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October 2007

DEFENSE HEALTH CARE

DOD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure

GAO-08-122

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Highlights

Highlights of GAO-08-122, a report to congressional committees

Why GAO Did This Study

The Department of Defense (DOD) operates one of the largest and most complex health systems in the nation and has a dual health care mission—readiness and benefits. The readiness mission provides medical services and support to the armed forces during military operations. The benefits mission provides health care to over 9 million eligible beneficiaries, including active duty personnel, retirees, and dependents worldwide. Past GAO and other reports have recommended changes to the military health system (MHS) structure. GAO was asked to (1) describe the options for structuring a unified medical command recommended in recent studies by DOD and other organizations and (2) assess the extent to which DOD has identified the potential impact these options would have on the current MHS. GAO analyzed studies and reports prepared by DOD's Joint/Unified Medical Command Working Group, the Defense Business Board, and the Center for Naval Analyses, and interviewed department officials.

What GAO Recommends

GAO is recommending that DOD address the expected benefits, costs, and risks for implementing the fourth option and provide Congress the results of its assessment. In commenting on a draft of this report, DOD concurred with GAO's recommendations.

To view the full product, including the scope and methodology, click on GAO-08-122. For more information, contact Henry L. Hinton, Jr. at (202) 512-4300 or hintonh@gao.gov.

What GAO Found

DOD considered options to address the department's dual health care mission that differed in their approaches to both command structure and operations. In April 2006, the Joint/Unified Medical Command Working Group identified three options: (1) establishing a unified medical command on par with other functional combatant commands; (2) establishing two separate commands—a Medical Command, which would provide operational/deployable medicine, and a Healthcare Command, which would provide beneficiary health care through the military treatment facilities and civilian providers; and (3) designating one of the military services to provide all health care services across the department. Subsequently, in November 2006, a fourth option was presented that would consolidate key common services and functions, which are currently performed within each of the services, such as finance, information management and technology, human capital management, support and logistics, and force health sustainment. This option would leave the existing structures of the Army, Navy, and Air Force medical departments over all military treatment facilities essentially unchanged. The Deputy Secretary of Defense approved this fourth option in November 2006.

Although DOD initiated steps to evaluate the impact that some restructuring options might have on the MHS, it did not perform a comprehensive cost-benefit analysis of all potential options. GAO's *Business Process Reengineering Assessment Guide* establishes that a comprehensive analysis of alternative processes should include a performance-based, risk-adjusted analysis of benefits and costs for each alternative. The working group used several methods to determine some of the benefits, costs, and risks of implementing its three proposed options. For example, it used the Center for Naval Analyses to determine the cost implications for each option, and it solicited the views of key stakeholders. However, based on the working group's methodology, the group intended to conduct a more detailed cost-benefit analysis of whichever of the three options senior DOD leadership selected, but the group's work ceased once the fourth option was formally approved. While DOD approved the fourth option, DOD has not demonstrated that its decision to move forward with the fourth option was based on a sound business case. Based on GAO's review of DOD's business case, DOD has described only what it believes its chosen option will accomplish. The business case does not demonstrate how DOD determined the fourth option to be better than the other three in terms of its potential impact on medical readiness, quality of care, beneficiaries' access to care, costs, implementation time, and risks because DOD does not provide evidence of any analysis it has performed of the fourth option or a sound business case justifying this choice. Without such analysis and documentation, DOD is not in a sound position to assure the Secretary of Defense and Congress that it made an informed decision when it chose the fourth option over the other three or that its chosen option will have the desired impact on DOD's MHS.

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Abbreviations

ASD (HA)	Assistant Secretary of Defense (Health Affairs)
BRAC	Base Realignment and Closure
CNA	Center for Naval Analyses
DBB	Defense Business Board
DOD	Department of Defense
MHS	military health system
MTF	military treatment facility
USD P&R	Under Secretary of Defense for Personnel and Readiness

GAO
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United States Government Accountability Office
Washington, DC 20548

October 12, 2007

The Honorable Carl Levin
Chairman
The Honorable John McCain
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Ike Skelton
Chairman
The Honorable Duncan L. Hunter
Ranking Member
Committee on Armed Services
House of Representatives

The Department of Defense (DOD) operates one of the largest and most complex health systems in the nation and has a dual health care mission—readiness and benefits. The readiness mission provides medical services and support to the armed forces during military operations and involves deploying medical personnel and equipment as needed to support military forces throughout the world. The benefits mission provides health care to over 9 million beneficiaries, including active duty personnel, retirees, and dependents worldwide. DOD's health care mission is carried out through military hospitals and clinics, commonly referred to as military treatment facilities (MTF), such as Walter Reed Army Medical Center in Washington, D.C.; National Naval Medical Center in Bethesda, Maryland; and Landstuhl Regional Medical Center, in Landstuhl, Germany, as well as civilian providers. Each military service, under a surgeon general, is responsible for managing its own MTFs. The Army and Navy each have a medical command, which manages each service's MTFs and other activities through a regional command structure. The Navy's medical department supports both the Navy and Marine Corps. The Air Force Surgeon General, through the position as medical advisor to the Air Force Chief of Staff, exercises essentially the same authority as the other surgeons general. Each service also recruits and funds medical personnel to administer its medical programs and to provide medical services to beneficiaries.

Past GAO reports have highlighted a range of long-standing issues surrounding the military health system (MHS) structure. For example, in a 1995 report on defense health care, we found that interservice rivalries

and conflicting responsibilities hindered MHS improvement efforts.[1] We further noted that the services have historically resisted efforts to change the way military medicine is organized, including consolidating the services' medical departments, in favor of maintaining their own health care systems, primarily on the grounds that each service has unique medical activities and requirements. We also noted that the lines of authority and accountability between hospital commanders, the services, the service surgeons general, and the Assistant Secretary of Defense (Health Affairs) (ASD (HA)) are complicated and sometimes conflict. In 2001, a RAND Corporation study[2] on reorganizing the MHS uncovered at least 13 studies that had addressed military health care organization since the 1940s. All but 3 of those studies had either favored a unified system or recommended a stronger central authority to improve coordination among the services.

In our February 2005 report on key challenges facing the U.S. government in the 21st century,[3] we identified DOD's health care system as an example of an area in which DOD could achieve economies of scale and improve delivery by combining, realigning, or otherwise changing selected support functions. That report also noted that while DOD's civilian and military leaders appear committed to reform, DOD must overcome cultural resistance to change and the inertia of various organizations, policies, and practices that became well rooted in the Cold War era—along with long-standing organizational and budgetary problems, such as the existence of stovepiped or siloed organizations and the involvement of many layers and players involved in decision making. DOD's February 2006 *Quadrennial Defense Review Report* acknowledges the department's need to reform its defense enterprise, including the MHS.

In December 2004, DOD directed the Under Secretary of Defense for Personnel and Readiness (USD P&R), to work with the Chairman of the Joint Chiefs of Staff to develop an implementation plan for a joint medical command by the fiscal years 2008–2013 program/budget review. In 2005, the USD P&R and the Director, Joint Staff established the Joint/Unified Medical Command Working Group, which developed options with the goal

[1]GAO, *Defense Health Care: Issues and Challenges Confronting Military Medicine*, GAO/HEHS-95-104 (Washington, D.C.: Mar. 22, 1995).

[2]Rand Corporation, *Reorganizing the Military Health System: Should There Be a Joint Command?*, MR-1350-OSD (2001).

[3]GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, GAO-05-325SP (Washington, D.C.: February 2005).

of improving DOD's MHS by eliminating unnecessary duplication; streamlining organizational structures; and aligning authority, responsibility, and financial control.

The House Armed Services Committee[4] directed us to review the various unified medical command studies that DOD and other organizations have undertaken and provide an analysis of the various unified medical command structures under consideration. This report (1) describes the options for structuring a unified medical command that have been recommended in recent studies by DOD and other organizations and (2) assesses the extent to which DOD has identified the potential impact these options would have on the MHS. We provided a briefing to congressional committees on our preliminary observations in March 2007. This report expands on the information delivered in that briefing and includes recommendations to the Secretary of Defense.

To identify and describe the options for structuring a unified medical command, we obtained and reviewed studies and reports undertaken by DOD's Joint/Unified Medical Command Working Group, the Center for Naval Analyses (CNA), and the Defense Business Board (DBB). We also obtained and reviewed a concept plan presented by the USD P&R and the ASD (HA). To gain a better understanding of the structure and organization of each option and how each differs from the current MHS's structure, we interviewed officials from DOD's Joint/Unified Medical Command Working Group, the Office of the ASD (HA), the Joint Staff Logistics Directorate, and the Offices of the Surgeons General of the Army, Navy, and Air Force. To determine the extent to which DOD has identified the potential impact these options would have on the MHS, we analyzed studies and documents obtained from the Joint/Unified Medical Command Working Group, the Joint Staff Logistics Directorate, the Office of the ASD (HA), and CNA. In addition, we interviewed officials from DOD's Joint/Unified Medical Command Working Group, the Office of the ASD (HA), and the Joint Staff Logistics Directorate, and CNA to discuss the implications of each option and to identify any limitations in their assessments. We also reviewed GAO's *Business Process Reengineering Assessment Guide*[5] to determine guidelines for assessing reengineering efforts. Other issues, such as determining the appropriate command and

[4]H.R. Rep. No. 109-452, at 343 (2006).

[5]GAO, *Business Process Reengineering Guide*, GAO/AIMD-10.1.15 (Washington, D.C.: May 1997).

control structure within DOD to manage the MHS, did not fall within the scope of this review nor did evaluating the validity of the cost implications developed by CNA. We conducted our work from December 2006 through September 2007 in accordance with generally accepted government auditing standards. Further details on our scope and methodology can be found in appendix I.

Results in Brief

DOD considered options to address the department's dual health care mission that differed in their approaches to both command structure and operations. In April 2006, the Joint/Unified Medical Command Working Group identified three options. These options were (1) establishing a unified medical command on par with other functional combatant commands; (2) establishing two separate commands—a Medical Command, which would provide operational/deployable medicine, and a Healthcare Command, which would provide beneficiary care through MTFs and civilian providers; and (3) designating one of the military services to provide all health care services across the department. Subsequently, in November 2006, the USD P&R and the ASD (HA) presented a fourth option that would consolidate key common services and functions, which are currently being performed within each of the services, such as finance, information management and technology, human capital management, support and logistics, and force health sustainment. This option would leave the existing structures of the Army, Navy, and Air Force medical departments over all MTFs essentially unchanged. In November 2006, the Deputy Secretary of Defense approved the latter option.

Although DOD initiated steps to evaluate the impact that some restructuring options might have on the MHS, it did not perform a comprehensive cost-benefit analysis of all potential options. GAO's *Business Process Reengineering Assessment Guide*[6] emphasizes that an organization should explore each alternative thoroughly enough to convincingly demonstrate its potential to achieve the desired performance goals. The Guide has also established that a comprehensive analysis of alternative processes should include a performance-based, risk-adjusted analysis of benefits and costs for each alternative. The working group used several methods to determine some of the benefits, costs, and risks of implementing its three proposed options. For example, it used CNA to

[6]GAO/AIMD-10.1.15.

determine the cost of implementing each option, and it solicited the views of key stakeholders. However, DOD did not comprehensively analyze any of the four options. According to the working group methodology, the group intended to conduct a more detailed cost-benefit analysis of whichever of the three options senior DOD leadership selected, but the group's work ceased once the fourth option was formally approved by the Deputy Secretary of Defense. Moreover, DOD has not demonstrated that its decision to move forward with the fourth option was based on a sound business case. A sound business case should include detailed qualitative and quantitative analyses in support of selecting and implementing the new process in terms of benefits, costs, and risks. We have not evaluated the pros and cons of DOD's chosen approach. However, based on our review of DOD's business case, DOD only described what it believes its chosen option will accomplish. The business case does not demonstrate how DOD determined the fourth option to be better than the other three in terms of its potential impact on medical readiness, quality of care, beneficiaries' access to care, costs, implementation time, and risks because DOD does not provide evidence of any analysis it has performed of the fourth option or a sound business case justifying this choice. Without such analysis and documentation, DOD is not in a sound position to assure the Secretary of Defense and Congress that it made an informed decision in choosing the fourth option over the other three or that its chosen option will have the desired impact on DOD's MHS. Furthermore, the business case does not document any performance measures that will be used to assess whether the fourth option will meet the goals for improving DOD's MHS—eliminating unnecessary duplication; streamlining organizational structures; and aligning authority, responsibility, and financial control—or whether it will achieve the promised benefits.

We are recommending that DOD address the expected benefits, costs, and risks for implementing the fourth option and provide Congress the results of its assessment. We are also recommending that DOD develop performance measures to monitor the progress of its chosen plan toward achieving the goals of the transformation. In written comments on a draft of this report, DOD concurred with our recommendations. DOD's comments are reprinted in appendix II.

Background

DOD operates one of the largest, most complex health systems in the nation. DOD's MHS has a dual health care mission—readiness and benefits. The readiness mission provides medical services and support to the armed forces during military operations and involves deploying medical personnel and equipment as needed to support military forces

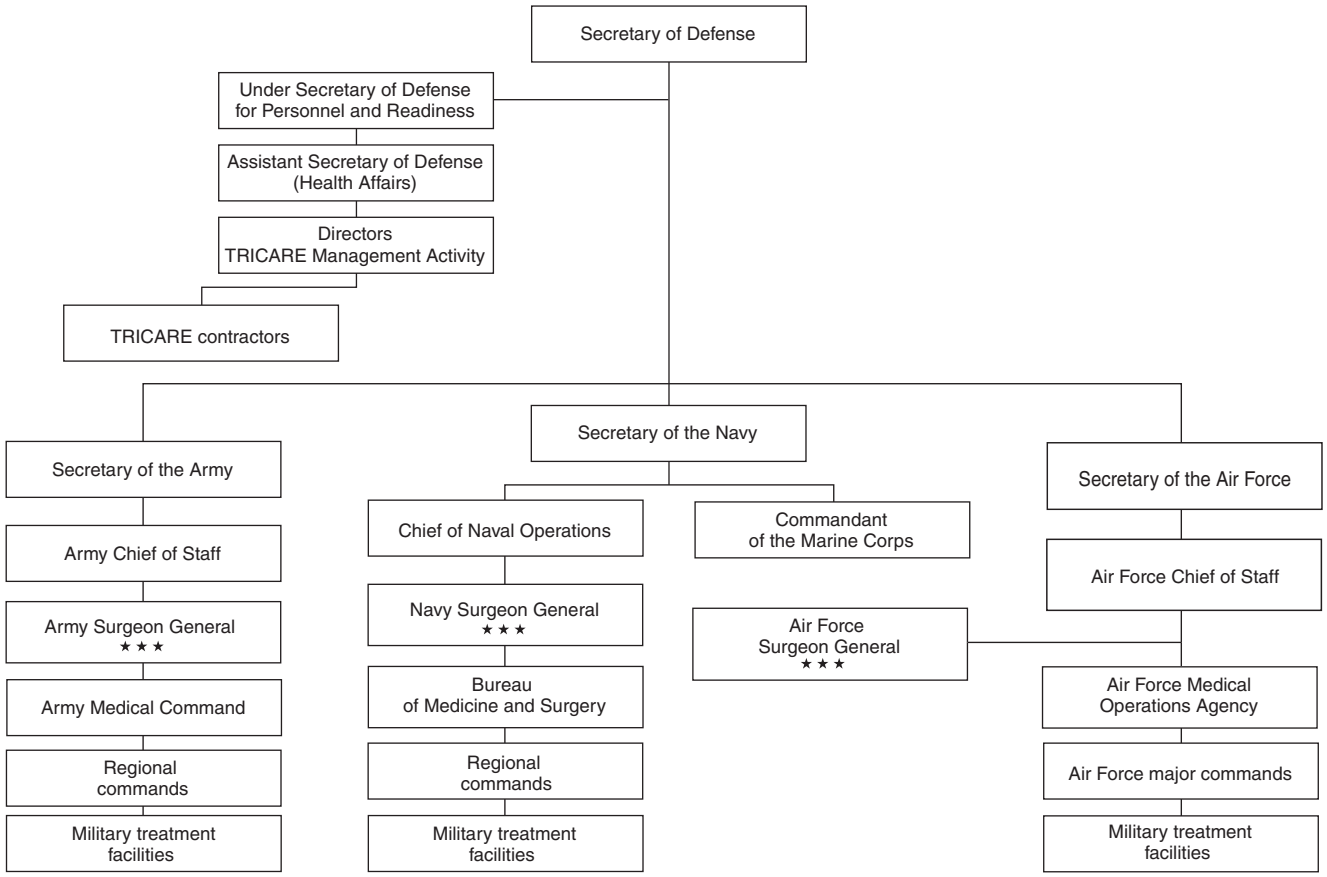
throughout the world. Additionally, activities that ensure the readiness of medical and other military personnel to deploy also contribute to the medical readiness mission. The benefits mission provides medical services and support to members of the armed forces, their family members, and others entitled to DOD health care. The ASD (HA) is responsible for executing DOD's dual health care mission and exercises authority, direction, and control over the medical personnel, facilities, funding, and other resources within DOD.

DOD's dual health care mission is carried out through military hospitals and clinics, commonly referred to as MTFs, and civilian providers. MTFs comprise DOD's direct care system for providing health care to beneficiaries. Within the direct care system, each military service, under its surgeon general, is responsible for managing its MTFs. The Army and Navy each have a medical command, headed by a surgeon general, who manages MTFs and other activities through a regional command structure. The Navy's medical department supports both the Navy and Marine Corps. The Air Force Surgeon General, through the position as medical advisor to the Air Force Chief of Staff, exercises essentially the same authority as the other surgeons general. Each service also recruits and funds its own medical personnel to administer the medical programs and provide medical services to beneficiaries.

DOD also operates a purchased care system that uses civilian managed care support contractors to develop networks of civilian primary and specialty care providers. The TRICARE Management Activity, under the ASD (HA), is responsible for awarding, administering, and overseeing these contracts.

Figure 1 shows the current organizational structure of the MHS.

Figure 1: Current Military Health System Organizational Structure



Source: GAO analysis of DOD information.

DOD Considered Different Options for the Command Structure and Operations of Its Military Health System

DOD considered options to address the department's dual health care mission that differed in their approaches to both command structure and operations. In April 2006, the Joint/Unified Medical Command Working Group identified three options: the establishment of a unified medical command; establishing two separate commands, one to provide operational/deployable medicine and another to provide beneficiary care through MTFs and purchased care providers; and designating one of the military services to provide all health care services across the department. Subsequently, senior DOD officials presented a fourth option, which consolidates key common services and functions that are currently being

performed within each of the services. In November 2006, the Deputy Secretary of Defense approved the latter option.

Joint/Unified Medical Command Working Group Identified Three Options

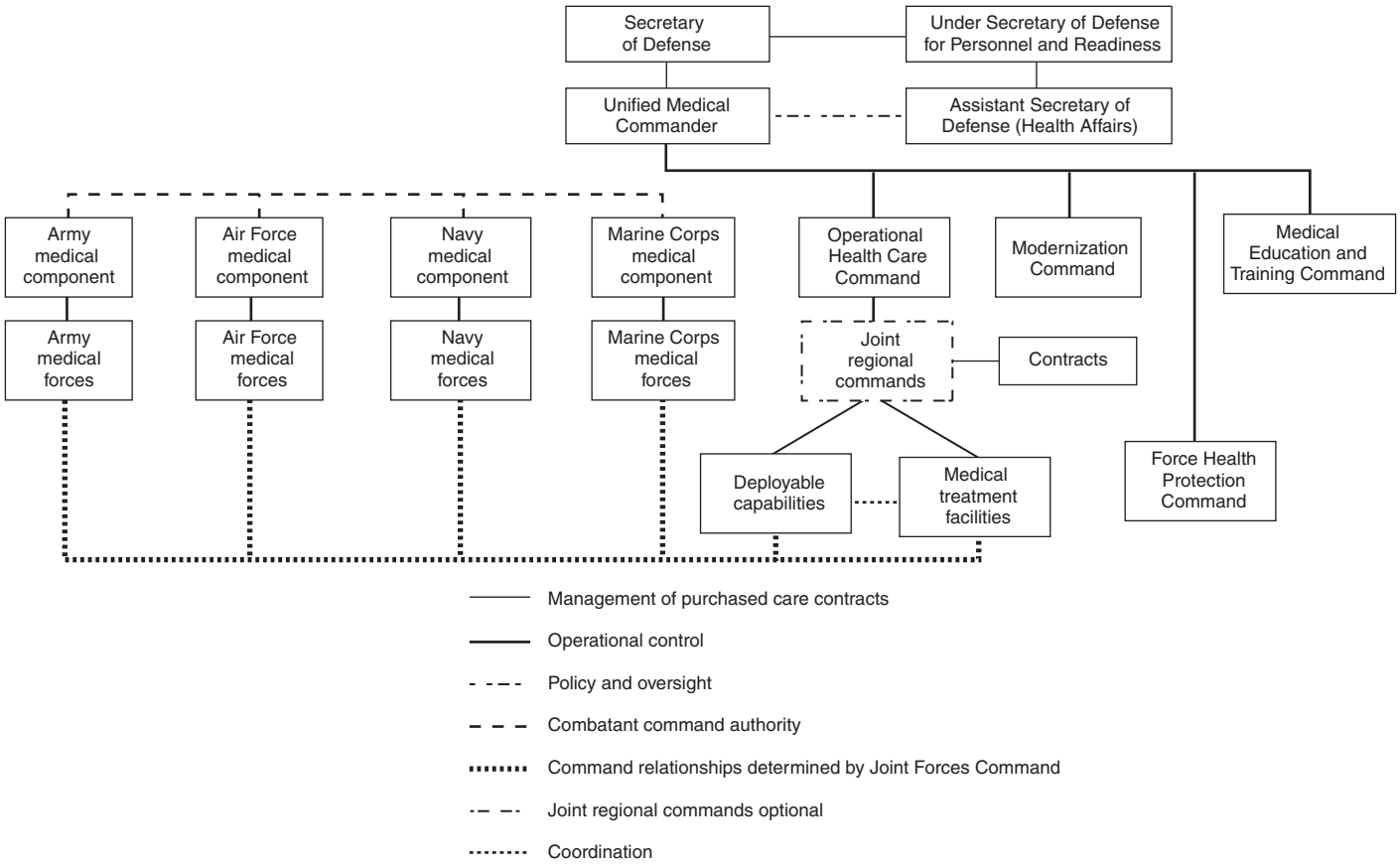
In April 2006, the Joint/Unified Medical Command Working Group proposed three options for restructuring the MHS.[7] According to the working group, each of its options was designed to promote effectiveness and efficiency by increased sharing of resources, use of common operating processes, and reduction in duplicative functions and organizations. However, each differs in its approach to both command structure and operations.

Option 1: Establish a Unified Medical Command

This option would establish a unified medical command on par with other functional combatant commands. As the single organization for managing both halves of DOD's dual health care mission—readiness and benefits—the unified medical command would oversee four subordinate commands: the Operational Health Care Command, the Modernization Command, the Force Health Protection Command, and the Medical Education and Training Command. Figure 2 illustrates the proposed unified medical command structure.

[7]The Joint/Unified Medical Command Working Group initially developed a range of options and eventually proposed three options for restructuring the MHS.

Figure 2: Notional Structure for a Unified Medical Command



Source: GAO analysis of Joint/Unified Medical Command Working Group information.

Under the unified medical command option, operational responsibilities would be divided across the following four subordinate commands:

- The Operational Health Care Command would exercise command and control over MTFs, which are currently being operated by each of the services through the direct care system. It would also manage the purchased health care for beneficiaries that the TRICARE Management Activity, under the ASD (HA), currently oversees through a network of contracted civilian providers.
- The Modernization Command would develop joint medical combat and medical doctrine, in addition to overseeing acquisition, contracting, and medical research and development.

- The Force Health Protection Command would have command and control over institutional force health protection assets that have both medical surveillance[8] and preventive medicine[9] capabilities.
- The Medical Education and Training Command would work with the services to set standards for all medical training and conduct initial military medical training and professional medical training for both officers and enlisted personnel. This command would also be responsible for joint medical training and specialized training to meet unique mission requirements, with the exception of the joint interoperable medical training and standards currently overseen by the Special Operations Command.

This option is similar to a recommendation made by DBB. In July 2006, the Deputy Secretary of Defense requested that DBB form a task group to give an independent and objective assessment and make actionable recommendations regarding the most rational model for the MHS. DBB unanimously approved the task group's recommendation that the Secretary of Defense establish a unified medical command, and included it in its September 2006 report.[10]

Option 2: Establish Two Separate Commands

This option proposed establishing a command structure for each of DOD's two medical missions—a Medical Command, which would provide operational/deployable medicine, and a Healthcare Command, which would provide beneficiary health care through MTFs and purchased care providers.

The Medical Command was designed as a unified command headquarters with the same four subordinate commands as under the first option. The responsibilities of three of its four subordinate commands would be the same as under the first option. The Operational Health Care Command, now called the Operational Medical Command, would be responsible only for the readiness mission—providing medical services and support to the armed forces during military operations. Under the Medical Command, the

[8]DOD defines "medical surveillance" as the ongoing, systematic collection, analysis, and interpretation of health data.

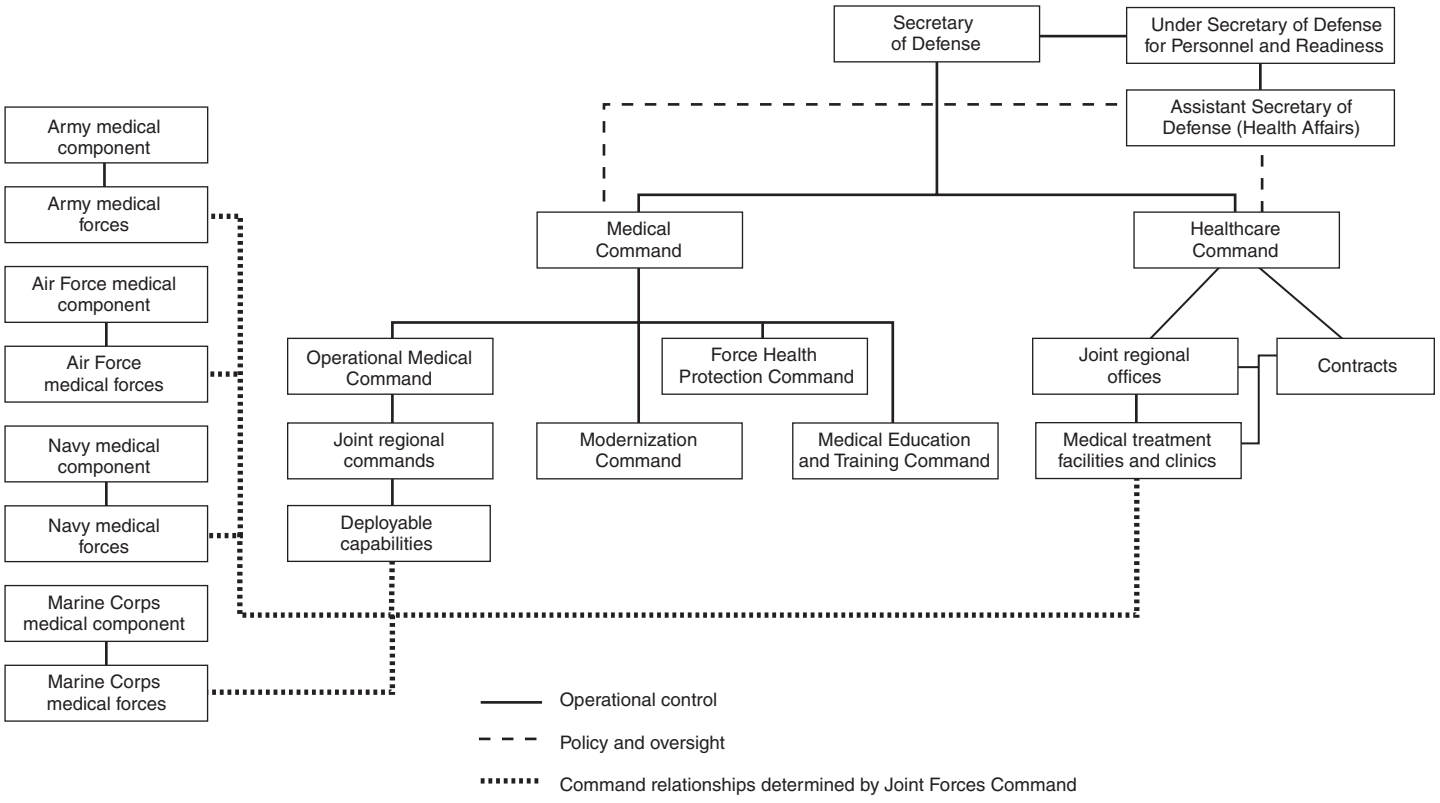
[9]DOD defines "preventive medicine" as the anticipation, identification, and control of preventable diseases, illnesses, and injuries while on duty at home or during deployment.

[10]Defense Business Board, *Military Health System—Governance, Alignment and Configuration of Business Activities Task Group Report* (Washington, D.C.: September 2006).

services would provide information on planning and programming to ensure that service-specific issues are addressed.

The Healthcare Command would be responsible for the benefits mission—providing both direct and purchased health care to all beneficiaries. Under this command, the services would identify clinical training needs for deployable personnel. Also, the services would exercise administrative control for personnel assigned to the different commands. Figure 3 shows the proposed general organizational structure for the two commands and highlights the relationships between the services and their subordinate commands.

Figure 3: Notional Structure for a Separate Medical Command and Healthcare Command

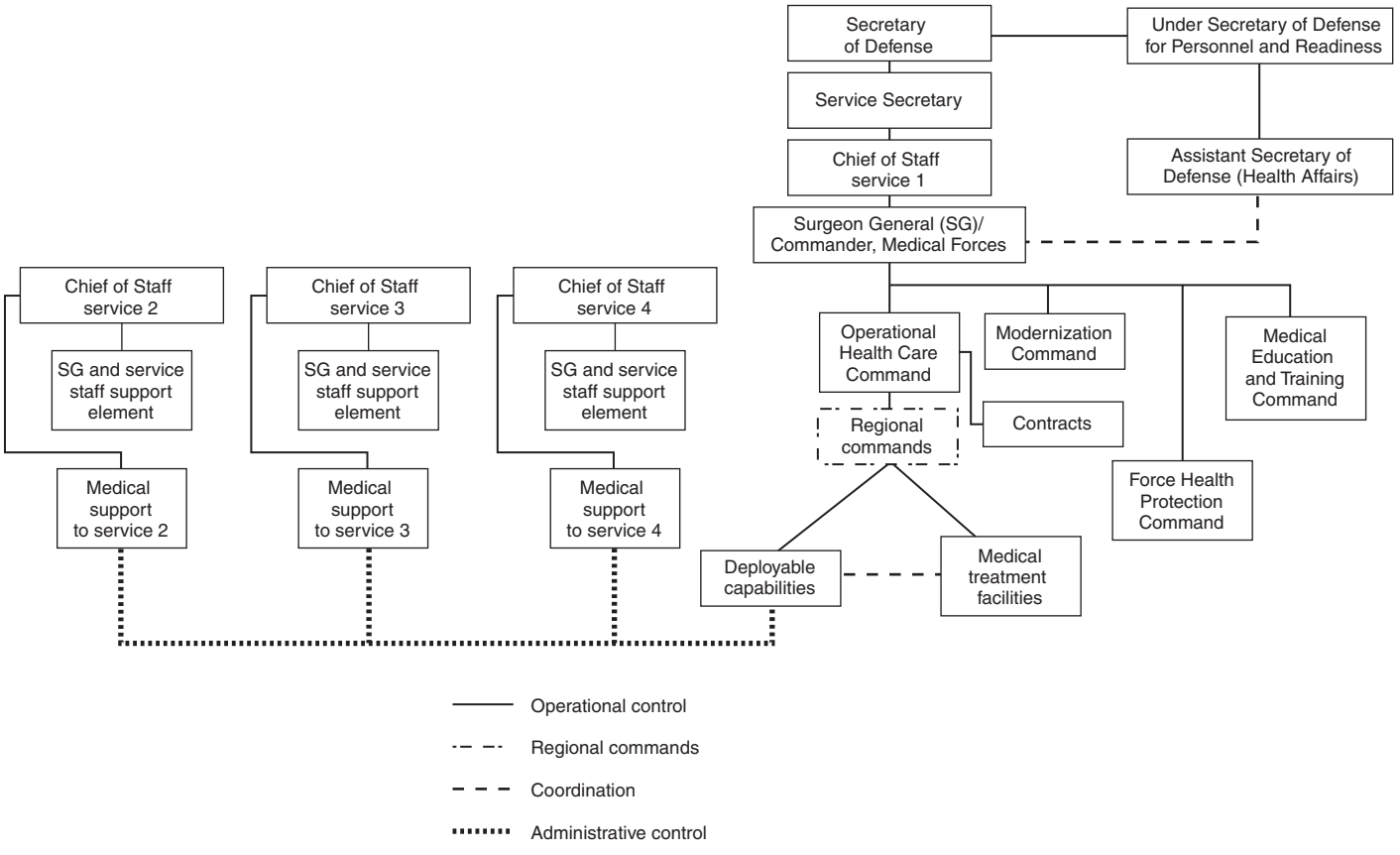


Source: GAO analysis of Joint/Unified Medical Command Working Group information.

Option 3: Designate One Military Service to Provide All Military Health Care

The single medical service option designates one of the services—the Army, the Navy, or the Air Force—to serve as a single unified medical commander that would provide all health care services across the department. This structure would operate much like the current arrangement between the Navy and Marine Corps, in which the Navy provides all health care for the Marine Corps. As shown in figure 4, the single service proposal includes the same four subordinate commands as the first two options.

Figure 4: Notional Structure for a Single Service Medical Command



Source: GAO analysis of Joint/Unified Medical Command Working Group information.

Under this option, the subordinate commands would have the same responsibilities as in the first option. However, the single service would assume administrative control over all medical personnel regardless of service affiliation. Nevertheless, each of the services would retain a

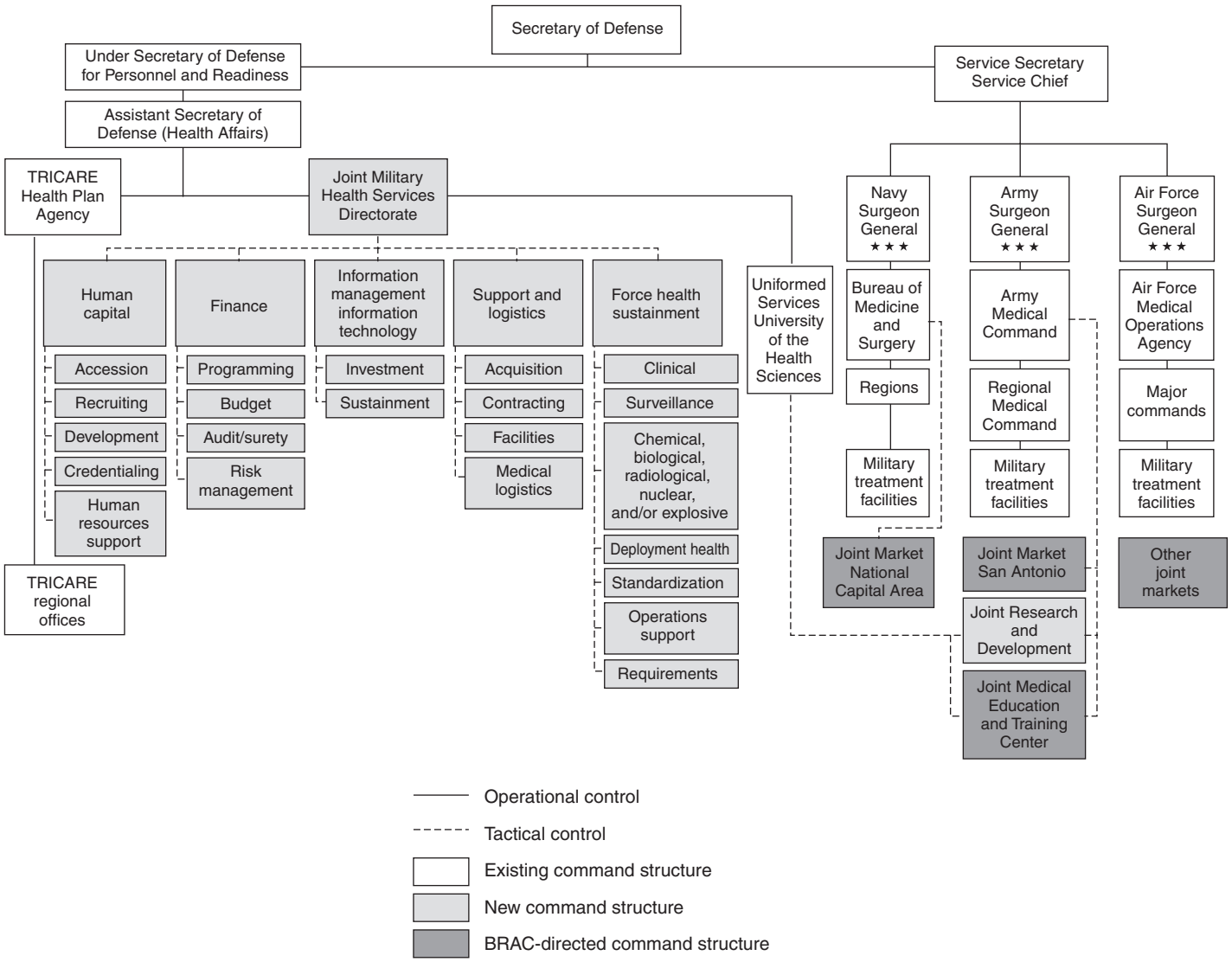
surgeon general with only a small support staff to monitor and advocate for service-specific requirements.

Under each of the preceding three options, the command and control of medical forces would change during deployment and transition to war. In all three instances, commanders would transfer operational control of deployable elements to the relevant joint force commander.

Senior DOD Officials Proposed a Fourth Option

In November 2006, the USD P&R and the ASD (HA) presented a fourth option. Although senior officials described this option as a refinement to the working group's three options to achieve the goals of eliminating unnecessary duplication; streamlining organizational structures; and aligning authority, responsibility, and financial control, it leaves the existing command structure governing DOD's MTFs essentially unchanged. As shown in figure 5, the fourth option's principal feature is the creation of a new Joint Military Health Services Directorate.

Figure 5: Notional Structure for a Joint/Unified Medical Command



Source: GAO analysis of DOD information.

The proposed Joint Military Health Services Directorate would consolidate key common services and functions, which are currently being performed within each of the services, such as finance, information management and technology, human capital management, support and logistics, and force health sustainment under a joint senior flag officer who will report to the

ASD (HA). Another innovation proposed by this option is the combination of all medical research and development assets and programs under the Army Medical Research and Material Command. As figure 5 also shows, this option includes several actions that were previously recommended by the 2005 Base Realignment and Closure (BRAC) round, including establishing joint medical markets—one in the National Capital Area and the other in San Antonio, Texas; establishing a Joint Medical Education and Training Center; and colocation of services' medical headquarters.

This option essentially leaves the current service-centric medical command structures in place—with separate Army, Navy, and Air Force medical departments. Each military service, under a surgeon general, will continue to be responsible for managing its own MTFs.

Although the fourth option helps to consolidate some services and functions, it does not fundamentally alter the way DOD provides health care services to servicemembers and their beneficiaries. In November 2006, the Deputy Secretary of Defense approved the fourth option. In the memorandum approving the fourth option, the Deputy Secretary of Defense established a 3-year timeline, beginning in fiscal year 2007, for establishing a transition team and beginning the phased implementation of the fourth option. According to DOD officials, the phased implementation of the fourth option is currently under way.

DOD Initiated Steps to Evaluate Options, but Did Not Perform a Comprehensive Analysis of All Options

Although DOD initiated steps to evaluate the impact that some restructuring options might have on the MHS, it did not perform a comprehensive analysis of all proposed options. Although DOD's working group determined some of the benefits, costs, and risks of implementing its three options, it did not complete a comprehensive analysis.

DOD's Working Group Determined Some of the Benefits, Costs, and Risks for the First Three Options

DOD's working group took steps to determine some of the benefits, costs, and risks of implementing its three options, but it did not complete a comprehensive analysis. GAO's *Business Process Reengineering Assessment Guide* emphasizes that an organization should explore each alternative thoroughly enough to convincingly demonstrate its potential to

achieve the desired performance goals.[11] The Guide has also established that a comprehensive analysis of alternative processes should include a performance-based, risk-adjusted analysis of benefits and costs for each alternative. An organization should also factor into its analysis a consideration of barriers and risks of implementing each alternative.

The working group used several methods to evaluate its proposed options. First, the working group's Navy representative commissioned CNA to determine the cost implications of its three options. In May 2006, CNA issued a report on the cost of the working group's three options.[12] Based on CNA's report estimates, DOD could achieve savings from $254 million to $417 million annually,[13] depending on which of the three options it implemented. Based on our discussion with a CNA official and our review of CNA's report findings, we concluded that CNA's analysis was generally logical, well-documented, and reasoned given its assumptions, which focused primarily on the potential annual savings from changes in personnel levels in the long run. CNA's methodology did not include any transition costs, except for an estimated annual cost of adopting a single accounting and finance system, which would be necessary for implementing the first two options. In addition, CNA's methodology did not include cost implications associated with infrastructure changes or possible changes in clinical operations. Therefore, the actual cost implications of any option will remain uncertain without more rigorous analysis.

Second, the working group solicited the views of key stakeholders in 23 different DOD offices, including the Joint Staff, the military services' departments, and the combatant commands. The stakeholders were asked whether the working group should proceed with restructuring the MHS and, if so, which of the working group's three options would they support. According to working group officials, the results showed that the majority (15 of 23) of the stakeholders contacted endorsed implementing option one—a unified medical command.

[11]GAO/AIMD-10.1.15.

[12]Center for Naval Analyses, *Cost Implications of a Unified Medical Command* (Alexandria, Va.: May 2006).

[13]CNA reported its estimates in 2005 dollars.

The working group also used the military medical judgment of its members to identify the benefits and risks of each option. The group was made up of representatives from the offices of the joint staff, ASD (HA), and each of the services. As a result of these quantitative and qualitative assessments, the working group chose option one, the unified medical command, as its preferred option.

DOD Did Not Comprehensively Analyze Costs, Benefits, or Risks of Any Options

DOD did not comprehensively analyze the costs, benefits, or risks of any of the four options. According to the working group methodology, the group intended to conduct a more detailed cost-benefit analysis of whichever of the three options senior DOD leadership selected, but the group's work ceased once the fourth option was formally approved by the Deputy Secretary of Defense. In addition, DOD has not demonstrated that its decision to move forward with the fourth option was based on a sound business case.

While there is no one approach to business process reengineering, such as DOD's efforts to restructure its MHS, GAO's Guide advocates a business case as a key document for agency executives to use in deciding whether to go ahead with implementing a new process.[14] A sound business case should include detailed qualitative and quantitative analyses in support of selecting and implementing the new process in terms of benefits, costs, and risks.

According to DOD's business case, its preferred approach to restructuring its MHS

- takes incremental and achievable steps that will yield efficiencies of operations,
- achieves true economies of scale by combining common functions,
- provides structural changes enabling MHS transformation initiatives outlined in the *Quadrennial Defense Review*,
- preserves service-unique culture for each of the services' medical components,
- supports the principles of unity of command and effort under joint operations,
- maintains USD P&R and ASD (HA) oversight of the Defense Health Program,

[14] GAO/AIMD-10.1.15.

- facilitates consolidation of medical headquarters under 2005 BRAC law,
- creates a joint environment for the development of future MHS leaders, and
- positions the MHS for further advances, if warranted, toward more unification.

Although we have not evaluated the pros and cons of DOD's chosen approach, based on our review of DOD's business case DOD only described what it believes its chosen option will accomplish. DOD's business case does not, however, document how it determined the fourth option to be better than the other three in terms of its potential impact on medical readiness, quality of care, beneficiaries' access to care, costs, implementation time, and risks. In addition, DOD has not provided documentation to show that the stated benefits of the fourth option were obtained based on any quantitative analysis. DOD officials told us that the fourth option takes incremental and achievable steps that will yield efficiencies of operations. The officials acknowledged that the business case lays the foundation for future analysis. Until DOD provides documentation of any analysis of the fourth option and a sound business case with specific information for implementing this fourth option along with a cost-benefit analysis justifying this choice, DOD will not be in a sound position to assure the Secretary of Defense and Congress that it made an informed decision when it chose the fourth option over the other three or that its chosen option will have the desired impact on DOD's MHS.

Furthermore, the business case does not document any results-oriented performance measures that will be used to assess progress toward achieving the goals of restructuring DOD's medical command structure. The Government Performance and Results Act of 1993[15] requires federal agencies to develop performance plans with goals and indicators to measure or assess the outcomes of program activity and provide a basis for comparing actual program results with established performance goals. DOD's business case outlines broad goals the fourth option will accomplish, but does not provide measures by which to judge the relative success of the option in achieving the goals. For example, although DOD cites that the fourth option will yield efficiencies of operations and achieve true economies of scale, it does not provide an indicator or target by which to measure the success of this effort in reducing costs and

[15]Pub. L. No. 103-62 (1993).

improving efficiencies. As a result, the department is not in a position to assure itself or Congress whether the fourth option will achieve the promised benefits.

Conclusions

As DOD begins to restructure its MHS, it is important that DOD be able to make informed decisions when selecting and implementing the way ahead. Although DOD initiated steps to evaluate options for restructuring its system and selected one option to implement, it has not demonstrated that its decision to move forward with the option was based on a sound business case that includes detailed qualitative and quantitative analyses in support of its decision. Without such a business case, DOD is not in a sound position to assure the Secretary of Defense and Congress that it made an informed decision or that its chosen options will have the desired impact on DOD's MHS. Further, until DOD develops results-oriented performance measures that focus on the outcome of DOD's chosen fourth option, the department will not be well-positioned to determine or assure Congress that its chosen option is achieving the desired impact.

Recommendations for Executive Action

To improve visibility over its decision-making process related to the establishment of a unified medical command structure, we recommend that the Secretary of Defense direct the Deputy Secretary of Defense to take the following two actions:

- demonstrate a sound business case for proceeding with its chosen option, including detailed qualitative and quantitative analyses of benefits, costs, and risks associated with implementing the transformation, and
- provide Congress with the results of that assessment.

Furthermore, to monitor whether the transformation is meeting its goals of eliminating unnecessary duplication; streamlining organizational structures; and aligning authority, responsibility, and financial control, we recommend that the Secretary of Defense direct the Deputy Secretary of Defense to establish and monitor outcome-focused performance measures to help guide the transformation.

Agency Comments and Our Evaluation

DOD provided written comments on a draft of this report and concurred with our recommendations.

DOD concurred with our first recommendation to demonstrate a sound business case for proceeding with its chosen option, stating that an implementation team will conduct comprehensive planning to include an assessment of implications for doctrine, organization, training, material, leadership, personnel, and facilities. According to DOD, the implementation team will then write a comprehensive business case for DOD's chosen option, including a qualitative and quantitative analysis of the risks, benefits, and change management challenges. DOD further stated that Congress will be provided with the results of the analysis. While DOD's response is encouraging, we remain concerned that the department's description of its planned actions does not include what actions, if any, DOD plans to take to document how it determined the fourth option to be better than the other three in terms of its potential impact on medical readiness, quality of care, beneficiaries' access to care, costs, implementation time, and risks. In the absence of more specific details on its planned actions, we continue to emphasize the department's need for a sound business case with specific information for implementing the fourth option along with a cost-benefit analysis justifying this choice. Without such information, DOD will not be in a sound position to assure the Secretary of Defense and Congress that it made an informed decision when it chose the fourth option over the other three options.

In an overall comment discussing the basis for its decision, DOD noted that once the review of the three options proposed by the Joint Unified Command Working Group was completed, there remained very strong objection to proceeding with full implementation of a unified medical command. DOD noted that in the opinion of the department, this reluctance to proceed with wholesale change was an indicator of the strength of the cultural challenges to successful implementation. DOD further noted that as in GAO's *Business Process Reengineering Assessment Guide*, failure to address change management issues can result in failure of transformation efforts.

While DOD's response correctly identified cultural challenges as a potential barrier to implementing a unified medical command, DOD's business case only described what it believes its chosen option will accomplish. GAO's Guide cites numerous potential implementation barriers—including cultural resistance to change—that need to be considered when deciding among various business options. GAO's Guide, however, makes clear that the potential impact of these barriers and the

costs of addressing them are to be factored into the cost-benefit analyses before the decision—not simply used as justifications for not carrying out the suggested analyses of those options, as DOD has done. The department's view that there is a strong cultural challenge to successful implementation should underscore the need for department leadership to address the challenge rather than be used to justify a decision by the department to avoid necessary change. While we agree that there are occasions when incremental improvements are appropriate to address change management issues, such as when an organization is not prepared to undergo dramatic change, a crucial step for the department is to comprehensively analyze and document the costs, benefits, and risks of all proposed options and provide a sound business case justifying its decision to choose one option over the others. We believe that it is very important that DOD include the outcome of this analysis in the assessment results provided to Congress as we recommended.

With regard to our second recommendation to monitor whether the transformation is meeting its goals, DOD concurred with our recommendation, noting that it will implement specific outcome-focused performance measures.

DOD's comments are reprinted in appendix II. DOD also provided technical comments, which we have incorporated in the final report where appropriate.

We are sending copies of this report to the appropriate congressional committees. We are also sending copies to the Secretary of Defense; the Deputy Secretary of Defense; the Under Secretary of Defense for Personnel and Readiness; the Assistant Secretary of Defense (Health Affairs); the Vice Chairman of the Joint Chiefs of Staff; the Secretary of the Air Force; the Secretary of the Army; the Secretary of the Navy; the Executive Director, Defense Business Board; and the Director, Center for Naval Analyses. This report will also be available at no charge on GAO's Web site at http://www.gao.gov.

Should you or your staff have any questions concerning this report, please contact me at (202) 512-4300 or hintonh@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made major contributions to the report are listed in appendix III.

Henry L. Hinton, Jr.
Managing Director
Defense Capabilities and Management

Appendix I: Scope and Methodology

To address our objectives, we obtained and reviewed documents, reports, and other information, as available, related to the development of options for a unified medical command structure within the Department of Defense (DOD). We also interviewed officials within the Office of the Assistant Secretary of Defense (Health Affairs); the Offices of the Surgeons General of the Air Force, Army, and Navy; the Joint Staff Logistics Directorate; the Defense Business Board; and the Center for Naval Analyses.

To identify and describe the options for structuring a unified medical command that have been recommended in recent studies by DOD and other organizations, we obtained and analyzed various reports, studies, and DOD documents outlining options and proposals to reconfigure the military health system (MHS). In conducting our review, we limited our focus to studies for a unified medical command structure within the last 3 years. Specifically, we reviewed concepts of operations for three unified medical command structure options developed by DOD's Joint/Unified Medical Command Working Group and a concept plan presented by the Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense (Health Affairs). We also reviewed recent reports issued by the Center for Naval Analyses and the Defense Business Board related to reconfiguring the MHS. In addition, we reviewed relevant sections of Program Budget Decision 753, *Military Health System Strategic Plan*, *2006 Quadrennial Defense Review Roadmap for Medical Transformation*, and *Medical Joint-Cross Service Group 2005 Base Closure and Realignment Report*. To gain a better understanding of the structure and organization of each option, we interviewed officials from DOD's Joint/Unified Medical Command Working Group, the Office of the Assistant Secretary of Defense (Health Affairs), and the Joint Staff Logistics Directorate. We also interviewed officials from the Defense Business Board to discuss their effort related to the restructuring of DOD's MHS and their recommendation to implement a unified medical command structure.

To determine the extent to which DOD has identified the potential impact of the options for a unified medical command under consideration, we analyzed the documents and studies obtained from DOD's Joint/Unified Medical Command Working Group, the Joint Staff Logistics Directorate, and the Center for Naval Analyses to identify their assessments of the implications for each option on quality of care, access to care, and medical readiness. We reviewed and analyzed the DOD Joint/Unified Medical Command Working Group briefings, point papers, organizational charts, and any other documents that were available that pertained to DOD's MHS

restructuring efforts, plans, and status. Additionally, we reviewed and analyzed the cost implications study performed by the Center for Naval Analyses for the three options developed by DOD's Joint/Unified Medical Command Working Group and interviewed its chief author to determine the extent of the analyses performed, the basis of the analyses, and any limitations of the study. We did not independently review the validity of the estimates that the Center for Naval Analyses developed, but we concluded that its study was logical, well-documented, and reasonable given its assumptions and focus. We interviewed officials from DOD's Joint/Unified Medical Command Working Group, the Office of the Assistant Secretary of Defense (Health Affairs), and the Joint Staff Logistics Directorate to discuss the implications of each option and identify any limitations in their assessments. We also reviewed GAO's *Business Process Reengineering Assessment Guide* to determine guidelines for assessing reengineering efforts. Other issues, such as determining the appropriate command and control structure within DOD to manage the MHS, did not fall within the scope of this review.

We conducted our work from December 2006 through September 2007 in accordance with generally accepted government auditing standards.

Appendix II: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

SEP 27 2007

Mr. Henry L. Hinton, Jr.
Managing Director, Defense Capabilities and Management
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

Dear Mr. Hinton:

This is the Department of Defense's (DoD) response to the Government Accountability Office (GAO) draft report, GAO 07–1190, "DEFENSE HEALTH CARE: DoD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure," dated September 5 (GAO Code 350934).

Thank you for the opportunity to review and comment on the draft report. Overall, the Department concurs with the report's findings and conclusions. Our responses to the recommendations are enclosed. Included in our comments are Technical Corrections for your consideration. The three Military Departments, the Joint Staff, and Pacific Command also reviewed the draft report and concur with the report's conclusions and recommendations. Among the suggested technical changes is a recommendation to change the title of the report to more accurately reflect the beneficial progress made to date in redesigning the Military Health System (MHS). The GAO's overall finding was that the Department initiated steps to review the various options to evaluate the MHS redesign implementation options but did not complete a sound comprehensive analysis of the chosen option to support its decision. In addition, the Department should develop performance measures to monitor the progress of its plan.

While we agree with the description of the decisional process used by the Department, we would like to clarify one step in the path. Once the review of the three options proposed by the Joint Unified Command Working Group was completed, there remained very strong objection to proceeding with full implementation of a unified medical command. In the opinion of the Department, this reluctance to proceed with wholesale change was an indicator of the strength of the cultural challenges to successful implementation. As noted in the GAO Business Process Reengineering Assessment Guide, failure to address change management issues can result in failure of transformation efforts. After internal dialogue and further review the chosen course of action was approved by the Deputy Secretary of Defense. The approved framework is, in fact, a set of initiatives that will result in improvements in effectiveness and efficiency by achieving increased unity of effort and economies of scale in providing support functions.

Taken together these initiatives will provide the foundation for further improvements and could be an intermediate step towards future unification of command in the MHS. By taking this approach we are specifically designing a system that can be monitored and tested. If economies are not achieved or mission effectiveness is compromised, the Department will be able to reassess and change course.

The plan to move forward includes establishment of an Implementation Team (I-Team). This team will be tasked with developing a complete Doctrine Organization Training Materiel Leadership Personnel and Facilities analysis of the proposed plan. The I-Team will write the comprehensive business case for the way forward to include an analysis of each of the organizational elements (education and training, shared services, research and development, multi-service markets) including qualitative and quantitative analyses of risks, benefits and change management challenges.

The MHS has adopted the balanced scorecard methodology to monitor success in achieving the goals of transformation. The scorecard includes a mixture of outcome, output, and efficiency measures. In addition to this set of agency measures, the I-Team will propose and the Department will implement specific measures to monitor the success of the implementation of governance improvements.

Again, thank you for your review of this critically important issue to the Department and the opportunity to provide these comments.

My points of contact on this audit are COL Thom Kurmel (Functional) at (703) 697-2111 and Mr. Gunther Zimmerman (Audit Liaison) at (703) 681-4360.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

**GOVERNMENT ACCOUNTABILITY OFFICE DRAFT REPORT–DATED SEPTEMBER 5
(GOVERNMENT ACCOUNTABILITY OFFICE CODE 350934/GOVERNMENT ACCOUNTABILITY OFFICE 07–1190)**

"DEFENSE HEALTH CARE: DEPARTMENT OF DEFENSE NEEDS TO ADDRESS THE EXPECTED BENEFITS, COSTS, AND RISKS FOR ITS NEWLY APPROVED MEDICAL COMMAND STRUCTURE"

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATIONS

RECOMMENDATION 1: To improve visibility over its decision-making process related to the establishment of a unified medical command structure, we recommend that the Secretary of Defense direct the Deputy Secretary of Defense to take the following two actions: a) demonstrate a sound business case for proceeding with its chosen option, including detailed qualitative and quantitative analyses of benefits, costs, and risks associated with implementing the transformation; and, b) provide Congress with the results of that assessment.

DOD RESPONSE: Concur. The Department will implement an I-team to assist in the planning for whichever "option" is approved by the Deputy Secretary of Defense. That team will conduct comprehensive planning to include assessment of implications for doctrine, organization, training, material, leadership, personnel and facilities. The results of that qualitative and quantitative analysis will be an implementation plan including a sound business case. Congress will be provided with the results of the analysis.

RECOMMENDATION 2: Furthermore, to monitor whether the transformation is meeting its goals of eliminating unnecessary duplication; streamlining organizational structures; and aligning authority, responsibility, and financial control, we recommend that the Secretary of Defense direct the Deputy Secretary of Defense to establish and monitor outcome-focused performance measures to help guide the transformation.

DOD RESPONSE: Concur. The Military Health System (MHS) has adopted the balanced scorecard methodology to monitor success in achieving the goals of transformation. The scorecard includes a mixture of outcome, output, and efficiency measures. In addition to this set of agency measures, the I-Team will propose and the MHS will implement specific outcome-focused measures to monitor the success of the implementation of governance improvements.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Henry L. Hinton, Jr., (202) 512-4300 or hintonh@gao.gov

Acknowledgments

In addition to the contact named above, Derek B. Stewart (retired Director); Sandra B. Burrell, Assistant Director; Rebecca S. Beale; Benjamin A. Bolitzer; Grace A. Coleman; Susan C. Ditto; Steve J. Fox; Julia C. Matta; Clara C. Mejstrik; Ty B. Mitchell; Charles W. Perdue; and Terry Richardson made key contributions to this report.

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