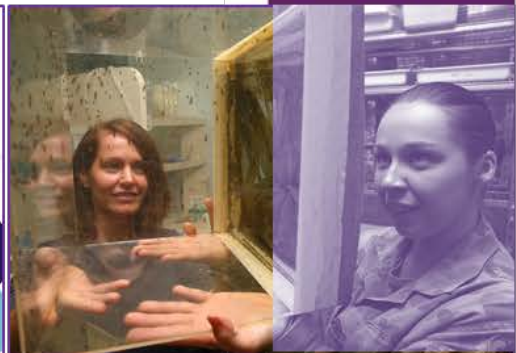
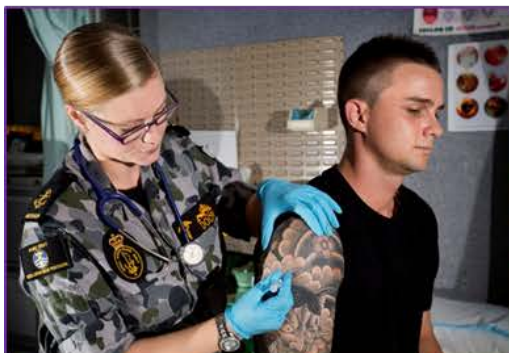




Joint Health Command

Annual Review

2017–18



EXECUTIVE SUMMARY

About this report

This publicly available report provides the Commander Joint Health's review of joint health services and support for the period 1 July 2017 to 30 June 2018. It also satisfies the requirement for Defence to produce an annual report on Mental Health Services, a recommendation of the 2013 Joint Standing Committee on Foreign Affairs, Defence and Trade Inquiry into *The Care of ADF Personnel Wounded and Injured on Operations*.

The year in review

Financial year 2017–18 represented the tenth year of operations for Joint Health Command and its first as part of Joint Capabilities Group. The reporting period was characterised by a maturation of the Command, improvements in business intelligence and management, increased responsibility in delivery of operational health services, progression of major projects, and deepening of our relationships with key customers. Evidence indicates that our customers received high quality health services, including for mental health concerns, and are satisfied with these services. There is increasing evidence that the Command delivers the best holistic health care in the country, and that it is 'trusted to care' by all Defence members.

We continued to deliver garrison health services to over 80 000 Defence members and support to over 48 000 dependants (through the ADF Family Health Program). We have also defined and established the next model of health service delivery in Defence.

Key achievements this year were the release of the Defence Mental Health and Wellbeing Strategy; the release of the first reports from the Transition and Wellbeing Research Programme; approval of the health facilities project; ongoing development of e-health and digitisation capabilities; establishment of the Bungendore Health Outreach Service; and introduction of a periodic mental health screen.

Outlook for 2018–19

In 2018–19, we will continue to provide operationally-focused, command-responsive, member-centred, and recovery-oriented health services as we design and implement our new service delivery model. We will work closely with partners such as the Defence People Group and the Department of Veterans' Affairs to better prepare our members for their post-service life. We will deliver a digital health framework and use the experience gained over our journey to produce a strategy for the next 10 years.



T Smart AM

Air Vice-Marshal
Commander Joint Health
Surgeon General Australian Defence Force

31 January 2019

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OVERVIEW

1. Commander Joint Health (CJHLTH)/Surgeon General ADF (SGADF) is responsible to Chief Joint Capabilities to produce a joint health effect to enable Australian Defence Force (ADF) capability and care for our people. This requires the exercise of technical control of the Defence health system, health capability coordination, provision of strategic health advice and delivery of garrison health services.

Health dependency

2. In 2017–18, Joint Health Command (JHC) supported a dependency of 81 476 Defence members. Army is the largest segment (54.8 per cent), with 24.2 per cent from Air Force and 21 per cent from Navy. This was similar to the dependency supported in 2016–17.

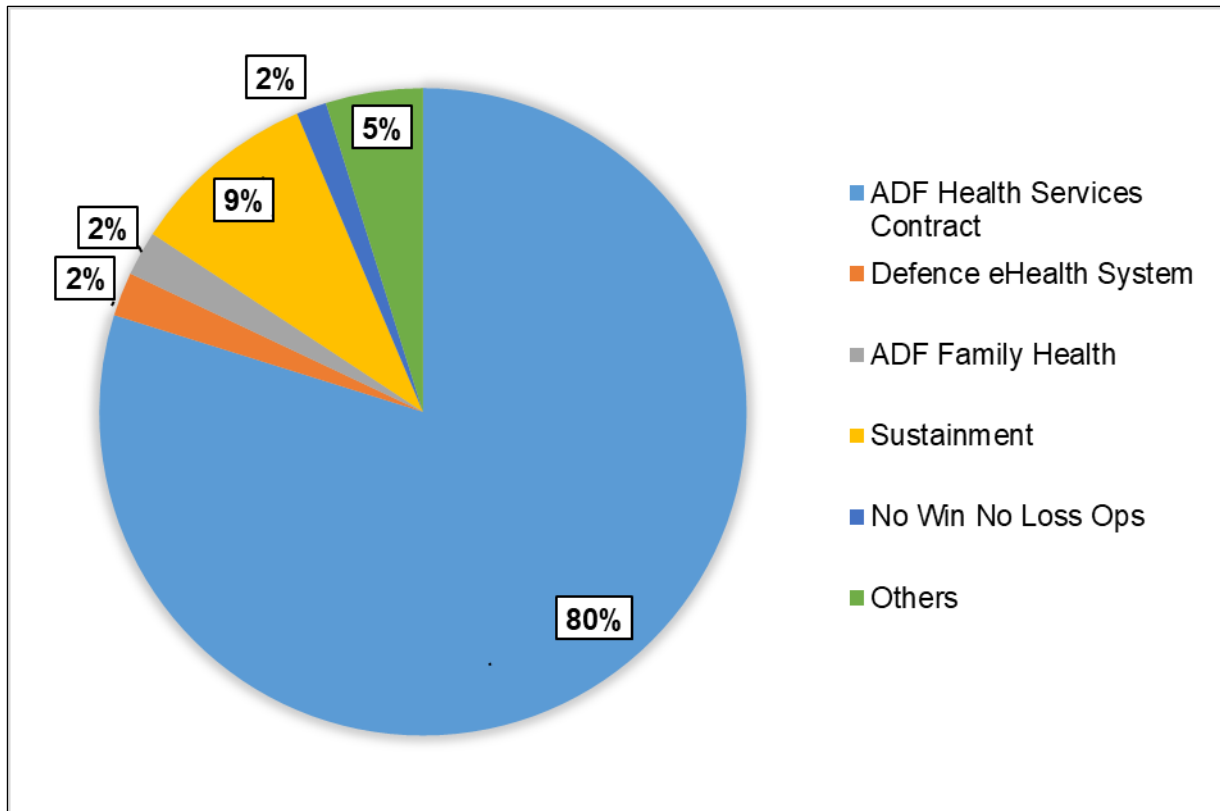
Command priorities

3. In providing the enabling joint health effect, JHC aims to maximise the health, fitness and preparedness of members; support commanders in their duty of care; mitigate individual and organisational health-related risk; contribute to regional health security; and optimise the rehabilitation and recovery of members. In 2017–18, JHC focussed on the following:

- a. delivering reliable, resilient and affordable health services
- b. progressing customer-centric reforms
- c. delivering health (including mental health) products, initiatives and research
- d. enhancing the deployable health capability
- e. developing a sustainable electronic health system
- f. improving business intelligence and management
- g. progressing the new health services contract and service level agreements
- h. improving corporate and health governance.

Financial expenditure

4. In 2017–18, JHC expended \$510 million of which 80 per cent (\$462 million) was for health services and workforce delivered under the ADF Health Services Contract. The primary expenditure categories are represented in Figure 1.

Figure 1: JHC Cash Expenditure (\$m)

GARRISON HEALTH SERVICE DELIVERY

Overview

5. In 2017–18, JHC continued to deliver garrison health services via eight joint health units and 59 health facilities around Australia and in Malaysia. This year saw the opening of the Bungendore Health Outreach Service to support Headquarters Joint Operations Command. The on-base services were provided by 2000 health personnel (870 full-time equivalents (FTE)) who were posted Defence members, single-Service augmentees, reservists, APS employees and contractor personnel.

6. In 2017–18, the ADF Health Services Contract with Medibank Health Solutions (Medibank) continued to provide access to off-base medical specialists, allied health services and in-patient services. The Medibank off-base network comprised 5200 medical specialists, 10 700 allied healthcare providers and 280 hospitals. Medibank also provided the Health Hotline service, pathology provider network, and imaging and radiology provider network.

On-base health services

7. Throughout 2017–18, JHC continued to provide on-base primary health care, dental, occupational health, mental health and psychology, specialist consultations, physiotherapy, rehabilitation and low dependency in-patient services.

8. JHC captured data on the quantity of health services delivered in garrison (see Table 1). As this is the first year of this type of data capture, there is no comparative data. However, the number of self-referrals for mental health issues

were double that of medical referrals, which indicates that mental health awareness continues to increase among Defence members.

Table 1: On-base health services

Service	Total
Health appointments: booked	741 802
Health appointments: walk-in	477 574
Dental appointments: booked	140 694
Dental appointments: walk-in	9 037
Mental health: medical referrals	2 605
Mental health: self-referrals	4 436
Psychology: command referrals	1 979
Psychology: screens	4 436
Psychology: in-Service selection assessments	2 565
Health record entries	1 948 031
Imaging requests	50 290
Scripts for pharmaceuticals	458 350
Total medications dispensed	658 204
Referrals to off-base providers	114 402
Occupational Rehabilitation: members in a program	6 401
Occupational Rehabilitation: meaningful engagement activity	197

Contracted health services

9. In 2017–18, there was an increase in most contracted services (see Table 2). Despite this, JHC continued to realise contract efficiencies through nationally consistent and centralised key objectives, performance indicators, service delivery standards, contract management practices, reporting and invoicing. Health contract costs have been contained over the past two financial years.

Table 2: Contracted health services

Service	Measure	2016–2017	2017–2018
Health practitioner workforce	Hours	1 597 939	1 546 251
Pathology services	Number	307 231	321 296
Imaging and radiology services	Number	70 642	74 820
Health hotline (1800 IM SICK) calls	Number	13 579	13 517
Rehabilitation services	Number	496 407	220 686
Optical services (tests and items)	Number	137 884	143 499
Off-base services (medical specialists, civilian hospital, allied health)	Number	535 753	593 900

10. The decrease in rehabilitation activity resulted from a new occupational rehabilitation service delivery model (as of May 2017), which improved oversight of external referrals and communication. Average per case costs reduced by 33 per cent in FY 2017–18 despite a five per cent increase in members under rehabilitation care.

Rehabilitation Outcomes 2016–17

11. The 2016 Australian National Audit Office report on the *Administration of Rehabilitation Services under the Military Rehabilitation and Compensation Act 2004* identified the need for Defence to better measure, analyse and report on rehabilitation service delivery.

12. In response, JHC identified a military-specific measure of rehabilitation outcomes, which reflects that Defence members must achieve a higher level of function than a civilian employee in order to fully return to work.

13. Our new Return to Duty measure, based on one used by the Canadian Armed Forces, measures the proportion of Defence members who successfully return to a deployable medical employment classification (MEC) after completion of a rehabilitation program.

14. Return to Duty is measured 12 months after the closure of a rehabilitation program that returned a Defence member to work. The return to duty rate for 2016–17 was 76 per cent. The return to duty rate for 2017–18 will be calculated after June 2019 as this will be 12 months after the closure of the final rehabilitation program for 2017–18.

MEASURES OF QUALITY

Compliments and complaints

15. In 2017–18, there was a 4.4 per cent decrease in compliments and a 4.6 per cent increase in complaints. However, the number of complaints in 2017–18 was below the five-year average. Table 3 provides a summary of the compliment and complaint data for the past five years.

Table 3: Compliments and complaints

Service	Compliments	Complaints
2013–14	569	1 230
2014–15	610	1 114
2015–16	611	810
2016–17	570	718
2017–18	545	751
5-year average	581	925

Customer satisfaction

16. JHC has measured customer satisfaction via survey since 2012. The survey gathers information on patient perceptions around the quality of services and areas for improvement.

17. In the second quarter of 2017–18, JHC distributed the survey to a stratified random sample of Defence members who attended a garrison health facility. There were 25 140 surveys distributed with a response rate of 19.4 per cent (4864 responses received), which is consistent with response rates in previous years.

18. There has been no significant change in satisfaction rates since the previous reporting year with 73 per cent of Defence members reporting that they were satisfied or very satisfied with the quality of health services.

Clinical incidents

19. In 2017–18, there were 692 clinical incidents compared with 355 in the previous year. This increase reflects improved compliance reporting from enhancements to the reporting tool. There has not been an increase in unsafe practices. Fifty-three per cent of incidents were clinical or medication-related. The remaining were related to administration, access to care or communication. These percentages were similar to previous years.

On-base wait times

20. Members continued to gain same-day access to a medical practitioner and other health providers for urgent health care. Non-urgent cases are prioritised according to clinical and operational priority. JHC has set wait time benchmarks for non-urgent care in consultation and agreement with the Services. Table 4 provides the agreed benchmarks and achieved wait times.

21. Wait times are affected by operational demands for pre- and post-deployment health care, the profile of the health dependency, and health facility staffing levels. Operational health requirements take precedence over other non-urgent health care appointments, resulting in a concomitant increase for non-urgent wait times. This is directly influenced by the operational tempo of the ADF.

22. Average wait times for non-urgent medical appointments were stable in 2017-18 and reflect difficulties in recruiting and retaining medical practitioners in non-urban Defence bases. Wait times decreased slightly for physiotherapy and periodic dental examinations.

Table 4: Non-urgent on-base appointment wait times (business days)

Activity	Benchmark	Achieved (average) 2016–17	Achieved (average) 2017–18
Medical	5	9	9
Mental health	8	4	5
Physiotherapy	8	4	2
Dental	10	9	11
Periodic health exam	20	13	14
Periodic dental exam	20	11	10

Off-base wait times

23. Wait times for specialist services are lower than that of the general community across most disciplines. Access is prioritised by clinical and operational requirements. The ADF and general community both access off-base specialists, and share challenges in accessing high-demand specialities or services in some remote locations. In 2017–18, the average wait time for a medical specialist was 16.8 business days. This was slight less than 2016–17 (17.1 business days). Although difficult to benchmark, it is believed that this is better than civilian standards in most specialities and in most locations.

24. In 2017–18, Medibank expanded its network of medical specialists, allied health professionals and hospitals by 4.7 per cent. Wait times were also improved by:

- a. establishing on-base psychiatrist clinics in Duntroon and Holsworthy
- b. expanding the dental laboratory network
- c. re-establishing the part-time medical officer at Anglesea Clinic.

MEDICAL EMPLOYMENT CLASSIFICATION SYSTEM**Central medical employment classification reviews**

25. In 2017–18, the demand for central medical employment classification reviews increased by 10.3 per cent (see Table 5). The major driver is thought to be the extant policy which enabled the MEC Review Board to flag specific cases for further review after two years. This has now been extended by the Board to five years.

Table 5: Quantity of central MEC reviews

Service	2016–2017	2017–2018
Navy	787	890
Army	2 248	2 552
Air Force	750	955

26. During the period, JHC set processing benchmarks in consultation with the Services¹. Previously, performance was not reliably measured but was considered to be poor due to workforce restraints. Stability of the workforce and improvements in workflow processes supported achievement of benchmarks during the reporting period.

27. In 2017–18, 248 appeals were received, a 15 per cent increase from previous years. Most appeals related to changes in clinical conditions. This did not impact on overall performance.

Transition on medical grounds

28. In 2017–18, 1343 Defence members were transitioned from Defence on medical grounds (compared to 1325 in 2016–17), an increase of 18 medical transitions (1.4 per cent) from the previous year. Table 6 highlights that the primary reason for medical transition continues to be a mental health condition, mainly depression or post-traumatic stress disorder. In 2017–18, there was a noticeable increase in transitions related to mental health conditions.

29. Approximately 60 per cent of cases have more than one condition that contributes to discharge decision. For example, there were 366 cases where mental health and musculoskeletal conditions co-existed.

Table 6: Permanent members discharged on medical grounds

Condition	2016–2017	2017–2018
Mental health	371	515
Musculoskeletal	166	163
Spine (back pain)	165	207
Other	288	370
Not known	335	88

30. In 2017–18, JHC reviewed 175 applications for retrospective consideration of medical conditions for superannuation purposes. This is an increase of 20 per cent from the 146 applications in the previous year. The reasons for this increase are not known but will be examined in association with Commonwealth Superannuation Corporation.

MENTAL HEALTH AND PSYCHOLOGY

31. In 2017–18, mental health continued to be an important strategic and reputational issue for Defence. There was considerable ministerial, media and public interest in the mental health of serving and ex-serving Defence members.

¹ The agreed benchmarks are that cases defined as urgent by the MECRB will be processed by JHC HQ to the MECRB within a week of receipt in the HQ and other cases will be processed within four weeks of receipt.

Defence Mental Health and Wellbeing Strategy

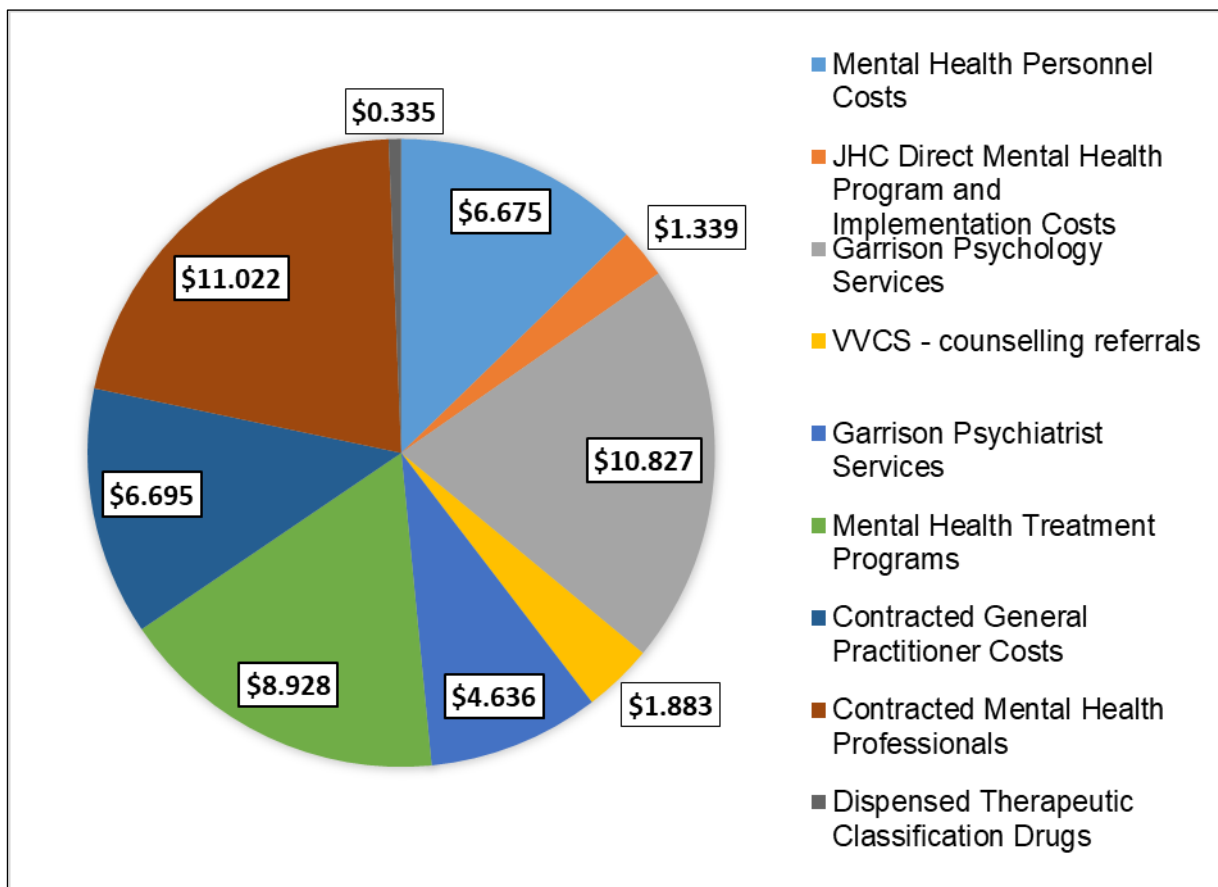
32. Following extensive consultation, a new [Defence Mental Health and Wellbeing Strategy 2018-2023](#) (the Strategy) was released in October 2017. The strategy includes Defence members and APS employees and its theme is *Fit to Fight, Fit to Work, Fit for Life*. It encourages understanding and action to ensure a thriving culture and healthy workplace.

33. In 2017–18, JHC publicised the strategy via a promotional roadshow. JHC also supported the Groups and Services in the development of their action plans.

Mental health expenditure

34. In 2017–18, Defence spent \$52.34 million on mental health programs, training and treatment which includes \$1.883 million spent on contracted mental health services by the Veterans and Veterans' Families Counselling Service (VVCS).

Figure 2: Mental health expenditure (\$m)



Mental health programs and services

35. In 2017–18, JHC continued to work with the Services, the Department of Veterans' Affairs (DVA) and Defence People Group (DPG) on resilience, mental health promotion, early intervention, evaluation and research. These activities were overseen by the Mental Health Advisory Group.

36. A key outcome of the Strategy was the development of a Defence Mental Health and Wellbeing Continuous Improvement Framework (CIF). The framework provides a consistent approach to evaluating, improving and monitoring mental

health and wellbeing programs and services. In the reporting period, the focus was on applying the CIF to the Defence Suicide Prevention Program and supporting other program owners across Defence to build capacity and develop plans.

Suicide prevention

37. JHC continues to deliver a comprehensive Defence Suicide Prevention Program to Defence personnel. 2017–18 was characterised by the release of several reports that validated Defence's approach while also recognising areas for improvement.

38. On 15 August 2017, the Foreign Affairs, Defence and Trade References Committee released its inquiry report: 'The constant battle: Suicide by veterans'. While there were no specific findings in relation to current programs, the Government committed Defence to:

- a. improve the transition process for Defence members moving from military life into post-service civilian life and provide targeted support to families
- b. improve family support through the engagement of families and family sensitive practice
- c. enhance the ADF Centre for Mental Health (ADFCMH)
- d. developing a peer support program.

39. Activities to improve transition (paragraphs 83 to 84), family support (paragraph 89) and the ADFCMH (paragraph 47 to 48) were commenced in 2017–18. A peer support pilot will be developed in the following year.

40. In 2017–18, JHC continued to work with the Australian Institute of Health and Welfare (AIHW) and DVA to research the incidence of suicide in current and former serving Defence members. In January 2018, AIHW reported that the suicide rate was 53 per cent lower for full-time serving males, 49 per cent lower for men in the Reserves, but 14 per cent higher for ex-serving men when compared to all Australian males of the same age.² The findings support international research and previous indications that protective factors put in place by Defence are working to reduce the risk of suicide among serving Defence members.

41. In addition to the ongoing delivery of suicide prevention training, key achievements in the suicide prevention program were:

- a. improving electronic health processes to support population surveillance and reporting of suicide and deliberate self-harm behaviours
- b. consulting Defence and community experts on the evaluation of the suicide prevention program using the CIF
- c. consulting community experts to ensure program improvements and innovations are aligned with best practice and to contribute to the community's understanding of suicide as part of the CIF project.

² The numbers of females were too small to support statistical analysis

Alcohol management

42. In 2017–18, JHC evaluated the ADF Alcohol Management Strategy. The JHC-led working group sought expert advice from the original members of the Independent Advisory Panel on the Management of Alcohol in the ADF. JHC will present recommendations to extend the current Strategy to the Chiefs of Services Committee in 2018–19.

Resilience

43. Resilience continued to be a key focus for Defence in 2017–18 with a broadening of focus from individual to organisational resilience. Key resilience achievements in 2017–18 were:

- a. hosting the third Defence Resilience Forum to promote the coordination and evaluation of resilience initiatives across Defence
- b. developing the next iteration of BattleSMART to include reality based-training, immersion into the leadership training continuum, and virtual reality platforms.

Mental health screening

44. A 2016 Senate Inquiry into the *Mental health of Australian Defence Force members and veterans* recommended more regular mental health screening for ADF members. In 2017–18, JHC continued to develop the mental health screening continuum and implemented a periodic mental health screen.

45. After a successful pilot, in March 2018 the screen was implemented in seven health facilities (Albatross, Amberley, Edinburgh, Enoggera, Larrakeyah, Lavarack and Russell) and was evaluated. The screen will be introduced across Defence in 2019.

Occupational psychology

46. In 2017–18, JHC continued to support occupational suitability assessments for initial entry and in-Service candidates, and support the application of unit climate reports through the Profile of Unit Leadership, Satisfaction and Effectiveness (PULSE) Survey. Key achievements were:

- a. trialling enhanced screening measures for combat controller and Special Forces roles
- b. supporting the review of Air Force employment profiles
- c. supporting the Services and Information Warfare Division in developing selection policies, assessment frameworks, processes and standards for the emerging cyber capability
- d. expanding the Post Operational and Return To Australia database to include surveillance data from Operation Resolute and the Submarine Force
- e. administering and reporting on seven PULSE surveys and supporting the Services with a further 22 PULSE surveys.

ADF Centre for Mental Health

47. As recommended in the 2017 Senate Inquiry into veterans' suicide (paragraph 38) expansion of the ADFCMH commenced with the creation and recruitment of a director position.
48. Key outcomes for 2017–18 were:
- a. clinical supervision to support both garrison and operational mental health
 - b. Second Opinion Clinic consultations for 24 Defence members (seven via tele-psychiatry)
 - c. conduct of two coaching/training groups with 17 JHC mental health professionals which led to conduct of 24 Reset programs (two-day prevention and early intervention programs) conducted within Garrison Health for a total of 406 Defence members
 - d. development of strong strategic partnerships through the Royal Australian and New Zealand College of Psychiatrists' Military and Veterans' Mental Health Network.

NATIONAL ADF FAMILY HEALTH PROGRAM

49. As at 30 June 2018, the ADF Family Health Program had 48 541 registered dependants (20 617 families), a two per cent increase from the previous financial year. The ADF population remained constant during the reporting period. Key achievements in 2017–18 were:
- a. reimbursing families' expenses for a total of 168 535 services, a 19 per cent increase from the previous year
 - b. introducing a mobile claims App to improve the claims process, which was downloaded on 11 138 occasions from April to June 2018.
50. Growth in program registrations and claims reimbursement shows increased acceptance by families of the financial benefits of program participation. The growth is within expectations and budget.
51. A survey of the program found that 92 per cent of dependants were happy with the customer service and claims administration process.

HEALTH POLICY AND CLINICAL ADVICE

Defence Health Manual

52. In 2017–18, JHC continued to review and update the *Defence Health Manual* (DHM), which has almost 350 chapters. The review project (known as DHM Phase 2) aims to remove duplication and unnecessary educative material; resolve policy conflicts; improve compliance with current best-practice approaches; simplify the language; and improve the end-user experience.
53. As of 30 June 2018, 50 per cent of DHM chapters were either in the clearance process or published.

Psychology Services Manual

54. In 2017–18, JHC published 11 amendments to the *Psychology Services Manual* to reflect changes to the assessment procedures and rating scales, suitability for service in remote localities, and occupation standards for maritime logistics support, intelligence officer, clearance diver, field human intelligence operator, Royal Australian Corps of Signals trades, security forces and pilots.

Occupational and environmental medicine

55. JHC updated health policy on monitoring and managing exposure to occupational hazards during 2017–18. This included further development of systems for reporting and recording health monitoring data.

56. JHC provided clinical advice to support the Defence Per- and Poly-Fluoroalkyl Substances (PFAS) Management Program, and continued to deliver a voluntary blood-testing program.

HEALTH CAPABILITY

Joint Deployable Health Capability Coordination

57. In 2017–18, JHC undertook a Chief of the Defence Force (CDF) directed task to review how the ADF generates and sustains its joint deployable health capability; in particular its tri-service clinical specialist workforce. JHC was subsequently tasked to develop a capability to coordinate the clinical specialist workforce necessary to support the single-Services' deployable medical treatment facilities.

58. Work has commenced on this concept with the single-Services and Defence People Group (DPG) and it will be further developed during the coming financial year.

Health materiel

59. Key health materiel achievements in 2017–18 were:

- a. ongoing management of the Health Materiel Sustainment Agreement for the provision of equipment, consumables and pharmaceuticals to garrison and the Services
- b. development of the garrison allowance lists to improve ordering and delivery of health materiel
- c. working with Capability Acquisition and Sustainment Group to expand direct vendor delivery contracts for pharmaceuticals and health consumables.

Health information systems

60. The performance and stability of the Defence eHealth System (DeHS) improved during 2017–18. System availability was intermittently affected by network-wide service disruptions and contractor infrastructure issues. Key achievements in 2017–18 were:

- a. 'onshoring' the application code to increase JHC's ability to fine-tune the underlying DeHS code and be more responsive to fixing system defects

- b. adding the periodic mental health screening to the DeHS Patient Portal (only to the trial areas) and introducing new word templates and clinical templates
- c. extending DeHS for use on fixed bases in overseas locations and introducing functionality for cost capture for health care for members injured on operations
- d. providing DeHS access to DVA and Commonwealth Superannuation Corporation staff to expedite processing of member claims
- e. creating Personnel Management Key Solution (PMKeyS) proficiencies for DeHS training and releasing eAssessments for Campus training.

HEALTH RESEARCH

Transition and Wellbeing Research Programme

61. In 2017–18, JHC continued to work with DVA on the Transition and Wellbeing Research Programme, comprising the Mental Health and Wellbeing Transition Study, the Impact of Combat Study and the Family Wellbeing Study. On 05 April 2018, the Minister for Veterans' Affairs and Defence Personnel released the Mental Health Prevalence Report, and the Pathways to Care Report. These reports confirmed that more needs to be done to address veteran mental health concerns, particularly during transition from military service and in the early months post transition.

62. This is an ongoing project with reports expected in 2018–19 for Family Wellbeing; Physical Health Status; Technology Use and Wellbeing; Mental Health Changes Over Time: a Longitudinal Perspective and Impact of Combat.

Longitudinal ADF Study Evaluating Resilience

63. Defence and Phoenix Australia continued to work on the Longitudinal ADF Study Evaluating Resilience. As at 30 June 2018, there were detailed reports on Prior Trauma Exposure and Mental Health, Alcohol and Tobacco Use, Coping and Mental Health, and Exploring Social Support in the Initial Years of Military Service.

64. The final report is expected in late 2018.

Rapid Exposure Supporting Trauma Recovery Trial

65. In 2017–18, JHC continued to work with DVA, Veterans and Veterans Families Counselling Service (VVCS), and Phoenix Australia on the Rapid Exposure Supporting Trauma Recovery (RESTORE) Trial. In June 2018, JHC added five more trial sites and continued to promote the trial in all states.

66. As at 30 May 2018, 17 serving members had been referred to the trial. Seven were randomised to treatment and four completed treatments.

Frozen platelet clinical trial

67. Since 2014, JHC has worked with the Australian Red Cross Blood Service (Red Cross) on the frozen blood project. A key achievement in 2017–18 was reporting the findings from the frozen platelet clinical pilot trial in four Australian hospitals. The trial demonstrated that frozen platelets were feasible to deliver, not

associated with a trend to more adverse events, and likely to be more effective in reducing bleeding.

68. JHC supported an application to the National Health and Medical Research Council for \$1.8 million to support a definitive trial. If successful, this would change the method of platelet storage for surgical/trauma bleeding worldwide.

Military trauma research

69. In 2017–18, the ADF Professor of Military Medicine and Surgery continued to conduct, support and oversee research on military trauma. Key achievements involved:

- a. research on pre-hospital management of trauma-related haemorrhage, sedation strategies in critical illness, management of severe traumatic brain injury and patient blood management
- b. ongoing collaboration with the US Joint Trauma Registry, the Australian Resuscitation Council, the Australasian Trauma Society, the National Blood Authority and national and international academic institutions
- c. supervision of 13 research students including eight Defence members, working on various projects related to military trauma
- d. publishing research papers, book chapters and conference presentations (see Annex A).

Malaria and infectious disease research

70. On 01 November 2017, the Army Malaria Institute was renamed the ADF Malaria and Infectious Diseases Institute (ADFMIDI) to better reflect its force protection and regional health security role. In 2017–18, ADFMIDI continued to research drug resistance and diagnostics, vector surveillance and control, clinical studies and surveillance, and arbovirology. Key achievements were:

- a. conference presentations and scientific journal publications (see Annex A)
- b. contributions to regional health security through research collaborations with Vietnam and other nations (see paragraph 89)
- c. managing concerns about the health effects of mefloquine and tafenoquine, (used in Army studies during 2000–2002).

Ethics review of research

71. On 01 July 2017, the Departments of Defence and Veterans' Affairs Human Research Ethics Committee (DDVA HREC) was established. JHC provides Secretariat support to the Committee. Key outcomes in 2017–18 were:

- a. transfer of 142 active research proposals to DDVA HREC for monitoring
- b. consideration of 55 new proposals
- c. receipt of 59 resubmissions and 102 amendments.

72. In 2017–18, the JHC Low-Risk Ethics Panel received 16 new protocols. Of these, nine were approved.

73. In 2017–18, the Defence Animal Ethics Committee (DAEC) received and approved seven new protocols. Other achievements were a mandated assessment of DAEC functions and a revision of the DAEC Terms of Reference.

PROJECTS AND INITIATIVES

Next Generation Health Service Project

74. In 2017–18, JHC continued to define and establish the next model of health service delivery in Defence. The Next Generation Health Service Project remained on track to transition in a new contract and service level agreement with the Services by 01 July 2019. Key achievements were:

- a. major review of the garrison health service delivery model, including consultation with customers and stakeholders to identify opportunities for improving health services and identify lessons from the current model
- b. an Industry Insights Workshop to improve understanding of industry norms and future directions for the pricing and payments of medical service items
- c. continued procurement activities for the new ADF Health Services Contract

75. Development of the service level agreement progressed in 2017–18 through a series of working groups, each involving significant input from single Service representatives. One key focus has been to confirm the workforce commitment from the single Services, a workforce that supports the ‘raise, train, sustain’ responsibilities of the Services by ensuring ADF health personnel undertake garrison clinical duties in JHC facilities as frequently as possible.

Health Records Digitisation Project

76. In 2017–18, JHC continued to establish the project to digitise health records. This is the largest digitisation project in Defence. It involves preparing, scanning and filing more than 51 million pages of health information. This project remains a priority as Defence needs complete and electronically accessible health records to improve clinical continuity and support transition from service. This project also reduces the physical storage requirements for health records.

77. Key achievements in 2017–18 were completion of user acceptance testing and commencement of digitisation activities (expected completion in early 2020). In May 2018, JHC transferred the digitisation project to Information Warfare Division.

Project JP2060 Phase 3: Deployable Medical Capability

78. In 2017–18 the Health Services Program was established as a key Defence program. Coordinating Service input into this Army led project remains a priority for JHC. The program narrative was published, the JP2060 request for tender closed, and tender evaluation was commenced.

Project JP2060 Phase 4: Health Knowledge Management

79. In 2017-18 JHC investigated the 'harmonisation' of two projects – JP2060 Phase 4 and Project ICT 2250: Health Modernisation, the DeHS replacement – to provide a single Health Knowledge Management solution in both the connected (garrison) and disconnected (mobile and deployed) environments. The aim is to create a tailored commercial solution for both environments.

80. Investment Committee approval was given to combine these projects into an expanded JP2060 Phase 4. Sponsor responsibility was transferred to Information Warfare Division. The procurement process commenced with an industry briefing and a request for information activity.

81. To enable this new approach, JHC began negotiations on a DeHS contract extension, including changes to support arrangements to increase its sustainability.

Frozen Blood Project

82. In 2017–18, JHC continued to collaborate with the Red Cross to introduce deep frozen blood products into service. Key achievements were

- a. completion of the frozen blood stockpile (stored at the Red Cross in Sydney)
- b. achievement of initial operating capability in the land environment and continued work for the maritime environment
- c. completion of enduring sustainment agreements with the National Blood Authority and the Red Cross
- d. inclusion of a hardware refresh in the basis of provisioning for JP2060 Phase 3
- e. commencement of integration of blood product data (technical and supply) into JP2060 Phase 4.

Health aspects of transition from service

83. In 2017, the Australian Government established a Transition Taskforce to improve transition of members from the ADF. The taskforce formed an inter-departmental Single Medical Assessment Project (SMAP). In 2017–18, key SMAP achievements were:

- a. reviewing the health assessment requirements for transition
- b. developing the Transition Health Assessment (THA), which is a process for pre-transition submission of claims, assessment of initial liability and any requirement for compensation
- c. completing a six-month THA pilot at Holsworthy Health Centre, involving 142 transitioning members.

84. Evaluation of the THA pilot is expected to be completed in late 2018.

Project J0105: Joint Health Command Facilities Upgrade

85. The rationalisation and upgrade of garrison health facilities achieved Parliamentary Works Committee approval on 31 January 2018. Project J0105 will deliver eight new and five refurbished health facilities by end-2020. The request for tender for the first body of work was released in June 2018.

86. JHC has identified a further 12 health facilities for inclusion in an estate planning review. The aim is to review compliance with codes, regulations and Acts. Release of a tender for the review is planned for September 2018.

Health Services Delivery Improvement Program

87. Initiatives under the Health Service Delivery Improvement Program in 2017–18 were:

- a. national implementation of the garrison continuous improvement program, following pilot work in the Canberra region
- b. development and education on data use, cost signals, self-efficacy and minimising failure to attend appointments
- c. reviewing clinical follow-up and recall practice to minimise clinical risk
- d. providing health business intelligence to the Services and Headquarters Joint Operations Command to support clinical care, clinical administration and resource management.

Customer engagement

88. To foster improved customer engagement with Defence members and Command, JHC has developed and distributed the following in consultation with the Services:

- a. JHC Command Compact – emphasises the relationship between Command and Garrison Health in optimising Defence capability, and commits to ongoing dialogue between local health service providers and commanders
- b. JHC Patient Pledge – supports Defence members in making informed decisions regarding their health care and encourages their active participation in healthcare decisions
- c. 'Choosing wisely' – a poster empowering customers to take a proactive role in their health care by suggesting questions to ask their health providers.

Family engagement

89. The March 2017 National Mental Health Commission review into suicide and self-harm prevention services recommended that Defence improve family support through better engagement of families. In 2017–18, the Bouverie Centre at LaTrobe University was engaged to provide family sensitive training to health practitioners in Simpson, Edinburgh, and Cerberus Health Centres in preparation for a pilot program to be conducted early in the next financial year.

HEALTH WORKFORCE

Headquarters realignment

90. In 2017–18, Headquarters JHC was reorganised to clarify accountability and responsibility; strengthen clinical and corporate governance; build an operational health coordination capability; increase strategic staff support; strengthen organisational resilience; and minimise functional duplication.

91. Headquarters JHC now has four branches, each led by a Director General (DG). The Office of CJHLTH provides support and coordination for the Headquarters. JHC's organisation chart is at Annex B.

Values compact

92. In early 2018, JHC developed a Culture and People Statement to define the JHC values of Pride, Positivity, Professionalism, emPathy and Passion – the 5Ps. Inspiration was drawn from Pathways to Change and contextualised for the JHC workforce. Key achievements were the conduct of two gallery days to obtain Headquarters JHC staff feedback on the statement and facilitated conversations through the chain of command in regions. JHC then developed and distributed a Values Compact, which is complementary to the Joint Capabilities Group cultural vision.

Education, training and workforce initiatives

93. In 2017–18, JHC worked collaboratively with the HR Business Partners to manage FTE within guidance and to implement health workforce initiatives from the 2016 Defence White Paper. Key health workforce achievements were:

- a. maintaining 62 clinical deeds of agreement for placements with community health services providers
- b. worked with the Australian College of Rural and Remote Medicine (ACRRM) on an ADF Pathway for General Practice Registrars and a military-specific Advanced Skills Training year
- c. arranged access to Australian Health Practitioner Regulation Agency data to enable monitoring the registration status of health practitioners and to better target expressions of interest for operational deployment
- d. continued to improve the skills of the mental health workforce, including implementation of the Mental Health Workforce Skilling Framework and the Defence Mental Health Practitioner Development and Evaluation Program.

94. The Medical Specialist Program (MSP) facilitates a pathway to Fellowship for six medical specialties that are critical to the provision of health support to operations. It provides a deployable capability and increases retention of experienced ADF medical officers. The MSP currently has 30 positions in the specialties of emergency medicine, intensive care, anaesthetics, orthopaedic surgery, and general surgery. Seven psychiatry positions are managed in conjunction with the MSP. The MSP continues to grow, with 12 registrars and 12 qualified specialists at the end of 2017–18.

INTERNATIONAL ENGAGEMENT

General engagement

95. In 2017–18, JHC published its first International Engagement Plan and continued to engage with other military health services and health agencies. Key achievements were:
- a. met with and/or hosted senior representatives from the United States (US), Japan, United Kingdom (UK), New Zealand, Canada and India
 - b. provision of representatives to the International Committee of Military Medicine World Congress on Military Medicine, the Asia Pacific Military Health Exchange, and the US Society of Federal Health Professionals conference.
 - c. SGADF and DG Health Policy, Programs and Assurance (HPPA) presented an overview of the ADF approach to mental health to the NZDF Board via video conference
 - d. increased involvement in regional health security via liaison with other militaries and the Indo-Pacific Centre for Regional Health Security in the Department of Foreign Affairs and Trade
 - e. ongoing cooperative malaria studies with the Vietnam People's Army
 - f. collaboration on infectious diseases with the Papua New Guinea Defence Force, the Solomon Islands Ministry of Health and Medical Services, the New Zealand Defence Force and the Malaysian Armed Forces.
 - g. DGHPPA attended the 2017 Warrior Care Symposium held in Toronto, Canada and participated as the Australian lead in planning for the Warrior Care Symposium to be held in Sydney in October 2018.

Five Eyes Forums

96. In 2017–18, JHC continued to maintain ties with international peers via collaborative international research and information exchange forums and arrangements. Key achievements were:
- a. providing a panel member on the Technical Cooperation Program's Technical Panel 22 (Military Medicine), Technical Panel 23 (Human Military Resources) and Technical Panel 21 (Resilience)
 - b. overseeing three trauma management studies, which are registered as Collaborative Projects led by Australia in Technical Panel 22
 - c. SGADF attendance at the Five Eyes Veterans' Ministers forum in the UK with the Minister for Veterans' Affairs and representatives from DVA.

North Atlantic Treaty Organization

97. SGADF remains a member of the Committee of the Chiefs of Military Medical Services, which provides access to NATO doctrine, research, training and emerging issues.

98. In late 2017, JHC was invited to contribute to the activities of NATO Human Factors & Medicine, Research & Technology Group 290. This Group is exploring emerging themes in military selection and assessment, primarily diversity, integrity testing, and on-line psychometric testing.

Chemical, Biological and Radiological Memorandum of Understanding

99. In 2017–18, JHC continued to engage with international military medicine, public health, and defence science and technology partners through the Medical Countermeasures Consortium. This ongoing engagement with the US, UK and Canada focused on:

- a. treatment and prophylaxis for chemical and biological agents
- b. field deployable diagnostic capabilities and all-hazard preparedness and response
- c. emerging infectious diseases, pandemics and chemical, biological and radiological threats
- d. biosurveillance, force health protection and global health security.

Annexes:

- A. Health presentations and publications
- B. JHC organisational diagram as at 30 June 2018

HEALTH PRESENTATIONS AND PUBLICATIONS

Presentations

- Five Eyes Ministerial Conference on Veterans Issues, United Kingdom. (Cosson E, Smart TL)
 - Barriers to Effective Mental Health Treatment in the Australian Veteran Population
 - Rehabilitation Initiatives and Proactive Interventions
- The Defence Health System, Security and Health Executive Leadership Institute Course, Sydney (Smart TL)
- Australasian Military Medicine Association Conference, Melbourne:
 - Keynote presentation: The ADF Mental Health Journey (Smart TL)
 - JHC Update (Smart TL, Sharkey SE, Brennan LB, Paterson MCJ)
- Royal Australasian College of Medical Administrators, Melbourne (Smart TL)
 - Challenges in Leadership: Where military command meets health leadership
 - Panel member: Women in Leadership.
- Women in Combat: Challenges for health care providers, International Committee of Military Medicine World Congress of Military Medicine, India. (Smart TL)
- Leading Cultural Change, DVA Leadership Seminar (Smart TL)
- Cultural Change in the Navy Naval Officers Club of Australia, Sydney. (Sharkey SE)
- Keynote address, Banka Island Day Memorial Service, Bangka Island Memorial, Adelaide (Smart TL)
- The Defence Health System and current challenges, Defence Materials Technology Centre Annual Conference, Canberra (Smart TL)
- Tackling low value care issues in the Defence environment, Royal Australasian College of Medical Administrators meeting, Canberra (Sharkey SE)
- Battle casualties from the Middle East Area of Operations – What does it mean for the future? 1st ASEAN Military Medicine Conference, Yangon Myanmar (Brennan LB)
- ADF Health Support in Peace and War United Services Institute, Canberra (Smart TL)
- Medicine in War, speech to opening exhibition 'For Humanity: Medicine in war and peacekeeping since 1945', Shrine of Remembrance, Melbourne (Smart TL)
- Royal Australasian College of Surgeons Annual Conference, Sydney (Smart TL)
 - Generating ADF Surgeons

- Challenges in Leadership
- Royal Australian and New Zealand College of Psychiatrists Annual Conference, New Zealand (Smart TL and Wallace D))
 - Women in Leadership - Panel member (Smart TL)
 - The ADF Mental Health Journey (Smart TL)
 - Telepsychiatry in the ADF, Royal Australian and New Zealand College of Psychiatrists Annual Congress, Auckland NZ, 15 May 2018 (Wallace, D)
- ANZAC Day Address, Murrumbateman (Sharkey SE)
- The Defence health system: Where to next? Opening Plenary to DSTG Human Biotechnologies Symposium (Schramm CA)
- In vitro characterisation of anti-major histocompatibility complex class I mediated transfusion-related acute lung injury (TRALI), Australasian Society for Immunology Annual Scientific Meeting, Brisbane (Sultana AJ, Dean MM, Reade MC, Flower RL, Tung JP)
- Cryopreserved vs. liquid platelets for surgical bleeding: proposal for a definitive trial, ANZICS Clinical Trials Group Winter Research Forum, Queenstown (Reade MC)
- Data sharing - Early Goal Directed Therapy Individual Patient Data Meta-analysis Lessons Learnt. ANZICS Clinical Trials Group Winter Research Forum, Queenstown (Reade MC)
- Dexmedetomidine to lessen ICU agitation. 8th International Congress of the German Sepsis Society, Weimar (Reade MC)
- What does a credible Army clinical workforce look like? Army Health Services Conference, Brisbane (Reade MC)
- Traumatic Cardiac Arrest. Australian and New Zealand College of Paramedicine Annual Meeting, Brisbane (Reade MC)
- Cryopreserved sheep platelet concentrates: hemostatically efficient and suitable for transfusion research. United States Military Health Service Research Symposium, Orlando (Simonova G, Pedersen S, Reade MC, Johnson L, Dean M, Tung JP)
- Current best practice and likely future innovations in blood products for trauma care. Injury 2017, Auckland (Reade MC)
- Clinical trials methodology: building on 20 years' experience in the ANZICS Clinical Trials Group. National Taiwan University Hospital Invited Professorial Address, Taipei (Reade MC)
- ICU delirium: current and future research. Taiwan Society of Critical Care Medicine Clinical Update, Taipei, (Reade MC)
- Current management and future research for ICU delirium. Taiwan Society of Emergency and Critical Care Medicine CME lecture, Tainan (Reade MC)
- Surgical services at the ANZAC Role 2E hospital, Taji, Iraq. Royal Australasian College of Surgeons Annual Scientific Conference, Adelaide (Reade MC)
- Traumatic cardiac arrest. Australian Resuscitation Council Spark of Life Conference, Adelaide, 2017 (Reade MC)

- Cardiac arrest due to trauma: new Australian and New Zealand guidelines. Australasian Trauma Society Annual Scientific Meeting, Melbourne (Reade MC)
- Big data: examples of military registry data answering hypothesis-driven research questions. Australian and New Zealand College of Anaesthetists Annual Scientific Meeting, Brisbane (Reade MC)
- Military anaesthesia. Australian and New Zealand College of Anaesthetists Annual Scientific Meeting, Brisbane (Reade MC, Scott D, Scarff C, Mahoney A, Luckin P, Thomas P, Douglas A)
- Blood products for austere environments - the new ADF policy. Ortho Clinical Diagnostics Lab Leader Scientific Summit, Singapore (Reade MC)
- What is delirium and what are the diagnostic tools? Austin Health Delirium Symposium, Melbourne (Reade MC)
- Challenges of diagnosing delirium in the ICU. Austin Health Delirium Symposium, Melbourne (Reade MC)
- Treatment of delirium in ventilated patients. Austin Health Delirium Symposium, Melbourne (Reade MC)
- Tranexamic acid - too early or too late? 1st Annual Perioperative Patient Blood Management Symposium, Brisbane (Reade MC)
- Faculty seminar, Uncovering parasite stealth strategies, QIMR-Berghofer Medical Research Institute 24 August 2017, (Cheng, Q)
- Oral presentation at The 4th International Conference of Tropical Medicine and Hygiene, 4-9 September 2017 (Peatey, C)
- Malaria microscopy external competency assessment course, World Health Organization and AMI, 25-29 September 2017 (Lilley, K)
- Characterisation of the parasitological activity and mode of action of the aminomethylphenol, JPC-3210 for malaria treatment and prevention, Molecular Parasitology Meeting, Woods Hole, USA, 10-14 September 2017 (Chavchich, M)
- Asia Pacific Malaria Elimination Network (APMEN) Vivax Working Group, 9-11 October 2017 (Cheng, Q)
- Genetic origins of *P. falciparum* parasites with *hrp2* gene deletions in Peru and Eritrea, Malaria in Melbourne, Melbourne, 26-27 October 2017 (Cheng, Q Dr, Peatey C)
- Genetic origins of *P. falciparum* parasites with *hrp2* gene deletions in Peru and Eritrea, US DoD GEIS State of the Science meeting, Silver Spring, USA, 2-4 November 2017 (Cheng, Q)
- Genetic origins of *P. falciparum* parasites with *hrp2* gene deletions in Peru and Eritrea, The 66th ASTMG Annual Meeting, Baltimore, USA, 5-9 November 2017 (Cheng, Q)
- Malaria microscopy external competency assessment course, PNG-DFAT Project and ADFMIDI, 30 October - 03 November 2017 (Lilley, K)
- Malaria microscopy external competency assessment course, Exxon Mobil Collaboration Project, 13-17 November 2017, Papua New Guinea (Lilley, K)
- Characterisation of the parasitological activity and mechanism of resistance of the aminomethylphenol, JPC-3210 for malaria treatment and prevention,

Malaria in Melbourne (MIM), Melbourne, 26-27 October 2017 (Chavchich, M et al)

- Metals, Oxygen and Malaria, Malaria in Melbourne (MIM), Melbourne, 26-27 October 2017 (Parkinson, C et al)
- Vector Competence of Australian Aedes aegypti mosquito for the Highly Divergent Dengue Type 2 Virus, The 9th Australia Virology Society meeting at Adelaide, 5-8 December 2017 (Pickering)
- Localised outbreaks of epidemic polyarthritits among Australian Defence Force personnel in Shoalwater Bay Training Area (Central Queensland) in 2016 and 2017 due to different lineages of Ross River virus, The 9th Australia Virology Society meeting at Adelaide, 5-8 December 2017 (Kizu)
- 'Blood thirsty and ready to strike' Mosquito and Arbovirus surveillance within a military training area, The 9th Australia Virology Society meeting at Adelaide, 5-8 December 2017 (Neuman)
- Epidemiology of Influenza Pandemic of 1918-1920 from USA, UK, Canadian, ANZAC Military Sources, Immunization Science Group, Melbourne VIC Australia, January 2018 (Shanks, GD)
- Australia's Experience of the 1918-19 Influenza Pandemic: Lessons Learned, University of Otago Medical School, Wellington, New Zealand, February 2018 (Shanks, GD)
- Epidemiology of Influenza Pandemic of 1918-1920 from USA, UK, Canadian, ANZAC Military Sources, Uniformed Services University, Bethesda MD, USA, June 2018 (Shanks, GD)
- A Tale of Two Drug Programs: Chinese Army and Artemisinin; US Army and Mefloquine, Walter Reed Army Institute of Research, Washington DC, USA, June 2018 (Shanks, GD)
- Antimalarial Mass Drug Administration in the Military, Oxford Martin School, University of Oxford, Oxford, UK, June 2018 (Shanks, GD)
- The Centenary of the 1918 Influenza Pandemic: how the dead can inform the living, Commonwealth War Graves Commission, Maidenhead UK, June 2018 (Shanks, GD)
- Untargeted metabolomics identifies novel mechanism of action and putative targets of new antimalarial drugs in development, JPC-3210 and TSC-3, 66th Annual meeting of the American Society of Mass spectrometry, San Diego, USA, 1-3 June 2018 (Birrell GW, Siddiqui G, De Paoli A, Jacobus DP, Parkinson C, Drinkwater N, McGowan S, Edstein MD, Creek DJ)
- Malaria microscopy external competency assessment course, PNG-DFAT Project, 5-9 February 2018, Papua New Guinea (Lilley, K)
- ADFMIDI - Malaria microscopy external competency assessment course, 19-23 February 2018 (Lilley, K)
- ADF Mental Health Initiatives, Mental Health and First Responder Conference, Melbourne 7 March 2018 (Morton, D)
- ADF Mental Health & Wellbeing, Emergency Services Conference Melbourne 30 May 2018, (Sinclair, L)

- Operational and Occupational Stressors: Links to Mental Health in Military Personnel, International Military Testing Association (IMTA) Conference, Bern, Switzerland, 09-13 October 2017 (Cooper, M)
- Review of Gender Differences in Spatial Ability', 12th Industrial & Organisational Psychology (IOP) Conference, Sydney, 13-15 July 2017 (Douglaris, T)
- Health Benefits of Work, Royal Australian College of Physicians, May 2018 (Kelaheer, C)

Publications

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JHC ORGANISATIONAL DIAGRAM AS AT 30 JUNE 2018

