Senate Foreign Affairs, Defence and Trade References Committee

SUBMISSION COVER SHEET

Inquiry Title: Defence Health Arrangements Prior to Deployment

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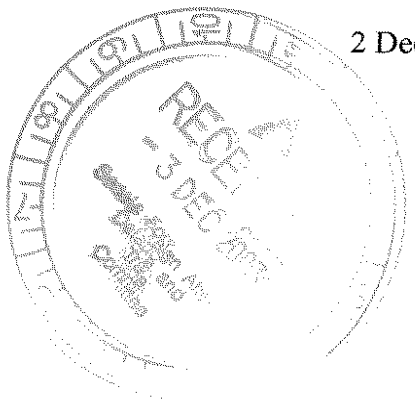
Ref: 65.27
2 December 2003



Mr Brenton Holmes
Secretary, FADT Reference Committee
Parliament House
CANBERRA ACT 2600

Dear Mr Holmes,

INQUIRY INTO CURRENT HEALTH PREPARATION ARRANGEMENTS FOR THE DEPLOYMENT OF AUSTRALIAN DEFENCE FORCED OVERSEAS

On 26 November 2003 this Association forwarded a submission to you regarding the above inquiry. As I explained to a member of your staff this morning, we would like to make some changes to our submission. Attached is the replacement submission and I request you delete all reference to our earlier submission on this matter.

I apologise for the inconvenience this might involve.

Yours sincerely,

John A Paule
National Secretary

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INQUIRY INTO CURRENT HEALTH PREPARATION ARRANGEMENTS FOR THE DEPLOYMENT OF AUSTRALIAN DEFENCE FORCES OVERSEAS

SUBMISSION BY

THE REGULAR DEFENCE FORCE WELFARE ASSOCIATION

Background

1. The Regular Defence Force Welfare Association (RDFWA) was formed in 1959 to promote and protect the interests of serving and former members of the Regular Defence Force, their spouses, dependants, widows and widowers. The Association provides advice and advocacy services to serving and retired regulars, and their families, who may have a claim under military compensation, veterans' entitlements, or superannuation legislation or regulations. Our organisation is federally based with branches throughout Australia. We have over 6000 members but our constituency is of the order of 300,000. The RDFWA is not a union and is staffed by volunteers except for a paid, part-time, national secretary. The Association does not become involved in the general defence debate, limiting our activities to welfare matters.

The Inquiry

2. 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. The comments in this submission should be viewed as a constructive commentary designed to ensure the best health outcomes for all Australian servicemen and women. The Terms of Reference are addressed seriatim.

(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.

3. Recent statements in the publicly accessible literature have given examples where the ADF has not been adequately prepared for overseas deployments. The following are indicative and if these are

in the public domain it would be reasonable to suspect that other deficiencies have either not been assessed or are not available outside the Defence Department.

4. With respect to the ADF's ability to undertake aero medical evacuation an "analysis of cases from May 200 to January 2002 demonstrates that ADF medical officers may not be adequately trained in various aspects of medicine to provide appropriate care to both ADF and civilian personnel and may not meet civilian standards. ADF personnel are required to do several courses prior to deployment but often are deployed without these prerequisites. Permanent medical officers are also often not as clinically competent as their civilian counterparts. The issue of competency and training needs to be addressed for current and future operations where the increased incidence of small-scale operations other than war has reduced the ADF health support capability. The paucity of combat casualties since Vietnam has decreased the requirement for a first class highly specialised aero medical retrieval and resuscitation team." (1).

5. Another article discussed the malaria attack rates on six Australian infantry battalions that had served in East Timor and noted that preventive medicine assets, including personnel, equipment and consumable items were in short supply for the early forward units in INTERFET. Subsequent units have deployed with larger and more robust integral preventive medicine assets (2).

6. The preceding appear to be two examples where an operational health capability was allowed to run down while aspects of ADF health capability were civilianized as a short term cost cutting exercise.

7. These capabilities, when required at short notice, are difficult to recreate. Therefore more thought must be given to areas where the civilian sector may not be able to be utilised, and where knowledge and expertise is required to be an ADF core function.

8. In the 1991 Gulf War conflict the RAN had up to date in house expertise to advise the command of the potential for casualties from chemical and biological weaponised agents. This was as a result of a past program of selected medical officers having had significant training and experience both within the UK and USA in this field. The program continued after this conflict and the availability of this pool of expertise allowed Australia to contribute personnel to the UNSCOM missions in Iraq that supervised the destruction of the Iraqi weapons arsenal. This was a significant contribution that Australia could make to the UN. Australian personnel gained from participation in these UNSCOM missions by building on their own knowledge.

9. In 2003 the last of the Navy medical officers to have been involved in such programs resigned from full time service. Although this expertise may be still available in the Reserve Force, it is understood that the previous pattern of overseas training or exchange programs that resulted in the ADF having its own core expertise in the important medical aspects of NBC warfare have not been continued. This is despite the fact that the threat of the use of such weapons has increased significantly in its spread and sophistication.

10. Such in-house expertise is essential if Australia is to maintain a capacity for its own evaluation of threats. It would appear that the ADF command acknowledged this deficiency when assurances about the safety of anthrax vaccinations were issued under the authority of the Chief Medical Officer of Health of the Commonwealth rather that that of the Surgeon General ADF.

11. In addition to planning countermeasures for familiar threats such as infectious diseases, injuries and psychological trauma, consideration must also be given to hazardous environmental exposures, potential interactions of different exposures, and medically unexplained illnesses.

12. Whereas Australian-led missions have the ability to ensure that Australian standards of documentation, vaccination policy and health surveillance can be implemented, there are doubts whether these would be applicable in situations where Australian personnel are embedded in allied or UN operations. In a UN operation, in which the responsibility for health is entrusted to another nation, there are few, if any, assurances that Australian standards will be enforced. For example, where policy decisions are taken by foreign command authorities, as was the case when US CENTCOM decided that the principles of *informed consent* were not to apply to medical treatment and prevention, Australian personnel attached to US forces in the Gulf conflict would not have had the principles of *informed consent* available to them.

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

13. The First Gulf War elicited examples of war syndromes and, as a result of inadequate records of exposures to environmental and drug exposure, misunderstanding and doubts in the minds of veterans of that conflict inevitably resulted.

14. One of the main obstacles in resolving many of the Gulf war health questions was the lack of individual data on exposures during deployment and health status before and after deployment

15. It is not only a problem for deployed forces but also in the Australian mainland in peacetime service that diseases can occur as a result of occupational exposure. The ongoing health problems of RAAF maintainers involved in the F-111 deseal/resreal process at RAAF Base Amberley and the inadequacy of health and personnel records detailing exposure history is but one example. The death of four aircraft maintenance sailors at NAS Nowra many years ago is another example. Although it is understood that Defence now maintains more detailed records of hazardous substance exposure than it did in the past, there does not appear to be one agency in the Department that links these with personnel records.

16. All personnel deployed should have mandatory health surveillance incorporating exposure data and accurate medical record keeping. Although it is understood that the ADF is presently updating its medical record system to an electronic record, it is not known what capabilities there are in this system for it to be totally embraced in a deployed situation. The concept of an electronic *smart dog tag* needs close study.

17. An aim must be for each military member to have a comprehensive lifelong computer based patient record of all illnesses and injuries, medical care, immunizations, prophylaxis and exposures to potential health hazards. They should be standardized to avoid the situation experienced by some in the First Gulf War who had immunizations recorded only on their WHO booklet and not in their medical documents. Some prophylactic drugs were not recorded at all on medical documentation as the administration of some drugs was a command initiated action and not an exclusively health one.

18. Whereas Australian-led missions have the ability to ensure that Australian standards of documentation are implemented, there are doubts whether this is the case where Australian personnel are embedded in allied or UN operations. We have been advised that Australian personnel who were treated in the UN hospital at Dili in recent deployments to East Timor have been unable to obtain copies of their treatment records from that hospital.

19. The decision to vaccinate Australian personnel who had already deployed may be indicative of a lack of early medical input at the highest level of the military planning process. This points to a lack

of experience in the command, which ought to be cognisant of the need to involve health planning at a very early stage, or to a lack of experience within the personnel in Defence health, or both.

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

20. The anthrax vaccine controversy in 2003 demonstrated the challenges of risk communication on issues involving the health of ADF personnel and their families. The instant availability of information, whether factual and soundly based, or more or less unsubstantiated, on the Internet means that Defence must be pro-active in providing accurate health information. Highly educated members expect detailed information that affects their health. This includes servicewomen whose health profiles are different to their male colleagues.

21. 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.

22. As the Commander of the *Australian Surface Task Group* in the Gulf from October 2002 - April 2003 noted recently:

> *"It is difficult to encapsulate the anthrax saga in the Journal. It is also impossible to capture the emotion and heat it generated. The implementation of a voluntary policy that required compulsory compliance to deployed personnel was inevitably difficult in deployed units. The implementation was aggravated by a combination of unreliable communications and an incomplete education program... the vast majority of those who refused to be injected were sincere in their conviction. This issue highlighted our sailors' great strength, that is, that they are intelligent and questioning people."* (3)

(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

23. Certain medical countermeasures were considered to be used in the Gulf wars that may not have had the appropriate license cover under the Therapeutics Goods guidelines

24. It is understood that the Defence view is that a need to use an unlicensed product may reflect an over-riding need to protect troops against a specific threat in the absence of an appropriate licensed alternative.

25. There is a need to establish clear guidelines to be used in the future as to what is the Department's moral and legal duty to Australian personnel in such cases and with it the obligation for a clear policy on informed consent. Relevant to the establishment of such guidelines is the need for highly qualified medical officers within Defence to advise the command in this area. See paragraphs 10 and 11 above.

(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

26. The full benefit of increased medical and environmental surveillance will be realized only if medical record keeping and data access are improved within Defence and compatible with DVA systems. An integrated information system, which collects all health and exposure data, translates data into useable formats and makes it available, is needed.

27. The Repatriation Medical Authority (RMA) represents a potentially valuable resource, not only to DVA and the Veteran community. In a wider context than that within which they at present operate - monitoring and analysis of epidemiological and other studies of factors that can be considered to cause and to aggravate diseases that arise out of military service - their capability could be applicable to future deployments. 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 under the Veterans' Entitlement Act. 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.

28. Some veterans of the First Gulf War have expressed the view that 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. Indeed, the Monash Study team in the *Gulf War Health Study* noted:

> *"The lack of actual incidents should not minimize the significance of stressors described more commonly by Australian Gulf War veterans."* (4)

and in a recent editorial in the *Journal of the Australian Defence Health Service* there is the conclusion that:

> *"The Gulf War, with its peculiar threats of chemical and biological warfare, left in its wake novel patterns of physical and psychological morbidity demanding exploration."* (5)

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 out-sourcing of Defence health services to a civilian health population that has had no experience of Defence service. This is in contrast to the situation in the past where civilian health specialists that the ADF employed were either currently serving members of the Reserve Forces or had had personnel experience in WW2 or Vietnam. The same could be said for the DVA and the RMA. The first recommendation of the *Australian Gulf War Veterans Health Study 2003* was that:

> *"There should be wide promotion of the study findings to the veteran and service communities, the Departments of Defence and Veterans' Affairs, the Repatriation Commission..."*

To date, some six months after 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 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'.

30. The ADF Health system in conjunction with DVA should implement an improved strategy to address medically unexplained systems in service members that includes education of care providers and identification of such symptoms as they develop in veterans.

(f) The adequacy of the current research effort focusing 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

31. Improved countermeasures to protect personnel from a wide range of health risks are essential. Obviously the size of the ADF limits the extent of research that can be undertaken to ensure self-sufficiency but it is essential that information be shared between our allies. The newly established *Centre for Military and Veterans Health* (CMVH) should have a major role in this research effort. However, being a civilian organisation there is also a need for a group within Defence to maintain effective links with our allies in accessing research data which may have security implications and which would not be available to the civilian academic community of which the CMVH will be a part.

32. One of the CMVH's tasks should be to identify research gaps in military deployment health and commission new research to fill these gaps.

33. Although funded by Defence and DVA, it is essential that the academic integrity of the CMVH be seen as independent in order that it may arrive at conclusions and recommendations that might be politically difficult or unpopular. External peer review is crucial to its operations. A demand for a scientific investigation initiated by the ex-service or veteran's community should be just as easily undertaken as one initiated by Defence itself provided that each has merit.

Additional Submission

34. In recent Australian deployments there has been an increased use of Reservists either in small groups or as individual components of a regular force. On their return to Australia these reservists lose their ready access to military health care because only actively serving personnel are eligible for full health care benefits unless they can establish an entitlement under the Veterans Entitlements' Act.

35. In 1998 the United States Congress enacted legislation that allows the US Veterans Administration to provide health care for a two-year period to US service members that have been involved in military conflict. This two years period aids in the diagnosis of specific health questions such as illnesses that are difficult to explain or that may have arisen because of particular exposures or experience. It has the advantage of veterans being treated by physicians that are more likely to be aware of conditions that may be attributable to military service. It has the added bonus for a period of collection of basic health information in a standardised form that may be useful in future health studies. A similar example of this type of approach has recently been adopted by Defence and DVA in offering medical treatment for former RAAF members who were involved in the F111 deseal/reseal process pending the outcome of the health study and without the necessity of having a claim accepted. Such an approach has the advantage of this group being able to access treatment from health providers who are much more aware of the circumstances surrounding their health problems than would be the case if they were reliant on their local practitioner.

36. Such a policy goes some way to ensuring that attending physicians have some knowledge of the unique occupational and environmental background of service members that may not appear so relevant in the isolation of civilian practice. In the simplest of scenarios, a civilian health professional

that treats a Reservist who has returned from overseas operational service may not associate the early symptoms of malaria or stress related symptoms associated with a deployment where no casualties were sustained but where dangers may have been real.

37. The RDFWA recommends that all Australian Reserve personnel deployed overseas have access to health care either from the Defence Department or through Veterans Affairs medical arrangements for a two year period post return from deployment and that this should also be extended to all personnel who discharge from the ADF within a two year period following return from deployment.

References:

1. Cook S and Fredericksen S. *Aeromedical Evacuation Issues in East Timor – The Implications for Deployment: Australian Military Medicine Vol 12, p 22, 2003*

2. Kitchener and Warwarek. *Operational Malaris in East Timor: Six Battalions Later. Australian Military Medicine Vol 11, p 30, 2002*

3. Jones P D. *Maritime Interception Operations. Screen Commander in the Gulf. Journal of the Australian Naval Institute, No 110, p13, 2003*

4. *Australian Gulf War Veterans Health Study 2003, p200*

5. McFarlane A C. *Military Mental Health in the 21st Century. ADF Health Vol 4, April 2003*