PERSONNEL SERIES

ADDP 1.2

HEALTH SUPPORT TO OPERATIONS

Australian Defence Doctrine Publication 1.2—Health Support to Operations, is issued for use by the Australian Defence Force and is effective forthwith. This publication supersedes edition 1.

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Chief of the Defence Force

Department of Defence
Canberra ACT 2600

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FOREWORD

1. Australian Defence Doctrine Publications (ADDP) and Australian Defence Force Publications (ADFP) are authorised joint doctrine for the guidance of Australian Defence Force (ADF) operations. ADDP are pitched at the philosophical and high-application level, and ADFP at the application and procedural level. Policy is prescriptive as represented by Defence Instructions, and has legal standing. Doctrine is not policy and does not have legal standing, however, it provides authoritative and proven guidance, which can be adapted to suit each unique situation.

2. ADDP 1.2—Health Support to Operations supersedes the first edition. The aim of this publication is to provide philosophical doctrine on operational health support. It provides broad guidance on the nature and scope of health support across the spectrum of operations, within joint, combined and/or intra-agency operations. It informs operational planning, command and delivery of health services. It also informs ADF education and training.

3. This publication is to be used by commanders, staff and key personnel employed in the planning or conduct of operational health support. This publication describes the concepts, health system, organisation, command, control and planning for the effective provision of operational health support.

4. Health Support to Operations needs to be viewed within the total context of war fighting. To this end, additional recommended reading is:
   - ADDP 00.1—Command and Control;
   - ADDP 00.4—Operational Evaluation;
   - ADDP 06.4—Law of Armed Conflict;
   - ADDP 3.0—Operations;
   - ADDP 3.3—Joint Airspace Control.
   - ADDP 3.4—Operations in a Chemical, Biological, Radiological and Nuclear Environment;
   - ADDP 3.11—Civil Military Cooperation;
   - ADDP 4.0—Defence Logistics;
   - ADDP 5.0—Joint Planning;
   - ADDP 6.0—Joint Communications and Information Systems;
   - ADFP 1.1.1—Mortuary Affairs;
ADDP 1.2

- ADFP 1.2.3—Casualty Evacuation and Patient Movement;
- ADFP 5.0.1—Joint Planning;
- ADFP 710—Blood Banking Methods Manual;
- ADFP 711—Blood Transfusion Manual; and
- ADFP 714—Operational Stress Management.
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CHAPTER 1

OVERVIEW

Executive summary

• Health support is an enabler of maritime, land and air power. It is provided in permissive, uncertain and hostile environments. In addition to caring for a deployed force, health elements can be tasked with providing humanitarian health care.

• Australian Defence Force (ADF) health elements support all phases of an operation: pre-deployment, conduct of operations and post-deployment.

• Deployed operational health support is organised into roles of care, which range from first aid through to definitive health care. It contributes to all operations—from war fighting to humanitarian relief.

The soldier’s health must come before economy or any other consideration.

Napoleon, 1813

INTRODUCTION

1.1 The Australian Government is committed to protecting the lives and welfare of Defence personnel deployed on operations. A key component of this commitment is the provision of health support to deployed forces. Operational health support is provided to all operations—from war fighting to humanitarian relief.

1.2 Health support is a key logistics function in the maritime, land and air domains. This support ensures that a force deploys at optimal fitness with adequate preventive health measures. Health support also ensures that appropriate treatment and evacuation capabilities exist to maximise the early return to duty of casualties.

1.3 While there is a continuum of health care, from enlistment through to transition from the ADF, this publication focuses on the provision of health support to operations.
CONCEPT OF HEALTH SUPPORT

Approach

1.4 Military operations are interdependent with political, humanitarian, economic and development goals. They often require a national approach, involving military, diplomatic and civilian agencies.

1.5 ADF health assets must be capable of delivering health support to joint, combined and inter-agency operations. They must also be capable of delivering health care to humanitarian assistance operations. ADF health assets must be capable of working effectively with diplomatic and civilian agencies that specialise in humanitarian relief and health care.

1.6 The environment, threat and risk determine the approach, or combination of approaches, used to deliver health support to operations. The ADF is capable of deploying rapidly and establishing a basic level of security at the outset of a crisis. This is often an essential element of a national approach.

Diplomatic and civilan efforts

1.7 Diplomatic organisations provide extensive assistance to health elements. They provide local knowledge, access to local health networks, assistance with clearances and sustainment support. Civilian efforts may include provision of health care services by other government agencies, international government organisations and non-government organisations.

1.8 Chapter 3—‘Health Organisation’ describes the contribution of diplomatic and civilian agencies to operational health support.

Military health support to operations

1.9 Military health support is commensurate with force strength and assessed health risks. Support starts before deployment and expands as the force strength expands and risks increase. It focuses on both battle casualties as well as disease and non-battle injuries (DNBI). Health support must have a surge capacity to support peak casualty periods. This health support may be required by either day or night and under any climatic or topographic conditions.

1.10 The ADF provides comprehensive health services in permissive, uncertain and hostile environments. Health elements must be capable of responding to diverse incidents in a range of environments. In addition to caring for Defence personnel, ADF health elements may provide humanitarian health care in higher threat environments until the situation has sufficiently stabilised for handover to civilian providers.
Health tasks

1.11 The ADF provides health support during all phases of an operation: pre-deployment, conduct of operations and post-deployment. This involves more than the treatment of illness and injury. Implicit are the core functions of preparing personnel for deployment, provision of treatment and evacuation during deployment, and post deployment care.

1.12 Pre-deployment. Pre-deployment health tasks include:

- **Raise, train and sustain.** Service Chiefs are responsible for ensuring that health assets are competent, certified and sustained during the operational viability period. This may include garrison or civilian placements.

- **Readiness.** Garrison health contributes to force readiness through assessment of individual medical, dental, physical and psychological fitness. They also provide health care and casualty prevention programs. Health staffs contribute to operational planning.

- **Force preparation.** Garrison health provides health preparation for deployment. Headquarters Joint Operations Command identifies and mitigates environmental and occupational health threats in a specific joint force area of operations (JFAO). This includes preventive and controlling measures, such as immunisation, countermeasures, psychological preparation and preventive health training.

1.13 Deployment. Operational health support maintains the health of the deployed force. It comprises the common health picture, joint trauma system, force health protection, health knowledge and governance, and health materiel. Chapter 2—‘Deployed Operational Health System’ provides further information on the deployed operational health support system.

1.14 Post-deployment. Garrison health provides post-deployment health care. Care focuses on individual health, including medical, dental and psychological clearance for return to duty, re-deployment, discharge or rehabilitation. Health staff monitor health data and conduct operational evaluation.
Roles of health care

1.15 Operational health support is organised into roles of health care, which range from first aid through to definitive health care. Roles of health care extend from the point of injury or illness, rearward through a JFAO, providing continuous care to casualties. Each tier has increasingly sophisticated treatment capabilities. A casualty is treated at the most appropriate role of health care. This may involve either movement through the care continuum or casualty evacuation to the most appropriate health facility.

1.16 The roles of health care provide a guideline of capability. Annex A describes the broad capabilities of each role of health care. Planning staff identify the required health effects and assign appropriate health capabilities to the required roles of care.

HEALTH THREATS

1.17 The health threat to the force, the type of operation and the operating environment determine the deployed health capability. Health threats may take a number of forms. They are categorised as:

- **Operational threats.** These are threats posed by warfare systems and weapons and include conventional and non-conventional weapons. Operational threats arise from adversary action.

- **Environmental threats.** These are threats posed to ADF personnel by the natural environment. They include communicable and vector-borne diseases, food and waterborne diseases, physical and mental unfitness, extreme environmental conditions and industrial materials.

- **Occupational threats.** These are threats posed by friendly systems and equipment. They include biological, chemical, physical, psychosocial and human factors. They also include the risks posed by individual actions, conditions and characteristics.

Casualty definitions

1.18 The predicted number and types of casualties directly influence the health support required for an operation. At an individual level, clinical need determines priority. At an organisational level, commanders may allocate priorities to elements of the force when health resources are limited.
1.19 Casualties are those personnel who are wounded, become ill or are injured during operations. This may include adversary forces and non-combatants. Operational, environmental or occupational threats can cause casualties. They are categorised as follows:

- **Battle casualty.** Battle casualties are personnel who are killed, wounded, missing or captured as a result of action against the enemy.

- **Disease and non-battle injury.** DNBI are personnel losses not directly attributable to action against the enemy. DNBI includes sick or diseased, accidentally injured and non-battle missing. DNBI are influenced by the environment and epidemiology of the JFAO, and the state of preparedness of forces.

- **Psychological casualty.** A psychological casualty is an individual who is no longer able to perform their duties due to mental debilitation. An example is a combatant exhibiting symptoms of acute or traumatic stress disorder. A psychological casualty may be classified as either a battle casualty or a DNBI.

- **Mass casualties.** A mass casualty situation arises when the number of casualties requiring care is greater than the evacuation and/or treatment capability and/or capacity available.

- **Patient.** A casualty becomes a patient when entering the health care system.

1.20 Civilian casualties continue to be an aspect of many operations. Health elements may be required to treat non-combatants until civilian health agencies are available to fulfil this task. Further information on stability operations and humanitarian assistance is in Australian Defence Doctrine Publication (ADDP) 3.0—*Operations*.

**PRINCIPLES AND PRECEPTS**

1.21 Principles and precepts affect the provision of health support to operations. They derive from operational experience, political and community expectations, and compliance with Australian and international laws and agreements.

**Principles**

1.22 **Conformity.** Health plans must be integrated with operational and logistic plans. They must also conform to the highest practical level of professional practice, standards and ethics, agreements, and relevant conventions of humanitarian law to which Australia is a signatory.
1.23 **Proximity.** Health support must be provided as soon as possible to reduce morbidity and mortality. Health resources must be provided as close to the battlespace as the tactical situation allows for rapid clearance of casualties and provision of health care as far forward as possible.

1.24 **Flexibility.** Health support orders and plans must have inherent flexibility to enable immediate response to changing tactical situations. Health elements must be capable of rapid re-grouping or restructuring to meet the requirements of specific operations. Plans and orders must factor in redundancy where possible. Health support must be flexible enough to expand as the force strength expands and risks increase. This support must have a surge capacity to support peak casualty periods.

1.25 **Mobility and protection.** Health elements require compatible mobility and protection, complemented by appropriate communications, to enable them to maintain contact with supported forces.

1.26 **Continuity.** Triage, treatment and evacuation must be a continuous, integrated process until the casualty reaches a health facility capable of providing definitive care. No casualty should be evacuated further than their condition requires or the operational situation warrants.

1.27 **Prevention.** Measures designed to promote health and prevent DNBI can significantly conserve personnel. Prevention includes training, application of appropriate health protection measures, providing ongoing health care, health surveillance and health advice.

1.28 **Control.** Health support to operations is a complex and highly specialised service. Command and control should be exercised at the highest level.

**Precepts**

1.29 **Geneva Law and the Law of Armed Conflict.** Australia’s ratification of the Geneva Conventions and their Additional Protocols places obligations on the way the ADF provides health support to operations. The law of armed conflict (LOAC) encapsulates Geneva Law and all ADF members are responsible for ensuring that their conduct complies with LOAC. The ADF unilaterally complies with LOAC. In other words, this obligation is not conditional upon an enemy’s compliance. Chapter 6—‘Geneva Law’ describes the impact of Geneva Law on the provision of health support.
1.30 **Care expectations.** When ADF personnel are injured or become ill, there is an expectation that they will receive prompt and effective health care. ADF health care meets contemporary professional Australian standards except when the exigencies of military operations dictate otherwise. Care expectations include the following:

- **Providers.** Defence policy stipulates who can provide definitive health care. It provides a framework of accountability for health services and individual health staff.

- **Standards of care.** High quality health care contributes to the morale and confidence of troops, as well as acting as a public statement of assurance to families, the public and the international community. Where the ADF is committed to operations, there is an expectation that casualties will be minimised and where personnel are wounded, become ill, or are injured, they will have access to the best health care outcomes that Australia can provide. Defence Instructions stipulate the standard of health care expected for ADF personnel.

- **Continuity of care.** Health care to casualties should be continuous. Casualties should progress through the treatment process, supported by the provision of in-transit health care during evacuation. Health elements must be able to provide continuity of care in all threat environments.

- **Balance.** Commanders must balance the highest clinical standards possible against the constraints resulting from the operational environment.

- **Health confidentiality.** Health information is only communicated to individuals or organisations on a need to know basis. Health confidentiality is managed in accordance with the *Privacy Act, 1988.*

1.31 **Medical rules of eligibility.** Health elements are generally deployed to provide health care to ADF personnel, including deployed Defence civilians; however, they may also be tasked with providing health care to civilians or to military personnel from other nations. This may be as a primary task, secondary task or as life-saving care in emergencies. Medical rules of eligibility must clearly state the eligibility for treatment of the following:

- Australian citizens in a JFAO, which is generally limited and necessary treatment when there is no other acceptable source for that care;

- ADF civilians, other government agencies and contractors;

- foreign military personnel, as authorised through agreements regarding the contributions to the operation;
third country nationals that may be supporting the operation such as manual labourers, contractors, and private military and security companies who may be entitled under agreements to health care; and

• host nation citizens, with consideration given to host nation treatment standards and the subsequent requirements for follow up or longer term treatment.

CONTRIBUTION TO JOINT OPERATIONS

War fighting

1.32 Warlike operations use force to pursue specific military objectives. Joint operations are primarily, but not exclusively, about war fighting; however, in the current global context war fighting operations are often conducted concurrently with other activities, such as humanitarian assistance.

1.33 The ADF must be able to provide health support to joint, maritime, land, air and amphibious forces conducting warlike operations. Information on war fighting operations is in ADDP 3.0.

HEALTH SUPPORT TO MARITIME OPERATIONS

In 2004, HMAS STUART was patrolling the northern Persian Gulf with three coalition vessels during Operation CATALYST. These vessels were tasked with the protection of Iraq’s offshore assets, such as oil platforms. They were also tasked with the detection, interception and deterrence of vessels suspected of undertaking illegal activity within Iraqi waters.

At dusk on 24 April, one of the coalition vessels, USS FIREBOLT, detected a dhow that had entered the security zone and sent a boarding party to intercept the dhow. The dhow was later found to be part of an attack on the Khawr Al Amaya Oil Terminal.

The dhow exploded as the boarding party drew alongside in a rigid hull inflatable boat. The boat capsized and seven people were in the water. The USS FIREBOLT notified HMAS STUART, which was 4.1 nautical miles from the incident.
Disaster relief and humanitarian assistance

Health elements contribute to strategic goals through the provision of disaster relief and humanitarian health care to civilian populations. This either precedes or accompanies humanitarian assistance provided by civilian agencies. Provision of health care to civilian populations is complex and requires integrated planning between military forces, non-government organisations and other government agencies. Health elements must be provided with treatment eligibility matrices and medical rules of eligibility that can be explained to target populations. The ADF may be required to deploy additional capabilities when providing humanitarian care, such as paediatrics, obstetrics and chronic illness care.

Disaster relief and humanitarian assistance can either be carried out within the framework of an ongoing operation or in the form of a stand-alone humanitarian operation. Health elements may be tasked with:

• providing health support to the deployed force,
• supplementing local health assets, and
• capacity building with civilian health agencies.

HEALTH SUPPORT TO MARITIME OPERATIONS—(cont)
HMAS STUART responded, closing with USS FIREBOLT in order to lend assistance. STUART brought the crew to action stations and dispatched a helicopter and rigid hull inflatable boat to retrieve casualties. The action medical organisation comprised a medical officer, clinical manager, advanced medical assistant and the ship’s medical emergency team. They prepared to receive casualties in the wardroom and helicopter hangar.

The helicopter and boat crews assisted the USS FIREBOLT to rescue casualties. Seven casualties were retrieved from the water and transferred to the HMAS STUART for triage, treatment and evacuation. All casualties, including the deceased, were evacuated to shore based facilities in three flights. They were treated, maintained and monitored by the health staff through this process, assisted by the ship’s medical emergency team. Of the seven casualties, three American sailors died and four were seriously wounded.
The health aspects of disaster relief and humanitarian relief are likely to differ from other military operations, particularly concerning types of injury and illness, population mix, and structure and type of medical response required. Health support could include provision of aeromedical evacuation teams, supplementary health teams, preventive health teams, critical incident mental health support teams, psychological support teams and major health facilities.

Chemical, biological, radiological and nuclear environment

A chemical, biological, radiological and nuclear (CBRN) environment impacts health care. Specific information on health care in a CBRN environment is contained in Australian Defence Force Publication 1.2.2.4—Health Aspects of Nuclear, Biological and Chemical Defence.

Non-combatant evacuation operations

Non-combatant evacuation operations are operations in support of the Department of Foreign Affairs and Trade. Non-combatants (Australians and approved foreign nationals) are evacuated from foreign countries when their lives are endangered by war, civil unrest, or natural disaster to safe havens in Australia or overseas. Health elements may be tasked with the following:

- tailoring an appropriate health response to the situation,
- providing health support to force elements, and
- health screening and treatment of evacuees.

Non-combatant evacuation operations are described in ADDP 3.10—Noncombatant Evacuation Operations.
HUMANITARIAN ASSISTANCE—OPERATION PADANG ASSIST

The ADF provided assistance to the Indonesian region of Padang-Pariaman following an earthquake in 2009. HMAS KANIMBLA deployed on Operation PADANG ASSIST with the ship’s company and an embarked force of 350 ADF personnel. Air Force C–130 crew, aeromedical evacuation teams and air-load teams also supported the operation.

During this operation, Navy and Army health teams provided health care in Seigerringing and surrounding districts. They treated 1300 civilian patients in a purpose built health facility. The ADF transferred the Australian Army Primary Health Care Facility to local health authorities on completion of the operation.

Operation PADANG ASSIST was a humanitarian assistance operation. In addition to the humanitarian outcomes, the efforts of the ADF strengthened the relationship between Australia and Indonesia.

Figure 1–1: Building the hospital—Operation PADANG ASSIST

Annex:
A. Roles of health care
ROLES OF HEALTH CARE

First response

1. Non-health personnel normally provide the first response capability. This includes locating the casualty, provision of first aid and care of the battle casualty.

2. Buddy aid. Buddy aid is the assistance provided to an injured person by their non-medical companions. All Australian Defence Force (ADF) personnel are trained to provide first aid and basic resuscitation.

3. Advanced first aid. This is provided by personnel who are trained in delivery of advanced first aid.

Role 1

4. Role 1 provides primary health care, triage, resuscitation and stabilisation. It manages minor sick and wounded for immediate return to duty. A Role 1 health facility can collect and care for casualties from the point of injury/onset of illness and prepare them for evacuation to a higher role of care. It is also capable of psychological first aid and limited occupational and preventive health advice to supplement measures taken by individuals and commanders.

5. Depending on operational requirements a Role 1 health facility may be supplemented with limited casualty holding, primary dental care, basic laboratory testing and psychological first aid. Role 1 health care may include underwater and aerospace medicine support.

Role 2

6. Role 2 provides enhanced clinical support, which is based on formed health teams. This type of health facility is capable of reception and triage of casualties. A Role 2 health facility provides resuscitation and treatment of casualties with shock to a higher level than Role 1. The deployment of a Role 2 health facility is mission-dependent. It is generally used where:

   a. there are large numbers of personnel or a risk of high numbers of casualties; and
   b. geographic, topographic, climatic or operational factors may limit evacuation to higher levels of the continuum of care within treatment time imperatives.
7. A Role 2 health facility provides primary health care services. It is capable of medical officer led resuscitation; triage and stabilisation for further evacuation and limited casualty holding with appropriate nursing support. In the land and air environment it also has basic imaging and diagnostic capabilities; primary dental support; and first aid and triage of psychological casualties with expectation of return to duty.

8. An R2 health facility generally has enhanced prevention capabilities, including disease outbreak investigation; integrated pest management and vector control programs; theatre health threat assessment; water, air, soil and chemical sampling, analysis, and interpretation; and routine preventive medical examinations. The health element also has a health materiel and administration capability for health records maintenance and casualty tracking.

Role 2 light manoeuvre

9. A Role 2 light manoeuvre (R2LM) is primarily an Army capability. It extends the Role 2 capability to include provision of triage and advanced resuscitation procedures up to resuscitative surgery. An R2LM health facility is generally only used for initial crisis or war-fighting deployments where direct evacuation to a primary surgical capability is impossible. The health facility acts as a focal point, but may be bypassed if situation and resources allow. Usually post-surgical cases are evacuated for stabilisation and possible primary surgery.

10. R2LM provides light, highly mobile surgical facilities. R2LM does not provide a robust capability and the health element is not normally deployed as the sole theatre surgical capability for enduring operations.

Role 2 enhanced

11. Role 2 enhanced (R2E) provides second health care built around primary surgery, intensive care and nursed beds. An R2E health facility has a health materiel and administration capability. R2E nodes are scalable and Service doctrine describes the specific capabilities for maritime, land and air R2E.

12. An R2E health facility may be employed as a small hospital or hub where provision of Role 3 is not justified. It may provide force extraction psychological screening; enhanced field laboratory including blood collection, banking and distribution; advanced diagnostic imaging capabilities; extended occupational and environmental health care capability; primary dental care and operational mental health support. An R2E health facility prepares casualties for evacuation to a Role 3 health facility or directly out of theatre.
13. R2E is the highest level of care the ADF will routinely provide on operations, with Maritime Role 2 Enhanced the highest level of care at sea.

Role 3

14. A Role 3 health facility provides comprehensive secondary health care within the restrictions of the theatre holding policy. It is capable of primary and specialist surgery; advanced and specialist diagnostics; major medical and nursing specialties; casualty holding for diagnosis, treatment and holding of patients that can be treated and returned to duty; advanced dental support; rehabilitation support; and psychological intervention with the expectation of return to duty.

15. A Role 3 health facility has a health materiel and administration capability. This includes reception and storage of medical and dental materiel and blood; repair of medical equipment; and liaison teams for casualty tracking in multinational force operations.

16. Role 3 for the ADF is often provided through use of coalition facilities, with the ADF contributing either specialist individuals or discrete teams where possible. Alternatively, a Role 3 health facility can be generated by joint supplementation of R2E elements in order to bring them to Role 3 status. Where this occurs, enabling contracts with major medical suppliers generally support the health facility.

Role 4

17. Role 4 offers the full spectrum of definitive medical care. Role 4 health care is provided either from or within the national support base. Coalition partners may provide Role 4 health care for deployed forces.

Evacuation

18. The objective of casualty evacuation is the safe and efficient movement of casualties, with the provision of en route medical care, from point of injury or illness to the appropriate health facility as soon as possible. Evacuation comprises both surface evacuation and aeromedical evacuation.

19. The evacuation system should have the following capabilities:
   
   a. evacuate casualties 24 hours a day, in all weather, over all terrain and in any operational scenario;

   b. provide clinical sustainment of the casualty throughout the journey, using appropriately trained clinical staff;
ADD P 1.2

c. regulate the flow and types of casualties when circumstances require;

d. accurately track patients and equipment throughout evacuation; and

e. collect and analyse data regarding the evacuation system.

20. Evacuation in the maritime, land and air environment is described in Australian Defence Force Publication 1.2.3—Casualty Evacuation and Patient Movement.
INTRODUCTION

2.1 The deployed operational health system supports a deployed force from the point of departure and into a joint force area of operations (JFAO). It continues to provide support until the force redeploys or returns to Australia.

2.2 The deployed operational health system contributes to operational success through conservation of personnel, preservation of life and minimisation of physical and mental disabilities. It contributes to both force protection and morale by the prevention of injury and disease, rapid evacuation, treatment of the sick and injured, and the return to duty of as many individuals as possible.

2.3 Deployed operational health support has five components: the common health picture, the joint trauma system, force health protection, health knowledge and governance, and health materiel. The deployed operational health support system is depicted in figure 2–1.
2.4 The common health picture aggregates the information available in health and other systems. It is part of the commander's common operating picture and provides real-time epidemiological data. The common health picture tracks patients, health threats, key health personnel, and dedicated health treatment and evacuation platforms. It provides health planners, commanders and clinicians with access to information on bed statistics, health materiel and streamed clinical data in order to optimise the deployed health system.

Health information, intelligence and surveillance

2.5 Health information is the collection and communication of both raw and processed data concerning a wide range of health related factors including disease, health infrastructure and environmental conditions. The information is collected from personal experience, study, research, multi-media, multi-source reports or casual observation.
2.6 Health intelligence is a product of the intelligence cycle. This type of intelligence considers civil and military health risks and capabilities, environmental and biotechnical information, and scientific and technical intelligence. Health intelligence supports the planning and conduct of operations. It is used to assess health risks, develop estimates, identify preventive health measures, conduct health surveillance, conduct force health preparation, prepare risk assessments, plan health support, and analyse adversary and civil health capabilities and vulnerabilities.

2.7 Health surveillance monitors the incidence of wounding, injury and illness of deployed personnel. Such surveillance identifies health care trends and health threats so that intervention measures can be developed to minimise casualties. All health elements conduct health surveillance and submit health surveillance reports. Health surveillance informs the common health picture by providing quantitative data on the health of the force and health threats.

Visibility

2.8 Visibility is central to the regulation and tracking of patients within a JFAO. All patients admitted to health facilities from Role 1 onwards are tracked within and between health facilities and while on dedicated evacuation platforms. Visibility of patients informs the common health picture and supports decision making on regulation and resource allocation. This also informs the common operating picture with data on an individual’s health status, readiness implications to the force element of origin, and media and family sensitivities.

2.9 The Australian Defence Force (ADF) must retain visibility of ADF personnel in third party evacuation and treatment chains. The ADF must also provide reports and returns on the location and health status of non ADF personnel within the ADF evacuation and treatment chain.

Outputs

2.10 Health commanders, staff and clinicians require operational and clinical situational awareness to inform decision making. The common health picture is a decision support tool. It aggregates health data for use by health commanders and informs the commander’s common operating picture.

2.11 The common health picture informs the commander’s common operating picture through the following:

• support to casualty estimates;
• casualty flow, type and location modelling;
ADD P 1.2

Chapter 2

- bio-attack warning; and
- predictive modelling for blood product and health materiel use.

JOINT TRAUMA SYSTEM

2.12 The joint trauma system is a continuum of care from injury to rehabilitation. The system focuses limited resources to maximise clinical effect. Casualties are evacuated to the most appropriate facility in the shortest time while applying appropriate clinical processes. This approach enables forward deployment of health elements and concentrates resource-intensive casualty care in more secure areas where health facilities are not required to move with changing tactical situations.

2.13 Effective treatment aims to minimise mortality and morbidity. The provision of an effective system of casualty treatment also has a positive effect on force morale.

Casualty regulation

2.14 Casualty regulation directs the casualty to the health facility that is best able to manage the condition in terms of nature and availability of required treatment. Regulation ensures proper routing of patient to health facilities.

2.15 Casualty regulation minimises casualty handling and transfer. To be effective, this requires direct communication between health staff, health facilities and the aeromedical control centre.

The importance of time

2.16 Expert care should be delivered as soon as possible after wounding. The best practice for treatment and evacuation uses the 10–1–2 time metric, which is described in table 2–1. The 10–1–2 time metric is a guiding principle that drives the structure of the joint trauma system, including the location of health facilities and evacuation assets.
Table 2–1: 10–1–2 time metric

<table>
<thead>
<tr>
<th>Time Imperative</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 minutes from time of injury</td>
<td>Control major haemorrhage and airway within 10 minutes of injury.</td>
</tr>
<tr>
<td>1 hour from time of injury</td>
<td>Advance resuscitative care within one hour of injury, provided en route or in a health facility.</td>
</tr>
<tr>
<td>2 hours from time of injury</td>
<td>Surgery with a facility equipped to provide this within two hours of injury.</td>
</tr>
</tbody>
</table>

2.17 Meeting the best practice time metric may not be possible in all operational situations and should be considered in the planning process. For example, deployments in the maritime environment may have difficulty achieving the best practice time metric.

2.18 The first 10 minutes. Non-health personnel will usually be responsible for first response, including arresting haemorrhage and controlling the airway. Tourniquets, haemorrhage control agents and simple vascular access systems support first aid and care of the battle casualty.

2.19 One hour. Evacuation is provided for those casualties who require it. Evacuation for the severely injured should reach the casualty within one hour.\(^1\) Qualified retrieval or aeromedical evacuation (AME) teams stabilise the casualty and provide resuscitation en route:

- **Advanced resuscitation.** Health personnel assume responsibility for treatment as soon as practicable, sustaining the casualty until evacuation assets arrive. Health personnel provide mechanical ventilation, non-invasive monitoring and diagnostics.

- **Evacuation.** Casualty evacuation is the qualified movement of casualties in accordance with current best practice. Casualty evacuation is part of the continuity of health care. Medical attention is provided to casualties/patients en route. A casualty evacuation capability has a positive influence on morale and allows optimum location of health facilities. Information on casualty evacuation is in Australian Defence Force Publication (ADFP) 1.2.3—Casualty Evacuation and Patient Movement.

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\(^1\) In the maritime and Special Forces environment this may extend to days but there remains a general presumption of evacuation within 60 minutes.
2.20 **Two hours to surgery.** The two hour to surgery time imperative dictates the method of evacuation, location of health facilities and/or the requirement to project a light surgical capability forward.

**OPERATIONAL HEALTH SUPPORT IN EAST TIMOR**

Operation TANAGER was the ADF contribution to the United Nations Transitional Administration in East Timor (January 2000–May 2002).

Australian Army battalions deployed to Batugade, which is on the border with Indonesia. From the initial point of injury casualties were transferred to the Regimental Aid Post, which provided Role 1 health care. If additional treatment was required, casualties were transported to the Role 2 health facility in the main camp at Moleana by surface evacuation or forward AME. If either further investigation or surgical intervention was required, tactical AME transferred the patient to a Role 3 hospital in Dili.

Patients requiring specialist treatment or longer stays in hospital were transferred to Royal Darwin Hospital using Air Force strategic AME. If major rehabilitation was required, patients were transferred to a large teaching hospital in the southern states of Australia.

If required, casualties bypassed health facilities to minimise handling and ensure they were directed to the most appropriate health facility.

**FORCE HEALTH PROTECTION**

2.21 Disease and non-battle injuries are a constant risk to deployed personnel. Health support plans and orders must include force preventive health measures to reduce or eliminate the incidence of disease and non-battle injuries. This enhances operational health readiness, conserves the combat potential of a force and protects individuals against health threats.

Primary health care

2.22 Deployed forces have access to primary health care services. This may include general practice, primary dentistry, basic imaging, basic pathology, physiotherapy and rehabilitation services, mental health services, health promotion services and low dependency patient holding. These services are not always organic to the deployed forces.
2.23 **Pre-deployment phase.** Before deploying, personnel are screened for physical, dental and mental fitness. Immunisations and specific countermeasures are provided in accordance with health intelligence estimates of the infectious health risk. Deploying personnel are trained in preventive health measures for key infectious diseases, environmental health risks and core preventive health tasks. The health staff establishes baseline health surveillance data.

2.24 **Deployment phase.** During the deployment phase health staff use health surveillance to monitor health readiness. This contributes to the common health picture and provides commanders with an assessment of the readiness of troops and adequacy of the health support structure. During the deployment phase, primary health care is generally provided as follows.

- **Role 1.** A limited primary health care capability is available in Role 1 health facilities organic to ships, units and air bases. These are not necessarily medical officer led as the requirement will vary according to the type of unit and operational environment.

- **Role 2.** The clinical capability at Role 2 is led by a medical officer with a general practitioner available at all Role 2 health facilities. Role 2 primary health care is provided by elements of the Health Support Battalion and the Health Services Wing in the land and air environments respectively. In the maritime environment, Role 2 is confined to larger task groups/forces.

2.25 **Post-deployment phase.** Primary health care and health surveillance continues during the post-deployment or troop return phase of an operation. Information on changes in the health readiness status of returning forces is important to the provision of ongoing care, liability determinations and operational evaluation.

2.26 **Hub and spoke delivery.** Primary health care is generally provided through a hub and spoke system. This is not a command relationship between Role 1 and Role 2 facilities; it is a method for coordination and governance. For example, an Air Force Role 2 health facility located on an air base may provide the hub for local Army Role 1 facilities. Where facilities are fixed for prolonged periods, the senior clinical staff in the Role 2 health facility may assume technical control of these Role 1 health facilities.

2.27 **Reach-back.** Role 1 and Role 2 health elements have reach-back facilities, including data streaming and video, to enable clinical support from the national support base as necessary.
Mental health care

2.28 Psychological support helps to prevent the loss of fit personnel by managing mental health, operational stress and responses to critical incidents and/or potentially traumatic events. Early identification and intervention by commanders and mental health providers can prevent escalation of issues and concerns. Further information on identification and interventions is contained in ADFP 1.2.1—*Operational Stress Management*.

![Figure 2–2: Return to Australia psychological screen](image)

2.29 Mental health care includes the provision of psychological resilience training, psychological screening and treatment.

Occupational and environmental health

2.30 *Occupational health*. Occupational health identifies and advises on the mitigation of occupational health threats. This identifies risks and threats from workplace hazards to the health of all personnel deployed in a specific JFAO. It also assesses medical suitability for employment.
2.31 Environmental health. Environment health identifies and advises on the mitigation of environmental health threats. This identifies risks and threats from terrain, climate and endemic disease to the health of all personnel deployed in a specific JFAO.

2.32 Military medical specialities. Military medical specialities are deployed as required to support operations. They include submarine and underwater medicine, aerospace medicine, and chemical, biological, radiological and nuclear medicine.

2.33 Preventive health. Occupational and environmental health identifies preventive and controlling measures, such as immunisation and prophylaxis measures. It also identifies preventive health training requirements, especially on prevention of food/waterborne and insect-borne diseases.

HEALTH KNOWLEDGE AND GOVERNANCE

2.34 Health knowledge and governance support technical control of clinical processes. This knowledge exploits health data to improve health support. It consists of reports and returns, health documentation, clinical health governance and operational evaluation.

Reports and returns

2.35 Commanders are required to maintain records and submit reports and returns that meet the information requirements of national authorities, the national chain of command and any requirements under multinational or interagency agreements.

2.36 Australian reports and returns. The health support order and standard operating procedures dictate the requirement for health reports and returns.

2.37 Multinational reports and returns. In a multinational environment the ADF may be required to submit multinational reports and returns. The health support order provides direction regarding multinational reports and returns.

Health Documentation

2.38 Health documentation should be contemporaneous, clear and comprehensive. Health documents should be interoperable throughout the JFAO and use standardised formats. Copies of health documents and records move with the casualty or patient throughout the health care system. An information database should underpin health documentation and casualty management.
ADF health facilities may admit, treat, transfer and discharge members of allied forces and civilians as specified in medical rules of eligibility. Each health facility is responsible for notifying the appropriate national authority of information concerning casualties of that nation, through the casualty regulation cell.

**Clinical health governance**

2.40 Health governance is a system of clinical continuous improvement using internal audit, risk analysis, improvement actions and feedback. Clinical health governance provides audit and oversight of clinical practices.

2.41 Clinical health governance ensures that deployed health care conforms to relevant legislation, standards and guidelines. The Surgeon-General is responsible for clinical governance. Director Health in Headquarters Joint Operations Command (HQJOC) exercises technical control and clinical governance of deployed forces.

2.42 Technical directives reinforce clinical health governance. They are issued by the command and control structure to ensure compliance with technical control authorities.

**Operational evaluation**

2.43 Operational evaluation involves the conduct of assessments to identify lessons, gather and use knowledge, and take actions to enhance capability and preparedness. Operational evaluation is also used to improve clinical processes, tactics, techniques and procedures. Operational evaluation and the identification of lessons are described in Australian Defence Doctrine Publication 00.4—*Operational Evaluation*. Key tools for operational evaluation include the after-action review and post-activity report.

2.44 **After-action review.** The after-action review is a professional discussion of an event, focused on performance standards, which enables personnel to discover for themselves what happened, why it happened and how to sustain strengths and fix weaknesses. The review is a tool that health commanders may use to get maximum benefit from every health mission, exercise and task.

2.45 **Post-activity report.** A post-activity/post-operations report records the outputs of the after-action review. The report includes observations and lessons on what was gained from the activity.
2.46 Lessons. The health staff within HQJOC are responsible for managing the operational health lessons from operational evaluation. The Surgeon-General is responsible for managing clinical lessons learned and also as lead capability manager ensures that lessons are incorporated into doctrine and training.

HEALTH MATERIEL AND LOGISTICS

2.47 While part of the broader logistics process, health materiel and logistic support has a number of distinguishing features including:

• medical materiel is afforded protected status under the Geneva Conventions if stored and distributed separately;

• there is critical interdependence between treatment capability and health logistics support;

• health materiel supplies require tight controls and specialised management due to the technical nature of commodities, often limited shelf life, sensitivity to storage and transport conditions, and national and international regulation; and

• health facilities require high standards of accommodation and guaranteed reticulated services, such as power and water.

2.48 Health materiel and logistics is mission based. The logistic system must be capable of delivering health material rapidly and theatre-wide.

2.49 Stockholding. Stockholding levels are determined by the operational viability period, casualty estimates, treatment regimes, holding policy, resupply cycles and storage constraints. Stockholding is expressed as days of operating stock based on anticipated consumption rates. Consumption of health materiel and consumables is unpredictable and usage is dependent on injuries sustained and treatment provided.

2.50 Distribution and storage. Health materiel must be stored and distributed correctly to prevent accelerated chemical degradation, reduction in, or loss of, potency. Storage requirements for sensitive health materiel are included in the product information for each item. The major factors affecting the storage and stability of health material are:

• compliance with provisions of the Law of Armed Conflict for the protected status of health materiel;

• specific packaging and storage to ensure safety and efficacy of thermolabile supplies, including temperature control, humidity and/or security measures;
method for destroying those thermolabile supplies that have not been maintained at the required temperature or that have reached their expiry date;

- specific packaging and handling of substances that are flammable, corrosive and/or radioactive;
- special handling of fragile commodities; and
- standardised system of colour coding in accordance with international agreements.

Disposal

2.51 Pharmaceuticals and other medical materiel pose serious environmental hazards if disposed of improperly and may require controlled disposal methods. Disposal issues include:

- expired drugs or materiel are not issued to any external agency, even for humanitarian reasons, but rather are disposed of in accordance with health directives;
- in some circumstances, certain consumables such as whole blood may be donated to local agencies before the expiry date in accordance with the force gifting policy; and
- disposal of narcotics and other controlled drugs is subject to explicit ADF health directives and Australian legislation.

2.52 Clinical waste management must be conducted in accordance with applicable standards.

Blood and blood products

2.53 Blood and blood products are critical treatment items. Blood is one of the most perishable commodities in a JFAO, and refrigeration and other storage requirements make its use in forward areas problematic. The operational health support order stipulates the theatre blood policy.

2.54 The supply of safe blood and blood products to all surgical elements is mandatory. Blood and blood products may be sourced from:

- the Australian Red Cross Blood Service, the preferred source of supply;
- blood donor panel, comprising local ADF donors to supplement stocks during surge—this only occurs in extreme situations because of the limited deployed collection and testing capability; and
third party provision of screened blood and blood products; however, caution should be exercised as the standards of many countries and the United Nations do not meet Australian standards.

2.55 The technical health chain controls blood. The health commander/J07, supported by logistics elements, controls the ordering and distribution of blood in the JFAO. Blood and blood products are usually distributed by air. AME assets can be used to distribute blood.

Support services

2.56 Medical equipment maintenance. Medical equipment can be technically complex. It is susceptible to the effects of climate and movement and is difficult to repair. It requires periodic servicing, recalibration and maintenance. Medical equipment maintenance in a JFAO is described in relevant orders, instructions and publications.

2.57 Support engineering. Health elements are normally self-contained for the initial phase of a deployment; however, support engineering is required to provide more permanent facilities and to reduce the burden on the health and logistics systems.

2.58 Catering. Patient catering includes post operative and convalescent diets, 24-hour meal availability and surge capacity. A medical officer authorises the special ration requirements for patients. Further information is in the Defence Catering Manual.

2.59 Laundry. Health elements require laundry support including medical and dental garments, theatre linen, bed linen and patient clothing. Operational conditions dictate the most suitable laundry method.

2.60 Showers and latrines. Ambulant and non-ambulant patients require showers and latrines. Prevention of cross infection and contamination must be considered.

2.61 Vessel services. Deployed Navy health elements depend on ships fitted with dedicated medical facilities to generate the full Role 2 enhanced capability. Ship medical equipment is not configured for deployment independent of the ship as some items, such as operating tables and sterilisers, are fixed to the ship. Health elements may deploy independent of ships; however, they are not self-supporting. Deployed Navy health elements rely on vessel services and support, including security, communications, power, logistics and hotel services. Hotel services include accommodation, meals, ablutions and laundry.
Mortuary affairs

2.62  Mortuary support is a logistics function. ADFP 1.1.1—Mortuary Affairs provides doctrine governing mortuary affairs. Health issues for mortuary affairs include:

• any tubes or devices, applied or inserted, should be left until the coroner has taken custody;

• where practicable, remains are not to be evacuated with wounded casualties;

• where possible, the logistics mortuary asset should not be co-located with a health facility; and

• a decontamination process is required for contaminated remains and items.
CHAPTER 3

HEALTH ORGANISATION

Executive summary

- Deployable operational health support uses a modular approach that focuses on the health effects required.
- Commanders and staff must consider how to leverage the Service, joint, civilian, diplomatic and multinational health capabilities.
- Health capability is supported by diverse platforms, facilities, health materiel, health logistics, and communications and information systems. It is also supported by health doctrine and training.

INTRODUCTION

3.1 Military power relies on maintaining personnel at a high level of readiness, often in inhospitable conditions. The deployable operational health system uses a modular approach that focuses on the required health effects. This system deploys the health capabilities that are necessary for the delivery of a complete continuum of care for deployed forces.

3.2 When designing a health solution, planners must ensure that health facilities are flexible and adaptive enough to conduct differing mission types either sequentially or simultaneously. Health care is a constellation of health facilities and evacuation capabilities united by a command and control (C2) structure.

HEALTH ELEMENTS

3.3 Health support to operations relies on cooperation and coordination between the Services, each of which has specific responsibilities in prevention, treatment and evacuation. This section describes the capabilities of Service and joint health elements.

Maritime health capability

3.4 The Royal Australian Navy is responsible for the delivery of health care at sea. Navy health elements provide force health protection and advanced levels of health care, including resuscitative surgery, allied health and extended inpatient holding capacity. The Navy is also responsible for rotary-wing aeromedical evacuation (AME) support to maritime operations.
3.5 The Navy shapes health support to suit a wide range of operational requirements. The capacity and configuration of Navy health elements are mission-specific; however, the roles of health care generically include:

- **First response.** A ship medical emergency team provides the first response capability on all Navy vessels.

- **Role 1.** Submarines, hydrographic survey vessels, mine warfare vessels, major fleet units and clearance diving teams deploy with a Role 1 health capability. Medics and/or clinical managers generally provide the Role 1 capability. In minor war vessels, the minor war vessel health care provider provides the Role 1 capability.

- **Deployable health care teams.** The Navy can assign additional health care teams, known as deployable Navy health elements. These augment integral Role 1 health and can extend capability up to Role 2 enhanced (R2E). These health care teams are at agreed readiness levels and can be deployed as required. The extent of capability depends on the facilities intrinsic to the ship. Additionally, Navy capability includes underwater medicine and submarine escape and rescue medical response.

- **Evacuation.** Major fleet units can have rotary-wing aircraft embarked, which provides opportune AME capability. Navy vessels frequently operate beyond the endurance of embarked aircraft. Where AME to appropriate shore health facilities is not possible, casualty evacuation may entail the ship making best speed to the nearest suitable port or rendezvous point.
Land health capability

3.6 The Australian Army is responsible for health support within the land area of operations and along the lines of communication where surface evacuation is employed. The Army is responsible for surface evacuation and forward AME in land area of operations.

3.7 Combat health support is shaped to meet a wide range of support and operational requirements. It ranges from highly mobile Role 1 health facilities supporting war fighting units to hubbed R2E static facilities in forward operating bases. The location of health facilities is mission dependent. The Army health capability includes the following:

- First response. First response is provided by self-aid and buddy aid and provides initial care of the battle casualty at point of injury.
Role 1. Close health platoons provide Role 1 health care. They also provide ground evacuation vehicles with health personnel who have pre-hospital care qualifications. Role 1 may be supplemented with other health specialties.

Role 2 light manoeuvre. Army Role 2 light manoeuvre is a light, highly mobile surgical facility. This is used for initial crisis intervention or war fighting deployments where direct evacuation to R2E/Role 3 is not viable.

Role 2 enhanced. Army health support companies provide surgery and in-patient medical/surgical care. An R2E health facility is scalable. They are generally supported by rotary-wing AME with trauma retrieval teams. These teams stabilise casualties and provide en route care.

Evacuation. Army is capable of surface evacuation and rotary-wing AME.

3.8 Further information on the land health capability is in Land Warfare Doctrine 1.2—Combat Health Support.

3.9 Special Forces. Special Operations planners also consider the provision of health care, including prevention, treatment and evacuation. The risk assessment ensures that treatment and evacuation times are analysed. Australian Defence Doctrine Publication (ADDP) 3.12—Special Operations provides further information on health care to Special Forces.

Air health capability

3.10 The Royal Australian Air Force is responsible for health support at deployed air bases, on aircraft and at appropriate locations in the tactical and strategic AME systems. The Air Force provides 24-hour aeromedical evacuation system (AES) support and advice though the aeromedical evacuation control centre. It also provides aerospace medicine support for 24-hour, all weather flying operations. This incorporates aerospace medicine support to aircrew, airfield emergency response, aircraft incident investigation and a limited search and rescue capability.

3.11 The Air Force health capability includes:

Role 1. Where there is a requirement for aircraft to operate from a forward operating base a health facility deploys forward to that airbase. The health facility provides aerospace medicine support, primary health care, limited resuscitation and environmental health.
• **Role 2.** A Role 2 health facility is generally located at a main airbase to provide Role 1 health care, AME and short-term staging of patients within the AES. Depending on the health effects required, a Role 2 health facility can provide aerospace medicine support, AME, primary health care, resuscitation, medium dependency holding, environmental health, field dental support, medical imaging, pathology, pharmacy and health administration. On airbases the Role 2 capability includes a crewed ambulance crash response.

• **Flyaway surgical team.** A flyaway surgical team (FAST) is a basic surgical facility that provides initial wound surgery, triage and preparation of casualties for AME. The team is designed for short notice contingencies and depends on a robust evacuation system. The FAST provides time for the Navy or Army to establish an R2E capability within a joint force area of operations (JFAO).

• **R2 enhanced.** The Air Force is capable of providing an R2E capability.

• **Evacuation.** The AES transports ill or injured personnel by air under qualified medical supervision to appropriate health facilities either within or outside the theatre. The Air Force is qualified to conduct both fixed and rotary-wing AME.

3.12 The Air Force is responsible for tactical and strategic AME of casualties to appropriate health facilities both within and outside a JFAO. The AES comprises standard and military critical-care AME teams, patient staging and an Aeromedical Evacuation Control Centre. The AES provides the following:

• coordination of forward, tactical and strategic AME;

• control of patient movement by air, which includes casualty tracking within the AES;

• specialised medical personnel and equipment for in-flight medical care;

• health care at staging locations, airheads and airbases for casualties entering, in transit, or leaving the AES;

• communications with destination and en route health facilities; and

• information transfer on casualty movements.

3.13 Australian Defence Force Publication (ADFP) 1.2.3—*Casualty Evacuation and Patient Movement* provides further information on the AES.
Joint health facilities

3.14 A joint health facility is a tailored response to an operational requirement. It is not a pre-existing structure. The element may be tasked to provide Role 1, Role 2, R2E or Role 3 health care. A joint health facility is tailored both in scope and size to meet the specific requirements of a joint task force.

3.15 An Australian Defence Force (ADF) Role 3 health facility can only be generated through joint capability. A Role 3 health facility comprises specialties similar to that of a major civilian hospital. This is achieved by supplementing R2E in the land or air environments. Role 3 is not provided in the maritime environment.

3.16 A joint Role 3 health facility would be capable of deploying mobile sub-elements in support of tactical activities. The surgical capabilities of this health facility would be relatively static and located near major transportation nodes. Detachments may be tasked to support the tactical activities of maritime, land or air elements.

HEALTH SUPPORT TO OPERATION SLIPPER

In the case of an Australian casualty in Afghanistan during Operation SLIPPER (Australia’s military contribution to the international campaign against terrorism, maritime security and counter-piracy), a 9–line medical evacuation request would be issued to the relevant Regional Command. This would then task a rotary-wing AME asset and team to retrieve the casualty for transfer to the most appropriate treatment health facility. The Regional Command would notify the treatment health facility to ensure that it received advance notice of the casualty arrival.

On arrival at the casualty location the forward AME team would ‘swoop and scoop’, spending as little time on the ground as possible. The casualty would be taken to a Role 2 or R2E health facility depending on the clinical situation. On arrival at the health facility, the Australian casualty would be assessed and resuscitated as appropriate.

If the patient required treatment unavailable within the health facility, a second 9–liner and a patient movement request would be sent to Regional Command; they then would task an appropriate rotary-wing AME asset and team to transport the casualty to a Role 3 health facility. There were Role 3 health facilities in Kandahar, Bagram, Bastion and Kabul.
HEALTH SUPPORT TO OPERATION SLIPPER—(cont)

If further treatment was required, the casualty may have been transferred to the United States of America Role 4 health facility, being the Landstuhl Regional Medical Centre in Germany. The AME operations officer and Chief of AME would assist in this transfer decision. The casualty would be cleared to fly by a qualified flight surgeon before movement by the United States Air Force AME system on a dedicated tactical C–130 AME flight to Bagram, Bagram being the tactical/strategic AME hub for the Afghanistan area of operations. From Bagram the patient would travel by strategic C–17 AME flight to the Role 4 health facility in Germany. If a delay in Bagram would have jeopardised the clinical situation, a C–17 could be sent from any Role 3 health facility for direct transport to Germany.

If necessary the casualty would be evacuated to Australia by Australian strategic AME dispatched from Australia as required. Garrison Health would take over clinical management of the casualty following handover from the AME team in the destination health facility. Once the patient had reached the destination health facility, and/or handed over the destination health facility medical staff, they would exit the AES.

Australian casualties would be escorted through the AES from the R2E until exiting the AES. An Australian aeromedical evacuation liaison officer (AELO) would remain with the casualty until handover to an Australian strategic AME team in Germany. The AELO would be in a liaison role, and not part of the clinical team. With handover complete, the AELO would return to the Afghanistan JFAO.

NON–DEFENCE CAPABILITY

3.17 There are significant non-Defence capabilities that may assist deployed operational health support. Commanders and staff must consider how to leverage the civilian, diplomatic and military capabilities of non-Defence organisations. Appropriate agreements with non-ADF capabilities should be made during the deliberate planning phase of an operation.
3.18 An effective interface between Defence and non-Defence organisations is required to facilitate continuity of care and ensure that ADF casualties are admitted to either military or civilian health facilities as appropriate to their condition.

Other government agencies

3.19 Other government agencies provide civilian and diplomatic support to the ADF. This can range from exerting influence in the JFAO through to the establishment of an interdepartmental emergency task force to handle the government response to a major incident.

3.20 Australian Health Protection Committee. The Australian Health Protection Committee coordinates the national civilian response to health emergencies. This committee is responsible for handling all civilian aspects of an emergency response, including ensuring that the government’s response, both overseas and in Australia, is coordinated and comprehensive.

3.21 Department of Foreign Affairs and Trade. The Department of Foreign Affairs and Trade (DFAT) maintains diplomatic missions abroad. These missions may support deployed health elements, especially when diplomatic efforts are required or host nation laws and/or international agreements must be considered. DFAT can provide access to in-country health services, assist in gaining clearances for the import and export of pharmaceuticals, and facilitate patient administration in third country locations. For example, during Operation SLIPPER, the Defence Attaché in Germany assisted health staff with the handover, clearance and administration of patients evacuated to the Role 4 health facility.

3.22 Australian Agency for International Development. The Australian Agency for International Development (AusAID) is responsible for managing Australia’s overseas aid program. Within a national framework, they provide support to nations that are devastated by natural events or recovering from conflict. AusAID has extensive links with international government organisations and non-government organisations (NGOs) that provide humanitarian care, such as the United Nations, International Federation of Red Cross and Red Crescent Societies.

3.23 Further information. A thorough understanding of non-Defence capabilities enables an effective national approach to the deployed operational health effort. Information on the capabilities of other government agencies is in ADDP 00.3—Multinational Operations and ADDP 3.11—Civil-Military Operations.
Other organisations

3.24 Civilian organisations can have an important role in the provision of health support to deployed forces and on humanitarian missions.

3.25 **Global organisations.** The World Health Organization is the United Nation’s (UN’s) health authority. It provides leadership on global health matters and ensures access to health services in crises. An example of UN involvement in a JFAO is the UN’s Humanitarian Action Plan for Afghanistan. This strategy aims to meet the immediate needs and build the resilience of the population. The strategy also defines boundaries for humanitarian action and targets assistance according to identified priorities.

3.26 **International authorities.** International agreements facilitate the provision of health care. This includes agreements with host nations on provision of civil and military health assistance. The quality and quantity of host nation civil and military health resources available in a JFAO is important in determining the size and capability of deployed operational health support. Resources that may be obtained through a host nation include patient evacuation assets, treatment capability, health materiel support and non-health support such as laundry and additional labour.

3.27 **Non-government organisations.** NGOs provide a range of services that may support or complement ADF health care or care of a civilian population. An example is The International Committee of the Red Cross whose work is based on the Geneva Conventions and provides assistance to victims of armed conflict.

3.28 **Contractors.** The use of contractors for longer-term stabilisation and reconstruction tasks provides flexibility and the ability to choose the most cost-effective workforce mix for a given operational task. Safety of contractors must be considered if planning to deploy contractors to non-secure environments. Contractors allow ADF elements to redeploy, reconstitute and prepare for subsequent operations.

3.29 **Civil labour.** During operations locally employed civilians may be used. This can pose a number of health hazards as they may be reservoirs of infectious disease and may not use similar preventive measures to the ADF. The host nation should be responsible for the health of civil labour; however, if the host nation’s health capability is inadequate, health planners need to make sufficient arrangements to protect the health of Defence personnel. Medical rules of eligibility should stipulate the care provided to civil labour.
OPERATION PAK ASSIST II

In July 2010, floods devastated Pakistan. The UN estimated that more than 21 million people were injured or left homeless as a result of the flooding and that over 2000 people lost their lives. Australia responded to the crisis by sending RAAF C–17 Globemaster aircraft with aid, personnel and equipment. This included an Australian Medical Task Force (AMTF) comprising 180 Defence and civilian doctors, nurses, paramedics and support personnel. A command and support team managed the AMTF.

The AMTF provided primary health care to the flood-affected people of Kot Addu in central Punjab. The services provided were similar to a general practice, with a ward for day treatment, basic diagnostic services including X-ray and pathology, a pharmacy and a preventive health program.

The AMTF delivered immediate, short-term primary health care and maternal and child health care to more than 11 000 flood-affected people. They also treated 3000 cases of malaria.

By October 2010, over 90 per cent of people had returned to their homes and local hospitals were returning to their normal case loads. The AMTF returned to Australia and the Australian aid effort was transitioned to meet Pakistan’s reconstruction needs.

The Australian Government also supported this disaster through provision of funding and expert personnel to assist the UN agencies, Australian NGOs and the Red Cross.
Other forces

3.30 Health support to multinational (MN) operations is generally the collective responsibility of the nations involved. The objective of health planning in an MN operation is to ensure that health support is provided in the most effective and efficient manner.

3.31 National approach. This is the provision of health support services to deployed forces using only Australian health resources. When using a national approach the ADF maintains absolute control over its own capabilities. There are certain health tasks that are always a national responsibility. These include Role 1 health care, casualty tracking and reporting, captured personnel casualty reporting, and mortuary affairs.

3.32 Customer approach. The ADF may become a customer of a lead or capability specialist nation for the provision of health support. This is especially useful when Australia has small contingents co-located with the large force of another nation that provides support services. The ADF may reach an agreement for the provision of evacuation support or Role 3 health care. This approach was used during Operation SLIPPER, where ADF force elements used the health facilities provided by coalition partners.

3.33 Module provider. The ADF may provide specific health modules for specific time periods or operational phases without becoming a capability specialist.
3.34 **Capability specialist.** The ADF may assume the responsibility for providing a specialist capability or procuring a particular class of supply or service for all or part of the MN force. Where necessary, the ADF would establish agreements regarding the provision of specialist support to other nations.

3.35 **Lead nation.** The ADF may be the lead nation for health support. It would assume overall responsibility for coordinating and/or providing an agreed spectrum of health support capabilities for all or a part of an MN force within a defined geographical area. The ADF would establish agreements governing the administrative, legal and financial issues between the ADF and members of the MN force.

3.36 **Multinational health unit.** To take advantage of economies of scale, health support capabilities may be provided by more than one nation as an MN health unit. This is used when a single nation is capable of providing the nucleus and the command structure, which is supplemented/augmented with capabilities, assets, and services from other nations. Agreements specify common funding, cost sharing and reimbursement as required.

3.37 **Considerations.** Health support to MN operations requires strict procedures for the integration of processes. Medical procedures, information sharing and the degree of integration are agreed before the start of operations and promulgated in the health support order. Factors that should be considered when developing an MN approach to health support include:

- Procedural and tactical differences may prevent health elements from different nations working effectively together.

- Language barriers may result in differences in interpretation of the mission or assigned tasks. This may be intensified by limitations in the communications technologies available. Additionally, communication between patient and health staff is a key element in health care.

- Incompatibilities, differences in health C2 and national security concerns can cause technical and interoperability difficulties and hamper the exchange of information, intelligence and clinical data.

- Health cooperation can be degraded because of concerns about other nations' capability and the lack of common standards of care.

- Varying standards of preparedness, underlying fitness and health care between nations will affect casualty estimates.

- Professional relationships between health staff vary between nations. For example, nurses in some nations have greater independence, autonomy and status than in others.
• Nations have differing blood supply policies, legal issues governing blood and health materiel.

• C2 relationships are to be clearly defined and embodied in the command directives issued to each nation. While Australian health assets may contribute to an MN force, C2 remains under Australian national command.

HEALTH MATERIEL

3.38 Platforms. Health support is delivered from diverse platforms, such as vessels, fixed and rotary-wing aircraft, airbases and combat health facilities.

Figure 3–2: C–17 aeromedical evacuation

3.39 Facilities. R2E and Role 3 health facilities are generally established using lightweight air-transportable and field deployable equipment. However, during enduring operations these temporary facilities are converted to fixed facilities with a similar clinical environment to that found in civilian hospitals. This includes purpose built peri-operative and intensive care suites. As well as optimising the clinical environment for patients, this releases equipment with operational and tactical mobility to other contingencies.
**3.40 Health materiel.** Health materiel is a critical component of patient care. This materiel can be technically complex, susceptible to the effects of climate and movement, difficult to repair and require periodic servicing and recalibration. Each Service is responsible for the health materiel specified by operational preparedness orders. Health Manual Volume 24, Part 1—*Management Procedures for Medical and Dental Material* provides further information on medical equipment.

**DOCTRINE AND TRAINING**

**Doctrine and procedures**

3.41 Doctrine and procedures provide the intellectual basis and common perspective upon which the ADF plans, operates, shapes and evaluates the conduct of operations. Doctrine also informs training. Doctrine and procedures ensure that the deployed health element meets its governance responsibilities and ensures clinical standards are maintained.

3.42 Defence health care doctrine and procedures provide general and technical health information for health personnel, commanders and staff. Sources include:

- ADDP and ADFP;
- Service publications;
- health manuals, directives and bulletins;
- ADF health journals and reports;
- Defence Instructions;
- health literature of allied nations; and
- civilian health publications.

**Training**

3.43 Service Chiefs are responsible for ensuring that health units under their command have the appropriate training and equipment to provide health support to operations.

3.44 **Non-health personnel.** The initial response at the point of injury is crucial. The provision of bleeding and airway control for the most seriously injured must take place within 10 minutes of injury. To provide this, combat personnel need to be trained and competent to deliver enhanced first aid, principally to stop bleeding and secure the airway.
COMBAT FIRST AID TRAINING

Exercise PRIMARY SURVEY I focused on care of the battle casualty and Role 1 health care in a simulated battlefield environment. Army engineer and infantry elements conducted this exercise before deployment to Afghanistan.

Approximately 60 combat first aiders and a Role 1 health element participated in the exercise. The combat first aiders were divided into sections that completed day and night battle lanes and skills stations over two days. The sections patrolled, contacted the enemy, suffered improvised explosive device casualties and completed a mass casualty scenario. Casualties were provided with first response treatment and evacuated back to the Role 1 health facility as required.
Figure 3–3: Care of Battle Casualty Training
3.45 **Individual health skills.** Health personnel need to be qualified, current and competent in their clinical and operational skills in order to effectively contribute to health capability. They must meet the credentialing requirements of Australia and coalition partners. Regular specialised continuation training, including the assets to support training, is required to maintain a viable capability. The skills necessary to provide health support across a wide range of permissive, uncertain and hostile situations are diverse and perishable. Where the ADF is deploying with civilians and contractors, consideration should be given to the training requirements of civilians and contractors.

3.46 **Collective and joint.** The melding of individual skills into single-Service collective skills and joint skills underpins effective capabilities. Commanders should ensure that health units conduct collective and joint training. The objective is to develop skills and knowledge of all aspects of operational health support. This includes training for personnel who may be assigned key roles in health planning and/or execution.

**Major exercises**

3.47 **Major exercises** provide an opportunity for the ADF to practise the planning and conduct of operational health support in a joint, interagency and/or MN environment. Exercising health support enhances the understanding of interoperability with MN forces, other government agencies and other stakeholders.

3.48 **To achieve operational readiness,** training exercises must be conducted on arrival in the JFAO. Personnel should then receive refresher or continuation training while in the JFAO.

3.49 **Exercise aims should be achievable.** Exercise planners should ensure that interoperability, intelligence, C2 and logistics aspects of the exercise are fully tested where possible. Mass casualty responses should be rehearsed by the force and health facilities as part of force preparation training and in-theatre training.
CARE OF BATTLE CASUALTY TRAINING

In 2011 Care of Battle Casualty Training was provided as part of force preparation for deployment to the Middle East Area of Operations. This training was provided to all non-health personnel to enable provision of first response care in the deployed environment.

Refresher training was also provided at Al Minhad Air Base during the reception, staging, on forwarding and integration training schedule.

The training environment simulated battle conditions by using audio-visual aids, land-battle soundtracks, smoke and lighting conditions. Medical and battlefield simulation equipment supported the training.
CHAPTER 4
COMMAND AND CONTROL

Executive summary

- The preferred command and control (C2) arrangement is for all health facilities to be deployed under a single health commander to maximise the clinical effects of scarce resources.
- The lines of C2, health accountability and clinical governance must be clearly established in relevant plans and orders. Command relationships, establishing supported and supporting relationships, help to integrate health support.

Think also of the poor wounded of both armies. Especially have paternal care for your own and do not be inhuman to those of the enemy.

Frederick the Great, 1747

INTRODUCTION

4.1 The complexity of delivering operational health support to deployed forces requires unity of health command. The preferred C2 arrangement is for all health facilities to be deployed under a single health commander in order to maximise the clinical effects of scarce resources. Where this is not possible, C2 arrangements must specify governance and technical control arrangements.

4.2 Health C2 arrangements should be clearly defined in orders at the outset of each operation and tactical activity. This chapter provides guidance on the generic C2 aspects of health. Command relationships are further defined and clarified in Australian Defence Doctrine Publication (ADDP) 00.1—Command and Control.

COMMAND

4.3 C2 of health is based on the operational requirements. Simplicity and flexibility dictate that the layers of health command should be minimised with responsibilities clearly defined. The lines of C2, health accountability and clinical governance must be clearly established in relevant plans, orders and technical directives.
4.4 The health C2 organisation must be capable of planning, executing, controlling, sustaining and assessing the full range of health functions. Health C2 must also be capable of providing operational health advice to commanders, including visibility of the health implications of decisions.

Joint Operations Command

4.5 Chief of Joint Operations. The Chief of Joint Operations (CJOPS) is responsible for the operational level of command of Australian forces participating in military campaigns and operations. The focus of command at this level is on forming joint forces, deploying them into joint force areas of operations (JFAOs), and sustaining them.

4.6 Director-General Support. Within Headquarters Joint Operations Command (HQJOC), Director-General Support is responsible for planning and monitoring support to operations, including health support.

4.7 Director Health. The Director Health provides the Director-General Support with the technical expertise to plan and execute deployed operational health support. Director Health is responsible for:

- providing specialist health advice to CJOPS and staff;
- planning and coordinating health support to operations in consultation with the Director-General Operations and Director-General Support staff;
- preparing, and monitoring implementation of, the health annexes of the administrative order;
- exercising technical control and clinical governance over deployed health assets; and
- managing operational health data.

4.8 Chief of Aeromedical Evacuation. The Chief of Aeromedical Evacuation (Chief of AME) is the specialist staff officer in charge of the aeromedical evacuation control centre (AECC) within the Air and Space Operations Centre in HQJOC. The Chief of AME is responsible for:

- aeromedical evacuation system (AES) planning;
- coordinating and controlling strategic aeromedical evacuation (AME), including tasking strategic AME teams;
- monitoring AME;
- AME reporting;
• providing technical advice to deployed AME assets; and

• arranging the charter of civilian aircraft, such as an air ambulance, should military assets be unavailable or specialist/additional AME teams are required.

4.9 Joint staff. The J07 staff interfaces with other joint staff to plan and execute health support. This includes coordination with both the vertical and horizontal levels of command. Areas of interface include:

• **Personnel staff.** The J1 staff provides the force strength and locations and, with input from the J07 staff, the disease and non-battle injury casualty estimates. The J1 staff is responsible for personnel tracking, field records, casualty reporting as part of personnel tracking, mortuary affairs, welfare and amenities, chaplaincy services, administrative referrals, and hiring and administering civilian employees.

• **Intelligence staff.** The J2 staff is responsible for providing health intelligence, estimates of adversary casualties and advice on adversary capabilities that could impact upon own force health support and casualty rates.

• **Operations staff.** The J3 staff is responsible for planning, managing and controlling operations on behalf of the commander. The J3 has oversight of all aspects of an operation. The J3 staff provides the battle casualty estimate, with input from J07 staff, and assigns assets to enable health support. They plan rear area security, interpreter support, casualty holding policy, force protection, coordination of critical incident management, mass casualty and disaster response.

• **Logistics staff.** The J4 staff is responsible for the logistic effort. This includes integration of health and logistics with the main effort; deployment/redeployment of health assets; supply and distribution of health materiel; facilities and engineering support; and, in conjunction with J07 staff, the storage and distribution of blood and blood products. Health support planning is part of the logistic planning effort and the health components of briefings are provided in the J4 briefs.

• **Communications staff.** The J6 staff is responsible for the provision of communications equipment, connectivity and bandwidth.
Legal staff. The legal staff provides legal advice and services to commanders during all phases of an operation. For each operation, the health staff works with the legal staff to resolve issues concerning both national and international law. This includes agreements, claims activity, public health liability, compliance with Geneva Law, and medical rules of eligibility.

Joint task force

4.10 CJOPS designates a commander joint task force (CJTF) to command all joint operations within a defined JFAO. CJTF is delegated operational command of all forces assigned to a joint task force (JTF). Health facilities and/or personnel are force assigned to the CJTF as required. An appropriate officer will be appointed as the health commander/J07.

4.11 CJTF exercises command through either the direct or the component method. If the direct method of command is employed, then the health commander is directly responsible to CJTF for the planning and conduct of operational health support. If the component method of command is used, then the health facilities are generally under command of the component commanders.

4.12 Health component commander. The JTF health commander should command assigned health capabilities within the JFAO. The JTF health component commander can also be the JTF J07 and be responsible for:

- providing health advice and support to CJTF and other staff branches;
- planning and coordinating health support in consultation with the staff;
- preparing and monitoring implementation of health plans and orders;
- assisting the personnel, operations and intelligence staff in providing battle casualty and disease and non-battle injury estimates and statistics;
- exercising technical control over health support in the JFAO;
- providing casualty regulation and health surveillance within the JFAO;
- liaising about casualty evacuation, including coordinating reception for patients in health facilities in the JFAO and national support base (NSB);
- managing operational health data;
- monitoring strengths and allocation of health resources;
forwarding health information and intelligence to the intelligence staff;

- obtaining updated health threat and intelligence information from the intelligence staff;

- controlling health materiel and consumables in the JFAO; and

- managing the disposition of captured medical materials.

4.13 Deployed health operations centre. On larger deployments the deployed health operations centre/J07 staff is located within the headquarters JTF to provide staff support to the health commander/J07. The size of the J07 staff varies with the mission and size of the force. The centre controls and coordinates all health effort within the JFAO on behalf of the CJTF. The centre also manages the common health picture.

4.14 Component commanders. The JTF component commanders are responsible to CJTF for integral and assigned health and evacuation capabilities.

Units/ formations

4.15 Health support to assigned forces is a command responsibility. This requires active participation and support from all Australian Defence Force (ADF) members, from the individual to the highest level of command. Unit and formation commanders are responsible for the health and wellbeing of their personnel.

Health facility commanders

4.16 Health facility commanders command and coordinate assigned health resources. They implement the operational health support order, develop tactical health support plans in support of tactical actions and provide health advice.

Command relationships

4.17 Operational health support requires centralised control with decentralised execution. Command relationships, establishing supported and supporting relationships either among or between components, help to integrate health support.
4.18 **Supported commander.** Supported commanders have primary responsibility for all aspects of an assigned task and are allocated resource priority. Supported commanders must indicate to supporting commanders their specific mission requirements and associated coordinating instructions. A health commander would be the supported commander on an operation with health and humanitarian care as the primary mission.

4.19 **Supporting commander.** Supporting commanders provide forces, equipment, logistics or other support to a supported commander, as required. They must advise the supported commander on the availability and most appropriate employment of their assets. Supporting commanders are responsible to complete the mission/tasks allocated to them by the supported commander. A health commander would be the supporting commander on operations where health is not the primary mission.

4.20 **Assignment.** Assignment of supported and supporting commanders is dynamic and will change with the needs of the situation.

**CONTROL**

**Technical control**

4.21 Technical control is the provision of specialist and technical advice by designated authorities for the management and operation of forces.

4.22 **Surgeon-General.** The Surgeon-General is responsible for strategic health policy, strategic level health advice and technical control of ADF health support.

4.23 **Director Health.** The Director Health at HQJOC is responsible for the technical control of deployed forces.

4.24 **Senior Medical Officer.** On operations the senior medical officer exercises technical control over all ADF health assets in a JFAO. While clinical intervention is executed at the lowest level, senior clinicians are responsible for oversight. The senior medical officer may also be the health component commander.

**Health support coordination**

4.25 **Deployed clinical coordination centre.** A deployed clinical coordination centre (DCCC) may be established in operations where an R2E or Role 3 health facility is deployed. The DCCC is the interface between the JTF health commander/J07, health facilities and individual health personnel. The lead clinician in the DCCC is the clinical director of the joint trauma system.
4.26 National clinical coordination centre. On larger deployments, a national clinical coordination centre (NCCC) may be established in Joint Health Command. The NCCC optimises clinical outcomes by facilitating the continuum of care from the JFAO to Australia. The NCCC maintains visibility of patients within R2E and Role 3 health facilities and cues clinical assets in Australia in anticipation of patients returning to Australia for definitive treatment. During major operations and periods of expected high casualty load, the Surgeon-General chairs clinical coordination conferences with civilian clinicians and government health agencies.

Aeromedical evacuation control

4.27 The AECC is a division of the Air and Space Operations Centre in HQJOC. It is force assigned to CJOPS and provides centralised control of assigned AME resources. The AECC plans, coordinates, executes, monitors and controls the AES support to operations. It has sole responsibility for coordinating and tasking strategic AME from a JFAO to and within the NSB.

4.28 The AECC validates and approves AME, analyses patient movement requirements, identifies and coordinates AME airlift, and notifies airlift schedules. The Chief of AME, or the deployed AME Operations Officer, has technical responsibility for AME approval, patient fitness to fly, AME equipment and AME team composition.

4.29 As an air asset a deployed AECC will form part of a JTF or combined air operations centre, air component or air mobility division. The deployed AECC provides centralised control of assigned AME theatre resources.

Health liaison

4.30 Health commanders, staff and clinicians require operational and clinical situational awareness to inform decision making. They also require the ability to clearly communicate their health requirements to civilian, diplomatic and military stakeholders. A robust civil-military liaison system is required to eliminate duplication of effort and maintain harmonious and cooperative working relationships.

4.31 Health liaison should be established with other government agencies, coalition partners, international government organisations, local hospitals and non-government organisations. Specific points of contact for health liaison should be identified at every level of the relevant organisation’s structure. The detailed duties of a health liaison officer will be mission specific; however, the broad responsibilities are as follows:

• maintain situational awareness and ensure the flow of health information and intelligence,
• coordinate health effort,
• patient management and transfer of clinical data between the sending and receiving organisations, and
• ensure effectiveness and continuity of treatment and evacuation.

COMMUNICATION AND INFORMATION SYSTEMS

4.32 Communication and information systems (CIS) are an enabler for health support to operations, providing commanders at all levels with the means to exercise C2 and disseminate vital clinical and operational information. CIS enhances shared situational awareness, which in turn facilitates better and quicker decision making. Reliable, secure and responsive communications are vital to health delivery.

4.33 CIS provides comprehensive multi-nodal (voice and data) communications links for health elements. For CIS to effectively facilitate the flow of necessary information, they should be reliable, have constant connectivity with suitable bandwidth, and be interoperable. The health CIS architecture extends from point of injury back to the NSB. The CIS architecture contains operational and clinical nodes.

• Clinical nodes. On larger deployments and when appropriate CIS equipment is available, clinical nodes may be established to enable the common health picture. They provide the technology and bandwidth for diagnostic and/or assessment capability at the point of injury. They stream real-time clinical data, including video footage, to facilitate clinical and operational decision making. CIS allows the personnel attending the casualty to transmit information to clinical staff within higher roles of care. It also allows clinical staff to interrogate forward and extract data about the casualty.

• Operational nodes. On larger deployments and when appropriate CIS equipment is available, operational nodes may be established to provide the health commander with visibility of all evacuation assets and control of ground evacuation assets not organic to combat units. In addition this visibility supports the tasking of air evacuation platforms during allocated periods.

4.34 Specific requirements. The communications plan specifies the CIS requirements for health support. Further information on CIS is in ADDP 6.0—Communication and Information Systems.
CHAPTER 5

PLANNING

Executive summary

- Health planning is an integral part of operational and tactical planning. It is synchronised within the joint military appreciation process (JMAP) to ensure that it occurs in unison with the core planning processes.
- A robust aeromedical evacuation system is a vital part of the overall health plan for the commander.
- Health staff should ensure that the commander is aware of the health risks of any plan. The health plan or order is generally part of the support order for an operation or tactical activity.

A big butcher’s bill is not necessarily evidence of good tactics.

Field Marshal Viscount Wavell of Cyrenaica, 1940

INTRODUCTION

5.1 Health support may be provided to Service, joint, combined and/or interagency activities conducted in diverse locations, tactical situations and threat levels. As a result of the complexity and diversity of potential tasks, health planning must be an integral part of operational and tactical planning. Health planners must ensure that the commander is aware of the health implications of any course of action (COA) and undertake detailed health planning in support of the operational or tactical plan.

5.2 Planners must consider all available approaches and methods to successfully plan for health support within a joint force area of operations (JFAO). This includes consideration of component, joint, interagency, multinational and civilian capabilities that are available for health support in a JFAO.
PLANNING RESPONSIBILITIES

5.3 Planning is an integrated process involving the commanders and staff of strategic, operational and tactical headquarters working in close coordination with the aim of producing the most effective military response. Health support should be planned at the highest levels to maximise the use of limited resources. The successful execution of health support relies on the inclusion of experts during planning.

Operational level

5.4 Director-General Support. The Director-General Support at Headquarters Joint Operations Command (HQJOC) is responsible for planning logistics, personnel, movements and health support to operations.

5.5 Director Health. The Director Health is responsible to the Director-General Support for detailed health support planning and for preparation of health concepts, plans and orders. The Director Health attends theatre planning groups and theatre administrative planning groups to ensure that the health plan is consistent with the operational, administrative and logistic plans.

5.6 Joint Health Planning Group. The Director Health convenes the Joint Health Planning Group (JHPG). In addition to HQJOC health planning staff, the JHPG may comprise the senior health officers of force elements, representatives from Joint Health Command, and logistics and intelligence staff as appropriate. The JHPG ensures that optimum health support is provided to joint operations. The JHPG develops the health concept and provides health input into the operation order (OPORD) and support order. The health support order is routinely an annex of the support order.

5.7 Director Air. The Director Air at HQJOC is responsible for planning, executing, monitoring and controlling the aeromedical evacuation system for operations.

5.8 Director-General Intelligence. The Director-General Intelligence is responsible for the provision of threat assessments and estimates of adversary casualties, in consultation with the health staff.

5.9 Director-General Operations. The Director-General Operations is responsible for force assignment of health assets, planning communications and information systems equipment and bandwidth, and preparation of battle casualty (Bcas) estimates, in consultation with the health staff.

5.10 Director-General Plans. The Director-General Plans is responsible for ensuring the proposed health support plan supports and synchronises with the concept of operations (CONOPS) and other supporting plans.
5.11 **Director Personnel.** The Director Personnel is responsible for the preparation of strength states for the preparation of casualty estimates and assisting the Director Health with disease and non-battle injury (DNBI) estimates.

5.12 **Director Logistics Plans.** The Director Logistics Plans is responsible to the Director-General Support for planning supply, provisioning and distribution. This includes health materiel and logistics.

### Tactical level

5.13 An operation planning group (OPG) is generally convened to conduct detailed planning for tactical level activities or operations. The role of the OPG is to provide planning support from the issue of the operation’s initiating directive through to execution of the OPORD. The health staff contributes specialist support to the OPG.

5.14 **Health commander/J07.** The health commander/J07 is responsible for tactical level health planning and development of tactical level health support plans. This requires interpretation of information from the OPORD, support order and health support order. In addition to the health considerations described in annex A, the health staff factor in the commander joint task force’s (CJTF) plan for the employment of forces. This determines the areas of casualty densities and the placement of health assets and casualty evacuation assets. The health commander/J07 ensures that CJTF is briefed on the health implications and risks of each COA.

5.15 **Joint staff.** The J07 staff interfaces with the joint staff in the development of the tactical health support plan. Staff responsibilities are described in chapter 4—‘Command and Control’.

5.16 **Component commanders.** The component commanders are responsible to CJTF for tactical level planning in the maritime, land and air environments.

### HEALTH SUPPORT PLANNING

**Joint planning process**

5.17 The JMAP is the joint planning process used to develop all operations plans. The JMAP consists of four consecutive steps with an integral and continuous joint intelligence preparation of the battlespace (JIPB). Health support planning is synchronised within the JMAP to ensure that it occurs in unison with the core planning processes.
5.18 The JMAP can be used either in full or abridged, depending upon the time and staff resources available. The JMAP is described in detail in Australian Defence Force Publication (ADFP) 5.0.1—Joint Military Appreciation Process.

Preliminary scoping

5.19 A theatre or operation planning group uses preliminary scoping to focus staff effort, provide a situational update, establish a planning time line and allocate tasks to staff. During preliminary scoping, time is allocated for development of health support and casualty evacuation plans.

5.20 The key health output preliminary scoping is the time and distance overlay.

Joint intelligence preparation of the battlespace

5.21 The intelligence staff continuously conducts the JIPB. The main focus of the JIPB is to analyse the operational environment and the threat. Deployed forces are particularly vulnerable to threats. Any health threats identified must be specific and quantifiable to enable the correct countermeasures to be employed.

5.22 The health staff, with J2 input, develops or updates the health threat assessment. The assessment considers:

- occupational, environmental and operational health threats;
- health status of adversary forces, likely adversary casualties, likely adversary weapons and adversary health capabilities;
- adversary compliance with the Law of Armed Conflict and Geneva Law.

5.23 Key health-related outputs of the JIPB are the health threat matrix and weather effects matrix.

Mission analysis

5.24 Mission analysis ensures that the planning staff clearly understands the superior commander’s intent, up to two levels above. At the end of mission analysis, the commander confirms the mission, intent and broad themes. During this step, the health staff examines the broad operating concept, JIPB products, assumptions and risks in order to identify the health mission and tasks.
5.25 The health staff gather and assess critical data regarding friendly health capabilities, including the following:

- health status of force;
- patient workload and casualty estimates, including likely locations, time frames, densities and types of injuries;
- evacuation capabilities and holding policies;
- health capabilities and limitations of own forces, allies and other health providers, including communications, health materiel, critical medical materiel and sustainment support;
- effects that can be achieved with the health assets available; and
- adequacy of allocated health resources.

5.26 During mission analysis the health staff develop a draft list of health tasks, a list of assumptions and information and intelligence requirements. They also prepare the health component of the mission analysis brief. The brief describes the following:

- health and casualty evacuation assets available;
- health effects that can be achieved with available assets; for example, number of treatment teams, surgical, time and range of evacuation;
- critical resource issues;
- battlespace effects on health and health support;
- health related constraints or other limitations, such as protected status, declared status and medical rules of eligibility;
- realistic assessment of capabilities of adversary health support;
- health time lines, particularly where there may be long lead times to set up a health facility or to prepare patients for movement; and
- recommendations on health support tasking and time lines.

Course of action development

5.27 The health staff contributes to COA development through advice on health capabilities and by developing the health concept in support of each COA.
5.28 The health staff analyse the workload of health assets to identify any resource shortfalls that may impact COA feasibility. In doing this they analyse the casualty estimate, including the interdependent relationship between casualties and holding policies; the type of operation and environment; and health risk. The health delivery options are analysed including joint, Service, civilian, multinational, interagency, contract and national support base (NSB) options. Health planners must develop treatment eligibility matrices and medical rules of eligibility that balance humanitarian assistance with operational requirements and capabilities. Factors that are considered during COA development are described in annex A.

5.29 The health concept contains the logical sequence of health tasks. It has specified effects, allocated assets and identified triggers. The concept statement describes when, where, how and why the health assets are to be used to accomplish the health mission. The concept statement includes information on:

- continuum of health care;
- critical vulnerabilities, such as ability to provide surgical support within the two hour time imperative;
- location and position of health facilities and evacuation assets;
- defensive and force protection measures;
- marking and notification of health facilities;
- humanitarian issues, including treatment of civilians and transfer of civilian patients to civil authorities;
- mass casualty plan;
- health materiel and sustainment support; and
- post operation health support.

5.30 At the end of the COA development step, a brief is provided to the commander. The commander needs to know the options available for providing health support, the health implications of any COA and the associated risks. The health component of the brief describes each health concept, employment of health assets, rationale for selected health objectives and tasks, casualty estimates and health limitations that may be deciding factors in COA development.
Course of action analysis

5.31 COA analysis tests the advantages and disadvantages of each COA. War gaming validates each friendly force COA for workability, strengths and vulnerability against each adversary COA. The aim of COA analysis is to improve the set of friendly COA. In analysing the health support, health threats and casualty estimates must be considered.

5.32 During war gaming, health staff synchronises evacuation and treatment with each COA. They also identify how many casualties will occur, at what points and locations, and how they may be produced. This enables planning for potential for surges and mass casualty situations. COA analysis also identifies:

- triggers that allow health facilities to occupy positions at appropriate times,
- health indicators that could provide the adversary with an indication of friendly intent,
- consequences of loss of a health asset, and
- shortfalls in health assets.

5.33 At the conclusion of war gaming, health staff refine the health concept. The commander is briefed on the health implications and risks of each COA.

Decision and execution

5.34 Once the COA analysis has been completed, the findings are presented to the commander for a decision. The commander confirms the preferred option and the CONOPS is developed.

5.35 The final stage of planning is the issue of the OPORD based on the approved CONOPS. The health staff contribute to the confirmatory warning order and finalise the health support plans and orders for inclusion in orders.

HEALTH PLANS AND ORDERS

5.36 The primary output of the JMAP is the OPORD. The OPORD is supported by the support order, which describes the operational requirements for logistics, health, personnel, finance and movements.
Operational health support order

5.37 HQJOC generally releases a health support order as an annex of the support order. The health support order provides the theatre wide health orders. This order generally directs the joint task force (JTF) health commander/J07 to produce health support plans for a specific JFAO and tactical activities.

5.38 The content of a health support order varies according to the type of operation, the operating environment, the level of planning and the detail required. The generic content of a health support order is in annex B.

Tactical health support plan

5.39 Tactical level health planning will be conducted by health staff in the headquarters JTF, component health staff and by the health operations staff of health facilities. Tactical health planning requires interpretation of information from the health support order and application to the tactical environment.

5.40 The commander’s tactical plan must be considered from a health perspective to determine the location of areas of casualty densities and the best placement of health facilities. JTF and component health support plans are to conform to the operational health support order.

Casualty evacuation plan

5.41 The casualty evacuation (CASEVAC) plan may be an appendix to the health support order or incorporated into the body of the order. An example CASEVAC plan is in ADFP 1.2.3—Casualty Evacuation and Patient Movement.

Mass casualty plan

5.42 The senior operational health staff member is responsible for developing a mass casualty plan, when required. The plan forms an appendix to the health support order. Tactical staff apply and adjust this plan to suit tactical activities. The mass casualty plan should include the following:

- authority to declare mass casualty situation,
- mass casualty triage priorities,
- alterations to treatment and evacuation scope and standards,
- diversion of evacuation assets,
- relocation of treatment assets to the mass casualty location,
• use of allied or civil resources, and
• deployment of additional resources from other JFAO or from the NSB.

5.43 Mass casualty plans should be war gamed during the JMAP. Both the force and health facilities should rehearse mass casualty responses as part of force preparation training and in-theatre training.

RISK ASSESSMENT

5.44 A risk assessment is completed as part of the JMAP to determine the viability of an operation. The level of acceptable risk must be determined and the means of mitigating the risk should be developed throughout the planning process. Health treatment and evacuation capabilities can impose limitations on the commander’s scheme of manoeuvre. Health staff should ensure that the commander is aware of the health risks of any plan. This includes a statement of risks, likelihoods and consequences of mitigation strategies.

5.45 Commanders must be able to justify and defend any decisions that are not compliant with best practice and the applicable Australian standards. Non-compliant decisions need to be conscious and defensible, and commanders must seek to work within the best practice framework and the application of commonsense within a risk management framework.

5.46 Risk is quantified by casualties, sustainability and opportunity cost, and environmental, humanitarian, political and social implications. ADFP 5.0.1 covers operational risk. Information on health risk management is in the Australian Standards Handbook 228—Guidelines for Managing Risk in the Health Care Sector.

CASUALTY ESTIMATES

5.47 A casualty estimate is based on assumptions. This predicts where, when, what numbers and what type of casualties will occur during the operation that is being planned. The casualty estimate is a key determinant of the health capability and resources that are allocated for the operation. The casualty estimate for adversary forces, friendly forces, civilians and neutrals must be constantly reviewed.

5.48 J1 and J3 staff, with assistance from health staff, are responsible for casualty estimates. There are a number of tools that assist casualty estimation; however, the main steps in estimating casualties are as follows:

• **Determine the population at risk.** This is based on force strength, which determines the health dependency and troops at risk of illness or injury.
• **Estimate the rate.** The rate may be estimated on a pro rata basis across the population at risk expressed as a rate over time, or as the total numbers of casualties expected for particular engagements. If a pro rata rate is used, this is then applied to the population at risk to give overall numbers of expected casualties. Generic Bcas and DNBI rates are provided in Allied Joint Medical Publication–1—*Allied Joint Medical Planning Doctrine*.

• **Estimate the profile.** The casualty profile is the relative proportions of different casualty types expected.

• **Estimate the casualty flow.** The casualty flow identifies when casualties are expected. This determines whether casualties can be cleared before the next influx. The estimate links the casualty flow with treatment and evacuation capability and holding policies.

• **Integrating the casualty estimate.** To obtain the total estimate of workload, Bcas and DNBI are integrated with the workload for health administration, routine medical and dental treatment, and adversary and civilian casualties.

**Annexes:**
A. Planning Considerations
B. Health support order
PLANNING CONSIDERATIONS

Legal
1. Legal factors that should be considered include:
   a. host nation laws, status of forces agreements and memoranda of understanding;
   b. Law of Armed Conflict and Geneva Law;
   c. constraints imposed by mandate, directives and plans;
   d. treatment of allied military forces, civilians and captured persons (CPERS);
   e. treatment of Defence civilians and civilians supporting the operation, such as private military security companies or locally engaged civilians; and
   f. scope of care.

Health threat
2. Health threat factors that should be considered include:
   a. operational, occupational and environmental hazards;
   b. common illnesses and endemic diseases;
   c. hostile action and other hazards, such as effect of weapon systems, land mines, accidents and chemical, biological, radiological and nuclear (CBRN) contaminants;
   d. mental health threats and stressors, such as exposure to human remains and mass human suffering; and
   e. health information and intelligence.

Friendly forces
3. Friendly force factors that should be considered include:
   a. size and health status of force;
   b. force protection and preventive measures;
   c. casualty estimates, including impact on medical skills required, evacuation and holding policies;
d. evacuation and treatment requirements, availability and capabilities;

e. airspace considerations and evacuation routes;

f. capability of allies or international support base, including standards of care and interoperability;

g. lead and contributing nations for health; and

h. existence of other government agencies, international government organisations and non-government organisations providing health care.

**Occupational and environmental**

**4.** Occupational and environmental factors that should be considered include:

a. geographical factors: climate, weather, terrain, physical distances, flora and fauna, condition of infrastructure, and other factors that may influence health;

b. biological factors: epidemic and endemic diseases—their types and prevalence, local prophylactic measures, resistant strains and treatment, vaccines and prophylaxis;

c. waste factors: disposal of medical and biological waste, including environmental issues, infection control, methods and future cleanup liability;

d. chemical factors: fumes, dust, vapours, heavy metals, asbestos, solvents and fuels;

e. physical factors: ionising and non-ionising radiation hazards, noise, vibration, road movement hazards, temperature extremes and lighting;

f. human factors: manual handling, fatigue, shift work and acclimatisation;

g. psychosocial factors: cultural issues, bullying, harassment, separation, grief, education, training and preventive measures;
h. CBRN factors: prevention, pre-treatment (vaccines and prophylaxis), decontamination (patient, clothing, equipment), augmentation, handling and treatment, contaminated and clean evacuation chains and treatment facilities, additional resources and supplies; and

i. urban factors: width, depth, size and location of built-up areas; attitudes and abilities of the local population, airspace, rescue teams.

Operational

5. Operational factors that should be considered include:

a. integrating with the operational and support plans;

b. duration of operation or tactical activity;

c. type of operation or tactical activity;

d. deployed force numbers and force dispersal;

e. adversary’s most likely course of action and the corresponding defensive and force protection measures for casualties, health personnel, health facilities and evacuation platforms;

f. disarming and handling personal effects of injured soldiers;

g. road network, route security and the dedicated medical evacuation routes (contaminated and clean);

h. impact of communication plan, airspace control plan and joint fire support plan on treatment and aeromedical evacuation;

i. casualty estimates: battle casualty, disease and non-battle injury, psychological casualties, expected areas of casualties and casualty densities;

j. mass casualties: process, triage, holding policy, augmentation;

k. humanitarian assistance: medical rules of eligibility, requirement to treat civilians, mandate, additional skills and equipment required, likely workload, impact on provision of health support to force; and
l. injured or ill CPERS: health screening, disarming, personal effects, guarding, security, inspection of health facilities, movement and evacuation of CPERS, provision of health care to CPERS camps, system for tracking CPERS, notification.

Civil

6. Civil factors that should be considered include:
   a. civilian population in the joint force area of operations (JFAO);
   b. population issues such as socio-economic factors, diseases, nutrition, housing, refugee movement, sanitation, hygiene;
   c. indigenous medical capabilities, standard of local health infrastructure, spare capacity;
   d. support from other government agencies, international government organisations, non-government organisations and host nations;
   e. interpreter support;
   f. medical rules of eligibility and clear guidance on rendering health care and transfer to civilian authorities;
   g. contract health practitioners and commercial providers; and
   h. health hazards posed by civil labour employed by force such as infectious diseases, hygiene in camp, potential of infected food handlers, sexually transmitted diseases, contaminated water.

Health provision

7. Health provision factors that should be considered include:
   a. availability and capability of health personnel, facilities and evacuation assets;
   b. command and control, including appointment of triage officers, succession planning, casualty regulation, networked communications, support relationships, liaison and coordination arrangements;
   c. health specialities required, including underwater and aerospace medicine;
d. level of care required, including number of beds, bed occupancy rate, numbers and types of health capabilities, specialists, pharmacy and blood stocking; hospital morgue capacity;

e. time imperative and impact on location of health facilities and evacuation assets;

f. evacuation modes available, evacuation and holding policy (far forward, forward, tactical and strategic), priorities, locations, airspace, road network and engineer obstacle plans, landing zones;

g. location, defence and siting of health facilities;

h. mobility of health facilities and redeployment arrangements;

i. camouflage, marking and notification of health facilities, equipment and personnel;

j. health reserve; and

k. pre-deployment force preparation and post deployment treatment and rehabilitation.

Health materiel

8. Health materiel factors that should be considered include:

a. links with personnel staff for patient tracking;

b. anticipated rates of effort;

c. unit medical equipment status in the JFAO, reserve holdings, repair pipeline, replacement policy, security, quarantine and customs issues;

d. supply status, including pharmaceuticals;

e. blood and blood products, including sourcing, transport and holding policy;

f. facilities and engineering support;

g. sustainment support including laundry, showers, catering, mortuary affairs, waste disposal and sustainment support;

h. communications with supported force, aeromedical evacuation assets, allies and civilian health infrastructure;
ADD P 1.2

i. continuity of logistics support through roles of health care, including proximity, stockpiling and mobility;

j. tracking of equipment and consumables;

k. contracting and commercial support requirements;

l. logistic support from other government agencies, international government organisations, non-government organisations and host nations;

m. handling deceased persons: certification of death, deaths in health facilities; identification processes; medical evidence for investigations; personnel tracking, personal effects, contaminated remains; repatriation;

n. health surveillance and administration; and

o. reconstitution of health elements.
HEALTH SUPPORT ORDER

1. At the operational level, Headquarters Joint Operations Command issues a comprehensive health support order as an annex to the support order. At higher tactical levels, the headquarters joint task force issues a health support plan for specific operations/activities where necessary. At the lower tactical level a health support plan may be written or issued as part of verbal orders. While the content of a plan varies substantially with the operating environment and the level of planning, relevant aspects of the following should be included:

Preliminaries

2. The preliminaries contain the following:
   a. security classification,
   b. file number,
   c. distribution list,
   d. the name of the person who compiled the plan,
   e. time prepared,
   f. time zone, and
   g. references that are relevant to this plan.

Situation

3. Describe the area of health responsibility. Describe the current health situation.

4. Summarise key events to date of a health interest. List assumptions, if any.

5. Describe the health threat including:
   a. health threat to friendly forces,
   b. casualty estimate, and
   c. adversary health capabilities and casualty estimates.

6. Describe friendly health capabilities.

7. List attachments and detachments.
Mission

8. Provide a clear concise statement of the health mission and essential tasks to support the operation.

Execution

9. Provide the intent, expressed as purpose, method and endstate. The method outlines how health support will be provided to meet the commander’s intent. Include the general nature and scope of health support.

10. Outline health support concept of operations including organisation, phases, command and control, and health capability roles.

11. Describe grouping and tasks of:
   a. all maritime, land and air health and evacuation capabilities;
   b. other government agencies;
   c. allied health capabilities; and
   d. access to non-Defence health capabilities, such as United Nations, multinational forces and civil infrastructure in joint force area of operations and national support base.

12. Describe tasks:
   a. medical rules of eligibility: treatment of Defence personnel, allies, civilians and captured persons (CPERS);
   b. pre-deployment and re-deployment preventive tasks and counter measures;
   c. deployment prevention tasks, evacuation tasks, treatment roles and tasks; and
   d. post-deployment health tasks.

13. Describe coordinating instructions:
   a. timings, including opening and closing times of health facilities;
   b. key locations and boundaries, including locations of supporting health facilities;
   c. treatment and evacuation priorities, including standards of care;
d. holding and staging policies;
e. evacuation policy, including surface and air evacuation procedures;
f. actions on chemical, biological, radiological and nuclear and mass casualty incidents;
g. protection, marking and notification of health facilities, platforms, equipment and personnel; and
h. managing CPERS.

Administration and Logistics

14. Describe:
   a. health administration
      (1) documentation of casualties,
      (2) health records,
      (3) casualty reporting, and
      (4) patient tracking
   b. health surveillance
   c. logistics
      (1) supply and resupply of health materiel,
      (2) blood supply and holdings,
      (3) surgical stores,
      (4) medical waste disposal, and
      (5) sustainment
   d. guarding CPERS casualties.

Command and Signals

15. Describe:
   a. locations of commander and key personnel;
   b. communications;
c. briefings and meetings;
d. command and control;
e. appointment of health commander/senior health officer and triage officer;
f. casualty regulation, holding policy, casualty handover points, aeromedical evacuation control;
g. required health reports and returns;
h. liaison;
i. technical control and governance; and
j. Law of Armed Conflict issues.

Signature Block

Appendices (as appropriate and not provided in this annex)
A. Synchronisation Matrix
B. Task Organisation Matrix
C. Mass Casualty Plan
D. Aeromedical Evacuation Plan
E. Health Component of Chemical, Biological, Radiological and Nuclear Plan
CHAPTER 6

GENEVA LAW

Executive summary

- All health personnel should thoroughly understand the Geneva Law provisions that apply to health support.
- Protected persons, objects and localities must not be attacked. As far as possible given the circumstances of a conflict, medical personnel, units and transports must be clearly marked with a protective emblem.
- Health implications of Geneva Law include limitations on employment of health personnel, priority of health treatment on the basis of clinical need, and special provisions regarding abandonment or capture of medical materiel, facilities and personnel.

INTRODUCTION

6.1 The aim of the Geneva Conventions and Protocols, and the subsequent Commonwealth Acts that ratify them, is to protect the victims of armed conflicts and the personnel responsible for providing treatment and patient care. They further recognise the unique rights and obligations of health personnel to assist the wounded and sick during conflicts.

6.2 As Australia is a signatory to the Geneva Conventions and Protocols, all health personnel should thoroughly understand the provisions that apply to health support activities. Health personnel should further ensure that tactical commanders understand the consequences of violating Geneva Law.

PROTECTED STATUS

6.3 Protected persons, objects and localities must not be attacked. This section describes the health-related classes with protected status.

6.4 Wounded, sick or shipwrecked. Personnel who are wounded, sick or shipwrecked at sea must be treated humanely in accordance with the provisions of the Second Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of 1949. The wounded, sick and shipwrecked are non-combatants and must not be attacked, provided they refrain from any further participation in hostilities.
6.5 Medical personnel. Medical personnel are non-combatants. They are protected so long as they do not participate in hostilities. Medical personnel include the following:

• Persons on the permanent staff of health establishments are medical personnel. If captured, medical personnel are protected against becoming a prisoner of war. They are classified as retained personnel and are only retained by the capturing force for the purpose of providing health care to their own troops.

• Any person temporarily assigned to medical duties, such as soldiers who are carrying wounded from the battlefield, are protected while conducting medical duties.

• Military and civilian personnel assigned exclusively to medical tasks, to the administration of medical units or the operation or administration of medical transports.

6.6 Health facilities and transport. Health facilities and transport are protected. This applies to any form of medical transportation, whether by sea, land or air. Their immunity ceases once they are used for hostile purposes and outside their humanitarian purpose. Military hospital ships that are built or equipped solely for the purpose of assisting the sick, wounded and shipwrecked, and which are appropriately marked, may not be attacked or captured. However, the fact that a warship has a health facility on board does not render it a hospital ship. Australian Defence Doctrine Publication (ADDP) 06.4—Law of Armed Conflict contains rules governing use and protection of facilities and transport.

6.7 Health materiel. Health materiel are any equipment and supplies that are exclusively used for the benefit of the wounded and sick.

6.8 Civilian medical facilities. Civilian medical facilities are entitled to the same protection as military medical units.

PROTECTED SYMBOLS

6.9 Several internationally recognised symbols and markings are used to identify protected persons, transport, facilities and materials. The main symbols and markings include:

• Red Cross. A red cross on a white background is the internationally accepted symbol for protected medical and religious personnel, facilities, transports and activities.

• Red Crescent. Muslim countries use a red crescent on a white background.
• **Red Crystal.** The Red Crystal (a hollow red diamond on a white background) is another protective symbol for the purposes of the Geneva Convention.

• **Oblique Red Band.** An oblique red band on a white background designates hospital zones and safe havens for non-combatants.

6.10 As far as possible given the circumstances of a conflict, medical personnel, units and transports must be clearly marked with the protective emblem as follows:

• **Personnel.** Australian Defence Force (ADF) health personnel are to wear the emblem on both their headgear and clothing. Temporary health personnel wear the armband when employed in health tasks, such as orderlies or stretcher-bearers. Identity cards are to be issued to medical personnel regardless of whether they are of either permanent or temporary status. Under no circumstances are they to be deprived of this identification. ADDP 06.4 describes the content and format of an identity card.

• **Facilities.** Fixed and mobile health facilities should fly a flag portraying the protective emblem. If the unit belongs to a neutral state, the national flag should be flown together with the flag of the belligerent that they are attached to.

• **Aircraft.** Medical aircraft should be marked clearly with the protective emblem together with the national emblem on their lower, upper and lateral surfaces, as well as with any other emblems, which may be agreed upon by the parties to the conflict.
Use of the protected symbols is strongly recommended but not compulsory. Not displaying a symbol does not automatically leave a protected facility or person open to attack. If a belligerent has knowledge that a person or facility is protected under Geneva Law, then the protected status of the facility or person must be respected. The practical problem is that it may be very difficult in combat for an attacker to identify and distinguish the unmarked protected person or facility.

The ADF uses protected symbols unless overriding military considerations dictate otherwise. A commander may choose not to display the protective emblem. For example:

- To conceal a military deployment, a commander may choose not to display the protective symbol on health facilities, which by necessity must be located close to a military objective such as a medical transit post adjacent to a military airfield.

- Where an enemy unlawfully targets medical personnel, a military commander may order military personnel to not wear their brassard. The military commander may order the medical personnel to reinstate the brassard without jeopardising their special protection.
6.13 Persons protected by the Law of Armed Conflict (LOAC) are not permitted to renounce any of their rights or obligations, regardless of whether they are either marked or unmarked. The protected status of medical personnel does not change whether the symbol is displayed or not. It is prohibited to improperly use the distinctive emblem of the Red Cross, Red Crescent or Red Crystal.

HEALTH IMPLICATIONS

Limitations on employment

6.14 The protected status of medical personnel incurs obligations that impact on the employment of health personnel. Health personnel are non-combatants and must abstain from all acts of hostility and any intervention in military operations. Medical personnel cannot be employed in any military actions outside of self-defence and the protection of patients. As such they cannot even be used as observers, in listening posts, upper deck security or on perimeter security.

6.15 Limitations include the following:

- **Self defence.** Health personnel may carry small arms for personal defence of themselves and of their patients. They must not resist either capture or control, but may use force if the enemy fires upon a health facility in contravention of LOAC.

- **Guard or piquet.** Health personnel may provide a security piquet for a health facility without jeopardising their non-combatant status. Any use of force by a health facility security force (whether health personnel or security forces) must be limited to their own and/or patient defence, and may not oppose the occupation or control of the health facility by the enemy.

- **Weapons.** Persons on the permanent staff of health establishments are medical personnel. They may carry light individual weapons for their own and/or patients’ defence.

Priority in treatment

6.16 Priority in medical treatment can only be determined on the basis of medical need. Health personnel can neither be compelled to give preferential treatment to any sick or wounded person, except on medical grounds, nor may they be compelled to carry out any act incompatible with either their humanitarian mission or medical ethics.
6.17 No person may be punished for carrying out medical activities in accordance with medical ethics, regardless of the nationality or status of the person treated.

Abandonment and capture

6.18 Medical materiel. When capture by the opposing forces is imminent, medical and dental materiel must not be intentionally destroyed. Every attempt should be made to evacuate medical and dental materiel and equipment. A command decision is required to abandon medical and dental materiel. Captured medical and dental materiel is neutral and protected property, and is not to be intentionally destroyed if it is functional and safe. It is treated as follows:

- a sample is back loaded for analysis and classification;
- if suitable for use, supplies may be used by retained health personnel to treat captured persons (CPERS), or provide aid to the civilian population or refugees;
- if unfit for use or not needed by friendly forces, the captured items may be abandoned for opposing forces use following a command decision to do so.

6.19 Sick and wounded. A party to an armed conflict, if compelled to abandon wounded and sick must, so far as military considerations permit, leave medical personnel and equipment to care for those left behind. The presence of such medical personnel does not exempt the enemy from providing additional assistance that may be necessary.

6.20 Medical personnel. Medical personnel who fall into enemy hands do not become prisoners of war; instead, they have special status as retained personnel. They must be treated as CPERS and be provided with all necessary medical facilities to care for their own CPERS. Medically qualified CPERS unattached to the medical branch of their own forces may be required by the detaining power to exercise their medical functions on behalf of CPERS. Although prisoners, they are to be treated as other medical personnel and are exempt from any other work.

6.21 Health facility. If a complete health facility is captured, the facility continues to function as it was before capture, other than command and control. The status quo remains until the enemy is in a position to make complete arrangements for the care of the wounded and sick. Enemy health facilities captured intact should be immediately reported through the chain of command.
6.22 Captured persons. Sick and wounded combatants are to be protected and respected, treated humanely, and cared for by any detaining power. Each camp should be provided with an infirmary for treatment of CPERS. Retained medical personnel may be employed in the infirmary but, if they are not available or sufficient, ADF health personnel must be tasked. Fit CPERS may be employed as stretcher-bearers for either sick or injured CPERS. Medical issues that should be considered for CPERS include:

- upon capture any urgent or necessary medical treatment should be provided according to strict medical triage criteria (regardless of whether they are CPERS or friendly forces);
- CPERS are examined, treated, evacuated and transferred to normal CPERS facilities using the same clinical criteria that apply to return to duty of friendly forces;
- while nations may provide centralised CPERS treatment facilities, the capturing nation remains legally responsible for CPERS wherever they are held or treated;
- special facilities for the care of disabled and blind, and for the rehabilitation of those CPERS pending repatriation;
- CPERS whose condition necessitates special treatment, must be admitted to any civilian or military unit where such treatment can be given;
- CPERS cannot be prevented from seeking medical attention;
- CPERS are to be adequately guarded by security forces or military police;
- all necessary preventive measures to ensure the cleanliness and healthfulness of camps and prevent epidemics must be implemented;
- an adequate diet and suitable medical and dental care is provided;
- medical inspections of CPERS should be conducted at least once a month;
- the appliances necessary for the maintenance of good health, such as spectacles, dentures and other prostheses, should be supplied;
- regular checks should be made on the fitness for work of those prisoners who are compelled to work and to exempt those who are unfit; and
- there is to be an official inquiry if a CPERS dies or is injured.
Planning considerations

6.23 Given political and strategic guidance, operational and tactical commanders need to address the implications of LOAC and Geneva Law, including:

- the location of health facilities in relation to combat elements and logistic facilities;
- which health facility locations are to be advised to the enemy;
- the extent to which guards or piquets may be assigned to those units;
- weapons that may be carried in by health personnel;
- arrangements for CPERS holding capacity and guarding CPERS casualties in health facilities;
- the extent to which mobile health facilities in forward areas are to be camouflaged and for what phases of an operation;
- whether all surface evacuation transport is to be marked;
- the extent to which aircraft and ships are to be dedicated to the aeromedical evacuation role, marked and thereby claim protection; and
- defence of patients, visitors, mobile health facilities and landing zones, if applicable.

LOSS OF PROTECTION

6.24 A protected person cannot renounce their rights; however, protected personnel lose their protected status when:

- they engage in hostile acts or attempt to shield military objectives from attack other than circumstances in which:
  - they use arms in self-defence or for the defence of the wounded and sick;
  - they are used as guards, piquets and sentries for health facilities protection; or
  - small arms and ammunition taken from the wounded and sick are found within a health facility.
• an otherwise protected person in the territory of one of the belligerents is suspected of, or engaged in, activities hostile to the security of that state; or

• an otherwise protected person in an occupied territory is detained as a spy or saboteur.

6.25 If health facilities are used for military purposes, inconsistent with their humanitarian purposes, the right to special protection is lost.

6.26 Before the protection of medical personnel and facilities is lost, a warning will normally be provided and reasonable time allowed to permit cessation of improper activities. In extreme cases, overriding military necessity may preclude such a warning.

6.27 Some examples of harmful acts include:

• sheltering unwounded combatants or fugitives in a hospital,

• making a health facility a depot for arms and ammunition,

• setting up a military observation post in health facilities or vehicles, or

• deliberately placing a health facility in such a position as to prevent an enemy attack or to shield military objectives from attack.
GLOSSARY

The source for approved Defence terms, definitions and abbreviations is the Australian Defence Glossary (ADG), available on the Defence Restricted Network at http://adg.eas.defence.mil.au/adgms/. Note: The ADG is updated regularly and should be checked for amendments to the entries in this glossary.

TERMS AND DEFINITIONS

aeromedical evacuation (AME)
The movement of patients under qualified medical supervision to and between health facilities by air transportation.

aeromedical evacuation control centre (AECC)
A facility established in an air operations centre, combined air operations centre, air component or air mobility/airlift division. It is an air asset that provides centralised control of all assigned aeromedical evacuation system resources and is responsible for AME operational planning and mission execution.

battle casualty (Bcas)
Any casualty incurred as the direct result of hostile action, sustained in combat or relating thereto or sustained going to or returning from a combat mission.

casualty evacuation
Casualty evacuation is the process of moving any person who is wounded, injured or diseased to and/or between health facilities.

casualty regulation
The process that directs casualties to the health facility best able to cope with their condition, in terms of medical specialty required and the availability of treatment capability and capacity.

definitive treatment
Definitive treatment refers to care that will improve, rather than simply stabilise, a casualty’s condition. Requirements for definitive treatment will vary widely depending on the magnitude and epidemiology of the military, humanitarian or disaster relief operation.
**disease and non-battle injury (DNBI)**

Disease and non-battle injury are personnel losses not directly attributable to being in action, including sick or diseased, accidentally injured, and non-battle missing. Disease and non-battle injury are influenced by the environment and epidemiology of the area of operations, and the state of preparedness of forces.

**en route care**

The care required to maintain the phase treatment initiated prior to evacuation and the sustainment of the patient’s medical condition during evacuation.

**first aid**

Urgent and immediate lifesaving or other measures that can be performed for casualties (or performed by the casualty) by non-medical personnel when medical personnel are not immediately available.

**forward aeromedical evacuation**

The evacuation of a casualty by air transportation from the point of wounding or injury to the initial health facility within the area of operations.

**mass casualty situation**

Any large number of casualties produced in a relatively short period of time, usually as the result of a single incident such as a military aircraft accident, hurricane, flood, earthquake, or armed attack that exceeds local health support capabilities.

**strategic aeromedical evacuation**

The evacuation of a patient by air transportation from a deployed health facility within an area of operations to a destination medical facility outside an area of operations or within the national support base. It is also evacuation by air from one health facility to another health facility within the national support base.

**tactical aeromedical evacuation**

The evacuation of a patient by air transportation from one deployed health facility to another deployed health facility within an area of operations or to another area of operations.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDP</td>
<td>Australia Defence Doctrine Publication</td>
</tr>
<tr>
<td>ADF</td>
<td>Australian Defence Force</td>
</tr>
<tr>
<td>ADFP</td>
<td>Australian Defence Force Publication</td>
</tr>
<tr>
<td>AES</td>
<td>aeromedical evacuation system</td>
</tr>
<tr>
<td>AECC</td>
<td>aeromedical evacuation control centre</td>
</tr>
<tr>
<td>AEOLO</td>
<td>aeromedical evacuation liaison officer</td>
</tr>
<tr>
<td>AME</td>
<td>aeromedical evacuation</td>
</tr>
<tr>
<td>AMTF</td>
<td>Australian Medical Task Force</td>
</tr>
<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>Bcas</td>
<td>battle casualty</td>
</tr>
<tr>
<td>C2</td>
<td>command and control</td>
</tr>
<tr>
<td>CBRN</td>
<td>chemical, biological, radiological and nuclear</td>
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<tr>
<td>Chief of AME</td>
<td>Chief of Aeromedical Evacuation</td>
</tr>
<tr>
<td>CIS</td>
<td>communications and information systems</td>
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<tr>
<td>CJOPS</td>
<td>Chief of Joint Operations</td>
</tr>
<tr>
<td>CJTF</td>
<td>commander joint task force</td>
</tr>
<tr>
<td>COA</td>
<td>course of action</td>
</tr>
<tr>
<td>CONOPS</td>
<td>concept of operations</td>
</tr>
<tr>
<td>CPERS</td>
<td>captured persons</td>
</tr>
<tr>
<td>DCCC</td>
<td>deployed clinical coordination centre</td>
</tr>
<tr>
<td>DFAT</td>
<td>Department of Foreign Affairs and Trade</td>
</tr>
<tr>
<td>DNBI</td>
<td>disease and non-battle injury</td>
</tr>
<tr>
<td>FAST</td>
<td>flyaway surgical team</td>
</tr>
<tr>
<td>HQJOC</td>
<td>Headquarters Joint Operations Command</td>
</tr>
<tr>
<td>JFAO</td>
<td>joint force area of operations</td>
</tr>
<tr>
<td>JHPG</td>
<td>Joint Health Planning Group</td>
</tr>
<tr>
<td>JIPB</td>
<td>joint intelligence preparation of the battlespace</td>
</tr>
<tr>
<td>JMAP</td>
<td>joint military appreciation process</td>
</tr>
<tr>
<td>JTF</td>
<td>joint task force</td>
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<tr>
<td>LOAC</td>
<td>Law of Armed Conflict</td>
</tr>
<tr>
<td>MN</td>
<td>multinational</td>
</tr>
<tr>
<td>MR2E</td>
<td>maritime Role 2 enhanced</td>
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<tr>
<td>NCCC</td>
<td>national clinical coordination centre</td>
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<tr>
<td>NGO</td>
<td>non-government organisation</td>
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<tr>
<td>NSB</td>
<td>national support base</td>
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<td>OPG</td>
<td>operations planning group</td>
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<tr>
<td>OPORD</td>
<td>operation order</td>
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<td>Abbreviation</td>
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<tr>
<td>R2LM</td>
<td>Role 2 light manoeuvre</td>
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<tr>
<td>R2E</td>
<td>Role 2 enhanced</td>
</tr>
<tr>
<td>RAN</td>
<td>Royal Australian Navy</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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