Foreign Affairs, Defence and Trade References Committee

Taking stock

Current health preparation arrangements for the deployment of Australian Defence Forces overseas

August 2004

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Terms of reference

(1) That the following matters be referred to the Foreign Affairs, Defence and Trade References Committee for inquiry and report:

(a) the adequacy of current arrangements within the Department of Defence for the health preparation for the deployment of the Australian Defence Forces (ADF) overseas;

(b) the adequacy of record keeping of individual health and treatment episodes of those deployed, and access to those records by the individual;

(c) the adequacy of information provided to individual ADF members, pre-deployment, of the likely health risks and anticipated remedial activity required;

(d) the adequacy of current arrangements for the administration of preventive vaccinations, standards applied to drug selection, quality control, record keeping and the regard given to accepted international and national regulation and practice;

(e) the engagement in this process of the Department of Veterans' Affairs and the Repatriation Medical Authority for the purposes of administering and assessing compensation claims; and

(f) the adequacy of the current research effort focussing on outstanding issues of contention from the ex-service community with respect to health outcomes from past deployments, and the means by which it might be improved.

(2) That, in undertaking the inquiry, the committee consider recommendations for an improved system within the Defence and Veterans' administrations which will give greater assurance to the individual that their health risks are minimised, and fully recorded for the purposes of future compensation where justified.

Summary of findings and recommendations

General

The Committee finds:

- Australia's veterans remain concerned at the unknown long term effects of exposure to hazardous material during deployments overseas.
- Some veterans are therefore concerned at their continuing ineligibility to obtain either health care for disabilities in question, or compensation.
- With respect to exposure to radiation in Japan and during the atomic tests in Australia in the 1950's, successive Australian governments have been reluctant to accept any but a few downstream health problems due to lack of sufficient medical scientific evidence on cause and effect, and the unavailability of exposure data.
- Despite the broad and generous application of the benefit of the doubt in Australia, policy with respect to scientific evidence on cause and effect is stricter than in the USA and New Zealand where a presumptive policy has been more readily applied.
- Australian veterans would like more use to be made of the presumptive policy as contained in Section 180 of the Veterans Entitlement Act.
- Australia's restricted use of presumptive policy and the concentration on medical scientific research remains appropriate.

Recommendation 1

The Committee recommends that the current restricted use of presumptive policy and the concentration on medical scientific research continue.

- Research by successive Australian governments into the long term effects of exposures to various substances decade may have been inadequate until the last decade, but reflected the state of research internationally, and the long gestation time of many disabilities, particularly cancers.
- Australian governments in the last decade have been much more active in collecting baseline health data through surveys of various veteran populations, with the result that veterans can feel more assured that their concerns are not being ignored.

Recommendation 2

The Committee recommends that this type of data collection become an integral part of ADF and DVA assessment of deployed personnel, so that basic information is available for researchers on health status at return from deployment.

- Recent mortality studies of Korean and Vietnam veterans have reinforced the views of veterans that their service has seriously affected their health**,** and reduced life expectancy.

- The long term separation of medical research management between the Departments of Veterans' Affairs and the Department of Defence has hindered a more holistic consideration of veterans' concerns.

- Current institutional changes, as evidenced by the creation of the Centre for Veterans**'** and Military Health, link the research capacity of DVA and Defence. This is a positive move which will lead to better prioritisation and bring greater focus to the need for better medical scientific knowledge.

- The international effort now being made in establishing the aetiology of illness and disease is such that veterans can have greater assurance that the shortcomings of medical science in the past will be more readily eliminated.

Recommendation 3

The Committee recommends that DVA and Defence ensure veterans are kept up to date about research on key issues and how these may have led to amendments in previous SOPs.

Current claims assessment

The Committee finds that:

- Despite veterans' concerns, the current process of claiming disability pension is working well, and that the current policy with respect to application of the benefit of the doubt, and the reliance on medical science as determined by the RMA, remain appropriate.

- While access to service and medical records by veteran claimants is generally satisfactory, the state of those records in recent years has declined so [to] such a state that claimants can have little confidence as to their accuracy or completeness.

Recommendation 4

The Committee recommends that:

In respect of recent deployments, the ADF ensure that a report on all likely exposures, records of potentially traumatising events, and statements as to injury and illness be available for all personnel. Updates should also be provided; and

In respect of earlier deployments, DVA continue with its practice of reconstruction of evidence, ensuring that all appropriate methodologies are utilised including those from new research.

- Access to some records where held by foreign governments in cases of attachment to allied forces, is highly unsatisfactory.

Recommendation 5

The Committee recommends that:

With respect to future deployments, a protocol be established to ensure complete and accurate copies of medical records are provided; and

With respect to relevant past deployments, DVA establish the location of medical data and records and identify the most effective way of obtaining copies of these.

- Veterans' views, that access to information is difficult, are reasonable. The RMA website in particular is not readily comprehensible.

Recommendation 6

The Committee recommends that the ADF and DVA work together to ensure that all relevant information, including that on illness, research and the impact of legislative change, is provided in a straightforward style and a user–friendly format. In particular, information provided on RMA Statements of Principle (SOPs) should use everyday terminology and provide links to specific SOPs.

Defence Health Administration

The Committee finds that:

- Administration of health in the ADF has long been plagued by shortage of skilled and qualified staff in a labour market suffering continual shortages.

- Administration of health in Defence, once divided between the services, has undergone considerable rationalisation and that efforts are continuing to achieve more effective and streamlined services.

- Considerable scope remains to further rationalise the coordination of medical research and service provision to all serving and ex service personnel receiving services from both the Department of Veterans' Affairs and the Department of Defence.

Recommendation 7

The Committee recommends that the Links Program continue in order to ensure effective rationalisation of service provision and co-ordination of medical research by the ADF and DVA.

- Planning for deployments both with respect to environmental hazards and exposure to all other risk to the health and safety of ADF personnel has dramatically improved, though records of that preparation and actual experience during deployment needs to be better communicated made more available post deployment.

Recommendation 8

The Committee recommends that detailed briefings on health issues be provided as much as possible in advance of deployment and that this information also be available in written format, for use on deployment and also for files. Updates must be communicated as soon as possible and centrally stored on computer based information systems as accessed by the ex service community.

- Information on personal health protection and treatment services, including vaccination regimes, needs to be better communicated to all personnel deployed.

Recommendation 9

The Committee recommends that a more effective electronic system of current health status be developed, allowing health service personnel to determine needs quickly pre-deployment and also providing opportunity for individuals to check their records and ensure these are accurate and complete.

- Pre deployment health checks for personnel have improved, but more attention could be given to psychological briefing, preparation and assessment prior to embarkation.

Recommendation 10

The Committee recommends that all briefings and assessments on potential deployment psychological issues must be developed or cleared by a psychiatrist with relevant experience.

- Equally**,** post deployment health checks, debriefing and assessment need to be given continued emphasis, with record keeping of those assessments being given priority.

Recommendation 11

The Committee recommends that priority be given to ensuring that accurate records are maintained of all post deployment briefings, checks and assessments, and that individuals be able to access these records.

- Defence is committed to improving the health status and recording of data on personnel to be deployed.

Recommendation 12

The Committee notes and commends the improvements made in health status and data collection of deployable forces, and recommends that this continue to be a priority.

- There is confusion within Defence ranks and among personnel with respect to the appropriate status and classification of medical personnel, and at the continuity of care available throughout any deployment.

Recommendation 13

The Committee recommends that terminology be clarified to ensure personnel are aware of the status of 'medical officers' and 'medical personnel'. Information on the level of 'medical officers' on deployment should be part of pre–deployment briefings. Records of medical services provided by other forces must include information on the treating doctors so that any required follow up can be facilitated.

Vaccination

- The Committee finds that while some aspects of the anthrax vaccination issue were exaggerated, the lack of pre-deployment information coordination demonstrated flaws in the deployment preparation process and in information co-ordination more generally.

Recommendation 14

The Committee recommends that all information in manuals be checked against other data provided to ensure consistency.

- The Committee finds that the importance of OH&S policy and administration is receiving more priority within Defence, but that a significant level of concern remains at the promulgation of those policies, the lack of accountability, and the need for incentives to do considerably better.

- The Committee finds that Defence is aware of the particular health needs of women, but it should demonstrate this by identifying the effect of policy and program changes on women's health status on an annual basis.
- Maintenance of health records for serving personnel in recent years has become chaotic due to incomplete information and shared responsibility.

Recommendation 15

The Committee recommends that personnel be made fully aware of potential problems with their health records and provided with the opportunity to obtain a copy of these well before discharge with a view to identifying and rectifying information gaps.

Recommendation 16

The Committee recommends that some form of electronic copy be made of health records of current personnel, both to facilitate their access to services if required and also to supplement HealthKEYS when this becomes operative. A copy of such information should also be held by Defence with ready access by DVA if required.

Research

The Committee finds that:

- DVA has become much more proactive in its research and more aware of the importance of obtaining as much data as possible rather than waiting for veterans to identify needs later.
- There has been improved rationalisation of research projects because of effective liaison between relevant agencies.
- Recent efforts have been excellent, though more needs to be done in communicating processes and outcomes to the veteran and ex service community. The Committee has made a recommendation above in respect of improved information access on research and other issues.
- Priorities for research need to be considered consultatively with the ex service community leadership.
- Mental health projects should continue to receive priority, including, where appropriate, specific projects on problems arising from peacekeeping and peacemaking.

Senator Steve Hutchins

Chair

CHAPTER ONE

BACKGROUND

> The perceptions and expectations of military personnel and their families have changed. No longer can the military health system just deliver a fit fighting force and care for battlefield casualties. It must also address the potential long–term health effects of military deployment including low level environmental exposures, occupational risks and psychological stress. The Australian Government, including the Department of Defence, has a continuing obligation of care for those who volunteer to serve in the ADF when in service and after discharge.[1]

1.1 The terms of reference of this inquiry were developed to address a number of questions about the extent to which the ADF had the capacity in its provision of health services to minimise potential injury or illness to personnel while on deployment, and post deployment.

1.2 This reflects the concern of veterans and ex service personnel that the health effects of exposure to a range of hazardous substances has not been sufficiently recognised and that compensation is not payable for a range of disabilities which they believe are service related.

1.3 The terms of reference therefore focus on current administrative arrangements between the Departments of Defence and Veterans' Affairs which have divided responsibility. It is suggested that within each agency, and between each agency, there are some serious discontinuities which prevent a more holistic approach to the management of health prior to, during, and after service.

1.4 Several of these issues have been addressed or discussed in recent reports, including the Clarke report on veterans' entitlements,[2] which listed a number of similar matters, and made recommendations for changes; and in specific studies on different conflicts. Nonetheless, a number of questions remain unanswered in that some groups are dissatisfied with the outcomes of these reports, or some inquiries have not yet been completed.[3] These questions include the following, against which the terms of reference are noted:

- If deployment health services in general meet their objective; 1(a)
- If there are adequate processes in place to identify and minimise the effect of environmental/chemical /biological hazards in more recent conflicts, and if the information on these is also maintained on individual files; 1(a), 1 (b), 1(c)

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1 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 1, paragraph 2.

2 Hon John Clarke, QC et al, *Report of the Review of Veterans' Entitlements*, Canberra 2003.

3 See below, Chapters 3 and 4.

- Whether the personal medical and related records of individuals in the ADF, and veterans, contain full and accurate information, including on environmental exposures; 1(c)
- If information provided on health risks and on drugs/vaccinations especially 'pre–deployment', is adequate; 1(c)
- Whether there is rapid access to personal medical records, especially for the purpose of filing a claim; 1(b)
- If there is rationalisation of research work undertaken by the ADF and by the Repatriation Commission and effective amalgamation; and whether this research is addressing the needs of ADF personnel and of veterans of earlier conflicts; 1(f) and
- The roles and effectiveness of all parties/agencies involved in deployment, record keeping, research and claim assessing; 1(e).

1.5 The Australian Defence Force (ADF) comprises three separate forces, Army, Navy and Air Force. The management and administration of each is a separate responsibility, and the day to day provision of health services to serving personnel has varied over time. At times each force had its own set of services, many of which were under-utilised, and it is only recently that there have been effective moves to centralise and integrate, following several reviews in the last few years which have emphasised high costs and waste, albeit mostly in non–deployed services, and recommended centralisation and greater efficiency in operation.[4]

1.6 Much of the emphasis on change in the ADF has followed similar strategies operating in both the United States and the United Kingdom, both of which have deployed substantially larger forces to a wide range of conflicts and other missions.[5] Above all, the objective of these strategies is to ensure that the deployable staff are fit and that injury and illness are minimised and treated effectively. However, there has not been a corresponding emphasis until recently in the ADF on appropriate training practices and occupational health and safety.[6] The effect of this has been to reduce the number of persons who complete the recruitment training, and limit the number of active personnel available for deployment. With a greater awareness of the effect of

4 See Australian National Audit Office (ANAO), Audit Report No.34 1996-97 *Australian Defence Force Health Services,* Canberra 1997 and Audit Report No**.** 51 2000-2001 *Australian Defence Force Health Services Follow-up Audit*, Canberra 2001. For other reviews, see *Defence Efficiency Review* 1996, *Defence Reform Program* 1996/97 (see below, Chapter 2, paragraph 2.17**,** and Inspector General Department of Defence Inquiry HealthKEYS, 2002 (*Submission* 9A, Defence Organisation, Question 7). Defence also advised on the nature of another recent review: 'The purpose of the Defence Health Service (DHS) Review, conducted by Major General J.P. Stevens, AO (Retd), was to evaluate whether the DHS was able to meet Defence's need for health services in the short to medium term and to propose any changes that may be necessary to achieve this,' *Submission* 9B, Defence Organisation, p. 5, Q3—additional details are contained in that document.

5 See Chapter 2, paragraphs 2.1–2.5.

6 See below, paragraph 1.7 and Chapter 2, paragraphs 2.92–2.93.

training and other injuries[7] and also of the poor occupational health and safety record in the ADF,[8] there is now more emphasis on preventive and pro–active approaches.

1.7 Previous lack of harm minimisation policies in operation within Australia resulted in resources being wasted and many problems not being identified until later, which can have the further effect of higher costs for rehabilitation or pensions. At the same time as there have been complaints about the use of chemicals and other substances in conflicts, there has also been a limited understanding of the effect of chemical hazards in the workplace, as illustrated by the report on the F–111de–seal/re–seal process at Amberly.

1.8 The extent of health services required for deployment will vary according to the size of the force and the nature of the deployment. In joint operations with major powers, Australia (with a very small force, relatively speaking) will only be required to send level 3 services which are essentially emergency treatment, as in–patient care will be provided by allies. In other instances, such as Timor, Australia may help operate a UN hospital and take a much greater role, with many more 'medical' staff being deployed. However, deployed health personnel also include psychological services, and there is often a requirement for health updates which may demand the provision of additional preventive treatment in the field.

1.9 Little direct information was provided about the quality of most of these services, but some problems were identified with the availability and accuracy of information on some processes, including exposures to various substances and the recording of such exposures, and with information on vaccinations.

Repatriation Commission/Department of Veterans' Affairs

1.10 Health services and disability payments for former members of the ADF are managed by the Repatriation Commission, which delegates its powers to the Department of Veterans' Affairs (DVA).[9] In recent times there have also been several reviews of, and reports on, aspects of the relevant legislation, the *Veterans' Affairs Entitlements Act* 1986, many of which have addressed concerns about the equity of

7 See Chapter 2, paragraphs 2.92–2.93.

8 'The rates of death and serious personal injury encountered in garrison conditions across all Australian Services remain considerably higher than for matched industry groups. As a result of injuries, significant numbers of personnel are unavailable for deployment and are restricted in performance of their normal duties,' Group Captain Peter S Wilkins, 'Occupational health and Safety Challenges for the ADF', *ADF Health,* 5 (2004) p. 1, and Chapter 2, paragraphs 2.92–2.97.

9 Reference to 'veterans' therefore generally means to persons who are not in the workforce or who have retired. However, many veterans of recent conflicts remain in the ADF or continue in employment as members of the Reserve or other forces. For those working for the Commonwealth, employment–related injury or health problems are dealt with under the Commonwealth Safety, Rehabilitation and Compensation Act (SRCA) which is managed by Comcare. Since 1999, DVA has managed SRCA claims for the ADF. The *Military Rehabilitation and Compensation Act* 2004 will also be used by ADF personnel and reservists.

pensions relative to the cost of living, and recognition of level of disability.[10] Other concerns have been the nature of service, primarily that which is not recognised as war–related, the extent to which certain diseases and injuries are recognised as service–caused,[11] and the role of environmental hazards in particular in contributing to service–related ill health.

1.11 In each of the areas in which concern has been manifested over many years, there has been a perception by distinct veteran communities that:

- governments have failed to meet perceived promises to look after veterans on the basis of increased cost;
- legislation has become more rigorous, [12] excluding many from disability pensions; the Repatriation Medical Authority is 'too scientific' in its Statements of Principle;
- other governments, including the United States, New Zealand, and, at times, the United Kingdom, have been more generous to veterans;
- there has been limited recognition of many factors believed to be responsible for service–related illness/injury, including radiation and chemicals, and exposures to these have not been measured or listed in records; and
- the organisation and maintenance of service records has been chaotic, with what are believed to be relevant causal factors not being listed.

1.12 A number of these issues indicate that some veterans do not recognise that modern warfare has changed, and the nature of many deployments has also changed. While acknowledging that each different type of deployment can result in particular stresses, governments are also seeking to bring the issue of compensation closer to that which is applicable in the broader community. The recent *Military Rehabilitation and Compensation Act* 2004 represents an effort to overcome the problems caused by the existence of a range of legislation where different payments were available based on factors such as date of joining the ADF, and some personnel had double entitlements. While many of these complicating factors will continue because of prior service by current ADF personnel, all injuries and illness from the commencement date will come under the new legislation which will help provide some uniformity.

1.13 A major feature of the new legislation is the importance of rehabilitation and of return to the workforce. While many may have been seriously injured in World War 2, Korea and Vietnam, and had a reduced capacity for employment, this outcome

10 See Professor Peter Baume et al, *A Fair Go*: *Report on Compensation for Veterans and War Widows,* Canberra 1994.

11 See Hon John Clarke, QC et al, *Report of the Review of Veterans' Entitlements*, Canberra 2003.

12 For example, through the creation of the Repatriation Medical Authority in 1994, along with the requirement that the Authority rely on medical–scientific information in making Statements of Principle, see below paragraphs 1.16–1.25.

is now less common in more recent deployments and missions.[13] Thus, while there is provision in the legislation for serious disability, there is an expectation that this will be more of an exception, and that treatment will assist with other injuries and illnesses. This is similar to the attitude behind recent equivalent legislation in the United Kingdom.[14]

1.14 This approach is not relevant to veterans groups, many of whose concerns go back to World War 2, and who believe that their entitlements should not be restricted by modern formulae requiring more rigorous medico–scientific evidence. This belief therefore does not accept some of the changes that have occurred in legislation and which have been in place for several years, especially the demonstration of a specific link between service and disease. However, in either case, the relatively limited research on the long–term effects of some exposures complicates this issue, since it raises the question of responsibility for providing information on exposures.

Veterans' issues

Governments and costs

1.15 Successive governments *have* tended to make reforms piecemeal rather than undertaking substantial change because of the sheer size of the veteran population, with cost a likely factor. However, the environment in which veterans' legislation developed between the first and second world wars was conducive to the extension rather than the contraction of benefits. The reverse onus of proof was introduced in 1929,[15] and has remained a key principle in the legislation, although on occasion it has been misunderstood by claimants. In conjunction with the term 'reasonable hypothesis' which linked the disease or injury to service, there was a very broad benefit of the doubt both with respect to facts and medical evidence on the medical causation (aetiology).

1.16 Both a concern about costs and about inappropriate claims influenced changes made in the 1980's and, especially, the 1990's. Originally, the veterans' legislation did

13 This includes serious injury caused in a non–deployment situation.

14 United Kingdom, Ministry of Defence, Veterans Agency/ Department for Work and Pensions, *Pathways to Work*: 'MoD and UK armed forces have a distinguished tradition in respect of successful rehabilitation and return to work. That tradition continues through the supported approach to medical downgrading (focus on rehabilitation at community level and by Headley Court), consideration of employability and the resettlement arrangements for those eligible.

Of these medically discharged each year, only a small number have serious disorders. The armed forces are a highly selected population and many medical dischargees leave only because of the very high standards of mental and physical health required for operational fitness and the relative lack of downgraded opportunities in the post Options for Change.' at http://www.veteransagency.mod.uk/pdfolder/vasecpdfs/pathways_work.pdf, p. 2.

15 The Hon John Clarke, QC et al, *Report of the Review of Veterans' Entitlements*, volume 1, paragraph 3.23: 'An important principle laid down in the legislation related to the onus of proof. Once the appellant had made out a prima facie case, the onus was on the Repatriation Commission to disprove it'.

not have regard to medical–scientific evidence, but a 1993 report by the ANAO[16] and the 1992 Bushell decision[17] had demonstrated the pitfalls of 'reasonable hypothesis' outside of scientific guidelines, leading, via a review,[18] to the development of the Repatriation Medical Authority (RMA) in 1994.[19] The RMA was established specifically to provide a medical–scientific input through the use of Statements of Principles.[20] Although eligibility for claims had become extensive, and the reverse standard of proof remained, a tighter definition of illness and injury restricted access to several veterans. It is this aspect of the legislation which remains the most contentious, because it has removed the opportunity for access to a disability pension where there is no satisfactory aetiology.

1.17 Under S 196B of the Act, the Authority can only operate in accordance with medical-scientific evidence, which is defined at S5AB(2):

> S5AB(2)
>
> Information about a particular kind of injury, disease or death is taken to be sound medical–scientific evidence if:
>
> (a) the information:
> (i) is consistent with material relating to medical science that has been published in a medical or scientific publication and has been, in the opinion of the Repatriation Medical Authority, subjected to a peer review process; or

16 Auditor General, *Audit Report No. 8 1992–93: Efficiency Audit, Department of Veterans' Affairs: Compensation Pensions to Veterans and War Widows*, Canberra 1993.

17 Bushell v. Repatriation Commission [1992] HCA 47; (1992) 175 CLR 408 F.C. 92/035 (1992) 29 ALD 1 (7 October 1992).

18 Professor Peter Baume et al, *A Fair Go: Report on Compensation for Veterans and War Widows*, Canberra 1994.

19 A brief outline of standards of proof in the legislation is given in the submission by the Vietnam Veterans Association of Australia to the Review Committee on the *Veterans' Entitlements Act, 2002* at www.vvaa.org.au, pp. 2–3. A more detailed history of the changes in legislation is given in Chapter 3 of the Hon John Clarke, QC, *Report of the Review of Veterans' Entitlements*, Canberra 2003, volume 1. The United Kingdom provides that claims made for a war disablement pension 'after 7 years', reverses the onus of proof from the 'department' to the claimant but 'reliable evidence' could raise a 'reasonable doubt', which would be sufficient for the claimant to succeed: this appears much the same situation as Australian legislation prior to the 1994 amendments: 'Whilst it is true that the rule switches the onus from the Secretary of State to the claimant at the seven year point, for a claim to succeed it requires only that the claimant produces reliable evidence to raise a reasonable doubt. Therefore, were further research to show any reliable evidence of there being a service–related cause for an otherwise unexplained illness, claims for war pension could succeed.

This applies not only to Gulf conflict related claims, but to any medical condition suffered by any participant in any theatre. The seven year rule applies not from the end of any given conflict but from the point the individual ends their total service. Some Gulf veterans could still be benefiting from its provisions for over 20 years to come,' United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Government Response to the House of Commons Defence Select Committee's Seventh Report—Gulf Veterans' Illnesses, Financial Assistance*, at http://www.mod.uk/issues/gulfwar/policy/gen_reports/hcdc7report.htm#7.

20 See above, paragraph 1.11.

> (ii) in accordance with generally accepted medical practice, would serve as the basis for the diagnosis and management of a medical condition; and
> (b) in the case of information about how that kind of injury, disease or death may be caused—meets the applicable criteria for assessing causation currently applied in the field of epidemiology.[21]

Legislation has become more rigorous

1.18 With the introduction of the RMA, a greater certainty and consistency of decision–making was possible. The emphasis on peer review and 'generally accepted medical practice' made speculative opinions of individual practitioners irrelevant. In reality, this was beneficial to veterans in that it both removed an element of uncertainty and helped maintain the integrity of the compensation process.

1.19 However, some groups claim that the RMA is 'too scientific',[22] which, in the context of their arguments, generally means that the RMA will not accept a new 'illness' or injury, or any causal factor which is not demonstrated by epidemiology or widely accepted professionally:

> Being deployed to a particular conflict is not a causal factor. When an elevated rate of disease is detected among a particular group of deployed veterans, it is necessary to try to identify a causal link, such as exposure to a specific hazard, which will enable compensation to flow to veterans. Under the SOPs, no presumption of causation can exist without some evidence of causation in the published scientific literature.[23]

1.20 The fact is that the RMA cannot work otherwise than according to the legislation. While research may eventually result in symptoms receiving an accepted diagnosis (as is the case, for example, with chronic fatigue), this does not demonstrate a failure on the part of the Authority. Scientific approaches are based on direct evidence of causal links, replication of situations (such as use of dosimetry in respect to exposure to radiation or calculation of dispersal of toxic substances such as Agent Orange), and the exclusion of other causal factors, all of which take time to demonstrate. By its nature, medical-scientific evidence will rarely be produced rapidly, even though popular beliefs may be vindicated by it:

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21 *Veterans' Entitlements Act 1986.*

22 Veterans' organisations have argued in the past that there is little external assessment of the SOPs because the process is medically dominated (Vietnam Veterans Association of Australia, *Submission to the Review Committee on the Veterans' Entitlements Act,* p. 6, at www.vvaa.org.au) Additional arguments are that a single medical view has no status under the SOP (see the opinion of the Repatriation Commission on the work of one doctor on *du,* at *Submission* 8A, pp. 7–8), and that it has often taken considerable time for scientific research to prove or satisfactorily demonstrate links between events such as exposures to substances and ill health (Vietnam Veterans Association of Australia, *Submission to the Review Committee on the Veterans' Entitlements Act*, pp.5-6, 13, at www.vvaa.org.au).

23 *Submission* 8, Repatriation Commission, p. 16, paragraph 84.

> The timescale of the epidemiology studies is determined by the work which must be carried out to ensure that a rigorous scientific assessment takes place. Accordingly, although many veterans are anxious to know the outcome as soon as possible, the studies cannot be accelerated.[24]

1.21 Prior to the amendments made in 1994, S 120 of the Act provided that the Commission '*shall* determine' a war–caused injury, disease or death 'unless it is satisfied beyond reasonable doubt, that there is no sufficient ground for making that determination'.[25] S120(3) required that there be a 'reasonable hypothesis' linking injury, illness or death 'with the circumstances of the particular service', but there was no guide to what constituted a reasonable hypothesis. With the introduction of the Statements of Principle, a reasonable hypothesis could only be an SOP or a determination of the Commission under S180A(2).[26] 'Reasonable satisfaction' was also to be assessed with reference to SOPs or an S180A (3) determination, reducing opportunity for individual opinions or speculation. Further, the Repatriation Commission was not able to determine claims unless or until the RMA either issued a SOP or stated that it did not intend to make one on the relevant illness or injury.[27]

1.22 The Specialist Medical Review Council[28] can review Statements or decisions not to determine Statements, and in this sense is an appeal mechanism. The Statements are also disallowable instruments,[29] which, in instances where a particular situation is not covered, does provide an opportunity for further public discussion. Nonetheless, S180A was also introduced under the same legislation as the RMA, the Specialist Medical Review Council, S120A and S120B and S 5AB,[30] and therefore seems intended to be a fail–safe. In spite of the emphasis on science and medicine in the other sections, S180A does not require the Repatriation Commission to be 'scientific' in exercising this discretion. If any 'political' decision is to be made, this will be carried out through the Repatriation Commission.

1.23 The Repatriation Commission could not be said to have made any determination that *ignored* medical–scientific evidence. The one instance of an S180A determination since the legislation was amended in 1994 was made under unusual circumstances when the RMA members had not yet been determined. However, although based on medical reports, it appears primarily a political decision.

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24 United Kingdom, Ministry of Defence, *Gulf War Illnesses—A New Beginning,* at www.mod.uk/issues/gulfwar/policy/newbegin, paragraph 32.

25 *Veterans' Entitlements Act* 1986, S 120(1).

26 *Veterans' Entitlements Act* 1986, S 120A (3).

27 *Veterans' Entitlements Act* 1986, S 120A(2).

28 See *Veterans' Entitlements Act* 1986, Part X1B, S 196W.

29 *Veterans' Entitlements Act* 1986 S 196W(3).

30 *Veterans' Affairs (1994-95 Budget Measures) Legislation Amendment Act* 1994, No. 98 of 1994.

1.24 The RMA had not had an opportunity to consider then recent US material on Agent Orange use in Vietnam and make any Statements of Principle on links between Agent Orange and various illnesses before the relevant Minister had received a report from two experts who had also been reviewing US information (Professors McLennan and Smith). The Minister announced in October 1994 that five illnesses[31] were referred to:

> Professors MacLennan and Smith came back and gave a report, which I made public at the end of last week, which specifically stated that in their view there was a sufficient link between herbicides used in Vietnam and some cancers. They said that there were approximately five cancers involved: multiple myeloma, leukemia and three forms of respiratory cancer—namely, lung, larynx and trachea cancer.
>
> In the context of the Veterans Entitlement Act and in the context of the generous nature of the repatriation system in this country—probably one of the best, if not the best in the world—it was decided that we would accept the recommendations of Professors MacLennan and Smith to the effect that we would give the Vietnam veterans the benefit of the doubt. [32]

1.25 The information provided by Professors McLennan and Smith was also similar to that provided by the United States Department of Veterans Affairs. Distinguishing *inter alia* its role in making recommendations regarding policy, from the National Academy's role in reviewing scientific evidence,[33] USDVA had recommended adding multiple myeloma and respiratory cancers. The United States DVA Task Force, however, had not accepted a link between herbicides and leukemia, which Professors McLennan and Smith did. [34] The use of S180A however, has been limited:

> …the Repatriation Commission has been cautious in applying this provision and, while not requiring the level of scientific evidence required by the RMA, has taken the view that the legislation requires some evidence and a plausible scientific basis.[35]

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31 The Repatriation Commission submission refers only to four diseases, *Submission* 8, pp.8–9: 'The Repatriation Commission has issued four S180A Statements, for the following conditions: Chronic myeloid leukaemia, Acute myeloid leukaemia, Acute lymphoid leukaemia, Chronic lymphoid leukaemia.' This suggests that the other disorders were accepted by the RMA, with only certain leukaemia's requiring the 'benefit of the doubt', see *Submission* 8, Repatriation Commission, p. 17, paragraph 85.

32 *Hansard*, House of Representatives, 13 October 1994, p. 2008, The Hon C A Sciacca. See also *Submission* 8, Repatriation Commission, p. 17, paragraph 85.

33 Professors R McLennan and P Smith, *Veterans and Agent Orange Health effects of Herbicides used in Vietnam* (27 September 1994), pp. 6–7.

34 Professors R McLennan and P Smith, *Veterans and Agent Orange Health effects of Herbicides used in Vietnam*, p. 9: 'If the association between leukaemia and smoking is accepted, the number of cases of leukaemia in non-smoking veterans would be small, and these should be given the benefit of the doubt'.

35 *Submission* 8, Repatriation Commission, p. 17, paragraph 85.

1.26 The RMA has also been seen as lacking an awareness of 'military' factors which are considered relevant in determining eligibility under Statements of Principles. Defence suggested that input from 'a senior Defence Health representative' into RMA determinations would be useful.[36] This position was supported, indirectly, by both the Regular Defence Force Welfare Association, which stated that the Authority lacks a complete perspective in some areas, affecting the outcome of claims,[37] and the Australian Peacekeepers & Peacemakers Association which suggests that the RMA needs to both become aware of some issues especially mental health ones, and ensure that the Statements of Principle reflect the results of research.[38]

1.27 However, as the Repatriation Commission points out, there will always be some conflict between what claimants perceive as appropriate and what departments or agencies are able to provide under the law:[39]

> Health research does not always produce evidence of a causal link between service and injury or death, which is fundamental to the acceptance of claims for compensation under departmental programs.[40]

1.28 Given that organisations may request a review and provide submissions to such reviews, there is already in place a process through which new information can be presented for consideration by the RMA.

1.29 The only area in which the Committee believes there could be some improvement with respect to the RMA is to make the website more user friendly, with clearer information on accepted disorders, rather than categorising them under medical terminology such as 'malignant neoplasm'.

More generous legislation in other countries

1.30 Some veterans believe that other countries have accepted the same information on matters such as exposure to chemicals or ionising radiation, and established a causal link in much the same way as the RMA does in respect of other matters. However, while there is a scientific basis to the causal factors in veterans' legislation in other countries, this does not always mean that there is detailed evidence of it, or that all symptoms are determined to be specific disorders.[41] Some countries have

36 *Submission* 9, Defence Organisation, p.7, paragraph 33.

37 *Submission* 5, Regular Defence Force Welfare Association, pp. 5–6, paragraphs 28–30: 'the current SOPs make it difficult for a Navy veteran to be successful for a claim relating to PTSD as the SOPs are written from an Army or land–based perspective' (paragraph 28).

38 *Submission* 6, Australian Peacekeepers & Peacemakers Association, p. 4.

39 *Submission* 8, Repatriation Commission, pp. 15-16, paragraphs 79–80.

40 *Submission* 8, Repatriation Commission, p. 16, paragraph 82.

41 See below, paragraph 1.40.

decided for many reasons to use presumptive cause, often to cut down individual litigation,[42] but will retain a requirement of further evidence in other instances.[43]

1.31 Essentially, all presumptive cause arguments are based on a demonstrable link between factors, but other principles may extend or narrow the field of eligible persons. One example is the role of the US National Academies' Institute of Medicine demonstrating the likely pattern of distribution of Agent Orange in Vietnam, based on data about other chemicals, and the role of the US Veterans Affairs department in deciding that all US personnel in Vietnam had been exposed to Agent Orange.[44] Regardless of the methodology of the inquiry, the scientific approach established a probable cause, but the field of those eligible to make a claim was determined by another, non-scientific, agency. In reality the VA decision may embrace more people than were actually exposed, but this is deemed less relevant than an outcome which may have been more concerned to demonstrate an interest in veterans' needs.

1.32 The United States has more recently accepted a relationship between ill–health and war service much more readily, thus providing more generous access to disability payments. The reason for greater acceptance by the United States of causal links is difficult to discern, especially as the US did not respond particularly quickly to problems arising from the Vietnam War,[45] or even the first Gulf War. Relevant factors contributing to change may include:

- the additional conflicts in the 1990's and the amount of time spent in deployment;

  The United States has been continually involved in conflicts and other missions in a number of countries through the 1990s, with substantial forces generally being deployed. There is therefore a greater data base of personnel available,[46] although in some instances research may be complicated by the

42 See, for example, the statement made in respect of Gulf War claims in the United Kingdom, for cases proceeding in civil courts: 'It is likely that each claim will have to be considered on its merits because each individual's symptoms, degree of disability and personal circumstances, which would determine the level of award, will be different. However, it is possible that a pattern may emerge in handling the first cases which would facilitate the handling of the remainder', United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Government Response to the House of Commons Defence Select Committee's Seventh Report—Gulf Veterans' Illnesses*, at http://www.mod.uk/issues/gulfwar/policy/gen_reports/hcdc7report.htm#15.

43 See below, Chapter 4, paragraphs 4.28, 4.29, 4.42.

44 See above, paragraph 1.25, and see below, Chapter 4, paragraph 4.50.

45 See Chapter 4, paragraphs 4.45–4.46, 4.50.

46 For example, there are some 697,000 Gulf War US veterans, and the UK Ministry of Defence maintains close contact with the US in terms of research. 'The US authorities have a significant programme of work underway in respect of Gulf veterans' illnesses ($155M has been spent and 192 projects commissioned). Hence it is important for the UK Ministry of Defence to keep in close touch with developments there. The Ministry of Defence continues to have a full time Gulf Health Liaison Officer based in Washington DC, who is also the UK representative on the (US) Military Veterans Health Coordinating Board's (MVHCB) Research Working Group. …

fact that some personnel have been involved in multiple exposures over a period of years, and relevant data has not always been collected.

- There is a substantial number of high quality scientific/medical research and review centres in the United States to whom several matters have concern have been referred; their reports are often the basis of legislative and regulatory decisions on eligibility for disability benefits.

1.33 Exposure to numerous hazards and to different operations has illustrated the possibility of injury arising from chemicals and other substances. These have been studied intensively, in spite of the problems in obtaining data and providing information on participants that are referred to below.[47] The fact that relatively new military personnel (including women and ethnic minorities) have been involved in conflicts and have also complained of similar effects from exposures, has helped support beliefs that such claims are not being made only by those who have been in previous conflicts and hence may be affected by multiple factors.

- The greater variation in personnel, with, for example, US forces in the 'Gulf War' including large numbers of women and ethnic minorities.

1.34 On political grounds alone, it would be unwise to not acknowledge the reality of the experiences of either women or ethnic minorities. There is also a much more obvious statement of past incompetence in respect to past policies in the US political arena, without apparent concern as to liability, and possibly a more effective machinery through which existing legislation can be updated.

United Kingdom

1.35 In the United Kingdom, there has been detailed discussion for some time on both the nuclear tests and the effects of the Gulf War. The major issue with respect to the nuclear tests is that the service is not considered war–related, and therefore there is no access to a 'war' disability benefit, even if it were accepted that exposure was sufficient to cause ill–health.[48] All cases therefore must proceed through the civil courts.

1.36 The Gulf War syndrome has resulted in a different outcome. Originally, there was some interest in whether it could be established that the illnesses forming the 'Gulf War syndrome' were 'the result of error',[49] establishing liability. This matter does not seem to have been resolved, and the issue of 'error' has become less

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Both directly and through the liaison officer, the Ministry of Defence maintain close links with the US authorities, including the Executive Office of the President, the Department of Defence (including the Office of the Special Assistant for Gulf War Illness (OSAGWI), the Department of Health and Human Services, and the Department of Veterans' Affairs.' http://www.mod.uk/issues/gulfwar/policy/hcdcmemo3.htm (April 2001).

47 See Chapter 2, paragraphs 2.3–2.6.

48 See below, Chapter 4, paragraphs 4.8–4.13

49 United Kingdom, Ministry of Defence, '*Gulf Veterans' Illnesses—A New Beginning'* (July 1997), at www.mod.uk/issues/gulfwar/policy/newbegin, and below, paragraph 1.37.

important, possibly because there were multiple exposures, some from Coalition forces. However, there remains the option of making a civil claim, a path which has been taken by some veterans:

> The Government is not persuaded that, on the basis of the information currently available to it, there is a case for paying additional no fault compensation to Gulf veterans, separate from and above that which is already available to both Gulf and other veterans by way of war pensions and ABRS. However, the matter will be kept under review in the light of developments and ministers have made clear that if legal liability is established by future research or investigation, MOD will of course pay compensation. [50]

1.37 Like Australia, and, to some extent, the United States, the United Kingdom has not accepted the 'Gulf War syndrome':

> 1. Since returning from the Gulf War in 1991, some British veterans have become ill. Many believe that this ill–health is unusual and directly related to their participation in Operation GRANBY. This is a view also held in some other Coalition countries, particularly the USA, where Gulf veterans have fallen ill since the conflict. However, there is still no medical or scientific consensus on this subject and, after six years, many veterans now feel frustrated at the lack of progress and abandoned to their plight.
>
> …

50 United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Current Activity Relating to Gulf Veterans' Illnesses—Memorandum 2,* at http://www.mod.uk/issues/gulfwar/policy/hcdcmemo.htm. See also House Lords, Official Report, 17 October 2001,Column 680—700: 'We have made a concession to Gulf veterans by undertaking not to rely on the defence of limitation under the Limitation Act 1980 without giving solicitors prior notice. I tell the House that as of 30th September this year we had 1,890 active notices of intention to claim from veterans and members of their families in respect of illness allegedly arising from the Gulf conflict.

However, the Ministry has yet to receive any writs or claims of sufficient detail', reprinted in United Kingdom, Ministry of Defence, Gulf Update December 2001, p. 7, athttp://www.mod.uk/linked_files/gulf_updatedec01.pdf.

See also: 'Since the repeal of Section 10 of the Crown Proceedings Act 1947 on 15 May 1987, British Service personnel have had the same right to claim compensation from the MOD as any other employee against his or her employer. No writs or claims of sufficient detail have been received from Gulf veterans to allow MOD to handle these cases. If such claims are received, the MOD will try to resolve them as quickly as possible and will pay compensation where a legal liability exists. It is likely that each claim will have to be considered on its merits because each individual's symptoms, degree of disability and personal circumstances, which would determine the level of award, will be different. However, it is possible that a pattern may emerge in handling the first cases which would facilitate the handling of the remainder. Where a legal liability is established the vast majority of compensation payments made by the MOD are made without proceeding to court.(United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Government Response to the House of Commons Defence Select Committee's Seventh Report—Gulf Veterans' Illnesses*, at http://www.mod.uk/issues/gulfwar/policy/gen_reports/hcdc7report.htm#15.

> 3. At present there are three significant unknown elements which affect sick veterans. First, some of them have symptoms which have not been fully diagnosed: it simply is not clear what is wrong with them. Second, it is not known in all cases what the cause or causes of the veterans' illnesses might be. Third, it is accordingly not possible to say whether those illnesses are the result of an error on anybodys' part.[51]

1.38 Following on this, the United Kingdom agreed that there would be a three principle approach:

- Access to medical advice (which had become available from 1993[52], through the Gulf Veterans Medical Assessment Programme–GVMAP) and which later included psychiatric assessment and treatment;[53]
- Appropriate research into the illnesses and 'factors which might have a bearing on them; and
- The public availability of all information.[54]

1.39 Research, when completed, produced much the same results as have been available to US and Australian researchers:

> The consensus of the international scientific and medical community is therefore that there is insufficient evidence to enable this ill–health to be characterised as a unique illness or syndrome.

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51 United Kingdom, Ministry of Defence, '*Gulf Veterans' Illnesses—A New Beginning'* (July 1997), at www.mod.uk/issues/gulfwar/policy/newbegin.

52 United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Current Activity Relating To Gulf Veterans' Illnesses: Memorandum 3*, at http://www.mod.uk/issues/gulfwar/policy/hcdcmemo3.htm.

53 'In 1999, an arrangement was set up whereby individuals, who in the opinion of the MAP physicians would benefit from a psychiatric assessment, can be referred at the Ministry of Defence's expense to consultant psychiatrists with a specialist interest and expertise in post traumatic stress disorder (PTSD). A network of such consultants across the country has been set up. Treatment of ex-Service personnel is undertaken by the NHS in the usual way. If the patient is assessed as not suffering from stress reactions to trauma, but some other psychological problem, he/she can be referred on to an appropriate NHS specialist within his/her own area for further assessment and treatment. When these arrangements were reviewed in mid-2000 it became clear that some veterans were waiting too long for appointments and for the reports from these referrals. A fast–tracking arrangement was introduced and is currently meeting targets of appointments within six weeks of referral and a report within four weeks. GVMAP also decided to conduct a follow-up of the effectiveness of the treatments recommended in these cases.

This will be done in conjunction with the referral network and aims to analyse the outcomes of treatment plans in 60–80 cases', United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Current Activity Relating To Gulf Veterans' Illnesses: Memorandum 3*, at http://www.mod.uk/issues/gulfwar/policy/hcdcmemo3.htm.

54 United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Gulf Veterans' Illnesses—A New Beginning* (July 1997), at www.mod.uk/issues/gulfwar/policy/newbegin.

> The Medical Research Council addressed this in a review of research published on 22 May 2003 and came to the same conclusion. The Ministry of Defence's approach must be guided by these findings from the scientific and medical community, and we do not therefore recognise "Gulf War Syndrome" as a medical condition.[55]

1.40 However, the United Kingdom defence compensation system was sufficiently flexible to be able to provide for symptoms as opposed to an accepted 'medical condition', on the basis that being disabled was the relevant factor:[56]

> …it is important to note that this does not stop 1990/1991 Gulf veterans who have left the armed forces and are ill, either ex–Regulars or ex-Reserves, from claiming a War Pension. **War Pensions are awarded not for a list of disorders but for any disablement which can be accepted as caused or made worse by Service, whatever that disablement is called**. The question of whether or not there is such a thing as "Gulf War Syndrome" is not therefore relevant from the point of view of War pensions.
>
> In addition the Armed Forces Pension Scheme and the Reserve Forces (Attributable Benefits Etc) regulations provide enhanced injury and death benefits to regular and reservist Service personnel whose injuries, illnesses or death, was were, on the balance of probabilities, attributable to, or aggravated by, their Gulf service.[57]

1.41 War pensions are not available to persons who remain in the forces, and it is assumed that those who made civil claims in respect of Gulf War syndrome are either still serving, or those who were unsuccessful in their application for war disablement pension. These pensions are tax free, and the claimant does not have the onus of proof;[58] indeed, as noted above, even when the onus of proof changes, the claimant remains in a favourable situation.

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55 United Kingdom, Ministry of Defence, *'Gulf War Syndrome'*, at www.mod.uk/issues/gulfwar/gws

56 United Kingdom, *Naval, Military and Air Forces (Disablement and Death) Service Pensions Order* 1983, as amended.

57 United Kingdom, Ministry of Defence, '*Gulf War Syndrome'*, at www.mod.uk/issues/gulfwar/gws, emphasis added.

58 United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Government Response to the House of Commons Defence Select Committee's Seventh Report—Gulf Veterans' Illnesses*, at http://www.mod.uk/issues/gulfwar/policy/gen_reports/hcdc7report.htm#15:'For deaths arising, or disablement claims lodged within seven years of termination of service, the onus lies with Secretary of State to show beyond reasonable doubt that the disablement or death is not due to service. There is no onus on the claimant to show any link between disablement and service.

1.42 In spite of this apparent concession as to disablement, it is important to evaluate the United Kingdom situation. There is no payment of pension unless one has at least 20 per cent disability;[59] and the rate of pension is not high, although pensioners may also be eligible for a range of allowances and other benefits. United Kingdom Ministry of Defence data for September 2003 states that the majority of war disablement pensioners receive 50 per cent or less pension, with the largest group receiving the 20 per cent level (the level at which any disablement pension is paid).[60] At this date, there were 208,000 active war disablement payments.[61]

1.43 Pension access, therefore, is likely only to provide an income supplement, and should not be seen as full income support. What is likely to be of greater value to veterans and those still serving is the very public recognition of the entire Gulf War experience by the United Kingdom government, including the continual assessment by the House of Commons Defence Select Committee, the research being undertaken, and the effort to ensure that Gulf veterans at least do not become part of the socially excluded.[62]

Australia and the Gulf War syndrome

1.44 Australia is not in a position to provide access to a disability pension, because there is currently no disorder accepted by the medical profession as the 'Gulf War

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Even where a claim for disablement is made more than seven years after termination of service, or where death occurs more than seven years after service, the onus of proof is still more generous than the burden of proof in civil tort which rests on a balance of probabilities. Article 5 of the Naval, Military and Air Forces (Disablement and Death Service Pensions Order 1983, as amended provides that it is necessary for the claimant only to raise reasonable doubt, based on reliable evidence, that the death or disablement is due to service. The benefit of any reasonable doubt is always given to the claimant'.

59 Under 20 per cent disability usually will receive a one–off payment/gratuity.

60 *UK Defence Today*, September 2003 http://news.mod.uk/news/press/news_press_notice.asp?newsItem_id=2744: 'Approximately 4 out of 5 Disablement Pensioners have pensions awarded at the 50 per cent rate or less. The largest group are those at the 20 per cent rate. Approximately 4 per cent receive the 100 per cent disablement rate. The overall average weekly amount of war disablement pension and associated supplementary allowances is £61.33'.

61 *UK Defence Today*, September 2003 http://news.mod.uk/news/press/news_press_notice.asp?newsItem_id=2744. Payments to other service personnel are also made under different schemes in the United Kingdom, so 208,000 does not represent the total number of persons receiving some form of pension in respect of war service. There are 5 million veterans and 8 million dependants in the United Kingdom, *Improving the Delivery of Cross Departmental Support and Services for Veterans—A Joint Report of the Department of War Studies and the Institute of Psychiatry*, Kings College London, July 2003, p. 5, paragraph 2.3, at http://news.mod.uk/news_press_notice.asp?newsItem_id=2616.

62 See in particular *Improving the Delivery of Cross Departmental Support and Services for Veterans—A Joint Report of the Department of War Studies and the Institute of Psychiatry*, Kings College London, July 2003, at http://news.mod.uk/news_press_notice.asp?newsItem_id=2616.

syndrome', and those deployed in the Gulf War are not unique in experiencing these symptoms:

> …we found that Gulf War veterans experienced a higher rate for many symptoms reported than a comparison matched group of personnel who did not serve in the Gulf. As the clusters of symptoms and the type of symptoms were the same in both groups there was no evidence of a unique symptom that could be called Gulf War Syndrome.[63]

1.45 The RMA therefore cannot proceed, and, given that there have already been some epidemiological studies in the United Kingdom which did not show any unique syndrome, nor lead to a new diagnosis, it is unlikely that the RMA will be able to proceed any further for some time, if at all. However, the Repatriation Commission notes that in some circumstances veterans in the situation of having symptoms may receive access to medical services, much the same step as was taken originally in the United Kingdom:

> For veterans who have symptoms that do not fall into established diagnoses, or do not fit with systematic evidence for a new category of diagnoses, it is difficult for our system, founded on evidence-based diagnosis, to provide compensation. The Repatriation Commission does, however, have the authority to selectively provide medical treatment in these circumstances.[64]
>
> Under a policy change announced by the then Minister, the Honourable Bruce Scott MP, any veteran returning from a deployment with symptoms that are difficult to diagnose is provided with treatment until the condition is diagnosed.[65]

1.46 The acknowledgment of the experience of Gulf War veterans is important, and the provision of medical services is a means of achieving this, although it could also be argued that this approach may encourage veterans to consider everything is a disorder or compensable in terms of a pension rather than in terms of required health services. The provision of these services is valuable, although a delay in access may have caused the belief that little attention was being paid to what had become a commonly experienced syndrome.

There has been limited recognition of many factors believed to be responsible for service–related illness/injury, including radiation and chemicals, and exposures to these have not been measured or listed in records.

1.47 With each deployment, veterans and currently serving personnel in Australia as well as in the United Kingdom and United States, have raised numerous issues about the extent of damage to their physical and mental health in combat or from a range of environmental factors, and their governments' seeming indifference to this.

63 *Submission* 8, Repatriation Commission, p. 16, paragraph 81.

64 *Submission* 8, Repatriation Commission, p. 16, paragraph 81.

65 *Submission* 9B, Repatriation Commission, p. 14.

These concerns go back to at least World War 2,[66] and the Korean War,[67] and the range of exposures has been considerable. Some have resulted from what were thought of at the time as environmental safety protection, such as the use of DDT to prevent malaria, and apparently also the use of DDT and kerosene, including on clothing, to check the effects of rats and other vermin.[68] Others have occurred because of the particular circumstances of a combat zone, including the burning of smoil, or the extensive use of herbicides and defoliants, as in Vietnam (Agent Orange included) to destroy vegetation and crops. Exposures also include those relevant to specific tasks, and may have been continuous until safer items became available.[69] Additional contributing factors also can result from the combat situation, such as lack of food, contaminated water, poor quality health services, unhygienic conditions, extremes of temperature which cannot be mitigated,[70] and combat stress.

1.48 To a degree, the lack of scientific knowledge of the effect of these hazards has previously limited research, and the fact that some disorders may only manifest later in life has meant there has been little data on possible outcomes. Political factors have also hampered acknowledgment of the effects of many substances, such as the use of napalm on civilians. The Gulf War is the first modern war where, in spite of initial resistance, there has been quicker recognition of the existence of some problems. At this point, the recognition, through research, has identified primarily what might be called mental health issues rather than environmental exposures and contributing factors. In part this is because technology has facilitated the collection of data suggesting that chemical and biological weapons have had a limited role. The long term effect of depleted uranium is still a contentious issue for some veterans, although much of the available research suggests that there is limited room for concern.

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66 Although chemical warfare, including mustard gas and phosgene, obviously also had a substantial effect in the First World War and for long period afterwards.

67 *Better Living Through Chemicals*, at http://eport2.cgc.maricopa.edu/published/d/du/dduncan91/collection/1/3/upload.htm, notes that napalm (petroleum and detergent) was used in World War 2, and Korea as well as Vietnam: 'it also "deoxygenates" the air, which can cause asphyxiation, and often generates enormous quantities of carbon monoxide gas'.

68 See http://www.parl.gc.ca/37/3/parlbus/chambus/house/debates/049_2004-05-06/han049_1455-e.htm, question on use of chemicals in Korea, in Canadian Parliament, and *The US Biological Warfare in Korea*, South Korean documentary, at http://www.kimsoft.com/2000/mbc.htm.

69 See the list of exposures including carbon tetrachloride, tin, lead, solder, electromagnetic fields, chlorinated solvents, for naval personnel in various occupations, US Navy Veteran Cohort, 1950–1997, in F.D. Groves et al, 'Cancer in Korean War Navy Technicians: Mortality Survey after 40 Years', *American Journal of Epidemiology,* 155 (2002) p. 812, Table 2. This supports the statement by the Repatriation Commission that 'exposure to a potential hazard may be related more to individual tasks within an occupational speciality rather than to an overall deployment, *Submission* 8, p. 15, paragraph 73.

70 See *Submission* 8, Repatriation Commission, p.17, paragraph 87, which notes that some of these matters are still relevant subjects for research.

1.49 Governments have also become increasingly responsive to issues that have been raised by veterans, a response which reflects the increased availability of medical/scientific knowledge and development of new methodologies, as opposed to anecdotal evidence or a single medical view. In some instances, attempts have been made to calculate the effect of such exposures. In others, research has indicated a higher level of some diseases than in the comparable age group of non–deployed men, although the extent to which exposures have contributed to this is not always clear.[71] However, the concern remains that because there was little interest in collecting data, or limited capacity to do so, some approximation of this data will not be sufficient to demonstrate either a specific illness or injury, or any individual's risk factors.

1.50 With respect to more recent deployments, some evidence suggests that more sophisticated methods of measurement of exposures has enabled the collection of data on chemical, environmental and other hazards.[72] Other information indicates that while the technology exists, human error and inadequate administrative processes have limited the collection of data.[73] The House of Commons Defence Select Committee noted in particular, in respect to the first Gulf War, that negative information was often quite as useful as positive evidence:

> The review highlights the problems created by inconsistencies in recording events at the time and by deficiencies in preserving records subsequently, when trying to examine such events nine years later.
>
> ... it must be recognised that there is an element of doubt about the assessment that UK troops on Al Jubayl on 19 January were not exposed to Iraqi CW agents ... we are dealing with history and the passing of nine years introduces an element of uncertainty. We no longer have available all of the information that we would like to see.
>
> The review recommends that 'in future, such alerts should be investigated more thoroughly at the time, even when it is suspected that there is no actual chemical threat' and that records of such alerts should not be destroyed, even when it becomes clear that alarms were false.[74]

1.51 If comments made by United States' agencies about the disparity between intent and practice are true, it is also possible that some data Australia may be relying on in respect of exposures is not available.[75] This will have a long term impact because there may continue to be gaps in available information and in individual records, even when a more sophisticated health record system is in place. At the same

71 See Chapter 4, paragraphs 4.40-4.42 on Korean war mortality rates.

72 See Chapter 2, paragraphs 2.25–2.27, and Chapter 3, paragraphs 3.9–3.12.

73 See Chapter 2, paragraphs 2.3–2.5.

74 United Kingdom Parliament, Select Committee on Defence Seventh Report, *Progress in Ascertaining the Causes of Gulf War Veterans' Illnesses*, paragraph 58, at http://www.parliament.the-stationery-ffice.co.uk/pa/cm199900/cmselect/cmdfence/125/12506.htm#a13

75 See Chapter 2, paragraphs 2.3–2.5.

time, it has to be recognised that while the extensive research being undertaken in both the United Kingdom and the United States may provide information that will be useful in at least making approximations of exposures, this will not necessarily lead to any specific diagnosis. While veterans in both these countries may receive the benefit of the doubt, be deemed to have been present during a specific event, or are able to demonstrate war–related disability, even the most explicit data on exposures may only result in medical treatment for Australian veterans.

The organisation and maintenance of service records has been chaotic, with what are believed to be relevant causal factors not being listed.

1.52 Much of the information provided to the Committee did not demonstrate that there were problems overall in obtaining access to service records. The main complaints from the point of view of veterans were that some data that should have been there were not. Obviously, data on environmental and other exposures in the past has been limited, and in some instances individual events have also not been recorded. These 'events' fall into two categories:

- Records of medical treatment or injuries; and
- Events or occurrences that may have a later impact.

1.53 The Committee would welcome signs that progress has been made in protocols for ensuring the electronic transfer of all data from allied theatre and other hospitals, or at least guaranteeing a paper copy.

1.54 With respect to the second issue, it is true that the nature of conflict may preclude a detailed report of every event that occurred, even though formal records[76] are used to reconstruct possible past scenarios:

> Where a Vietnam veteran says that he saw someone raped, that is more delicate and tricky, but there are ways and means for us to get information. We should emphasise that there is no burden of proof on the veteran: we have to take his word at face value, unless we have something evidentiary to make us think it is not correct.[77]

1.55 Up to a point, the current process of providing key information on a conflict may at least identify some possible problems in the future, but these are not a guarantee that all precipitating events will be registered. Even where an individual is considered to have a recognised disorder, it is possible that this will be challenged as not war–related. It is always necessary, because of the legislation, to be able to provide certain key events and to have these accepted as relevant:

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76 For example, ships' logs (Farmer and Repatriation Commission [2004] AATA 781 (23 July 2004), and the equivalent for other forces; patrol records, interviews with other platoon members, historians etc (*Committee Hansard*, p. 81, Repatriation Commission). See also Chapter 3, paragraphs 3.36–3.41, and Chapter 4, paragraphs 4.73–4.74.

77 *Committee Hansard,* p. 81.

> …he does suffer from Alcohol Dependence … However, that Alcohol Dependence is not a war–caused injury or disease and the Respondent is not liable to pay a pension to the Applicant pursuant to s 13(1) of the *Veterans' Entitlement Act 1986*.[78]
>
> …. The Tribunal concludes there is no evidence before it to disprove the hypothesis beyond reasonable doubt.[79]

1.56 The ADF does have in place processes by which such events can be recorded,[80] but it should also be accepted that many traumatic events are not immediately remembered in detail, even though aspects of them may be. Added to the rather late post–deployment health assessment[81]—which may not be available at all to reservists—this can result in crucial individual data being lost.[82] The only solution would be for each individual to maintain a record, and this is not practical for a number of reasons, not least being an unwillingness to relive some experiences.

1.57 The Committee was concerned at the slow roll out of the HealthKEYS system, not so much in terms of the past but because there is no facility to transfer information from current paper or disparate electronic files to the new system. Thus individuals who are currently serving and may still be in the forces for several years, will not have a complete electronic file.

1.58 Some of the information provided to the Committee, such as the loss of the Air Force records, indicates that there is a backlog of data to be processed.[83] The relatively late commencement by the ADF of a centralised tri–force IT system linking personnel and medical records means that some existing problems such as lost data, and data that was not provided, are likely to continue. Where there is a failure to follow established practices, such as full recording of vaccination information, this is also difficult to reconstitute. There is not always sufficient information available to personnel on these problems which would at least allow them to make a personal record of events including injuries, vaccinations and exposures which may be necessary in the future.

1.59 The United Kingdom was surprisingly open about some similar problems during the first Gulf War:

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78 Farmer and Repatriation Commission [2004] AATA 781 (23 July 2004), paragraph 92.

79 Benjamin and Repatriation Commission [2004] AATA 738 (13 July 2004), paragraph 62.

80 See *Committee Hansard*, p. 81 (ADF) and see also Chapter 2, paragraphs 2.30–2.40, 2.51–2.53, 2.60, 2.64–2.66, 2.67–2.69.

81 Chapter 2, paragraphs 2.53–2.54.

82 Although, as is also discussed in Chapter 4, either research or the standard of 'reasonable satisfaction' may result in otherwise unlisted information being accepted, as seen in the case of Organ and Repatriation Commission [2004] AATA 671 (29 June 2004), paragraph 76: 'Given the passage of time and the often encountered difficulty in finding relevant records, the Tribunal accepts the applicant's accounts of what took place…'

83 *Submission* 9, Defence Organisation, p. 4, paragraph 19.

> In summary, UK forces deployed to the Gulf with no established routines for recording primary care clinical information during a long deployment in the field, nor any robust method for recording immunisations and ensuring that the information was subsequently captured and transferred to the F.Med 4 [permanent medical records, equivalent to those GPs hold for civilians].[84]

1.60 Although there is no plan to enter any current information from ADF deployments into the new system, the fact that concerns about exposures, vaccinations, and medications have been raised suggest that the ADF must provide some equivalent electronic record for personnel to cover the period of service prior to the commencement of HealthKEYS.

1.61 This was also a lesson learnt by the United Kingdom from the first Gulf War:

> It appears that record keeping was inadequate from the start. It is certain that there was a significant failure to transfer what immunisation data was available on to permanent medical records after the Gulf conflict and that much of that data is probably now irrecoverable.[85]

1.62 United Kingdom research and reports have provided information on a number of issues from the first Gulf War which do not seem to have been raised by Australian personnel in respect of the second Gulf War. Nonetheless, these reports are all useful sources for both the ADF and DVA especially in the identification of potential problems, such as false alarms for chemical or biological warfare, and the effect this may have on personnel. After all, if there is to be recognition of the effects of conflict, this also has to include the effects of not knowing if there has been an exposure, or not being sure if protective equipment is in good condition, just as much as the effects of the different stresses of working in a peacekeeping mission with limited authority and control, or being affected by heavy smoil.

Deployment capacity

1.63 With the pressures arising from increased deployments at much the same time as the above mentioned reviews of health services,[86] there has been some concern that ADF health services were not capable of meeting needs, including during pre

84 United Kingdom Parliament, House of Commons Select Committee on Defence Seventh Report, *Progress in Ascertaining the Causes of Gulf War Veterans' Illnesses*, paragraph 49, at http://www.parliament.the-stationery-ffice.co.uk/pa/cm199900/cmselect/cmdfence/125/12506.htm#a13.

85 United Kingdom Parliament, House of Commons Select Committee on Defence Seventh Report, *Progress in Ascertaining the Causes of Gulf War Veterans' Illnesses*, paragraph 49, at http://www.parliament.the-stationery-ffice.co.uk/pa/cm199900/cmselect/cmdfence/125/12506.htm#a13.

86 See above, paragraph 1.5.

deployment and deployment periods,[87] as well as both immediate and longer–term post deployment periods. Concerns identified have not only related to the number and quality of services, but to the capacity of the ADF and the Repatriation Commission/DVA both to identify the need for new or changing services to meet current issues as well as needs in the future, and to act as much as is possible in accordance with community standards and expectations. These standards have helped to create new demands or expectations, additional to those required by earlier reviews.

1.64 These have been the stimulus in some ways for the development and testing of new health services, since they have demonstrated to a more aware management that the constant effects of war can vary in nature given the different circumstances of the tasks involved and the extent to which individuals have the capacity to deal with these.

1.65 Further, broader community awareness of the effects of drugs and alcohol, of more direct responsibility for, and participation in, individual health status has led to the development of a wide range of health services in the ADF, even though not all of these may be readily accepted. There is an increasing emphasis on mental health issues within the ADF and on the need to acknowledge that these are an integral part of the deployment process.

1.66 In discussing the quality of deployment health services, witnesses noted changes that had occurred in the community over time and the extension of these into the military culture which was seen generally as less open. It was thought that certain of the difficulties that had arisen had their basis in an incomplete acceptance by the military of community standards prevailing in matters such as access to information, informed consent, and the capacity to make choices without penalties. Specific examples included the controversy over non-acceptance of anthrax vaccinations,[88] a belief that services were not provided to meet the varying needs of veterans from more recent conflicts and other operations, and a lack of readily comprehensible information, including on items such as depleted uranium:

> There is a much larger debate in the civilian community regarding environmental risks and unexplained illnesses such as chronic fatigue syndrome and the potential risks from low–level chemical and radiation exposure in everyday life. It is understandable that veterans are concerned that they may be susceptible to a new or unexplained disease caused by their exposure in a hazardous environment.[89]
>
> …

87 The ADF commissioned a review of health services which was originally expected to report by the end of March 2004, *Submission* 9, Defence Organisation, p. 1, paragraph 5. In evidence, the ADF stated that this report had not then been completed, *Committee Hansard,* p. 91.

88 This issue is discussed at Appendix 3.

89 *Submission* 5, Regular Defence Force Welfare Association Inc., p. 4, paragraph 21.

> The days where you just receive injections and do not ask about side effects, or have medical procedures undertaken without a full explanation, have passed.[90]

Duty of care

1.67 Many of these community standards were expressed in terms of a 'duty of care', one that society owed its citizens and one that the ADF owed its personnel. Although there was no expectation that many other components of military culture should be dismissed because of the impact of such standards, it was considered feasible to demonstrate levels of respect for individuals in the ADF through modifying some of the processes that may have been seen as traditional. It was also thought that while the concept of individuals being responsible for their own health was sound, and a part of increasing community awareness of taking control and meeting an individual 'duty of care', the ADF and DVA also had the responsibility to provide services which met the needs of personnel and veterans as these were affected by broader social changes.

1.68 Duty of care is a concept which is continually evolving:

> In law all employers owe a duty of care to their employees, the general public and the wider environment. For the Ministry of Defence (MOD), there is also an obligation to manage the often greater safety risks associated with military operations. For the purposes of this document, the term '*safety'* covers the protection of people, property and the environment. The term *'environment'* is sometimes highlighted separately to encourage recognition of the growing importance being placed on environmental management. [91]

1.69 The relationship between governments and communities or individuals in terms of 'duty of care' is a complex one, but it is accepted that the 'government as employer' at least, owes a duty of care to its employees. This is both a statutory responsibility[92] and a principle of common law. A duty of care encompasses the health and safety of employees through provision of, and adherence to, standards which should apply uniformly.

1.70 This statutory responsibility may replace, to some degree, an older concept of a leader's responsibility for those under his command insofar as this was based on general principles rather than statute. However, there is room for both. Duty of care also requires that individuals minimise the risks to themselves and to others, and do not deliberately engage in conduct which is likely to result in injury. Doing so will generally result in a refusal to pay compensation if injury occurs. In this context, the

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90 *Committee Hansard*, p. 30, Australian Peacekeepers & Peacemakers Association.

91 See United Kingdom, Ministry of Defence, *JSP430 MOD Ship Safety Management*, at www.mod.uk. linked—files/dpe/JSP430.doc, p. 5.

92 Through legislation such as the *Safety Rehabilitation and Compensation Act* 1988 and the *Military Rehabilitation and Compensation Act* 2004.

refusal to have an anthrax or other vaccination seen as necessary for the particular combat zone would be overcome by the policy of 'no vaccination, no deployment', so that any potential difficulties arising for the individual and others would be reduced.[93]

1.71 The responsibility of commanders is extensive and can include ensuring the provision of necessary information, equipment, and guidance, including safe working environments, provision of required protective clothing, and necessary medical services. It can also include actions which may reduce future problems, such as the practice of some forces of discussing possibly traumatic events on a daily basis, rather than ignoring or minimising them.[94]

1.72 Notwithstanding the fact that there can be discrepancies between public perception of standards and the actual content of community standards, it is essential for an institution such as the ADF to continually develop its understanding of duty of care, especially where this may substantially lag behind what is commonly thought of as normal. Transparency and access to information and processes was seen as available to an individual in the community, and therefore will come to be expected by others.

1.73 The issues of 'duty of care' and 'community standards' are of particular interest to the Committee, which has examined prevailing cultures and expressed values which place an emphasis on the well–being of ADF personnel, to see if they are translated into action:

> …there are some serious human dimensions behind the need for this inquiry. We need to have a better conceptual understanding of the issues and of the history so we can go forward. Those affected need to know and understand the difficulties, but at the same time there is—particularly on their part—a need for some answers to questions that have been repeatedly asked for 30 or 40 years. If there are weaknesses in the system, we need to identify them and try and fix them. We also need to accept that our people are the most important part of the ADF. They are not a commodity to be used and thrown away. Active service in the field is not an excuse on the part of the administration to avoid responsibility for care. [95]

1.74 Some submissions stated that a lack of information both about vaccines and other matters did not assist ADF personnel in the making of informed choices, especially with regard to possible long term implications of certain vaccinations. To

93 See Appendix 3, which notes the problems caused in this situation through not advising of the requirement prior to departure.

94 *Improving the Delivery of Cross Departmental Support and Services for Veterans*—A *Joint Report of the Department of War Studies and the Institute of Psychiatry,* Kings College London, July 2003, at http://news.mod.uk/news_press_notice.asp?newsItem_id=2616, p. 25, paragraph 3.9.3 .4: 'the Swedes are keen to make talking about trauma an everyday occurrence within their regiments. There is structured time for debriefing every evening, which is protected time (often accompanied by beer)… British regiments [on the other hand] can be seen as 'the repressed leading the depressed' (on peacekeeping in Bosnia).

95 *Committee Hansard*, p. 2.

assess the current ADF understanding of 'duty of care', it is useful to look at a case study, the problem with anti–anthrax vaccinations. These were undertaken with a strong awareness of community standards and of the concerns that personnel from the first Gulf War had experienced:

> That was in fact one of the reasons that we put so much effort into our education campaign for anthrax vaccination, and why I was adamant that there would be a signed consent form—signed by the member following a verbal brief from the MO—so there could be absolutely no doubt whatsoever in anyone's mind as to the nature of the vaccines that they received prior to this deployment. My staff and I were firmly committed to the fact that we were not going to create a situation where there could be confusion on the part of individuals.[96]

1.75 Although effort had been put into providing information about the vaccine, other administrative issues contributed to an adverse result, suggesting that better coordination of information is required. This case study is at Appendix 3.

1.76 The duty of care also extends to best practice provision of services to both current personnel and veterans. Along with changes in the deployment and post-deployment process have come improvements in co-ordination between departments and, as noted above, some improvement in the capacity to provide accurate information on individuals, particularly older veterans. Currently, work is under way in the ADF to improve information collection and management both for deployment health and other reasons, and for the more effective management of the health of personnel post deployment. These will be impressive when in place and operating fully, although it is unfortunate that they have no capacity to include current data on currently serving personnel who may still be in the ADF in 2009, the date by which some systems will be operative.[97]

1.77 Appendix 3 is also useful as a case study on information issues, not so much on anthrax vaccination data but on the problems which can arise when both information and the ways in which it is communicated are not at best practice levels.

1.78 Much of the ADF and DVA research and program development that has occurred in the past two decades, and especially during the 1990's to the present has been intended to identify needs more accurately and develop services for both current personnel and veterans which meet the objectives of a healthy deployment force and address the concerns of those from previous deployments. While it is unlikely that deployments will have no short and long term casualties, there has been a trend towards more effective and coherent planning which can limit the range of effects of current war and more quickly develop services that meet the particular needs arising from both conflicts and work such as peacekeeping.

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96 *Committee Hansard,* p. 62.

97 See Additional Estimates, FADT, 18 February 2004, *Answers to questions on notice*, Defence, part 2, p. 6, and also below, Chapter 3, paragraph 3.6.

1.79 In brief, there is, in theory, a much more proactive approach from both the ADF and DVA which is able to take advantage of medical and scientific research in order to reduce hazards or the effects of these, and provide services and education/information programs which may help individuals identify and seek help for problems before these become entrenched. Similar processes are occurring in both the United States and the United Kingdom, although there are difficulties in restructuring substantial forces and implementing such changes, which are openly admitted.

1.80 This inquiry is primarily intended to determine how far these advances have become a part of both the ADF and DVA strategies, and whether previous and current dissatisfaction with either arises from the extent of change, the fact of change, or the belief that change has not improved the capability of the ADF or the capacity of the veteran to be an effective part of society, or to have his/her contribution valued.

Outline of the report

1.81 The terms of reference require that the Committee consider several issues, including the adequacy of administrative arrangements for deployment and of the management of records, the links between ADF and DVA, and the appropriateness of the research programs of both.

1.82 For some, DVA, the RMA or the Commission—or all three—are considered responsible for what are perceived as unfair or inflexible practices which exclude some veterans from disability benefits. However, none of these three parties can act outside the legislation, and as has been discussed, each individual country has both legislation and policies which may provide different outcomes.

1.83 Chapter 2 considers terms of reference 1 (a)(c) and (d) and identifies some areas of possible concern about the availability of accurate deployment information, the extent to which an individual in the ADF can effectively monitor his/her own health, and the effectiveness of some processes which may be well-intentioned but not always appropriately directed. In so doing, it demonstrates how successfully the ADF has adapted to substantial change, some from the broader community and some from similar change in overseas forces.

1.84 Although the adequacy of vaccination processes was term of reference 1(c), there is a more detailed consideration of the anthrax vaccination problems at Appendix 3. There were some faults with this process—a few with respect to information and the expectations of personnel, and some which demonstrate some information co-ordination issues for management. To consider these in detail in the report itself would interrupt the assessment of deployment health processes, and place an undue emphasis on one small aspect of these. Nonetheless, because of the effects on individuals and the potential for future confusion it was necessary to determine if the confusion occurred because of a lack of information, the timing of information, or the overall coherence of information available.

1.85 Chapter 3, (1(b)), which considers the administrative and coordination processes of both the ADF and DVA, examines the way in which technological

change can assist veterans in particular through facilitating the development and maintenance of accurate record systems and the production of information. It also looks at the links established between ADF and DVA to help ensure a connected pattern of services for those leaving the ADF and requiring assistance.

1.86 Chapter 4, (1(f)), considers the research programs of both ADF and DVA to see if these are directed towards identified needs and lead to the development of programs which meet such needs. In so doing, it refers to some contentious situations including the effect of Agent Orange, the British nuclear tests, and Gulf War syndrome.

1.87 Term of reference (2) has been considered throughout the report, with findings and recommendations provided in order to meet the requirement that recommendations be made 'which will give greater assurance to the individual that their health risks are minimised, and fully recorded for the purposes of future compensation where justified'.

Submissions and hearing

1.88 Ten submissions were received to the inquiry, and these are listed at Appendix 1.The Committee held one public hearing on 26 February 2004, in Canberra and a list of witnesses at that hearing is at Appendix 2. At the conclusion of the hearing, additional questions on notice were advised, and these were forwarded to both the Repatriation Commission and the ADF. Answers to these, which comprise *Submissions* 8A and 9B respectively, have been incorporated into the report, and effectively replace a second public hearing. Answers to questions asked but not fully answered in the hearing have also been provided by these and other witnesses and fully considered by the Committee (*Submissions* 5A and 9A).

References

1.89 References to the committee transcript are to the corrected edition of the public hearing of 26 February 2004. This can be read on the Foreign Affairs and Trade site: www.aph.gov.au/committees/Senate, under the name of the inquiry. Submissions are also available at the same site, although some attachments to submissions are not on the website. Copies of these can be obtained from the Committee Secretariat. All other references are quoted in full and some documents referred to in Appendix 3 have been attached to that appendix to facilitate evaluation.

CHAPTER TWO

DEPLOYMENT HEALTH

Deployment and health care planning

2.1 The United States and the United Kingdom have developed new health strategies relating primarily to deployment and to identifying and addressing the problems that occur in conflict.

> The US military underwent substantial changes after the end of the Cold War, resulting in a smaller, more flexible, lighter–equipped and more lethal military force with new health care needs. To meet and adapt to these changes, the Department of Defence developed an innovative health care strategy to protect the health of its soldiers, sailors, airmen and marines. This strategy, called Force Health Protection (FHP), uses preventive health techniques and emerging technologies in environmental surveillance and combat medicine to protect all service members before, during and after deployment. FHP is designed to improve the health of service members, prepare them for deployment, prevent casualties and promptly treat injuries or illnesses that do occur.
>
> The overarching goal of FHP is casualty prevention, achieved through a physically and mentally fit force trained for modern combat and supported by mobile, technologically advanced medical teams. FHP has re–engineered the military's approach to combat medicine—expanding beyond acute care services and toward proactive, preventive services that improve the health of service members and identify and address medical threats before casualties can occur. Three interrelated pillars support the goal of FHP:
>
> - A Healthy and Fit Force
> - Casualty Prevention
> - Casualty Care and Management.[1]

2.2 The United Kingdom's Defence Health Programme 2003–2007 outlines similar objectives, with an emphasis on linking preventive health strategies to the availability of a competent deployment force:

> From the outset it has been our declared intention to work together with the wider military, the NHS and independent healthcare providers to deliver the required Deployable Medical Operational Capability and a health and

1 United States, Department of Defence Force Health Protection (FHP) at www.ha.osd.mil/forcehealth/about/main.

> healthcare system that maximises the number of Service personnel fit for task.[2]

2.3 The United States in particular has used the considerable research resources of agencies such as the Institute of Medicine (IOM) and other branches of the National Academies of Science to further pre deployment and deployment health plans. The Institute of Medicine has produced several reports on military and veterans' health, and recommended that effective health strategies for deployments required stringent data collection and recording. In its study, *Protecting Those Who Serve: Strategies to Protect the Health of Deployed U.S. Forces* (2000) the Institute identified concerns about the rate of implementation of such recommendations:

> The overwhelming victory that [defence forces] achieved in the Gulf War[3] has been shadowed by subsequent concerns about the long–term health status of those who served. Various constituencies, including a significant number of veterans, speculate that unidentified risk factors led to chronic, medically unexplained illnesses, and these constituencies challenge the depth of the military's commitment to protect the health of deployed troops.
>
> Recognising the seriousness of these concerns, the US Department of Defense (DoD) has sought assistance over the past decade from numerous expert panels to examine these issues. Although DoD has generally concurred in the findings of these committees, few concrete changes have been made at the field level. The most important recommendations remain unimplemented, despite the compelling rationale for urgent action. A Presidential Review Directive for the National Science and Technology Council to develop an interagency plan to address health preparedness for future deployments led to a 1998 report titled *A National Obligation.* Like earlier reports, it outlines a comprehensive program that can be used to meet that obligation, but there has been little progress toward implementation of the program.[4]

2.4 The report, *A National Obligation*,[5] identified many of the administrative and planning issues that limited the capacity for immediate follow up of troops from the first Gulf War:

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2 United Kingdom, Defence Health Programme 2003-2007, p. 3 at www.mod.uk/publications/dhp. See also the concordat between the NHS and MoD at www.mod.uk/linked_files/publications/concordats/doh_mod_concordat.

3 The United States uses the term 'Gulf War' to cover both the 1990–91 war and the conflict in Iraq, distinguishing between these by the names of operations. This has facilitated access by veterans to various services set up after the first Gulf War as much of the administration work involved in determining conflict linked injury and disease has already been done.

4 See www.nap.edu.books/0309071895, Executive Summary, p. 1.

5 United States, National Science and Technology Council, *A National Obligation, Planning for Health Preparedness for and Readjustment of the Military, Veterans, and Their Families after Future Deployments* (1998), response to Presidential Directive No. 5 at www.ostp.gov.NSTC/html/directive5.

> Federal agencies discovered numerous health related deficiencies in monitoring the health of deployed troops. For example, our record keeping capabilities were not designed to track troop and asset movements to the degree needed to determine who might have been exposed to any given environmental or wartime health hazard. Seven years later, we just now have a complete accounting of who was actually deployed to the Gulf.
>
> In addition, we discovered major deficiencies in the way we approach health risk communication. While the desire is strong to disseminate all relevant health information to the affected groups as soon as possible, we must ensure that information is delivered in a way that is understandable and causes neither unwarranted concern nor undue complacency. We must ensure that even during wartime situations, the military leadership ensures accurate communication of risks associated with countermeasures, such as vaccines, and maintenance of accurate records.[6]

2.5 While noting that the number of persons killed and injured in war was small, the report concluded that unknown or unexplained illnesses or symptoms, and accidental injury were some of the later consequences which had not been foreseen and therefore not provided for.

> However, DoD and VA were not fully prepared to recognise, respond promptly, and treat the type of health problems reported by a large number of Gulf War veterans. The number of veterans wounded or injured in the line of duty was small, but new challenges included:
>
> - the possibility of injury due to chemical and biological warfare agents;
> - concerns over chronic diseases due to infectious and toxic exposures;
> - unexplained post–deployment symptoms;
> - concerns over illnesses with long latency periods following exposure;
> - concerns over illnesses that might affect family members, close contacts and children conceived post–deployment; and
> - higher rates of motor vehicle injury and death, and of other accidental injury, among war veterans. [7]

2.6 These comments suggest that attention must be paid not only to injury that occurs during conflict, but also to the longer term effects of it. This may appear contradictory, given that some of the difficulties experienced by past veterans have been the lack of immediate services,[8] but it indicates more that some of the longer term outcomes do not always appear obvious, however much they may be connected to conflicts.

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6 See www.ostp.gov.NSTC/html/directive 5.

7 www.ostp.gov.NSTC/html/directive 5.

8 See Chapter 4, paragraphs 4.3, 4.34–4.44.

ADF health service outsourcing

2.7 ADF Health services have been subject to considerable review in recent years,[9] with recommendations generally suggesting greater centralisation and more effective utilisation of resources, an emphasis on appropriate levels of staffing, and an awareness of good health as a necessary part of an effective deployable force.[10] This has led to more outsourcing of medical services, although this also reflects the employment market.

> It is true that Defence has experienced difficulty in recruiting and retaining sufficient numbers of health professionals in a range of disciplines. This has not been a matter of policy; it reflects the current extremely competitive employment environment. This is currently being addressed through a number of initiatives such as career and remuneration reviews.[11]

2.8 Some submissions suggested that with the reduction of qualified staff within the ADF, there had been a reduction in corporate knowledge. This was linked to the outsourcing of some services:

> I think that, if you are outsourcing, the pool of people that you have in the uniformed health service that have day–to–day knowledge of some of the conditions that service people come across, particularly from some exotic environmental threats, is diminished …you do not gain the corporate knowledge. And this was perhaps the experience at Amberley, with the conditions experienced there. [12]

2.9 However, outsourcing of service provision is not in itself a problem, and may be a more efficient way of meeting peaks and troughs in demand. It could create some problems if it were seen that some services were not available, but service provision is already limited to some degree to what is seen as necessary, not what is available.[13]

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9 See Brigadier Paul Buckley, 'The Defence Health Service—formative steps', *ADF Health*, 1 (November 1999), p. 8.

10 Budget estimates, FADT, 4 June 2003, p. 363. *Submission 9*, Defence Organisation, p. 1, paragraph 3.

11 *Submission* 9B, Defence Organisation, p. 4, Q2 (d): 'The current ADF medical screening processes are heavily focussed on preventive health and lifestyle issues. A working group has recently been formed to review our current health examination processes and determine if a change in emphasis towards a more occupational focus is warranted. This will involve extensive consultation and the development of a business case to support any move away from the current system'.

12 *Committee Hansard*, p. 8. See also *Submission* 5, Regular Defence Force Welfare Association Inc, p. 5, paragraph 29: 'Knowledge of the unique environmental exposures associated with ADF service and deployments is not as widespread within the ADF health system as it should be or used to be and this is compounded by the increasing outsourcing of Defence health services to a civilian health population that has had no experience of Defence service.'

13 In addition, some specialist services may not be approved as either not necessary for deployment/operational purposes or as making personnel unfit for these purposes: see DJHSA Directive 07/03, 30 July 2003, *Non Standard Health Care Procedures in the ADF,* p. 1: 'It

There could also be a belief that there is a rationing of a particular level of service, and that those who do not have access to it are less valued. However, Defence emphasised that cost was a secondary factor.

> The standard of health care provided to ADF members is determined by policies aimed at maintaining a fit and healthy deployable force, and are in keeping with usual community expectations of a good health care system.
>
> While efforts are made to provide health services cost effectively, standards of care are not sacrificed to achieve cost reductions.[14]

2.10 Although Defence witnesses conceded there had been a reduction in service providers with knowledge and experience in the type of diseases and injuries, and also of the environmental hazards likely to be experienced by personnel, they stated that this was only likely to be the case in areas where there was little deployment. Appropriate staff, that is those who were within the ADF, were available for personnel on deployments or who had been on deployments previously.[15] Nonetheless, it is obvious that efforts were also made to ensure that the contracted health practitioners became aware of the nature of ADF work[16] and kept up with relevant courses.[17]

2.11 Another issue raised in evidence was that outsourcing could signify a loss of expertise within the forces which could have long term effects in several ways,[18] such as a loss of status through being dependent on other departments for information:

> Early last year, when the second Gulf War deployments commenced, there were statements in service newspapers by the Commonwealth Chief Medical Officer to support views about anthrax vaccinations. To me, that jarred a bit. I thought you would seek the advice of a person like that about an outbreak of meningococcal infection in a base camp, but when you are talking about weaponised systems involving chemical or biological agents that core expertise should be in Defence and recognised as such. That is an

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should also be noted that, should it be undertaken at the member's cost,—the outcome may not be compatible with the maintenance of a deployable profile IAW references A and B.'

14 *Submission* 9B, Defence Organisation, p. 4, Q2(e).

15 *Committee Hansard,* p. 72 and see above, paragraphs 2.7, 2.9.

16 Some familiarity with the work of ADF personnel was to be obtained through all CHPs being given 'the opportunity to attend at least one field day annually with a major unit from the establishment in their normal working and training area,' DJHSA Directive 10/04, 7 April 2004, *Orientation of Contract Health Practitioners Working on Australian Defence Force Bases,* p. 2.

17 'Area Health Services may fund attendance of contract health practitioners on selected ADF health courses, and on those professional body health conferences which have a military component…', DJHSA Directive 10/02, 17 September 2002, *Contract Health Practitioner Attendance at ADF Medical Courses*.

18 See *Submission* 5, Regular Defence Force Welfare Association Inc, p. 5, paragraph 29.

> example of what, to us, appears to be a run-down. Whether or not that run–down is substantiated, I do not know; it is just an example.[19]

2.12 While there is some truth in this, it is likely that a greater danger to personnel is not loss of status, but whether the expertise of qualified scientists and medical practitioners is available and properly utilised and whether the overriding culture is one which values health and safety at all times.[20] Where a department is outsourcing, or seeking expert input, it is sensible to use the expertise of specialist agencies, and in effect the ADF does this through closely following key documents such as the Australian Immunisation Handbook. [21]

2.13 Given the substantial experience of the US and the UK in biological and chemical warfare issues, much of the information available on various hazards, exposures and material that is used, comes from research undertaken there. The only 'Australian input' required is approval of the information and of any substances such as vaccines. The capacity to deal efficiently with queries about anthrax and other hazards, including environmental exposures such as *du*, does not invariably require that high level medically or scientifically qualified persons be within the armed forces. It may be reassuring to have a member of the ADF announce a particular 'medical' program, but in reality this is unlikely to have proceeded without some input from qualified external agencies, including those from overseas.

2.14 However, the suggestion in one submission that there was a clear link between guidelines on issues such as informed consent and the availability of 'highly qualified medical officers to advise the command in this area,'[22] does raise some questions about the extent to which medical staff are involved in decision-making at the higher levels. The discussion on the anthrax immunisation issue indicates that there were problems with access to informative material for medical staff on the *Kanimbla*, the timely availability of which might have limited the concerns of personnel.[23]

2.15 However, a greater problem is likely to be whether the advice available at the planning stages of deployments identifies medical and other issues such as not giving anthrax vaccinations at the same time as others, or the practical effects of not agreeing to receive a particular vaccination.[24] In the particular instance of the anthrax vaccinations, the combination of poor quality and sometimes contradictory

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19 *Committee Hansard*, p.8. See also *Submission* 5, Regular Defence Force Welfare Association Inc, p. 2, paragraphs 8–10.

20 See *Submission* 5, Regular Defence Force Welfare Association Inc, p. 2, paragraph 4.

21 See especially Appendix 3, below, and also *Submission* 9, Defence Organisation, Appendix D, ADFP 1.2.2.1 paragraph 1.10.

22 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 4, paragraph 25.

23 See Appendix 3.

24 See Appendix 3.

information and incomplete medical data resulted in an unnecessarily chaotic situation. While the ADF has accepted that providing information earlier would have been better, it also needs to ensure that its management obtains clearer information itself.[25]

2.16 Defence advised that generally:

> At the strategic, operational and tactical levels, headquarters staff includes dedicated health planning staff. There are both single Service and tri-Service courses which teach operational health planning to ensure that, as part of their normal professional development, those who fill health planning appointments have the appropriate skill sets.[26]

2.17 Many of the programs recently developed demonstrate that the ADF has moved increasingly towards the approach set out by the US and the UK, a move which will be supported by the development of the Centre for Military and Veterans' Health. Following the reviews of Defence health services, specific objectives were outlined as a part of the Defence Reform Program:

- Provide a fit and healthy force which contributes to ADF mission success;
- minimise preventable injury and illness;
- provide appropriate and timely treatment;
- develop the capability of the Defence Health Service to support ADF requirements; and
- Provide a well managed adaptive and adequately resourced quality health system.[27]

2.18 Overall, the Defence submission to this inquiry did not consider that there were problems in providing adequate services as part of an holistic approach -'routine health care prior to deployment includes the monitoring of health and fitness standards',[28] and emphasis was placed on members of the ADF having responsibility for their own readiness for deployment.[29]

2.19 At the same time, the ADF emphasises that, given rationalisation of resources, the allocation of uniformed medical personnel will be to the areas likely to be

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25 See Appendix 3

26 *Submission* 9B, Defence Organisation, p. 3, Q 2(b).

27 See Brigadier Paul Buckley, 'The Defence Health Service—formative steps', *ADF Health*, 1 (November 1999), pp. 5–6.

28 Budget estimates, FADT, 4 June 2003, p.363. *Submission* 9, Defence Organisation, p. 1, paragraph 3.

29 *Submission* 9, Defence Organisation, p. 2, paragraph 9 and p.4, paragraph 21.

deployed, and the provision of health care is geared directly to operational requirements.

> Health care delivery in the Australian Defence Organisation is made up of four components: the active duty men and women of the ADF, the Reserve component, an element of Australian Public Service people, and a pool of contractors. The ratio of those four elements will depend on the base that you are looking at. If you go to an operationally focused base then the preponderance of providers will be uniformed people. It has been the thrust of the reorganisation of Defence Health Services to concentrate a scarce resource—that is, uniformed health providers—to our operational bases.[30]

2.20 The reason for this allocation is presumably that medical personnel within the ADF are seen as having a greater understanding of the needs of the ADF, and are more likely to have military–specific expertise. Where this experience is recent, this may well be true. However, unless there is detailed information available on day to day activities of individuals, many medical professionals may not be aware of some of the factors affecting their patients' health—otherwise many problems would have been identified long ago. It should also be borne in mind that, just as there may be problems with psychologists being used to try to get people to change their minds,[31] there is also a need for doctors and nurses to remember that their main duty is to the patient and not to the ADF. No detailed instances were given to this inquiry of any case in which there was a conflict of roles, but the use of civilian medical staff may provide a balance.

2.21 The provision of health care, while linked to Medicare, is directed primarily at maintaining a high level of fitness for operational duty:

> …equity with Medicare underpins the basic entitlement to the range of medical services available. The provision of health care differs to that available to the general public in that the range of, and ease of access to health care provided to the ADF will exceed that available through the public health care system because of the requirement to meet and maintain operational readiness. Conversely, the Director–General Defence Health Service (DGDHS) may also issue policy which precludes or limits the provision of certain medical and dental treatment, despite its availability on Medicare, on the grounds that it is either contra–indicated or unnecessary for operational readiness.[32]

30 *Committee Hansard,* p. 72.

31 See Redress of Grievance, Attachment to *Submission* 10, Mrs Screaton, paragraph 34, see also Appendix 3.

32 Joint Health Support Agency, DJHSA Directive 07/03, 30 July 2003, *Non Standard Health Care Procedures in the ADF.*

Health Services

Pre deployment

2.22 Planning for overseas deployments includes the assessment of health threats and the development of health support plans which operate across the pre deployment, actual deployment and post deployment stages.[33] The rate at which such strategies are developed may vary:

> The task of conducting health [threat] assessments is research and analysis based, requiring the coordination of a large amount of corporate knowledge to gather information and formulate coherent policy before it is turned into strategic guidance.[34]

2.23 There is an ongoing requirement for the collection and analysis of data which will help establish an information base about the deployment area, including endemic diseases, water and electricity supplies, and availability of established health services. While it is to be expected that many details of a deployment area may need to be revised, there seems to be little reason why a substantial amount of the information which is regularly collected would not have been analysed and a 'coherent policy' able to be put in place rapidly. More information on the day to day role of staff involved in the collection and analysis of information may indicate a need for a more efficient approach which could limit the time required to provide a basic strategy when decisions are made for deployment.[35]

2.24 This is especially important given that the existing health and environmental threats may determine personnel to be deployed (those already fully vaccinated) more than the deployment waiting on personnel to be available.

> Commanders seek advice from [health planning] staffs early in the planning process. Frequently the time needed to complete vaccination schedules to protect against a particular threat in an area of operations will have a direct influence on how quickly troops can be deployed fully protected against that threat. The environmental threat assessment, which is prepared by health intelligence staff, has a direct effect on the make up of any deployment as health support is configured, and pre–deployment preparation is tailored, to meet the operational, occupational and environmental threats.[36]

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33 *Submission* 9, Defence Organisation, p. 1, paragraphs 2–4, p. 2, paragraphs 6–9, pp. 2–3, paragraphs 10–13.

34 *Submission* 9, Defence Organisation, p. 3, paragraph 12.

35 *Submission* 9, Defence Organisation, p. 3, paragraph 12.

36 *Submission* 9A, Defence Organisation, p. 3, Q2(b).

Data collection/analysis and information

2.25 The 'health threat assessment' is developed by two agencies, the Defence Health Service Branch (DHSB) and the HQAST.[37] Without such plans, a deployment is likely to encounter substantial problems which will affect its capacity to undertake the deployment effectively. No problems were identified by Defence in its statements about current arrangements, but some submissions and oral evidence indicated flaws which may have arisen from these plans or from an inability to provide services as required by plans. One example was the lack of adequate protection from malaria experienced by personnel in East Timor.[38] Another referred to lack of information about environmental hazards:

> …recent discussions by Federation staff with East Timor veterans identified that many of them were unaware of many of the chemicals and substances which were known by Defence to be present in the area of operations. Although it is accepted that many of these hazards did not become apparent until personnel were in-country, subsequent briefings and information have not been forthcoming or adequately recorded for future reference.[39]

2.26 It is not clear what detail is provided to personnel on health threats, and to what extent they are required to keep themselves up to date, and seek additional information in the field, although some updates are provided:

> …once they are deployed there is an ongoing education program, which is usually conducted by the health providers, and that is either of a generic nature in relation to the operation itself or it may be focused, depending on things that have happened locally, such as an outbreak of gastroenteritis or that sort of thing.[40]

2.27 Nor is it clear if all personnel are able to accurately assess their exposures or risk of exposure to disease and environmental hazards.[41] Information about certain aspects of health plans are confidential, and personnel will only be allowed to know what is deemed necessary.[42] Even if they are aware of all relevant issues, inadequate provision of required medication or other services will limit the usefulness of this knowledge. Lack of effective monitoring of individuals, to ensure that they have not exceeded dosage of particular drugs, also appears to be lacking.

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37 *Submission* 9, Defence Organisation, p. 2, paragraphs 6–7.

38 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 2, paragraphs 4, 5.

39 *Submission* 3, Armed Forces Federation of Australia, p. 1.

40 *Committee Hansard,* p. 89.

41 *Submission* 9, Defence Organisation, p. 1, paragraph 8. See also chapter 3.The US in particular has collected some exposure data, but this may have limited value unless it can be matched to individuals through HealthKEYS, see below, paragraphs 2.64–2.66.

42 See Appendix 3.

> We are not 100 per cent sure of, and have not been provided with, the long-term effects of taking doxycycline for, say, seven to eight months. One particular case comes to mind of a member who did a number of deployments in a row and ended up being on doxycycline for some 13 or 14 months.[43]

2.28 Defence stated that information is provided on drugs used in deployments, including doxycycline,[44] but because doxycycline was common, not much information was given to personnel.[45] There was no mention of any studies on long term effects, although concern was expressed about the status of individuals for G6PD, 'a particular enzyme we are worried about in relation to antimalarials'.[46]

2.29 It is possible that a 'need to know' policy also limits both collection of information and its distribution:

> …the quality of early advice may be affected by the inability to consult with some supporting agencies.[47]

2.30 However, Defence considers that the information it provides pre-deployment is detailed, and includes data on 'potential operation, environmental and occupational hazards that may be encountered'. It is also the case that different forces may have different health needs, because the nature of their work may vary considerably.

> When the ADF engages in an operation, operational health threat countermeasures are not always universal across the three services because they may be operating in different operational milieus. Historically, Navy personnel have not received the suites of protective agents that, for instance,

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43 *Committee Hansard,* p. 30, Australian Peacekeepers & Peacemakers Association.

44 *Committee Hansard*, pp. 88–89.

45 *Committee Hansard*, p. 8: 'doxycycline is a registered drug in Australia and it is widely used, so we do not spend a lot of time telling people about it, nor do we require a signed consent from them'.

46 *Committee Hansard*, p. 76. Doxycycline is an antibiotic (tetracycline) which is used for several health problems, including as an anti-malarial and anti–anthrax drug. It is used as an anti-malarial in areas which have become mefloquine resistant (Mefloquine is an older anti-malarial which no loner provides adequate coverage against malaria in some areas) and this includes the Pacific region. It does have side effects including gastrointestinal upset and esophagitis. It can also be photo sensitizing, and therefore adequate sunscreen protection is required. It is contraindicated in pregnant women, Stephen J. Gluckman, 'Prevention of malaria in travellers', *American Family Physician*, 1 August 2003, pp. 3–4, www.findarticles.com/doxycycline). Although one source indicated that long term use of tetracyclines was tolerated well, another stated that some sources do not recommend taking it for more than three months (Australian College of Tropical Medicine, Faculty of Travel Medicine, *Travel Medicine Briefcase*, 2 (December 2001) p. 1). The Australian College of Tropical Medicine refers to the fact that there are no long-term anti–malarials, and mentions doxycycline as a short term drug. If this information was available, it does not appear to have been transmitted to the individual who had been taking it for 14 months.

47 *Submission* 9, Defence Organisation, p.3, paragraph 13.

> ground forces may receive because the nature of their duties is quite different and their risk of exposure is different. So, whilst a decision may be made for ground forces to be protected against anthrax based on threat assessment, the issue of whether Navy personnel should receive similar protection is not always clear cut. A lot of that will get down to quite pragmatic issues of where the ships will operate, the ports they will use, the probability of their personnel going ashore—there is a whole range of issues that need to be consulted.[48]

2.31 Examples of this variation were seen in the first Gulf War, with the majority of forces being naval, and consequently limited vaccination being required.[49]

Mental health

2.32 A psychological briefing is also given, 'emphasising operational stress training' [50] and a pamphlet containing 'practical information relevant to the Area of Operations with effective disease minimisation and prevention advice as well as mental health information' is issued.

> The pre–deployment education provided to ADF members deploying on operations includes a number of discrete modules that can be included when appropriate, including body handling and the psychological issues involved in operations in an environment where there is a threat of chemical or biological weapons.[51]

2.33 Nonetheless, it is possible that some personnel already emotionally adversely affected by previous deployments, or those especially vulnerable, may neither be picked up through the assessment process nor assisted by this information. One submission noted that there may be a lack of psychological screening pre deployment which could have serious effects later.[52] That there was in fact little early psychological assessment was noted in other material:

> At this stage we are not doing a comprehensive mental health assessment of people at recruitment….
>
> It is the goal of the mental health team to develop comprehensive recruitment profiling which can then form the baseline for further assessments.[53]

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48 *Committee Hansard*, p. 64. See also *Submission* 9B, Defence Organisation, p. 1, Q1(c): 'ADF personnel receive detailed health threat assessment briefings prior to deployment that provide sufficient information about the risks and possible consequences of different hazards'.

49 *Committee Hansard*, p. 61.

50 *Submission* 9, Defence Organisation, p.5, paragraph 23.

51 *Submission* 9B, Defence Organisation, p. 1, Q1(a).

52 *Submission* 6, Australian Peacekeepers & Peacemakers Association, pp. 2–3, paragraphs 9–14.

53 Budget supplementary estimates, FADT, 5 November 2003, p. 104.

2.34 While the development of the mental health teams is an important one, it is likely that early identification of alcohol and substance abuse and of psychological factors (including those contributing to harassment, intimidation etc) would be highly beneficial, preferably at recruitment.[54] There seems little point in providing extensive military training for a person who may be quite unsuited for deployment.

> Psychological assessment at intake cannot identify those more prone to break down in combat, although it can filter out the dull, the illiterate and the severely disturbed—such as those with schizophrenia. Normal men and women can break down.[55]

2.35 However, this is to be distinguished from pre-deployment screening. Defence's reasons for not conducting pre–deployment psychological screening included:

> The ADF does not conduct routine pre–deployment screening but does conduct assessments by request. There are a number of significant issues with the application of pre–deployment screening, not least the possibility of disadvantaging an individual who is incorrectly screened out from deployment. Another major issue for pre–deployment screening is that, by the nature of pre–deployment activity, individuals will be experiencing an elevated level of activity and some levels of anxiety that diminish the accuracy of the screening methodology.[56]

2.36 Another reason is that, depending on the length of the campaign, many individuals will be subject to stress, and this cannot be predicted:

> Overall, it was the Second World War that showed that it was not the case that breakdown could be avoided with selection, training and moral fibre, as had been concluded at the end of the First World War. The reality of industrialised warfare was inescapable—eventually, as US statistical inquiries showed—men would breakdown irrespective of training and courage. After about 120 days of combat, most units became incapable of further performance because of psychiatric injuries, which were also proportional to the number of physical casualties.[57]

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54 See *Committee Hansard*, Australian Peacekeepers & Peacemakers Association, p. 36: 'There is psychological suitability testing, psychometric testing, that is completed prior to entry into the service to identify people who are suitable and not suitable. The repeat of that as a tool before deployment may be an idea; I am not too sure'.

55 See John Ellard, 'Principles of Military Psychology', *ADF Health*, 1, 2000, p.83.

56 *Submission* 9B, Defence Organisation, p. 8, Q5(h).

57 *Improving the Delivery of Cross Departmental Support and Services for Veterans—A Joint Report of the Department of War Studies and the Institute of Psychiatry*, Kings College London, July 2003, p. 45, paragraph 5.3.1.3, at

http://news.mod.uk/news_press_notice.asp?newsItem_id=2616.

2.37 The policy with respect to pre–deployment psychological screening was criticised by one submission which suggested the process was inadequate, as was the post deployment screening. The main reason for this was that there were specific differences in mental health issues depending on the nature of deployment, and these were not considered:

> Neither Defence nor DVA have a clear picture of the state of the mental health of young veterans. Furthermore, they have not conducted sufficient research to understand the specific differences in the mental health problems associated with War Like Service and peacekeeping opposed to Peace Making operations. There is a clear requirement for Defence's Centre for Military and Veterans' Health to undertake extensive research into the symptoms and signs of operational stress related injuries for each type of stress injury to ensure the development of better rehabilitation and compensation programs.[58]

2.38 A further relevant factor in problems of identifying mental health is the stigma associated with mental health issues, which Defence has sought to overcome:

> Defence has made significant efforts in a number of different campaigns in order to address those but, at the base level, there is still that cultural problem.[59]

2.39 Defence noted, however, that as part of the information obtained from the study of the first Gulf War, psychological and substance abuse problems were addressed in the planning stages of a deployment,[60] as a means of trying to deal with issues before rather than afterwards:

> …prior to deployment, the members are given a deployment guide, which is quite a comprehensive document that goes into all of the possible problems they may experience prior to deployment, during deployment and on return to their families….The aim of that document is to heighten the awareness of the families about what signs may be significant. Through the Defence Community Organisation they can certainly access social workers and, through them, the regional mental health support teams if the family is concerned about any aspect of the behaviour of the partner who has returned from the deployment.[61]

2.40 In due course, it is assumed that the process that occurred prior to the return of personnel from Iraq will be in place for all deployments—that is, that there is some

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58 *Submission* 6, Australian Peacekeepers & Peacemakers Association, pp. 2–3, paragraph 11.

59 *Committee Hansard*, p. 33, Australian Peacekeepers & Peacemakers Association, and see also below, paragraph 2.89, and Chapter 4, paragraph 4.64.

60 Budget estimates, FADT, 4 June 2003, p. 367.

61 Budget estimates, FADT, 4 June 2003, p. 361.

attempt to identify potentially traumatising events prior to individuals returning home.[62]

2.41 Nonetheless, the responsibility placed on unqualified family members to identify problems appears excessive. The value of regional mental health support teams may be undermined by the lack of professional input in identification of issues at an early stage.

Other preparation

2.42 The health support plan outlines the processes by which adequate health services will be provided to personnel during the whole phase, including pre and post deployment.[63] This includes undertaking health reviews of returned deployed staff, and helping to identify any health issues that may arise in the short or longer term from such deployments. Post–deployment information gathered from various sources including medical reviews can help to determine patterns of injuries and disease arising from conflicts and therefore has a role in the prevention or moderation of such effects in future similar deployments.[64] Updates on the basic plan are provided throughout operations,[65]although these appear to be available to health staff only. This again raises the issue of the extent to which any relevant new information is passed on to those more directly involved, and how it is transmitted.

2.43 As a consequence of the 'readiness for deployment' approach, the ADF considered that it was capable of responding rapidly. All three forces were subject to an annual health review, regardless of need for deployment. When deployment was determined, Army and RAAF personnel underwent an 'update' interview 'to determine if any injury or condition has occurred since their Annual Health Assessment'.[66] While this interview was undertaken by health 'staff', it had to be signed off by a 'medical officer', a term which appears to mean 'doctor'.[67] The effectiveness and thoroughness of this approach will obviously depend both on the qualifications and skills of the health staff and the awareness of the individual, who may have some health problem which has minimal symptoms, or has not been clearly identified.[68] Naval personnel have a 'seagoing medical',[69] although they are presumably also required to remain deployment–ready.

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62 See below, paragraphs 2.69–2.71.

63 *Submission* 9, Defence Organisation, p. 1, paragraphs 4, p. 2, paragraph 10.

64 *Submission* 9, Defence Organisation, p. 4, paragraph 17.

65 *Submission* 9, Defence Organisation, p. 3, paragraph 13.

66 *Submission* 9, Defence Organisation, pp. 4–5, paragraph 21.

67 *Submission* 9, Defence Organisation, p. 5, paragraph 21; see also p. 3, paragraph 11**,** which notes that the medical and dental examinations are conducted by JHSA staff.

68 At the time of writing its submission (January 2004) the ADF had not yet incorporated into the annual assessment any information relating to compensation claims or acceptance of claims, which left the responsibility of identifying any problems to individual personnel. This was a

2.44 Pre–deployment readiness programs are unlikely to include standard inoculations which are part of the 'readiness for deployment' strategy,[70] and will rather comprise those required by the specific environment or situation of the deployment.[71] It is in this area that many of the issues concerning improved standards arose, with out of date vaccines, poor quality information, and apparent unwillingness to accept the effect of symptoms[72] all seen as evidence of second rate services. Another submission stated that given the extensive literature available on possible effects of exposures and of vaccinations,[73] an improved process regarding information provision and informed consent was seen as necessary.[74]

Deployment

2.45 There was little information provided on the capacity of the health services during deployments, whether this had been assessed against performance indicators and the extent to which involvement in joint operations resulted in ADF personnel receiving a lesser level of care than they might have expected. Australia provides its own primary level care on deployment, and believes that the standard of other care is appropriate.

> The only two countries under whose command ADF personnel have ever operated, or are likely to operate in the near future, are the UK and the US. Both those countries, along with Australia and Canada, with New Zealand as an observer, are members of the Australia, Britain, Canada and America Standardisation Program. The Program develops Quadripartite Standardisation Agreements (QSTAGs). QSTAG 470–*Documentation Relative to Medical Evacuation, Treatment and Cause of Death of Patients* sets documentation standards which are agreed by all parties while QSTAG 2042—*Common Principles for Deployment Health Surveillance* does the same for health surveillance.[75]

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matter which the ADF expected to rectify (*Submission* 9, Defence Organisation, p. 5, paragraph 21), although some cross–checking of responses with compensation claims may be necessary in order to determine the exact nature of such claims or conditions for which the individual is being compensated (because the proposed incorporation of this issue into the annual assessment takes the form only of an 'indication' (p. 5, paragraph 21) that may not elicit sufficient detail)—see *Submission* 9, Defence Organisation, p. 5, paragraph 29.

69 *Submission* 9, Defence Organisation, p. 5, paragraph 21.

70 See *Submission* 9, Defence Organisation, p. 2, paragraph 9. These standard inoculations were ADT (adult diphtheria and tetanus; measles, mumps, rubella; polio; hepatitis A and B; and typhoid (Estimates, FADT, 4 June 2003, p. 365).

71 *Submission* 9, Defence Organisation, p. 5, paragraph 22.

72 *Submission* 7, Major Laboo, p. 3.

73 *Submission* 5, Regular Defence Force Welfare Association Inc., p. 4, paragraphs 20–21.

74 See Appendix 3.

75 *Submission* 9B, Defence Organisation, p. 4, Q2(i).

2.46 Material from a 2000 review of the health status of the ADF identified a range of disorders from other deployments but no serious injuries.

> Data from some recent deployments, including Bougainville and East Timor, indicated that almost half of medical attendances were due to skin diseases, injuries, intestinal infections and other infections including dengue fever and malaria. Measures have already been put in place to apply lessons learned to current and future operations.[76]

2.47 As far as the Iraq deployment was concerned, there were no physical injuries of a serious nature.[77] To General Cosgrove, it appeared that in respect of the 2nd Gulf War a similar result emanated from the period of time that was spent acclimatising in the combat zone prior to conflict:

> I believe that the opportunity to acclimatise, to learn of the operating environment and to assimilate or integrate with coalition partners, was a major factor in our people being able to show a professional performance without friction, misunderstanding or those individual factors that exhausted and disoriented service men and women can experience if they are pitchforked into a harsh, hazardous environment at short notice.[78]

2.48 The available statistics on medical discharge do not demonstrate if some claims might have arisen subsequently, or if there were longer term injuries, including mental health problems that might not be obvious or identified until later.[79] Primary health care in recent deployments has been provided by Australia[80]with in patient services being a UN or Coalition responsibility.

2.49 The only issues identified for the deployment period were that Australian forces may have been required to meet standards of another force, and that medical records in deployment areas may not be easily obtained[81] because a hospital was

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76 Department of Defence, Media Release, 'First ADF health status report supports white paper aims', 2000.

77 Budget estimates, FADT, 4 June 2003, p. 358, Senator Evans: 'There seem to have been reports of nothing more than cuts and abrasions which seem quite remarkable given the large number of people and the potential for industrial accidents let alone anything involving a conflict'.

78 Budget estimates, FADT, 4 June 2003, p. 383.

79 Additional estimates, FADT, 18 February 2004, *Answers to Questions on Notice*, Defence, part 2, p. 68.

80 *Submission* 9B, Defence Organisation, p. 3, Q2(b): 'As a general principle, and in line with United Nation's policy, as a Troop Contributing Nation, the ADF provides its own primary health care'.

81 United Nations, Office of Mission Support, Department of Peacekeeping Operations, Medical Guidelines for Peacekeeping Operations, Medical Support Unit/ OSD/LMS Hospital Level Medical Care (2003) outlines the standards of equipment and staff to be provided. See www.un.org/Depts/dpko/medical/pdfs/472 hospital care.

under the command of another organisation such as the UN.[82] These issues, especially the latter, can have substantial consequences for people making claims for injury, but the Repatriation Commission believes that many former difficulties are being overcome by different means of obtaining information.[83]

Post deployment

Screening

2.50 According to Defence:

> The general policy with respect to post–deployment health care is in Health Directive 222—*Health requirements for deployed Australian Defence Force Personnel*. This is available on the Defence Intranet and is published on the Internet. For each operation a specific Post–deployment Medical Insert Slip is developed. This document is issued widely in Health Support Plans. It addresses the mission–specific health threats, environmental hazards and prescribed eradication courses to be undertaken. The Medical Insert Slip is placed in the member's medical documents for post–deployment action. Each individual also undergoes a health assessment and a follow–up psychological screen approximately three months post deployment.[84]

2.51 Evidence from earlier Estimates hearings stated that a form of health assessment was given prior to return from deployment,[85] but later information—in respect of the return of troops from Iraq—corrected this to advise that troops had rather been provided with a health briefing prior to return[86] which:

- identified exposures;
- provided pharmaceuticals that might be required; and

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82 In Timor, the original UN hospital at Comoro was established by Australia in 1999 and closed at the end of August 2002. It was replaced by the UN hospital in Dili. Medical staff for the hospital were provided by Australia, Egypt and Singapore. (See www.un.org/peace/timor 040902). However, under the system set up by the UN, hospital care is the responsibility of the UN (United Nations, Office of Mission Support, Department of Peacekeeping Operations, Medical Guidelines for Peacekeeping Operations, Medical Support Unit/ OSD/LMS Hospital Level Medical Care (2003), Introduction, p. 6) even though the facility in which the care is provided and the staff who provide it, may be contracted. This may account for the UN retaining medical records.

83 See Chapter 3, paragraphs 3.39–3.40.

84 *Submission* 9B, Defence Organisation, p. 3, Q2(b).

85 Budget estimates, 4 June 2003, p. 359.

86 See *Correction of evidence…concerning medical examinations for ADF personnel returning from active duty in the Middle East*, Material provided following Budget estimates of June 4, 2003 at www.aph.gov.au/committees/Senate/Foreign Affairs, Defence and Trade, Budget estimates 2003–2004.

- provided information on the post deployment health check.[87]

2.52 Personnel were able to raise concerns with a doctor if they had any further queries. While the process may have improved considerably since this time, a general briefing—even one which raises an opportunity for further private discussion—does not help to identify all issues that individuals may have, since many people may not wish to discuss these. It is not clear from this information what medicines were dispensed and whether these were handed out with adequate information, or took the needs of individuals into account. Defence notes that personnel are issued with cards 'detailing diseases endemic in the Area of Operations',[88] which are presumably linked to the inserts referred to above and which will be used during later medical assessments.

2.53 According to Defence, there is a extensive health screening process in place on return from deployment, although this does not occur for three months:[89]

> After returning from deployment, individuals are subjected to comprehensive health–screening processes. These are designed to eradicate disease and to document and treat potential exposure to operational, occupational and environmental hazards during deployment. These processes include medical testing, psychological debriefing and ongoing health care.[90]

2.54 Although this assessment is an Annual Health Assessment,[91] a three–month gap is surprising, given that numerous health issues may have arisen and need to be tested for. One reason given for this three month period was that 'certain infectious diseases may not in fact manifest themselves on the testing until a period of at least six weeks after return' and that other symptoms or signs might emerge during that time.[92]

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87 See *Correction of evidence…concerning medical examinations for ADF personnel returning from active duty in the Middle East*, Material provided following Budget estimates of June 4, 2003 at www.aph.gov.au/committees/Senate/Foreign Affairs, Defence and Trade, Budget estimates 2003–2004.

88 *Submission 9*, Defence Organisation, p. 5, paragraph 24. This card is apparently meant as a prompt for personnel during the post-deployment period, presumably by listing issues they may wish to raise with medical staff.

89 'All personnel are medically examined three months after returning to Australia and provided with appropriate treatment if required'(Budget estimates, FADT, 4 June 2003, p. 359).

90 *Submission 9,* Defence Organisation, p. 1, paragraph 3.

91 Defence Health Service, Health Directive 222, *Health requirements for deployed Australian Defence Force Personnel*, p.3 paragraph 20, at www.defence.gov.au/dpe/dhs/infocentre/publications/directives/HD222.

92 Budget estimates, FADT, 4 June 2003, p. 360.

2.55 However, this presupposes that various diseases were all caught just prior to return. Given that the average period of deployment in Iraq was 6 months,[93] it is more likely that at least a percentage of personnel would have been infected during the deployment. Diseases, including malaria,[94] HIV,[95] and TB,[96]can provide evidence of infection in short time span and treatment should start then.[97] TB is prevalent in Timor, Iraq and Afghanistan, with the latter two having rates of infection of approximately 142 and 148.9 (1991) per 100,000 respectively[98] which is likely to have increased because of the effects of war,[99] although ADF personnel may be less prone to the disease because of higher levels of overall health, and the relatively short period of time spent in affected areas.[100]

2.56 Personnel are provided with prophylaxis against malaria (found in Iraq, Afghanistan and Timor as well as other regions of the Pacific). This will not necessarily guarantee protection, unless taken as prescribed. One of the disadvantages of doxycycline was considered to be that, as it had to be taken daily, adherence to guidelines might wane.[101] Another problem, as indicated above, is that it may have adverse effects and its long term use should be monitored.

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93 See Budget supplementary estimates, FADT, 5 November 2003, p. 30.

94 See *History of Plasmodium Paragraph sites*, www. wehi.edu.au MalDB.

95 However, prevalence rates of HIV/AIDS are very low in Afghanistan and Iraq—see World Health Organisation (WHO), *Epidemiological fact sheets in HIV/AIDS and sexually transmitted infection*, 2000 at www.who.int/emc_hiv/fact_sheets 2000.

96 'The initial infection with *M. tuberculosis* often goes unnoticed; 95% of those infected enter a latent phase from which there is a lifelong risk of reactivation. The other 5% progress directly to pulmonary tuberculosis or by lymphohaematogenous dissemination of TB bacilli to miliary, meningeal or other extrapulmonary involvement. Infants, young children, older people and the immunocompromised are more likely to progress rapidly to severe generalized infection with poorer outcome. It is common for the initial infection to result in a characteristic nodular lesion in the middle or lower lungs, and this lesion acts as the source of disease during reactivation.' Asia Pacific Vaccination Council, *Tuberculosis: General Information on the Disease and the Vaccine*, www.vaccinenews.net/default.asp? articleID=209&Topic_ID+65.

97 National Health and Medical Research Council, *The Australian Immunisation Handbook*, 8th edition Canberra 2003, Part 2, p. 81: 'The incubation period for inhalational anthrax is thought to range from 1 to 43 days after exposure. The initial phase consists of flu–like symptoms such as sore throat, mild fever, chest pain, cough and myalgia. Within 2 to 3 days, a second phase begins with the abrupt onset of high fever, dyspnoea and hypoxia, rapidly progressing to shock and death within 24 to 36 hours.'

98 www.nevdgp.org.au/genin f/lung_f/tuberculosis.

99 People with poor health status, and limited access to food and medicine, are more vulnerable to TB.

100 See National Health and Medical Research Council, *The Australian Immunisation Handbook*, 8th edition, Canberra 2003, pp. 60, 61.

101 Stephen J Gluckman, 'Prevention of malaria in travellers', *American Family Physician*, 1 August 2003, p. 3.

2.57 In addition, the possibility of transmitting some diseases such as TB to others including family members, is heightened through absence of early identification. Although reference was made to prophylaxis for malaria, the ADF does not support BCG for preventing TB: 'the ADF will seek to minimise the impact of TB infection through targeted screening'.[102] It does not appear from information provided that the post deployment period is used to complete a vaccination program, including for anthrax, although this may not be the case. However, other evidence suggests that there may not be a standard process for providing immunisations by set dates, and that a catch–up process is used:

> The recommendation is that if there is a prolonged period between the vaccinations then you basically carry on as though that time gap did not exist. Say that, hypothetically, there are three vaccines in a suite of vaccines and that a person has had the first two, there may be a one or two–year gap, then you would only give the person the third shot and consider the sequence to be complete. You do not start from square one and start revaccinating.[103]

2.58 While many of the issues identified in submissions concern the difficulties experienced by individuals post deployment, the causal factors of many of these problems could be attributed in part to processes operating during the pre deployment stage and during the deployment period itself. In particular these concern absence or incompleteness of medical records; inadequate pre–deployment assessment; absence of adequate information on environmental and other hazards, especially those which are perceived as relating to slowly developing disorders; and some lack of clarity about the status of individuals relative to occupation—that is, that different activities may expose people to different risks.[104]

Environmental hazards

2.59 Although environmental/chemical exposures may have been identified just prior to return to Australia, it would be necessary for health examiners to be aware of these and of potential implications for future health. In addition, possibly inadequate levels of post–deployment health assessment may affect the capacity of the individual to identify problems in the short and long term, or to seek help for these.

> …in Bougainville we were exposed to a large number of chemicals that we are still not 100 per cent sure about the long-term effects of. When I was over there I never knew that was the case… all the ones associated with mining copper and gold. We are still not 100 per cent sure. We have a large list of chemicals that we were exposed to.[105]

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102 See *Submission* 9, Defence Organisation, Attachment D, ADFP 1.2.2.1, *Immunisation Procedures*, paragraph 5.80.

103 *Committee Hansard,* p. 63. See also Appendix 3.

104 See *Submission* 8, Repatriation Commission, p.15, paragraph 73.

105 *Committee Hansard*, p. 42 Australian Peacekeepers & Peacemakers Association.

2.60 The extent of exposures to substances such as depleted uranium (*du*) and smoil *(smoke and oil)* would be known to some degree, with land troops generally being more vulnerable than those on ships.[106] Although current information suggests there is limited long term effect of *du*, this prediction is made only on the basis of work undertaken on those who served in the first Gulf War: fourteen years is not a particularly long period to assess effects which may not manifest for two or three decades. It is the view of Defence witnesses that Australian personnel were not exposed to significant levels of *du*,[107] although a survey of personnel from the 2nd Gulf War will also be carried out. DVA's opinion on *du* is similar to that of Defence, that there are likely to be limited effects.

> There are no known health effects of depleted uranium in humans. What is suspected is that it might result in renal damage in the longer term. This is because in studies of laboratory animals, uranium given in high doses results in renal damage. It is also envisaged that there may be a risk for cancer, as DU is a weak emitter of alpha particles. However, this risk of increased cancer has not been actually observed in any population of humans that have been exposed to DU. Thus, we do not know if there is any level of DU related disease. Moreover, at the exposure level that we believe Australians experienced it would be difficult to envisage that there would be any adverse effects.[108]

2.61 Although some testing was eventually introduced for persons who had been exposed to *du* in the first Gulf War, it apparently was not made available to those who were not current members of the ADF.[109] However, Defence advised that:

> Former members of the ADF who are concerned about possible depleted uranium exposures can approach DVA and, if they have not already done so, can lodge a claim. As part of the investigation of the merits of their claim, DVA can undertake urinary uranium testing.[110]

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106 *Submission* 8A Repatriation Commission/Department of Veterans Affairs, p. 7. 'DVA understands that for a brief period in the 1980s, certain Australian close-in air defence systems used on Royal Australian Navy ships used depleted uranium. Depleted uranium is also used in a wide variety of industrial applications such as in drills in engineering and in early Boeing 747 aircraft. Given this, Australia has been broadly aware of the potential for exposure to DU since the early 70s, although it has not been seen as a matter of particular concern until the years after the 1990–91 Gulf War.'

107 Budget estimates, FADT, 4 June 2003, p. 369. See also Chapter 4.

108 *Submission* 8A, Repatriation Commission/Department of Veterans Affairs, p. 6.

109 See Budget estimates, FADT, 4 June 2003, p. 369, Budget Supplementary Estimates, FADT, 5 November 2003, p. 27, Additional Estimates, FADT, 18 February 2004, pp. 99–100.

110 *Submission* 9B, Defence Organisation, p. 4, Q2(h), *Submission* 8A, Repatriation Commission/Department of Veterans Affairs, p. 7: 'It should be noted that the levels of uranium in exposed persons decreased with the passage of time, thus with so many years since the Gulf War, it may be that urine testing has limited or even no value'.

2.62 Defence noted that the levels of exposure are risk of either (a) increased cancer rates or (b) kidney damage from the toxicology would at worst be twice that of the baseline population'.[111] This may be so, and also considered to be well under the amount necessary for an effect on health, but as one of the concerns of 1st Gulf War veterans appears to be the *combined* effects of various exposures and vaccinations, such statements may not produce much confidence.

2.63 Given the fact that many concerns develop and grow out of proportion to actual risk—as far as such risk is known—it would be more appropriate for services such as *du* testing to be made readily available. Even on a cost–effective basis, the reduction of fear and the belief that one's needs had been recognised is likely to reduce later claims. Some recognition of the effects of confusion and anxiety that arose from the problems with the anthrax vaccine is evident,[112] and this suggests that the way in which issues are handled, as well as the issue itself, is acknowledged as important.[113]

2.64 According to evidence, there is now available improved information on environmental exposures during conflict, at least in those areas which were monitored by the US:

> The US military has had a very robust system of putting environmental people on the ground to conduct routine soil, water and air sampling and they are linking that with geospatial data information so they are able to identify where an individual is at any point in time and what environmental threats were at play in that location, even down to things like overlaying satellite imagery to show the presence or absence of oil fire smoke plumes. We have access to that data for our deployed personnel…[114]

2.65 On occasion, information provided about the existence of environmental threats can also be used to avoid having personnel working in certain areas, thereby reducing hazards.[115] However, the information available about areas where US troops were not present may be limited.

2.66 Additionally, the remarks made by various US reports[116] suggest that a number of important procedures were not undertaken in the collection of data which could limit the availability of information on exposures in conflicts, reports on which Australia may be dependent. The fact that processes are available, therefore, does not mean that these have been followed or that relevant data have been obtained.

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111 Budget estimates, FADT, 4 June 2003, p.369.

112 Budget estimates, FADT, 4 June 2003, p. 371.

113 See also above, Chapter 1, paragraphs 1.46 and 1.75–1.77

114 Budget estimates, FADT, 4 June 2003, p. 368.

115 Budget estimates, FADT, 4 June 2003, p. 368.

116 See above, paragraphs 2.3–2.5.

Psychological hazards

2.67 Psychological problems in particular were identified as a sensitive area, in spite of substantial advances made by both departments in the awareness of such problems and in the development of research and programs.[117] Psychological assessment following deployment did not appear to be detailed, at least in respect of Iraq, where part of the above–mentioned health briefing included some assessment.[118] Comments from one submission in particular stated that in the past and even more recently, 'the … regime of debriefings is inconsistent, and the quality is arbitrarily dependent upon resource availability.'[119] One detrimental aspect of former debriefings was the process of asking groups if there were issues to be discussed, which tended to restrict the volunteering of concerns in public.[120] Nonetheless, post 1995–96, more personal individual debriefings were thought to have been pursued, although this might not be until six months after return from deployment.

2.68 Defence did not agree with the assessment that the mental health of younger veterans was not understood, nor that there were ongoing problems with the majority of persons who had experienced some psychological problems:

> For those who are affected, most will find that the psychological symptoms are transient and will result in no long-term adverse outcomes.[121]

2.69 The screening used after the Iraq conflict appeared to be 'a psychological screening tool'[122] which required identification by the individual of 'exposure to what is potentially a traumatic event':[123]

> The tool that we are using is a questionnaire. As I mentioned earlier, it looks at two things. Firstly, it looks to see whether the individual has perceived that they have been exposed to an event that is significantly outside their expectation or their normal experience—in other words, something to which they may adversely react. Secondly, it then looks at how they are responding to that, because we all know there is enormous individual variation—an event which may be quite traumatic to one individual may in fact be deemed quite normal or quite acceptable to another. So it is a broad-brush screening tool that works in two ways.

117 See below, Chapter 3, paragraphs 3.32–3.34 and Chapter 4, paragraphs 4.5, 4.34, 4.35, 4.45, 4.51–4.54.

118 Budget estimates, FADT, 4 June, 2003, p. 359, General Cosgrove: 'Prior to departure from the Middle East all ADF members were examined by a medical officer and debriefed by a military psychologist.' See also p. 362.

119 *Submission* 6, Australian Peacekeepers & Peacemakers Association, p. 3, paragraph 13.

120 *Submission* 6, Australian Peacekeepers & Peacemakers Association, p. 3, paragraph 12.

121 *Submission* 9B, Defence Organisation, p. 8, Q5(a).

122 Budget estimates, FADT, 4 June 2003, p. 360.

123 Budget estimates, FADT, 4 June 2003, p.361.

> Firstly, it gathers data, which works as a base line for the individual. Also, in a sense it is an education tool because it makes the person aware of what the potential range of symptoms are. Following the administration of that tool, they are then interviewed by a psychologist and given an opportunity, in quite an unstructured way, to discuss any concerns that they may have. That is an important part of the interaction. Firstly, it may pick up those people who are not being entirely honest or forthright in their questionnaire. Secondly, it also establishes a degree of personal rapport between the member and a psychologist so that hopefully the door is seen to be open if any problems develop later on.[124]

2.70 Again, a certain amount of onus appears to be on the individual to identify issues which they may not always be in a position to do. Nor may the assessment be any more valid through being completed prior to return 'when their thoughts are fresh',[125] since a traumatic event may have occurred long before. It was also noted that disorders such as PTSD must exist as a set of symptoms 'for a period in excess of six months before you can use that label'[126] which indicates it would be preferable to ascertain symptoms as soon as possible.

> Returning from overseas deployment without any counselling or intervention by a mental health professional can sow the seeds of long term mental health problems in traumatised personnel. It has been suggested that immediate treatment of combat–induced stress will reduce the likelihood, or at least the severity, of post–traumatic stress disorder. Early intervention is effectively a preventive strategy. Interventions before or immediately after developing stress symptoms promote an adaptive response to trauma and prevent maladaptive responses that lead to long term mental health problems.[127]

2.71 There are no doubt benefits and disadvantages to the current approach, and to the provision of information to the families of personnel so that they can check for changes in behaviour etc on a return from deployment.[128] Nonetheless, it seems more

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124 Budget estimates, FADT, 4 June 2003, pp. 360–361, see also *Committee Hansard*, p. 81: 'The issue is then reinforced when we do the post deployment medical screening: the medical officers are invited to ask open ended questions such as, 'Are there any of the above or is there anything else you would like to share with me?' Other than that, unless the person presented to a health care provider whilst they were deployed and said, 'I am here to see you because I have just had a near death experience,' or, 'I am upset because I witnessed such an event,' the only way we have to do that is through more formal things such as patrol logs or contact logs or that sort of thing. But I freely admit that there are many possible scenarios where someone may be exposed to a significant event and that event may not be recorded in real time. I can think of examples from Rwanda that I was made aware of'.

125 Budget estimates, FADT, 4 June 2003, p. 362.

126 Budget estimates, FADT, 4 June 2003, p. 361.

127 Karl L Haas, 'Stress and mental health support to Australian Defence Health Service personnel on deployment: a pilot study', *ADF Health*, 4 (1) 2003, pp. 19–22.

128 Budget estimates, FADT, 4 June 2003 p. 361: 'they are encouraged to provide that document to their spouses or partners or family members'.

efficient and professional for the ADF itself to do this, and within a shorter period than three months after return.

2.72 This is not to deny that families in the general community who have a member with serious mental illness will necessarily become more involved in monitoring, once a diagnosis has been made. However, it seems outside the current community standard to place a responsibility on partners or parents (who may not see much of their children) to make an assessment that is properly made at the least by an experienced psychologist. Even though 'leaders' and 'senior personnel' are also educated in the identification of symptoms of mental illness,[129] they will need to have support from other staff in this process—leaders and senior personnel may not have the ongoing contact which could help identify changes in behaviour.[130]

> It should be noted that stress is additive and that post-deployment issues such as readjustment to civilian life, relationship difficulties, financial hardship etc may contribute significantly more to the veteran's health than the original service–related stressor. While stressors can be identified in post–deployment checks there is a need for veterans to accurately report their health status. Sometimes this is not done, especially if the serving member believes it may lead to an early end of their career in the military.[131]

2.73 That there have been changes which have increased available information, and which are directed to improving services generally, is apparent. Health service provision includes regular collection of data on Key Performance Indicators (KPI) relating to issues such as patient satisfaction, vaccination levels, and deployable status.[132]

> Performance standards in the delivery of health services are expected to meet the appropriate professional standards of good practice. Key performance indicators are in place for ADF personnel and achievement is monitored centrally by the Joint Health Support Agency. Performance indicators are tailored to ensure the maintenance of individual fitness and a fit and healthy deployable force.
>
> There are set performance indicators that measure the quality of healthcare against clinical benchmark standards. Clinical benchmark standards are based on a comparison of key performance indicators (KPIs) across Defence health care providers. KPIs used in health support for Defence address quality of care and indicate individual readiness. The KPIs are

129 Budget estimates, FADT, 4 June 2003, p. 363.

130 See also below, Chapter 4, paragraphs 4.64–4.68.

131 *Submission* 8A, Repatriation Commission/ Department of Veterans' Affairs, p. 12.

132 Joint Health Support Agency, DJHSA Directive 04/02, 17 May 2004, *Collection of Key Performance Indicators*, pp. 2–3.

> mostly aligned to civilian standards as determined by the *Report on Health Sector Performance Indicators 2001,* Queensland Health, Brisbane.[133]

2.74 The development of a Mental Health Strategy for the ADF indicates that there is a good awareness of mental health issues: 'mental health issues are a significant by–product of involvement in both peacekeeping and warlike activities',[134] although some aspects of mental health services are not yet meeting needs.[135] There have been some advances in data collection and plans for improved medical records, although the electronic systems on which these will be based are not yet complete.[136]

The role of the individual and the family in deployment health

2.75 Regardless of whether a health service is home based or deployed, it has to meet both individual and group needs. Some of the evidence provided to the Committee indicated that there was quite a high level of responsibility placed on individuals in the ADF to maintain their health status and remain aware of potential problems in the future which might arise from deployments. It could be argued that this level sometimes demands too much of the individual, for, while responsibility for one's own health is a message increasingly promulgated in the community, it is not always possible for those within an institutional setting to be in control of health information and action.

'Medical' Staff in the ADF

2.76 It is more important for personnel on deployment to have confidence in the quality of 'medical' staff that are available. The role of doctors as opposed to other health staff in 'medical' work in the ADF is not clearly defined. While JHSA staff undertake the assessments made prior to and after deployment, the requirement for doctors in such assessments needs to be determined. The Defence submission refers to 'medical officers' having to sign off on pre–deployment checks,[137] although other evidence states that this medical assessment involves 'a questionnaire and a focused examination from a medical officer.'[138]

2.77 In the 1997 audit of non–deployment health services, the ANAO noted problems experienced with respect to the employment of medical staff.

> The ADF relies, almost exclusively, on Reserve members to provide specialist medical services during exercises and deployments. In view of the operational requirement for specialists, there was scope for employing

133 *Submission* 9B, Defence Organisation, p.4, Q2(e) and (f).

134 Budget estimates, FADT, 4 June 2003, p. 363.

135 Budget supplementary estimates, FADT, 5 November 2003, pp. 104–105.

136 See below, Chapter 3, paragraphs 3.6–3.21.

137 *Submission* 9, Defence Organisation, pp. 4–5, paragraph 21.

138 Budget estimates, FADT, 4 June 2003, p. 367.

> specialists full–time in the ADF. This could help alleviate the ADF's difficulties in attracting and retaining medical officers. Defence would need to compare the costs and benefits of engaging specialists under such a proposal with the usual methods of engaging them. In common with most career structures in the ADF, the higher ranks in the health services largely entailed command and associated management responsibilities. As a consequence, promotion to higher ranks in the health services largely resulted in health professionals spending more time on management and less time on clinical duties. A Defence review found that 45 per cent of doctors would prefer to confine their work to clinical duties.[139]

2.78 By the 2001 follow–up audit, there had been some progress with respect to the recommendation concerning a revised career structure and pay scale.[140] The situation affects mostly non–deployment services as higher level care during deployments is generally provided by other forces.

2.79 In deployments, the level of health staff available for level 1 care appeared not to be a medical officer, which may contribute to limited information being available on more complex issues:

> The health plan for Iraq was that each of the units deploying would have embedded what we call level 1 health support, which is not always a medical officer. In the case of a naval unit, that may be an advanced medical assistant, called a phase 4 medical sailor. In the case of Army units, it could be an advanced medical assistant or it could be a medical officer; it would depend on the size of the unit and where it was operating. But the intention was that all ADF units would have access to their own primary health care. Level 2 and level 3 health care support was provided by coalition partners.[141]

2.80 Primary health care was also addressed in the 1997 and 2001 reports by ANAO, which had originally recommended that there be greater access to relevant work experience by ADF personnel:

> Although the primary role of ADF health services is to support operational forces in combat situations, health staff had insufficient training and experience in treating trauma (wounds) and emergency cases, which are the kind most likely to occur in such situations. The greatest scope for obtaining this type of training and experience was in civilian hospitals and

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139 Australian National Audit Office, Report No. 51, 2000–2001, *Australian Defence Force Health Services Follow-up Audit, Department of Defence,* 2001, paragraph 3.14.

140 Australian National Audit Office, Report No. 51, 2000–2001, *Australian Defence Force Health Services Follow-up Audit, Department of Defence,* 2001, paragraph 3.24: 'Overall, the ANAO found that progress on Recommendation No.7 had been slow but that Defence has examined the medical officer structure. The proposed salary and career structures, once implemented, should provide greater flexibility, improve operational effectiveness and assist in retaining ADF medical officers'.

141 *Committee Hansard,* p.87—level 2 and 3 health care is *in patient* care.

ambulance services. Lack of civilian recognition of ADF training of medical assistants posed a difficulty in arranging placements with the civilian sector.

1997 Recommendation No.10*

The ANAO recommends that Defence make determined efforts to reach agreement with the necessary civilian health authorities for ADF personnel to work in areas where they will be exposed to emergency treatment of wounds and injuries and that a uniform ADF policy be developed. [142]

2.81 In the 2001 follow-up audit, it was reported that the situation had not changed substantially, for several reasons including the number of deployments in which staff had been involved.[143] However it is possible that practical experience in the field may also have improved the skills of such staff.

2.82 Other ADF material distinguishes medical officers from contract doctors, and also uses the terms 'health officer', 'health practitioner' and 'practitioner', the last three seemingly interchangeably.[144] All three terms appear to mean 'doctor'. An alphabetical list of 'medical' staff[145] included a 'medical scientific officer and 'doctor', but no 'medical officer'. There also appears to be quite a high turnover rate of 'medical' staff, and although data were not readily available on the reasons for

142 Australian National Audit Office, Report No. 51, 2000–2001, *Australian Defence Force Health Services Follow–up Audit, Department of Defence*, paragraph 4.15.

143 Australian National Audit Office, Report No. 51, 2000-2001, *Australian Defence Force Health Services Follow–up Audit, Department of Defence*, paragraph 4.16: 'The situation has not changed significantly since the original audit. Although a strategic alliance between 1st Health Support Battalion (1HSB) and Liverpool Hospital has been in operation since 1998, there are no alliances between other ADF health units and civilian hospitals. Defence advised that strategic alliance proposals were being discussed with a number of civilian hospitals including, a major Brisbane hospital, Royal North Shore Hospital and Westmead Hospital. The ANAO was advised that progress in making such agreements with civilian health authorities had been slow due to health personnel shortages and the high number of recent ADF operations in which the DHS has been involved. See also *Submission* 5, Regular Defence Force Welfare Association Inc, p. 2.

144 Joint Health Support Agency, DJHSA Directive 03/03, 25 March 2003*, Guidelines for Accurate and Legible Clinical Records*. See also DJHSA Directive 10/04, 7 April 2004, *Orientation of Contract Health Practitioners Working on Australian Defence Force Bases*

145 Additional estimates, FADT, 18 February 2004, Answers to Questions on Notice, Defence, part 2, p. 69: 'Assistant Dental/Dental Assistant, Dental Hygienist, Dental Technician/ Technician Dental, Dentist, Doctor, Environmental Health Surveyor, Environmental Health Officer, Examiner Psychological, Laboratory Officer, Laboratory Technician/Tech Lab, Medic/Medical Assistant, Medical Administrator, Medical Scientific Officer, Nurse, Pharmacist, Physical Training Instructor, Radiographer (Officer), Radiographer (Soldier), Technician Operating Theatre, Technician Preventive Medicine, Therapeutic Officer (Physio)'.

departure, it is assumed that the majority of such staff were not dismissed but chose to leave.[146]

2.83 Separation rates for ADF medical staff for 2001–02 and 2002–03[147]

Separations 2001–2002			**Separations 2002–2003**		
Navy	Army	Air Force	Navy	Army	Air Force
11.2%	12.4%	14.1%	14.8%	9.3%	11.5%

2.84 While it is likely that many persons will seek a rotation in the ADF for experience, it seems unlikely that the majority of 'medical' staff employed by the ADF will have had considerable experience within their own profession and even less likely to be at the head of it, unless they are a member of the reserve forces. The question therefore needs to be asked if there are sufficient staff with experience and qualifications available within the ADF,[148] especially because of the increased reference to mental health procedures, pre-deployment psychological assessment, and post-deployment evaluation of psychological problems or potential problems.[149]

2.85 It is also important to ensure that those who are working in the ADF are able to remain sufficiently independent of what might be seen as military objectives as distinct from 'medical' objectives. This is likely to be difficult when there is a clash between the principles of one profession and the other. For example, mention has been made of the alleged efforts of the 'medical officer' and the psychologist on board the *Kanimbla* to persuade personnel to accept the anthrax vaccination.[150] This can lead to situations where the professional skills are being misused to meet other objectives. Once the basic information is provided, any 'persuasion', if acceptable, should be carried out by some other person outside the medical unit.

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146 Additional estimates, FADT, 18 February 2004, Answers to questions on notice, Defence, part 2, p. 69.

147 Additional estimates, FADT, 18 February 2004, Answers to questions on notice, Defence, part 2, p. 69.

148 See above, paragraph 2.7 where Defence notes the difficulties experienced in obtaining sufficient numbers of qualified staff.

149 'A major limitation in the delivery of mental health services to the ADF identified in the ADF Health Status Report (2000) was the lack of integration between service providers. There are a number of organisations within Defence that deliver comprehensive mental health services, but due to a lack of integration they sometimes work at best in parallel and have the potential to work in opposition,' www.defence.gov.au/dpe/dhs/mental health. Mental health teams which have been established as part of the ADF Mental Health Strategy include 'doctors, psychologists, social workers and nurses,' see www.defence.gov.au/dpe/dhs/mental health/publications

150 See Appendix 3. Details of this alleged persuasion are not provided, and therefore it cannot be discussed further.

2.86 As the major role of providing support to the injured and conducting post deployment screenings is carried out by JHSA[151] its staff would be expected to be aware of a range of factors relevant to immediate and longer term rehabilitation. The skills and qualifications of such staff should therefore be appropriate to this task. Psychologists are also provided on site prior to return from deployments, and are involved in the administering of questionnaires designed to elicit information about PTSD in particular. Given that one of the reasons for the use of questionnaires was to build up a relationship which may need to be utilised later, it is assumed these same psychologists are involved in any further assessment or service provision, although staff turnover may limit this.

2.87 Some problems may also be difficult to identify, and require input from individual personnel, who are issued with a card which lists diseases endemic in the area of deployment which is to be used as a prompt in the post deployment review.[152] How effective these cards are may depend on the time available to JHSA staff and whether they are qualified to ask appropriate questions that elicit information not readily forthcoming.

2.88 To some extent, responsibility during the post deployment period of assessment and screening is also placed on individual personnel. Defence states that 'individuals are given the opportunity to discuss any concerns with health staff',[153] but, as suggested above, the usefulness of this process would need to be assessed. Some submissions said the post deployment de–briefing process was inadequate and would not encourage the identification of problems, quite apart from the broader sensitivity to being seen as vulnerable or unable to cope:

> I think there is also a culture within Defence and even within the general community, as can be seen by things like the recent advertising and information campaigns on aspects like depression, that means there is a stigma associated with mental health issues. A culture such as that in Defence, or the uniformed element of Defence, makes it quite difficult to discuss those sorts of issues. It makes it quite difficult to talk about them in general.[154]

2.89 Persons returning from deployment may not be in the best position to ensure that all issues are covered, and thus the effectiveness of information on mental health both pre and post deployment will depend very much on the extent to which there is an effective briefing and de-briefing. It has been suggested that many mental health issues may be those which personnel are unwilling to discuss, even though ADF

151 *Submission* 9, Defence Organisation, p. 3, paragraph 11.

152 *Submission* 9, Defence Organisation, p. 5, paragraph 24.

153 *Submission* 9, Defence Organisation, p. 5, paragraph 24.

154 *Committee Hansard*, pp. 32–33, Australian Peacekeepers & Peacemakers Association.

members can have access to treatment and management for any mental health problem irrespective of its cause.[155]

2.90 There is little evidence, overall, to demonstrate that placing a certain level of responsibility on the individual will always be the most effective way of ensuring issues are identified and able to be expressed. In theory, individual responsibility is part of the community standard, in that the greater availability of information and the provision of a wide range of health programs advertised and supported by state and commonwealth governments has made health a much more individual issue. Risk factors for disease, obesity, smoking and other campaigns have made potential health problems much more widely known. The capacity to act on these, however, will vary.

2.91 Insofar as deployments are considered welcome, there is an incentive for ADF personnel to remain fit, although it could also be said there is also an incentive to hide or minimise problems that might limit access to deployment. Quite apart from the identified issue of not having information on injuries or conditions for which compensation may be being paid, the ADF culture may not encourage identification of some problems and the individual may lack the skills to identify these as matters which must be addressed. It is possible therefore that greater availability of experienced doctors in some assessments is required, regardless of the emphasis on choice, awareness and responsibility.

Occupational/Employment Health

2.92 While much recent effort has been placed on the fitness of personnel for deployment, the ADF has also acknowledged that occupational health is a priority that is being addressed:

> The ADF is seeking to improve its knowledge and training in the area of occupational health. As a response to the F–111 Board of Inquiry, Defence Health Services Branch has proposed the creation of a centre of excellence in occupational health to provide a critical mass of expert knowledge, advice and training. Improved education, awareness and regular review of workplace practices should reduce unnecessary exposures in the workplace. This proposal is currently being considered by the ADF Occupational Health and Safety project team.[156]

2.93 This approach reflects the previous high rate of injury and level of disability in the ADF, an important factor in whether it is possible to provide fit personnel for deployment.

> The discharge figures shown in the table below were obtained from the Army Recruit Training Centre (ARTC). There has been a significant reduction in the discharge rate since the mid 1990s. This has been due to the implementation of a number of prevention strategies over that time. The

155 *Submission* 9B, Defence Organisation, p. 8, Q5(e).

156 *Submission* 9B, Defence Organisation, p. 4, Q2(g).

5 per cent discharge rate in 1998–99 is artificially low because it occurred during the introduction of common Reserve and Regular recruit training. Injured reservists were sent home rather than being discharged and urged to return when better. Subsequent Army Readiness requirements have stopped this. The later rates of 10–13 per cent better reflect the true discharge situation. This represents a greater than 50 per cent reduction in discharges over the last 10 years.

Total discharge rate (%)	
1994–1995	23
1995–1996	17
1996–1997	15
1998–1999	5
2002–2003	13
2003–2004 YTD)	10

The lessons learnt at ARTC have been packaged as the Defence Injury Prevention Program which is in the process of being implemented across the ADF. [157]

2.94 While the emphasis on healthy lifestyle is essential, a limited regard by the ADF to occupational/employment stresses also leaves individuals in a work environment where they are unable to control the factors which affect their career. Problems with injury rates were identified in the 1997 ANAO report.

> The original audit commended Defence's initiatives to reduce recruits' injuries and wastage but found little evidence of research on the incidence and cause of injuries more generally, especially in Army where the major problems occurred. Full direct and indirect costs associated with injuries in the ADF were not recorded or known, apart from identified post–discharge costs (for example, lump sum compensation payments). Individual ADF programs did not have to fund the premiums paid by Defence to cover compensation costs, and therefore there was no incentive for program managers to reduce injuries leading to compensation claims.[158]

2.95 The 2001 follow–up audit reported that there had been some progress in three key areas, including injury prevention.

157 *Submission* 9B, Defence Organisation, pp. 6–7, Q4.

158 Australian National Audit Office, Report No. 51, 2000–2001, *Australian Defence Force Health Services Follow–up Audit, Department of Defence*, paragraph 7.1.

> Short–term strategies aimed at reducing injuries in the ADF since the original audit had been limited to reducing injuries amongst recruits. The ANAO commends the work carried out in relation to injuries among ADF recruits and notes that savings in both personnel and costs that have been achieved. Nevertheless the ANAO considers that there is scope for short-term strategies to be developed and implemented with application to the wider ADF population, based on the findings of studies completed at the time of the original audit. For example, it has been known, from as early as 1991, that sport and physical training are the two main causes of injuries in the ADF. Implementation of short–term strategies in these areas would have led to earlier personnel and monetary savings. [159]

2.96 In 2000, the first ADF health status report made very similar comments, although these were based on 1997 data.

> Physical training is linked to the highest number of working days lost, hospital admissions, sick and light duties days. Sporting injuries are another significant factor.
>
> The study shows that physical fitness and military training injuries are higher within the part–time Reserve forces. The new Injury Prevention Strategy will focus on initiatives aimed at minimising these injuries across the ADF, including part–time forces.[160]

2.97 Early reports on the Defence Injury Prevention Program suggest that it has had an effect, at least as far as recruits are concerned.

> The program was developed at a number of pilot sites covering 15 per cent of the full–time ADF population. Within the sample selected for pilot testing, the program has resulted in a 95 per cent reduction in rates of pelvic stress fracture for female Army recruits, elimination of serious knee injuries in recruits negotiating an obstacle course and ten to 45 per cent reduction in rates of injury in other ADF groups.[161]

Women

2.98 Two organisations referred to women, although not in great detail. The Australian Peacekeepers & Peacemakers Association[162] and the Regular Defence

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159 Australian National Audit Office, Report No. 51, *Australian Defence Force Health Services Follow–up Audit, Department of Defence***,** paragraph 7.9.

160 See also Peter S Wilkins, 'Occupational Health and Safety Challenges for the ADF', *ADF Health*, 5:1, 2004, pp. 1–2: 'By 2000, Defence's annual OH&S cost per uniformed member was almost 3 times that for comparable civilian employee groups. Commanders and supervisors at all levels are greatly concerned for the health and safety of their subordinates, but there is an obvious lack of means to give effect to their good intentions.'

161 Department of Defence, *Annual Report 2002–2003*, Chapter 5, Section: Performance Against People Matter Priorities for 2002–03, p. 424.

162 *Committee Hansard*, Australian Peacekeepers & Peacemakers Association, p. 43.

Force Welfare Association Inc[163] both mentioned the special needs of women personnel. They would be mostly among the category of younger veterans for whom the Australian Peacekeepers & Peacemakers Association would act, and therefore include women subject to the different pressures of peacekeeping as described by that organisation and others.[164] From the information provided on occupational injuries,[165] women were also especially subject to some of the injuries that occurred in training, although the development of new processes had improved the injury rate, and possibly the retention rate.

> There are obviously different injuries, in some cases, but if you are talking about the compensation or TPI support that we provide, we provide it equally. DVA are just as good to males and females—and Defence have an excellent equity program—and, if they were not, we would be the first ones to be supporting our members and putting in complaints. I think there are some injuries that possibly are more prone to be suffered by one sex than the other—we do not have the facts on that.[166]

2.99 It was also suggested that there may be different responses to deployment issues, including different stress reactions.

> We are aware, as a general rule—if you want to talk generalisations—that the response to stress is different between men and women. That is what we have been told. In our limited research, there is a difference. But remember, of course, that now we are getting more and more women in the Defence Force.[167]

2.100 There is not a great deal of information on women in Defence's Annual Report, although a number of projects have been established which directly and indirectly will have an impact on women, including a Gender Diversity Strategy, and an assessment of 'physical characteristics and performance capacity' that could 'optimise an individual's likely success in each employment category'.[168] As noted above, there has been some work undertaken on reduction of injuries in recruitment processes, but otherwise it is not readily apparent that special attention is paid to physical health needs.

2.101 Both workplace harassment and bullying have also been addressed by the ADF,[169] although a more detailed report would be required to determine the extent to

163 *Committee Hansard*, Regular Defence Force Welfare Association Inc, p. 12.

164 See above, paragraph 2.37, and see also Karl L. Haas, 'Stress and mental health support to Australian Defence Health Service personnel on deployment: a pilot study', *ADF Health*, 4 (1) 2003, pp. 19–22.

165 See above, paragraph 2.97.

166 *Committee Hansard*, Australian Peacekeepers & Peacemakers Association, p. 43.

167 *Committee Hansard*, Australian Peacekeepers & Peacemakers Association, p. 43.

168 Department of Defence Annual Report 2002–2003, p. 432.

169 Department of Defence Annual Report 2002–2003, pp. 426, 430.

which women were subject to harassment and bullying and if this, as well as deployment issues, contributed to mental health problems and required specific services.

Reservists

2.102 Reservists were also a particular concern for organisations who believed they were at special risk of not obtaining required services.

> …it seems that reservists are a class of members of the ADF who, when they complete their period of service, go back very quickly to the civilian health system. Particularly if they think they are suffering from conditions that they are not quite sure about, their only access to health treatment is through practitioners in the civilian sector who may or may not be aware of the peculiar problems of that deployment.[170]

2.103 A similar point was made by another organisation which had been set up to assist younger veterans—including those who might undertake further deployments—to obtain holistic health treatment.

> … when our young veterans leave the Australian Defence Force they no longer have access to Defence's safety network. As soon as a young veteran leaves Defence, they are alone, facing both medical and health issues without Defence's help. The young veteran views the Department of Veterans' Affairs with scepticism and fear if they have not actually worked for them on a regular basis, and see them as only dealing with compensation.[171]

2.104 If reservists are not part of the post-deployment processes, including health checks, they are at risk of obtaining limited appropriate health services for a number of reasons, including not being fully aware of the risks experienced and not having the skills to identify other issues including mental health problems. Some of these issues may be picked up later if they go on further deployments, but even if this is the case, the delay in identifying a problem may have contributed to its becoming more entrenched.

2.105 In some instances, reservists will be eligible for DVA health care cards.[172] DVA also advised that efforts were made to provide required care and obtain specialist services where necessary.

> DVA understands that there is a shortage of specialist and expert medical skills in Australia in many areas, but efforts are made to ensure that returning reservists have all of their needs met. It is in the nature of reserve

170 *Committee Hansard*, Regular Defence Force Welfare Association Inc, p. 5.

171 *Committee Hansard*, Australian Peacekeepers & Peacemakers Association, p. 28.

172 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 2: 'Where a reservist is eligible for health care from DVA, they have access to the arrangements pertaining to DVA's White or Gold Card, as appropriate'.

> service that reservists are often difficult to get in contact with professionals with the appropriate skills. This has been a known problem for many years, both in Australia, the United States and the United Kingdom. Each country uses a variety of strategies to try to ensure that the health needs of reservists are met, and there is a regular exchange of information about this problem.[173]

2.106 Insofar as reservists include people with peacekeeping experience, they may have a particular need of services which understand the special pressures that can occur in this type of work. Such services may not need to diverge markedly from those available to others whose deployment has involved peacemaking and active combat, although assessment of needs should be undertaken by experienced researchers and staff.

173 *Submission* 8A, Repatriation Commission/Department of Veterans Affairs, p. 2.

CHAPTER THREE

ADMINISTRATION, COORDINATION AND INFORMATION

3.1 Some of the evidence provided to the Committee suggested that problems experienced by current ADF personnel, reservists and veterans, arose from the lack of effective electronic data collection and retrieval systems, incomplete links between Defence and DVA, and what was seen as a shortage of adequate information.

Data collection

3.2 In terms of health information, Defence has stated that there are two records kept of relevant information on injuries, illnesses and treatment, including that arising from pre and post deployment assessments, and from the deployment itself. These are the Unit Medical Record (UMR) and the Central Medical Record (CMR).[1]

> The unit medical record is raised the minute that someone is formally inducted into the ADF. It is intended to contain a record of the day–to–day health care delivered to the individual in their presentations for outpatient care. It also contains any specialist referrals that may be made; the results of any investigations, such as X–rays, pathology tests and those sorts of things; and copies of routine health forms, such as the annual health assessment or the comprehensive health promotion examination. It will contain copies of any other medical examinations that may be done—for instance, pre overseas deployment, pre promotion, pre change of category or pre engaging in specialist activities such as parachuting or scuba diving. It will also have embedded in it the record of vaccinations… The medical record will also usually contain the results of the annual fitness test.
>
> The central medical record is a duplicate of the unit medical record, and the only thing that it contains over and above the unit medical record is copies of any documents that arise as a consequence of in-patient care. So, if you are admitted to surgery for, let us say, an appendicectomy, the discharge summary will be in the unit medical record to acknowledge that this has taken place and whatever happened, but the actual detailed documentation such as the nursing notes and the progress notes during the hospitalisation will go into the central medical record.[2]

3.3 At present, such files lack any information arising from injuries for which compensation is claimed under SRCA,[3] although steps are being taken to address this gap. The individual medical record may remain with the individual, including when personnel are posted overseas (non–deployment postings) so there is a certain level of responsibility on the individual to ensure that new material on the individual file is

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1 *Submission* 9, Defence Organisation, p. 3, paragraph 15.

2 *Committee Hansard*, pp. 75–76.

3 See *Committee Hansard*, p. 79.

copied and sent on to the central file. Files for reservists are held by the reserve unit and activated when the individual is involved in a full time service:

> …every time they have a health interaction—dental, medical or whatever it might be—that record is updated with that information. If they in fact separate from the ADF—in other words, no longer have any affiliation with us—their record is physically transferred to the central medical records store. If nothing further happens, it sits there, and that is it.[4]

3.4 One organisation in particular believed that files were incomplete both because some immunisations might have been recorded only in a WHO booklet and not in their medical file, and some drugs were not recorded when their administration was 'a command initiated action and not an exclusively health one'.[5] As noted in Appendix 3, the attitude to recording vaccinations has varied, and it is possible that some files are incomplete or inaccurate in this respect.

3.5 Defence agrees that there has been a limited capacity to provide an integrated file, as:

> A member's health profile is captured through up to 14 disparate IT systems including medical and dental records, psychological file, and compensation and rehabilitation data.[6]

HealthKEYS

3.6 As part of a major overhaul of its data collection systems, the ADF is developing a tri service approach which 'will seek to establish uniform processes and information systems for the collection and collation of health information'.[7] This system is called HealthKEYS, and is expected to be rolled out over several years.[8] It is now 'the only corporate health information management system approved to operate in the Defence Standard Operating Environment'. Nonetheless, although some other systems have been decommissioned or will be, when replaced by HealthKEYS,[9] the project itself will not be fully operative for some years, with the second phase expected to be completed by 2009.[10]

3.7 A broad objective of HealthKEYS is to gather information which will help to change and develop health services to meet needs:

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4 *Committee Hansard*, pp. 77–78.

5 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 3, paragraph 17.

6 *Submission* 9, Defence Organisation, p. 4, paragraph 18.

7 *Submission* 9, Defence Organisation, p. 4, paragraph 19.

8 *Committee Hansard*, p. 77.

9 See Department of Defence, Joint Health Support Agency, DJHSA Directive 07/04, *Implementation of HealthKEYS*, 18 March 2004, www.defence.gov.au/dpe/dhs/jhsa/publications/djhsadirectives.

10 Somewhere between three to five years from early 2004, *Committee Hansard*, p. 77. Another source refers to 2009, Additional Estimates, FADT, 18 February 2004, *Answers to Questions on Notice*, Defence, part 2, p. 68.

> …for those men and women who remain in the ADF the issue is clear, because gathering the data and some of the analysis of that data is to assist us in the delivery of health care to those people. So that re–emphasises the point made …that, at the end of the day, the data can be used for different reasons. In our case, whilst those men and women remain in uniform, clearly my interests are to provide focused health care to those people which is appropriate; to identify trends or areas of concern so that we can review current practices; and to try to forecast future problems so that again we can make sure our strategies moderate that.[11]

3.8 Healthkeys is not unique to the ADF since it is a commercial clinical practice management system[12] with the potential to maintain records, generate recalls, and collect event and pattern data on which more detailed studies can be based. In terms of being a vital part of the ADF deployable service, it is stated that 'the system will be deployed on larger ships and in field hospitals and will interchange information with a number of other Defence systems to reduce double keying of data'.[13] This approach should help reduce lost data through providing at least some of the records needed for individual files and provide a better service through ready access to existing patient information.

> The goal of the project we have in place at present—the HealthKEYS project—is to provide a single point data management system for the health record. That is its stated goal. It is a three-phase project and we are only in phase one of the project, which is essentially putting in the administrative bedrock on which the rest of the clinical material will be built.[14]

3.9 A further advantage of HealthKEYS will be the capacity to link individual data with event data sets in order to develop a picture of the individual's exposure, including in deployments, to a range of environmental, chemical and other substances:

> We will hopefully be in a position to inject into that data set, in real time, the occupational and environmental threats to which they are exposed.[15]

3.10 Such links, coupled with information on the individual's health status, should facilitate the development of a better health profile, allowing rapid access to information on likely exposures and therefore suggesting required treatment.

> The Americans had enormous problems following Gulf War I in terms of being able to assess the threat exposure for their individuals, and they have put an enormous amount of effort into trying to address that. They did so during the recent Iraq conflict, where they put on the ground health

11 *Committee Hansard*, p. 67.

12 'Some of the key elements in the database will obviously be biographical data, but they may include things like height, weight, BMI, vaccination status, medical employment classification and history of previous injuries', *Committee Hansard*, p. 70.

13 www.ibatech.

14 *Committee Hansard*, p. 70.

15 *Committee Hansard*, p. 73.

> assessment teams that were doing air, soil and water sampling in real time. They were then linking that to the personnel records and to things such as geospatial imagery to look at things like smoke and oil plumes, sandstorms and so on, so that they could build an almost three–dimensional data set…[16]

3.11 It is also expected that the linking of sections of Defence will facilitate the inclusion of data that will help provide a better profile of an individual's health:

> That will facilitate us bringing psychological and mental health related issues into the central health record. I think that is going to be an extremely important part of our data manipulation.[17]

3.12 Such individual records would also have the benefit of being able to provide better background information to veterans in the future when they may wish to check exposures and link these to possible disorders:

> They could work out very specific hazard profiles for individuals, and that was important to be able to reassure people.[18]

3.13 The Repatriation Commission also outlined the potential benefits of HealthKEYS, including the capacity to provide, among other reports:

> Regular analysis of the health status of deployed veterans …compared with serving members who have not served overseas, as well as with the Australian population Compilation of regular reports on the health status of veterans and serving members for the purpose of informing policy development.[19]
>
> The long–term envisaged plan is that, for every deployment that goes overseas, there will be a systematic collection of data and a program of ongoing monitoring for things such as mortality and cancer incidence. We will vary that standard approach according to the deployment. It probably would not be, for example, so appropriate to have such a complete approach to a deployment like Bougainville, which was much less stressful than our deployment to Afghanistan and Iraq. Within the overall framework of having an ongoing process of monitoring the health of all groups of deployed, we will vary it to make it appropriate to the type of deployment that is occurring.[20]

3.14 However, as at early 2004, no individual data was on HealthKEYS:

> At this stage, no clinical components of the member's medical record are electronic. It is the intent of the HealthKEYS project to change that, but the

16 *Committee Hansard*, p. 73.

17 *Committee Hansard*, p. 70.

18 *Committee Hansard*, p. 73

19 *Submission* 8, Repatriation Commission, p. 18, paragraph 90.

20 *Committee Hansard*, Repatriation Commission, p. 66.

> entry of clinical data—in other words, the day–to–day working clinical data—will not come up until phase 2 of the project.[21]

3.15 It was also stated that even currently serving personnel would not have existing information scanned into the data base:

> …there is no viable way of migrating the extant paper record into healthKEYS. For continuity of care purposes and our archiving requirements, we will still need to keep that paper record.[22]

3.16 This must necessarily limit the effectiveness or usefulness of any environmental information relating to recent deployments since it would have nothing on an individual against which to register. Some service organisation witnesses expressed an interest in the operation of HealthKEYS,[23] but for the majority of their current members it is likely to be of limited advantage. There still remains a need, therefore, to obtain and retain as much information as possible on environmental factors in deployments as this will be the background against which many claims in the future are likely to be based.

3.17 This was noted in one submission which, while acknowledging that there had been improvements in relation to occupational health issues in a non–deployment context, believed that the lack of integrated files could result in future problems:

> …there does not appear to be one agency in the Department that links these [exposure records] with personnel records.[24]

3.18 It is to be hoped that the greater awareness of occupational health and safety issues[25] and the capacity to link personnel to other records[26] will also cover these exposures. In the context of the anthrax issue, the capacity to evaluate and monitor the health of those who received vaccinations,[27] must also be affected through the absence of electronic information. While it may be that the fact of vaccination is recorded as part of general deployment information, this will not provide information on the individual or make possible connections with later illness. Unless a separate detailed

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21 *Committee Hansard*, p. 77. See also p. 70 on the likely contents of individual data: 'Some of the key elements in the database will obviously be biographical data, but they may include things like height, weight, BMI, vaccination status, medical employment classification and history of previous injuries. All of those things, hopefully, will be coming from that one central database. I do not wish to go into the technical jargon, but what we can do is set up data cubes, Cognos cubes, which allow you to extract data from your master database, move it aside and, if need be, de-identify it so that it can then be used by a research facility, be that the Centre for Military and Veterans Health or one of our existing research organisations. They can do work on the data, and if need be it can be reinjected back into the database'.

22 *Committee Hansard*, p. 77.

23 *Committee Hansard*, p. 3.

24 *Submission* 5, Regular Defence Force Welfare Association, p. 3.

25 See above, Chapter 2, paragraphs 2.92–2.97.

26 See Additional Estimates, FADT, 18 February 2004, p. 70.

27 *Committee Hansard*, p. 66.

health review is undertaken for each deployment—and it is suggested this will not be the case—only future deployments will have this level of detail.

EpiTrack

3.19 EpiTrack is an electronic system into which event data can be entered, primarily in order to track patterns of events such as injuries and disease, especially those related to deployments.[28] It is a commercial system which can be adapted to identify other event patterns.[29]

> The EpiTrack system records the principle reason for presentation at health facilities and the impact of such attendances on manpower availability.
>
> The key components of EpiTrack are EVENT codes, which contain descriptors that are a mix of the causal event and the diagnosis, with the causal event taking precedence
>
> All ADF health units will conduct health surveillance during deployments and field exercises. EpiTrack is also to be used across the National Support Areas (NSA) to allow familiarity with use when deployed.[30]

3.20 The system can provide regular updates on the main causal factors of ill health and can therefore inform those in command of 'the general health of their forces'.[31] The extent to which this will allow active intervention 'before disease or injury can limit mission accomplishment',[32] however, may be open to debate, given that many people may have been injured or exposed to communicable disease prior to patterns becoming obvious. However, this type of information does have the potential to reduce health issues that may occur over a longer time period:

> …whilst undoubtedly at some point in a cost–benefit analysis you would factor in some value for that better information available on claims—as a

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28 A separate system is commercially available to track vaccinations and reactions/adverse events arising from these. However, it is more logical to have this type of event on HealthKEYS to ensure such information was readily available to medical officers treating a patient especially during deployments.

29 It is described as 'a real-time system for tracking the spread of infectious diseases', see www.ovistech.com/indexnsf/373d, *'Several solutions, many industries'*. See also *Submission* 9, Defence Organisation, Attachment C, Department of Defence, Director–General Defence Health Service, Health Directive No 128, *Health Surveillance in the Australian Defence Force*, 2003, paragraph 4, which refers to EpiTrack being based on the United Kingdom Army Health Surveillance System, J97 EPINATO.

30 *Submission* 9, Defence Organisation, Attachment C, Department of Defence, Director–General Defence Health Service, Health Directive No 128, *Health Surveillance in the Australian Defence Force*, 2003, paragraphs 4, 5, 7 and 9.

31 *Submission* 9, Defence Organisation, Attachment C, Department of Defence, Director–General Defence Health Service, Health Directive No 128, *Health Surveillance in the Australian Defence Force*, 2003, paragraph 3.

32 *Submission* 9, Defence Organisation, Attachment C, Department of Defence, Director–General Defence Health Service, Health Directive No 128, *Health Surveillance in the Australian Defence Force*, 2003, paragraph 3.

> possible offset saving or equally and in most cases, in fact, as a cost consequent on having additional information—far greater significance is attached to the possibility of preventing the logical consequence of a disease train being set in motion by that deployment. If, for example, it is possible to intervene on the basis of information flowing from our health studies—for example, by taking some sort of preventative or prophylactic action in a way that might minimise the risk of lung cancer developing downstream—then we think that is a legitimate saving to factor into our cost-benefit analysis.[33]

The interaction between HealthKEYS[34] and EpiTrack

3.21 The data provided by HealthKEYS and EpiTrack has the potential to provide both systemic data on broad trends and patterns, including occupational health and safety issues, and on individuals who may also demonstrate patterns of injury or illness. Whether information from EpiTrack will be available to DVA is not stated, but in terms of DVA's current responsibilities concerning compensation such access would be valuable. The identification of problem areas, in theory, would help to limit compensation claims and the loss of personnel from preventable injuries.

Health reviews

3.22 The government stated in 1999 that deployments would be subject to health reviews, and, according to DVA, these would need to vary to reflect the nature and size of the deployment.[35] Such reviews would presumably use data obtained from the health assessment undertaken 3 months after personnel returned from deployments as well as other data from HealthKEYS and EpiTrack. However, the limited information available through HealthKEYS at present suggests that detailed health reviews will only be available in the future.

3.23 As is noted by DVA, the value of studies depends on the objective, and the methodology needs to suit this. The absence of information via current systems therefore does not necessarily affect all reviews and research:

> The recent deployments to the Solomon Islands and Bougainville would have little effect on cancer incidence statistics, assuming any would ever be observed, until an appropriate latent period had elapsed… Such deployments could probably be more effectively studied by examining the effects of social and psychological distress, involving techniques such as surveys and small group interviews and monitoring mortality and cancer incidence over time.[36]

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33 *Committee Hansard*, p. 70.

34 HealthKEYS is also expected to be linked with the Defence personnel data system so that issues such as discharge through injury can also be monitored—see Additional Estimates, FADT, 18 February 2004, p. 70.

35 *Submission* 8, Repatriation Commission, p. 11, paragraph 52.

36 *Submission* 8, Repatriation Commission, p. 11, paragraph 53.

3.24 Nonetheless, an overall picture of the health outcomes of deployments would require that information of this type would need to be considered alongside the broad event patterns provided by HealthKEYS.

DVA access to electronic information

3.25 Currently, DVA does not have electronic access to HealthKEYS, although it is expected that in time such access will be available.[37] Defence is responsible for data entry and DVA is able to access this data if required. The records of veterans, including reservists, are available only as paper files, although in time some veterans' records will be in electronic format since they will have been entered when the individual was a current ADF member. For the short to middle term, electronic data will not be available to DVA on the majority of those making claims under the VEA. Similarly, those making claims under the VEA will need to operate under the procedures currently in place—that is, obtaining a paper record.[38]

3.26 The fact that existing data on medical records will not be incorporated into HealthKEYS also means that the records for currently serving personnel will be incomplete—some will remain as paper records because it is considered that entry of existing data will create a slower result time:

> …firstly, it would require someone scanning the information into an electronic format and then putting it into a format that makes it readily accessible… [and secondly] the practical issues of bandwidth: as that record becomes bigger and bigger, it becomes more difficult—the turnaround times become greater. So at this stage we do not believe it is viable to put that in electronically.[39]

3.27 To some degree, this problem could be overcome by the use of electronic tags which incorporate 'exposure data and accurate medical record keeping.'[40] Such tags may have been seen in the past as too invasive and as a threat to privacy, but, with increasing capacity to secure medical records, they may be extremely useful. DVA has undertaken trials on smartcards with respect to services for veterans, and this may provide some information on the security of data:

> DVA has been involved in a trial with the Brisbane Waters Private Hospital and an ICT firm called Smart Health Solutions as part of a NOIE IT Online grant. The aim of the trial was to evaluate the functionality of smartcards in providing authorisation to securely access patients' online clinical information and transmission of hospital discharge information.

37 *Committee Hansard*, pp. 82, 83.

38 *Committee Hansard*, p. 82. See also comment on the HealthKEYS system in respect of non current members, *Committee Hansard*, p. 73: 'we cannot construct historic data. If the data does not exist, I have no way of generating that'

39 *Committee Hansard*, p. 77.

40 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 3, paragraph 16.

> DVA's component of the evaluation of the trial was to conduct interviews and collate and analyse attitudinal and perceptive feedback from veterans and health care providers. These findings are of interest, and will report to, the HealthConnect project—the proposed national health information network to facilitate the safe collection, storage and exchange of consumer health information between authorised healthcare providers.[41]

3.28 DVA also noted that smartcards are a further way of obtaining secure access to medical records:

> The use of smartcards is one method that can be used to authenticate and access computerised medical records. Computerised medical records can be authenticated and accessed by other means such as a login and passphrase. Smartcards were used in this trial as an authentication and access method for a range of reasons including the generally accepted use of cards within the veteran community (Gold & White DVA Treatment cards), and with the Australian public (Medicare cards). Smartcards and their embedded chips can also be used to strengthen the identification and/or authentication for authorised card holders of that card—an important feature for ensuring security of computerised medical records.
>
> The outcomes of the trial will also contribute to the body of studies that will inform the national HealthConnect project in its role to develop a better connected health system for all Australians. Use of smartcards and other technologies are being assessed in a number of electronic health record implementations both within Australia and overseas.[42]

Problems identified in relation to the collection of medical data

3.29 One of the main issues identified by witnesses was the absence of systematic event recording, especially of events which might be productive of later psychological problems. There were at least two aspects to this, the failure to record and the limited understanding of psychological factors relating to service such as peacekeeping:

> There are continuing difficulties with Defence's recording of critical incidents that may affect psychological well being, and DVA's recognition of them in relation to compensation. There has been substantial anecdotal evidence that many incidents, which form potential stimuli for possible mental health problems have not been accurately reported by Defence. The current systems major problem is its susceptibility to human error.
>
> In 2000, an International Force in East Timor (INTERFET) veteran… was involved in a combat incident. The veteran later suffered a psychological condition, which can be linked to the stimuli of the incident. The incident was not however recorded by Defence and the veteran's account was in contradiction to a DVA historian's opinion that it 'never occurred', and the veteran's claim subsequently disallowed.[43]

41 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 2.

42 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 3.

43 *Submission* 6, Australian Peacekeepers & Peacemakers Association, pp.1–2, paragraphs 6–7.

3.30 The Australian Peacekeepers & Peacemakers Association also believed that there was limited understanding of the distinction between mental health issues experienced by those undertaking warlike service, peacekeeping, and peacemaking operations.[44] While this may result in lack of appropriate service provision, affected personnel may also consider their experiences are less important if relevant events are not recorded. This is an issue which would obviously also affect older veterans, for whom relevant events are more distant and something they may have difficulty remembering. Nonetheless, DVA notes that older veterans are also making claims in respect of PTSD, although it is not clear how many of these are successful, or if others are receiving treatment because they hold a Gold Card which does not require health problems to be war–related:

> The number of PTSD claims by older veterans has risen in recent years overtaking generalised anxiety as the most common mental health disability approved for this group. Other mental health problems may arise from a range of life experiences and adjustments relating to retirement, loss and bereavement and physical or mental health degenerative conditions related to ageing, such as dementia.[45]

3.31 DVA notes that there are many factors involved in the development of psychological problems, not all of them related to service. However, it does obtain information from other sources on issues, even though this would not necessarily provide information on precipitating events for individuals to making a claim:

> …DVA's picture of the mental health state of young veterans continues to be improved by the following:
>
> - findings of the Gulf War Study and the Pathways to Care Research Project;
> - presentation of young veterans to the Vietnam Veterans Counselling Service;
> - closer liaison with ADF on health issues such as mental health, alcohol and substance misuse;
> - participation in and representation of the APPA in forums, such as the DVA National Younger Veterans Consultative Group and the DVA Alcohol Management Health Promotion Working Group;
> - the Transition Management Service including the Defence Transition Pilot Scheme involving VVCS in Townsville which is providing assistance to those exiting the ADF and will also provide information about needs and ongoing assistance required by young veterans; and
> - ACPMH collaboration with the ADF on development of a post–deployment adjustment program from which further knowledge will be gained about the needs of young veterans.[46]

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44 *Submission* 6, Australian Peacekeepers & Peacemakers Association, p. 2, paragraph 11. See also below, Chapter 4, paragraphs 4.76–4.79.

45 *Submission* 8A, Repatriation Commission, Department of Veterans' Affairs, p. 13.

46 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 12. See also: 'The amount of information available to veterans and health providers on mental health and

3.32 DVA is also able to obtain information from services required by veterans which can help identify needs and ascertain if services are appropriate:

> Through the structure of the Medical Benefits Scheme a specific item number is used to identify the service accessed by a veteran. This item number also specifies the "fee" payable to the service provider. HIC collects this data which is transmitted to DVA on a daily basis. Through DVA's Departmental Management Information System the data can be manipulated to analyse usage and treatment trends.[47]

3.33 The limited information which may be available on a veteran's file can be enhanced, although, again, much of this is unlikely to provide evidence of specific causal factors. Additionally, there are limitations to the access of some data on the grounds of privacy and data integrity,[48] although data from research projects and AIHW will also help to identify needs:

> The Department of Veterans' Affairs (DVA), however, does obtain data from the Australian Institute of Health and Welfare on disorder prevalence in the community.
>
> The prevalence of various disorders for groups of veterans is being studied by DVA through research projects commissioned by DVA that deal with specific conflicts, such as the Gulf and Korean wars. DVA also conducts a Survey of Veterans, War Widow(er)s and their carers every three years that collects data on self–reported disorders. The last survey was conducted in 2003.[49]

3.34 In addition, with the development of programs to address mental health and related issues, DVA has provided training to staff which can aid them in assisting veterans:

- State Offices have conducted various customer service training sessions that encompasses awareness of mental health issues;
- training provided to Departmental claims and assessment officers incorporates information of the diagnostic criteria of a range of psychiatric and related conditions;
- a resource booklet available to staff and managers provides information and guidelines on how to respond to clients who present with challenging behaviours including mental health and related problems;

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related problems and coping strategies has improved with the implementation of their respective mental health and alcohol management strategies. However, as with the general community, the problem of poor mental health literacy and concern about the stigma of mental health disorders remain significant barriers for young veterans. Continued work is required to improve awareness and understanding of the nature of mental health problems experienced by veterans and ways to access assistance and treatment' (p.12).

47 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 1.

48 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 1.

49 *Submission* 8A, Repatriation Commission/Department of Veteran' Affairs, pp. 1–2.

- professional staff of the VVCS have the opportunity for professional clinical development through training and external supervision; and
- The Mental Health Policy Unit of DVA is formulating a strategy for improving mental health literacy that will include a consideration of the needs of DVA staff.[50]

Effects of lack of data collection

3.35 The lack of data collection in the past reflects the limitations of previous eras including awareness of the fact that there may be long term outcomes of various events. It also reflects the absence of information and technologies which increased awareness of the effect of substances and had the capacity to measure these. Referring to the Amberly de–seal/re–seal program, the ADF noted:

> We should, in a perfect world, have quite high–fidelity data on the risk exposure for an individual, but I put it to you that that is extraordinarily difficult.

3.36 Notwithstanding these limitations, there have been some efforts to obtain information on levels of exposure to substances in past events such as Hiroshima and Nagasaki and the series of bomb tests undertaken by various countries at which both defence and civilian personnel were present. With respect to Australian veterans, DVA has been involved in such measures, including the use of dosimetry at Maralinga and other test sites:[51]

> There are some difficult elements associated with the estimation of dose which the scientific advisory committee have suggested that we should look at, and in relation to that work there is still some ambiguity about exactly how long that work will take.[52]

3.37 Available information on likely radiation exposure in Japan at the end of World War 2 has also been assessed:

> In the case of BCOF,[53] they said, 'We accept fully that radiation causes these cancers; there is no doubt about that at all. For our veterans who were in Nagasaki they will be covered by the RMA's statements of principle and compensation will flow to them. But for our Hiroshima veterans, despite our best efforts, we cannot get within several orders of magnitude enough exposure to allow compensation to flow'. The level of science was not just at the margin, it was really quite a bit away. They did so looking at water, food, beer...

50 *Submission* 8A, Department of Veterans' Affairs, p. 13.

51 See below, Chapter 4, paragraph 4.10.

52 Budget supplementary estimates, FADT, 5 November 2003, p. 7.

53 BCOF, British Commonwealth Occupying Forces, who occupied Japan and other areas after the end of the War; some were also present at the British series of tests at Maralinga and other sites.

> I should also say that the BCOF veterans are a group of veterans that do actually have some health problems that we need to carefully consider. There were quite a lot of them exposed to mustard gas and quite a few of them were exposed to psychological stresses, and we do very carefully make sure that all of our statements of principle recognise BCOF service. Various infective agents which are only found in southern Japan are put into the statements of principle to make sure that the BCOF veterans are covered. But with respect to radiation, although we have been together on a path of exploration for some years, Ken maintains there was enough radiation and our best expert advice is that there was not enough radiation.[54]

3.38 Thus, there may well be instances in which what might be called retrospective collection of equivalent data will provide valuable information. Such technology as is now available can use a range of data to recreate or model various events such as exposures[55] (although this may not always be to the satisfaction of veterans):[56]

> Our experience with Vietnam was that at the time we did not know that dioxin was going to be a problem, but because we had pretty good unit records, in some cases it was possible to go forth and construct a model of exposure. This was done in the royal commission, and one of your previous committees also attempted to do that. You can get a proxy model for exposure. It might also be important to keep things like geographical information in addition to the medical information.[57]

3.39 The Repatriation Commission has also outlined the processes it undertakes in respect of specific events, although these will not necessarily assist every individual:

> A veteran who comes along with a compensation claim will say, 'I experienced a murder,' or, 'I saw atrocities,' and that sort of information is not kept—or is very rarely kept—on their central medical record. In fact, the usual thing is for a veteran exposed to such a traumatic event not to tell anyone about it for some time….
>
> We have a range of mechanisms in place for our people to go out and test the veracity of those sorts of statements. They include looking at patrol records and speaking to other members of the unit. There are a variety of mechanisms that we use to train our people to work out whether or not something was the case. There are obviously some cases where it is manifestly self–evident: if POW J says he saw people being killed, it is evident that he did….in some situations, particularly those involving, for example, naval deployments to Vietnam, where whole ships' companies may have been in the same spot at the same time—and contained in a metal ship, in the main—we have in the past made a practice of seeking an expert

54 *Committee Hansard*, pp. 46–47.

55 See also below, Chapter 4, paragraphs 4.4–4.5, 4.10, 4.18, 4.20, 4.26, 4.34–4.35, 4.38–4.39, 4.40–4.43, 4.73–4.82.

56 Similar work has also been undertaken in the United States, including civilian exposure to radiation arising from testing.

57 *Committee Hansard*, p. 68.

> historian's advice. As you would be aware, that has caused some ripples from time to time. But fundamentally it is our responsibility to investigate each claim and, if it is a legitimate means of inquiry, to ask a historian to assemble the ships' logs and the facts and compare the evidence introduced by the claimant against that. I think that is fair enough.[58]

3.40 Some of the processes which are now in place with deployments should overcome these problems through personnel being asked to identify issues or events experienced, prior to their return. This process will not necessarily provide full details or recollections, nor may all personnel choose to provide this information, but it is one means of identifying potential problems and working to overcome these.

3.41 Other instances of absence of information do not require such detailed assessment of the past, although administration changes may be required in order to ensure that full deployment event records are available. As was stated above, the practice of UN hospitals retaining records[59] has been a problem in the past, but should be overcome eventually if copies of hospital information are provided or electronically mailed to a source such as HealthKEYS or EpiTrack.

Nominal rolls

3.42 The nominal rolls for various conflicts have been the source of some dissatisfaction among veterans because the absence of these can delay research and the making of claims. The nominal roll for the British nuclear tests, although suggested by the 1985 Royal Commission, was not completed until fourteen years later.[60] There is still no BCOF roll, and one is unlikely 'as there has not been any separate listing of Service personnel during the period of service which would specifically define [members]'.[61]

3.43 Research on the Korean War was delayed also because of the need to establish a nominal roll.

3.44 Ascertaining the reasons for delay of such processes is difficult, but the main reasons are likely to be the absence of relevant information and the lack of staff and other resources. A further factor may be the absence of perceived need—DVA notes that Korean War veterans' specific concerns were only established some six years ago:

> Until about six years ago, the Korean War veteran community did not raise any specific need for such studies. When the community raised this issue, Government responded promptly to their needs, and began preliminary

58 *Committee Hansard*, p. 81.

59 Chapter 2, paragraph 2.49.

60 Chapter 4, paragraphs 4.8, 4.9

61 *Submission* 4, British Commonwealth Occupation Force, p. 1.

> work, such as the construction of a Nominal Roll. Once this was completed, the Cancer Incidence and Mortality studies were completed. [62]

3.45 However, the same factors may also reflect an earlier more reactive than proactive approach both to research and to the identification of needs of particular groups. While it may be the case that Korean veterans have only recently raised issues, it could also be said that the Vietnam experience much later almost forced the awareness of many specific problems and development of services to meet these.[63] Applying the same principles to other conflicts and undertaking relevant research is an appropriate task for the department, and one that is now much more likely to initiate.

Better coordination and management through the Links project

> The program… has been under way for some years, and it is motivated by two things. One is that the Department of Defence and the Department of Veterans' Affairs, by working more closely together, can hopefully achieve more effective services for serving personnel and veterans and more cost-effective services for the taxpayer. It is also motivated by an understanding that, as the World War II population passes on and Veterans' Affairs scales down to some extent, it needs to have a clear view about its future in the defence family, and that requires ongoing attention.[64]

3.46 The current components of the Links project include the Defence/DVA Medical Advisory Panel (MAP) which has a review, coordination and assessment role in elation to health, rehabilitation and compensation matters:

> The Defence/DVA Medical Advisory Panel:
>
> - Coordinates the examination of health issues emerging from Defence operations;
> - Assesses the state and direction of research, identifies gaps and recommends joint Defence/DVA research directions and priorities;
> - Reviews patterns of injury, disease and compensation claims from current and retired members of the Australian Defence Force to provide direction on appropriate joint preventive health responses, including rehabilitation;
> - Reviews outcomes of joint health care trials and health care provision arrangements;
> - Provides advice on health monitoring and health–related data collection activities;

62 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 4.

63 See Chapter 4, paragraphs 4.46–4.47, 4.48–4.54.

64 Budget supplementary estimates, FADT, 5 November 2003, p. 4, see also www.dva.gov.au: 'The objectives of the Links Project are to: improve service delivery and cost–effectiveness to ADF members and ex-members within existing resources; improve the cost–effectiveness of the services provided; and to take opportunities where appropriate to move functions, particularly transition, post–discharge and closely associated services, to DVA. Some possible options to achieve these objectives include: elimination of duplication; and increased coordination'. See also *Submission* 9B, Defence Organisation, p. 8, Q5(d).

- Reviews joint Defence/DVA health training and education; and
- Develops linkages with organisations in the provision of military and veteran health.[65]

3.47 It also includes the Transition Management project, which is to improve the transition from military to civilian life for ADF members; the Mental Health Focus Group;[66] and Records Management which has as an objective the more efficient management of data contained in personnel files.[67]

3.48 These projects have the capacity to streamline management and administration especially through limitation of duplication, including of research, and facilitation of greater awareness of DVA services by ADF members.

3.49 Some of the duplication or ineffective management that currently exists arises from factors beyond the control of either department—for example, the scattered information that comprises ADF health records, and the tendency for former members to seek records from DVA when they already have much of the available material. There is also recognition that with improved information gathering, services can be more proactive than reactive:

> Threat identification and investigation has shown that both of the organisations are very highly motivated to adopt a much more proactive approach to health related issues rather than the traditional reactive approach.[68].

3.50 DVA also has links with other departments, such as the Department of Health and Ageing,[69] both in the management of projects and in limiting duplication of research:

> DVA has close links with the Department of Health and Ageing though involvement in major research projects such as the Coordinated Care Projects.
>
> DVA operated a research grants program up to the round that commenced in early 2004. This program is being phased out in order to free up resources for more commissioned research. Individual grants extend over a three or four year term.
>
> The grants program was advertised nationally, as a component of the NHMRC research grants program, and applications were submitted in the

65 See www.dva.gov.au/adf/dlp/medadvisory.

66 'The DHS and DVA have very strong links through the Defence/DVA Links Program and the Mental Health Focus Group that is part of this program,' *Submission* 9B, Defence, p. 8, Q5(d)

67 See www.dva.gov.au/

68 *Committee Hansard*, p. 90.

69 *Submission* 8ARepatriation Commission/Department of Veterans' Affairs, p. 3.

> first instance to the NHMRC for scientific evaluation. This prevented duplication between the two agencies.[70]

Dissemination/discussion of information

Limited investigation of claims

3.51 The Regular Defence Force Welfare Association advised that one particular problem for claimants was a failure by DVA to identify any material lacking in a claim prior to consideration:

> The delegate…almost never identifies deficiencies in the information supplied in support of the claim, and seeks to have them rectified—as he/she might, if genuinely investigating it—and almost never contacts the claimant or his/her representative to advise… of any problems that are likely to arise as a result of deficiencies in information supplied….As a result, the onus is always on the claimant to supply whatever information he/she imagines the delegate will need to consider the claim fully and fairly.[71]

3.52 This problem was identified by the organisation as arising from a number of administrative factors, including:

- A lack of knowledge and experience on the part of the primary decision–makers
- The general lack of understanding of the circumstances of military service likely to have been experienced by veterans.[72]

3.53 While the first may be true, primary decision makers generally work to a guide as to key factors which must be present, and this helps limit adverse effects of inexperience. Nonetheless, it is possible that pressure to complete claims quickly and a need to remain separate from the claimant may result in required information not being asked for after the claim has been lodged.[73] DVA advises claimants that they should get assistance in completing the form, and that staff may also help, with Form D2582 (Claim for Disability Pension)[74] noting at the beginning:

> You are strongly encouraged to seek the assistance of an ex–service organisation of your choice in lodging this claim. An ex–service organisation should be able to provide you with advice on how the factors identified in the Statements of Principles may apply in your case.

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70 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 5.

71 *Submission* 5A, Regular Defence Force Welfare Association, p. 1.

72 *Submission* 5A, Regular Defence Force Welfare Association, p. 2.

73 These are both issues also raised by *Submission* 5A, Regular Defence Welfare Association Inc, p. 2.

74 This form is also used for claims relating to injuries by those still in the ADF.

Assistance from Veterans' Affairs

Veterans' Affairs staff can also help you to complete this form.
Note: It would be to your advantage to have each condition you are claiming properly diagnosed prior to completing this form. This will help to prevent delays in the time taken to process your claim.

The Basis for decisions

The decision on whether your disabilities are service-related is based on up–to–date medical and scientific evidence. This information is detailed in the Repatriation Medical Authority's Statements of Principles.

If your claim is for a condition not included in the Statements of Principles, it will be determined based on the best scientific and medical evidence available.[75]

3.54 The second factor (lack of military experience on the part of the assessor) should not be relevant, as the form is designed to elicit the required facts, many of which are to be completed by a medical practitioner. The lack of military experience may be more relevant for the RMA, although only one example has been explicitly identified.[76] The Committee has suggested that there should be some input from the ADF to address any such concerns.

3.55 However, because of the complexity of the RMA SOPs, and a not particularly user-friendly RMA website, it is possible that claimants, ESOs and medical practitioners have some difficulty in obtaining relevant information about causal factors. While SOPs are necessarily written in terms of a specific disorder, the 'View by Category'[77] approach, and even the alphabetical listing available, do not provide the claimant with a readily understandable guide or indicate the relevance of particular causal factors.[78] As a preventive approach, it may be useful to indicate what disorders have been linked to causal factors to alert individuals to potential health problems.

3.56 Although the United States DVA list of compensable disorders[79] may require less specific links to service, the fact that it lists these disorders under specific conflicts must assist claimants in determining if they are eligible. It is a good model which could be adapted if only as a layperson's guide to the SOPs.

3.57 A third issue was the extent to which claimants might be encouraged to apply for assistance citing an 'approved' illness if there was currently no SOP which recognised their real disorder. The Regular Defence Force Welfare Association Inc. noted that often claimants might try to second–guess what the assessor was looking

75 See www.dva.gov.au/forms.

76 See above, Chapter 1, paragraphs 1.26, 1.28.

77 www.rma.gov.au.

78 See above, Chapter 1, paragraphs 1.29, 1.31.

79 United States, Department of Veterans Affairs, *Federal Benefits for Veterans and Dependants*, 2004.

for, but distinguished this from ' "fitting" or adapting the facts about the circumstances of a claimant's service to fit the decision-maker's requirements'.[80] In the specific case provided in a submission, the claimant was clearly frustrated by the lack of a formal recognition of disorders such as Gulf War syndrome or the effects of multiple environmental and other exposures. A related frustration was the belief that what he perceived as disorders with a physiological basis were being transformed into psychiatric problems, and that departmental staff encouraged veterans to apply citing a psychiatric disorder.

3.58 As noted above,[81] there remain difficulties with the formal classification of some symptoms, but this in itself does not prevent the Repatriation Commission being able to provide access to treatment. Where there is a possibility that a veteran is experiencing PTSD there is no wrongdoing on the part of the department in suggesting a claim be made under this, since the claim will need to be supported by medical evidence and meet the SOP standards.

Updating of RMA Standards of Principles

3.59 Some submissions stated that the RMA was either not up to date or needed to review 'all present medical standards…for authenticity and relevance to the illnesses which Service personnel may encounter during their overseas service.'[82] However, the RMA's workload is likely to be such that it is unable to meet all needs for revision, and it does continually update SOPs. In addition, it receives advice on areas of need:

> In terms of the RMA's determination of its priority for the consideration of SOPs, DVA keeps the RMA informed on the frequency with which medical conditions are the subject of claims under the Veterans' Entitlements Act.[83]

Distribution and discussion of information

3.60 Notwithstanding the publication of detailed bulletins and updates and good websites provided both by Defence[84] and DVA, many of the issues affecting veterans are perceived by them as not being discussed openly or in detail:

> The first recommendation of the *Australian Gulf War Veterans Study 2003* was that:

80 *Submission* 5A, Regular Defence Force Welfare Association Inc., p. 2.

81 See Chapter 1, paragraphs 1.40, 1.44.

82 *Submission* 4, British Commonwealth Occupation Force, p. 2.

83 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 4.

84 *Committee Hansard*, p. 14: 'There is much greater awareness within Defence and the defence community on mental health strategies. I think a lot of very good work has been done within Defence on providing information pre and post deployment and on lots of available resources through their mental health strategy. In that way, I think there has been a big improvement. I have not seen any difficulties associated with it.'

> "There should be wide promotion of the study findings to the veterans and service communities, the Departments of Defence and Veterans' Affairs, the Repatriation Commission …"
>
> To date, some six months after the release of the Study, there has been no Government Response as to how this recommendation is to be implemented. We consider that some action is required to target veterans and their providers in the dissemination of this knowledge and that the mere placing [of] the report on some departmental website does not go far enough in implementing such a recommendation. The fact that only two hard copies of the report were provided to this Association and that additional copies could only be obtained at some significant cost are indicative of a lack of "wide promotion".[85]

3.61 Other submissions have noted that in some instances there has been little information provided which could assist personnel to identify potential problems.

> In the case of environmental exposures, however, a notated list of possible exposures are recorded on the ADF members file with little or no detail as to level of exposure or risk to health… Although deployment on specified operations preclude reporting to Comcare as the regulator, Defence still has the requirement under the Act [Commonwealth Employees Occupational Health and Safety Act] to raise and retain specified records. In the main, the Federation does not believe this is occurring.
>
> …recent discussions by Federation staff with East Timor veterans identified that many of them were unaware of many of the chemicals and substances which were known by Defence to be present in the area of operations. Although it is accepted that many of these hazards did not become apparent until personnel were in–country, subsequent briefings and information have not been forthcoming or adequately recorded for future reference.[86]

3.62 Another submission referred to the anthrax vaccination controversy in stating that 'Defence must be pro-active in providing accurate health information', and that, because of greater community awareness of environmental hazards and illnesses which may take a long time to develop or present as a cluster of inexplicable symptoms, 'it is understandable that veterans are concerned that they may be susceptible to a new or unexplained disease caused by their exposure in a hazardous environment'.[87]

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85 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 5, paragraph 29.

86 *Submission* 3, Armed Forces Federation of Australia, p. 1.

87 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 4, paragraphs 20, 21. See also *Committee Hansard*, p. 3 'Our experience, and that of servicemen who took part in the 1990 Gulf War, has been one of inadequate record keeping. The department seemed confused about who received preventative vaccinations and at what time they were given, and there are deficiencies in individual records. This led to justified concerns among those who were deployed—not so much at the time but later when they were trying to reconstruct a medical history—which may explain the symptoms that they reported in later years. We therefore believe that the department should be required to implement a record keeping system that combines an individual's health record with accurate details of his or her exposure to

3.63 Concern was also expressed about the lack of aggregate data on earlier deployments:

> …when men who have served in the various campaigns and deployments, going right back to the Vietnam days, come to lodge claims for compensation or reviews of entitlements arising out of matters which they think relate to their service activities, they often come up against the almost impenetrable wall of privacy. I do not say that is necessarily a bad thing, but it is a problem in the field for people supporting their claim, because they cannot get access to extra or comparative or aggregate information. So that is a problem, but you say it is being attended to.[88]

3.64 Generally, these issues suggest that there is concern about both a lack of pro-active strategy which either advises of potential hazards in advance or as soon as these are known, and the lack of recognition of various health problems that individuals and groups attribute to deployments. Disorders, such as gulf war syndrome and, previously, chronic fatigue syndrome may not be classified as a distinct 'disorder',[89] with only some symptoms being apparent. Although longer–term outcomes are measured, these depend on 'all medical presentations from each deployment'.[90] Not all 'injuries' may have been notified either during or immediately after deployments, and the significance of these may not be understood:

> It is always difficult to determine what is a legitimate syndrome and what is an imagined syndrome based upon legitimate feelings.[91]

3.65 In these circumstances, it is the individual or group which is likely to be disadvantaged because there is no formal acknowledgment of the illness even though its effects may be substantial. This situation is understood by DVA, with reference previously being made to the availability of treatment in some circumstances for symptoms which are not yet a disease.

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environmental threats and that is capable of receiving continual updating on the nature and extent of environmental exposure'.

One submission also noted that when there was an absence of information on a particular issue, it might be suggested that the individual seeking to make a claim relied in other factors instead (*Submission* 2, Confidential, p. 3). It is not possible to assess the accuracy of this statement, which reflects that there is no formal recognition as yet by the RMA of any ill health resulting from combined effects of biological and environmental exposures with other factors, whereas there is recognition of PTSD. Insofar as the individual suffers from PTSD it is appropriate for DVA to advise him to make such a claim.

88 *Committee Hansard*, p. 68.

89 See *Submission* 8, Repatriation Commission, p. 16, paragraph 81 on the difficulty of determining the validity of some syndromes ('Gulf War syndrome' as opposed to others (e.g. chronic fatigue syndrome, CFS). However, the Commission does not note that CFS itself was once perceived as 'a collection of symptoms' rather than a syndrome, i.e. it is often more a matter of time and an increase in the number of reports, than a change in the nature of a disorder, that allows it to be seen as a causal factor which is 'evidence based'.

90 *Submission* 9, Defence Organisation, p. 4, paragraph 17.

91 *Committee Hansard*, p. 74.

3.66 There are numerous other instances of delays in awareness of health issues, such as the recent investigation into the re–seal/de–seal of F1–111s at Amberley. Bearing in mind that there will be occasions when several years of assessment reveals limited causal connection with illness, there may be room for a much more pro-active strategy of information about health issues. Although there is good information available on research projects, and DVA believes that many veterans are aware of these,[92] perhaps more effort is needed to advise of research that has been undertaken in Australia and elsewhere on the range of concerns that currently serving members and veterans have, to provide readily comprehensible data on these issues, and to develop information strategies which include more personal contact. Although DVA may believe its role will decline with the passing of World War 2 veterans, there appears to be a demand from an informed audience for a continued level of service.

3.67 Where there is other physical evidence of injury, disease or exposure to events the individual may need still to take the initiative in documenting this until such time as processes are in place for institutionalised collection of data. It is also possible that keeping veterans up to date on information about particular issues may help allay some concerns. One example is exposure to depleted uranium (*du*) which has caused some concern, although evidence provided by the ADF indicates that exposure to this in the 1st Gulf War was limited as Australian forces were primarily naval where the risk of exposure was limited.[93]

3.68 Notwithstanding the fact that neither Defence nor DVA see *du* as likely to be a major problem in the future, it will continue to be a problem for some if the reasons for this belief are not clear. The relevant ADF Health Bulletin provides explanations,[94] but it also notes some changes in the previous assessment made by the RMA which considered *du* in the context of the Balkans conflict:

> …in reaching its view, the Expert Committee made various assumptions about background radiation levels in the Balkans region. These assumptions may not have been entirely relevant to the Gulf and Iraq regions. It is no longer safe to assume that the risks to health are as low as previously thought; however, the level of risk to Australian troops is still likely to be low.[95]

92 See Chapter 4, paragraph 4.80.

93 Budget Supplementary Estimates, FADT, 5 November 2003, p. 27.

94 Department of Defence, Director–General Defence Health Service, *Australian Defence Force Policy on Depleted Uranium Health Screening* (6 August,2003), Annex B, paragraph 5.

95 Department of Defence, Director–General Defence Health Service, *Australian Defence Force Policy on Depleted Uranium Health Screening* (6 August, 2003), Annex A, p. 2, last dot point. Nonetheless, the Health Bulletin also notes that the risks from *du* are less likely to be from radiation than from chemical toxicity. This is in line with overseas research which places little emphasis on the radiation problems and hence on urinary screening. See also Additional estimates, FADT, 18 February 2003, *Answers to questions on notice*, Defence, part 2, Question W22, p. 53, where further information is provided on Australian input into the level of *du* in the Balkans.

3.69 For Australian veterans, who do not appear to have experienced such levels of exposure, there may be very limited risk. If this is the case, it may be useful to ensure that a summary of US studies is made regularly available on the internet so that individuals can assess their levels of exposure against those persons who are the subject of study. As much the same information is available in the above–cited Health Bulletin, this should not create excessive additional work and would demonstrate the appropriate level of interest in the well being of those no longer serving.[96]

3.70 The United Kingdom Ministry of Defence also has substantial information on the Gulf War and related issues, which outlines in detail the research being undertaken, the discussion of various illnesses, and the situation with respect to claiming a war pension for symptoms as opposed to a disorder.

96 With respect in particular to information issues, it was considered the RMA might contribute to the more pro–active assessment of issues relevant to future deployments—something akin perhaps to the provision of data required for the development of health plans: 'A substantial amount of their work involves assessment of environmental factors. At present the information which is gained, in the form of Statements of Principles (SOPs), is used in a retrospective way to determine the acceptability of claims for compensation…There might therefore be scope for using their considerable expertise in monitoring, and anticipating, environmental hazards both for ongoing peacetime service in Australia and for overseas deployments'. However, this is not a suitable role for the RMA. Some of the issues raised about the role of the RMA may be overcome by the fact that the RMA is an observer of the Medical Advisory Panel (*Submission* 8, Repatriation Commission, p. 12, paragraph 59) which, among other things, reviews patterns of injury, disease and compensation.

CHAPTER FOUR

RESEARCH AND PROGRAMS

4.1 Much of the research previously undertaken has been based on retrospective analysis and data collection, and has been directed at best to the provision of services towards the end of veterans' lives. A large number of other research projects have only recently been undertaken on deployments or services that date back several decades, although some countries have commenced study on these at earlier periods.

4.2 The reasons for this retrospective approach are multiple, and some have been addressed already, including:

- Policy decisions which limit growth of the overall benefits/pensions bill through restriction of service definitions and requirement for a level of connection between disability and service higher than in some other countries; and
- The structure of the RMA and its role in determining cause of illness or injury.

4.3 However, there are other factors which have limited the development of services, in spite of the vociferous statements of many veterans. These include:

- The belief that ill effects from deployments would only manifest late in life;[1]
- The atmosphere surrounding various earlier deployments, service in which were seen as a duty (World War 2 in particular) or which eventually became unpopular and less acknowledged (eg Vietnam).[2] These social contexts did not always limit the availability of benefits, but may have limited recognition by individuals of the relationship between health and war, and contributed to governments not actively seeking to investigate some health issues;
- Limited acceptance of psychological/psychiatric problems which can have short and long term effects;[3]
- Reluctance to acknowledge the effects of chemicals and other hazards, and of any longer term effects of substances such as agent orange.[4]

4.4 According to the Repatriation Commission, there was limited research undertaken of the effects of war following both World Wars.[5] Social factors[6] and

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1 See below, paragraphs 4.34–4.44.

2 See paragraphs 4.45–4.46.

3 See below, paragraphs 4.51–4.54.

4 See paragraphs 4.45–4.50.

5 *Submission* 8, Repatriation Commission, pp. 5–6, paragraphs 24, 25–26. See also *Improving the Delivery of Cross Departmental Support and Services for Veterans—*A *Joint Report of the Department of War Studies and the Institute of Psychiatry,* Kings College London, July 2003, at http://news.mod.uk/news_press_notice.asp?newsItem_id=2616, p. 32, paragraph 4.3.1.1 which notes the limited research undertaken on world war 2 veterans in the UK.

possibly a limited understanding of more immediate effects of deployment contributed to this, as well as the absence of methodologies and technologies that can now re-create data collection and identify a wider range of effects. DVA notes:

> Epidemiology is a relatively recent science, having developed as a mainstream area of study only in recent decades. DVA commenced its current focus in 1994 with the study of the Mortality of Vietnam Veterans. DVA has been building up its expertise since that study.[7]

4.5 Other developments include a more expansive understanding of psychological ill–health, links between physical and mental injury, the existence of complex syndromes, and the effects of chemical and other hazards. These may have been discussed but lacked the scientific basis achieved through long term study of substantial numbers of persons, comparisons with others in the community not exposed, and the identification of numerous viruses. Persons with visible injury or obvious disease could be compensated but where no specific cause could be identified, the relevant links could not be established.[8]

4.6 Even then, some of the studies referred to on World War 2 veterans have dealt only with small groups (such as prisoners of war in Nagasaki)[9] and persons likely to have contracted hepatitis B and other disorders.[10] Where such studies have followed directly upon medical discovery, they have been an appropriate response, but where they have been undertaken only years after established awareness of problems, they represent a failure to take a pro-active approach.

4.7 A number of groups of older veterans, from World War 2 to Vietnam in particular, have considered they have been excluded from war related disability compensation, that little consideration was given to possible health effects of their service, or that their ill health has been ignored for long periods. Some of these concerns are justified, even though the context in which their service occurred did not include an acceptance of a duty of care similar to that which is now current. In many of these cases, a mixture of factors has affected outcomes, but in those where the service is not war related, both the nature of service and the difficulty in measuring

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6 Including a reluctance to discuss recent conflict. See *Improving the Delivery of Cross Departmental Support and Services for Veterans*—A *Joint Report of the Department of War Studies and the Institute of Psychiatry,* Kings College London, July 2003, at http://news.mod.uk/news_press_notice.asp?newsItem_id=2616, p. 95, paragraph 6.5.1 which notes the difference between past attitudes and current ones where personnel are less inclined to tolerate a lack of response to issues.

7 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 5.

8 See *Improving the Delivery of Cross Departmental Support and Services for Veterans*—A *Joint Report of the Department of War Studies and the Institute of Psychiatry,* Kings College London, July 2003, at http://news.mod.uk/news_press_notice.asp?newsItem_id=2616, p. 46, paragraph 5.3.1.2 which notes that in the UK there was originally a reluctance to pay a war pension for psychiatric illness after world war 2, although this policy was changed.

9 *Submission* 8, Repatriation Commission, p.6, paragraphs 27–29.

10 *Submission* 8, Repatriation Commission, pp. 6–7, paragraphs 30–32.

exposures combine to limit access to a disability pension. Although compensation has been paid in a number of cases relating to the British nuclear tests,[11] each of these has been considered separately, with some being settled out of court. There is no presumption of cause which would reduce the burden of proof.

British Nuclear Tests in Australia[12]

4.8 These were carried out between 1952 and 1957, with some additional tests between 1953 and 1963.[13] Although evidence from Hiroshima and Nagasaki was available immediately on the effects of direct exposure to nuclear weapons, the then Australian government approved of the tests and of the involvement of both civilians and defence personnel. A Royal Commission, reporting in 1985, effectively acceded that exposure to radiation was instrumental in causing illness or death, through its recommendations including the extension of provisions of the then *Compensation (Commonwealth Government Employees) Act* 1971 to civilian personnel, and the establishment of a nominal roll. [14]

4.9 However, these recommendations were not fully implemented and have not been considered to have met identified needs. The first was seen as ineffective in that it was impossible for most persons to demonstrate their exposure, or, sometimes, even their presence at the site. The development of a nominal roll, which would have helped in this regard, was considerably delayed, not commencing until 1999, some fourteen years later.[15] Further, the recommendation on extension of legislative provisions was misunderstood, as is noted in the Clarke inquiry:

> The Commission was, in fact, recommending that those same provisions, which applied to members of the armed services, be extended to 'civilians who were at the test sites at relevant times, and Aborigines and other civilians who may have been exposed to the Black Mist'. This is very different from recommending a presumptive approach to claims or recommending that a reverse criminal standard of proof be applied to claims.[16]

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11 *Adelaide Advertiser*, 3 August 2001: 'Industry Science and Resources Minister Nick Minchin has revealed 79 court cases have been started since the program finished in SA in the early 1960s but only four have gone to trial. The remaining cases either had been withdrawn or confidentially settled out of court, with only one resulting in a $867,100 payout ordered by a judge in 1989'.

12 *Submission* 8, Repatriation Commission, p. 10, paragraph 47.

13 The Hon. John Clarke QC et al, *Report of the Review of Veterans' Entitlements* (January 2003), volume 2, paragraph 16.8.

14 The Hon John Clarke QC et al, *Report of the Review of Veterans' Entitlements* (January 2003), volume 2, paragraph 16.10.

15 The roll is available at www.dva.gov.au

16 The Hon. John Clarke QC et al, *Report of the Review of Veterans' Entitlements* (January 2003), volume 2, paragraph 16.37.

4.10 As was noted by the RSL, even if members of the forces concerned made a claim under the VEA, the standard of proof now required by the RMA is expressed in terms of si everts.[17] This type of exact measurements of likely doses is not available for all personnel present at the tests, although DVA has accepted the use of dosimetry to calculate these doses as an integral part of the project on exposure at test sites.[18]

4.11 With respect to the British atomic tests, the Clarke Inquiry studied the issues of eligibility in considerable detail[19] and concluded:

- participation by Australian Defence Force personnel in the British atomic tests be declared non–warlike hazardous and the legislation be amended to ensure that this declaration can have effect in extending VEA coverage; and
- the Government move quickly to finalise the cancer and mortality study.[20]

4.12 The government response was outlined by the Minister:

> The Government will respond positively to the needs of those affected by the British Atomic Tests programme when the outcomes of the Australian Participants in the British Nuclear Test Programme—Cancer Incidence and Mortality Study, are published later in [2004].[21]

4.13 The Clarke inquiry also studied the access of BCOF personnel to benefits as a result of service in Japan. Its recommendations included that personnel who were present in Japan as part of the BCOF, for a specific period, become eligible for warlike service. The Committee recommended that service with BCOF be declared: 'warlike from 21 February 1946 to 30 June 1947'.[22] However, the government has stated that it will not change access to benefits for BCOF personnel:

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17 *Submission* 1, Returned and Services League of Australia Ltd, p. 2: 'claimants would have great difficulty in obtaining specialist medical evidence to meet the appropriate SOP'. Additionally, some of the SOPs which refer to si evert levels also require that a cancer become evident within 40 years of claimed exposure. Thus, those veterans who have not developed some form of cancer connected with radiation before this 40 year limit (1986–1992 for BCOF forces in Japan) would not be eligible even if they could demonstrate the required si evert or mili si evert levels. On the other hand, SOP 18/2003 'malignant neoplasm of the brain', requires a si evert dose of 0.1, and for this to have been given/received at least 5 years prior to onset of the disease (section 5(b)).

18 Budget supplementary estimates, FADT, 5 November 2003, pp. 6–7. This was described by the Clarke report as 'a very complex, but achievable, task,' Hon John Clarke QC et al, *Report of the Review of Veterans' Entitlements* (January 2003),volume 2, paragraph 16.22.

19 The Hon John Clarke QC et al, *Report of the Review of Veterans' Entitlements* (January 2003), volume 2, chapter 16.

20 The Hon John Clarke QC et al, *Report of the Review of Veterans' Entitlements* (January 2003), volume 2, chapter 16.

21 Minister for Veterans' Affairs Press Release, *Response to the Clarke Committee Report on Veterans' Entitlements,* 2 March 2004, p. 2.

22 The Hon John Clarke QC et al, *Report of the Review of Veterans' Entitlements* (January 2003), volume 2, chapter 15.

> We would create anomalies if we were to confuse a state of readiness, or presence in a former enemy's territory, with the real and tangible risks of facing an armed and hostile enemy….The Government therefore does not accept the Committee's recommendations for an extension of Qualifying Service for certain service in Northern Australia during World War II and in the British Commonwealth Occupational Forces.[23]

4.14 The Clarke report does not, and was not intended to; solve the medical issue of exposure to ionising radiation. It only recommended extension of qualifying service, to a limited extent. The same is true for personnel at the British atomic tests. Thus, although access to 'war service' is important, the relationship between exposure and ill health remains a major issue for those persons who believe their health status is linked to their time in Japan rather than to any other service period.

4.15 Allocation of responsibility for what is perceived by many to be governmental delay in implementing earlier recommendations is complex. However, the above Ministerial comment reflects a long-standing belief that warlike service is quite different from either hazardous or peacekeeping service. Whether the community as a whole still endorses this belief is not known, but there is little agreement among the scientific community on the effects of exposure in either Japan several months after the war or during the British atomic tests. This will remain a key factor for both Australian and British personnel with respect to the latter.

New Zealand

4.16 The situation in other countries is not necessarily the same, either because the definition of eligible service is broader than in Australia, or the reverse onus of proof is higher. In the case of New Zealand in particular, there is a level of proof which requires the government to demonstrate that the illness or injury was not caused by an accepted war or emergency, and the extent of eligible service is wide. With respect to World War 2 and later occupation forces, this has allowed New Zealanders serving in J Force in Japan between 14 August 1946 and 28 April 1952[24] to also claim war disability.

4.17 As far as the nuclear tests are concerned, the New Zealand response has been that service personnel able to demonstrate a 70 per cent rate of disability from relevant service, including service in Operation Grapple—the main involvement by New Zealand in the British nuclear tests—are entitled to a war disablement pension which is tax free. A separate, but tax assessed, veterans pension may also be available.[25] The

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23 Minister for Veterans' Affairs Press Release, *Response to the Clarke Committee Report on Veterans' Entitlements,* 2 March 2004, p. 2.

24 New Zealand, Ministry for Social Development, *War Veterans Entitlements* (April 2004) at www.workandincome.govt.nz/get-financial-assistance,war-veterans-pensions/war-disablement.html#wars-and-emergencies.

25 New Zealand, Ministry for Social Development, War Veterans *Entitlements* (April 2004) at www.workandincome.govt.nz/get-financial-assistance,war-veterans-pensions/war-disablement.html#wars-and-emergencies.

government extended the provisions of Section 80A of the War Pensions Act to Operation Grapple Servicemen on 31 March 1998. However, this situation does not easily correlate with Australian experience, since Operation Grapple was a NZ Navy operation,[26] with very little likelihood of exposure to radiation.[27]

4.18 Research undertaken in New Zealand supported the lack of relationship between the role of the ships involved and any ill effects by those on board:

> In his report at Appendix Three, Dr Andrew McEwan, Scientific Director, National Radiation Laboratory, noted that analysis conducted by the National Radiological Protection Board in the United Kingdom showed that of 21,358 participants in all British tests, only 1716 had non–zero radiation doses recorded, most of which were insignificant. There is no evidence, nor any suggestion from those responsible for radiological protection, that any RNZN vessel or crew member received any significant exposure to radiation during Operation Grapple.[28]

4.19 However, the same report also concluded that:

> 18.9 Against this background, we concluded that the children of Operation Grapple and Vietnam veterans should be given a package of special assistance to deal with the social and medical circumstances they face.[29]

4.20 Nonetheless, veterans from the ships have continued to press for additional compensation, and were funded to undertake additional research when a new method of identifying radiation exposure was developed:

> As a result of research being undertaken in Dundee and St. Andrews Universities, a simple test has been developed that uses the saliva and blood of people who claim to have been exposed to nuclear radiation. This test is able to clearly demonstrate whether exposure had, in fact, taken place, enabling an accurate assessment of the causal link to the levels of radiation and any health problems suffered. …the New Zealand Government has made funds available for their own Test Veterans' Association for this purpose.[30]

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26 Wars and Emergencies recognised for a war pension: Operation Grapple at Christmas and Malden Islands on the ships: Rotoiti 15 May 1957–8 Nov 1957, Pukaki 15 May 1957–8 Nov 1957 and 28 Apr 1958–23 Sept 1958, New Zealand, Ministry for Social Development, *War Veterans Entitlements* (April 2004) at www.workandincome.govt.nz/get-financial-assistance,war-veterans-pensions/war-disablement.html#wars-and-emergencies.

27 Apart from sailors, there were five 'officers' from New Zealand who were involved in ground tests.

28 *Inquiry into the Health Status of the Children of Vietnam and Operation Grapple Veterans*, at www.executivegovt.nz/96-99/minister/shipley/vietnam/01, paragraph 8. 5.

29 *Inquiry into the Health Status of the Children of Vietnam and Operation Grapple Veterans*, at www.executivegovt.nz/96-99/minister/shipley/vietnam/01, paragraph 18.9.

30 June Beckett, Forgotten Veterans Still Waiting for Justice', *The Issue* Dec/Jan 2001, p. 1, www.theissue.com.au/maralinga.

4.21 The current status of New Zealand veterans in this respect therefore is that they are eligible for a war pension if they can demonstrate a particular level of disability, with the connection between that disability and war or emergency service being at a lesser level of proof than that required by Australia.

United States

4.22 The RSL also referred to what was seen as a much more preferable system adopted by the US government with respect to veterans and exposure to radiation.[31] However, the history of radiation-related compensation in the US has been long and not without some battles. There are two main factors which govern the variety of legislation—both that relating to veterans and to civilians—and these are a greater awareness of and willingness to admit to the involvement by government in activities which affected both civilians and the military,[32] and reliance on specific scientific information to limit access to compensation.

4.23 Veterans have been eligible for radiation–related benefits since 1981.[33] The US legislation relating to specific cancers was passed in 1988, [34] prior to legislation

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31 *Committee Hansard*, p. 21. See also US Department of Veterans Affairs, *VA Proposes New Aid For 'Atomic Veterans'*, 27 December 2000, www. va.gov. 'In 1988, Congress established a presumption of service connection for 13 different cancers in veterans exposed to "ionizing radiation", with later changes bringing the number to 16. Under provisions of the Radiation-Exposed Veterans Compensation Act (Pub. L. 100–321), veterans are presumed to be service connected if they participated in a radiation-risk activity: 'The proposed changes apply to those veterans who participated in "radiation-risk activities" while on active duty, during active service for training or inactive duty training as a member of a reserve component. Those activities include the occupation of Hiroshima or Nagasaki, internment as a POW in Japan, or onsite involvement in atmospheric nuclear weapons tests. People in this group are frequently called "atomic veterans"'. The number of conditions was eventually increased to 21 in 2002.

32 See for example the comments by Congress relating to extension of benefits to energy workers in 2000: 'Congress finds that— The Congress finds the following: (1) Since World War II, Federal nuclear activities have been explicitly recognised under Federal law as activities that are ultra–hazardous. Nuclear weapons production and testing have involved unique dangers, including potential catastrophic nuclear accidents that private insurance carriers have not covered and recurring exposures to radioactive substances and beryllium that, even in small amounts, can cause medical harm....(4) scientific data resulting from the enactment of the Radiation Exposed Veterans Compensation Act of 1988 (38 U.S.C. 101 note), and obtained from the Committee on the Biological Effects of Ionizing Radiation, and the President's Advisory Committee on Human Radiation Experiments provide medical validation for the extension of compensable radiogenic pathologies', www.acranet.com/pdxavets/broudy

33 'Since 1981, these veterans have been eligible for care for all conditions except those that VA affirmatively determines have causes other than radiation exposure. As a result of legislation enacted in 1996, special eligibility for care now is limited to those exposed veterans with an illness that VA has recognised as potentially radiogenic through statute or regulation. Health care also is available to veterans determined to have service-connected diseases related to radiation exposure they suffered anytime during their military service. VA also pays compensation to veterans and their survivors if the veteran is determined to have a disability due to radiation exposure while in service', US Department of Veterans Affairs, *VA Programs for Veterans Exposed to Radiation*, VA Fact Sheet January 1997, www.va.gov/ooa/pocketcard/

relating to civilians who had been exposed during US based testing in the 1950's and 1960's.[35] The *Radiation Exposure Compensation Act (RECA)* of 1990 legislated for presumptive status for civilians:

> …an additional law administered by the Department of Justice (DOJ), P.L. 101–426 (RECA) was enacted in 1990. This was a compensation program for uranium miners and down winders. Subsequently, an amendment to that law, P.L. 101–510 was enacted benefiting onsite participants, test site workers and atomic veterans physically present in an area affected by atmospheric nuclear tests for specified periods from 1951 through 1962. Note: "Specified periods" does not include any tests before 1951, or exposures in Japan.[36]

4.24 However, there were limitations placed on causal factors, and also the same type of date limitations as are currently used by the RMA:

> Those cancers are leukaemia (other than chronic lymphocytic leukaemia) provided that initial exposure occurred after the age of 20 and the onset of the disease was between two and 30 years of first exposure, and the following diseases, provided onset was at least five years after first exposure: multiple myeloma, non-Hodgkin's lymphomas and primary cancer of the thyroid (provided initial exposure occurred by the age of 20), female breast (provided initial exposure occurred prior to age 40), esophageus (provided low alcohol consumption and not a heavy smoker), stomach (provided initial exposure occurred before age 30), pharynx (provided not a heavy smoker), small intestine, pancreas (provided not a heavy smoker and low coffee consumption), bile ducts, gall bladder, or liver (except if cirrhosis or hepatitis B is indicated).[37]

4.25 Payments were also subject to offset if any other payment was made relating to the same illness:

> Benefits provided under the Act for any onsite test participants including atomic veterans/widows is a lump sum of $75,000 which would be offset by the amount of any payment made pursuant to a final award or settlement on a claim (other than a claim for worker's compensation), against any person of any payment by the Federal Government, that is based on injuries incurred by the claimant for which his/her claim under the Act was submitted. If any such award, (Social Security disability, for instance, children and spouses), settlement of Federal payment was made, the

34 *Radiation Exposed Veterans Compensation Act* of 1988 (38 U.S.C. 101 note); see also US Department of Veterans Affairs, *VA Proposes New Aid For 'Atomic Veterans'*, 27 December 2000, www.va.gov.

35 Other legislation also provided compensation to persons involved in tests at the Marshall Islands, etc.

36 www.acranet.com/pdxavets/broudy, referring to the amendments made in 1999.

37 www.acranet.com/pdxavets/broudy, referring to the amendments made in 1999.

> Assistant Director shall calculate the present value of such payments, and subtract the present value from the payment to be made under the Act.[38]

4.26 Hence, the benefits are not open–ended, and the reduction in standards of proof have resulted only from lobbying and the acceptance that some 'facts' are hard to demonstrate. For example, the *Justice for Atomic Veterans Act* was introduced in 1999:

> …to provide a presumption of service-connection for certain radiation-related illnesses suffered by veterans who were exposed during military service to radiation. These veterans include those who participated in atmospheric testing of a nuclear device, who participated in the occupation of Hiroshima or Nagasaki between August 6, 1945 and July 1, 1946 and who were interned as prisoners of war in Japan during World War II and were therefore exposed to ionizing radiation.
>
> Under present law, veterans who engaged in radiation risk activities during military service are entitled to a presumption of service–connection for some illnesses, but for other illnesses must prove causation by "dose reconstruction estimates" which many reputable scientists have found fatally flawed. Last year, the Department of Veterans Affairs Deputy Under Secretary for Health, Dr. Kenneth Kizer, wrote that he personally recommended strong support for a similar bill introduced by Senator Wellstone as a "matter of equity and fairness".
>
> It is not the fault of these veterans that accurate records of their exposure were not kept and maintained. Many veterans have been unable to obtain even medical records relating to their exposure during military service. Records have been lost. Records of radiation-related activities were classified and not made available to the veterans seeking compensation.
>
> According to Dr. Kizer "the scientific methodology that is the basis for adjudicating radiation exposure cases may be sound, the problem is that the exposure cannot be reliably determined for many individuals, and it never will be able to be determined in my judgement. Thus, no matter how good the method is, if the input is not valid then the determination will be suspect".[39]

4.27 For US veterans, the relevant period in Japan after the end of the war is from September 11th 1945 to July 1, 1946,[40] whereas the BCOF forces arrived in February 1946.

4.28 There has not been an automatic acceptance by the US that presence at sites equals compensable illness. There are two forms of status, relative to the type of condition suffered: presumptive and non–presumptive. Presumptive status entitles an

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38 www.acranet.com/ ≅pdxavets/broudy, referring to the amendments made in 1999; www.acranet.com/ pdxavets/broudy9 (106TH Session of the US Congress, January 2000.

39 www.acranet.com/pdxavets/broudy6

40 US Department of Veterans Affairs, *VA Programs for Veterans Exposed to Radiation*, VA Fact Sheet January 1997, www.va.gov/ooa/pocketcard/

individual to health coverage, but 'under the non–presumptive program, additional factors must be considered to determine service–connection, including amount of radiation exposure, duration of exposure and elapsed time between exposure and onset of disease.'[41] Presumptive status may also entitle an individual to a disability benefit, which will vary according to the level of disability and number of dependants.[42]

4.29 Changes to US veterans' legislation in 2000 also required the Veterans Affairs Department to further assist veterans with plausible ('well grounded') claims including an enhanced duty to provide relevant information.[43] However, this did not mean that any claim would be accepted. The onus of proof changed with the development of presumptive status, but some conditions are still excluded. [44]

4.30 As far as the U.S atomic tests are concerned, the potential for considerable effect on large numbers of civilians has been a crucial factor, and therefore the US decision may have been both a political and an administrative one, acknowledging what now appears to have been total indifference to the ordinary citizen as well as the need to minimise some of the effort involved in individuals making claims.

4.31 These instances demonstrate again that policy decisions and the nature of legislation can be paramount in the extension or contraction of eligibility. In New Zealand, the emphasis on a very limited burden of proof in legislation with the onus being on government to demonstrate that a disease is *not* caused by a specific factor, and a strong emphasis on the government's duty to service personnel, combine to provide greater access to benefits:

> The fundamental philosophy on which New Zealand's war pension legislation is based is that of giving veterans who have served in a war or emergency, the benefit of the doubt in terms of demonstrating the attributability of a medical condition to their military service. The establishment of absolute certainty or even limited suggestion that a condition is attributable is not required. The balance of probability is not used in war pensions' decision making. Pensions are payable where a medical assessment of a condition states that it can not be disproved that the condition could have had its genesis in the Service environment. This characteristic of New Zealand's War Pensions Act makes it fundamentally different from other countries' war pensions' legislation which, in general, requires legal proof before accepting attributability. The New Zealand

41 US Department of Veterans Affairs, Fact Sheet, September 2002, Attachment C.

42 The 21 types of cancer covered under the presumptive program are: all forms of leukaemia except chronic lymphocytic leukaemia; cancer of the thyroid, bone, brain, breast, colon, lung, ovary, pharynx, esophageus, stomach, small intestine, pancreas, bile ducts, gall bladder, salivary gland and urinary tract (kidneys, renal pelvis, ureter, urinary bladder and urethra); lymphomas (except Hodgkin's disease);multiple myeloma; primary liver cancer; and bronchio–alveolar carcinoma (a rare lung cancer).

43 See www.va.gov/vetapp02files 01/0202427.

44 The *Radiation Exposure Compensation Act Amendments* of 2000 provided for further changes to categories and also to the amount of exposure.

> philosophy is indicative of our Government's acceptance of its obligation to safeguard the welfare of Service men and women. [45]

4.32 The United States does rely more on scientific evidence, but has conceded that radiation exposure has the potential to cause or contribute to certain cancers, or, in the case of Vietnam, that all personnel were exposed to Agent Orange. As noted, the current structure of Australian veterans' legislation limits the capacity of the RMA[46] and the Repatriation Commission to act in the same way, apart from the S 180A discretion.[47]

4.33 Notwithstanding the numerous studies undertaken on the British nuclear tests, including in the United Kingdom, there has been considerable dissatisfaction from some veterans in Australia. Some perceive the problem to be with administrative approaches which, at best, are perceived as using the lack of definitive conclusions from medical research to justify non–recognition of various symptoms as war–caused. However, governments have successively declined to change the status of some service, perhaps under pressure from those organisations seen as representing veterans who were directly involved in war, as opposed to hazardous service, peacekeeping, or peacemaking.[48]

Ill effects of war likely to manifest only later in life

4.34 Information provided by the Repatriation Commission suggests that the idea of undertaking research into the ongoing effects of war on the lives of veterans did not become common until relatively recently.[49] This is not to deny that considerable efforts were made to assist veterans adjust to society and to provide appropriate care for those visibly injured. It rather indicates that the understanding of needs was limited, and that it was not fully understood that different wars may have had different effects, over different time periods, including the short term.[50] In its reference to an article on the existence of some form of psychological response being demonstrated after numerous conflicts, the Commission stated:

> …it generated a new way of thinking about the health effects of being deployed. Previously, most people who were concerned about the health of veterans had looked for specific exposures on particularly deployments. The paper by Hyams et al indicated that it was the fact of deployment that created feelings of ill–health.[51]

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45 *Inquiry into the Health Status of the Children of Vietnam and Operation Grapple Veterans*, at www.executivegovt.nz/96-99/minister/shipley/vietnam/01, paragraph 16.2.

46 See above, Chapter 1, paragraphs 1.16–1.25.

47 See above, Chapter 1, paragraphs 1.23–1.29.

48 As is indicated in the government's response to the Clarke report's recommendations concerning BCOF service in Japan, see above, paragraph 4.13.

49 *Submission* 8, Repatriation Commission, p. 5, paragraph 23, p.6, paragraphs 27–31.

50 See *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 5.

51 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 9.

4.35 This appears to be a step towards the situation prevailing in the UK, that feelings or symptoms can attract compensation.[52] However, while the UK is able to provide a pension, the direct flow on in Australia is at present limited to treatment:

> The paper had an effect on the way we treat veterans returning from a deployment. Under a policy change announced by the then Minister, the Honourable Bruce Scott MP, any veteran returning from a deployment with symptoms that are difficult to diagnose is provided with treatment until the condition is diagnosed.[53]

4.36 In effect, this will provide some support unless and until the situation has progressed to the stage where the RMA is able to provide a SOP.

4.37 Effects will also vary according to an individual's experience—for example, some of the US studies have demonstrated an increase in psychiatric problems among former prisoners of war, but these have been identified as varying depending on the circumstances and type of imprisonment. Short and long term effects from nutritional deficiency have also been suggested.[54]

4.38 Many of the research projects recently undertaken, such as that on the health of survivors of the Korean War,[55] might be considered to reflect an approach which did not see health issues as immediately relevant. The survivors of this conflict are now in their 70s and 80s,[56] may well have experienced health problems specific to the particular conflict for some time,[57] and are likely to be less familiar than younger veterans with disorders such as PTSD.[58] Their capacity to lobby as a group with specific needs may have been reduced by all three factors, quite apart from the limited research that may have been possible because of absence of data or the lack of epidemiology.[59]

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52 See above, Chapter 1, paragraph 1.40.

53 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 9.

54 United States, Institute of Medicine, Report, *Health of Former Prisoners of War—Findings* (1992) at www.veterans.iom.edu/conflict.asp?id= 6149 (Korea/Reports).

55 *Submission* 8, Repatriation Commission, pp.7, 9–10, paragraphs 34–35, 45–46.

56 Older veterans also served in World War 2 or BCOF forces. 'The DVA client database indicates that at least 30% of Korean War veterans participated in World War 11', *Australian Veterans of the Korean War Mortality Study 2003*, Executive Summary, Effect of Nature of Service, at www.dva.gov.au/publications

57 See for example *Korean War Health Issues Readings and other resources*, www.va.gov/ooaa/pocketcard/korea.asp, and also: 'It is pertinent to examine veteran mortality studies which relate to all recent conflicts whilst, additionally, addressing those facts and situations peculiar to the Korean conflict,' *Australian Veterans of the Korean War Mortality Study 2003*, Executive Summary, at www.dva.gov.au/publications.

58 That is, less familiar with terminology and literature, although likely also to be affected by PTSD—see *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 13.

59 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 5.

4.39 Another related factor is that there is little data available on lifestyle from the contemporaneous records, requiring gaps in methodology to be filled by recollection. This strategy may be more effective when data collection is undertaken shortly before deployment—for example, the US study on the health of Gulf War veterans prior to their deployment. The absence of data collection in Australia probably reflects a limited attention paid to specific issues arising from the Korean War and also the limited knowledge at the time of the long term effects of smoking, as well as other factors.

Korean War health studies

4.40 The Executive Summary of the Australian Veterans of the Korean War Mortality Study 2003 states that the study 'was prompted by concerns from the Korean War veteran community that their death rates were higher than the Australian male population, and that this increase was due to their service in Korea.'[60] This study began in 1999, and concluded that there was an increase in mortality relative to the general male population of the same age, due mostly to cancers and respiratory and circulatory problems rather than other disease or psychiatric illness.[61] However, because there were limited environmental/social data available, the study agreed that there were weaknesses in methodology:

> There was a lack of measurement of exposure to risk factors that might contribute to the observed associations, such as cigarette smoking, alcohol intake, hepatitis B virus infection, endemic parasites and bacteria, pesticides, solvents, chemical exposures and environmental exposures in Korea; and the exposure measures available were duration and period of service in Korea. These could not reflect occupational variations or the variation in exposure to Korean War service within and between the Royal Australian Navy, Australian Army and Royal Australian Air Force. [62]

4.41 Consequently:

> Although Korean War veterans have a higher mortality for several causes of death that have been identified, there is no way of determining whether this resulted from some exposure in Korea or whether it was the result of lifestyle changes arising as a consequence of Korean War service or a combination of both.[63]

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60 *Australian Veterans of the Korean War Mortality Study 2003*, Executive Summary, at www.dva.gov.au/publications

61 Although there was a higher rate of suicides among those who served between 1953–1956, this may not be significant; *Australian Veterans of the Korean War Mortality Study 2003*, Executive Summary, at www.dva.gov.au/publications. The more detailed Health Status study may provide more information on mental health issues. However, the higher rate of accidents in Gulf War veterans (see above, Chapter 2 paragraph 2.5 may indicate similar problems).

62 *Australian Veterans of the Korean War Mortality Study 2003*, Executive Summary, Strengths and Weaknesses of the Study, at www.dva.gov.au/publications

63 *Australian Veterans of the Korean War Mortality Study 2003*, Executive Summary, Conclusion, at www.dva.gov.au/publications. 'Another important factor may be the distinction between

4.42 United States research has indicated that cold injury and cirrhosis of the liver (for former POWs of both World War 2 and Korea) are likely long term problems. The first arose from the environment and, in some cases, inability to get appropriate treatment for damage caused by the cold.[64] The cause of the second, which is not attributable to alcohol use, is not yet known. However, the causal link is not required to be demonstrated individually:

> This final amendment adds cirrhosis of the liver to the list of conditions for which entitlement to service connection is presumed for former prisoners of war (POWs) under § 3.309 (c). This regulatory change is based on scientific and medical research findings.[65]

4.43 Much of the United States research relating to Korean and World War 2 veterans has been undertaken by the Institute of Medicine, part of the National Academies of Health.[66] Some of the research began shortly after World War 2, allowing for long term study results.[67]

> IOM initially conducted a 30–year follow–up of American POWs of World War II and the Korean Conflict and found evidence of increased mortality from cirrhosis in American former POWs compared to the US general population. Furthermore, the results of the October 2000 IOM [Institute of Medicine] study are consistent with other studies, including a 1999 mortality follow–up of British POWs and a 1968 mortality study of Australian World War II POWs.[68]

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those who served in both World War 2 and Korea and those who served only in the former—if the comparison is between men of the same age group, a percentage of that cohort would have been World War 2 veterans. The Cancer Incidence Study (*Australian Veterans of the Korean War Cancer Incidence Study* 2003, at www.aihw.gov.au/publications/index/cfm) compared deaths from cancer 1982–1999 between Korean veterans and those of the same age who did not serve in Korea. Mortality from 13 causes of death of *a priori* interest were elevated … They included mortality from all causes, chronic obstructive pulmonary disease, ischaemic heart disease, stroke, alcoholic liver disease and external causes, such as suicide and motor vehicle accidents. Among the cancers of interest, mortality rates for cancer of the oesophagus, gastrointestinal and colo–rectal cancers, head and neck, lung, genito–urinary and prostate cancers were elevated. Mortality rates from two *a priori* diseases (tuberculosis and peptic ulcer disease) and four cancers (liver and gallbladder, mesothelioma, melanoma and leukaemia) did not differ from that of Australian males'.

64 *Korean War Health Issues Readings and other resources*, www.va.gov/oaa/pocketcard/korea.asp

65 *'Cirrhosis of the Liver A Presumptive Medical Condition in Former Prisoners of War,'* Press Release Secretary of [US[Veterans Affairs Department, at www.vba.va.gov/bln/21/Benefits/POW/docs/cirrhosis.doc

66 www.iom.edu/topic

67 See United States, Institute of Medicine, Report, *Health of Former Prisoners of War—Findings* (1992) at www.veterans.iom.edu/conflict.asp?id=6149

68 '*Cirrhosis of the Liver A Presumptive Medical Condition in Former Prisoners of War*,' Press Release Secretary of Veterans Affairs Department, www.vba.va.gov/bln/21/Benefits/POW/docs/cirrhosis.doc.

4.44 Unfortunately, little specific research was previously undertaken in Australia on these veterans, who may have been considered as part of the World War 2 group because of the overlap in service.

Vietnam—mental health and chemicals

4.45 Possibly the most contentious health issues have arisen from the Vietnam War,[69] where large scale spraying and other use of defoliants/herbicides affected not only the Vietnamese population but also the military of several nations. The Vietnam conflict is also noted for a range of psychiatric disorders, already known to the military–psychiatric world from at least the Korean War period, but not yet fully classified and accepted. Foremost among these is PTSD.[70]

4.46 Vietnam is also the first war in modern times which was opposed by some groups in both the United States and Australia. As a consequence, while military action was broadly accepted by some in the community, there were strong feelings about this by many groups, which had a long term effect. This has had no noticeable direct consequence in the United States where research on effects has been long term, but may have contributed to the relatively late date at which Australia commenced specific studies.

> There have been many and varied studies with regard to veterans of this conflict. There have been two mortality studies, a cancer incidence study, a health census, several toxicological laboratory studies, a morbidity study and several studies of the children of Vietnam veterans. The more recent studies have shown that Vietnam veterans suffer from an increase in illness and elevated mortality rate for some conditions such as lung cancer, melanoma, prostate cancer, suicide and ischaemic heart disease. The

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The Australian research referred to in this quote is presumably that mentioned by the Repatriation Commission at *Submission* 8, Repatriation Commission, p. 6, paragraph 28. By 2004, the US recognised the following diseases for Prisoners of War (United States, Department of Veterans Affairs*, Federal Benefits for Veterans and Dependants*, 2004): 'Former prisoners of war (POW) are eligible for disability compensation if they are rated at least 10 percent disabled from conditions presumed to be related to the POW experience. The following presumptive conditions apply to former POWs who were imprisoned for any length of time: psychosis, any of the anxiety states, dysthymic disorder, organic residuals of frostbite, and post-traumatic osteoarthritis. Former POWs who were imprisoned for at least 30 days are also eligible for the following additional presumptive conditions: avitaminosis, beriberi (including beriberi heart disease), chronic dysentery, helminthiasis, malnutrition (including optic atrophy), pellagra and/or other nutritional deficiencies, irritable bowel syndrome, peptic ulcer disease, peripheral neuropathy and cirrhosis of the liver'. www1.va.gov/opa/vadocs/Fedben, pp.19–20.

69 *Submission* 8, Repatriation Commission, p. 10, paragraphs 49–50.

70 See *Improving the Delivery of Cross Departmental Support and Services for Veterans*—A *Joint Report of the Department of War Studies and the Institute of Psychiatry,* Kings College London, July 2003, at http://news.mod.uk/news_press_notice.asp?newsItem_id=2616, p. 52, paragraph 5.3.2.6 which refers to a particular 'culture' growing up around the Vietnam war experience. PTSD was recognised in 1980, although a wide range of effects of war had been studied long before that date (p. 60).

> children of Vietnam veterans have a higher incidence of spina bifida maxima, cleft lip/palate and suicide.[71]

4.47 The Repatriation Commission notes that such studies have helped to develop appropriate services such as counselling, compensation, and services for children of Vietnam veterans.[72] Again, however, the date at which research has commenced does not reflect any lessons learnt from previous conflicts, nor any data collection which could minimise the need for retrospective assessment of lifestyle factors and calculation of pre-existing illness or vulnerability to certain situations.[73]

Herbicides/defoliants—the effects of Agent Orange

4.48 The United States had undertaken some research into Agent Orange by 1969 which led to its use being discontinued in Vietnam in 1971, although there was a lack of correlation between outcomes of research and the beliefs of veterans. In 1991 Congress required that a major study be undertaken:

> Because of continuing uncertainty about the long-term health effects of exposure to the herbicides used in Vietnam, Congress passed Public Law 102–4, the Agent Orange Act of 1991. This legislation directed the Secretary of Veterans Affairs to request the National Academy of Sciences (NAS) to conduct a comprehensive review and evaluation of scientific and medical information regarding the health effects of exposure to Agent Orange, other herbicides used in Vietnam, and the various chemical components of these herbicides, including dioxin. A committee convened by the Institute of Medicine of the NAS conducted this review and in 1994 published a comprehensive report entitled Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam.
>
> Public Law 102–4 also called for the NAS to conduct subsequent reviews at least every 2 years for a period of 10 years from the date of the first report. The NAS was instructed to conduct a comprehensive review of the evidence that had become available since the previous IOM committee report and to reassess its determinations and estimates of statistical association, risk, and biological plausibility. [74]

4.49 The IOM established the Committee to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides, which reported in 1994 and has provided updates

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71 *Submission* 8, Repatriation Commission, p. 7, paragraph 36.

72 *Submission* 8, Repatriation Commission, pp.7–8, paragraphs 37–38.

73 The establishment of agent orange and depleted uranium registries by the US Veterans Affairs department will not guarantee full enrolment of all those who believe they have been exposed but will allow for the collection of at least a percentage of these, thus reducing later need for reconstruction of rolls.

74 United States, Institute of Medicine, *Health of Veterans and Deployed Forces, Vietnam*, at www.veterans.iom.edu/conflict asp?id=6139.

in 1996, 1998, 2000, and 2002.[75] There have also been other reports on Agent Orange from the IOM,[76] as well as studies from other sources. Since that first report, the updates as well as additional research on specific subjects have provided information demonstrating links between other disorders and agent orange:

> After years of debate, Congress directed the National Academy of Sciences to conduct a comprehensive review and evaluation of the available scientific and medical literature on Agent Orange and the other herbicides used in Vietnam.
>
> As a result of the first two reviews, published in 1994 and 1996, VA now recognises eight conditions which are presumed to be related to service in Vietnam for the purposes of establishing service–connection: soft tissue sarcoma, non–Hodgkin's lymphoma, Hodgkin's disease, chloracne, porphyria cutanea tarda, respiratory cancers, multiple myeloma, prostate cancer, acute peripheral neuropathy, and spina bifida in offspring.[77]

4.50 As noted above, the US allows for a presumptive approach,[78] relying on scientific evidence, and then adds the respective illnesses to its list of compensable disorders:

> VA presumes that all military personnel who served in Vietnam were exposed to Agent Orange, and federal law presumes that certain illnesses

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75 United States, Institute of Medicine, *Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam* (1994), see www.veterans.iom.edu/subpage.asp?id=10316. Summaries of the 1994 report and of subsequent updates are available at this address.

76 See also the additional reports produced by the IOM: *Veterans and Agent Orange: Length of Presumptive Period for Association Between Exposure and Respiratory Cancer*(2004);*Characterising Exposure of Veterans and Agent Orange and Other Herbicides Used in Vietnam: Interim Findings and Recommendations* (2003); *Veterans and Agent Orange: Herbicide/Dioxin Exposure and Acute Myelogenous Leukaemia in the Children of Vietnam Veterans*(2002); *Veterans and Agent Orange: Herbicide/Dioxin Exposure and Type 2 Diabetes* (2000).

77 www.va.gov.gov/ooa/pocketcard/vietnam_summary asp. In 2001, diabetes mellitus was added to the list of compensable diseases, United States, Department of Veterans Affairs, *'Vietnam Veterans Benefit From Agent Orange Rules'* (2001) at www.vba.va.gov/bln/21/Benefits/Herbicide/AOno1.

By 2004, one form of leukaemia was also listed, chronic lymphocytic leukaemia: see *Agent Orange and Other Herbicides*, in United States, Department of Veterans Affairs, *Benefits for Veterans and Dependants*, 2004: 'Eleven diseases are presumed by VA to be service–related for compensation purposes for veterans exposed to Agent Orange and other herbicides used in support of military operations in the Republic of Vietnam between January 9, 1962, and May 7, 1975. The diseases presumed are chloracne or other acneform disease similar to chloracne, porphyria cutanea tarda, soft–tissue sarcoma (other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma or mesothelioma), Hodgkin's disease, multiple myeloma, respiratory cancers (lung, bronchus, larynx, trachea), non–Hodgkin's lymphoma, prostate cancer, acute and subacute peripheral neuropathy, diabetes mellitus, (Type 2) and chronic lymphocytic leukaemia', www1.va.gov/opa/vadocs/Fedben, p. 20. The US Department of Veterans Affairs is able to make independent assessments of research and add compensable diseases.

78 See paragraphs 4.28, 4.29, 4.42 and also Chapter 1, paragraphs 1.30–1.31.

> are a result of that exposure. This so–called "presumptive policy" simplifies the process of receiving compensation for these diseases since VA foregoes the normal requirements of proving that an illness began or was worsened during military service.[79]

PTSD and other psychiatric problems—under–diagnosed

4.51 The Vietnam War had a substantial effect on both military personnel and civilians, with rejection of the war by parts of society probably a contributor to some level of psychological problems among veterans. In 1991, a US report on Vietnam veterans estimated that:

> …15.2% of all male and 8.5% of all female Vietnam theatre veterans currently suffer from PTSD—approximately 450,000 veterans in all. Furthermore, more than twice that number, (30.6% male and 26.9% female) of theatre veterans have had the full PTSD syndrome at some time since their war–zone experience in South-East Asia.[80]

4.52 However, mental health issues including readjustment problems, have not always been identified or effectively addressed, reflecting the level of knowledge of such issues, and the social context which provided little outlet for discussion of them.[81] PTSD itself was only formally accepted in 1980,[82] although other forms of reaction to war were recognised prior to that time.

4.53 The Repatriation Commission has stated that the Vietnam Veterans Counselling Service was established 20 years ago 'in recognition of the fact that there were Vietnam veterans who felt alienated from government processes'.[83] As well as developing the Centre for Post Traumatic Stress Disorder, the Commission has been instrumental in commissioning research on numerous mental health issues both in recognition of the fact that mental health is a major concern for veterans as well as current ADF personnel, and as part of the National Mental Health Strategy.[84]

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79 United States, Department of Veterans Affairs, *'Vietnam Veterans Benefit From Agent Orange Rules'* (2001)at www.vba.va.gov/bln/21/Benefits/Herbicide/AOno1.

80 M. Friedman, '*Current Trends in PTSD Research*,' NCP Clinical Quarterly 2(1): Fall 1991 at www.ncptsd.org/publications/cq

81 See, for example, B.Engdahl and R.Eberly, '*Assessing PTSD Among Veterans Exposed to War Trauma 40–50 Years Ago*,' NCP Clinical Quarterly 4(1): Winter 1994, at www.ncptsd.org/publications/cq/v4/n1/engdahl

82 See J. Hamblen, *'PTSD in Children and Adolescents*,' at www.ncptsd.org/facts/specific/fs_children

83 *Submission* 8, Repatriation Commission, p. 7, paragraph 37.

84 The latter, which is the responsibility of the Commonwealth Department of Health and Ageing, is concerned to identify the mental health needs of all Australians. In so doing it has developed greater awareness of a range of community needs in this field and, with other programs, can help to overcome some of the stigma that remains associated with psychiatric health.

4.54 This process is similar to that which occurred in the United States, where the US Veterans Affairs department has also responded to identified needs, though with the impetus coming much more obviously from Congress.[85] However, although PTSD was originally seen as peculiar to the Vietnam conflict, it was subsequently recognised as a disorder that affected other military veterans and the civilian population as well, with the National Centre for Post–Traumatic Stress Disorder also providing service to civilians:

> [PTSD] is no longer considered an isolated problem for Vietnam veterans. PTSD is recognised as a major public health problem and a behavioural health problem for military veterans and active duty personnel subject to the traumatic stress of war, dangerous peacekeeping operations, and interpersonal violence.[86]

Gulf War/s

4.55 Notwithstanding the perceived failure to learn lessons from the first Gulf War,[87] the United States has included various disorders deemed to have been war–related in its list of compensable illnesses (entitling the individual to disability payments).[88] It has also undertaken extensive research which addresses the existence of symptoms for which there is no clear diagnosis:

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85 However, the extent to which Congress has initiated policy reform is difficult to assess, since the role of lobby groups has been important.

86 See M Friedman, '*About the National Centre for PTSD'*, NCP at www.ncptsd.org/about/index.

See also www.ncptsd.org 'The National Centre for Post–Traumatic Stress Disorder (PTSD) was created within the Department of Veterans Affairs in 1989, in response to a Congressional mandate to address the needs of veterans with military–related PTSD. Its mission was, and remains: To advance the clinical care and social welfare of America's veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders'.

87 The United States considers the Gulf War to have been ongoing since 1990, distinguishing between the two Gulf Wars by names of battles, eg 'Iraqi Freedom'.

88 'Gulf War veterans who suffer from chronic disabilities resulting from undiagnosed illnesses, medically unexplained chronic multi–symptom illnesses (such as chronic fatigue syndrome, fibro myalgia, or irritable bowel syndrome) that are defined by a cluster of signs or symptoms, and any diagnosed illness that the Secretary of Veterans Affairs determines warrants a presumption of service-connection may receive disability compensation. The undiagnosed illnesses must have appeared either during active duty in the Southwest Asia Theatre of Operations during the Gulf War or to a degree of at least 10 percent at any time since then through December 31, 2006. The following symptoms are among the manifestations of an undiagnosed illness: fatigue, skin disorders, headache, muscle pain, joint pain, neurologic symptoms, neuropsychological symptoms, symptoms involving the respiratory system, sleep disturbances, gastrointestinal symptoms, cardiovascular symptoms, abnormal weight loss and menstrual disorders. A disability is considered chronic if it has existed for at least six months. Amyotrophic Lateral Sclerosis (ALS) may also be service–connected if the veteran served in the Southwest Asia Theatre of Operations', United States, Department of Veterans Affairs, *Benefits for Veterans and Dependants,* 2004, pp. 20–21.

> Most have health problems similar to those experienced by veterans of other eras. However, some veterans report chronic multi–symptom illnesses that often are difficult to diagnose. Thus, most of the symptoms reported by veterans in VA registry examinations were found to be caused by conventional illnesses.
>
> However, in about 20 percent of examinations, primary diagnoses of physical complaints could not be provided. (For comparison, approximately 17 per cent of Vietnam veterans on VA's Agent Orange registry examination have undiagnosed symptoms).[89]

4.56 Extensive websites and research/information programs on all aspects of Gulf War disorders including du, some by Veterans Affairs and some by the US Department of Defence. Research on Gulf War veterans had begun in 1992[90] and, in conjunction with the research undertaken by other agencies and the development of detailed health guides, extensive information is available to veterans, their families and doctors.[91]

4.57 The United States publicly acknowledges shortcomings in its capacity to address the needs of veterans within short time frames.[92] It also acknowledges that veterans have been critical of services, not just in respect of the Gulf War, but those provided after earlier conflicts.[93] These two factors are likely to be important to veterans and currently serving personnel because they are recognition of the reality of their experience.

4.58 The development of extensive medical guidelines and training programs for those treating personnel involved in specific conflicts are also recognition of the reality of the symptoms experienced and of the need for professional awareness of the extent of these. This places the responsibility for dealing with identified health issues on medical staff, rather than on the individual.

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89 See United States, Department of Veterans Affairs, *Guide to Gulf War Veterans' Health*, 2002 (originally published 1998), www.va.gov/gulfwar/docs/VHIgulfwar, p. 3.

90 United States, Department of Veterans Affairs, *Guide to Gulf War Veterans' Health*, 2002, p. 3: 'Since 1992, about 130,000 of the 750,000 Gulf War veterans from the US, Great Britain and Canada have received a systematic clinical registry examination conducted by the US Departments of Veterans Affairs (VA) and Defence (DoD), or comparable examination programs in other countries,' www.va.gov/gulfwar/docs/VHIgulfwar

91 '… in April 2001, VA announced the establishment of two new Centres for the Study of War–Related Illnesses, with the goal of serving not just for Gulf War veterans, but all veterans of past and future combat and peace–keeping missions,' United States, Department of Veterans Affairs, *Guide to Gulf War Veterans' Health*, 2002, p. 2, at www.va.gov/gulfwar/docs/VHIgulfwar

92 See above, paragraph 4.26 and see also above, Chapter 2, paragraphs 2.3–2.5.

93 See United States, Department of Veterans Affairs, *Guide to Gulf War Veterans' Health*, 2002, p. 2.

4.59 The awareness of 'undiagnosed' symptoms or unexplained illnesses arising from all conflict[94] does not lead to a rejection of the relevance of these, but more to a recognition of their inevitable appearance after all conflict and therefore the importance of addressing them. In fact, considering they are seen as almost inevitable, although varying in content, appropriate services can be developed to meet such needs in advance.

4.60 The *Australian Gulf War Veterans' Health Study* 2003[95] has identified a similar pattern of unexplained illness in Australian veterans:

> The Australian Gulf War Veterans' Health Study was prompted by several factors. These include:
>
> - the results of several overseas studies, which had shown that the Gulf War veterans from coalition partner countries were reporting poorer than expected health,
> - an increasing number of reports among Australian Gulf War veterans of a wide range of medical problems, which were difficult to explain,
> - concern amongst Gulf War veterans about the possible health effects of some of the exposures and experiences unique to the Gulf War, such as smoke and oil from burning oil wells (SMOIL), exposure to depleted uranium and the possible use of chemical or biological weapons.[96]
>
> Australian Gulf War veterans have an increased risk of psychological disorders including depression, anxiety, posttraumatic stress disorder and substance use disorders in the post Gulf War period and persisting within the previous 12 months. These psychological disorders are strongly associated with reported military service experiences that occurred in the Gulf War, especially the threat of attack
>
> Australian Gulf War veterans have increased rates of reporting of all symptoms, and some medical conditions; in particular musculoskeletal, psychological, skin, respiratory and neurological conditions and these are associated with several reported exposures and experiences that occurred in the Gulf War. These include immunisations (especially where 10 or more were reported), pyridostigmine bromide and being in an area where chemical weapons had been used.[97]

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94 United States, Department of Veterans Affairs, *Guide to Gulf War Veterans' Health*, 2002, p. 5: 'poorly understood "war syndromes" characterised by multiple physical symptoms have been reported since at least the U.S. Civil War. Consistent with this observation, unexplained syndromes have been reported among troops involved in more recent hazardous military deployments to the Balkans and other areas around the world. Unexplained illnesses appear to be one inevitable health consequence associated with any hazardous military or peacekeeping deployment.' See also *Submission* 8, Repatriation Commission, p. 9, paragraph 44.

95 See www.dva.gov.au/media/publicat/2003/gulfwarhs

96 www.dva.gov.au/media/publicat/2003/gulfwarhs, paragraph 19.1.

97 See www.dva.gov.au/media/publicat/2003/gulfwarhs, paragraph 19.2.

4.61 The report concluded, however, that although there was a higher level of reporting of some symptoms, there was no 'unique symptom complex or cluster' arising from the Gulf War.[98] Although Gulf War veterans may have been concerned that this study was not undertaken earlier, there has been some access to treatment nonetheless, which may reflect an increased awareness of the importance of acknowledging symptoms.

Effects of research on the development of programs

4.62 The ADF now has in place a more pro-active policy at least with respect to deployments, with efforts made to identify potential hazards, to protect personnel from these and to minimise injury.[99] It is also involved in research relevant to deployment:[100]

> Historically many Defence health studies were reactive in nature, in response to perceived problems or issues promoted by particular interest groups. DHSB is currently adopting a more pro-active response to future health research in the ADF and has initiated the conduct of operational health studies for more recent operations. Such studies should ideally begin prior to deployment however the short planning timeframes involved will not always allow this.[101]

4.63 It is also apparent that relatively recent audits and other reviews have contributed to some changes in the ADF health services and to the development of occupational health and safety plans.[102] Generally speaking, ADF has responsibility for research into more recent deployments,[103] with DVA being responsible for work on older ones, although it is expected that the new Centre for Military and Veterans' Health will gradually take over the research capacity from DVA.[104] The amount of available funding 'will remain a key determinant in how much can be achieved',[105] as far as Defence is concerned, although its objective would be 'a structured research program' which could address 'a wide range of research issues'.[106]

4.64 In Australia, the development of mental health services for both Vietnam veterans and others has increased considerably in recent years. Factors which limit

98 www.dva.gov.au/media/publicat/2003/gulfwarhs, paragraph 19.2.

99 See Chapter 2, paragraphs 2.22–2.30. See also *Submission* 9, Defence Organisation, pp. 8–9, paragraphs 43–45 on health and medical intelligence work.

100 *Submission* 9, Defence Organisation, p. 7, paragraphs 34–35, although see also the limitations involved in undertaking research on particular deployments, pp. 7–8, paragraph 37.

101 *Submission* 9, Defence Organisation, p. 8, paragraph 38.

102 See Chapter 2, paragraphs 2.92–2.97.

103 *Submission* 9, Defence Organisation, p.8, paragraph 41.

104 *Submission* 8, Repatriation Commission, p. 13, paragraphs 66–67.

105 *Submission* 9, Defence Organisation, p. 7, paragraph 35.

106 *Submission* 9, Defence Organisation, p. 7, paragraph 35.

social acceptance of mental health issues, including a tolerance of excessive alcohol consumption and violence, and a lack of connection between experience and various behaviours, have probably helped to disguise a level of need in society generally and veterans in particular. Even ADF health professionals appear reluctant to use the very services which they provide:

> More of the 2002 group were aware of the availability of counselling services than the 1999 group, but no survey participants actually used counselling services. Most of the 1999 group and half of the 2002 group indicated that they would not use counselling services to cope with stress, even if they were available. This is of concern, as the survey respondents were health personnel who should have had an understanding of the value of mental health interventions.
>
> The reluctance to use mental health services may be attributable to a perception that using such services is an admission of inability to cope and meet the obligations of a soldier.
>
> Despite this reluctance, about 70% of participants felt that counselling services should be deployed.[107]

4.65 This probably results in specific programs having gradual rather than immediate effects:

> The amount of information available to veterans and health providers on mental health and related problems and coping strategies has improved with the implementation of their respective mental health and alcohol management strategies. However, as with the general community, the problem of poor mental health literacy and concern about the stigma of mental health disorders remain significant barriers for young veterans. Continued work is required to improve awareness and understanding of the nature of mental health problems experienced by veterans and ways to access assistance and treatment.[108]

4.66 The ADF has set up an extensive program which seeks to address both drug/alcohol related issues and those arising from deployments. Information on these is provided in various publications and on the internet, with an emphasis on the fact that such issues are common and on providing advice on different sources for help.[109] There is therefore an effort to demonstrate that psychological problems including PTSD and difficulties in readjustment on return from deployment are to be expected, and not contrary to a military culture. However, there is no mention in the pamphlets of the fact that many people outside the military have similar problems, and that mental health issues are a major health concern for the Australian community in general.

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107 Karl L Haas, Stress and mental health support to Australian Defence Health Service personnel on deployment: a pilot study, *ADF Health*, 4 (1) 2003, pp. 19–22.

108 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 12.

109 See www.defence.gov.au/dfe/dhs/mental health–see *ADF Mental Health Strategy; Suicide Fact Sheet; and Post Traumatic Stress Disorder.*

4.67 The ADF has also changed its method of responding to 'critical events,[110] and reorganised mental health services to provide regional teams that are working together:

> A major limitation in the delivery of mental health services to the ADF identified in the ADF Health Status Report (2000) was the lack of integration between service providers. There are a number of organisations within Defence that deliver comprehensive mental health services, but due to a lack of integration they sometimes work at best in parallel and have the potential to work in opposition. [111]

4.68 The increasing emphasis on the contribution of lifestyle does reflect the community expectation that individuals bear some responsibility for their own health. This responsibility also demands, however, that there be a duty of care to personnel to minimise the risks to which they are exposed, particularly in peacetime, including limitation of the high rate of injury. For some veterans and current personnel, there may be a belief that this duty of care is not well developed and that various factors make it difficult for an individual to ensure that the workplace has the appropriate standards and a commitment to enforcing them.

Research priorities

4.69 Research priorities are identified in various ways, with the joint Defence/DVA Medical Advisory Panel (MAP) identifying needs.[112] These decisions appear to be based on a range of data collected by Defence and DVA,[113] and will include in time the data from post–deployment reviews. Defence also stated that:

> The ADF documents health and human performance research requirements in a Master Plan, which is reviewed and updated annually. While this document is heavily influenced by the extant capabilities of relevant research organisations in Defence, the plan also indicates areas of research interest for which there is no intrinsic capability. The intention is that the Centre for Military and Veterans' Health will link into external organisations that may provide some of those capabilities and the Master Plan should evolve to reflect more accurately research 'requirements' that could be addressed in these ways. Examples of areas where operationally relevant research might be undertaken are in the areas of gastro–intestinal disease and combat casualty care.[114]

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110 www.defence.gov.au/dfe/dhs/mental health, *Enhanced Mental Health Service Delivery ADF Model of Critical Incident Mental Health Support.*

111 www.defence.gov.au/dfe/dhs/mental health, *Integration of Mental Health Services in Defence.*

112 *Submission* 8, Repatriation Commission, p. 12, paragraphs 59–61.

113 *Submission* 8, Repatriation Commission, p. 12, paragraph 60.

114 *Submission* 9B, Defence Organisation, p. 9.

4.70 The protocols and objectives for Defence health research are outlined in ADFP Personnel Series 1.2.5.3, *Health and Human Performance Research in Defence—Manual for Researchers*.[115] The manual states that:

> The primary focus [in research on the physical and/or mental health of personnel] is the study of the preventive, evacuation, treatment and rehabilitation strategies that will improve the management of health and health hazards encountered in areas of strategic interest to Australia.
>
> Human performance research is defined as the group of investigations where the aim is to improve the normal performance, output and capability of humans to complete tasks and maintain or improve performance levels…this research has a focus on the development of human capacity and sustainability with respect to both physical and cognitive performance.[116]

4.71 This approach may include some measures to deal with non-deployment issues, but the emphasis is primarily on operational service.

Repatriation Commission/DVA

4.72 DVA has a long established research program which has increasingly been used to support new services intended to meet the identified needs of veterans.[117] With the development of ADF data collections, technology such as HealthKEYS and EpiTrack, the initiation of health reviews following deployment, data from health plans, and the use of environmental data, future research will benefit from information that is collected before, during and within a short time of deployments. Such data will help DVA undertake programs and identify issues that affect those leaving the forces as well as current personnel, and place emphasis on younger veterans as well as those from earlier deployments.

4.73 DVA has indicated that the information which it obtains from its data collection and from research informs the development of more appropriate programs:

> Two examples are:
>
> Results of the Vietnam Veterans Morbidity Study which the Repatriation Commission developed into a range of program responses to enhance health service delivery for this veteran cohort; and
>
> An analysis of mental health disorders in the veteran community conducted to inform development of DVA's mental health policy led to research on the pathways to care taken by veterans recently compensated for a mental

115 *Submission* 9, Defence, Attachment G, ADFP Personnel Series 1.2.5.3, *Health and Human Performance Research in Defence—Manual for Researchers.*

116 *Submission* 9, Defence Organisation, Attachment G, ADFP Personnel Series 1.2.5.3, *Health and Human Performance Research in Defence—Manual for Researchers,* Chapter 1, sections 1.4, 1.5.

117 *Submission* 8, Repatriation Commission, pp. 5-19, Paragraphs 23–88.

> health disability. The Repatriation Commission will consider the findings of this research in the near future.[118]

4.74 DVA also has a somewhat different perspective of veterans, since it may see more directly the needs of different groups through its knowledge of the nature of applications being made for compensation and a range of other sources.[119] Given that DVA is aware of the constancy of certain responses to deployments, and has gradually developed programs to meet such needs, their input into research on current deployments may also be of use in defining probable needs for current personnel, rather than waiting for these to become veterans with ill–defined needs. DVA was responsible for the establishment of the then National Centre for War–Related PTSD, in 1995, which later became the CPMH:

> The Australian Centre for Posttraumatic Mental Health (ACPMH), working in collaboration with the Department of Veterans' Affairs (DVA) and the Australian Defence Force (ADF), as well as with clinicians, researchers, and consumers around Australia, acts as a focus for an integrated approach to veteran and military mental health.
>
> The active involvement of both the ADF and DVA provides new opportunities to address psychiatric morbidity at every stage, from recruitment through deployments and discharge to veteran status.[120]

4.75 This Centre has a major role in the provision of clinical services, including early intervention, training, and collection of data on outcomes of treatment. It therefore provides an external view of services provided and covers both current ADF personnel and veterans.[121] DVA's continued involvement with this Centre will help provide it with insight into current issues and an awareness of the ways in which the ADF is dealing with these:

> In 2000 the Repatriation Commission determined that the role of the Australian Centre for Posttraumatic Mental Health (ACPMH) should be expanded beyond a focus on PTSD to include broader mental health conditions that impact on veterans. ACPMH has provided assistance with the development of guidelines for the treatment of anger management problems and currently is developing alcohol treatment guidelines. This work specifically relates to treatment of veterans. However, the centre has also established liaisons and other work with the Australian Defence Force (ADF) with regard to post–deployment adjustment and development of the ADF alcohol strategy.

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118 *Submission* 8B, Department of Veterans' Affairs, p. 13.

119 See above, Chapter 3, paragraphs 3.31–3.34.

120 Professor Mark Creamer and Professor Bruce Singh, The Australian Centre for Posttraumatic Mental Health, An integrated approach to veteran and military mental health, *ADF Health*, 5(1) 2004, pp. 36–39.

121 Professor Mark Creamer and Professor Bruce Singh, The Australian Centre for Posttraumatic Mental Health, An integrated approach to veteran and military mental health, *ADF Health*, 5(1) 2004, pp. 36–39.

> Other research work undertaken by the centre covers areas such as Alzheimer's disease, psychiatric morbidity, cognitive counselling techniques, anxiety disorders, depression, psychometric analysis, Quality of Life assessments, military stress and performance and schizophrenia.[122]

Research priorities

> In determining the Commission's research agenda, many factors are considered. These include the wishes of the veteran community, the scientific interest in the questions that are raised, the viability of the proposed research, the availability of resources, and ethical, legal and moral considerations.[123]

Issues raised by veterans

4.76 Several issues were raised by ESOs on research programs, including:

- Lack of adequate research undertaken on mental health.[124]
- Limited holistic approach to health, especially on the issue of the interaction of effect of exposure to multiple substances or multiple exposures to substances; [125] and
- Concern that research is being replicated, and therefore that decisions about some issues could be made if existing research was accepted.[126]

Lack of research on mental health

4.77 There has been an increase in mental health research, especially for younger veterans, which will continue with the work of the ACPMH, which looks at all mental health issues. DVA has also stated that the ACPMH has paid limited attention to the needs of older veterans, and that its main focus has been on Vietnam veterans and those from more recent deployments:

> The needs of older veterans has not been a major focus for the centre to date. ACPMH accredits PTSD treatment programs of which two programs are specifically tailored to the needs of older veterans. Much of the centre's work, since opening in 1995, has been focussed on the group of Vietnam veterans who have been highly represented in the cohorts of PTSD treatment programs. It's more current collaboration with the ADF means it

122 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 5.

123 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 4.

124 *Submission* 6, Australian Peacekeepers & Peacemakers Association, p. 2, paragraphs 9–14.

125 *Submission* 5, Regular Defence Force Welfare Association, p. 2, paragraph 11; *Submission* 6, Australian Peacekeepers & Peacemakers Association, pp. 3–4, paragraphs 14–15.

126 *Submission* 4, British Commonwealth Occupation Force Executive Council of Australia, pp. 1–2.

> has been developing a body of knowledge and experience about the needs of more recent young veterans and current serving ADF personnel.[127]

4.78 In May 2004 DVA circulated a consultation paper, *Towards Better Mental Health for the Veteran Community*, which notes proposed changes arising from reports and also from the National Mental Health Plan.[128] DVA has also released *Mental Health Disorders in the Veteran Community and their Impact on DVA's Programs*,[129] based on 1997–1998 data. 'A total of 87,874 people met one or more of the inclusion criteria, representing 26% of the DVA treatment population'.[130]

4.79 Matters of specific interest to some groups of veterans, such as the differing stressors produced by different roles,[131] may also be studied by individuals or units outside of the ADF and Repatriation Commission research areas, including those with direct experience:

> Peacekeeping missions, which bring soldiers into war zones as non–combatants, present a wide variety of stresses that have short– and long–term effects on mental health. Frequently, peacekeepers witness large–scale devastation and atrocities. Soldiers are trained to win the day by the application of tactics and up to date weaponry, yet peacekeeping and humanitarian missions generally restrict tactical freedom and the use of force, exposing soldiers to stresses for which they are not prepared or trained, large–scale devastation and atrocities. Various authors have described UN personnel as exposed to a wider range of stressors than they would be in combat. Isolation, boredom, feelings of frustration, rage and helplessness due to strict UN rules of engagement, which only allow a soldier to shoot if under direct threat of loss of life or limb, all increase the stress of military personnel in a peacekeeping role.[132]

4.80 DVA is well aware of the concerns of the younger veteran groups, and believes that ESOs are familiar with the work undertaken by the ACPMH.[133] There seems no reason to suppose that the specific issues raised on peacekeeping or peacemaking would not be addressed. However, it may be that the relevant organisations need to outline proposals for research which will cover areas of need.

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127 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 6.

128 Department of Veterans' Affairs, *Towards Better Mental Health for the Veteran Community*, pp. 1–2, at www.dva.gov.au/health/younger/mhealth/policy

129 Department of Veterans' Affairs, *Mental Health Disorders in the Veteran Community and their Impact on DVA's Programs*, at www.dva.gov.au/health/younger/mhealth/data

130 *Mental Health Disorders in the Veteran Community and their Impact on DVA's Programs,* p. 4 *at* www.dva.gov.au/health/younger/mhdata

131 *Submission* 6, Australian Peacekeepers & Peacemakers Association, p. 2, paragraph 11.

132 Karl L Haas, 'Stress and mental health support to Australian Defence Health Service personnel on deployment: a pilot study', *ADF Health*, 4 (1) 2003, pp.19–22.

133 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 5.

Limited holistic research

4.81 One of the problems identified by DVA in undertaking research on multiple exposures is the difficulty of establishing cohorts:

> More recent deployments have tended to involve smaller numbers of personnel. Moreover, in many of these deployments the same individuals have participated in multiple deployments, and each of the deployments has multiple exposures. These circumstances of small deployments, multiple deployments and multiple exposures make attributing causality difficult.[134]

4.82 While there has been some research on exposures, such as may have contributed to the Gulf War syndrome, it could be impossible to separate out individual causal factors. It may be possible to identify some cases where new personnel have deployed, such as in some of the US forces in the 2nd Gulf War battles, because they have limited previous exposure; but if they receive multiple exposures in conflict, the benefit of such research may be minimal. It is possible also that if similar effects are seen after all conflict, there will be a tendency to move towards treating symptoms rather than seeking a diagnosis, which may put more emphasis on psychiatric issues than on the physical effects of exposure—not necessarily what veterans want.

Replication of research

4.83 This concern has been addressed by the Repatriation Commission which outlines the reasons why some research duplication is necessary, and how specific factors may mean the experience of Australians in some deployments may differ from those of personnel from other countries in the same deployment.[135]

> It is important to note that DVA's research efforts in these fields are not taken in isolation…Its studies are usually carried out at the same time that similar research is being undertaken in the United States, the United Kingdom, Canada, New Zealand and other nations.
>
> Often, the research by other countries is on deployments that are similar to those of the ADF. This similarity of deployments, necessarily with some duplication of effort, has both advantages and disadvantages. Often when there has been a good study of a particular problem…an argument might be raised that reduplication of what others have already found is not a prudent use of limited resources. Conversely in science there is a need to confirm finding made in other studies, and, when two groups of researche[r]s make the same finding, working independently of each other, the two findings have a synergistic value.[136]

134 *Submission* 8, Repatriation Commission, p. 11, paragraph 52.

135 *Submission* 8, Repatriation Commission, p. 9, paragraph 43; pp.14–15, paragraphs 69–70, 72.

136 *Submission* 8, Repatriation Commission, p. 14, paragraphs 69–70.

4.84 It could also be argued that in many cases, the research will cover somewhat different factors, given that forces may have been subject to different types and amounts of exposures, have different experience, and are undertaking different work. It may also be that this difference is so great or the methodology is not acceptable that the work of other bodies will not always be accepted as useful.[137]

4.85 A further issue is that which has been referred to previously, that while much research may not find a correlation between events and illness, political and policy factors may result in different outcomes for veterans of different countries. The most effective use of the research of other countries is to use what is generic, where possible, and also to explain why it is that there is not sufficient evidence to demonstrate causal links, or why different systems will accept some situations.

Women

4.86 There was no detailed reference to the specific needs of women in the ADF, or to any research areas which they may wish to have addressed.[138] Given that their health needs are different, it may be useful for both the ADF and DVA to consider the US military websites which have a specific website for women members.

4.87 While women may be included within the research into the needs of younger veterans, their particular needs should be identified for all research on issues where they are represented. However, it is noted that in many instances, the numbers of women involved in deployments will often be too low to obtain any meaningful results:

> Only 38 female Australian Gulf War veterans took part in the study, which was 84% of those who served there. This small number meant that there was limited statistical power for the analysis of this group. However, a similar, but less marked, pattern in relation to adverse psychological outcomes as for male Gulf War veterans was found. No firm conclusions can be made about any of the other physical health indicators studied, due to the very small numbers of female Gulf War veterans.[139]

137 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 14.

138 See above, Chapter 2, paragraphs 2.98–2.101.

139 *Australian Gulf War Veterans' Health Study* 2003, www.dva.gov.au/media/publicat/gulfwar paragraph 19.219.

ADDITIONAL COMMENTS

AUSTRALIAN DEMOCRATS

The Australian Democrats support the report of the Committee and make the following additional statement.

1. The Report of the Review of Veterans' Entitlements (the Clarke Report) made a number of recommendations which have subsequently been rejected by Government. A number of these specifically relate to health of Veterans and their eligibility for fee–free medical treatment.

2. Specifically at Recommendation 43, the Report recommended that Service with BCOF be declared warlike from 21 February 1946 to 30 June 1947. The Minister for Veterans Affairs' rejection of this recommendation on the basis of an absence of a hostile enemy force, fails to acknowledge the incurred danger from exposure to radiation at or near Hiroshima and Nagasaki.

3. The 1991 Gulf war showed that Australian troops can return damaged in ways that are not immediately apparent One in five veterans of the 1991 Gulf war are on some form of disability compensation related to that war. We cannot dismiss the possibility of similar outcomes for veterans of the present war in Iraq.

4. Thirteen years after Australia stopped using depleted uranium in ammunitions, our troops are still at risk because it continues to be used by allied forces. The health impact of this and the long term effect of anthrax vaccinations on our forces serving in Iraq will not be fully evident for some time.

Senator Andrew Bartlett

Appendix 1

Submissions received by the Committee

1	Returned & Services League of Australia Limited
2	CONFIDENTIAL
3	Armed Forces Federation of Australia
4	British Commonwealth Occupation Force Executive Council of Australia Inc
5, 5a	Regular Defence Force Welfare Association Inc, National Office
6	Australian Peacekeepers & Peacemakers Association
7	Mr Brett Laboo
8, 8a	Repatriation Commission
9, 9a, 9b	Department of Defence
10	Ms Janet Screaton

Appendix 2

Witnesses who appeared before the Committee

Canberra, 26 February 2004

Australian Peacekeepers and Peacemakers Association

Mr John William Coyne, National Vice President

Defence Health Service, Department of Defence

Air Commodore Tony Kenneth Austin, Director–General

Department or Veterans' Affairs

Dr Keith William Alexander Horsley, Director (Health Studies)

Mr Willam Raymond Maxwell, Division Head, Compensation and Support

Regular Defence Force Welfare Association Inc

Commodore Harold Adams (Retd), National President

Commodore Michael Dowsett (Retd), Honorary Medical Adviser

Air Vice Marshal John Paule (Retd), National Secretary

Returned and Services League of Australia

Mr Kenneth Stuart McKenzie, Immediate Past Chairman, National Veterans' Affairs Committee

Appendix 3

ANTHRAX VACCINATIONS

While standard vaccinations[1] are not identified as having caused any problems, anthrax vaccinations are seen by some as evidence of a lack of community standards in the provision of health care services, and a lack of 'duty of care'. The major issue concerning anthrax vaccinations[2] is whether some ADF personnel had an opportunity to exercise informed consent. Other concerns have also been expressed, including the quality of some batches of vaccine, the safety and efficacy of the product, and possible long term effects.[3]

The issue of informed consent for 2nd Gulf War vaccinations

The Defence perception of consent is that any individual undertaking a standard vaccination program has in effect consented to its use.

> In the administration of routine vaccination to our people, in accordance with current civilian practice, there is implied consent. So where a vaccine is made routinely available and is on a routine vaccination schedule, the fact that a person presents themselves for vaccination is usually sufficient to imply that they understand the risks and the nature of what they are receiving.[4]

However, acceptance of standard vaccinations may be based on the premise that, in spite of some limited adverse effects, these are generally safe and that consent was

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1 These standard vaccinations are listed at Budget Estimates, FADT, 4 June 2003, p. 365.

2 It was suggested that mencevax ACWY vaccinations—against meningococcal disease A, C, W135 and Y—were given at the same time as the anti-anthrax vaccine (Budget Estimates, FADT, 4 June 2003, p. 365), but in fact were given before the *Kanimbla* left Australia. There was no consent form used: ('We did not require a signed consent form for the mencevax. Mencevax has been a routine immunisation for operationally deployed personnel for quite some time', Additional Estimates, FADT, 4 June 2003, p. 372) but General Cosgrove stated that anyone who had not agreed to this vaccination would not have been able to deploy (Budget Estimates, FADT, 4 June 2003, p. 364).

3 It is stated that there were also Air Force and Army personnel on board the *Kanimbla* who would have received information about the vaccination at the same time as naval personnel (Additional Estimates, FADT, 12 February 2003, p. 71). For simplicity's sake, the discussion refers to naval personnel insofar as the relevant actions were taken by the navy and it appears that only naval personnel made a decision not to accept the vaccination.

4 *Committee Hansard*, p. 51. See also Additional Estimates, FADT, 12 February 2003, p. 40:'Within Defence Health, we obviously treat our men and women we serve in exactly the same way as other citizens of Australia. Implicit in that is that, when they receive any health care, there is informed consent on their behalf so they understand what is being put forward to them, what the ramifications of that may be and they always retain the right to decide whether they will or will not proceed'.

'informed' in the sense of the individual having enough readily available information to make a choice and being familiar with the issue of side effects, often over a period of years:

> A wide range of immunisations are offered to Australia citizens both in childhood and in adult life that are common, community accepted standards and it is therefore expected that most people would be familiar with those immunisations and would understand their benefits and possible consequences. In that sense, we do not require a signed consent form when people receive routine immunisations.[5]

Unlicensed or unregistered vaccines

Anti-anthrax and some other vaccines are classed as unlicensed or unregistered, terms which are used for vaccines which are not registered with the Therapeutic Goods Administration (TGA) as items of common use. The TGA has no direct administrative responsibility for use of such items, and delegates this authority: in this case to the CDF, or to a medically qualified person. The delegation requires that 'ADF members are fully informed of benefits and risks'.[6]

The Defence submission states that consent with respect to the use of unregistered vaccines is covered by 'ADF policy [which] provides comprehensive guidance on matters of informed consent…'[7]

> In the case of an unregistered vaccine there is a much greater responsibility on us to provide people with information, answer any reasonable questions that they ask of us and ensure that when they receive the vaccine that it is truly done under the provisions of informed consent—that is, they know the risks, they know the reasons why it has been given and they have made the decision freely.[8]

Where a consent form does not provide full information about other implications, an individual may or may not be able to make an informed decision about the full impact of the procedure, regardless of whether consent is given.[9] With respect to the Navy, this wider issue does not appear to have been considered. It would appear that the 'consent' form included two options—one being that consent was given, the other that

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5 Senate Estimates, FADT, 12 February 2003, p. 41.

6 *Submission* 9, Defence Organisation, p. 6, paragraph 25. One of the reasons perhaps for concerns is that different standards may apply in deployments where Australia is not in command of its own forces, *Submission* 5, Regular Defence Force Welfare Association Inc., p. 3, paragraphs 12, 17. Consent was not an option for US forces in respect of anthrax vaccinations, Senate Estimates, FADT, 12 February 2003, pp. 37–38.

7 *Submission* 9, Defence Organisation, p.6, paragraph 26.

8 *Committee Hansard*, pp 51–52.

9 For example, the refusal to have a child vaccinated has led to non-payment of various benefits. This consequence was openly stated and known to those who choose not to proceed, see www.health.gov.au/pubhlth/strateg/immunis/7point.htm, *The Seven Point Plan.*

it was not - and that certain consequences might follow. Everyone signed the consent form, and in some cases it is likely that it was the information on the form or the absence of other information on consequences, which at least contributed to the decision made not to agree to the vaccination.

This is apparent from a response to a complaint made by one of the sailors from the *Kanimbla*, which notes:

> You say that …your informed consent [ie non–consent] was based on the briefing, which advised that there would be no administrative action taken against [n]on–consenting personnel.[10]

It has also been stated that the consent form available at the time included the words 'may not participate in deployment' (if vaccination was refused), rather than the words 'will not participate'.[11] The consent form which was given to *Kanimbla*[12] personnel, dated 29 January 2003, reads: 'I understand that I may refuse to accept Anthrax vaccine without prejudicing my medical care but that I may not be eligible for specific operational deployments'.[13] This is true also of the form dated 6th February 2003. Insofar as this information led individuals to believe that they would remain on the ship, it was misleading. Later comment that the form was going to be changed and would make it clear that continuation with a specific deployment was not possible,[14] does not address this concern.

Similarly the statement that there was in place a policy that those who were not vaccinated were not deployable[15] does not effectively counter the statement that the specific briefing on the ship about this particular vaccination stated that no adverse administrative action would be taken. It is unlikely that the difference between no administrative action and the consequences of failing to meet a 'policy' was appreciated in the circumstances, accounting for some of the confusion experienced when personnel were removed, having become non-deployable to the MEAO exercise.

It is also to be noted that long after personnel were removed from ships, the information available on the defence website[16] and still there in mid July 2004, did not clarify many issues:

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10 *Submission* 10, Mrs Screaton, p. 6. This is taken from the document Redress of Grievance, part of Submission 10.

11 *Submission* 10, Mrs Screaton, p. 3.

12 *Submission* 10, Mrs Screaton, p. 4.

13 See below, Attachment A, document 1.

14 Redress of Grievance, p. 4, paragraphs 15–16.

15 *Submission* 10, Mrs Screaton, p. 6; 'I am satisfied that there was no need to provide an advance explanation of the possibility of medical re–categorisation to the ship's company'.

16 The information on the website—see www.defence.gov.au/dps/dhs/infocentre —as at mid July 2004 was dated August 2003, well after the date by which documents concerning the effect of not agreeing to the anti-anthrax vaccine were supposed to have been changed.

> **11. What happens if I don't get vaccinated?**
>
> Getting the vaccine is not compulsory and you may refuse to receive the vaccine at any stage (even if you have already had one or two injections). You will not be punished or discriminated against because you have not elected to be vaccinated, however, because of ADF risk management procedures you ***may*** not be allowed to deploy to, or remain in, certain areas overseas if you have not been vaccinated.
>
> The Defence Health Service recommends all personnel at risk be vaccinated.
>
> **12. Will declining [the] Anthrax] vaccination affect my individual readiness status?**
>
> Although vaccination against Anthrax is voluntary, and can be declined, members will not be deemed fit to deploy to certain overseas areas. They can deploy, however, to other areas where Anthrax vaccination is not required and therefore your individual readiness status will not change.[17]

Any individual reading this would understand that they would not be able to go to areas where anthrax was a risk, but it is not clear that if one were already on the way there, one would be removed. But it is clear, especially in the answer to Q12, that their 'readiness to deploy' status would not be changed in respect of *all* deployments. However, in response to some queries raised, the Chief of Navy wrote that the revised policy manual dated June 2003 clarified the issue:

> Any uncertainty for similar situations in the future has been removed with June 2003 issue of ADFP 1.2.2.1—Immunisation Procedures which replaced ADFP 702 as outlined [above].[18]

This policy manual[19] is somewhat different in tone and ruling to the advice that still remains on the website, and some differences within the manual itself can only continue the same confusion that previously existed. It states, for example:

- Failure to undertake a vaccination program *can* lead to members being deemed non–deployable, and *may* lead to a review of their fitness to continue serving in the ADF.[20]
- There will be no vaccination waivers[21]

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17 www.defence.gov.au/dpe/dhs/infoline/anthrax, FAQ, Q 11, Q 12, emphasis added.

18 *Submission* 10, Mrs Screaton, p. 5.

19 See *Submission* 9, Defence Organisation, Attachment D.

20 *Submission* 9, Defence Organisation, Attachment D, Chapter 1, paragraph 1.4.

21 *Submission* 9, Defence Organisation, Attachment D, Chapter 2, paragraph 2.9.

- Any member [of the ADF] who is not current with routine and any designated additional vaccinations *is not* compliant with Individual Readiness and therefore *is* unfit to deploy.[22]

It would be preferable to clarify the situation, which seems to have moved from not being able to deploy to areas where a specific threat exists or was believed to exist (website information) to not being able to deploy at all (policy manual). On the other hand, the section on anthrax vaccinations within the policy manual states:

> If vaccination is declined, however, that member *may* not be considered eligible to deploy to regions or environments where there is a threat of Anthrax exposure.[23]

This contrasts somewhat with the policy manual that was in place during the deployment period, which states:

> Any member who refuses vaccination with Anthrax *is not to be* deployed to regions or environments where there is a threat of Anthrax exposure.[24]

From the above, it is still unclear what the formal position is with regard to deployments. Nonetheless, it was stated by General Cosgrove in February 2003 that non deployment in MEAO was always going to be the response to those who did not take the vaccination:

> **Senator CHRIS EVANS—**In terms of the decision about procedure, when was it determined that those who were unwilling to take the vaccine *would not* be allowed to stay in the theatre of operations?
>
> **Gen. Cosgrove**—That was an in–principle decision when we decided that was the regime necessary.[25]

If this was so, it is unfortunate that this was not made obvious to personnel at the beginning, through being on the consent form.

With respect to at least one of those members of the ADF who refused the vaccination, there was a re–classification of status to MEC 207 for a 12 month period.[26] This did not prevent deployment *per se*. For other persons who were returned

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22 *Submission* 9, Defence Organisation, Attachment D, Chapter 2, paragraph 2.10.

23 *Submission* 9, Defence Organisation, Attachment D, Chapter 5, paragraph 5.10 (c). See also Redress of Grievance Determination, p. 9, paragraph 47 which quotes the relevant paragraph, 5.11.c.

24 Redress of Grievance Determination, p. 9, paragraph 47.

25 Additional Estimates, FADT, 12 February 2003, p. 36, emphasis added; see also p. 37.

26 *Submission* 10, Mrs Screaton, pp. 5-6 MEC 207 is defined as 'fit for deployment or sea going service except in geographic areas as defined', Redress of Grievance Determination, p. 8, paragraph 42.

to Australia, it was stated that they would not be subjected to 'institutionalised retribution', although it is not clear if their medical status was also changed:

> **Senator BARTLETT**—But what are the implications of not taking it?
>
> **Gen. Cosgrove**—They will not be kept in the environment where those hazards are felt to be possible.
>
> **Senator BARTLETT**—That is all—they are just redeployed elsewhere?
>
> **Gen. Cosgrove**—Yes.
>
> **Senator BARTLETT**—So you are able to guarantee that there are no other adverse career or other consequences for people?
>
> **Gen. Cosgrove**—I mentioned the personal perceptions amongst some people who say yes and a very small number who may say no. All I will say is there will be no institutionalised retribution or anything of that nature…[27]

The timing of vaccinations for Navy personnel

According to Defence, sufficient time was available at least for non-Navy personnel to receive information on the anthrax vaccine and even to consult other persons about it,[28] allowing 'informed consent' to be given. Anyone who did not agree to the vaccination did not go on the deployment.[29] According to Air Commodore Austin, the ADF generally hopes to have sufficient notice of deployment to give vaccinations 'in accordance with the manufacturer's recommendation':

> What we do not want to do is to shorten the administration regimen or increase the number of shots.[30]

With respect to some Navy personnel (on the *Kanimbla*), the main issue is whether personnel should have been told before embarkation from Australia that they would require an anthrax vaccination.[31] This is distinct from the issue of whether there was sufficient time for vaccinations to be completed prior to embarkation.[32]

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27 Additional Estimates, FADT, 12 February 2003, p. 24.

28 *Committee Hansard*, p. 52.

29 Approximately 10 non–Navy personnel did not agree to the vaccination.

30 Additional Estimates, FADT, 4 June 2003, p. 365.

31 There was some discussion in Senate Estimates about whether personnel on ships would have had access to public information available in January that anti-anthrax shots would be provided—see Additional Estimates FADT, 12 February 2003, pp. 34–35. Even if they had, they may not have considered it further since nothing was formalised until later.

32 *Committee Hansard,* p. 65: 'Clearly we are also talking about the issue of when the members were advised of the program, and that does not have to be linked directly to when the vaccine is administered. They are actually two parts of the process'.

The *in principle* decision that anti–anthrax vaccine would be required was taken by 10 January 2003.[33] From evidence provided, it appears that a decision was made not to advise of the need for this prior to embarkation, whenever embarkation was to occur and whichever ships would be commissioned.[34]

The main reasons for this are given as:

- It was not known which ships and therefore personnel would be affected;
- Once this decision was made there was no time to give the vaccine before embarkation on the basis that staff would be required to undertake various physical tasks, and the known side effects might interfere with these.[35]

The first factor is in accordance with the principle that vaccinations are not given unless required, although this also needs to take into account the amount of time for vaccinations to become effective. However, there seems to be no good reason why personnel could not have been informed as soon as the decision was made about which ships were to be deployed,[36] regardless of when the vaccine was to be given. On 4 February personnel were advised of the need for anthrax vaccinations, and these were given on 5 February.[37] Thus there was only one day in which to obtain other information, and it appears that this was insufficient for the MO on board the *Kanimbla*.[38]

If non–navy personnel had been given sufficient time to discuss the issues, and were able to consult with relatives, the issue cannot be one of confidentiality. Had personnel been advised when ships were still in port, those who chose not to have the vaccine would have been in no worse position in terms of a removal than those in other forces who made a similar decision. As far as adequacy of available information is concerned, when personnel *were* informed it appears that navy personnel did not have access to as wide a range of information as those in the army and air force did.

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33 Additional Estimates, FADT, 18 February 2004, p. 65; however, see also *Committee Hansard*, p. 57, Senator Bishop—the information that militarised anthrax could be used in the 2nd Gulf War was known by approximately 11 January 2003.

34 Submission 9A, Defence Organisation, Q2, part (j). The order to vaccinate was given on 3 February 2003, and implemented on the *Kanimbla* on 5 February 2003 (*Submission* 10, Mrs Screaton, pp. 3–4)

35 *Submission* 9A, Defence Organisation, Q2(j). However, according to one submission, the greater part of these tasks had been completed prior to leaving Darwin for the second time—see *Submission* 10, Mrs Screaton**,** pp. 2–3.

36 20 January 2003—see Additional Estimates, FADT, 18 February 2004, p. 65.

37 *Submission* 10, Mrs Screaton, pp. 1–3.

38 See also www.defence.gov.audpe/dhs/infoline/Anthrax FAQ: ‘Almost all medical personnel who deploy with you will have undergone specialist NBC training. The ADF runs an intensive two week course that teaches medical personnel about recognising and treating NBC injuries, including Anthrax’.

According to Air Commodore Austin, a wide range of information was available and there was time to consult with others.[39] The same manufacturer's material or product information may have been available to both Navy and non–Navy personnel, but the fact that the ships had embarked reduced the access of navy personnel to other sources of information and opportunities for consideration with people outside the system. Although one example was given of a radio consultation with another doctor, [40] this is not the same as being free to raise the matter over a longer period of time and seek information from other sources. Having information on the vaccine on the consent form does not in itself demonstrate that the information was taken from a range of sources.[41]

According to one source, the information available to naval personnel was not detailed, and it was stated in a report on the individual's complaints that even the manufacturer's information (for the UK vaccine) was not as useful as that provided generally with medicines in Australia.[42]

> The leaflet is dated December 2002 and does not identify the medium or media used to carry the active components of the vaccine or attempt to identify the chemical composition of any of the non–active ingredients of the vaccine.
>
> The leaflet does not indicate whether any of the possible "undesirable effects" of the vaccine is related to the active ingredients or could be related to other chemicals in the vaccine.
>
> The other electronic information made available to him [the Medical Officer on board the Kanimbla] by [the] Deputy Fleet Medical Officer (DFMO) would have taken some time to search to see whether it addressed issues as specific as this one.[43]

Regardless of what is generally provided with Australian medicines, however, the apparent shortage of information can hardly be excused. It may be that the Medical Officer was unaware of the fact that anti–anthrax vaccinations were to be given, unless the ship's commanding officer had advised other officers:[44]

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39 *Committee Hansard*, p. 52.

40 See *Committee Hansard*, p. 52 where it is stated that one naval officer at least had the opportunity to discuss possible long term effects with an external source.

41 It was stated that although policy did not require that information on the vaccine and its date of expiry be on the consent form, this was in fact done at least for the Navy (*Kanimbla* and *Darwin*), *Committee Hansard*, p. 60. However, other information in the Redress of Grievance (p. 4, paragraphs 10(d), (e), and (f)) states that required information was not listed at all, but this was apparently an error.

42 *Submission* 10, Mrs Screaton, p. 7.

43 *Submission* 10, Mrs Screaton, p. 7. However, the information provided on the UK Ministry of Defence website about the UK vaccine is detailed, and does provide the information referred to above.

44 Additional Estimates, FADT, 12 February 2003, p.32.

> **Vice Adm. Ritchie**—The commanding officer of the *Kanimbla* would definitely have been aware that there was going to be a requirement. As to whether or not the commanding officer of *Kanimbla* told his ship's company in a formal manner, we can only ascertain that by asking him.[45]

The vaccine itself had been provided before *Kanimbla* left Sydney:[46]

> **Vice Adm. Ritchie**—In a nutshell, the vaccine was provided to *Kanimbla* the day before *Kanimbla* left Sydney, on 22 January, and in the period between 22 January and 4 February further information, the consent form, clearance to use the particular vaccine and education material was provided to the ship.[47]

However, if the medical officer was unaware, he/she would not have had much opportunity to go through the relevant material and see if there were issues which might be raised by personnel but which were not addressed in any of the documents.[48]

One issue that was raised was the components of the vaccine and of the media in which these were held, and it is stated that the MO on board the *Kanimbla* did not have the answers to these questions.[49] Given that some people may have needed to know to clarify the issue of possible allergies to the agent in which the vaccine is carried or possible severe reactions to the vaccine itself,[50] this was information that should have been provided, especially as it may have affected the level of informed consent. In fact, the consent form dated 29 January 2003, which was the one used on the *Kanimbla*, has a section listing those people who should not receive the vaccine, or should temporarily defer receipt.[51] These include those who are immuno–compromised, have HIV, or an active infection/illness with fever. The form dated 6 February also has this information.

While it is not obvious what other information had been forwarded electronically to the *Kanimbla*, the data provided by the UK Ministry of Defence (MoD) on the UK vaccine was extremely detailed,[52] and did include information on the components of

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45 Additional Estimates, FADT, 12 February 2003, p. 35.

46 Additional Estimates, FADT, 12 February 2003, p. 31.

47 Additional Estimates, FADT, 12 February 2003, p.31.

48 Additional Estimates, FADT, 12 February 2003, p. 31: 'the ship's captain was aware that he would have to have an education program once he announced that he was going to do this and he sought extra material to enable him, the medical officer and the psychologist who was on board that ship to explain that to individuals collectively and then individually as each one talked through the business'.

49 *Submission* 10, Mrs Screaton, pp. 6–7.

50 Although the likelihood of this was limited, as there is no live anthrax in the US or UK vaccines.

51 See Attachment A, document 1, paragraph 21.

52 See United Kingdom, Ministry of Defence, *Anthrax, Voluntary Immunisation Programme, A Guide for Medical Staff*, 2000.

the vaccine and the agent, although this was dated 2000. The UK MoD link is on the Department of Defence website on this issue.[53]

The process of vaccination does not seem to have been fully thought through and as a result the medical/nursing staff were perhaps ill–equipped to handle some queries. The responsibility for this is difficult to determine, because confidentiality appears to have played some part in access to information such as the health plan:

> **Vice Adm. Ritchie**—…there was some degree of classification around the health plan for Operation Bastille. Therefore, I do not think that it was appropriate for those sorts of things to be talked about until such time as it was decided to put that health plan into action… The health plan, which comes down through the theatre, had a classification on it that would not allow it to be discussed openly on the ship.[54]

Nonetheless, it seems unlikely that the MO at least would have been unaware of some basic components of the health plan such as the intention to give anthrax vaccinations. It is obviously important to ensure that MOs have access to basic technical information which they can translate into everyday language for the benefit of personnel in general.

This point has been conceded to some extent:

> Nevertheless the experience of these briefings does suggest that precise questions of this kind can be asked and is better that the information be available. As ADF personnel become better trained and with more specialized engineering and scientific skills, the possibility of such questioning obviously increases. It is desirable, with new vaccinations, that education programs be planned thoroughly after a focus group of personnel have been used to draw out the range of possible questions that are likely to arise for the MO. Accordingly I have made a recommendation to Chief of Staff, Maritime Headquarters that this should occur in future.[55]

That it was a mistake not to provide information to naval personnel prior to departure from Australia is now conceded by the ADF.[56] The problems that have occurred for

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53 As noted above at footnote 41, the Australian Defence website also notes that a special course was available on the anthrax vaccine for medical officers, although this may not have been known to the deployed MOs.

54 Additional Estimates, FADT, 12 February 2003, p. 32.

55 *Submission* 10, Mrs Screaton, p. 7. Material available by 18 March 2003 in fact provides some detail on the components of the vaccine and its media, although how easily this information was understood is unknown, as the language used is quite technical, www.defence.gov.au/dpe/dhs/infocentre/anthrax/FAQ, Q5 and Q6.

56 *Committee Hansard,* p .53: 'The lessons learnt report highlights that as being a failure on our part because it could certainly be construed that it was taking away people's freedom of choice and that there was an unintended but potential degree of coercion being exercised on these people by the very fact that they had already embarked onboard ship heading towards an area of operations'.

some personnel in the Navy (having to be taken off ships)[57] did not occur for those in the RAAF and other naval personnel who did not consent, although this seems to have been the case only because they were already in the Middle East and 'were moved back routinely on aircraft that were operating in and out of the gulf'.[58] The issue has therefore become one of whether some navy personnel were discriminated against through the more public circumstances of their return, and, to some extent, whether there was undue pressure on them, while aboard, to be vaccinated.[59]

The quality of vaccines used

A further issue with respect to anthrax has been the quality of the vaccine used. This issue seems to have arisen in part at least because of the some of the reported reactions which were considered excessive, and some queries about the 'use by' date of the imported vaccine,[60] in respect both of Afghanistan and 2nd Gulf War deployments.

The ADF has noted that when reporting of reactions is required, one may have 'over reporting' and a 'higher than expected side effect profile'.[61] Those reactions to the anti-anthrax vaccine which have been noted, primarily a sore arm or an inability to use the arm where the injection was given, or short term fever, are not in themselves seen as out of the ordinary. They would not be considered adverse reactions in the sense of being registered,[62] and they would have been expected by management given that one of the reasons for not advising navy personnel of anthrax vaccinations in January 2003 was said to be the need to deploy, which required a certain amount of physical labour:

> In preparing a ship for deployment there is a lot of hard physical labour on the part of the men and women embarked on the ship and I believe that was a factor that was considered by the commander of the ship in terms of delaying the administration of the vaccine, because once a ship is actually embarked and crew go into a normal work–rest cycle there are fewer physical demands upon them and therefore there will be less operational impact of the vaccine.[63]

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57 Other Navy personnel on the Darwin and the Anzac who refused the anti-anthrax vaccine were already in the Gulf; those on the *Kanimbla* landed on Christmas Island and were flown home from there, Senate Estimates, FADT, 3 June 2003, pp. 374–375.

58 Senate Estimates, FADT, 3 June 2003, p. 373, General Cosgrove.

59 See above, Chapter 2.

60 The ADF has stated that some personnel believe they received anti–anthrax vaccinations during Gulf War 1, and that this has led to a belief that various illnesses are linked to such vaccinations (*Committee Hansard*, p. 61). Because the anthrax vaccine is used only when circumstances require, some of the terminology used ('unlicensed', 'unregistered') may have suggested to personnel that it was unsafe.

61 *Committee Hansard,* p. 53.

62 Major reactions are registered with the Adverse Drug Reaction Unit, Therapeutic Goods Administration, see www.tga.health.gov.au/adr

63 *Committee Hansard,* p. 65.

Defence witnesses noted that the problems of assessing the effects of the anthrax vaccine were both 'over reporting' of what be seen as normal side effects, and the lack of knowledge of the effects of other factors:

> …the rates that we saw when we looked at it in the light of other confounders that may have been present, such as co–administration of other vaccines or the physical activities that people were engaged with, made it very difficult for us to determine whether it was as a direct consequence of a problem with the vaccine or just part of the normal distribution of what we would have expected to see. [64]

The issue of other vaccine administration, however, appears to lead to further confusion. It appears from Defence evidence that mencevax had already been given to the crew of the *Kanimbla* prior to its departure from Australia, and therefore the confounding of other vaccinations would have been limited for those personnel.[65] For personnel on other ships, the mencevax vaccine was not given until later.[66]

Although Defence believes that there are no difficulties in administering both mencevax and anti–anthrax on the same day, at different vaccination sites,[67] other information suggests that this would not be best practice. Anthrax shots themselves should not be given as part of a combined vaccination.[68] The Australian Defence Force Vaccination Handbook itself states that:

> **Anthrax vaccination is not to be given concurrently with other vaccines**. This will reduce the incidence of more severe advents from occurring.[69]

Product information on mencevax states that:

> No information is available concerning the effects of drugs, intercurrent illnesses or other vaccines on the response to the administration of Mencevax.[70]

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64 *Committee Hansard,* p. 54.

65 Additional Estimates, FADT, 4 June 2003, p. 378.

66 Additionl Estimates, FADT, 4 June 2003, pp. 365,372, 378–379.

67 'in general, anthrax and mencevax may well be administered on the same day at two different locations [ie, vaccination sites on the body]', Additional Estimates, FADT, 4 June 2003, p. 365.

68 'Interactions with other Medicaments and other forms of Interaction. The vaccine should be used alone. There is no evidence for the safe use in combination with other vaccines or medicinal products'. See United Kingdom Ministry of Defence, *Anthrax, Voluntary Immunisation Programme*, *A Guide for Medical Staff*, p. 26, at www.mod.uk/ linked_files/mod_vip_mo_guide

69 *Submission* 9, Defence Organisation, Attachment D, *Immunisation Procedures*, Chapter 5, Section 5.12.

70 See www.avn.org.au/Vaccinations%20/Information/Meningococcal_mencevax

The NHMRC, in the *Australian Immunisation Handbook*, is referred to as stating that it is appropriate to give one of the anti-meningococcal vaccines in conjunction with other items in the Australian Standard Vaccination Schedule (ASVS): 'the vaccine may be administered simultaneously with other vaccines in the ASVS'.[71] However, anthrax is not a part of the ASVS, and the above statement applies only to the Meningococcal C conjugate vaccines (MenCCV), while Mencevax is a Meningococcal polysaccharide (4vMenPV).

It is ironic that the one fact that would have been a sound medical reason for not giving anthrax shots prior to departure—that there was to be an interval after the mencevax shot—was not referred to, although this does not overcome the issue of not providing information on the need for an anthrax vaccination.

Efficacy and safety of the vaccine

Since anthrax and some other vaccines have been used rarely, it is inevitable that there will be concerns about them, well founded or otherwise. Anthrax vaccinations were formerly used mostly by persons working in industries where there was constant contact with animal skins.[72] Because of the limited use, there have been few studies undertaken, and by the time of the 2nd Gulf War, the two studies that had recently been undertaken could not provide definitive information on long term effects. Any difference between exposure from animal skins and militarised anthrax is not mentioned.

The United Kingdom Ministry of Defence website, however, states that:

> Independent medical advice from the MoD's Advisory Group on Medical Countermeasures has confirmed that anthrax immunisation is safe and effective. Anthrax vaccine has been used routinely to protect those at risk from anthrax since 1963 and licensed in the UK since 1979. Many thousands of people, including laboratory workers, veterinary surgeons, abattoir workers and military personnel, have safely benefited from the high levels of protection that anthrax immunisation confers.[73]

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71 See National Health and Medical Research Council, *Australian Immunisation Handbook*, p.167. In this context, 'simultaneously' presumably means 'on the same day as' or 'at the same time as' (although not at the same site, or mixed in with other vaccines).

72 AVA was initially administered on a limited basis, primarily to protect veterinarians and workers processing animal products such as hair or hides that could be contaminated with anthrax spores. The Institute of Medicine, National Academy of Science ran two projects on anthrax, with the following reports: Committee to Review the CDC Anthrax Vaccine Safety and Efficacy Research Program, *CDC Anthrax Vaccine Safety & Efficacy Research Program: Interim Report*, 2001, and Committee to Assess the Safety and Efficacy of the Anthrax Vaccine, *The Anthrax Vaccine: Is It Safe? Does It Work?,* Washington,2002, see *The Anthrax Vaccine: Is It Safe? Does It Work?,* Executive Summary, p.1.

73 United Kingdom, Ministry of Defence, *Anthrax Vaccine*, see www.mod.uk/issues/anthrax/vaccine.htm

Nonetheless, any study of longer term effect and of the interplay of factors such as repeated vaccination, use of other vaccinations and to exposures to other substances in a war zone will take some time to complete and any conclusions can only be described as provisional at this point.

Anthrax vaccinations in the first Gulf War

Some of the concerns raised about anthrax vaccinations related to the first Gulf War although such concerns may have gained strength because of the later controversy about their use in the 2nd Gulf War. According to Defence, no personnel received anti-anthrax shots in the 1st Gulf War, apart from those who were working with US or UK forces who would have followed the vaccination program of those countries.[74]

> We were very aware that a large number of the people who had deployed as a part of the first Gulf War firmly believed that they had received anthrax vaccine as part of that deployment. When that was reviewed, we found that almost none of them had in fact received the anthrax vaccination. There had clearly been a misunderstanding on their part about the vaccines that they had received as part of that deployment.[75]

> In Gulf War I, I think we administered quantities of anthrax vaccine to very small groups of people, mainly those that were involved in the sensitive site examinations. These were specialist teams of personnel whose job it was to go into Iraq after the first Gulf War and seek out weapons of mass destruction sites—also, those who were part of the UN teams that were doing site surveys.[76]

Afghanistan deployment

According to Defence, the anthrax vaccine used for troops deployed to Afghanistan[77] had been obtained from the UK and at one time a batch of this was thought to have been affected by a breach of storage temperature. Some of this vaccine had resulted in high levels of adverse reaction amongst personnel deployed to Afghanistan,[78] and led to the anti-anthrax program for Australian troops in Afghanistan being suspended for two months from November 2001.[79] However, after testing, the vaccine was deemed to be safe. [80] The vaccine had been manufactured in January 2001 and the expiry date was January 2003.[81]

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74 Additional Estimates, FADT, 12 February 2003, p. 37.

75 *Committee Hansard,* p. 61.

76 *Committee Hansard,* p. 62.

77 See Additional Estimates 2002-2003, FADT, *Answers to Questions on Notice*, Question 3, p. 50.

78 Budget Estimates 2003–2004, FADT, 3 June 2003, pp. 376 and 377.

79 *Submission* 9A, Defence Organisation, Q2(b).

80 *Committee Hansard*, p. 56 (Air Commodore Austin).

81 *Submission* 9A, Defence, Q2.

Second Gulf War

The vaccine used for the 2nd Gulf War deployment came from both the US[82] and the UK. The date of manufacture of the UK vaccine used for this deployment was February 2002, with an expiry date of February 2004.Although there were some problems with the UK vaccine, these seem to relate only to a batch used in the 1st Gulf War, and, later, the difficulty in obtaining the required product on schedule. The US vaccine had expiry dates of August 2003, February 2004 and June 2004,[83] which indicates that they were manufactured in 1999 and 2000 respectively, as the US vaccine has a four–year life. The US report on the Safety and Efficacy of the Anthrax vaccine [84] notes that the production of the vaccine was halted in February 1998 as a result of adverse reactions,[85] and the facility was the subject of review. [86] This report is somewhat obscure about the results of the assessment of the production prior to its review:

> The newly produced vaccine is expected to have greater assurance of consistency than the vaccine produced at the time of its original licensure.[87]

The report concluded that the method of vaccination—subcutaneous—and also the number of shots required might account for the adverse reactions, recommending that research continue to develop options for administering the vaccine and to determine if fewer doses could be given.[88] The expiry dates of the U.S. vaccine used in Australia

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82 *Committee Hansard,* p. 59.

83 *Submission* 9A, Defence Organisation, Q2—which means the date of manufacture would have been 4 years previously if the same process was used in post 1998 manufacture—see *Committee Hansard*, p. 60. However, if it had been decanted, the shelf life would have been one year, *Committee Hansard*, p. 58

84 *The Anthrax Vaccine: Is It Safe? Does It Work?,* Executive Summary, p. 1.

85 None of the adverse effects noted from the US vaccine was considered serious, although it is not entirely clear if testing included batches made prior to the review of the manufacturing facility:

After examining data from numerous case reports and especially epidemiologic studies (see *The Anthrax Vaccine: Is It Safe? Does It Work?* Chapters 5 and 6), the committee also concluded that AVA is reasonably safe. 'Within hours or days following vaccination, it is fairly common for recipients to experience some local events (e.g., redness, itching, swelling, or tenderness at the injection site), while a smaller number of vaccine recipients experience some systemic events (e.g., fever and malaise). But these immediate reactions, and the rates at which they occur, are comparable to those observed with other vaccines regularly administered to adults,' *The Anthrax Vaccine: Is It Safe? Does It Work?,* Executive Summary, p. 2.

86 The study was also to address the issue of validation of the manufacturing process, with a consideration of discrepancies identified by the US Food and Drug Administration (FDA) in February 1998, the definition of vaccine components, and identification of gaps in existing research (*The Anthrax Vaccine: Is It Safe? Does It Work?,* Executive Summary, p. 2).

87 *The Anthrax Vaccine: Is It Safe? Does It Work?*, Executive Summary, p. 2.

88 'Finding: The currently licensed subcutaneous route of administration of AVA and the six-dose vaccination schedule appear to be associated with a higher incidence of immediate–onset, local effects than is intramuscular administration or a vaccination schedule with fewer doses of AVA. The frequencies of immediate-onset, systemic events were low and were not affected by

for the 2nd Gulf War indicate that it was manufactured after the review of the faulty manufacturing process, and was therefore less likely to be of a variable standard.

Storage issues

There appears to be some confusion about the effect of vaccines which may not have been maintained at the correct temperature. In evidence it was stated that if this occurs:

> It does not make the vaccine unsafe; it cannot result in any significant adverse impact on the individual. It simply reduces the efficacy of the vaccine. [89]

Nonetheless, once the cold chain has been broken, the loss of efficacy should not be discounted:

> The 'cold–chain' is the system of transporting and storing vaccines within the temperature range of 2°C to 8°C from the place of manufacture to the point of administration. This temperature range is recommended because outside this range vaccines may (very quickly) lose their potency. ***Immunisation service providers should maintain their vaccine refrigerators as close as possible to 5°C, as this gives a safety margin of + or – 3°C.*** Maintenance of the cold–chain system requires that processes are in place to ensure that a potent vaccine reaches recipients.[90]

Although the above statement on there being no adverse effects may be intended to mean only that the individual won't have an *adverse* reaction, a loss of efficacy could be crucial at any stage and would have an 'adverse impact' on the individual in that they may not receive a full primary dose. [91]

There has been little reference to issues of vaccine storage in the inquiry. However, one submission did state that vaccination against anthrax was required for some personnel who had volunteered to work at the Sydney Olympic Games, and that the vaccine provided for them was out of date[92] and may have deviated from cold storage

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the route of administration. Recommendation: DoD [Department of Defense] should continue to support the efforts of CDC [Centers for Disease Control] to study the reactogenicity and immunogenicity of an alternative route of AVA administration and of a reduced number of vaccine doses', *The Anthrax Vaccine: Is It Safe? Does It Work?*, Executive Summary p. 13.

89 Budget Estimates, FADT, 4 June 2003, p. 377.

90 National Health and Medical Research Council, *The Australian Immunisation Handbook*, 8th edition, Canberra 2003, p. 41, emphasis in text.

91 There is also a reference to another storage incident when material was returned to the manufacturer for checking because of a 'minor deviation in temperature' (Senate Estimates, FADT, 3 June 2003, p. 377). Reference to a 'lower' side effect 'profile' (Senate Estimates, FADT, 3 June 2003, p. 378) in this particular case might in fact indicate a reduced efficacy, although the vaccine was found to be both effective and safe. Possibly the deviation in temperature was not beyond the limits recommended.

92 *Submission* 7, Mr Laboo, p. 1.

standards.[93] The same submission also stated that second vaccinations had been prepared two weeks earlier in syringes and stored in a 'travel' fridge,[94] and that no consent form was provided.[95] The *Australian Immunisation Handbook* states that small fridges are those least likely to be able to maintain the stable temperature of between 2–8C required for storage of anti-anthrax and many other vaccines.[96] While larger fridges are acceptable, special vaccine holding fridges are the best option. Of even more importance, no vaccination should be given from a syringe that has been pre-prepared two weeks in advance, when there can be little control over access to the storage unit, and contamination is possible. Although Defence has noted that it now has approval 'to store Anthrax multi–dose vaccine vials for periods of up to 28 days once the first dose has been removed, [97] this is distinct from storing syringes. Out of date vaccines should have been disposed of.

The information in this submission indicates a very low and in fact unacceptable level of medical service provision, well below acceptable community standards. If the information is accurate, any of the ADF personnel who received these vaccinations and went on to serve in the 2nd Gulf War, could have been at risk through not receiving an appropriate level of vaccination. It is also possible that the vaccine, which was from the US, and had an expiry date of March 2000,[98] was from stock manufactured under less than acceptable conditions, since it would have been produced in March 1996.[99]

Did Australian personnel receive an effective measure of vaccination?

Given that anti–anthrax was little used it is not surprising that there was limited awareness of manufacturing and dose details, and the extent of coverage provided by part of the primary dose. Some of this confusion was obvious in the early months of 2003, when questions were asked about the amount of time from the first vaccination before 'effective cover or protection is provided'.[100] There was also uncertainty about the difference between 'effective' and 'maximum' protection,[101] and the number of

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93 *Submission* 7, Mr Laboo, p. 2—reference is made to the vaccine being carried from Sydney to Brisbane in a 'small styrofoam esky'. For information on the use of such items—although within a larger fridge—see *Australian Immunisation Handbook*, pp.42, 46.

94 *Submission* 7, Mr Laboo, p. 2-3

95 The ADF should therefore check the medical file of the relevant personnel to see if the batch is recorded and determine if this batch would be deemed ineffective.

96 National Health and Medical Research Council, *The Australian Immunisation Handbook*, 8th edition, Canberra 2003, p. 41. See also *Submission* 9, Defence Organisation, Attachment ADFP, 1.2.2.1, *Immunisation Procedures*, Chapter 7, p. 7–1, paragraphs 7.1–7.5.

97 See www.defence.gov.au/dpe/dhs/infocentre/anthrax vaccine.

98 *Submission* 7, Mr Laboo, p. 1.

99 The US vaccine manufacturer was the subject of an adverse FDA notice, also followed up by the US General Accounting Office (GAO) on vaccine manufactured up to and including 1998.

100 Additional Estimates, FADT, 12 February 2003, pp. 29–30, 47–48.

101 Additional Estimates, FADT, 12 February 2003, p. 30.

shots in a 'primary' program.[102] Although these issues were raised after the major publicity on anthrax vaccinations in early February 2003, senior ADF officials themselves were unclear on some aspects of the program.[103]

The US vaccine comprises six shots for what is called a primary program, and annual boosters thereafter.[104] The six shots are completed 18 months after the one given at 12 months, so in effect the time for full coverage is two and a half years. The United Kingdom vaccine comprises 4 shots for a complete primary course, three given over 6 weeks, and the fourth at six months after the third shot. Annual boosters are then required. While the first three UK vaccinations are given at 0, 3, and 6 weeks, the US ones are given at 0, 2, and 4 weeks. This may have been the source of some of the early confusion about the date by which some level of protection is available.

Both the US and the UK have argued that their inoculation programs were commenced prior to any specific conflict in order to provide maximum protection. Their emphasis therefore is on the time at which there is 100% protection rather than a level of up to 90%. UK information does not deny that some protection is available earlier, but emphasises that 'fully effective' protection is better and the main reason why troops in the UK are vaccinated as much in advance as possible:

> Immunisation against anthrax takes six months to become fully effective. This is much longer than the warning we might have of a change in the threat, and longer than the time–scales over which our Forces could be asked to deploy to a high–threat area. Therefore, it makes sense to offer it to personnel in advance. Previously, we have offered immunisation against anthrax to personnel deploying on operations to the Gulf and to those in specialist NBC units. We have always kept the scope of the programme under review, contingent on new stocks of the vaccine. Now that new supplies are available, and because we cannot expect to predict exactly where or when a threat might arise, or which units of our Armed Forces might be called upon to respond, we have decided to expand the immunisation programme so that all Service personnel, including reservists and those essential civilians who are likely to deploy on operations overseas, are routinely offered immunisation against anthrax[105]

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102 Additional Estimates, FADT, 12 February 2003, pp. 47–48.

103 See also Commonwealth Department of Health and Ageing, Population Health Division, Q and A on Anthrax , www.health.gov.au, where information relates only to the US vaccine: 'The vaccination itself involves six doses, three given two weeks apart followed by three additional injections given at 6, 12, and 18 months, after the first dose. An annual booster is required to maintain ongoing immunity'.

104 The first three doses are given 2 weeks apart, and the following doses are given 6, 12, and 18 months after administration of the first dose. Annual booster doses are required, Committee to Assess the Safety and Efficacy of the Anthrax Vaccine, *The Anthrax Vaccine: Is It Safe? Does It Work?,* Washington,2002, Executive Summary, p. 5.

105 United Kingdom Ministry of Defence, at www.mod.uk/issues/anthrax/faqs

The phrase 'takes six months to become fully effective' may mean six months from the first vaccination, or six months after the third vaccination. If the latter is meant, it would be more accurate to say 'takes 7.5 months'.

The US claims that full protection is only available after the complete first course of the US vaccine:

> Immunization for our troops is a prudent action. The immunization program will consist of a series of six inoculations per Service member over an 18–month period, followed by an annual booster. Although protection levels increase as shots in the primary series are given; the entire six–shot series is required for full protection, as determined by the FDA.[106]

How many shots are required for elementary protection?

The emphasis by the Australian Defence department, however, is more on acquiring a high, rather than 100%, level of protection. It notes, therefore, the distinction to be made between the completion of the primary schedule and the earlier time by which adequate protection is available:

> Both vaccines provide some protection after the second injection and good protection after the third injection (ie after four or six weeks). If you are exposed to anthrax before you have had your third dose, you may be given antibiotic treatment.[107]

The Australian Immunisation Handbook states that:

> A number of studies suggest greater than 90% production of protective antibodies after the third dose of anthrax vaccine.[108]

Material provided by Defence on the level of protection available after three shots does not make apparent the fact that very few personnel would have received the full primary dose of even the UK vaccine by the time their deployment to the 2nd Gulf War was completed. Since a decision was made to cease the anthrax vaccinations in April 2003,[109] only approximately two months after commencing them, and there was no exposure to anthrax, testing by Australia of vaccine efficacy at particular points in time did not occur. With respect to the number of personnel deployed to the 2nd Gulf War who were vaccinated on more than one occasion, Defence advised that

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106 US Defense Department Report, 22 May 1998, Anthrax vaccination, Partnership for Peace exercises, (1040), *[Secretary of Defense] Cohen Orders Total Military Force Anthrax Vaccination to Proceed'*, www. defenselink.mil/otherinfo/protection.html

107 www.defence.gov.au/dpe/dhs/infocentre/anthrax . The consent form dated 29 January 2003, which refers to both the UK and the US vaccines, is misleading when it states 'primary schedules' are complete at 18 months, which is true only of the US vaccine (Attachment A, document 1, p. 3, paragraph 14).

108 National Health and Medical Research Council, *The Australian Immunisation Handbook* ,8th edition, Canberra 2003, Part 2, p. 82. The reference immediately before was to the US vaccine.

109 Senate Estimates, FADT, 4 June 2003, p. 382.

353 personnel received two doses of anthrax vaccine, 2,263 received three doses, and 17 previously vaccinated (and presumably having received a full primary course) received a booster.[110] It is assumed that the 2,263 persons who received three doses would have had 90% protection. The alternative is that they had received one shot for the Afghanistan conflict and then two shots, although this would have meant some considerable delay between the first and second shots. The 353 who received two shots may have been deployed later, with the program ceasing before the third shot was due.

There is no specific reference in the Defence submission to the post deployment follow up of vaccine programs, and it is not clear if anyone who received the first three shots completed the program upon return.[111] Those who had received the US vaccine were likely to need another three shots, and those who received the UK vaccine may have needed at least the final one. Annual boosters would continue the immunity conferred by a full course. According to Defence, incomplete vaccination courses are generally continued where they had been left off,[112] so that a person who had missed the six-month shot of the UK vaccine would be given this, and then proceed with the booster one year later.

On its website, Defence states that:

> You must complete the primary schedule for your vaccine type. If a longer interval than that recommended in the schedule has elapsed since your last dose, you should resume the schedule, extending the times according to the schedule.[113]

Although this issue may be one of particular concern for current personnel, it is one which would also affect reservists since they would need to keep track of their immunisation status, and are not necessarily aware of whether they received the US or the UK vaccine.

Accuracy of vaccination records

In its submission, Defence stated that JHSA was responsible for 'conducting the majority of inoculations'[114] and that 'a database of non–standard vaccinations administered (for example anthrax and smallpox) is held at HQAST.[115] It also states that 'all vaccines administered to ADF personnel are recorded in medical documentation and that 'DHSB has a responsibility to retain details of ADF personnel

110 *Submission* 9A, Defence Organisation, Q5.

111 See above, Chapter 2, paragraph 2.58.

112 *Submission* 9, Defence Organisation, Attachment D,

113 www.defence.gov.au/dpe/dhs/infocentre/anthrax vaccine.

114 *Submission* 9, Defence Organisation, p.3, paragraph 11.

115 *Submission* 9, Defence Organisation, p. 5, paragraph 22.

who are administered any vaccine not registered with the Therapeutic Goods Administration, including batch details'.[116]

> The requirement is that, if an ADF member receives a vaccination, that information is to be recorded in the member's international certificate of vaccination—ICV. That is an international document. Whilst it comes out rebadged under an ADF number, it follows international policy requirements.[117]
>
> There is a second part to the recording of the information and that is that an entry should be made into the member's medical record onto one of the running sheets in that record. So there are actually two points of entry of information—which should in fact say exactly the same thing. It should show the nature of the vaccine, the brand name, the dosage, the date of administration and the batch number. That is the obligatory information that is recorded.[118]

Other information suggests that this has not always been the case. The submission referred to above on out of date vaccines also noted that there was no consent form available,[119] and that this form was said to have been 'no longer in use' (in 2000). However, this may have been an anomaly, with the Olympic Games not being seen as a deployment. The situation with respect to this case, including any lack of accurate recording of information, such as batch details, is best dealt with through an assessment of the safety and efficacy of the material used.

Another submission stated that some vaccinations in the First Gulf War had only been recorded on the WHO form (the ICV) and not on the personal medical file.[120] However, there seems to be no reason why such information could not be transferred to the personal file, including in cases where non-standard vaccines may have been given because the individual was working under other forces.[121]

A third instance was stated in the Redress of Grievance document, where it is claimed in respect of *Kanimbla* personnel, that:

- 10(d) Only the date of vaccination not the shelf life or batch number were recorded.
- (e) The shelf life of the vaccination and the batch number are unable to be provided because these were not recorded. The vaccines were checked at the time of inoculation to ensure they were in date and the

116 *Submission* 9, Defence Organisation, p. 6, paragraph 26.

117 *Committee Hansard,* p. 60.

118 *Committee Hansard,* p. 61. See also *Submission* 9, Defence Organisation, Attachment D, Chapter 2, Sections 2.24–2.26.

119 *Submission* 7, Mr. Laboo, p. 2.

120 *Submission* 5, Regular Defence Force Welfare Association, p. 3, paragraph 17.

121 *Committee Hansard*, p. 62.

batch number was recorded on the packaging or the ampoules which were destroyed after vaccination.

- (f) The batch number of vaccinations is sometimes recorded but there is no strict requirement to do so… Rarely will [the batch number] be used in post retail recall of medications and there has been no recall by the manufacturers of any batch numbers of Anthrax vaccine used by the ADF.[122]

Strictly speaking, there may have been no manufacturer's recall of the UK vaccine, but there have been instances in which a check has been initiated by others, including in the United Kingdom with batch No. 348E, during the first Gulf War.[123] However, the statement that there is no requirement to record the batch number is inaccurate. This statement was written in January 2004, but it was stated in February 2004 that this information was incorrect and that the batch numbers had been recorded.[124]

Another concern with medical records is whether data are available on the need for additional shots or boosters, and whether there is currently in place a system which produces such information. It is apparent from the information on HealthKEYS that this will operate in the future, but in the meantime there is a need for accurate records for individuals.

Assessment of information overall

The anthrax vaccine issue highlights some problems, including the ease with which misinformation can circulate. One of these is that it is important for long term credibility to make accurate statements about what is and is not known about unusual vaccinations, as the available information provided by various sources can be misleading if not seen within context.

Issue of long term safety of the vaccine

Although some work was undertaken in the 1960s and later on the effect of vaccine on textile mill workers in limiting anthrax,[125] the anthrax they may have been exposed to was not a militarised form.[126] In these circumstances, to say that there are no data

122 Redress of Grievance, p. 3, paragraphs 10 (d), (e) and (f).

123 United Kingdom, Ministry of Defence, *Background to the use of Medical Countermeasures to protect British forces during the Gulf War (Operation Granby)*, at www.mod.uk/issues/gulfwar/info/medical/mcm. It had been decided that ' use of pertussis as an adjuvant could significantly reduce the numbers and severity of casualties in the event of an anthrax-based BW attack,' paragraph 51.

124 Additional Estimates, FADT, 18 February 2004, p. 62.

125 *The Anthrax Vaccine: Is It Safe? Does It Work?,* Washington,2002, Executive Summary, pp.9–10.

126 See www.defence.gov.au/dpe/dhs/infocentre/anthrax: 'As a biological weapon, anthrax bacteria would be released into the air in invisible clouds that when inhaled by personnel would infect them with anthrax. The first symptoms of this type of 'inhalational' anthrax would

demonstrating long–term effects may easily be read as meaning 'there **are** no long term effects'. Even the comment that 'the literature on safety suggests it is a safe vaccine'[127] would have to be read with caution, bearing in mind the very recent date of the studies on long term outcomes.

Both Defence and the Repatriation Commission state they are not aware of 'any research that suggests there are long–term harmful effects from anthrax vaccinations',[128] but this view must also be seen within the context of research based on the 1st and 2nd Gulf Wars. Both are too recent to provide information on effects that may not occur for some time, and may also be affected by interaction with other vaccinations and exposure to other substances. The response by the AMA to the Department of Health's statement was more cautious:

> I don't think we have enough data in the medical press, certainly in the peer reviewed medical journals, that would convince medical practitioners in Australia of the safety and efficacy of this vaccine'. And 'If they [the ADF] have that data, [that the vaccine was safe] the medical profession in Australia would very much like to see it.[129]

The US report on the safety of anthrax vaccinations, though generally positive, also noted that there was insufficient epidemiological evidence:

> The committee found no evidence that vaccine recipients face an increased risk of experiencing life–threatening or permanently disabling adverse events immediately after receiving AVA, when compared with the general population. Nor did it find any convincing evidence that vaccine recipients face elevated risk of developing adverse health effects over the longer term**,** although data are limited in this regard (as they are for all vaccines).[130]

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generally appear within a week (typically 2–3 days) and include flu–like symptoms, general lethargy and mild fever. Without treatment, these would quickly progress to serious breathing difficulties, collapse, shock, and, in almost all cases, death'.

127 *Committee Hansard*, p.75. See also interview with then AMA President Kerryn Phelps, 14 February 2003, at www. abc.net.au/am/s784207.htm, see Attachment A, document 2.

128 *Committee Hansard,* p. 75.

129 www.abc.net.au/am/s784207.htm—

130 Committee to Assess the Safety and Efficacy of the Anthrax Vaccine, *The Anthrax Vaccine: Is It Safe? Does It Work?,* Washington,2002, Executive Summary, p. 2.

ATTACHMENT A

Document 1: Copy of consent form dated 29 January 2003

Version: 29-Jan-03
Page 1 of 4
Unit
Number
Rank
Surname
Given Name
Date of Birth Sex

CONSENT FORM FOR ADMINISTRATION OF ANTHRAX VACCINE

I, ...
(full name)

hereby consent / do not consent * to the administration of Anthrax vaccine for myself.
(* Strike out whichever is not applicable)

In addition I confirm that:

- I understand that this product is not registered by the Therapeutic Goods Administration for sale in Australia but it has been approved for importation;
- I have read the information provided on pages 2–4, relating to the use of Anthrax vaccine and have understood the information presented;
- I have discussed the use of the above with the medical officer and been given the opportunity to ask questions;
- I understand that I may refuse to accept Anthrax vaccine without prejudicing my medical care but that I may not be eligible for operational deployment; and I have signed this form in the presence of an ADF Health Care professional.

Signed:..... Date:.....

I confirm that I have discussed the relevant products with the above named.

Signed:..... Date:.....

Printed Name:.....

Position/Designation:.....

ANTHRAX IMMUNISATION INFORMATION SHEET

WHAT IS ANTHRAX?

1. Anthrax is a serious illness caused by the bacterium, *Bacillus anthracis.* It is primarily a disease of plant-eating animals - cattle and sheep being common hosts. Human infection with anthrax can result in death, even with the best available treatment.

2. It is not a new disease, having been recorded from around 1500 BC. During the 1930s, extensive research was conducted in Germany, Russia, and Japan toward the use of anthrax as a biological weapon. During World War II, several countries produced anthrax, yet Japan was the only country to use it as a biological warfare agent. Since 1945 several countries have developed anthrax as a biological weapon, including the former Soviet Union and Iraq.

HOW IS IT SPREAD?

3. Human infection with anthrax can be caused by direct contact with products from infected animals (hides, hair or wool), eating infected meat or inhaling anthrax spores. Natural infection through direct contact or ingestion is very uncommon due to widespread measures to control the disease. The greatest threat from anthrax for ADF personnel is inhalation of aerosol spores produced as a biological warfare agent.

WHAT HAPPENS TO PEOPLE WHO ARE INFECTED WITH ANTHRAX?

4. There are two main forms of anthrax, cutaneous (skin) and inhalation, based on route of entry to the body. The incubation period for anthrax is usually 1 to 7 days, with most cases occurring within 2 days of exposure. The incubation period for inhalational anthrax has been recorded up to 60 days. Inhalational anthrax results in death in 90—100% of cases.

5. The first symptoms of inhalation anthrax are flu-like symptoms such as sore throat, mild fever, chest pain, cough and muscular pain. Within 2 to 3 days, serious breathing difficulties, collapse and shock develop. Death occurs within 24 to 36 hours of development of these serious symptoms.

CAN PEOPLE WITH INHALATION ANTHRAX BE TREATED?

6. After exposure to anthrax, treatment with antibiotics may be effective in preventing disease if it is begun before the onset of any symptoms. To be optimally effective, preventive treatment should be started within hours of exposure. As aerosol spores are invisible, tasteless and odourless, personnel may be exposed without their knowledge. Once symptoms have started, the efficacy of antibiotic treatment is very poor. If not treated immediately and aggressively in a state–of–art hospital centre, once severe symptoms develop, 45% to 80% of patients will die.

DO INFECTED PERSONS SPREAD THE DISEASE TO OTHERS?

7. Anthrax is not spread from person to person.

WHY IS ANTHRAX AN EFFECTIVE BIOLOGICAL WARFARE AGENT?

8. Anthrax bacteria are capable of forming spores, which are thick walled inactive forms. Bacterial spores may survive quite extraordinary extremes of temperature, dehydration or chemical insult. Spores are easily stored and remain dangerous for a long period.

9. Anthrax spores are well suited for delivery by missiles or bombs. They can also be dispersed by small devices using explosives, generators that use either explosives or compressed air, or spray devices. Anthrax would most likely be dispersed in aerosol form.

HOW CAN ANTHRAX INFECTION BE PREVENTED?

10. The single best way to protect against many life–threatening diseases is via vaccination. Vaccines work by stimulating the human body's natural defences to prevent the development of a disease if later exposed to it.

IS THERE MORE THAN ONE TYPE ANTHRAX VACCINE?

11. Two types of anthrax vaccine are available for ADF personnel, one made in the United States and the other made in the United Kingdom. These vaccines are equally effective in preventing anthrax infection. Although each vaccine is approved for use in its country of manufacture, the Therapeutic Goods Administration (TGA) has not registered them for general use in Australia. TGA has, however, approved the importation and subsequent administration of these vaccines to ADF personnel and for other persons, such as veterinary surgeons, considered being at–risk. Vaccination should be completed with the one type of vaccine, as the vaccines are not interchangeable.

HOW EFFECTIVE ARE THE VACCINES?

12. No vaccine provides 100% protection. However, the available evidence indicates that both types of vaccine provide equally effective protection against anthrax.

HOW QUICKLY DO THE VACCINES PROVIDE PROTECTION?

13. Both vaccines provide some protection after the second injection and good protection after the third injection (ie after four or six weeks). If you are exposed to anthrax before you have had your third dose, you may be given antibiotic treatment.

HOW LONG DOES PROTECTION PROVIDED BY ANTHRAX VACCINES LAST?

14. In order to maintain immunity, personnel require a booster vaccine dose each year after completion of the primary schedule. The primary schedules are complete at the 18 month injection.

WHAT HAPPENS IF I HAVE ALREADY HAD SOME VACCINE DOSES?

15. You must complete the primary schedule for your vaccine type. If a longer interval than that recommended in the schedule has elapsed since your last dose, you should resume the schedule, extending the times according to the schedule. Additional doses to compensate for any delay are not required.

CAN I GET ANTHRAX INFECTION FROM VACCINATION?

16. Neither type of anthrax vaccine contains live bacteria. Therefore, they do not introduce any form of anthrax infection.

WHAT ARE THE POSSIBLE ADVERSE EFFECTS OF THE VACCINES?

17. **Local reactions.** Reactions at the injection site usually last from one to three days and go away without treatment. Redness, itching, and/or swelling, occurs in up to one third of men and up to two thirds of women following anthrax vaccination. Such reactions are usually only small but in rare cases may be up to 13 centimetres in diameter. Soreness or local pain occurs in up to one fifth of persons vaccinated. A lump at the injection site is common, occurring in up to 90% of people vaccinated. The lump may persist for a few weeks.

18. **Systemic reactions**. Reactions away from the injection site occur in up to one third of people vaccinated. These reactions may include muscle aches, joint aches, chills, low–grade fever, decreased appetite, headaches, nausea, and swollen glands. They usually go away in a few days.

19. **Acute allergic reactions.** These reactions, which may be severe, are very rare (about 1 in 100,000) but may occur with anthrax vaccines, as with any vaccine. There is no evidence that other types of serious reactions occur with either type of anthrax vaccine.

WHAT DO I DO IF I EXPERIENCE ADVERSE EFFECTS?

20. You should avoid strenuous exercise for at least 48 hours following local or systemic reactions. You should report to your ADF Health Care professional for further advice. Treatment will not usually be required. It is very unlikely that you will not be able to complete the schedule.

WHO SHOULD NOT HAVE ANTHRAX VACCINATION?

21. The following should not have anthrax vaccine at all:

a. Persons who have had an acute allergic reaction to a previous dose of anthrax vaccine or to any of the vaccine's components,

b. Persons younger than 18 or older than 65,

c. Persons who are HIV positive.

22. Vaccination should be temporarily deferred in the following circumstances:

a. Pregnancy, suspected pregnancy,

b. Women who are breast feeding,

c. Active infection/illness with fever,

d. Depressed immune response, including corticosteroid or other immuno–suppressive treatment.

IS THE VACCINE COMPULSORY? WHAT HAPPENS IF I DON'T HAVE IT?

23. Anthrax vaccination is not compulsory. However, if the Joint Health Support Agency Health Support Plan for a particular operation indicates that Anthrax vaccination is a requirement, personnel who decline vaccination may not be considered eligible for deployment to that operation.

ARE ANTIBIOTICS AN ALTERNATIVE TO VACCINATION FOR PREVENTION OF ANTHRAX?

24. No. Long-term antibiotic treatment is not an acceptable alternative to vaccination because it is less effective in preventing infection and has unacceptable side effects.

ONCE I HAVE BEEN VACCINATED, DO I NEED TO DO ANYTHING ELSE TO PROTECT MYSELF AFTER EXPOSURE TO ANTHRAX?

25. Even when fully immunised, antibiotics may be still indicated after aerosol exposure, to achieve survival as close to 100% survival as possible.

WHERE CAN I GET FURTHER INFORMATION?

26. Ask your ADF Health Care professional, as there is a great deal of information available.

Document 2: ABC Radio interview of Dr Kerryn Phelps

Navy message to soldiers

AM—Friday, 14 February, 2003, 00:00:00

Reporter: Jo Mazzocchi

LINDA MOTTRAM: Meanwhile, faced with the dissent within the ranks, the Chief of the Navy, Vice Admiral Chris Ritchie, has been forced to take the highly unusual step of delivering a message to all serving Australian Navy personnel that the anthrax vaccine is safe.

But now, Australia's peak medical lobby group, the Australian Medical Association, has joined those taking the opposite view, in a contribution that will only complicate life for Australian defence personnel caught in the middle of the debate with life and death issues looming.

Jo Mazzocchi reports that Vice Admiral Ritchie has also publicly rebuked the young sailor who told the media of his concerns about taking the anthrax vaccine.

JO MAZZOCCHI: The Chief of the Navy rebuked the young sailor, Able Seaman Simon Bond, who sparked this controversy, by saying that the types of breaches that have occurred in the last twenty four hours "create far greater upset for families for our people than they are of any help to either individuals or your mates".

But judging by the depth of public confusion over this issue, some might disagree, claiming Able Seaman Simon Bond has in fact done them a favour.

The Australian Medical Association says the sailor has acted as a catalyst on the issue.

AMA President Dr. Kerryn Phelps.

KERRYN PHELPS: Look I think that raising issues and speaking about the concerns that his colleagues have is not really causing any harm.

I mean if what this does is act as a catalyst for the Defence Forces to release the information that they have about safety and efficacy then I think it would have done a power of good.

JO MAZZOCCHI: Today in Sydney, there are more farewells for the final deployment of defence personnel to the Gulf.

It is now believed vaccinations are being carried out before they leave, but defence sources are refusing to confirm that.

In his message, the Vice Admiral also stressed that the anthrax vaccine is safe, saying it has been very widely used with no greater incidence or side effects or risks of complications than those associated with any other vaccine.

And that's a view shared by Australia's Chief Medical Health Officer, Professor Richard Smallwood, who says the vaccine is regarded as safe and effective.

But Kerryn Phelps is not convinced.

KERRYN PHELPS: I don't think we have enough data in the medical press, certainly in the peer reviewed medical journals, that would convince medical practitioners in Australia of the safety and efficacy of this vaccine.

The truth is sometimes difficult and I'm not in the business of propaganda, what I'm about is to express what I believe is the medical profession's view on this particular incident.

JO MAZZOCCHI: So there's no clear cut, definitive study either way?

KERRYN PHELPS: Not that the peer reviewed medical literature has available to it.

JO MAZZOCCHI: When the Chief of Navy Vice Admiral Chris Ritchie sends out a message and says the vaccine is safe and effective, what is your response to that?

KERRYN PHELPS: If they have that data, the medical profession in Australia would very much like to see it.

LINDA MOTTRAM: AMA President Kerryn Phelps speaking to our reporter Jo Mazzocchi.