Health implications of Adaptive Campaigning: an overview

Susan J Neuhaus

TRADITIONAL TACTICAL DOCTRINES have lost relevance in current operations. Deployed forces now simultaneously face a combination of counterinsurgency, stabilisation, peace-support, conventional war-fighting and humanitarian responsibilities. In response to this change, "Adaptive Campaigning" now forms the conceptual basis of Army's land operations.[1] The challenges posed to operational health support by this conceptual shift extend beyond Army to the full spectrum of Australian Defence Force health operations. To meet these challenges, health services will need to undertake significant doctrinal, organisational and philosophical changes.[2]

With the outcome of operations now increasingly decided in the minds of populations rather than on the battlefield, health can have an important role by "shaping" a particular strategic effect. This may be achieved through a short-term crisis intervention, a "hearts and minds" campaign or longer term capacity building. Adaptive Campaigning doctrine defines five overlapping lines of operation, each of which has implications for health care provision: joint land combat, population protection, public information, population support, and indigenous capacity building.

The nature of casualties sustained during current expeditionary operations differs from previous campaigns. Although the casualty load may be relatively low, the injuries are complex and their management vastly more resource-intensive. Combat health assets must be able to support many small teams, while retaining the ability to quickly "surge" in response to changes in the tactical scenario. This requires them to be protected, equipped and structured to operate and survive in a potentially lethal environment, while retaining the ability to concurrently perform diverse humanitarian, counterinsurgency and peace-support tasks.

Population protection operations require large-scale collective action and have traditionally been undertaken by non-government organisations (NGOs) rather than the military. However, under a "whole-of-government" approach, ADF health planners are likely to be increasingly engaged in provision or planning of refugee support and preventive health interventions.

One of the keys to effective counterinsurgency operations is "presence". Moving freely among a community builds confidence and helps to shape community perceptions. This is where health has its greatest opportunity to contribute to strategic success and positively influence the attitudes of a population. In complex operations, health facilities are often the first to be destroyed and the last to be rebuilt. Local health care services may be inadequate due to lack of personnel, facilities or resources, or as a result of targeting by insurgent action. Provision of health care to civilian populations is complex and requires integrated planning between military forces, NGOs and other government organisations. Treatment eligibility matrices and medical rules of engagement (M-ROE) need to be carefully articulated and balanced against the operational health footprint. However, in long-term engagements with a fragile security situation, rebuilding civilian health infrastructure may facilitate land health disengagement.

From a health viewpoint, indigenous capacity building includes provision of transferable skills, restoration of confidence in local health providers, equipment repair and maintenance, and strategic health planning. Compared with ongoing service provision, such capacity building is relatively low-cost, offers greater long-term benefit and facilitates military disengagement. It requires skill sets not normally contained within combat health support, with a greater focus on education and planning. Sustainability and appropriateness of health standards within the population must also be recognised, respected and used as the basis of any intervention.

In an Adaptive Campaigning model, success is largely determined, not by caseload, but by improvements in health measured against realistic and sustainable benchmarks. The desired health effects must have relevant measures of success to avoid false dependencies and unrealistic expectations.

To meet the demands and agility required by Adaptive Campaigning, health should consider a task-organised structure with the flexibility to provide combat and non-combat health support modules, and the ability to switch effort between capabilities. This will require significant changes in force structure, particularly in the areas of midwifery and paediatrics. The emerging role of contractors also needs to be considered.

As most conflicts around the world are unconventional, it is important to recognise and adjust the strategies required to meet these challenges. Delivery of medical capacity is an important adjunct to achieving whole-of-government outcomes in Adaptive Campaigning operations, and effective use of health assets as a form of "soft power" may assist the operational commander to achieve strategic and operational objectives. Adaptive Campaigning should not distract from the primacy of combat health. Meeting each of the lines of operation does not imply delivery of land health services, but each health effect must be articulated and coordinated across the battlespace. New doctrine is required to describe how land health components within an Adaptive Campaigning framework can provide flexible and focused effects-based solutions to meet the operational health demands of the 21st century.[2]

Lieutenant Colonel Susan Neuhaus *enlisted in the Australian Regular Army as an undergraduate medical officer and has served in Cambodia and Bougainville. Lieutenant Colonel Neuhaus is a consultant surgeon and a graduate of Australian Command and Staff College (Reserve). She is currently the Commanding Officer of 3rd Health Support Battalion.*

3rd Health Support Battalion, Keswick Barracks, Keswick, SA.
Susan J Neuhaus, PhD, FRACS, Commanding Officer.
Correspondence: Lieutenant Colonel Susan J Neuhaus, 3rd Health Support Battalion, Keswick Barracks, Keswick, SA 5035.
Susan.Neuhaus@defence.gov.au

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