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Aeromedical Evacuation

3.1 This chapter considers the aeromedical evacuation (AME) process and continues to highlight the importance of family in repatriation and recovery.

3.2 It also discusses the tax and leave entitlement implications of an early return to Australia for a wounded soldier when compared to the soldier's compatriots who remain in theatre on operations.

Australian aeromedical evacuation capability

3.3 Defence submitted that Australian Defence Force (ADF) Aviation Medical Officers, located at Kandahar Air Field in Afghanistan, are responsible for coordinating the AME of ADF casualties by either ADF aircraft, or through the United States (US) AME system. Casualties evacuated by ADF aircraft are provided medical care in the air by the Royal Australian Air Force (RAAF) personnel.[1] One soldier aeromedically evacuated commented that:

> My treatment has been awesome. … That is across the board from the AME team that brought me home on day two, to the doctor, the psychologist and psychiatrist that I have here in town now.[2]

3.4 Patients requiring transfer to the US Role 4 Landstuhl Regional Medical Center are evacuated by the US AME system. They are cared for by US

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1 Department of Defence, *Submission 17*, p. 7.

2 Sergeant (Sgt) Craig Hansen, 7th Battalion Royal Australian Regiment, *Committee Hansard*, 8 February 2013, p. 26.

medical personnel, and supported by a dedicated ADF AME-trained RAAF nursing officer throughout the conduct of their AME.[3]

AME direct to Australia

3.5 Defence submitted that ADF members who require return from operational areas for medical reasons are evacuated to Australia via the Air Force strategic AME system. The AME system seeks to ensure that members are evacuated in a safe and appropriate manner. It also provides a valuable patient tracking function ensuring that returning members are identified to the ADF medical system, Defence Community Organisation (DCO) and their chain of command for management and support.[4]

3.6 Air Marshal (AIRMSHL) Mark Binskin AO, Acting Chief of the Defence Force (CDF), told the Committee that Defence's aeromedical evacuation teams are 'second to none', and provide first-class care when bringing Australia's wounded and injured home.[5]

3.7 Once it is known that an ADF member has been wounded or injured, Joint Health Command liaise with Headquarters Joint Operations Command (HQJOC), the Air Operations Centre (an Air Force element embedded within HQJOC) and health staff within the area of operations to ensure that the wounded or injured member is repatriated to the most appropriate health facility. This could be a Defence health facility or a public or private hospital, depending on the nature of the condition and requirements for health care.[6] Lieutenant Colonel (LTCOL) Michael Reade, Defence's Professor of Military Medicine and Surgery told the Committee:

> The provision of that care has also become excellent. Again, it was not initially. We would not have the facility, for example, at the outbreak of all of this to return a critically ill mechanically ventilated patient to Australia but we have now the airframes, we have got the medical equipment that is compatible with those airframes and we have got the trained and now experienced clinicians to do that. So it is really an outstanding medical system up until the point of return to Australia.[7]

3 Department of Defence, *Submission 17*, pp. 7-8.

4 Department of Defence, *Submission 17*, p. 13.

5 AIRMSHL Mark Binskin AO, Acting CDF, *Committee Hansard*, 9 October 2012, p. 1.

6 Department of Defence, *Submission 17*, p. 13.

7 LTCOL Michael Reade, Professor of Military Medicine and Surgery, *Committee Hansard*, 25 March 2013, p. 24.

3.8 Wounded or injured personnel are repatriated to a facility within their home area where possible; however this depends on the nature of the wounds or injuries and the services available at that location. Access to family and their Unit/Service support is also considered in the return to Australia planning.[8]

3.9 On return to Australia, medical/clinical management of the care of the wounded or injured individual is transferred to Garrison Health Operations, and a comprehensive range of clinically appropriate health care is delivered through one of the five Regional Health Services. As previously stated, the overall responsibility for ensuring the support and welfare of the member remains with the member's Commander.[9]

AME via Germany

3.10 While most wounded or injured ADF members can be directly returned to Australia, members who become critically ill or injured while in the Middle East Area of Operations (MEAO) may be evacuated by the US AME system to the US Role 4 Military Hospital in Germany.[10] The AME Operations Officer situated in Afghanistan and the Aeromedical Evacuation Control Centre (AECC) would assist in this transfer decision. This AME is usually by the US AME system on a dedicated tactical C–130 AME flight to Bagram, then by strategic C–17 AME flight to Germany. If a delay in Bagram jeopardises the clinical situation, a C–17 could be used from any Role 3 health facility for direct transport to Germany.

3.11 The AME Officer in-theatre is responsible for coordinating the AME of ADF members to Germany. HQJOC AECC is then responsible for organising the subsequent AME to return members to Australia when clinically appropriate.

3.12 ADF casualties who enter the US AME system are all provided with an ADF medical escort. Within the MEAO there is an AME Liaison Officer whose primary role is to provide this escort duty. Other ADF escorts may also accompany casualties transferred to Germany, such as a unit representative to provide emotional support and assistance to the patient.

3.13 When a casualty arrives in Germany, the AME liaison role is then transferred to another AME trained liaison officer who has been dispatched from Australia. Typically this liaison officer is an AME and

8 Department of Defence, *Submission 17*, p. 13.

9 Department of Defence, *Submission 17*, p. 15.

10 Department of Defence, *Submission 17*, p. 13.

aviation nursing qualified registered nurse, or depending on complexity of the case, an additional AME and aviation medicine qualified medical officer may also be required.

3.14 The presence of an ADF medical liaison officer ensures that there is direct communication of clinical details throughout the AME process, as well as visibility of the patient's movements and ensures that the member is never left without support or contact with the ADF. The liaison officer provides clinical updates and advice on the patient's 'fitness to fly' for strategic AME. They also provide assistance to any next of kin who may travel to Germany. They are integral to the AME planning process, providing accurate and timely clinical information and usually form part of the AME retrieval team to Australia.[11]

3.15 Defence advised that the US AME system had facilitated the movement of four Australian casualties in 2012. These personnel transited through Landstuhl Regional Medical Center for a period of approximately seven days, before their evacuation to Australia. Their medical care at Landstuhl included surgery, multiple investigations, wound care, and intensive and general nursing care.

3.16 Care in Landstuhl is directed towards improving casualty outcomes and expediting their return to Australia. While at Landstuhl casualties are supported by Australian health personnel and commonly members from their Unit.[12]

Case management

3.17 Defence advised that an individual's case is managed through the Member Support Coordination system which is designed to ensure that:

- the member:
  - ⇒ remains the central focus of support;
  - ⇒ is supported effectively;
  - ⇒ has, in the Member Support Coordinator, a single point of contact with whom they may turn to for assistance, support and guidance (but not specialist advice);
  - ⇒ understands the support and services available to them and their family;
  - ⇒ receives coherent and coordinated support tailored to their needs;
  - ⇒ understands their obligations during the period of support;

11 Department of Defence, *Submission 17*, pp. 13-14.

12 Department of Defence, *Submission 17*, pp. 7-8.

- ⇒ is provided with all the information and specialist advice needed to make sound and timely judgements;
- the member's Commander is provided with the resources, support and access to the additional skills required to ensure the facilitation and coordination of all necessary support.

3.18 Member Support Coordination arrangements are established to support individual cases where there are complex circumstances and comprise:

- the member and their family;
- the member's Commander, who remains responsible to the relevant Chief of Service for the continued support and wellbeing of the member;
- a Member Support Coordinator;
- a Healthcare Coordinator; and
- all health and administrative agencies and service providers, both within and external to Defence, who are engaged with, or support, the member.[13]

Family support

3.19 The Defence Community Organisation provides emotional and practical support to the family in the form of social work and counselling or referral to appropriate community support and services.[14]

3.20 Defence advised that DCO administers the Australians Dangerously Ill Scheme that allows for a nominated family member or close friend to access financial assistance to visit and support an ADF member who has been hospitalised through serious wounding, injury or illness. The DCO facilitates the movement of eligible family members under this scheme to visit their wounded family member who has been evacuated to Germany. Family members are usually accommodated at one of two US military supported 'Fisher Houses' immediately adjacent to the Landstuhl Regional Medical Center.

3.21 Fisher House is a non-profit social service providing a 'home away from home' for family members of ill/injured patients and is located within walking distance of the treatment centre. The homes have been built by the Fisher House Foundation and given as gifts to the United States military Services. The houses are manned six days a week to help family

13 Department of Defence, *Submission 17*, p. 10.

14 Department of Defence, *Submission 17*, p. 15.

members endure the stresses associated with a loved one's serious medical condition. Social workers are also available throughout the week.[15]

3.22 Defence Families of Australia (DFA) submitted that in the event of a multiple casualty incident requiring more than one family being flown overseas at the same time, that one case worker or support officer per family is required.[16]

3.23 Defence advised that in 2012 the ADF made a donation of $225,000 to the Fisher House Foundation in recognition of the outstanding support provided to ADF families during these difficult times.[17]

Recommendation 1

The Committee recommends that the Department of Defence continue to make regular contributions to Fisher House as an ongoing measure of Australia's appreciation for the service provided to our wounded soldiers, until such time that Australian soldiers are no longer deployed to Afghanistan.

3.24 Defence advised the Committee that DCO works closely with the military chain of command to manage the support requirements of the member and their family to ensure the wounded or injured member has the best chance of recovery and the family is adequately supported to reduce their stress.[18]

3.25 DFA highlighted the importance of provision being made for next of kin to visit the member if repatriation to home locality is not immediately possible (or at least access to communications), no matter where rehabilitation is to occur.[19]

3.26 The Returned and Services League of Australia (RSL) National Office advised that it regularly supports deployed personnel through its RSL Australian Forces Overseas Fund (AFOF) which provides a package twice a year to every serving member overseas, including those who required treatment through the NATO medical facilities in Germany.[20]

15 Department of Defence, *Submission 17*, p. 14.
16 Defence Families of Australia, *Submission 8*, p. 1.
17 Department of Defence, *Submission 17*, p. 14.
18 Department of Defence, *Submission 17*, p. 14.
19 Defence Families of Australia, *Submission 8*, pp. 1-2.
20 Returned and Services League of Australia, *Submission 11*, p. 6.

Return to Australia from Germany

3.27 Identification and confirmation of the most appropriate destination medical facility, for the patient on return to Australia is done in consultation with the patient, next of kin, Joint Health Command and the member's respective Service. The most suitable means for the AME is identified by the AECC; military air, civilian charter or civilian airline, using standard or critical care (Military Critical Care Aeromedical Team) AME teams as appropriate. This is intended to ensure the patient receives appropriate care and is returned safely to Australia.

3.28 Most AME returns from the MEAO and Germany can be conducted on civilian airlines using RAAF AME teams. When this is not appropriate, ADF aircraft can be utilised. Defence advised that in the last two years, the RAAF has conducted two multi-casualty AME retrievals of injured ADF members from Germany. In both cases, these AME missions involved multiple patients with complex care requirements, including intensive care type support. These missions were conducted on C-17 aircraft using both Permanent Air Force and Reservist AME trained personnel, and the dedicated C-17 AME equipment suites.

3.29 There have also been several C-17 AMEs conducted directly from the MEAO when the patients were not suited to other available means of transport.[21]

Tax implications

3.30 The Veterans' Advisory Council (VAC) of South Australia expressed concern at the inequity that appears to exist between the way wounded soldiers who are returned to Australia are taxed, and the way other soldiers who remain on active service deployment are treated for tax purposes.

3.31 Under current arrangements, a soldier in this situation is entitled to receive their tax-free salary and accrue War Service Leave while in hospital, but not during outpatient treatment or rehabilitation. This means that any soldier wounded in action also suffers a financial detriment relative to soldiers continuing their deployment. This is felt most by a soldier who is wounded early in a tour of duty. A soldier in this situation would lose all tax-free pay and allowances after leaving hospital in Australia, thereby not only suffering physically and mentally in the line

21 Department of Defence, *Submission 17*, p. 14.

of duty, but also financially. Sergeant Craig Hansen, 7th Battalion Royal Australian Regiment, commented that:

> Maybe that is a little bit unfair because my mates, my soldiers, are still in Afghanistan and I am here through no fault of my own.[22]

3.32 The VAC's suggested solution was that wounded soldiers medically evacuated to Australia remain on the same taxation arrangement as those remaining in-country until they return to Australia.[23] Sgt Hansen, who was one of the first soldiers injured in Afghanistan, has had a private tax ruling agreeing that the income he earned in Australia from the date of his discharge from hospital until the expected end date of his overseas deployment, would be exempt from income tax in Australia under subsection 23AG(1) of the *Income Tax Assessment Act 1936* (ITAA 1936).[24]

3.33 The RSL's National Conditions of Service Committee also identified this as a critical problem. They similarly recommended that tax free status should be retained, particularly while the member is undergoing out-patient treatment and/or rehabilitation, for the notional length of the operational tour.[25]

3.34 As noted by the VAC, this loss of eligibility also applies to the accrual of War Service Leave for ADF members wounded or injured on operations and evacuated to Australia.[26]

3.35 VAC submitted that these recommendations would cost, based on an approximate average tax disadvantage per wounded soldier of $5,000.00, a total of approximately $1,200,000 for veterans of the Afghanistan campaign.[27] The Committee estimates that these soldiers could have accrued a total of approximately 500 additional leave days.

Committee comment

3.36 The committee agrees with Young Diggers in that Australian repatriation arrangements are excellent and commends Australia's AME organisation for their efforts.

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22 Sgt Craig Hansen, 7th Battalion Royal Australian Regiment, *Committee Hansard*, 8 February 2013, p. 22.

23 The Hon. Jack Snelling MP, *Submission 13*, pp. 1-2.

24 Mr Michael (Baron) von Berg MC, Veterans Advisory Council of South Australia, *Committee Hansard*, 8 February 2013, p. 22.

25 Returned and Services League of Australia, *Submission 11*, pp. 5-6.

26 The Hon. Jack Snelling MP, *Submission 13*, pp. 3-4.

27 The Hon. Jack Snelling MP, *Submission 13*, p. 3.

3.37 The Committee agrees that solders repatriated from operations due to injuries or wounds sustained in the course of authorised activities are currently treated inequitably in terms of tax and leave entitlements. The Committee recommends that tax and leave arrangements be reformed to eliminate this inequity.

Recommendation 2

The Committee recommends that the Department of Defence and the Australian Taxation Office ensure that Australian Defence Force personnel medically evacuated to Australia retain tax free status for the notional length of their operational deployment, or the actual length of the deployment of their unit, per subsection 23AG(1) of the *Income Tax Assessment Act 1936*.

Recommendation 3

The Committee recommends that the Department of Defence ensure that Australian Defence Force personnel medically evacuated to Australia continue to accrue War Service Leave and allowances for the notional length of their operational deployment, or the actual length of the deployment of their unit.

3.38 These recommendations should apply from the moment a member qualifies for tax free status on departure on operational deployment.

Recommendation 4

The Committee recommends that the Department of Defence and the Australian Taxation Office assist Australian Defence Force personnel previously medically evacuated, and to whom Recommendations Two and Three would have applied, to make successful retrospective claims for reimbursement.

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