STRATEGIC INSIGHTS

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Next step in the step-up

The ADF's role in building health security in Pacific island states

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Executive summary

The ADF has long had an important role in providing humanitarian assistance to Pacific island countries (PICs). The force has extraordinary capabilities—people, expertise, training and equipment—in delivering necessary assistance quickly and efficiently.

From Australia's perspective, the ADF is one of our most important agencies in engaging with our PIC partners, particularly in helping them to develop capabilities to address a range of security challenges. In Australia's new strategic environment, the ADF can also play an important role in helping to build regional health security as part of a new phase in Australia's Pacific Step-up.

The needs of PICs for assistance in building their community health systems will probably grow significantly in coming years. The PICs are likely to endure ever more natural disasters. Climate change is likely to cause ongoing stresses to

Royal Australian Air Force Dentist, Squadron Leader Alistair Soon provides dental advice to a patient at the Bowali Primary School during Pacific Angel 19-4, held in Lae, Papua New Guinea. Image: Department of Defence

island health systems through extreme weather events, increased incidence of waterborne diseases, reduced water quality, mosquito- and food-borne diseases, heatwaves and population displacement.[1] Calls for assistance from Australian civil and military organisations will almost certainly grow ever louder.

But caution about using military organisations to deliver health assistance has led to the underutilisation of Australia's military health capabilities in the Pacific. Important opportunities to reinforce regional partnerships aren't being pursued.

This Strategic Insight looks at ways in which the ADF can play to its strengths in building health security in the Pacific.

In the short term, the ADF is well placed to support the rollout of Covid-19 immunisation programs by providing transport and logistical support for local health systems, and will no doubt do so as part of existing government planning and as part of delivering on the vaccination initiative, as announced at the recent Quad leaders' meeting.[2]

But the ADF can also play an important long-term role in building health capabilities, while also avoiding many of the problems traditionally associated with using militaries as direct providers of health services.

This paper argues that the Australian Government should consider a new role for the ADF in the Pacific through developing mutually beneficial enduring military health partnerships.[3] That would involve the regular rotation of ADF health professionals through partner medical facilities where they would have the opportunity to gain unique frontline experience from local experts, while also sharing their own knowledge and skills. The mutuality of benefits inherent in such an arrangement means that they shouldn't be considered as traditional humanitarian assistance.

An enhanced role for the ADF in regional health security, properly structured, might ultimately come to be seen alongside the Pacific Patrol Boat Program as a successful example of mutually beneficial partnerships between the ADF and our Pacific neighbours.

Using hard military assets to provide health assistance

Australia provides humanitarian assistance to our partner nations in the Pacific for several reasons. There's a genuine altruistic humanitarian imperative, which is at the heart of Prime Minister Morrison's 'Pacific Family' initiative. And it's in our interest to enhance stability and development in the region. It's also an opportunity for us to build soft power.

Because of militaries' unique capabilities and expertise, many countries use them, including military health professionals, to provide humanitarian assistance through long-term programs or in response to natural disasters or other crises. With physical assets such as ships, planes and trucks and expert personnel, military organisations are often best placed to deliver food, logistical support, engineering assistance and emergency medical services in times of crisis, especially to remote areas where commercial options are scarce.

The use of 'hard' military assets to provide humanitarian assistance to other countries can deliver several important types of benefits to the provider, including signalling commitment, helping facilitate geographical access, demonstrating capabilities and providing opportunities for coalition building and engagement with new partners.[4]

Medical assistance is an important element of this assistance, and its provision to communities in need has come to be called 'medical diplomacy'.[5] Tommy Thompson, the US Health Secretary in the George W Bush administration, became well known for his promotion of medical diplomacy as a tool for what he described as 'winning of hearts and minds of people in the Middle East, Asia, Africa, and elsewhere by exporting medical care, expertise, and personnel to help those who need it most'. Medical diplomacy can involve short-term relief, such as responding to disasters or crises, or long-term measures to build capabilities in personnel or facilities.

For the US, the military is often at the forefront of assistance efforts in medical diplomacy, alongside civil agencies such as the US Agency for International Development. US military medical capabilities are frequently an integral part of humanitarian assistance and disaster relief (HADR) missions.[6]

As a result, US military health medical teams and facilities are frequently deployed in response to natural disasters alongside other military personnel and assets. That has included substantial US military medical contributions to HADR missions following the Japanese earthquake (2011), Typhoon Haiyan in the Philippines (2013) and the Nepali earthquake (2015).

But Australia takes a different approach. The ADF regularly provides humanitarian assistance to PICs and others following natural disasters as part of broader Australian Government programs. Over the past two decades or so, that has included participation in HADR operations in Papua New Guinea, Niue, Indonesia, Samoa, Japan, New Zealand, Solomon Islands, the Philippines, Vanuatu and Fiji, providing assistance in such things as food, logistics and engineering.

Throughout the Covid-19 crisis, the ADF has also played a key role in maintaining a humanitarian corridor to the Pacific, including by delivering humanitarian aid and Covid-19 testing equipment. In March 2021, the ADF airlifted Covid-19 vaccines and tents to Port Moresby at the start of vaccine deliveries throughout the region.

But, while it may seem natural that the ADF would also provide medical services as part of humanitarian operations, that hasn't been the case for more than a decade.

As a result, there's now significant underutilisation of the ADF's considerable military health capabilities in providing assistance to our Pacific partners. This paper looks at ways in which the ADF could play to its strengths in helping to build health security in Pacific island states as part of a new phase of Australia's Pacific Step-up. This could include:

- using ADF personnel and assets to provide transport and other logistical support for the rollout of the Covid-19 immunisation program in the coming months
- building enduring military health partnerships involving mutual sharing of expertise and training between ADF clinicians and local health providers.

The ADF's role in responding to the Covid-19 crisis in the Pacific

The ADF can play an important role in assisting Australia's Pacific island neighbours to respond to the Covid-19 crisis.

Many PICs, by virtue of their geographical isolation and timely responses, have avoided large numbers of Covid-19 transmissions, although we've seen a significant uptick in cases in PNG. But risks remain for all the PICs, including still large numbers of their citizens who are awaiting repatriation from overseas.

However, Covid-19 has had a devastating economic impact on the islands by effectively shutting down the international tourism industry. It's therefore an imperative to create the conditions in which tourism can be safely recommenced so that the PICs can begin their economic recovery.

The next phase in dealing with the Covid-19 crisis in the Pacific islands will involve a large-scale immunisation program. Most PICs are eligible to participate in the UN-sponsored Gavi COVAX vaccination program, to which Australia has been a major contributor. The COVAX program aims to provide vaccines for up to 20% of the populations of eligible countries in its first phase.[7]

On top of the COVAX program, the Australian Government has also pledged an additional $200 million over three years to help ensure that PICs such Fiji, Kiribati, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu are able to achieve full immunisation coverage (involving the immunisation of around 80% of local populations).[8] This will be a major challenge, involving the transport of vaccines and the development of necessary systems, records and facilities in remote communities in numerous far-flung archipelagic island states.

A successful Covid-19 immunisation program will therefore involve not just the acquisition of vaccines, but also the training of local personnel and the establishment of necessary health systems and vaccination facilities and complex logistical requirements, such as transport and cold storage chains to remote areas. Australia and likeminded partners such as Japan[9] have already pledged to help improve the PICs' immunisation systems.

Arguably, some of these needs could be delivered by commercial partners, as China is demonstrating in its Covid-19 vaccine rollout in Africa (although the line between the Chinese state and private companies isn't always clear).[10] But there's no doubt that the ADF has the expertise and assets to play an essential role in assisting PICs in areas such as transport and logistics (see box). There are good reasons, both practical and symbolic, why the ADF should step up to assist in this way.

The ADF's military health capabilities

The ADF is one of the biggest and most capable healthcare providers in Australia. The defence force's military health capabilities are provided through the Joint Health Command, which is responsible for approximately 3,800 permanent and reserve clinical staff in total. They comprise around 1,000 clinical staff in the permanent defence force, including around 150 medical officers, 200 registered nurses and 600 medics. A significant majority of military health clinicians are reserve personnel. Army Reserve clinicians alone account for around 200 doctors, 200 nurses and 350 medics. This is about meeting the ADF's own health needs, of course, but it's also a significant national capability.

The Joint Health Command manages around 60 health facilities in Australia and overseas, including specialist facilities such as the Submarine and Underwater Medicine Unit, the ADF Malaria and Infectious Diseases Institute, the Institute of Aviation Medicine and the ADF Centre for Mental Health.

In addition to so-called 'Role 1' health support that's provided within individual units, the ADF has the capability to deploy several 'Role 2' and 'Role 2 Enhanced' hospitals. They're forward-deployed field hospitals that treat patients who are evacuated from small unit medical facilities. They provide triage and resuscitation and treatment, including both limited definitive and lifesaving 'damage control' surgery. The Role 2 hospitals also hold patients until patients can be returned to duty or evacuated to tertiary facilities.

The 2nd General Health Battalion provides the Army's deployable Role 2 Light Manoeuvre and Role 2 Enhanced capabilities, which may include one large or two medium-sized Role 2E hospitals.

The Royal Australian Air Force operational health capability is managed by its Health Services Wing, which consists of an operational training unit, two Expeditionary Health Squadrons that can generate a deployable health capability up to Role 2E, and an Aeromedical Evacuation Squadron that provides a tactical and strategic aeromedical evacuation capability.

The Royal Australian Navy has the capacity to deliver Role 2 and Role 2E capabilities through a small number of appropriately equipped ships within the fleet. This capability is currently provided through the Bay-class LSD HMAS *Choules* and the huge LHDs HMAS *Canberra* and *Adelaide*.

Traditional models for delivering direct military health assistance

The ADF also has the opportunity to use its health capabilities to make an important long-term contribution to the PICs' health security. In doing so, it will need to avoid many of the mistakes made by other military organisations in providing health services to local populations. But, if implemented correctly, enduring military health partnerships could become an important long-term element in Australia's Pacific Step-up.

Traditionally, many countries have used their military to provide health assistance to other countries, generally through *ad hoc* short-term engagements in response to disasters or other crises, or as a by-product of the deployment of larger military units. The thinking is that, if military health professionals are in the neighbourhood, whether during a conflict or as part of a peacetime deployment, then what could be the harm in providing treatment to needy local communities?

But, in practice, many problems can arise from the use of military health professionals in this way. During the Vietnam War, the US military provided extensive medical civilian aid programs in South Vietnam, including by establishing *ad hoc* medical clinics in local

villages as part of the battle for 'hearts and minds'. But this became the subject of considerable criticism[11] from those involved and outside observers, who made the following arguments:

- The programs delegitimised the South Vietnamese Government by implying that it could not provide those services.
- They provided an unacceptably low standard of care.
- With no ability to provide long-term treatment, they raised patient expectations that soon led to disappointment.
- They created resentment among local physicians by reducing their business and by implying that the physicians were offering a low standard of care.
- They removed any incentive for the South Vietnamese Government to provide more appropriate services in the regions visited.
- They undertook no proper evaluation of impact, focusing instead only on numbers of patients treated.

More recent case studies of the deployment of US Army field hospitals following the 2005 earthquake in Pakistan raised similar concerns.[12]

Hospital ship diplomacy in the Pacific

A high-profile exemplar of traditional approaches in delivering military health assistance to developing countries of particular relevance to PICs is the use of naval hospital ships. These gleaming white ships with red crosses on their sides certainly capture the imagination. Indeed, who couldn't be impressed with the idea of a floating hospital, fully staffed and with access to all the latest technology, anchored off a tropical island, delivering the best medical services available to (hopefully, grateful) locals?

Hospital ships have been an important element in US military medical services since World War II, when the US Navy used them as mobile combat hospitals in its Pacific island-hopping campaign. For the past several decades, the US Navy's huge 65,000-tonne hospital ship, USNS *Mercy*—larger than many aircraft carriers—has toured the Pacific and Indian oceans as part of around 20 humanitarian assistance missions,[13] providing assistance to local populations through its 12 operating theatres, 100 intensive care beds, 900 ward beds and a large team of US military personnel and volunteers. The *Mercy's* sister ship, USNS *Comfort*, also operated by the Military Sealift Command, provides similar services to the Caribbean island states and elsewhere in the Atlantic.

On the face of it, it may seem obvious that the deployment of hospital ships in this way would be a good use of military assets while they aren't immediately required for military purposes. Some proponents even argue that the US should have fleets of hospital ships venturing forth to win hearts and minds around the globe.[14]

Nevertheless, there's been considerable scepticism in recent times about the value of using large hospital ships to respond to US domestic health crises such as Covid-19.[15] In March 2020, the *Comfort* and *Mercy* were deployed to New York and Los Angeles, ostensibly to treat Covid-19 cases. However, they remained essentially unused, apart from a very small number of non-Covid cases, as they were deemed unsuitable and dangerous for treating victims of Covid-19.[16]

In fact, the US Navy has long wanted to mothball the USNS *Mercy*, the *Comfort*, or both, because they were no longer a cost-efficient or efficacious way to treat combat casualties from military operations. In 2004, the US Navy's Chief Medical Officer, Vice Admiral Michael Cowan, called the ships 'dinosaurs', arguing that the eventual move away from big hospital ships at sea is mirrored by a trend towards using smaller, more flexible and more mobile hospitals on land, together with greater use of air evacuation.[17]

But proposals to retire the ships in 2018 triggered a backlash from members of the US Congress,[18] some of whom argued that the US shouldn't be pulling back on a symbol of soft power just when China is ramping up its use of hospital ships. In 2020, there were even proposals from Congress to build four new expeditionary medical ships at a cost of US$1.45 billion.[19]

The People's Republic of China, too, has now adopted the old-style hospital ship model of delivering military health services to developing countries. It reportedly began to realise the potential soft-power benefits of using its military to provide humanitarian assistance in the early 2000s, and especially after the 2004 Indian Ocean tsunami, when military and medical personnel from the US and other countries were at the forefront of delivering aid to Indonesia and other regional states.

As a result, China built the 14,000-tonne naval hospital ship *Daishan Dao* (translated as '*Peace Ark'* for its peacetime persona), which is equipped with eight operating theatres and 300 beds and staffed by more than 100 medical personnel. Since 2007, the *Daishan Dao* has undertaken regular deployments throughout the Indian Ocean, the Pacific and the Caribbean and to African ports, visiting some 40 countries and treating more than 180,000 people. That included 2018 visits to Papua New Guinea, Vanuatu, Fiji and Tonga (when the ship also reportedly bypassed island states, including Tuvalu, Palau, the Marshall Islands, Solomon Islands, Nauru and Kiribati, that diplomatically recognised Taiwan).[20]

In the past few years, China has continued to add to its fleet of hospital ships, including the 4,000-tonne *Nanyi 12* and *Nanyi 13* ships, each with 100 beds and three operating theatres.

Hospital ships can be useful for scoring political points. In December 2020, the *Global Times* reported that *Nanyi 13* made its first deployment to the South China Sea, commenting:

> Unlike the US, which has been pushing for militarization in the South China Sea, China is becoming more capable of providing international public services, including maritime search and rescue. By providing these public services, China will be able to showcase its presence in the region and demonstrate its practice of civil administration.[21]

Using hospital ships in developing countries can also generate upbeat media coverage and impressive statistics. Local leaders are often quoted expressing their appreciation for the ships' work.[22] Analysts and journalists frequently praise the use of hospital ships as a key soft-power tool[23] in winning 'hearts and minds' in geopolitical competitions.[24]

Indeed, the case for hospital ships appears (at least superficially) to be so compelling that there have been calls for middle powers such as Australia[25] and Japan[26] to use them to reinforce their influence in the Pacific as part of regional geopolitical competition with China.

But questions about the use of hospital ships to deliver humanitarian assistance and these issues provide broader insights into the costs and limitations of using militaries to deliver health assistance. How efficacious is the delivery of fleeting and *ad hoc* military health assistance to local communities as a foreign policy tool? How cost-effective is it in terms of patients treated? What are the long-term benefits to patients and local communities? Is it an effective way of building the capabilities of partner states?

In fact, despite considerable rhetoric, there's little or no data to support the value of the substantial investments made in hospital ships in terms of meaningful soft-power benefits.[27] Indeed, one extensive study noted the 'complete absence' of any empirical studies on the efficacy of US Navy hospital ship missions from diplomatic, development and host-nation perspectives.[28] Another study concluded:

> While soft power continues to be advocated, empirical evidence has not shown that military medical missions can and do generate it; nor do leaders or mission personnel set goals that can be assessed or collect data to help evaluate outcomes over time.[29]

Nor do the numbers stack up for hospital shops as a cost-effective means of delivering humanitarian assistance to civilian populations. According to one estimate, the costs of treatment of civilians in HADR crises using the USNS *Mercy* may exceed US$30,000 per patient, which is far greater than the cost of delivering health care through civil organisations or NGOs.[30]

There's also considerable scepticism about the health benefits that hospital ships actually deliver to local communities. For individuals who have received treatment, there's an obvious mismatch in the level of follow-on care available to them once the ship leaves the area. One searing report on US hospital ships by the US Center for Naval Analyses argued that they caused as many problems as they cured, noting:

> The most common problems that come with drive-by medicine include undercutting local private medical practices, providing drug regimens that cannot be sustained by the local clinics (which then has the effect of discrediting the capability of the local health care in the eyes of the local population), and providing care that may need follow up attention, but medical records are not left with any local medical provider.[31]

Nor do brief visits by military health professionals add in any appreciable way to the long-term capabilities of host countries. Another report noted that the use of military hospital ships:

> … intrinsically limits what real, durable health impacts are possible and raises skepticism in professional health and development communities, particularly when ship visits are not connected, before and after, to on-shore programs and future planned engagements.[32]

Caution about the use of military personnel and assets, including military health professionals, in responding to disasters is reflected in UN-sponsored guidelines that stipulate that, in responding to disasters, foreign military and civil defence assets can be requested only when there's no comparable civilian alternative.

The ADF's approach to delivering military health assistance in disasters and crises

The ADF provides humanitarian assistance in times of disaster or complex emergencies under a framework adopted in 2013.[33] The ADF's approach reflects UN guidelines, including the 2006 MDCA guidelines,[34] which apply to the use of military and civil defence assets to support UN humanitarian activities in complex emergencies, and the 2007 Oslo guidelines,[35] which apply more generally to the use of foreign military and civil defence assets in international disaster relief operations in times of peace.

These international guidelines for general application are complemented by the 2014 Asia–Pacific regional guidelines for the use of foreign military assets in natural disaster response operations, which were developed in consultation with regional states.[36] The regional guidelines reflect a somewhat greater recognition that in the Asia–Pacific, in the absence of civilian HADR capabilities, military actors are often required to provide direct assistance in response to natural disasters.

But, in general, the guidelines reflect caution about the use of military assets in responding to humanitarian crises and also broader concerns about the potential 'militarisation of aid'. Importantly, the UN guidelines state that foreign military assets should be used in responding to crises only where there's no comparable civilian alternative and only when the use of military assets can meet a critical humanitarian need.

Consistent with those guidelines, ADF doctrine states that military assets used in disasters and crises:

> … must be unique in capability and availability. Military assets should be seen as a tool complementing existing relief mechanisms to provide specific support to specific requirements, in response to the acknowledged humanitarian gap between the identified needs and the resources available to meet them. At the onset, any use of military assets should be limited in time and scale and present an exit strategy that defines clearly how the function it undertakes could, in the future, be undertaken by civilian personnel.[37]

Those requirements have had the effect of limiting the ADF's role in HADR operations in the Pacific and elsewhere, including in the provision of medical assistance. Between 1998 and 2007 (when the Oslo guidelines were adopted) the ADF undertook four major HADR operations with a significant health focus,[38] but, since 2007, none of the 10 Pacific island HADR operations has had a substantial ADF medical component. ADF contributions to HADR operations are now largely confined to logistic and engineering support.

The last major HADR operation involving the deployment of a significant number of ADF health professionals was Operation Sumatra Assist in 2004–05, in which 1,100 ADF personnel deployed a surgical field hospital to Indonesia for three months. Since then, Australia's health contribution to HADR operations (for example, in response to the 2010 Pakistan floods and Typhoon Yolanda in the Philippines in 2013) has been provided through the civilian Australian medical assistance teams, or AusMATs.[39]

While AusMATs provide sound training in development principles, their focus is disaster response and they have no enduring presence overseas.

Aside from the requirements of the UN guidelines, there are also practical limitations to what can be achieved through HADR operations in terms of building influence. No doubt, HADR responses are well received during the crisis, but their enduring effects can be questionable. HADR cooperation isn't in itself enough to overcome all the problems that can plague a bilateral relationship, and gratitude and admiration may fade with time. Arguably, lasting effects require longer term relationships by civilian or military agencies.

Delivering long-term military health assistance in times other than crisis

Despite those concerns, ADF health personnel can still play an important role in our Pacific neighbourhood. The ADF could effectively use its substantial military health assets to build soft power through collaborative long-term partnerships with host nations in times other than disaster or crisis. It would be much less constrained in delivering health assistance as part of long-term collaborative arrangements compared with traditional HADR operations. Among other things, such arrangements other than in times of crisis wouldn't fall within the constraints of the UN Guidelines and, indeed, wouldn't even fall within the ADF's definition of a 'humanitarian operation' or 'humanitarian assistance'[40] (although many of the basic principles relating to 'humanitarian assistance' may still be relevant to long-term ADF military health collaborations).

The US military makes a clear distinction between humanitarian assistance provided in times of crisis and at other times. What it calls 'foreign humanitarian assistance'[41] is provided in times of disaster or other crisis, while 'human and civic assistance' (HCA)[42] activities serve 'the basic economic and social needs of host nations'. Importantly, a primary intent of HCA is to enhance 'specific operational readiness skills of the service members who participate'.

But the value of HCA activities for host countries, especially in medical assistance, will often depend considerably on whether they involve building enduring institutional relationships. Among the most prominent of HCA initiatives currently undertaken by the US military is Exercise Pacific Partnership, which has been undertaken annually since 2006 and is typically centred on the USNS *Mercy*, other amphibious warfare vessels of the US Navy's Pacific Fleet, or both, with other nations (including Australia) making regular contributions of medical personnel. But US military health experts suggest that, instead of short-term individual engagements, enduring and mutually beneficial institutional engagements are needed to build partners' capacity.[43]

Enduring health civic assistance partnerships—an opportunity for the ADF

Australian Army Doctor Captain Olly Mills watches Vanuatu Police Force members perform improvised first aid techniques during a humanitarian aid and disaster relief scenario on Epi Island as part of Exercise Vanuatu Alliance 2019. Image: Department of Defence.

Australia is well positioned to build on US experience by developing our own enduring military health engagement program.[44] ADF health projects throughout the Asia–Pacific region are currently led by the ADF's Malaria and Infectious Disease Institute.[45] Its numerous research projects are co-funded by the World Health Organization, the US Department of Defense, Australia's Department of Foreign Affairs and Trade, and private industry.

In recent years, those projects have been augmented by reinvigorated training partnerships with military and civilian colleagues in PICs such as Solomon Islands and Vanuatu. The ADF gains benefits by exposing its clinicians and scientific officers to an operational environment unavailable domestically, guided by the experience of local experts. The host nation benefits from an injection of personnel, equipment and knowledge that can be relied upon in the medium to long term. Far from creating dependency, the program has built self-sustaining local capabilities that wouldn't have otherwise existed in the host nations. Could that be achieved across a broader range of health care?

There's potential for the ADF to build enduring partnerships with relevant health agencies in PICs (both military and civil) through which several ADF clinicians could work in host-nation hospitals for, say, four weeks each, with rotations of teams providing a near-continuous presence. This would simultaneously enhance the ADF's health capabilities and build the PICs' health capacity in a respectful and collaborative manner.

Importantly, such partnerships would give the ADF clinicians the opportunity to learn from the local experts in their own environment, while augmenting the capability of their busy hospitals. Team composition would be guided by host requirements, but the most critical capability constraints in many PICs are in surgery and treating tropical infectious diseases. However, given the high prevalence of dental morbidity, complex obstetrics and untreated chronic illness, there would be ample scope for all ADF medical, dental, nursing and allied health specialties. The logistic and organisational challenges also suggest valuable work for ADF pharmacists and health general service officers.

In several ways, the development of an enduring military health presence would avoid an 'aid trap', in which the economic priorities of developing countries become tailored to the continued receipt of external assistance. ADF clinicians would only undertake procedures already performed in the host-nation hospital, not introducing any new clinical service.

And each one-month rotation would comprise clinicians of different specialties, so, although the ADF presence would endure, no clinical specialty would always be present. To avoid interfering in the hospitals' own supply chains, ADF clinicians wouldn't bring equipment or consumables.

ADF clinicians would understand that their role is to work with, and learn from, host-nation clinicians, not to replace them. ADF personnel would never take leadership roles within the host-nation hospital. Using such rules, the ADF has previously carried out this type of engagement without creating dependency in both Solomon Islands and East Timor.

For the ADF, the costs of rotating deployments of relatively small numbers of permanent and reserve personnel should be relatively modest and could potentially be managed as part of overall training costs. The program would of course need to take into account Covid-related travel restrictions.

These partnerships could be negotiated by the ADF bilaterally with relevant military and civilian health agencies in PICs, or through multilateral forums such as the Pacific Islands Forum, the Pacific Community or the Pacific Defence Ministers Meeting.

Australia's effective withdrawal of ADF health assets from HADR operations since 2007 has left the force's permanent and reserve clinical staff with few overseas operational roles outside primary care, small-team deployments to coalition facilities and a limited hospital deployment to the Middle East from 2015 to 2019. The competencies required for field-deployed health care (for example, in treating tropical diseases and in lifesaving 'damage control' surgery) can't easily be acquired in the Australian civilian healthcare system. That can leave an experience gap, especially for specialist clinicians.

As a result, many ADF clinicians lack experience and mentorship from working in small, remote hospitals without advanced diagnostics and subspecialist medical expertise in the context of a high prevalence of trauma and infectious disease. Yet those are exactly what, say, an ADF Role 2E hospital is intended to be deployed to deal with in a military contingency. In contrast, many medical colleagues who currently practise throughout the Pacific islands are experts in those areas. This means that ADF clinicians might miss important training opportunities necessary to properly fulfil their military roles.

It isn't just a question of training, but potentially also one of recruitment and retention. Many health professionals join the ADF, as either permanent or reserve personnel, with a view to serving Australia through helping those in need within our region. Current policies effectively deny them the opportunity to serve in the region as ADF members, forcing some to join civilian health teams in order to provide that service.

The Australian Government already supports many development assistance programs in PICs, including visits by civilian AusMATs and contracted private providers in times of crisis.

Since 1995, the government has also provided financial support to the Pacific Islands Program provided by the Royal Australasian College of Surgeons and involving the deployment of visiting teams of specialist clinicians to PICs.[46] Over the past two decades, this has involved more than 600 volunteer medical teams visiting 11 PICs and providing more than 60,000 consultations and 16,000 procedures. The program typically involves short-term (1–2 week) deployments of teams of volunteer practitioners on a fly-in/fly-out basis to provide specialist surgical procedures and mentoring/training to PIC practitioners, sometimes accompanied by the donation of necessary specialised equipment. This highly regarded program focuses on the provision of specialist medical services that may not otherwise be available locally. A recent review of the program acknowledged the challenges of weaving capacity-building activities into the imperatives of providing medical services.[47]

An ADF program involving the regular rotation of Australian military health professionals through PICs would differ from traditional humanitarian assistance in that it would be explicitly focused on delivering *mutual* benefits. A focus on *sub*specialist medical care in the context of a high prevalence of trauma and infectious disease would mean that ADF clinicians would have the opportunity to learn as much from local practitioners as the other way around. In other words, both sides would gain training opportunities that might otherwise not be readily available to them. Ideally, relatively long deployments would result in a regular presence of ADF clinicians in participating institutions. Enduring military health partnerships shouldn't therefore be characterised as official development assistance, which is within the remit of the Department of Foreign Affairs and Trade and not the ADF.

The optimal relationship between a clinician and a patient is built on trust developed over a long period. In most cases, specialists in emergency medicine haven't met a patient or their family before having to help them make decisions in response to a life-threatening event. Both patients and emergency personnel find that extraordinarily challenging. The patients are likely to seek the opinion of a general practitioner or surgeon they know and trust, even if they know that that person has little technical advice to offer.

Building the ADF's relationships with our Pacific partners around HADR interventions may place it in the position of the emergency specialist unknown to the patient. How much better to have gained mutual knowledge and trust in good times so that, when it really matters, we're the trusted and capable partners of choice.

Conclusion

The ADF is one of Australia's leading agencies in our engagement with PIC partners, helping them to develop capabilities to address a range of security challenges. In future, the ADF could also play an important role in helping to build regional health security as part of a new phase in Australia's Pacific Step-up.

This paper has looked at ways in which the ADF can play to its strengths in helping to build health security in the PICs as part of a new phase of our step-up. This could include:

- using ADF personnel and assets to provide transport and other logistical support for the rollout of the Covid-19 immunisation program in the coming months
- building enduring military health partnerships involving mutual sharing of expertise and training between ADF clinicians and local health providers.

Provision of medical assistance has come to be seen as a particularly valuable way of 'winning the hearts and minds' of communities in need, and, traditionally, many militaries have provided health assistance through *ad hoc* short-term engagements. There's no doubt that public health assistance during the current pandemic is a critical element in Australia's international relationships, so it's useful to think through the ADF's potentially larger role over time—during and beyond the pandemic.

But there are significant questions about the provision of 'drive-by' medicine. For more than a decade, concerns about the impact of short-term military health assistance has led the ADF to avoid providing medical assistance as part of HADR operations in the Pacific. As a result, there's now significant underutilisation of the ADF's considerable military health capabilities in providing humanitarian assistance to our Pacific partners.

Australia's effective withdrawal of ADF health assets from HADR operations has left the ADF's clinical staff with few overseas operational roles. As a result, ADF clinicians lack experience and mentorship working in small, remote hospitals in the context of a high prevalence of trauma and infectious disease.

This paper has argued that the ADF could effectively use its substantial military health assets to build collaborative long-term partnerships with host nations in a way that builds the capabilities of *both* the ADF and our PIC partners. That would provide essential experience to ADF health professionals while also building the health capacity of the PICs in a respectful and collaborative manner.

The ADF has an important role to play in addressing health security challenges faced by the region as part of the Pacific Step-up, building upon the logistical and planning support being provided now as part of Operation Covid Assist. Ultimately, such collaborative arrangements might come to be seen alongside the Pacific Patrol Boat Program as a successful example of mutually beneficial partnerships with our Pacific neighbours.

Notes

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Acronyms and abbreviations

ADF	Australian Defence Force
AusMAT	Australian medical assistance team
HADR	humanitarian assistance and disaster response
HCA	human and civic assistance
NGO	non-government organisation
PIC	Pacific island country
UN	United Nations

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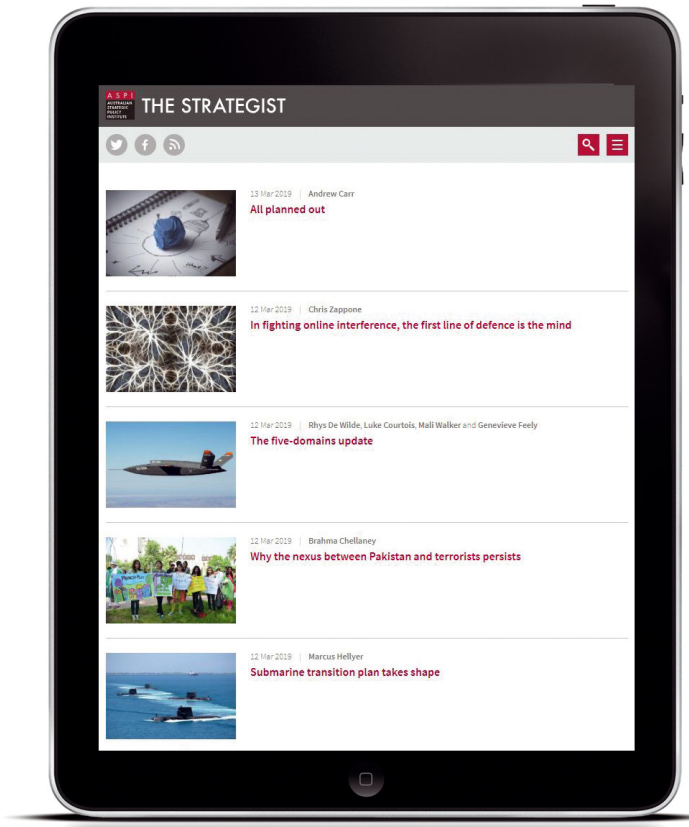

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