

PURPLE MEDICINE

The Case for a Joint Medical Command

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In response to a broad set of complex national security challenges of the twenty-first century, the Quadrennial Defense Review (QDR) report of February 2006 advised that all the organizations, processes, and practices within the Department of Defense be given a high degree of agility, flexibility, responsiveness, and ultimately effectiveness in supporting the joint war fighter and future national defense goals. In that connection, the 2006 QDR recommends that medical support be likewise aligned with emerging joint force employment concepts. Indeed, the Department of Defense, in conjunction with the chairman of the Joint Chiefs of Staff, had already been directed to develop an implementation plan for such a unified structure, the Joint Medical Command. An antecedent clause in the Department of Defense Program Budget Decision 753 of 23

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December 2004 laid the conceptual groundwork. It directed that a plan for a Joint Medical Command be accomplished by the fiscal year 2008–2013 Program/Budget Review. How can this intention be best brought to fruition?

The organizational structure of the present military hospital system predates World War II, when each service provided for all of its own health care.¹ In the sixty years since the conclusion of that conflict, there have been numerous proposals for a unified medical command structure. Largely due to cost-containment pressure exercised by the executive branch, Congress,

and the services themselves, some cooperation has evolved in the delivery of peacetime health care to eligible Department of Defense beneficiaries in a framework known as the Military Health System (MHS). During this time no less than fifteen federally sponsored studies and numerous scholarly reports have examined the MHS, and the overwhelming majority has proposed the creation of a unified medical command.

One of the more recent recommendations is found in section 726 of the National Defense Authorization Act for fiscal year 2000, mandating a study of not only the expansion of joint medical operations but an assessment of the merits and feasibility

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of establishing a joint command. It calls for an examination of the potential for creating a joint medical command endowed with comprehensive budgeting author-

ity, a joint training curriculum, and a unified chain of command. This inquiry would further identify areas of military medicine in which joint collaborative functions might be facilitated, including organization, training, patient care, hospital management, and budgeting. The act appropriately held that in order to provide the existing combatant commands with health-services support across the operational spectrum, a new, separately resourced, and functional medical or health-services command should be created, on a level with the current unified and specified commands. On another level, however, it remains to be seen whether the services themselves will finally take into account medical support requirements that are realistically necessary to meet operational demands of the twenty-first century, and the means by which these can be implemented in an effective and harmonious fashion. Indeed, however much lip service is given to the concept of cooperation, their separate budgets mean substantial competition. Still, a command structure that enhances teamwork rather than conflict would help, even if budget development remains primarily a service responsibility. True team planning, as well as the articulation of requirements and their priorities, would result if emanating from a joint or unified command. However, there will be no changes in the posture of the Department of Defense (DoD) toward medical support until this critical element of flesh-and-blood personnel support is recognized and appropriately represented as an essential element of "putting ordnance on target." This is further exemplified by the traditional line-leadership modus operandi of consistently deploying the "medics" too far behind the "shooters." Too many Time Phased Force Deployment Lists* have been corrupted by lowering the planned priority of medics in the deployment queue. Lack of a day-to-day presence in the highest circles of the Joint Chiefs is a

* Or TPFDLs, basic logistical tools for logistical deployment planning.

handicap. A joint medical commander on equal footing with the other joint commands, unified and specified, would more effectively address these many challenges.

THE MISSION OF THE MILITARY HEALTH SERVICE

The MHS currently includes organizations tailored to distinct but related tasks: maintaining deployable personnel as well as medically unique units for implementing the “readiness mission”; managing medical treatment facilities (hospitals and clinics); and facilitating managed-care support contracts—the “benefit mission.” In essence, the military health system has concurrent responsibilities for maintaining readiness of health care personnel to provide medical support to military operations and likewise providing a comprehensive health benefit to at least nine million beneficiaries, including active-duty personnel, retirees, survivors, and their dependents. In support of these responsibilities, the Defense Department operates one of the largest and most complex health care organizations in the nation. Including overseas facilities, the three services operate about seventy hospitals and over eight hundred clinics (411 medical and 417 dental). The benefit and readiness missions are inextricably linked by the fact that the same medical personnel are used for both.

The Military Health System is funded through a single, consolidated appropriation, the Defense Health Program. Since the creation of the program in 1992, the Assistant Secretary of Defense for Health Affairs (ASD/HA) has been the program manager for all fiscal resources used to provide medical care in garrison.² Over the years, the assistant secretary has been given enhanced authority for resource management and contracting, the latter executed through the TRICARE Management Activity. In contrast, authorizations and funding for military personnel, including those in the medical services, are resourced by Congress directly to the services. The services also receive direct appropriations to pay for health services delivered in operational settings, including training, exercises, and humanitarian assistance, etc., as well as war. These resources flow through the service chiefs to both line and deployable medical units via the operational chains of command.

To represent the “stakeholders” perspective in the Defense Health Program, a Defense Medical Oversight Committee was created in 1999. It was used to provide top-level oversight and efficiency that were previously lacking. That committee has now been superseded by two groups: the Senior Military Medical Advisory Council, with membership including, among others, the ASD/HA and the surgeons general; and the Military Health System Executive Review Committee, chaired by the Under Secretary of Defense for Personnel and Resources. The latter’s membership comprises the Assistant Secretary for Manpower and

Reserve Affairs of each of the three services; the vice chiefs of the Army, Navy, and Air Force; the Assistant Commandant of the Marine Corps; the DoD comptroller; the ASD/HA; the director of the Joint Staff; and the director of Program Analysis and Evaluation. The surgeons general and the other agency representatives are ex officio members.

These efforts may have enhanced interservice cooperation, but they have by no means created “jointness” among the medical departments. Indeed, the tradition of independence, even competitiveness, between the services remains the biggest obstacle to developing a joint approach among the medical departments, even for the peacetime benefit mission.

MILITARY MEDICINE: DUAL RESPONSIBILITIES AND COMPETING IMPERATIVES

The requirements for maintaining qualified personnel who have skills and knowledge relevant both in garrison hospital settings and in support of military operations make medical readiness unique from other military disciplines. The development and maintenance of these distinct skills call for training and experience in military medical treatment facilities (MTFs) as well as within deployable units. Although the two missions complement one another in some ways, joint pursuit of both readiness and benefits involves a complicated set of trade-offs and management challenges. A large standing force is required to attain and maintain medical readiness, particularly during wartime; accordingly, many active-duty personnel—physicians, nurses, and other health care personnel—must be employed in regular patient care during peacetime in order to keep their clinical knowledge and skills current. Service at MTFs, where health care for most beneficiaries is provided, thereby contributes to readiness, by keeping active-duty personnel at peak clinical performance. Likewise, caring for the families of mobilized personnel constitutes an employer health benefit to military personnel and their family members during active service, as well as after retirement.

However, the military readiness mission involves deploying these same medical personnel (and necessary equipment) to support military forces throughout the world in wartime, peacekeeping, and humanitarian operations, and during military training. To do so requires ongoing training not only in specific medical specialties needed for wartime but in military skills as well. Furthermore, some medical skills have only military applications, such as aspects of undersea and flight medicine, or facility with stabilizing combat casualties under austere conditions for rapid evacuation through an echeloned system.

Manning and training requirements drafted by the services envision continuous staffing of deployable medical units at levels sufficient for maintenance of

equipment, as well as military and medical-specific unit training in combat conditions. They call for personnel qualified to support medical readiness across the spectrum of military activity—personnel with medical training, clinical experience, military training, and operational experience. Consequently, some active-duty health care personnel must regularly leave the MTFs to join deploying medical units. Experience in operational units is also important for learning to communicate with supported units and earning their trust and respect. Such relationships point to an important cultural component for maintaining readiness. Likewise, medical personnel must become accustomed to the constraints of operational environments and understand their medical ramifications while maintaining proficiency.

From all these mandates, the operative reality of competing imperatives arises. The two missions draw upon overlapping resources. The readiness mission must be balanced against the demands of the benefits mission. But if personnel are to practice medicine in operational contexts, often in austere conditions, under high stress, and with limited resources, they must train with operational units. Unfortunately, over the last fifty years the costs of providing peacetime health care for eligible beneficiaries have consumed an increasing proportion of military health service resources. Today, the MHS not only gives priority to the benefit role but focuses heavily upon reduction of beneficiary health care costs—when in fact those costs should be accepted as part of the price of being medically prepared for going to war.

COORDINATING PEACETIME HEALTH CARE WITH THE OPERATIONAL MISSION

A key consideration when restructuring the MHS of the future, then, will be a firm commitment to optimizing the coordination required to execute both missions effectively. Allocation of personnel between the two constitutes a challenge for the MHS, and it would be a major responsibility of any new joint or unified health services command.

The Present Status

The medical readiness mission is unique, and few lessons from the civilian sector are applicable. Among its requirements is the ability to coordinate the many and varied elements of DoD. The Military Health System's current diffuse management structure appears to lack this ability. For example, although a medical treatment facility can control the readiness activities of its personnel, such as individual skills training, many objectives (for instance, materiel maintenance and unit training) can be met only within deployable medical units. Furthermore, these operational units are often under nonmedical commanders, with no direct

medical chain of command. In these cases medical unit leaders are evaluated by line or support commanders, who might not appreciate or understand the competing issues they face.

The Need for Coordination

Presently, the services' medical departments have no centralized command and control, though their missions are essentially the same. This lack of unified command produces inefficiencies in manpower, resources, coordination, planning, and innovation. The services' semi-independent systems arguably cooperate to the greatest extent possible, under an organizational structure that makes them competitors for the same readiness and peacetime-benefit missions. This loose organization lends itself to inefficiency and poor resource management within such a large, complex health care organization. Furthermore, within each of the unified combatant commands (e.g., U.S. Central Command, U.S. Pacific Command, etc.) joint forces surgeons, although ostensibly responsible for coordination and integration of medical support among the services, have neither command authority nor staff empowered to synchronize and integrate truly what they are given by the individual services.³

Greater interoperability and interdependence could result from reducing redundancies, conserving resources, and initiating collaboration. A desirable degree of coordination is most likely to emerge from a unified structure with clearly defined lines of authority, responsibility, and accountability, supported by both appropriate and timely information, performance evaluation, and suitable incentives. What is needed is an unambiguous assignment of responsibility, adequate resources, and authority to ensure readiness, as well as mechanisms for coordinating all this with peacetime health care, given the duality of the military medical mission.

Searching for Precedents

Any new joint health-service entity must be capable of supporting military operations, whether they are single-service, joint, or combined. Consequently, a key driver of organizational structure must be the provision for institutional and situational coordination dedicated to readiness. Its leadership will require the information, authority, and responsibility to allocate any resources necessary for efficient readiness training of DoD medical personnel.

In the U.S. Special Operations Command (SOCOM), the unified commander has certain responsibilities and authority in special operations activities, whether carried out within the command or not: programming and budgeting, budget execution, acquisition of specialized assets, training, determining and validating requirements, and monitoring the services' personnel management activities. A unified medical command would be similar in that it too would

have broad continuing missions and be composed of forces from all military departments; accordingly, its commander should be given similarly expanded responsibilities and authority. Specifically, all Defense Health Program funding would be apportioned to the unified command instead of to the services. This would ensure coordination between medical readiness and TRICARE management, and encourage a unified approach to the readiness mission. The SOCOM model would also give the unified medical commander oversight of the services' management of medical personnel. The services would retain responsibility for organizing, manning, and equipping operational medical units, while deployable human assets would be assigned to the unified commander (who might choose to keep them within their current line organizations if that is most operationally effective). Also, medical personnel and activities organic to the supported operational unit would most likely remain outside the joint purview. Some of these functions are thoroughly integrated within nonmedical units—for example, Marine battalion aid stations and warship sickbays.

U.S. MEDICAL COMMAND

The Commander, U.S. Medical Command, would likely advise the secretary of defense and chairman of the Joint Chiefs of Staff on uniformed military medical issues while working with the Assistant Secretary of Defense for Health Affairs on policy. The joint U.S. Medical Command would, as implied above, be the optimal agency for centralizing the budget for readiness and medical activities. A unified command of this size would be best commanded by a four-star flag or general officer (whether from the line or medical communities would be a determination best made by Defense Department leadership). Thus, the commander would outrank the surgeons general of the services and would also be in the best position to consolidate health plan authority for TRICARE. This model envisions dual roles for the surgeons general—as medical component commanders reporting to the unified medical commander, and as senior medical staff officers reporting to their respective service chiefs.

The U.S. Medical Command structure must transform the MHS into an integrated team with service and TRICARE components. The task of establishing the “wiring” for this integration will be enormous. It requires construction of a network of command relationships to articulate budgetary requirements and establish end strength and infrastructure size, while ensuring the requisite links between the services and TRICARE contractors. Likewise, it must align accountability and authority with responsibility and resources for both these readiness and benefit missions. The command must also effect a balance between health care (prevention and treatment), education, and research.

The proposed unified medical command needs to give the Military Health System the resource efficiency and operational flexibility it requires to change the ways in which it provides force protection in support of the combat forces and the manner in which it does business and works with others—specifically by relieving the Assistant Secretary of Defense for Health Affairs of responsibility for the benefit mission, including integration with the TRICARE health plan. Also, whereas line-medical relationships at the operational and tactical levels have traditionally been mediated by service component medical commands, the

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command relationship between U.S. Medical Command and service medical departments will enhance doctrinal jointness, by centralizing command and control

without sacrificing operational control by the services. It will also enhance technical and intellectual jointness, by capitalizing on the synergies between the benefit and readiness missions.

The arguments against a unified medical command are centered upon the uniqueness of each service's mission, environment, and role. Indeed, while the benefits of combining training activities presumably include lower costs from economies of scale and improved interoperability, the reality of service-specific training does exist, and it must be addressed before training is combined. The relationships between each service's medical and line units must likewise be fostered and sustained. In general, any reorganization of the health care system must identify and give careful consideration to medical support that is unique to a specific service or mission, while it attempts to ensure appropriate levels of interoperability.

The appropriate assignment of units and personnel would need to be determined before a U.S. Medical Command could be established. In an ideal setting, this would require extensive negotiation and agreement among the stakeholders. In reality, because of the differences between the existing formal organizational structures of the medical departments of the three services, this will require a mandate by law. Once in place, the concept would create a separate chain of command for much of the medical readiness mission under the joint commander's overall authority. All deployable units, other than those that remain organic to line commands, would report through service component commands to either a deputy commander for readiness or directly to the unified medical commander. The resources needed for readiness would be identified and allocated to the readiness components. This would include personnel assigned to deployable units and, ideally, personnel assigned to medical treatment facilities but available to the deployable units when needed.

As noted above, ASD/HA currently manages the large Defense Health Program budget (approximately \$36 billion per year) through the TRICARE Management Activity. (The Defense Medical Oversight Committee had been used to provide some level of oversight and efficiency that was previously lacking. This has now been superseded, also as noted previously, by both a Senior Military Medical Advisory Council and a Military Health System Executive Review Committee.) The budget is managed by a staff and through the three military services. The staff of the U.S. Medical Command would encompass a TRICARE Management Activity and assume these responsibilities, including contracting support. The U.S. Medical Command would provide the needed command and control, maintain (no doubt) civilian contracting authority, and free the Assistant Secretary of Defense for Health Affairs to focus upon policy formulation and oversight. The TRICARE Management Activity itself would be structured within regional medical organizations to coordinate care between the MTFs and regional contractors, and it would ultimately be responsive to the needs of the three surgeons general, who would serve in the joint command as service component commanders.

Responsibility for health matters at an installation, and for the health of all assigned military personnel, would continue to be the responsibility of the medical treatment facility commander, as would management of MTF personnel resources, which has great impact upon operational readiness. The surgeons general would oversee medical readiness in their services, being in the best position to see that the MTF commanders do not neglect their commitment to operational readiness in order to enhance the “productivity” of their health care services. The surgeon general, in his or her capacity as chief medical officer for each respective service, would monitor and retain authority over the MTFs in maintaining the health of active-duty personnel, providing care to families, and supporting readiness training and deployment. In essence, the surgeons general, as component commanders, would have linkages to both the service chiefs and to the commander of the unified medical command—the former for operational control and the latter for program development, personnel management, and training. Having the same individual in both chains should enhance both balance and clarity of mission.

The Military Health System requires an organizational overhaul. A radical restructuring is necessary, primarily to ensure sustained medical readiness but also to improve cost management and achieve better integration of health care delivery across the component services. With a budget expected to exceed \$50 billion by 2010 and a mandate to provide care for more than nine million people, military medicine needs a specified joint medical commander “with portfolio”—that is,

with direct access to the highest levels of military and civilian Defense policy making. The ultimate mission of the U.S. Medical Command would be to articulate effectively the requirements for current and future medical support of an increasingly joint and interdependent defense establishment, and likewise to ensure their implementation.

NOTES

1. Susan D. Hosek and Gary Cecchine, *Reorganizing the Military Health System: Should There Be a Joint Command?* (Santa Monica, Calif.: RAND, 2001), pp. xi, 5–23.
2. *Ibid.*, p. 6.
3. Darwin D. Kumpula, *Joint Medical Command: Do It Now* (Carlisle, Pa.: U.S. Army War College, 2005), p. 8, available at www.strategicstudiesinstitute.army.mil/pdffiles/ksil247.pdf.