Senate Foreign Affairs, Defence and Trade References Committee

SUBMISSION COVER SHEET

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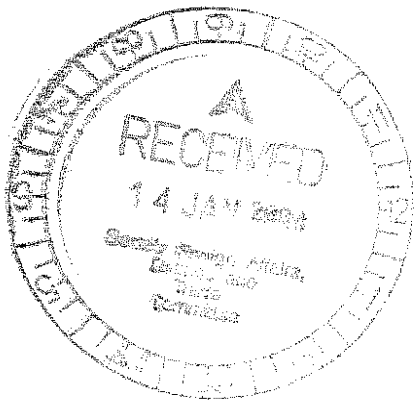

SRA 2/2003

13 January 2004

Mr Brenton Holmes
Secretary
Senate Foreign Affairs, Defence
and Trade References Committee
Parliament House
CANBERRA ACT 2600

Dear Mr Holmes

Attached is the Defence submission into the Committee's inquiry into current health preparation arrangements for the deployment of Australian Defence Force personnel overseas. The submission has been approved by the Minister Assisting the Minister for Defence.

Yours sincerely

Tony Corcoran
Director
Statutory Reporting and Accountability

SUBMISSION TO THE SENATE FOREIGN AFFAIRS, DEFENCE AND TRADE REFERENCES COMMITTEE

HEALTH PREPARATION ARRANGEMENTS FOR ADF OVERSEAS DEPLOYMENTS

The Defence Health Service

1. The Defence Health Service consists primarily of the Defence Health Service Branch (DHSB), the Joint Health Support Agency (JHSA) and operational health units. The DHSB forms part of the Defence Personnel Executive and is responsible for health policy, resource management, capability development and health planning at the strategic level. JHSA coordinates the provision of garrison health support across Australia. The majority of the operational health units come under single service command arrangements, exercised through the Maritime, Land, Air and Special Operations components. In terms of providing health support to operations, these units provide the deployable health care. The DHSB and JHSA organisational structure are at annexes A and B respectively.

Health Support to ADF Operational Deployments

2. At the commencement of operations, DHSB staff conduct strategic level health planning. As such, they shape and influence the key components of the operational health plan by contributing to the Strategic Guidance provided by the CDF to his Operational Commander, the Commander Australian Theatre (COMAST). COMAST staff at HQ Australian Theatre (HQAST) then conduct operational level planning and oversee the implementation of the operational plan and the conduct of operations in a given Area of Operations. COMAST senior health advisor provides the specific health oversight within that context.

3. The Defence Health Service considers health preparation to be part of a continuum of health care for ADF members. While this submission concentrates on the health preparation for operational deployments, such processes should be viewed as part of this broader continuum. Routine health care prior to deployment includes the monitoring of health and fitness standards to ensure personnel are fit to deploy. After returning from deployment, individuals are subjected to comprehensive health screening processes. These are designed to eradicate disease and to document and treat potential exposures to operational, occupational and environmental hazards during deployment. These processes include medical testing, psychological debriefing and ongoing health care.

4. In preparing ADF personnel for deployment, DHSB provides continued support to the operational commander through technical advice. JHSA prepare a Health Support Plan that details responsibilities for the conduct of health preparation in mounting locations. These arrangements have proven very effective during recent operations conducted in the Middle East and Solomon Islands. A more detailed outline of how the Defence Health Service prepares personnel for overseas deployments is contained in this submission.

5. In early October 2003, Major General J.P. Stevens, AO (Retired) commenced a review of the Defence Health Service. The purpose of the review is to evaluate whether the Defence Health Service will be able to meet Defence's needs for health services in the short to medium term and to propose any changes that may be necessary to achieve this. The review is scheduled for completion by 31 March 2004. The Terms of Reference for the review are enclosed as Annex F.

PART A - ADEQUACY OF CURRENT ARRANGEMENTS

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

Current Arrangements

6. **Assessment of Health Threats.** Defence Health becomes involved early in the planning processes for operational deployments. The first step in health planning is the conduct of a Health Threat Assessment. Such an assessment provides a detailed understanding of operational and environmental threats, thus giving an early indication of the number and type of casualties to be expected. This in turn provides a sound basis to develop options for providing health support to the force including the capabilities required in-country and the preparation of personnel in terms of inoculations and briefing requirements.

7. Health Threat Assessments are developed by both DHSB and HQAST. Within DHSB, the Strategic Health Intelligence Cell makes the assessment in close consultation with the Defence Intelligence Organisation and other relevant agencies including coalition partners. The process identifies endemic diseases of greatest risk, other endemic diseases of potential military significance, environmental health threats, the safety of the local blood supply, the adequacy and location of host nation health facilities and the local electricity and water supply. The end product of this process provides a sound basis for further decision making regarding the scope of counter measures that need to be implemented to deal with threats. Such counter measures could include recommendations for the inclusion of specific capabilities in the health support to the operation as well as individual vaccination requirements. A concurrent process is followed at the operational level.

8. **Recommendation of Appropriate Health Countermeasures.** The recommendations on health countermeasures gained from the Health Threat Assessment are passed to the CDF for inclusion in Strategic Guidance to COMAST. These orders will list the requirement for vaccinations, malaria prophylaxis and for any biological or chemical countermeasures required. HQAST further develops these countermeasures and provides direction on individual requirements; priority for use (if vaccines in short supply) and an implementation plan if required. Further direction on issues including water safety, prevention of disease and prevention of heat/cold stress is supplied.

9. **Pre Deployment Issues.** ADF personnel have an obligation to maintain readiness to deploy. All personnel must be medically and dentally fit prior to deployment. Whilst all ADF personnel should be current with standard vaccinations the requirement for additional operational specific vaccinations and the lead time to ensure completion of the vaccination schedule can result in individuals needing to complete the vaccination schedule once deployed. Further detail on pre-deployment preparation is contained in Part C.

Implementation

10. **Responsibilities of HQAST.** As a result of the planning process detailed above, the Operational Health Support Plan is produced. This plan is an annex of the broader operational plan and articulates the concept of health support and the method of implementation. The concept of health support is developed by the Theatre Health Planning Group in conjunction with, and in support of the Theatre Planning Group. The planning group is the standing forum in which health support to operations is developed and monitored. Senior health planning and intelligence staff from DHSB, HQAST and its operational components (Maritime, Land, Air and

Special Operations) (referred to herein as 'the components') are members of the Theatre Health Planning Group. Support includes details of health requirements in the pre-deployment, deployment and post-deployment phases of the operation.

11. **Responsibilities of JHSA.** JHSA is responsible for providing garrison health support to ADF bases. It plays a key role in supporting operational deployments in all phases from pre-deployment to post deployment. During the pre-deployment phase, JHSA staff implement many of the requirements of the health support plan, conducting the majority of inoculations and pre-deployment medical and dental examinations. During the deployment JHSA continues to prepare reinforcements and provide ongoing support to those members of the ADF who have returned injured. JHSA carry most of the clinical load in conducting post deployment screening.

Adequacy of Implementation

12. The primary difficulties in implementing health preparation arrangements are time and security related issues. Like other planning, the time available to develop detailed health support plans can be limited. The task of conducting threat health 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. Sound planning processes and frequent consultation is required, and current approaches are under ongoing review by Defence.

13. **Operational Security Issues.** Particularly early in the operational planning process, information about the operation is often compartmentalised – that is, it is only released to those individuals and organisation that "need to know". Compartments are strictly controlled and it is often difficult to initiate preparation of individuals until information is released. While the need for tight control of information is recognised, the quality of early advice may be affected by the inability to consult with some supporting agencies. Advice is based on the best possible information available at the time. As the operation progresses, health support plans are updated and amendments are promulgated direct to deployed health and posted to the HQAST and DHSB websites.

PART B – ADEQUACY OF RECORD KEEPING

"the adequacy of record keeping of individual health and treatment episodes of those deployed, and access to those records by the individual"

Policy

14. DHSB is responsible for the sponsorship of policy regarding the requirement to capture medical information for overseas deployments. Such policy addresses the need to record details of pre and post deployment medical screens and vaccinations as well as any treatment that was received during the deployment. Policy specific to particular deployments is articulated in the operational Health Support Plan.

15. Copies of all medical documentation related to deployment screening and treatment received (pre, during and post) are placed on individuals' Unit Medical Record and Central Medical Record (CMR). Information includes the following:

a. all pre-deployment medical and dental checklists;

b. medical treatment summaries from the deployment; and

c. copies of all post-deployment medical and psychological screening documentation.

16. The Directorate of Record Management Policy within the Corporate Support and Infrastructure Group has responsibility for document management of the CMR for the three services. CMR are held at the Queanbeyan Record Repository in the case of RAAF and Navy. Army CMR are held at the Dandenong repository (for discharged personnel) and Victoria Barracks Melbourne for serving members.

17. In addition to policy on record keeping requirements, separate DHSB policy provides guidance on health surveillance - the capture of statistical data about the nature of injuries and illnesses sustained by personnel whilst on deployment (see Annex C). A report on all medical presentations from each deployment is forwarded to DHSB for entry onto an operational database. The system utilises operational infectious disease tracking software known as EpiTrack. EpiTrack can produce basic reports and data can also be extracted for statistical analysis to identify trends and assist in identification of preventive strategies for future operations.

Adequacy of Current Arrangements

18. In early 2003, Management Audit Branch raised concerns about Defence's ability to produce a complete and current health picture of an individual ADF member. The CMR for an individual is not a single entity. 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. The current process of capturing data is largely a physical one. The physical CMR is increasingly managed through the Defence Document and Record Management System.

19. In 2002, the RAAF electronic record management system failed. As the RAAF had no redundancy systems for their records, this caused a significant loss of data. This had no direct impact on health preparation for deployment; rather, the impact was more administrative in nature. This is evidenced by the current backlog of up to three million entries yet to be re-entered onto the database. The Directorate of Records Management Policy has prepared a proposal to develop a tri-Service approach to records management. The proposal, which is currently being staffed within the Corporate Services and Infrastructure Group, will seek to establish uniform processes and information systems for the collection and collation of health information.

PART C - ADEQUACY OF PRE DEPLOYMENT PREPARATION

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

Pre Deployment Health Checks

20. HQAST, its components and JHSA medical personnel conduct pre-deployment preparation. Medical and dental fitness issues are dealt with at the Component HQ level whilst request for vaccination waivers are administered through HQAST. Procedures to be followed in the event of refusal of vaccination are promulgated by HQAST.

21. Prior to deployment, a pre-deployment medical and dental checklist is completed on all personnel. No requirement for a physical examination is required. This is because of existing readiness requirements and Annual Health Assessments, both of which ensure the fitness of members to deploy. Army and RAAF personnel undertake an "update" interview with health

staff to determine if any injury or condition has occurred since their Annual Health Assessment and medical officer 'sign off' is required. Navy personnel undergo a seagoing medical prior to sailing and their health status is monitored en route to an Area of Operations. Checks also include a review of previous treatment to ensure that the individual is able to safely take disease countermeasure and vaccines. Defence is in the process of amending its Annual Health Assessment to ask members to indicate whether they have applied for compensation under the *Veterans' Entitlements Act 1986* (VEA) or *Safety Rehabilitation and Compensation Act 1988*, or whether they have a claim already accepted.

Vaccinations

22. Vaccination currency is checked at the time of the pre deployment medical and dental check. Where specific to deployment vaccinations are required, health staff develop a plan to complete vaccinations as soon as possible. A database of non-standard vaccinations administered (for example anthrax and smallpox) is held at HQAST. Further details about vaccination arrangements are contained in Part D of this submission.

Briefing

23. DHSB staff develop a detailed health briefing for all personnel. Briefings provide comprehensive information about the potential operation, environmental and occupational hazards that may be encountered during operations. Briefings are developed in consultation with and approved by the Senior Health Officer at HQAST and delivered by health personnel during the force preparation process. The briefings are styled to meet the needs of the group deploying based on likely area of operation, tasks and potential exposure. Individuals also receive a psychological briefing emphasising operational stress training. Medications required by individuals for the duration of the deployment are issued at this time.

24. DHSB have recently introduced health information cards detailing diseases endemic in the Area of Operations. The cards are intended as a prompt to medical officers who may treat members in the future. These cards are issued prior to returning home. A pre deployment health advice pamphlet is also prepared by DHSB. This is distributed at the pre deployment health briefing and contains practical information relevant to the Area of Operations with effective disease minimisation and prevention advice as well as mental health information. At any stage during this process, individuals are given the opportunity to discuss any concerns with health staff.

PART D - ADEQUACY OF VACCINATION ARRANGEMENTS

"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"

Vaccination Policy

25. The National Health Medical Research Council shapes ADF vaccination policy. All routine vaccinations utilised within the ADF are administered according to the principles of the current Australian Immunisation Handbook, approved by the Therapeutic Goods Administration (TGA). Many operations will require additional vaccinations that are identified during the health planning process. The ADF must gain approval for use of any unlicensed or investigational vaccine. Such requests are staffed through the Australian Defence Human Research Ethics Committee (ADHREC) to the TGA. The TGA delegates the authority to allow administration of Anthrax vaccine to specific medical practitioners within the ADF only.

Authority is conditional on DHSB agreement to ensure that ADF members are fully informed of benefits and risks.

26. ADF policy provides comprehensive guidance on matters of informed consent pertaining to the administration of vaccines that are currently unregistered in Australia but required for mission specific deployments. Informed consent in no way affects an ADF member's right to access compensation. All vaccines administered to ADF personnel are recorded in medical documentation. DHSB has a responsibility to retain details of ADF personnel who are administered any vaccine not registered with the Therapeutic Goods Administration, including batch details.

27. Once identified, DHSB provides guidance to operational commanders and subordinate health staff on the vaccination plan for each operation. Authority to administer these operational specific vaccines is included in CDF orders to COMAST. JHSA issues a Health Support Plan indicating a requirement for specific vaccinations. For certain topical vaccinations, DHSB develops briefings to ensure that ADF personnel are aware of all issues associated with the vaccine.

Quality Control of ADF Vaccinations

28. Requirements for the storage and control of vaccines are highlighted in ADF immunisation policy (see Annex D). These procedures can be adapted for use while on operational deployments. Policy is routinely updated to reflect Government and related Defence policy and procedure. Emerging guidelines and practices as they are issued in the wider community by relevant bodies are also incorporated in order to reflect community standards.

PART E – ENGAGEMENT OF THE DEPARTMENT OF VETERANS' AFFAIRS AND THE REPATRIATION MEDICAL AUTHORITY

"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"

Defence/DVA Relationship

29. DVA and Defence recognise that there is a continuum of health care from enlistment through to discharge and the transition across to DVA for management of post-service care. Personnel who have claims accepted under the various Acts will have ongoing health care provided by DVA. As there is no clear distinction between where Defence's responsibilities end and DVA's commence, both departments acknowledge the need for close cooperation. The Defence Links Branch within DVA has been established specifically to improve the links and professional relationships between executives of both organisations with the aim of providing high quality, consistent and seamless transition for serving members transferring to the DVA system.

31. Cooperation between DHSB and DVA also extends to collaboration on issues such as post deployment medical screening, for example with regards to urinary uranium screening following exposure to depleted uranium in Gulf Wars 1 and 2. Defence and DVA also cooperate in the conduct of studies into the health effects of operational service. These studies are discussed further in Part F.

Defence/Repatriation Medical Authority Relationship

32. Historically, Defence has had only a peripheral relationship to the Repatriation Medical Authority (RMA). The RMA is an expert body established by the Repatriation Commission to oversee the development of Statements of Principles (SOP). These SOP are medico-scientific determinations, which assess the strength of medical and epidemiological evidence that are used as the published basis for determination of eligibility of claims under the VEA.

33. Periodically, the Government has also referred to RMA Expert Committees, questions that require external and independent review of Defence related issues. Examples where this has occurred include comment on the exposure of Allied troops to Depleted Uranium in the Balkans conflicts and more recently in relation to health concerns raised by former SAS personnel. Defence and DVA have offered assistance in these processes however at this stage, the RMA Committee has declined our offers of assistance to ensure that their findings could not be seen to have been "biased" by involvement of Defence or DVA. Defence believes this process could be improved by the appointment of a senior Defence Health representative to the RMA, ensuring appropriate levels of Defence Health input into future RMA determinations.

PART F - ADEQUACY OF RESEARCH

"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"

Health Research

34. ADF personnel remain at considerable risk to a range of diseases while on operational deployment. Research on operational deployments is currently focused on epidemiological and scientific studies looking at the health burden on those who deploy. Health research is responsive to operational requirements of the single Services however Defence has limited intrinsic capability to conduct health research related to operations, except in centres of excellence. Principally the Defence Force Psychology Organisation, Defence Science and Technology Organisation and the Army Malaria Institute undertake studies. With the establishment of the Centre for Military and Veterans' Health (CMVH) in 2004, further opportunities will be available.

35. Funding is a key limitation to the degree of research that can be conducted. The Army Malaria Institute for example has a global reputation in the effort to reduce the impact of malaria and other vector borne disease, however much of its research funding comes through collaborative projects with the US military or commercial entities. Only through a structured research program can a wide range of research issues be addressed and resourcing will remain a key determinant in how much can be achieved.

Research Protocols and Ethics

36. Research involving members of the ADF is subject to ethics scrutiny outlined in the National Health and Medical Research Council (NHMRC) National Statement. The ADHREC oversees the process. Health research is co-coordinated by the Defence Health and Human Performance Research Committee. Policy for the conduct of research is contained in Defence Instructions (see Annex E).

37. ADHREC operates within the framework of established Australian Medical Research protocols. The limitations of the principles of human research ethics places logistical limitations

on the conduct of research studies. Immediately prior to a deployment, personnel deploying are usually very busy focusing on operational issues. The ability of Defence to put together a proposal is problematic, and ADHREC should not compromise the protection of the individual in these circumstances. Pre-approved protocols may be of some benefit, but it remains very doubtful that Defence would be in a position to activate such a protocol prior to deployment to a new operation.

Studies

38. Deployment related health studies have the potential to provide valuable insight into potential effects of a range of deployment health issues. 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 timelines involved will not always allow this.

39. The focus of the studies will often vary. Each will be a 'cohort' study, comparing two groups, an 'exposed' group that deployed and a 'comparison group' that did not deploy. In some cases, further stratification may be possible. In these cases, the exposed group may be broken down into sub-groups based on the degree of exposure or the time and/or specific location of the deployment. By comparing the health outcomes in the two groups, differences can be evaluated. There are significant logistical, scientific and ethical issues in the conduct of operational health studies.

40. In 1999, the Government announced its support for the conduct of health reviews for all future operational deployments. As funding becomes available, studies will be conducted on operations conducted in the Middle East, East Timor and Bougainville. A study of operations in the Solomon Islands will commence in the near future as funding was allocated during pre-deployment planning. Studies for other operational areas will commence as funding is approved.

41. Defence and DVA cooperate in the conduct of operational health studies. We agree that for studies into events well in the past, DVA will retain primary responsibility. For more recent or current events, Defence accepts primary carriage. In reality however, both departments need to be consulted, and where appropriate, be involved in the oversight and management of operational health studies. Studies completed or currently underway include Maralinga Atomic Tests, Korean War and Gulf War health effects.

42. Many ADF personnel have now deployed to several operations, and it is becoming increasingly difficult to identify and recruit personnel to act as comparisons. A better way to meet the requirement is to have a single study, into which all those who have deployed and have consented would be enrolled. A single group of comparisons would also be recruited by consent. It is from these groups that appropriate subjects will be selected for each specific operations health study. This concept is currently being discussed within the two departments.

Health Intelligence Research and Collaboration

43. The Quadripartite Medical Intelligence Committee is an intelligence program group that sponsors the Quadripartite Analysts Working Group. The working group is a small, active and robust group of health/medical intelligence analysts from Australia, USA, UK and Canada that is consistently working towards new ways of improving medical intelligence within these countries. Working group members are regularly in contact to exchange intelligence on current

operational issues, information, develop new approaches to assessment methods and conduct research. The Armed Forces Medical Intelligence Centre at Fort Deitrick, Maryland USA sponsors officers from Australia, Canada and the UK for a non-reciprocal exchange posting of two years. Recent research activities with the QAWG include the development of medical indicators and warning software that has now been taken up by the broader intelligence communities in the US and the UK.

44. The Strategic Health Intelligence cell in DHSB has regular access and liaison with the Scientific Advisory Committee of the World Health Organisation Global Outbreak and Alert Response Network and various academic institutions in Australia and internationally. DHSB uses a range of disease outbreak surveillance and early warning systems and has consistent collaboration with other government departments such as Foreign Affairs and Trade, Health and Ageing and the Australian Federal Police.

45. DHSB was instrumental in instigating the relationship between Defence and the Australian Bio-security Co-operative Research Centre. This centre emphasises the importance of developing collaborative arrangements between researchers, and between researchers and research users in the private and public sector in order to maximise the capture of the benefits of publicly funded research through an enhanced process of commercialisation or utilisation by the users of that research.

Centre for Military and Veterans' Health

46. Defence and DVA have also recently extended their relationship with the establishment of the Centre for Military and Veterans' Health (CMVH). Defence has contributed funds of $0.9m in FY 03/04 for the establishment and DVA will provide $1 million per year for the operation of the Centre. Defence will embed six Defence staff to work with the university staff at the CMVH. The CMVH will be located at the School of Medicine at University of Queensland. Partners in the consortium supporting CMVH are University of Queensland, Adelaide University and the Menzies School of Health Research. While the Centre will not officially open until March 2004, plans are well advanced on how it will function. One key benefit will be the provision of high quality health research studies to both groups with the ability to draw on outside additional expertise to provide specialist research and education services. Funding for research will be on a fee for service basis, but with a favourable arrangement. CMVH will provide a coordinating and advocacy role, with all the resources of the consortium institutions available. A number of reservists will be attached to CMVH and can support research projects.

LIST OF ANNEXES