volume 1 is administrative policy and provides health principles and authorisations to support implementation of Volume 2 and 3 policy. Volume 1 policy applies to all Defence personnel, and is sponsored by the Chief of Personnel.

b. Volume 2 is issued under the technical authority of SGADF and applies to all ADF Health personnel. SGADF is the policy sponsor for all Volume 2 policy.

c. Volume 3 policy provides supporting guidance for implementation of Volume 2 policy. While released under the technical authority of the SGADF, approval for publication of Volume 3 policy is delegated to the relevant one star policy sponsor in JHC.

131. A variety of other policy instruments exist that require SGADF endorsement and Defence Health Policy Working Group or Steering Group input, including doctrine, forms, handbooks and Health Bulletins.

132. Policy proposals require one star/SES Band 1 sponsorship and review by the DHPSG, including an analysis of the key issue, risks, resources and any foreseen implementation issues. The policy proposal is then referred to the DHPWG Chair for coordination of policy development. Once developed, approval is required from either the relevant one star sponsor (for Volume 3) or the DHPSG (for Volume 2, for subsequent submission to SGADF) for approval to publish.

The Defence Strategic Review

133. The DSR presented to Government in 2023 sets an ambitious agenda of reform and force posture based on Australia's evolving strategic circumstances. Health – as a key enabler of combat power – was grouped with logistics. In its consideration the DSR noted:

> *8.60 The Defence logistics and health networks must deliver persistent support and sustainment for operations. An optimal Defence logistics network must be resilient through disaggregated and dispersed mutually supporting nodes that enhance redundancy and survivability.*
>
> *8.61 Logistics and health networks must be integrated into national and global networks to deliver the full range of logistics and health effects required by Defence. Ongoing engagement with industry and partners is required to ensure additional maintenance, manufacturing, storage and load capacity can be drawn upon to meet increases in demand.*

134. The DSR made the following recommendation:

> *Commander Joint Logistics and Commander Joint Health should be adequately resourced to deliver Defence logistics and health networks that are able to deliver persistent support and sustainment for operations.*

135. Defence continues to maintain and further develop lines of effort for the planning, delivery and assurance of health care, which aligns with this recommendation. Defence recognises that in a conflict situation, health services must be able to provide adequate care to enable the greatest good for the greatest number, in support of the mission. The health system 'network' is greater than the capabilities native to Defence — it also includes consideration of the interdependence of that system with the civilian sector through a variety of arrangements.

The future Defence Health System

136. The future Defence Heath System must be able to meet the requirements of the ADF in conflict, as described by the DSR. Work is underway to appreciate, analyse, and respond to identified challenges arising from Australia's strategic environment. The specified task, that *Commander Joint Health should be adequately resourced to deliver Defence … health networks that are able to deliver persistent support and sustainment for operations* must be enabled by a comprehensive assessment of the inputs to achieving that, for a whole of capability standpoint.

137. CDF directed work in 2023 provides the basis for further analysis of the resource requirement for health as stated in the DSR. This work, presented to the Chiefs of Services Committee in November 2023, sets the Defence Health System's requirements. It will be subject to further pressure-testing and analysis, including through experimentation to inform future force design.

Conclusion

138. The DHS supports the ADF, governed by appropriate systems and policies to enable safety and quality of care, continuous improvement, and an environment, which supports Defence members, Commanders and Health Practitioners in maintaining and optimising members' health and wellbeing in the context of their employment in the military. It does so though the technical authority of the SGADF.

139. The DSR, together with preparedness work directed by the CDF, directs Defence's requirements of its health system to prepare to respond to Australia's evolving geostrategic environment.

140. The health workforce nationally and internationally is being significantly impacted by shortages of health professionals, increasing demand for services, evolving information technology requirements, changing community expectations and ageing health infrastructure. As an integrated component of the broader health system, Defence shares these challenges.

Capability Assurance Mechanisms

Introduction

141. Capability acquisition and sustainment enables the timely delivery of effective, suitable and integrated military capabilities within allocated resources. A competitive tension exists between scope, cost and schedule, which is heightened by the need identified in the DSR to deliver minimum viable capability.

142. Defence equipment must be suitable in terms of safety, security, and sustainability, as well as integrated with other systems, and ultimately must be effective for the missions for which it was designed.

143. The capability assurance processes must give confidence that capability acquired will meet all of these requirements. Capability assurance processes must also ensure Defence capabilities remain viable and relevant to Australia's strategic circumstances as they change throughout a capability's life.

Capability Assurance in general

144. Capability assurance occurs within the context of the mission, operating intent and usage of the systems and equipment. These form the foundation for setting requirements that define the effectiveness of the capability. Detailed capability requirements include both how the system must function and those needed to assure compliance with the established standards to which the system will be certified.

145. Assurance involves the Verification and Validation (V&V) of these requirements. Verification is the process of determining whether the elements of a product fulfil the established requirements. Validation evaluates a complete capability at the end of development to ensure that it not only complies with requirements (including safety), but is fit for purpose. These are answered by gathering and analysing objective quality evidence (OQE) on the capability. There are several ways to obtain OQE, including inspection, demonstration, analysis and test and evaluation (T&E).

146. Capability system development needs to be adaptive to changing mission requirements and technological innovation. During development, circumstances can change in ways that affect the intended use of the system. Capability assurance must be able to adapt to ensure validation against contemporary, capability needs, including the evolution of threats. Capability assurance during acquisition verifies that specified requirements are met and identifies early what may be required to change in order to align to an evolving environment.

147. Capability assurance does not end with delivery of new equipment into operational service. Capability is also dependent on Defence's people, and the tactics they employ in the use of the equipment. Changes to configuration, role, environment and tactical procedures also occur through the in-service life of a capability to keep it relevant to contemporary threats. These in-service changes to capability must also be assured.

148. Capability is achieved through a combination of equipment, support and sustainment systems for that equipment as well as suitably trained and prepared personnel. The three Service Chiefs are accountable for the assurance of effective Defence capabilities within the Air, Land and Maritime domains in relation to each of these aspects of capability. Accountability for the assurance of purely joint capabilities, for example Health, Space and Cyber, rest with the Chief of Joint Capabilities. The Vice Chief of Defence Force is accountable for the assurance of integrated joint capabilities that are formed through collective, coordinated application of capability elements from multiple domains.

Early life-cycle capability assurance

149. High-level capability requirements, often expressed as Critical Operating Issues (COIs), are articulated in a Joint Capability Needs Statement (JCNS) developed by the sponsoring Capability Manager and ratified by the Vice Chief of the Defence Force Group (VCDFG) through the Head of Force Design (HFD) and Head Force Integration (HFI). Once agreed, the JCNS, Project Execution Strategy and associated Business Case, and draft Cabinet Submission are assessed at a Capability Gate Review (CGR[6]) prior to being considered by the Investment Committee (IC[7]) and presented to Government for approval.

150. CGRs involve consideration of the submission by HFD and HFI, supported by Contestability Division, at monthly sittings. This stage of the process occurs approximately six months prior to the Government's decision, therefore detailed cost and schedule assurance is relatively challenging as the data set matures as the project develops. Assurance that the capability requirements will be met is largely dependent on the maturity of the capability solution sought and the degree to which effective T&E, or other risk-reduction activities, has been conducted. Any known capability risks are described by the capability sponsor, and are reviewed by the Force Design, Force Integration, and Contestability Divisions. The CGR assures the proposed acquisition is sufficiently understood, and documented and is ready to be considered by the IC.

151. The IC sits monthly and considers the refined acquisition proposal suite in the context of the wider Integrated Investment Program (IIP) to decide whether the capability proposal is fit for Government consideration. The IC is informed of significant capability risks.

152. DSTG also contribute to early-life-cycle capability assurance through the provision of Technical Risk Assessments to inform acquisition projects and decision makers on the likelihood of developmental difficulties based on the maturity of the technology underpinning the proposed capability.

153. Engineering processes determine how capability requirements will be verified and validated. Traditional verification methods include inspection, demonstration, analysis and T&E. These are being supplemented by the digital transformation of engineering in Defence, which includes:

    a. Model based systems engineering, which permits a level of engineering assurance in advance of T&E and the assurance of systems integration and interoperability.

    b. Agile design and delivery methods for iterative and evolutionary design development and virtual testing of designs. Agile design can define the minimum viable capability required. This approach allows rapid design and integration of new technology or innovative solutions and allows early identification of risks and issues through iterative developmental T&E to ensure that the scope of delivery is quickly and effectively narrowed down to align with the delivery timescales and funding.

Domain-worthy capability assurance

154. Defence has three mature "worthiness" domains, Air, Land and Sea. Although domain specific in their approaches, each provides a level of capability assurance within its own domain. They are primarily designed to assure that the capability system can deliver the required operational output, for the expected duration within the expected operating regions and threat environment. Domain worthiness agencies are engaged during acquisition of capabilities to provide advice on certification and fitness for purpose. They also continue to provide a capability assurance function throughout the life of type of a capability.

155. When reviewing capabilities, the worthiness agencies seek inputs from the Capability Managers, acquisition and sustainment organisations and users to determine the appropriateness of the Fundamental Inputs to the Capability (FIC). Worthiness Boards are held to review any recent incidents and T&E reports relevant to the capability. These Boards enable the worthiness Authorities to identify capability risks and actions to be completed, to remediate or enhance the capability system and advise

[6] The inclusion of contestability in the CGR provides a degree of independent assurance within Defence.
[7] The inclusion of Central Agencies in the IC quorum provides an element of assurance beyond Defence.

the Capability Mangers. The worthiness domains provide an annual report to the Chief of Services Committee on the state of capabilities within their domains and any key issues.

156. The worthiness agencies provide capability assurance of capabilities and are able to trigger actions to remediate any issues within a capability system. Cyber and Space Worthiness agencies and processes are under development within Defence to provide a similar degree of capability assurance in those domains.

Test and Evaluation in capability assurance

157. T&E is a process to obtain information to support the objective assessment of a capability system with known confidence, and to confirm whether risk is contained within acceptable boundaries across all facets of a system's life cycle. A test is an activity in which a scientific method is used to obtain quantitative or qualitative data relating to the safety, performance, functionality, contractual compliance and supportability of a system. Evaluation is the analysis of test results to provide OQE supporting V&V or other processes seeking OQE.

158. T&E is unique from other ways to obtain OQE in that it typically exercises the product in an operationally realistic environment and produces data that must often be analysed by T&E specialists to answer the relevant questions. T&E is applicable at various stages of development:

    a. Preview T&E (PT&E) – to compare different platforms competing for selection, to fill knowledge gaps regarding a candidate platform's suitability for the intended role or environment and to refine requirements development.

    b. Developmental T&E (DT&E) – to develop the design of a platform prior to it being offered for Defence acceptance, typically by the designer or developer, but also by the Capability Manager to assure in-service changes.

    c. Acceptance T&E (AT&E) – to confirm that the platform meets contracted and certification requirements, typically conducted by the capability supplier and witnessed by the Delivery organisation on behalf of the Capability Manager. AT&E is a key determinate prior to capability acceptance by Defence and transfer into operational service.

    d. Operational T&E (OT&E) – to confirm the platform meets operational requirements when employed in the intended operating environment, by the intended operators using the intended procedures. OT&E is conducted following the capability's introduction into operational service when the capability and its supporting FIC are sufficiently mature against operational capability milestones (e.g. Initial Operational Capability [IOC] and Final Operational Capability [FOC]).

    e. Force-Level OT&E (FLOT&E) – to confirm a combination of capabilities or platforms operating as an integrated system meet operational requirements when employed in the intended operating environment, by the intended operators using the intended doctrine and procedures.

    f. In-service T&E (IT&E) – can be any combination of preview, developmental, acceptance, operational and force level T&E applied to verify and validate the capability, or its modernisation, meets the needs of its changing environment.

159. Defence policy on T&E is set out in the Defence Test and Evaluation Manual (DTEM). In relation to informing the capability acquisition process, the DTEM states that:

    a. Capability Managers are responsible for ensuring that risks identified through T&E are reported to the IC and Government.

    b. Delivery Group Heads are responsible for managing, coordinating and enabling the following on behalf of the Capability Manager:

        i. Sufficient preview T&E to support requirements development;

        ii. Sufficient preview T&E to ensure informed and risk appropriate solicitation decisions;

        iii. Sufficient developmental and acceptance T&E to verify agreed function, performance and certification requirements; and

iv. Sufficient support to operational T&E to finalise program and product validation of capabilities.

160. Capability Managers are responsible for conducting OT&E and in-service Developmental and Acceptance T&E. As the Joint Force Authority, VCDF is responsible for the conduct of Force Level Assurance, including Joint Force T&E, noting that this is an emerging facet of ADF T&E.

161. Governance of T&E in Defence is the responsibility of Force Integration Division (FID) under the VCDF Group. FID manages overarching policy on the conduct of T&E within Defence, plans Joint Force T&E, monitors T&E planning and outcomes, and provides training and development opportunities for T&E practitioners across all Groups and Services.

162. T&E in support of acquisition and sustainment is conducted by a combination of Defence and Industry entities:

a. A T&E Principal is assigned by each Capability Manager to: ensure sufficient and suitable T&E is planned and conducted; to oversee their T&E Accountable Units (T&EAU); and to set domain-specific policy subordinate to the DTEM. Fourteen T&E Principals form the T&E Capability Steering Group (TECSG), which is chaired by the Director General of Joint Warfare Development, providing a direct link between T&E governance and conduct.

b. Defence formally identifies T&EAUs in the Groups and Services that are recognised to meet the standard required to conduct T&E in their respective domains. There are currently 23 T&EAUs across Defence, governed by their respective domain T&E Principals.

c. Demand for T&E services within acquisition projects exceeds the capacity of Defence's T&EAUs to satisfy. As a result many projects rely on contractor support to deliver T&E outcomes. In a developmental project the Original Equipment Manufacturer (OEM) will typically conduct DT&E, monitored by the project's Engineering or T&E Manager. Preview, acceptance and operational testing remain the responsibility of the Commonwealth, enabled by the Delivery Group and informing the Capability Manager, and tasked to a T&EAU or contracted test team. In some circumstances, the OEM will be tasked by the Delivery Group to conduct acceptance testing on the Commonwealths' behalf, although this is typically avoided in the interests of obtaining an impartial outcome. Where an OEM conducts acceptance testing on behalf of the Commonwealth, conflict of interest is managed by requiring transparency in the collection and analysis of the underlying OQE.

d. In cases where it is appropriate, Defence also embeds staff within partner nation T&E agencies to enable collaborative capability assurance (e.g. F35-Joint Strike Fighter and P-8 Poseidon embedded within the US program). Such arrangements exist under T&E Memoranda of Understanding overseen by the Defence T&E Directorate. Where necessary, domain-worthiness processes are used to assure that such agencies conduct T&E to a standard acceptable to Defence.

163. Test outcomes are reported through project staff within the Delivery Group or T&EAU staff within the domains to the Capability Manager to inform acceptance and operational capability declaration decisions. This is monitored by the T&E Principal for the respective Group or Service. Joint Warfare Development Branch within FID produces an annual report outlining the health of the Defence T&E enterprise. In December 2023 an upgraded module was added to the Defences capability decision support tool, Capability-One, to improve the fidelity and transparency of records related to T&E activities and outcomes for acquisition projects.

Examples

164. The following examples reflect specific instances of the use of T&E to inform capability assurance by Defence. Approaches vary between the stage of development and domains, but all share common principles consistent with the mechanisms described above.

Preview T&E – Counter Improvised Explosive Device – Remotely Piloted Vehicles

165. The aim of the trial was to conduct Preview T&E on tendered solutions, to inform the down-selection decision in preparation for Second Pass.

166. The trial was conducted in the first quarter of 2022 at Gallipoli Barracks Enoggera. Multiple venders tendered potential solutions to replace the ADF's legacy suite of Counter Improvised Explosive Device – Remotely Piloted Vehicles (JCIED RPV). Participants from Army, Navy and Air Force, as well as experts from DSTG, enabled the testing. The trial assessed preparation of the platform, deployment, movement to target, accessing the threat, component isolation disruption and destruction, platform disassembly, and storage and exporting of data.

167. The testing provided an evaluation of all tendered solutions and identified the strengths and weakness for each, appropriately informing the project down-select decision.

Development T&E – Air to Air Refuelling

168. This activity collected data to assess if the KC-30A RAAF Multi-Role Tanker Transport (tanker) and the RC-135 US Air Force large reconnaissance aircraft, e.g. Rivet Joint (receiver) were suitable for air-to-air refuelling (AAR). The test was conducted in the second half of 2023.

169. The data collected during this activity was used to inform the certification of AAR for the United States Air Force RC-135 reconnaissance aircraft.

170. Following a desktop technical and operational compatibility assessment, flight-testing of the tanker-receiver pair was conducted to establish a safe air-to-air refuelling envelope, within speed, altitude and geometry limits.

171. This DT&E activity is an example of in-service testing which is not directly linked to a capability milestone for a specific project. It is one of several AAR clearance DT&E activities conducted by the Aircraft Research and Development Unit over many years.

Acceptance T&E – SEA 2000 Maritime Mining

172. The program confirmed the submarine launched mine variant can be successfully released from a Collins Class Submarine (CCSM).

173. Two mine shapes of identical dimension to the "action mines" were loaded into and then released from a submarine. These were assessed incrementally through computer modelling and land based test facilities, however a "live" release from a CCSM was required to fully prove and baseline the system.

174. The mine shapes were released from the submarine, and a Clearance Diving Team recovered and returned them for post-trial inspection. The gathered data was analysed by the OEM and DSTG.

175. The trial identified areas for rectification. Data collected was used to optimise the discharge profile for the mine and thereby informing OT&E. Design changes were planned for CCSM mine handling equipment utilising the evidence from this trial.

Operational T&E – Electronic Warfare

176. The aim of testing was to confirm IOC of a classified Electronic Warfare (EW) capability. This trial included end-to-end assessment of select FIC for the use of the system by Defence in several operational scenarios.

177. The capability was assessed by observing deployed ADF EW elements undertaking operations in a larger EW focussed event in the US. The testing covered a range of scenarios with respect to network connectivity and complementary communications bearers. The trial report included sections addressing each high-level requirement (Critical Operational Issue) and wider observations that highlighted important aspects of the capability.

178. An OT&E report formed the basis of a brief to Chief of Joint Capabilities to inform his decision to declare IOC. Specific findings of the trial were subsequently used to refine operator training and inform subsequent development iterations.

Force Level Operational T&E (FLOT&E)

179. VCDFG has produced a comprehensive set of Joint Force requirements based on defined missions informed by the DSR. These requirements will inform Directives to Capability Managers, and will form the basis for future FLOT&E test planning. The process will involve determining a set of testable requirements that the system-of-systems[8] needs to meet in order to achieve a defined mission, such as multi-domain strike.

Verification and Validation without Australian Defence T&E during acquisition

180. In some circumstances, Defence is able to rely wholly on OQE generated by other, reputable T&E agencies to inform acquisition decisions. Australia acquired the C-17A transport aircraft between 2006 and 2012 via a Foreign Military Sales (FMS) agreement with the US. The aircraft were acquired without modification, and operated in configurations, roles, and environments (CRA) essentially the same as tested and authorised for US service.

181. Australia did not conduct Preview or Developmental T&E during this acquisition but sought and received OQE from the US Air Force to inform Australia's acceptance and certification. The US Air Force conducted Acceptance Testing following production, on Australia's behalf, under FMS arrangements.

182. Following delivery, the Capability Manager, Air Force, conducted Operational Testing to assess and refine the integration of the new aircraft type with supporting infrastructure, where the CRA of the US Air Force was different to that for Australian Air Force.

Enhancing capability assurance – key reforms

183. Defence is implementing reforms to enhance capability assurance, and is undertaking further consideration of additional measures to implement the DSR direction.

184. On 10 October 2022 the Deputy Prime Minister and the Minister for Defence Industry announced six measures to strengthen and revitalise the oversight of project performance, including:

    a. establishing an Independent Projects and Portfolio Management Office (IPPMO) within Defence;

    b. requiring monthly reports on Projects of Concern and Projects of Interest;

    c. establishing formal processes and "early warning" criteria for placing projects on the Projects of Concern and Projects of Interest lists;

    d. fostering a culture in Defence of raising attention to emerging problems and encouraging and enabling early response;

    e. providing troubled projects with extra resources and skills; and

    f. convening regular Ministerial summits to discuss remediation plans.

185. Defence has established the IPPMO within CASG and made progress against each of the six measures, including:

    a. centralised production of performance monitoring and reporting across all Delivery Groups to senior Defence stakeholders and committees, to government, and to external bodies;

    b. a revised Projects of Concern and Interest policy, published in February 2023, including formal processes and 'early warning' criteria for placing projects on the Projects of Concern and Projects of Interest lists; and

    c. convening ministerial summits with industry to discuss remediation plans.

186. The IPPMO contains the Independent Assurance Review (IAR) and Smart Buyer functions. The Smart Buyer function independently reviews projects strategy prior to acquisition decision. The IAR process reviews projects throughout the capability life-cycle. These processes typically use specifically chartered

[8]System-of systems: A set of systems or system elements that interact to provide a unique capability that none of the constituent systems can accomplish on its own.

Boards with the relevant skills and experience to conduct reviews of programs, projects or products. The independence of the Board is realised through its advisory role; authoritative, expert and independent Board composition, including non-Defence membership; and expert non-advocate preliminary analysis.

187. In August 2021 the Defence Test and Evaluation Strategy was released with the aim to ensure that T&E across Defence supports risk-based capability decisions. Under the Strategy, a new T&E Governance Model will be implemented in February 2024 and will enhance capability assurance by:

    a. Assessing the technical nature of proposed capability solutions at the outset of a project to identify potential capability risks and prioritise T&E activity.

    b. Monitoring T&E reports throughout the capability lifecycle to ensure that T&E outcomes and capability risks are actively reported to HFI.

    c. An upgraded module in Defence's capability decision support tool, Capability-One. The new module, which went live in December 2023, improves the fidelity and transparency of records related to T&E activities. It also documents T&E outcomes reporting directly against the products ability to meet high-level requirements (Critical Operating Issues).

Conclusion

188. Defence capability assurance mechanisms must ensure the delivery of effective, suitable and integrated military capabilities within timeframes that are strategically relevant and within allocated resources. This submission describes the mechanisms implemented since the First Principles Review (2016) outlines the policies and processes that underpins the full spectrum of capability assurance, from capability inception to disposal, from the force-level to the platform, across all Domains, and through all types of assurance methods. New initiatives underway are enhancing capability assurance efficacy, to ensure Defence is best positioned to meet the challenges described in the DSR.

189. Defence maintains several mechanisms providing assurance that its capability is fit for purpose. The different mechanisms focus on a different aspect of the capabilities provided within Defence. Generally, the aim of capability assurance is to identify issues that require the attention of management rather than simply to measure performance. As a consequence, many of the capability assurance mechanisms are closely integrated into the decision-making processes they support.

190. It is worth noting that in Defence a "capability" is the power to achieve a desired operational effect. It is not simply military equipment, but the whole system that allows that equipment to be effective.

191. It is also important to note that much of the information produced on capability assurance has to be classified. Information on the ADF weaknesses and vulnerabilities would be highly valuable to an adversary who means to do us harm.

192. At the whole-of-force level, capability assurance is managed through the force design process. The aim of force design is to identify the performance of the ADF against future threats and identify priorities for new capabilities. The force design process will draw on subject matter expertise via workshops, the results of joint experimentation and wargaming, and the outcomes of scientific studies and operational analysis. Through these processes, the outcomes of other forms of capability assurance are integrated into decision-making. This process is being redesigned following the DSR.

193. While force design focusses on future threats, the preparedness management system is concerned with the force-in-being. This provides for systematic reporting by Capability Managers (including the Service Chiefs) and operational commanders on the preparedness (readiness and sustainability) against the objectives set by the CDF's Preparedness Directive. These assessments are supported by exercise evaluations, operational test and evaluation, assessment of stockholdings and the material condition of equipment. This reporting is compiled into the Defence Preparedness Report to inform the CDF and the Strategic Command Group. Currently, Defence is working to extend the coverage of the preparedness management system to cover the contribution of all Groups, not just the ADF.

194. Looking specifically at procurement, the Delivery Groups regularly monitor the performance of projects and provide reporting to the capability managers. A compiled Quarterly Performance Report is provided to senior management including the Minister for Defence Industry and the IC.

195. In a similar way, sustainment performance is considered on a regular basis through a series of Sustainment Deep Dives, with the outcomes reported to the Defence Finance and Resourcing Committee and the IC.

196. Independent Assurance Reviews assist the Delivery Groups in understanding performance risks in both procurement and sustainment and are typically commissioned ahead of key decision points.

197. Within Defence, it is the responsibility of the Capability Managers to determine that projects have delivered the agreed outcomes that is to declare Initial Operational Capability (IOC) and Final Operational Capability (FOC). This is supported by test and evaluation and an assessment of the project deliverable and their integration into broader Defence systems.

198. T&E supports projects at various points in their life cycles. The nature and extent of T&E depends on the maturity of the proposed solutions and the complexity of the systems they need to be integrated into. Preview T&E can identify potential solutions early in the project development process. Where new capabilities are being designed and developed, developmental T&E can provide assurance of the solution performance and identify the need for modification. Acquisition T&E helps evaluate whether the product delivered by the project is fit for purpose. Operational T&E considers the performance of the product through its life. An important aspect of project planning is the early identification of a T&E Concept and the development of a full Test and Evaluation Master Plan.

Artificial Intelligence and Autonomous Weapons

Introduction

199. This section outlines Defence's approach to artificial intelligence (AI) and autonomous weapons, including relevant policy settings, legal requirements and regulatory frameworks. Defence recognises that these emerging technologies are complex, with many advantages in both civilian and military domains.

200. The DSR identified the need for Australia to shift from a balanced force to a focused force capable of producing asymmetric effects. AI and autonomy, applied appropriately in concert with human direction or operators, offers the ability to realise asymmetry in areas such as logistics, intelligence, surveillance and reconnaissance, targeting, tracking and strike applications.

201. Defence is committed to using AI-enabled technologies responsibly, with careful consideration of the opportunities and risks, consistent with our international legal obligations. Noting the rapid advancements of these technologies and their potential military applications, Defence continually assesses the implications of these technologies for Defence policy, as well as corresponding legal and regulatory requirements and frameworks, as needed.

Policy

202. Recognising the risks and implications of AI and autonomy in the military domain, Defence is developing an internal Responsible AI Policy, for finalisation in 2024, to set strategic direction and bounds for the research, development, deployment and use of AI-enabled technologies within Defence. The policy will adopt a risk and values-based approach to governance, in line with international best practice, and adhere to Australia's laws and international obligations.

203. Defence's development of the Responsible AI Policy will be informed by multiple sources, including: the Department of Industry, Science and Resources' *AI Ethics Framework*; the Australian Signals Directorate *Ethical AI in ASD* policy; and, the policies of allies and likeminded partners, including the US and the UK. Australia is also an active participant in international discussions on the responsible use of AI in the military domain, and will continue to support development of shared international norms and standards. For example, in 2023, Australia publically endorsed the first-of-type Responsible AI in the Military Domain Summit *Call to Action*, and the US-led *Political Declaration on Responsible Military Use of AI and Autonomy*.

204. Australia also continues to actively participate in the Convention on Certain Conventional Weapons discussions on autonomous weapons systems. Australia supports practical and tangible outcomes in this forum. This includes the paper, which Australia co-sponsored, "Principles and Good Practices on Emerging Technologies in the Area of Lethal Autonomous Weapons Systems" to clarify and enhance compliance with international humanitarian law.

Legal aspects

205. Australia recognises that autonomous weapons systems have the potential to save lives by minimising casualties and reducing the risk to Defence personnel, but must be used in accordance with international law. Existing international law regulates the development, acquisition, deployment and use of new and emerging technologies, including autonomous weapons systems.

206. All ADF weapons, means and methods of warfare must comply with Australia's international and domestic legal obligations, and are subject to legal review under Article 36 of the Additional Protocol I of the Geneva Conventions. Australia upholds its Article 36 obligation by conducting legal reviews of new and materially modified weapons, means and methods of warfare prior to acquisition and operational use to ensure they are capable of use in accordance with Australia's international legal obligations. If a weapon system cannot be used in accordance with Australia's legal obligations, Defence will not deploy it.

207. Additionally, Defence applies a "systems of control" approach to enable effective management of risks in using capability at the operational and technical levels. "Systems of control" describes the layers of governance architecture, policies and procedures applied to all technologies, including autonomous weapons and AI.

Armaments manufacture, procurement and inventory

Introduction

208. In response to the DSR, a key Government priority, is to hold sufficient stocks of guided weapons and explosive ordnance (GWEO) and have the ability to manufacture certain lines.

209. For many decades Australia's GWEO inventory levels have reflected an assessed 10-year strategic warning time for a major conventional attack against Australia. In an increasingly challenging strategic environment, this 10-year warning time can no longer be assumed and GWEO inventory needs to grow. The conflict in Ukraine is a sober reminder of the importance of guided weapons in modern warfare. It has also highlighted the challenge in trying to increase production rates for modern guided weapons, which have complex supply chains.

210. On 5 May 2023 the Government appointed Air Marshal Leon Phillips OAM as the inaugural Chief of GWEO. The Government also committed $2.5 billion over the forward estimates to accelerate the GWEO Enterprise, an increase of more than $1.5 billion above the previous allocation. This investment includes funding for:

    a. Manufacturing guided weapons and their critical components, to improve Australia's self-reliance;

    b. Critical enablers to underpin an expanded GWEO Enterprise, including increasing testing and research capabilities and rapidly expanding the storage and distribution network to accommodate a growing inventory; and

    c. Acquisition of more GWEO to supplement other Defence acquisition programs.

Plans and processes for the acquisition of specific munitions from coalition partners

211. Defence engages with the Foreign Military Sales (FMS) process of the US Government, and direct military sales from other partners.

212. Defence is pursuing accelerated acquisition of GWEO to meet its strategic objectives. The Government has agreed to investments of:

    a. $1.3 billion on more than 200 Tomahawk cruise missiles for Navy's Hobart class destroyers.

    b. $431 million on Advanced Anti-Radiation Guided Missile-Extended Range missiles for Air Force's Growler and Super Hornet aircrafts, and in future the F-35A Lightning II fighter jets.

    c. $1.6 billion to expand and accelerate the acquisition of High Mobility Artillery Rocket System (HIMARS) launchers and associated missiles for the Army.

    d. $50 million for Spike Long-Range 2 anti-tank guided missiles for Army's Boxer combat reconnaissance vehicles.

Requirements to enable domestic manufacturing and storage

213. Few countries manufacture all of their own guided weapons and even fewer are capable of manufacturing every component in any individual guided weapon. It is not realistic, affordable or necessary for Australia to do so. Australia will need to be selective and strategic in choosing which weapons and components to manufacture domestically.

214. Australia currently manufactures some munitions at the Government Owned, Contractor Operated (GOCO) facilities at Mulwala (New South Wales) and Benalla (Victoria). These facilities manufacture propellants, explosives and a range of non-guided munitions, including small arms ammunition and aircraft bombs. All of the ADF's guided weapons are currently manufactured overseas. A small number of components for one missile – Raytheon's Evolved Sea Sparrow Missile – are manufactured in Australia as part of the global supply chain.

215. Defence expects the two GOCO facilities to play an important role in the expansion of GWEO manufacturing in Australia. The facilities provide a solid industrial foundation for manufacturing munitions and critical energetic components, such as rocket motors and warheads. The Government is

investing an additional $220 million in the two facilities to upgrade infrastructure, acquire larger explosive mixers and improve manufacturing processes.

216. Defence is currently developing detailed, costed plans to manufacture selected GWEO in Australia, for Government consideration in 2024. Given the high barriers to entry and technical complexity of guided weapon manufacturing, Defence is focussed on a small number of guided weapons. The plans are being developed with Defence's industry partners, including two Strategic Partners: Lockheed Martin Australia and Raytheon Australia. The pathway for domestic manufacturing will likely commence with local assembly of imported components and materials, with the number of Australian-made components gradually increasing over time. In due course this may include rocket motors and warheads for selected missiles.

217. At the Australia-US Ministerial Consultations 2023, Australia and the US agreed to deepen cooperation on Australia's GWEO Enterprise by collaborating on a flexible guided weapons production capability in Australia, with an initial focus on the potential for co-production of Guided Multiple Launch Rocket Systems (GMLRS) missiles by 2025.

218. The US also agreed to transfer technical data for the M795 155mm artillery shell in support of future production in Australia. Both sides reaffirmed their commitment to the maintenance, repair, overhaul, and upgrade of priority munitions in Australia, noting this would enhance supply chain resilience, with an initial focus on MK-48 heavyweight torpedoes and SM-2 missiles.

219. A rapidly expanding GWEO inventory will require an expanded GWEO storage network. The Government has approved additional GWEO storage infrastructure at a number of locations including HMAS *Stirling* (Western Australia), RAAF Amberley (Queensland) and existing storage depots at Jennings and Myambat (both New South Wales). Defence is also developing plans for further storage expansion at other existing sites, including Defence Estate Orchard Hills (New South Wales). In the longer term, new storage and distribution nodes will need to be developed, including in northern Australia.

Comparison of current stock holdings against what is required for high-intensity conflict

220. The details of Defence's GWEO stockholdings are highly classified. Defence has developed an internal methodology – known as the Strategic Materiel Reserve – Explosive Ordnance (SMR-EO) – for assessing its optimal GWEO stock levels in preparing for high intensity conflict. Defence uses the SMR-EO to inform decisions about priority acquisitions of additional war stock.

QUARTER 3 2023

Appendix 1

TOTAL ADF PERMANENT HEALTH WORKFORCE IS COMPOSED OF 1,941 MEMBERS

331
Posted to JHC
62 in HQ | **269** in Garrison

1,462
MEC 1 & 2
deployable capability

A further
560
under training

RAN
436
Members

ARMY
1,069
Members

RAAF
436
Members

WORK FORCE	MEDICAL OFFICERS	NURSE	MEDIC	DENTIST	PSYCH.	HEALTH MGMT	OTHER HEALTH	TOTAL
RAN	56	77	237	17	0	23	26	436
ARMY	73	176	424	22	65	150	159	1,069
RAAF	82	102	138	13	0	0	101	436

COMPARING THE ADF ACROSS INSTITUTIONS

AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY

Medical Practitioners:	**115,521**
Registered Nurses:	**309,851**
Enrolled Nurses & Paramedics:	**72,330**

ADF PERMANENT (SERCAT 6/7)

Medical Officers:	**211**
Nursing Officers :	**355**
Medics:	**799**

DATA CAVEATS

APHRA counts for the listed professions are correct as at 3 October 23. The counts for Medical Practitioners were retrieved via the Factsheet Selector Dashboard: Medical Practitioners provided by Department of Health (National Health Workforce Dataset) for the year 2022, the counts for Registered and Enrolled Nurses were retrieved via Factsheet Selector Dashboard: Nurses and Midwives provided by Department of Health (National Health Workforce Dataset) for the year 2022, and the counts for Paramedicine Practitioners were retrieved via Factsheet Selector Dashboard: Paramedicine Practitioners provided by Departmentof Health (National Health Workforce Dataset) for the year 2021. All counts are for members categorised as either "In the Labour Force" or "Employed' . Totals may include Unknown category numbers, thus figures may not sum to the expected total.

The total ADF Permanent health workforce data was extracted September 2023 from PMKeYS for all REG (SERCAT 6/7) members. Members in each trade were identified by the Category Long Description, Function Short Description and Sub Function Short Description in PMKeYS:

Medical Officer count included:
- *Medical Officer*

Nurse count included:
- *Nurse, Nursing Officer, and Senior Officer (Function Short Description: NURS)*

Medic count included:
- *Medical, Medical Submariner, and Medical Technician*

Dentist count included:
- *Dentist and Dental Officer*

Psychologist count included:
- *Army Psychologist*

Health Management count included:
- *Navy Health Services Officer and Medical Corps Officers*

Other count included:
For RAN, Dental; For Army, Dental Assistant, Environmental Officer, Medical Imaging Specialist, Pharmacist, Physiotherapist, Preventive Medicine Technician, and Scientist; For RAAF, Dental Assistant, Environmental Health Officer, Pharmacy Officer, Radiography Officer, Scientific Officer and Warrant Officer (Tier B) (Function Short Description: DENTASST).

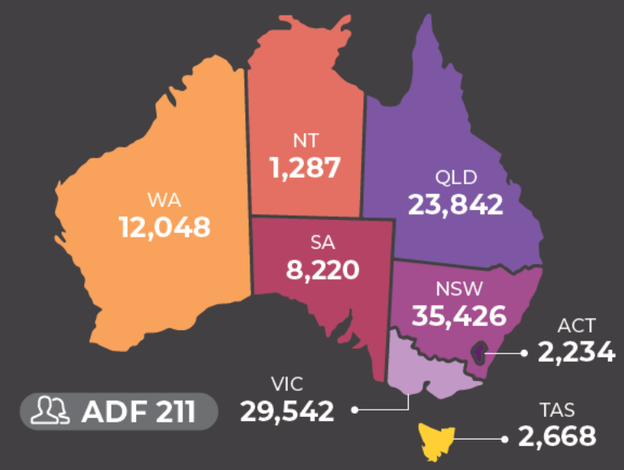
These counts may include persons who are 60+ years of age and/or who have incomplete COVID-19 vaccination; thus, they may not be indicative of true ADF Permanent health workforce deployability status. The count excludes protected identity members and other crafts who may be considered as working in the Health domain; therefore, totals will be lower than published workforce reports by Defence People Group.

An additional count is provided for the health workforce currently under training ("T", "U/G", "UG", "PG", "UT", "Intern", "MED TR", "MML 1", "Resident", "TR", "/T", "U/G") ") as identified by Function Short Description and Sub Function Short Description in PMKeYS and counted separately.

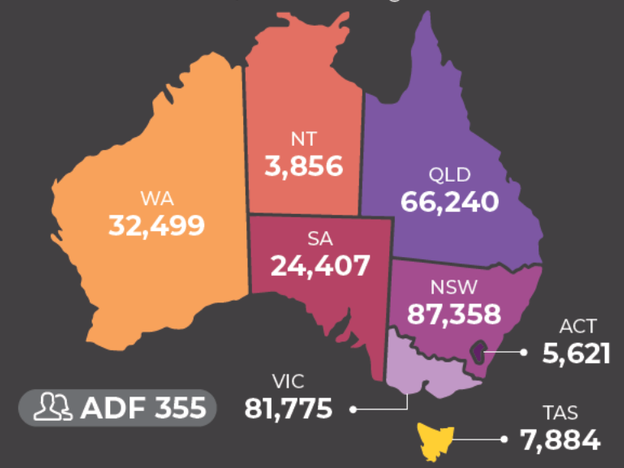
The count of members who were posted to Garrison Health centres includes anyone working at a Health Centre or JHU. The count of members who are posted to JHC HQ includes: ADF MIDI Enoggera, Garrison Health, Operational Health, HPP, Health Business & Plans, National Operations, and Joint Health Command (OCJHLTH). These categorisations were defined by each member's assigned Unit Long Description.

COMPARING THE ADF ACROSS THE NATION

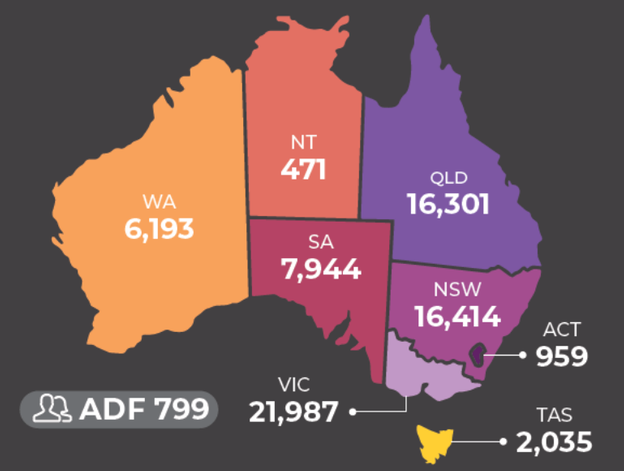
MEDICAL OFFICERS
*Registered Medical Practitioners **vs** SERCAT 6/7 ADF Medical Officers*



NURSING OFFICERS
*Australian Registered Nurses **vs** SERCAT 6/7 ADF Nursing Officers*



MEDICS
*Australian Enrolled Nurses and Paramedicine Practitioners **vs** SERCAT 6/7 ADF Medics*



Appendix 2

QUARTER 3 2023

TOTAL ADF RESERVIST HEALTH WORKFORCE IS COMPOSED OF 1,775* MEMBERS

108
Posted to JHC
64 in HQ | 44 in Garrison

1,583
MEC 1 & 2
deployable capability

A further
124
under training

RAN
343
Members

ARMY
1,010
Members

RAAF
422
Members

WORK FORCE	MEDICAL OFFICERS	NURSE	MEDIC	DENTIST	PSYCH.	HEALTH MGMT	OTHER HEALTH	TOTAL
RAN	104	65	86	17	31	25	15	343
ARMY	240	256	142	23	91	115	143	1,010
RAAF	154	139	43	19	5	0	62	422

COMPARING THE ADF ACROSS INSTITUTIONS

AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY

Medical Practitioners:	**115,521**
Registered Nurses:	**309,851**
Enrolled Nurses & Paramedics::	**72,330**

ADF PERMANENT (SERCAT 3/4/5)

Medical Officers:	**498**
Nursing Officers:	**460**
Medics:	**271**

DATA CAVEATS

***4% of members were SERVOP C**

APHRA counts for the listed professions are correct as at 3 October 23. The counts for Medical Practitioners were retrieved via the Factsheet Selector Dashboard: Medical Practitioners provided by Department of Health (National Health Workforce Dataset) for the year 2021, the counts for Registered and Enrolled Nurses were retrieved via Factsheet Selector Dashboard: Nurses and Midwives provided by Department of Health (National Health Workforce Dataset) for the year 2022, and the counts for Paramedicine Practitioners were retrieved via Factsheet Selector Dashboard: Paramedicine Practitioners provided by Departmentof Health (National Health Workforce Dataset) for the year 2022. All counts are for members categorised as either "In the Labour Force" or "Employed' . Totals may include Unknown category numbers, thus figures may not sum to the expected total.

The total ADF Reservist health workforce data was extracted September 2023 from PMKeYS for all REG (SERCAT 3/4/5) members. Members in each trade were identified by the Category Long Description, Function Short Description and Sub Function Short Description in PMKeYS:

Medical Officer count included:
- *Medical Officer*

Nurse count included:
- *Nurse, Nursing Officer, and Senior Officer (Function Short Description: NURS)*

Medic count included:
- *Medical, Medical Submariner, Medical Technician, and Warrant Officer (Tier B) (Function Short Description: MEDTECH)*

Dentist count included:
- *Dentist and Dental Officer*

Psychologist count included:
- *Army Psychologist (Function Short Description: Army PSYCH, Workforce Segment: Health), Clinical Psychologist (Function Short Description: PERS PSYCH, Workforce Segment: Health) and RAN Psychologist (Function Short Description: PSYCH, Workforce Segment: Enterprise and Command Support)*

Health Management count included:
- *Navy Health Services Officer and Medical Corps Officers*

Other count included:
For RAN, Dental; For Army, Dental Assistant, Environmental Officer, Medical Imaging Specialist, Pharmacist, Physiotherapist, Preventive Medicine Technician, and Scientist; For RAAF, Dental Assistant, Environmental Health Officer, Pharmacy Officer, Radiography Officer, Scientific Officer and Warrant Officer (Tier B) (Function Short Description: DENTASST).

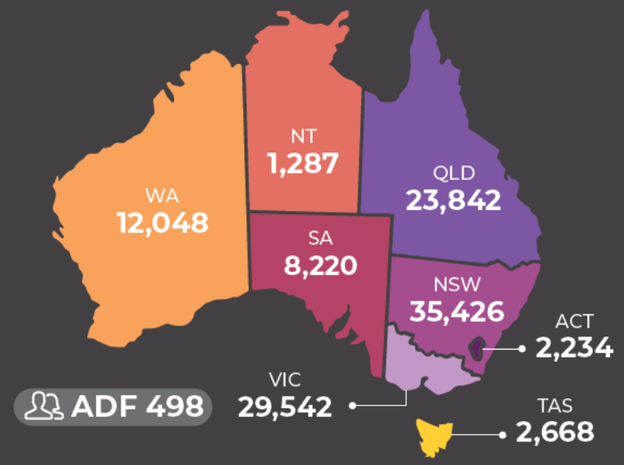
These counts may include persons who are 60+ years of age and/or who have incomplete COVID-19 vaccination; thus, they may not be indicative of true ADF Permanent health workforce deployability status. The count excludes protected identity members and other crafts who may be considered as working in the Health domain; therefore, totals will be lower than published workforce reports by Defence People Group.

An additional count is provided for the health workforce currently under training ("T", "U/G", "UG", "PG", "UT", "Intern", "MED TR", "MML 1", "Resident", "TR", "/T", "U/G") ") as identified by Function Short Description and Sub Function Short Description in PMKeYS and counted separately.

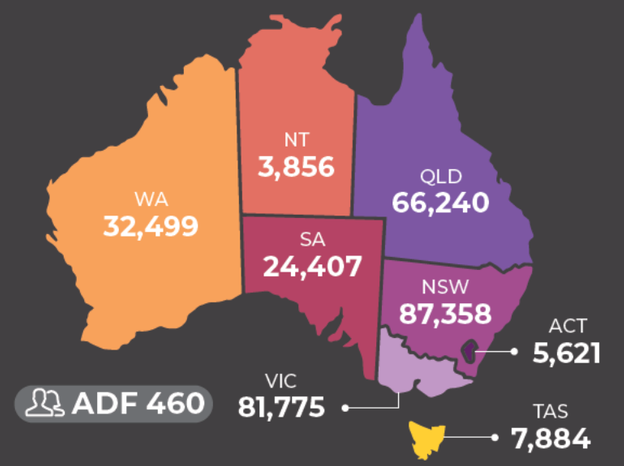
The count of members who were posted to Garrison Health centres includes anyone working at a Health Centre or JHU. The count of members who are posted to JHC HQ includes: ADF MIDI Enoggera, Garrison Health, Operational Health, HPP, Health Business & Plans, National Operations, and Joint Health Command (OCJHLTH). These categorisations were defined by each member's assigned Unit Long Description.

COMPARING THE ADF ACROSS THE NATION

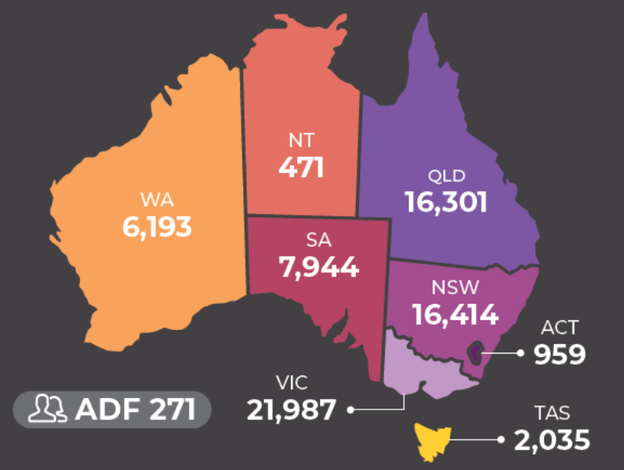
MEDICAL OFFICERS
*Registered Medical Practitioners **vs** SERCAT 3/4/5 ADF Medical Officers*



NURSING OFFICERS
*Australian Registered Nurses **vs** SERCAT 3/4/5 ADF Nursing Officers*



MEDICS
*Australian Enrolled Nurses and Paramedicine Practitioners **vs** SERCAT 6/7 ADF Medics**vs** SERCAT 6/7 ADF Medics*



Appendix 3 - ADF Health Services Contract Performance Measures

Inactive performance measures are either unable to be measured or not applicable.

Performance Measure		Frequency	Active/Not Active
Enterprise Key Performance Indicators (EKPI) – aim to deliver improved longitudinal health and functional outcomes for Eligible Personnel and value for the Commonwealth. Each KPI provides a contributory outcome against Defence objectives.			
EKPI-01	**Population Health Management** - Measures health outcomes for Eligible Personnel	N/A	Not Active There is ongoing consultation between Defence and Bupa to find appropriate and measurable health metrics.
EKPI-02	**Patient Experience** – Measures a patient's overall satisfaction and will be influenced by, but not limited to: timeliness, privacy, communication, ease of use, facilities, perception	Quarterly	Active
EKPI-03	**Command Experience** - Measures the satisfaction of the Command and will be influenced by the quality of the clinical outcomes, ability of the Services to enable the capability outcome through communication, reporting and understanding of the Defence environment.	Quarterly	Active
Contract Key Performance Indicators (CKPI) – measure the Contractor's performance in delivering the contracted health workforce to provide a joint health effect that enables capability and provides care for Eligible Personnel. This is reflected in the Contractor's ability to provide health service delivery capacity relative to the requested, scheduled hours, to support Defence Capability.			
CKPI-01	**Flex Fill Rate** - Measured based on Long and Extended Notice Flex Requests and not Short Notice Flex Requests.	Monthly	Active
CKPI-02	**General Fill Rate** - General Fill Rate is measured based on National T1 Critical Fill Rate, National T2 Critical Fill Rate and National Non-Critical Fill Rate.	Monthly	Active
Strategic Performance Measures (SPM) – Performance measures used by the Commonwealth to assess whether to award a Term extension to the Contractor			
SPM-01	**Agility to Support readiness** - Represents the Contractor's ability to be agile and flexible in scaling its workforce to meet Commonwealth requirements.	Quarterly	Active
SPM-02	**Commitment to Patient Satisfaction** - Measures the Contractor's commitment to patient satisfaction through the proper management of Complaints and Clinical Incidents.	Quarterly	Active

Performance Measure		Frequency	Active/Not Active
Strategic Performance Measures – Performance measures used by the Commonwealth to assess whether to award a Term extension to the Contractor.			
SPM-03	**Health Steward** - Continuously monitor and assess the Contractor's performance, processes and procedures in managing health stewardship and enterprise risk while delivering cost efficacy in support of the Services until the end of the Term.	Bi annually	Active
SPM-04	**Innovation** - Represents the Contractor's ability to demonstrate a continuous focus on innovation. The purpose is to monitor the Contractor's performance in demonstrating innovation in the provision of Services that is expected to result in strategic disruptive change and reduce the cost to the Commonwealth.	Annual	Active
SPM-05	**Defence Ready** - Represents the Contractor's performance in ensuring that it has sufficient health practitioners that are Defence ready.	Quarterly	Active
SPM-06	**Cost Control** – Represents the Contractor's ability to demonstrate cost control in the provision of the Services. The purpose is to continuously monitor the Contractor's performance in demonstrating cost control in the provision of the Services, in a manner that does not compromise the quality or the timeliness of the Services.	Bi annually	Active
SPM-07	**Relationships** - Represents the Contractor's ability to demonstrate positive working relationships.	Bi annually	Active
SPM-08	**Best for Defence** – represents the Contractor's ability to demonstrate Best For Defence behaviours.	Bi annually	Active
Strategic Health Indicators (SHI) – used to validate the effectiveness of the Key Performance Indicators (KPIs) and measure the performance of Services that are not linked to a Performance Incentive, measure the health of the Services, process efficiency or changes in environmental parameters or measure contract behaviours.			
SHI-01	**Readiness Dashboard** – The Contractor's performance in accurately reporting data concerning Readiness under the Contract.	N/A	Not Active The Health Information Office in JHC manage medical and dental fitness data.
SHI-02	**Population Dashboard** – The Contractor's performance in the accurate reporting of data concerning Population Health.	N/A	Not Active Data is obtained through multiple Defence sources.

Performance Measure		Frequency	Active/Not Active
Strategic Health Indicators – used to validate the effectiveness of the Key Performance Indicators (KPIs) and measure the performance of Services that are not linked to a Performance Incentive, measure the health of the Services, process efficiency or changes in environmental parameters or measure contract behaviours.			
SHI-03	**Average Resolve Time** – Continuously monitor the timeliness of the delivery of Services under the Contract.	Bi annually	Active
SHI-04	**Command Dashboard** – Continuously monitor the high-level Command aspects of the Services.	N/A	Not Active Some information is obtained though the EKPI02 Command Satisfaction Survey.
SHI-05	**Contractor Personnel Dashboard** – Continuously monitor the satisfaction of Contractor Personnel including their levels of job satisfaction, training, experience, understanding of Defence culture and turnover rate.	N/A	Not Active Information is provided via other sources. Bupa undertake their own contractor personnel surveys and provide relevant data to Defence if requested. JHC has undertaken a Pulse Survey to all JHC staff members, which includes CHPs.
SHI-06	**Cost Dashboard** – Continuously monitor the cost aspects of the Services.	N/A	Not Active Information is provided via other sources. Defence has a robust financial audit program in place and undertake annual periodic cost reviews. Financial trends are reported and monitored through Contact Governance meetings.
SHI-07	**Cost Transparency** – Continuously monitor performance in demonstrating Cost Transparency with the Commonwealth in order to promote greater efficiency and visibility of costs in the Services.	Bi annually	Active