



Submission No 31

**Inquiry into the Care of ADF Personnel Wounded and Injured  
on Operations**

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Submission to Defence Sub-Committee, Joint Standing Committee on Foreign Affairs,  
Defence and Trade.

## INQUIRY INTO THE CARE OF ADF PERSONNEL WOUNDED AND INJURED ON OPERATIONS

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Susan J Neuhaus CSC

### INTRODUCTION

#### **Background experience relevant to this Sub-Committee:**

Completed an Army career spanning over 20 years, working with both Regular Army and Reserve forces, in a number of roles; as a staff officer, a commander and a clinician (medical officer and surgeon).

- Graduate of Command and Staff College (Res);
- Promoted to Colonel in 2008;
- Military service recognised with the Conspicuous Service Cross in the 2009; Queen's Birthday Honours' List; and
- Operational experience includes deployments Cambodia, Bougainville and Afghanistan (as clinical director, NATO Role 2 Hospital, Uruzgan).

Active involvement in Veterans health issues.

- Member of the External Review Committee, Centre of Military and Veterans Health, 2011;
- Widely published on strategic implications of operational health care;
- Chairman of The Repat Foundation, a Not-For-Profit, supporting Veterans Health Research;
- Appointed to the Veterans Health Advisory Council, South Australia;
- Ambassador for the Defence Reserve Support Council, South Australia; and
- Leader of a research collaborative with particular interest in health outcomes of Australia's servicewomen and female veterans.

Appointed as Clinical Associate Professor of Surgery at University of Adelaide.

#### **Terms of Reference and Scope of Submission**

This submission will be limited to items 'c' and 'e' of the Terms of Reference, being:

- c) Care of wounded and injured personnel on return to Australia, including ongoing health, welfare, and rehabilitation support arrangements; and
- e) Management of personnel who cannot return to ADF service including:
  - (i) the medically unfit for further service processes;
  - (ii) transition from ADF managed health care and support to Department of Veterans' Affairs managed health care and support; and
  - (iii) ongoing health care and support post transition from the ADF.

## **SUBMISSION**

### **1. Fragmentation of Defence and Veteran Health Care – managing an un-quantified future dependency**

The Terms of Reference imply a focus on management of currently injured personnel. However, in addition to the acknowledged number of ADF personnel wounded and injured during service in operational areas, the burden of ‘unseen wounds’, in particular the results of mental health injury sustained on recent operations, are not likely to emerge for many years.

Whilst the majority of these ‘unseen wounds’ are likely to relate to mental injury, studies have shown that physical impacts of service may also take a considerable time to be recognized (e.g. back injuries, effects on future fertility or cancer risk).

Currently, the health needs of Defence and Veteran personnel are met by a complex array of providers, agencies and entitlements. A number of agencies may be involved including:

- Federally based agencies such as DVA (and its subsidiaries VVCS and DCO) or Medicare;
- State and Territory health systems (including services not funded by DVA and public mental health services in community and inpatient settings);
- Private providers; and
- an increasing range of charitable groups and Non-Government Organisations.

Whilst DVA provides for those with established ‘entitlements’, there are a number of vulnerabilities, particularly for those without established claims, and for those who may not be aware of the linkages of their condition to their service. This is of particular relevance post transition from the ADF (e.g. orthopedic and obstetric issues or delayed mental health).

Sub-populations who may not identify, or be identified as part of the Veteran cohort and may be otherwise at risk, also need to be accounted for. This group potentially includes Veterans of Peacekeeping operations, Reservists, female Veterans and families, each of whom are likely to have specific health needs. In addition, there are specific conditions that are more relevant to specific ADF employment groups: for example back injuries and pilots, hearing degradation and artillery, and chemical exposure for engineers.

This complexity, and the lack of a unique veteran identifier within Federal, State and Territory Health organisations, creates challenges as it relies on the individual and/or their health professional to make a linkage of their medical condition to a particular aspect of their service. Furthermore for the individual, such a complex system can be difficult to navigate, particularly when suffering from illness.

The capacity of health series to accurately identify serving members, veterans and their families at the point of access is important for a range of reasons. Not least of these is that it enables provision of more appropriate service responses, enhances ability to monitor health services across these groups and a mechanism by which comprehensive data collection includes all points of entry into the health care system for those with service related conditions. Currently service provision is based on DVA entitlement figures, which underestimates the total burden of service related health conditions.

The inadequacy of appropriate services following the Vietnam conflict is well recognized. Delay in recognising, understanding, or responding to the health issues of our current generation of ADF service personnel will impact not only individual Veterans, but their

families and the broader community, through the social and economic burden and health care cost).

It is critical, for current and future veterans, that active health advocacy and research is undertaken. This will enhance understanding of:

- the nature of the health issues arising from service;
- any barriers to care;
- emerging trends in treatments;
- development of service delivery models; and
- mitigation strategies that need to be developed, tested and implemented.

A system integrated across the spectrum of 'service-to-veteran' health care, would not only provide greater equity of health care for all with service related health conditions, but would enable greater coordination and synergy between multiple care providers and agencies.

## **2. Coordination and Governance of the health research agenda**

The complexity of health service delivery is replicated in the field of Defence and Veteran Health research. Care of wounded, injured and ill service personnel and veterans is currently underpinned by a fragmented research agenda. There is an inherent polarity of research focus between DVA and the ADF.

The risks of a fragmented research agenda are that there may be;

- Significant research 'gaps' in areas of current/future relevance;
- Duplication of research effort;
- Failure to address the continuum of care across the entire 'service-to-veteran' cohort, or exclusion of vulnerable groups (e.g. reservists); and
- Failure to translate research outputs into improved, innovative and effective health care programs that improves the quality of life of those that have served.

A national strategic health research program addressing the needs of ADF personnel wounded or injured on operations, and the subsequent veteran cohort requires:

- Ongoing health surveillance and identification of veterans needs over their lifetime;
- Driving and coordinating a nationally driven research agenda specific to veterans' needs; and
- Translating knowledge into the development of innovative and targeted programs for prevention, mitigation and treatment;

This can only be achieved via the national coordination of research priorities, development of education, early intervention and outreach strategies to improve the health and wellbeing of current and future veterans and their families.

## **3. Leveraging the lessons of war into the wider civilian community**

Throughout history, war has provided advances in medicine that have benefited the wider civilian community. Many of the health lessons learned from contemporary operations have direct relevance to the civilian community. Examples include advances in trauma management and use of novel blood agents.

Current models of defence and veteran health research are not optimized to achieve this leverage. In particular, current models are heavily weighted to contract health research. This creates an environment which is less conducive to traditional academic outputs – publications, peer review, scientific scrutiny, and competitive grant funding.

It is in the area of PTSD that the greatest legacy from ADF operations in recent years is likely to come. Translation of evidence-based research into clinical practice, and development of early intervention and mitigation strategies will translate to wider Australian community benefit, particularly in Emergency Services, disaster response, and communities affected by flood or bushfire.

It is only by such integration of Defence, Veteran and community health research that the social and economic impact of both war and national disasters on Australian society can be reduced.

#### **4. RECOMMENDATIONS**

(1). **Increase the capacity of the national health system to track the future dependency of personnel wounded, injured or harmed by ADF operations.**

This can only be achieved by a robust commitment to longitudinal research studies, in order to identify lag effects, late presentation, and unseen wounds or as yet unidentified health consequences of service.

(2). **Clarify ADF-Veteran service delivery models to reduce complexity, overlaps and gaps in service.**

Development of a holistic and simplified service model, integrated with existing clinical networks, agencies and providers would ensure equity of access and care for all veteran cohorts.

(3). **Develop a unique service/veteran health identifier.**

Identification of service-related issues at point-of-entry into the health system, and longitudinal linkages would be facilitated by a unique service/veteran identifier.

(4). **Establish strategic research priorities to address the needs of those wounded injured or harmed by defence service and national disaster events at a national level.**

This will provide integration, coordination and research governance across the entire 'service-to-veteran' continuum. Further, such a mechanism will ensure that health research outputs and findings are translated into improved care delivery models thereby providing the greatest benefit to wider Australian community.

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