Address to RUSI of South Australia

"Contemporary Challenges in Operational Health Care: The Battlefield and Beyond."

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Mr Chairman, Senior Officers, Ladies and Gentlemen

Thank you very much for that kind introduction.

What I would like to do today is to take a journey through our current battlefields – to look at some of the challenges that face our health care planners, our health care providers and time permitting, the health challenges that face our newest, and growing, group of young veterans when they return home.

We all acknowledge that conflict is an evolutionary art but traditional tactical doctrines distinguishing between low-medium and high intensity conflict have really lost relevance in current operations. Recent deployments demonstrate that forces simultaneously face a ***combination*** of tasks, such as counterinsurgency, peace support, conventional war fighting, reconstruction and humanitarian responsibilities. In addition we have moved into an era of operations with a much greater significance on civil-military integration and Whole of Government outcomes – an era focused very much on 'shaping' effects rather than on 'attritional' warfare. Health has an important role in achieving these effects.

Army's Adaptive Campaigning framework now forms the conceptual basis of Army's land operations. Under this framework we recognise that contemporary operations are increasingly about managing competing factional allegiances, about influencing populations, about rebuilding security, supporting reconstruction and at the same time preserving the agility and ability to engage in war fighting.

Operational heath support has traditionally been focussed solely on provision of 'combat health support' but an Adaptive Campaigning model requires health to act outside of this role and to take on a much more diverse range of activities that enable health effects to be achieved across a much broader front. But to meet these challenges health services will need to meet significant doctrinal, organisational, and philosophical challenges.

With the outcomes now increasingly decided in the minds of populations rather than on the battlefield, health has an important role in "shaping" a particular health effect. This may be achieved through short-term crisis intervention, a 'hearts and minds' campaign or longer-term capacity building. The provision of health services to indigenous populations offers a potent tool to shape perceptions and to improve quality of life. Not all of these will be the responsibility of the military, but the military will play an important role in coordinating these effects and ensuring they comply with the overall campaign plan.

Enhancing the ability of the existing government to provide sustainable infrastructure and basic health care delivery creates a tangible link between the central government and the people and builds trust – just like the rule of law, health care is a pillar of stable society and health effects can be used as an extension of 'non-kinetic' or 'soft power' in achieving the Whole of Government objectives in an operational setting.

Adaptive campaigning doctrine defines 5 overlapping lines of operation, each of which has implications for health care provision:

- Joint Land Combat
- Population Protection
- Population Support
- Public Information
- Indigenous Capacity Building

Joint Land Combat

Combat health support is the core of Army's health services. In current counterinsurgency operations Combat health assets must be able to support many small teams, while retaining the ability to quickly 'surge' in response to changes in the tactical scenario. To do this they must be protected, equipped and structured to operate and survive in a potentially lethal environment.

The nature of casualties has also changed. Although the casualty load tends to be low by comparison with previous conflicts, the injuries are complex, and injury management is vastly more resource intensive.

This has changed our approaches to 'point of injury' care. The modern battlefield is characterized by rapid, sophisticated interventions by well-trained members of the combat team followed by evacuation to forward/Role 2 capabilities where immediate resuscitation and surgery is performed prior to evacuation.

Trauma care has undergone a revolution in the last 2 decades and this is particularly evident on the battlefield. The move to 'damage control' philosophies, combined with better personal protection such as enhanced body armour has seen significant improvements in overall survival of often seriously injured casualties. Damage control comes however at a cost – highly trained first responders armed with combat tourniquets and haemostatic bandages instigating the 'platinum 10 minutes' rather than the 'golden hour'. Effective damage control is also predicated on providing *far-forward* intensive care and resuscitation facilities, proximate trauma surgery and intensive care level strategic evacuation to an appropriate tertiary level facility usually well outside the area of operations, such as Landsthul.

It is also reliant on the ability to source and provide often massive amounts of blood and blood products as part of the resuscitation phase and the ability to generate large amounts of medical gasses (up to 6000 litres per day per patient) which carries a significant logistical burden.

It would be fair to say also that society's expectations about trauma care have also changed. Coalition casualties are predominantly the result of burns, blast, improvised explosive devices, and we expect that those that arrive at a coalition facility have a very high rate of surviving often quite extreme injuries. And in fact this is the case; casualties who in previous conflicts would almost certainly have died from their injuries are now surviving and returning home.

The ability to protect health assets is a key challenge in current land combat operations. The long assumed indemnity held by the symbol of the red cross no longer as holds true as in the past with insurgents targeting what is seen as an 'easy target'. Sadly, neutrality is a commodity which would appear to have lost some of its value.

In addition the need to 'push forward' key health elements carries a significant liability in terms of the need for individual self-protection and competence in IED/counter-ambush drills, particularly for those involved with casualty transport and evacuation. Equally, where our main threat is indiscriminate or indirect fire, we need to think carefully about the requirements for ballistic protection of our health assets and what that means in terms of their maneuverability.

Protection of health personnel also poses challenges in term of interacting with local communities. One of the keys to effective counterinsurgency operations is 'presence'. Presence requires mixing with the people, of engaging at their level, of reaching into their society. Presence requires careful considerations of the risks to non-combatant health staff and also cultural expectations and traditional gender roles – for example use of female health personnel to gain access and entry to certain sectors of the community.

Population Protection

Population protection operations require large scale collective action and have traditionally been undertaken by NGOs rather than the military. None-the-less under a 'whole of government approach' ADF health planners are likely to be increasingly engaged in provision or planning of refugee support, including mass vaccination, environmental health and increased interagency engagement.

Whilst providing security to indigenous health assets is *not* the responsibility of the military, the freedom of movement afforded to populations to access civilian health assets will impact on the overall effectiveness of the mission and it may well be that such protection is required to support and enable access to local health facilities.

Population Support

In complex operations health facilities are often the first to be destroyed and the last to be rebuilt. Local health care services may be inadequate due to lack of personnel, facilities or resources or as a result of targeting by insurgent action, in an attempt to undermine confidence.

Civilian populations also have significant underlying dependency of health issues which are non-conflict related, reflecting the consequences of breakdown in standards of living and chronically inadequate health care systems. Layered into this are the realities of human rights violations**,** competition for limited health assets and the rise in

malnutrition, infectious disease, increased infant and maternal mortality associated with refugees or internally displaced populations.

Military forces have historically taken on roles in providing commitment to public health interventions such as engineering support, provision of clean water and road repairs to allow access to rural areas but are rarely configured to meet the complex need of a civilian dependency dominated by the elderly, women and children.

Within an Adaptive Campaigning construct, Army retains its moral and ethical obligation to provide health support to sick and injured civilians who access Military Treatment Facilities, regardless of their combatant status as governed by International Humanitarian Law and the provisions of the Geneva Conventions. This includes responsibility for civilian casualties resulting from Australian/coalition actions.

In distinction however, Army's operational health units have *no* obligation to provide health care to civilians presenting with chronic or non-acute conditions or to provide care when satisfactory host nation or NGO health capabilities are available. This requires a stringent casualty regulation system, clear agreement and task allocations between different health care providers and strict adherence to medical rules of engagement (M-ROE).

Military health involvement in Population Support operations requires careful planning. The level of care provided should be affordable, achievable and sustainable, and must not interfere with the provision of health care to the military force. Access, egress and resource usage by civilians entering military medical chains must be controlled to prevent the system becoming rapidly overloaded. This can only occur in the setting of mutual assistance between humanitarian, Host nation and military medical staff.

Strict adherence to accepted local/NGO treatment protocols when treating civilian patients facilitates standardisation of treatment, minimises perceptions of differential standards of care and facilitates transfer of patients from military to civilian health facilities**.** Military casualties will generally be rapidly evacuated beyond the immediate operational area to sophisticated 'home nation' medical facilities, however this option is not available for 'non-designated' civilian personnel and treatment plans must take this into account.

Treatment eligibility matrixes and entitlements need to be carefully articulated to avoid perceptions of bias. In providing health care to civilians that extends beyond our international obligation, ethical conflicts may exist if restrictions are applied determining who may, or may not, access the full capabilities offered by Land health facilities. And whilst as health professionals we endeavor to provide care impartially, the reality is more complex. As General Sir Michael Rose, then Commander UNPROFOR observed during the Bosnian campaign:

> *"There is no such thing as impartial humanitarian assistance. In this environment, every time you help someone, you hurt someone else"*

Provision of military health services must also be balanced against the need to minimise the operational health footprint. This is best achieved by utilising low footprint interventions whenever possible.

We must also recognize that in engaging in population support operations the dependency is significantly different to combat health and requires different skill sets, robust regulation and governance frameworks *without* competing with our primary combat health responsibilities.

Public Information

The use of health personnel interactions to shape perceptions is well recognized in counterinsurgency and unconventional warfare doctrines. This is perhaps where Health has its greatest opportunity to contribute to strategic success. Health elements have a unique opportunity to positively influence the attitudes of a population.

Used well, health has tremendous potential to reinforce strategic success but it is imperative that this is both integrated with the overall psy-ops campaign and that health is not used in a cynical or punitive manner which would be in clear violation of our International obligations.

The impact of overt campaigns must also be well thought through to avoid unforeseen consequences. Suggestions that medical assets are being used to support factional alliances, or obtain intelligence can gravely undermine the neutrality of both the medical personnel and the overall force. One of the key elements to achieve this is consistency and this has been helped significantly over recent years by the development of "Military rules of Engagement/Entitlement " (M-ROE). Just as clear rules of engagement and rules for opening fire provide clarity for soldiers in combat, so too, medical rules of eligibility clarify issues of 'entitlement' to military health care.

Indigenous Capacity Building

From a health viewpoint indigenous capacity building includes provision of transferable skills, restoration of confidence in local health providers, key equipment repair and strategic health planning. Compared to ongoing 'service provision' it offers a greater long-term benefit and facilitates military disengagement. But is requires a skill set not normally contained within combat health support, with a greater focus on education and planning.

Rather than delivery, the ADF is best postured to be involved in needs assessment and planning. And planning is essential to avoid 'hollow' bricks and mortar projects with no real health capability. In long term engagements with a fragile security situation it may be necessary for the military to contribute to rebuilding civilian health infrastructure to facilitate medical disengagement**.** We should also remember that we do subtlety build indigenous capacity each time we support the local health care system, rather than trying to replicate it. We do build capacity by encouraging local health care providers and by demonstrating our confidence and support.

Measures of Effectiveness

Without going through this in any great detail the focus of any capacity building activity must be on validating the government's role as service provider and this is clearly most effective when the host nation is engaged in care delivery, rather than the military providing direct services.

But how do we define tactical and strategic success? Success in an Adaptive Campaigning model is determined largely, not by caseload, which has been our traditional measure (more operations, more patients seen equals 'better' effort), but by improvements in health care interpreted within an appropriate cultural framework and measured against realistic and sustainable benchmarks.

This requires us to *define* appropriate measures of effectiveness either through surrogates or existing measures such as humanitarian care standards. Regardless of the indicators used, they must be relevant to ensure that false dependencies and unrealistic expectations are not created.

Perceptions of improvements in health care need to be interpreted within the cultural framework of the society under review. For example improvements in basic infection rates are more relevant performance metrics than for example cancer treatment or trauma outcomes. These outcomes then must be linked back through public information campaigns to maximize their benefit.

FORCE STRUCTURE IMPLICATIONS

But all of this has clear force structure implications and it is timely that Army is currently undergoing a major Force structure review. Inherent in the force structure implications is the need to determine how we best coordinate health effects across the five lines of operations. We need to ensure our current capability bricks are best postured to provide the breadth and flexibility required to support Adaptive Campaigning and importantly in a strategic sense the agility to move effort between these effects as the situation on the ground changes and new opportunities are identified.

This is challenging for us: 'switching effects' in health is difficult – whilst infantry can relatively easily switch from offensive to defence operations a primary health care facility cannot so easily ramp up to trauma operations, nor could a trauma surgeon easily take on a primary health care role. The ability to provide a 'balanced' operational health capability which can maintain effectiveness across a range of tasks, situations and conditions may require individualised, rather than template solutions with a strong emphasis on Health planning, Health intelligence, Force structure, survivability and agility.

To meet these needs and shape effects we also require integration with non-military health care providers including NGOs, OGOs and contractors and these effects need to be synchronised with the overall campaign plan whilst meeting the agility, flexibility, resilience and responsiveness requirements of combat health support.

So in conclusion Mr Chairman

Delivery of medical capacity *is* an important adjunct to achieving whole-of-government outcomes in Adaptive Campaigning framework. In the words of General Westmoreland in 1965:

> *"This is a political process as well as a military war- the ultimate goal is to regain the loyalty and cooperation of the people. It is abundantly clear that all political, military, economic and security [..] programs must be integrated in order to attain any kind of success"*

Health is no exception to this. As the vast majority of conflicts around the world are unconventional it is important to recognise and adjust the strategies required in order to provide flexible and focused health solutions aimed at meeting the operational health demands of the 21st Century.

This address was based on an article 'Adaptive Campaigning- Implications for Operational Health Support', Neuhaus SJ, Klinge NI, Mallet RM, Saul DHM in Australian Army Journal 2008;5 (3).