

The Military Health System(s) Separate But Equal

By DAVID A. LANE

FEATURE

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Army and Air Force surgeons from JTF-Bravo work with chief surgeon at Honduran hospital

U.S. Army

Joint operations are the baseline of all future military activities. Yet the Services continue to operate their own health care systems that, at best, cooperate with each other in providing benefit and readiness missions to eligible patients during peace and war. Despite numerous recommendations for organizational change to improve resource efficiency and operational responsiveness, the Military Health System (MHS) structure has evolved little since World War II. The Services operate relatively separate but equal deployable medical systems to support deployed combat forces.

As called for in *Joint Vision 2020*, current resource shortages and threats in the security environment demand revolutionary innovations. By leveraging existing transformation efforts and creating a unified U.S. Medical Command—headed by a four-star medical force commander with subordinate Service and TRICARE components—the MHS can achieve the resource efficiency and operational flexibility needed to change both how it provides force health protection to combat forces and brings all players together to carry out its benefit and readiness missions.

The Missions

The MHS is one of the largest and most complex health care organizations in the United States. Its mission is “to

enhance DOD [Department of Defense] and our nation’s security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.”¹ In operating its network of 76 hospitals and more than 500 medical and dental clinics, the MHS is a \$28 billion annual enterprise that cares for almost 9 million patients, including nearly 1.5 million uniformed personnel.

There are two parts to the MHS health support mission: the readiness and benefit components. The readiness component, or force health protection, includes fit and healthy force maintenance, casualty prevention, and casualty care management. In operational settings, force health protection provides health service support (HSS) to combatant commanders during wartime military operations and other ventures, such as peacekeeping, humanitarian assistance, and training. The benefit component involves delivering a full spectrum of preventive and restorative medical care to active and retired members of the Armed Forces, their families, and other eligible beneficiaries.

In the last 50 years, the benefit component (also called the peacetime mission) has consumed an increasing proportion of MHS resources. In 1955, for example, Active duty personnel comprised 45 percent of beneficiaries, dependents 44 percent, and eligible

retirees 11 percent. In fiscal year 2005, the Government Accountability Office predicted that these same personnel will constitute just 18 percent of the nearly 9 million beneficiaries, and their family members an additional 26 percent. Eligible retirees, meanwhile, will comprise 55 percent of patients.²

Critics of the MHS note that this demographic shift means that considerably more resources must be devoted to the benefit mission at the expense of the readiness mission, prompting some to argue that the benefit mission should be civilianized on the assumption that caring for family members and retirees is not a core Department of Defense competency. In contrast, the medical leadership believes the two missions are inextricably linked. They insist that the benefit mission helps the MHS recruit and retain talented personnel who otherwise might be disinclined to volunteer for service in military medicine and who, in carrying out peacetime medical duties, maintain military members at optimum health while simultaneously preserving essential clinical skills for the wartime readiness mission. In the words of one former Surgeon General of the Navy, “Readiness is the real benefit derived from the benefit mission.”³ Few would disagree, however, that the readiness component is the *raison d’être* for the MHS and “determines the minimum number of Active duty medical personnel required by each Service.”⁴

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its 1999 report on DOD's need for a tri-Service strategy for determining and allocating medical resources among MTFs:

While the agreements appear beneficial, they are mostly ad hoc and the results are not well documented. . . . A recent DOD effort to further consolidate . . . medical centers met with major disagreements about what care should be provided where. As a result, the effort was put on hold and the centers continue to operate independently.⁶

Similar cooperative agreements are in place between the Air Force's Wilford Hall Medical Center in San Antonio and its cross-town counterpart, Brooke Army Medical Center, where DOD directed the merger of the obstetrics-gynecology and pediatric departments in 1995. The two centers subsequently signed a letter of agreement combining their graduate medical education programs under a common academic leadership to form the San Antonio Uniformed Services Health Education Consortium.

Despite the many bi- and multilateral sharing agreements in locations where facilities from two or more Services are in close proximity, individual treatment facilities continue to operate as independent hospitals, and in most cases gains made by one institution are interpreted as losses by the others.

HSS for Deployed Forces

In addition to its international network of medical facilities—which function as civilian hospitals and clinics, including the maintenance of quality accreditation by the Joint Commission for the Accreditation of Healthcare Organizations—the MHS includes operational medical units that provide HSS for deployed forces. These units range in complexity and capability from a simple battalion aid station in the field or sickbay aboard ship providing first aid and initial stabilization of casualties, to a deployable 500-bed fleet/field hospital or 1,000-bed hospital ship with advanced capabilities such as critical/intensive care units and neurosurgery. Operational HSS is resourced almost exclusively by the individual Services, with manpower and money provided by the Service chiefs to both line and medical units via administrative chains of command.

Present doctrine includes five echelons of casualty care. In general, all Level I and some Level II care is provided by medical

Organization

The MHS is organized and resourced to carry out its two missions, and more resources are being allocated for delivering the benefit mission in traditional health care settings (hospitals and clinics) than for the readiness mission. The benefit mission is financed by the Defense Health Program (DHP), a single \$21.4 billion budget appropriation that covers the operating and maintenance costs of health care in military hospitals and clinics, as well as care purchased from the civilian sector through regional, managed-care support contracts under DOD's TRICARE program.⁵ The DHP is administered by the Assistant Secretary of Defense for Health Affairs through the TRICARE Management Activity, which disperses funds to hospitals and clinics via the Surgeons General of the Army, Navy, and Air Force. The Assistant Secretary does not exercise command and control authority over the Surgeons General. Nor does this office pay the personnel costs for the more than 180,000 Active duty medical people staffing the Army, Navy, and Air Force treatment facilities. Those responsibilities rest with the individual Service chiefs.

The organizational structure of the present hospital system predates World War II, when each Service provided its own health care. In the intervening 60 years, cooperation in delivering the peacetime benefit mission has improved considerably, largely due to pressure to contain costs applied at various times by the executive branch, Congress, or the Services themselves. During this time, no fewer than 15 federally sponsored studies and numerous scholarly reports have examined the MHS organization, with the

overwhelming majority calling for a unified medical command and only 3 preferring the present structure.

In response, DOD has adopted some changes but kept the basic structure. Changes include establishing a central office to oversee health care operations, implementing a uniform tri-Service managed care health plan, consolidating most budget resources under the DHP, and establishing the TRICARE Management Activity to govern the business side of the MHS. While these efforts have enhanced inter-Service cooperation, they have by no means created jointness among the medical departments. This "cooperation without jointness" with respect to the benefit mission is best illustrated in geographic areas where two or more Services have medical treatment facilities, such as in Washington, DC, or San Antonio, Texas.

The MHS operates three medical centers in the Washington, DC, area: Walter Reed Army Medical Center, the Air Force's Malcolm Growe Medical Center, and the National Naval Medical Center. Until recently, the three Services had enough resources to operate the centers autonomously, resulting in overlapping capabilities and excess capacity. In response to the budgetary constraints of recent years and the impact of regional support contracts under TRICARE, the three medical centers have entered into numerous agreements to share personnel, space, and equipment, and have combined several graduate medical education programs. They have also parceled out specialized clinical services, such as inpatient maternity care and child and adolescent mental health. Nonetheless, as the Government Accountability Office noted in

personnel integral to the combat forces they support. However, some Level II and most Level III care is doctrinally provided by deployable medical treatment facilities (DEPMEDS) that are resourced, equipped, and staffed by a unit's parent Service. DOD directs that DEPMEDS "shall be standardized to the maximum extent possible, consistent with the missions of the Services, to enhance interoperability, increase efficiency, and maximize resources."⁷⁷ DOD does not direct that DEPMEDS be joint, and they are not.

Level II care includes resuscitative surgery, administration of blood products, and the like. Current doctrine states that combat casualties remain in Level II DEPMEDS for less than 72 hours. However, the Army, Navy, and Air Force each have their own Level II and Level III DEPMEDS platforms. The Army, for example, uses medical companies as its primary Level II asset. They are usually assigned to a forward support battalion but can be found within medical brigades or groups as well. The Navy, on the other hand, provides Level II care at sea aboard aircraft carriers and large amphibious assault ships. It also fields Level II medical battalions in direct support of Marine Corps operations. These battalions are integral to Marine Expeditionary Forces or smaller types of Marine Air Ground Task Forces, giving those units an organic Level II HSS capability. The Air Force provides Level II operational HSS with rapidly deployable air transportable clinics and hospitals, designed to support between 300 and 500 personnel. While the names and venues for delivering the care may vary, the actual care provided—that is, its complexity and the clinical skills and materiel required—is the same for all three Services.

Level III care for all Services is provided by their own deployable hospitals (including seagoing hospital ships), which can be configured with appropriate inpatient holding capacity tailored to the specific mission. The Army uses combat support hospitals and field hospitals, the Navy uses

U.S. Navy (Joseph Caballero)

VADM Donald Arthur, USN, Surgeon General of the Navy, tours USNS *Mercy* during its deployment to Pacific Islands and Southeast Asia



fleet hospitals and hospital ships, and the Air Force uses air transportable hospitals. In most operational settings, these DEPMEDS can be configured to hold from 100 to 500 patients. Each Service staffs, equips, trains, and maintains its own deployable inpatient treatment facility with nearly identical medical capabilities to carry out the same readiness mission, namely to provide Level III HSS for deployed combat forces.

Recent history provides several examples of the clinical and operational risk of the present "separate but equal" HSS force structure. In October 1983, 237 Marines were killed when terrorists bombed their barracks at Beirut airport. While many more were immediately killed than wounded, easing the strain on the casualty care system, the bombing uncovered problems in the joint planning and execution of the operational plans for casualty care and evacuation in use at the time, particularly with respect to readiness and command and control of HSS personnel and assets. Corrective actions were put in place and then "field tested under fire" during Operations *Desert Shield* and *Desert Storm* in 1991.

The results were disappointing, as reflected in a postoperation report by the DOD Inspector General that criticized the

Department for having persistent problems with medical command and control and for outdated plans that lacked sufficient joint input and execution. The report specifically noted that the operation plans "did not plan for integrated support and, instead, tasked each of the Service components to provide medical care for only their own forces."⁷⁸ In addition, the Inspector General observed that the Services' DEPMEDS platforms lacked sufficient mobility, transportation, and employment guidance to support warfighting doctrine.

Following the 1991 Gulf War, a series of "Medical Readiness Strategic Plans" was used as the blueprint for overcoming the medical readiness shortfalls identified in the Inspector General's report. Using the plans as guidance, the Army, Navy, and Air Force medical departments independently focused on making their DEPMEDS platforms more modular, agile, and adaptable, striving to develop an information network that would give opera-

the low casualty rates from the latest conflicts have prompted some observers to question the need for resource-intensive deployable medical assets

tional medical forces a common operating picture. Although they generally succeeded in improving the weight, cube, and maneuverability of DEPMEDS assets by the start of Operations *Enduring Freedom* and *Iraqi Freedom* in 2001–2003, the issues of medical command and control and integrating medical support across the Services remained largely unchanged from the first Gulf War. They may have gotten worse.

In addition, in their spring 2004 testimonies before congressional committees concerned with military medicine, each of the Services' Surgeons General praised the often heroic achievements of their medical departments during the operations. Absent, however, was testimony illustrating how HSS doctrine had changed since Operation *Desert Storm* to make the MHS a more effective, integrated, and joint team.

Ribbon-cutting marks transformation of Keesler Hospital, Keesler Air Force Base, Mississippi, from outpatient clinic to fully functional hospital



U.S. Air Force (Cecilio Ricardo, Jr.)



U.S. Marine Corps (Jose E. Guillen)

Marines undergo physical therapy

More recently, the low casualty rates from the latest conflicts have prompted some observers to question the need for such resource-intensive deployable medical assets in the first place. This uncertainty, along with newer clinical strategies for the stabilization and en route care of casualties, and innovative new and planned warfighting concepts such as sea-basing and ship-to-objective maneuvers, put new pressure on medical departments to reduce further the size of their individual HSS “footprints.”

The Government Accountability Office and RAND Corporation have separately reported that the tradition of independence by the Services has been the biggest obstacle to the medical departments developing a joint approach to delivering health care. Still, throughout military medicine there are scattered examples of jointness that illustrate the integration called for in *Joint Vision 2020*, such as the Uniformed Services University of the Health Sciences, the Armed Forces Institute of Pathology, and the Defense Medical Readiness Training Institute. The medical

and support staffs of these commands are tri-Service in composition and resourced collectively by the Services or centrally by DOD. For the most part, however, the Army, Navy, and Air Force continue to operate their own semi-independent health care systems that arguably cooperate as much as possible under the existing structure, while concurrently operating somewhat as peer competitors for exactly the same wartime readiness and peacetime benefit missions.

In response to periodic criticisms of the status quo, DOD has first opted to grant and then increase central authority under the Assistant Secretary for Health Affairs both to manage costs in delivering the benefit mission and to react to operational lessons learned in supporting the readiness mission. This approach seems to be inadequate given the current threats both to resources and the security environment. How then can the MHS achieve the desired endstate and become fully joint intellectually, operationally, organizationally, doctrinally, and technically, as called for in *Joint Vision 2020*? The answer lies in the current strategy of DOD transformation.

Transformation Recommendations

Under the present hierarchy, the MHS has many masters—or it has none. Military medicine needs a unified medical command to change the outlook of the medical departments and of the Services toward the MHS, enabling it to transform from a confederation of autonomous medical departments into

a truly joint medical force. A U.S. Medical Command (USMEDCOM), as the new organization might be called, would be a functional combatant command along the lines of the U.S. Transportation and Special Operations Commands. The commander would be a four-star flag/general medical corps officer with consolidated accountability, responsibility, and authority to execute both the benefit and readiness health care missions.

USMEDCOM could be structured in a number of ways, each with strengths and weaknesses concerning resource efficiency and operational flexibility. In one recent study of reorganizing the MHS, for example, researchers at RAND described three potential models: a joint command with Service components, a joint command with readiness and TRICARE components, and a joint command with Service and TRICARE components.⁹

The first option, a joint command with Service components, mirrors the organizational structure of present combatant commands, including U.S. Special Operations Command. This arrangement would resemble the present MHS structure except that it would assign overall responsibility to a single military medical commander. This structure would strengthen the organizational and doctrinal jointness of the MHS but have little impact on the technical and operational aspects since the Army, Navy, and Air Force medical departments would remain intellectually aligned with their parent Services. In addition, the health affairs Assistant Secretary would continue to oversee the benefit mission through the TRICARE Management Activity.

The next option, a joint command with readiness and TRICARE components, presents a radical departure from the organization of today's MHS. Under this model, operational medical units would report to USMEDCOM via a joint medical readiness component command, whereas medical treatment facilities and contractors supporting the benefit mission would report via a TRICARE component command. This structure could strengthen the medical department's operational and doctrinal jointness. Because the benefit and readiness missions must share medical personnel, competition for resources may increase between the two. As discussed earlier, the Surgeons General of the Army, Navy, and Air Force have repeatedly asserted that the two missions are vitally linked and mutually supporting.

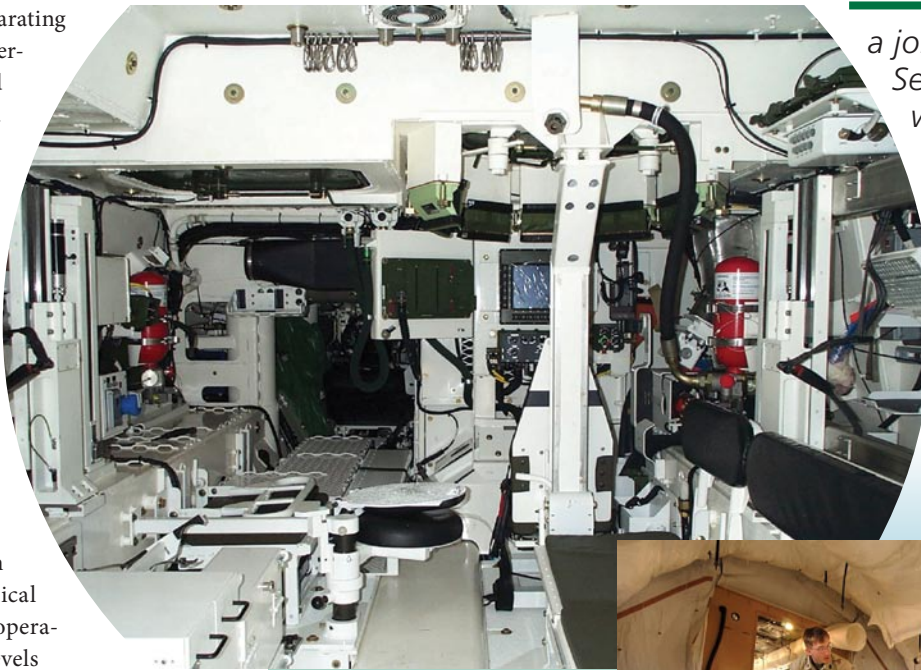
Organizationally separating them would risk undermining technical and intellectual jointness.

The organizational structure for USMEDCOM that holds the most promise for effectively transforming the MHS into the desired integrated team is a unified command with both Service and TRICARE components. This structure would maintain traditional line-medical relationships at the operational and tactical levels through Service component medical commands, each headed by a medical flag/general officer from that Service.

The proposed organizational structure would enhance operational and doctrinal jointness though a simpler centralized command and control relationship between USMEDCOM and the Service medical departments. At the same time, USMEDCOM would improve technical and intellectual jointness through the clinical synergy between the benefit and readiness missions, as advanced by the Surgeons General. This structure would consolidate accountability and authority in a functional medical combatant commander with the responsibility and resources for both the readiness and benefit missions.

Specific strategic- and operational-level examples where this alignment might improve the status quo include overcoming the previously cited “Service independence” with regard to delivery of the peacetime mission, and scrapping the “separate but equal” doctrine with regard to the operational HSS force structure.

The capstone strategic planning documents for the Department of Defense—the *National Military Strategy of the United States of America 2004*, the *Quadrennial Defense Review Report for 2001*, and *Joint Vision 2020*—stress that joint operations will be the hallmark of all future military activities. The Chairman of the Joint Chiefs of Staff writes:



Project Manager's Office, Brigade Combat Team

Interior of Stryker Medical Evacuation Vehicle, an armored ambulance

The integration of core competencies provided by the individual Services is essential to the joint team, and the employment of the capabilities of the Total Force (Active, Reserve, Guard, and civilian members) increases the options for the commander and complicates the choices of our opponents. To build the most effective force for 2020, we must be fully joint: intellectually, operationally, organizationally, doctrinally, and technically.¹⁰

The Department of Defense must leverage current transformation efforts to create a unified medical command—the U.S. Medical Command—to integrate the Military Health System culturally and form the desired joint medical team. **JFQ**

NOTES

¹ “Mission Statement of the MHS,” June 17, 2004, available at <www.ha.osd.mil/ha/default.cfm>.

² Government Accountability Office, *Defense Health Care: Tri-Service Strategy Needed to Justify Medical Resources for Readiness and Peacetime Care*, Report to Congressional Requesters GAO/

a joint command with Service components would resemble the present Military Health System except that it would assign overall responsibility to a single military medical commander



U.S. Air Force (Quinton T. Burris)

Navy corpsmen assemble chemical-biological protective shelter, Kuwait

HEHS-00-10, (Washington, DC: November 1999), 16.

³ Vice Admiral James Zimble, USN (Ret.), correspondence with author, October 7, 2004.

⁴ *Defense Health Care*, 4.

⁵ Assistant Secretary of Defense (Health Affairs), *Defense Health Program Fiscal Year (FY) 2004/FY 2005 Biennial Budget Estimates*, available at <http://www.dod.mil/comptroller/defbudget/fy2004/budget_justification/pdfs/dhp/VOL1_Justification/K-PB%20DHP%20OP-32%20CHS%20Feb%2003.xls>.

⁶ *Defense Health Care*, 18–22.

⁷ Stephen C. Joseph, “DOD Medical Standardization Board (DMSB),” Department of Defense Instruction 6430.2, March 17, 1997, available at <www.dtic.mil/whs/directives/corres/pdf/i64302_031797/i64302p.pdf>.

⁸ DOD Inspector General, *Final Report on the Inspection of the Department of Defense Medical Mobilization Planning and Execution*, DODIG 93-INS-13 (Arlington, VA: September 30, 1993), 9.

⁹ Susan D. Hosek and Gary Cecchine, *Reorganizing the Military Health System: Should There Be a Joint Command?* (Santa Monica, CA: The RAND Corporation, 2001), 17–22.

¹⁰ Chairman of the Joint Chiefs of Staff, *Joint Vision 2020* (Washington, DC: U.S. Government Printing Office, June 2000), 2.