

SINGLE, INTEGRATED, SERVICE-CENTRIC MODEL OF  
MILITARY HEALTH SYSTEM GOVERNANCE

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MASTER OF MILITARY ART AND SCIENCE  
Strategic Studies

by

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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

## ABSTRACT

SINGLE, INTEGRATED, SERVICE-CENTRIC MODEL OF MILITARY HEALTH SYSTEM GOVERNANCE, by Major Jimmy Lewis McClain, Jr, 94 pages.

Ad hoc, temporary solutions developed due to Service collaborations have overcome shortcomings in joint health services and increased the efficiency and effectiveness of operational medical support. According to the *Joint Concept for Health Services (JCHS)*, the need for integrated medical support that keeps pace with the operational agility and organizational flexibility requirements to support globally integrated operations is clear. This research offers a review of the last major Department of Defense (DOD) transformation, which saw the Military Health System transition from three Service department medical commands to Service department medical commands with a Defense Health Agency (DHA), and relevant U.S. strategic doctrine. The goal of the research is to establish what the model of governance of the Military Health System should be. That, with other recommendations, should be the foundation for the impending transformation. The research found that the model of governance should be a single service model with regional health commands that support the geographic combatant commander (GCC). With an organization based on the presented model of governance, the Military Health System would be more efficient in accomplishing missions and tasks prescribed by the strategic documents.

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## ACRONYMS

AOR	Area of Responsibility
CBA	Capabilities-Based Assessment
CCMD	Combatant Command (unified command)
DHA	Defense Health Agency
DOD	Department of Defense
DOTMLPF-P	Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, Facilities and Policy
DSR	<i>Defense Strategy Review</i>
JCHS	<i>Joint Concept for Health Services</i>
JCS	Joint Chiefs of Staff
MTFs	Military Treatment Facilities
NDAA	National Defense Authorization Act
SOCOM	Special Operations Command (United States)
U.S.	United States

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# CHAPTER 1

## INTRODUCTION AND BACKGROUND

### Introduction

Even before the Army, Navy, and Air Force had service-specific medical departments, there was a call for jointness of governance for the Military Health System (MHS). Since 1947, there have been over 15 of the Department of Defense (DOD) studies conducted either internally or externally. Despite the continued calls for organizational change, the DOD only implemented policy and programmatic changes “that incrementally increased the interoperability and jointness of both combat and peacetime health care delivery” and “control[ed] the increase in health care costs.”<sup>1</sup> The latter has been the driver of change over the last 10 years as health benefits and the number of beneficiaries has increased the costs to the MHS exponentially from \$19 billion in 2001 to “\$48 billion in fiscal year 2016, “roughly one in every 12 dollars in the defense budget that year.”<sup>2</sup>

In 2011, an internal task force was established by the Deputy Secretary of Defense to review governance of the MHS and to provide options of governance of the MHS as a whole, of multi-Service medical markets, and of the National Capital Region

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<sup>1</sup> Department of Defense, *Task Force on Military Health System Governance* (Washington, DC: U.S. Department of Defense, September 2011), 27.

<sup>2</sup> Department of Defense, *Task Force on Military Health System Governance*, 3; Task Force on Defense Personnel, “Health, Health Care, and a High-Performance Force” (Report, Bipartisan Policy Center, March 2017), 12.

(NCR) to “ensure that they were organized in an effective and cost-efficient manner.”<sup>3</sup>

The recommendations from this task force were for a Defense Health Agency (DHA), Multi-Service Market (MSM) Areas and a National Capital Region (NCR) Directorate outlined in a memo on March 2, 2012, “Planning for Reform of the Governance of the Military Health System,” codified in section 731 of the National Defense Authorization Act (NDAA) of Fiscal Year 2013, and became effective October 1, 2013. Aside from the establishment of the Air Force Medical Service in 1949, this would become the first major change to governance that would affect all services within the Military Health System in over 60 years.

These changes in governance, as with the recommended changes of previous task forces, boards and commissions, focused too much on governance as a means to reduce cost and failed to address governance as a means to improve responsiveness to the combat commander. The rising costs associated with health care are not the only challenge that the United States (U.S.) will face in the future. The *Joint Operating Environment 2035* describes others as: “The United States will face a wide range of emerging—and often unforeseen—challenges in the future security environment featuring both *contested norms* and *persistent disorder*. Specific U.S. strategic and military objectives to

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<sup>3</sup> Ashton B. Carter, U.S. Secretary of Defense, “Planning for Reform of the Governance of the Military System” (Memorandum for Secretaries of the Military Departments, Washington, DC, January 22, 1992), 1.

address these challenges will be many, multi-faceted, and tailored to a specific time, place, and set of circumstances.”<sup>4</sup>

The *Capstone Concept for Joint Operations: Joint Force 2020* calls for a force that is globally postured and joint; one that can quickly combine capabilities in order to meet the previously mentioned challenge. Irrespective of all of the efforts of the DOD to change governance, this was and still is a challenge for the MHS “as each Military Department maintains nominal responsibility for the health of its respective Service members from point-of-injury through rehabilitative care.”<sup>5</sup>

Since the Revolutionary War, the service medical departments have singularly or jointly made advancements in technology or concepts to overcome shortcomings while supporting forces during battle. Their most recent collaborations have increased “efficiency and effectiveness of operational medical support”<sup>6</sup> but only through the application of “ad hoc, temporary solutions.”<sup>7</sup> With the increase in military innovation, the MHS will need to increase effectiveness by overcoming its current “disparate application of the Services’ respective medical capabilities”<sup>8</sup> to support the joint force.

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<sup>4</sup> Joint Chiefs of Staff, *Joint Operating Environment 2035 (JOE 2035)* (Washington, DC: Government Printing Office, 2016), 40.

<sup>5</sup> Joint Chiefs of Staff, *Capstone Concept for Joint Operations: Joint Force 2020* (Washington, DC: Government Printing Office, 2012), 1.

<sup>6</sup> Joint Chiefs of Staff, *Joint Concept for Health Services (JCHS)* (Washington, DC: Government Printing Office, 2015), 1.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

In 2013, a DOD study led to the establishment of an initial operating capability of the DHA that consolidated MHS-wide shared services activities. The DHA would be led by a three-star general or flag officer who reported to the Assistant Secretary of Defense (Health Affairs) and was designated as a combat support agency. DHA fulfills support functions for joint operating forces across the range of military operations in support of combatant commanders executing military operations.

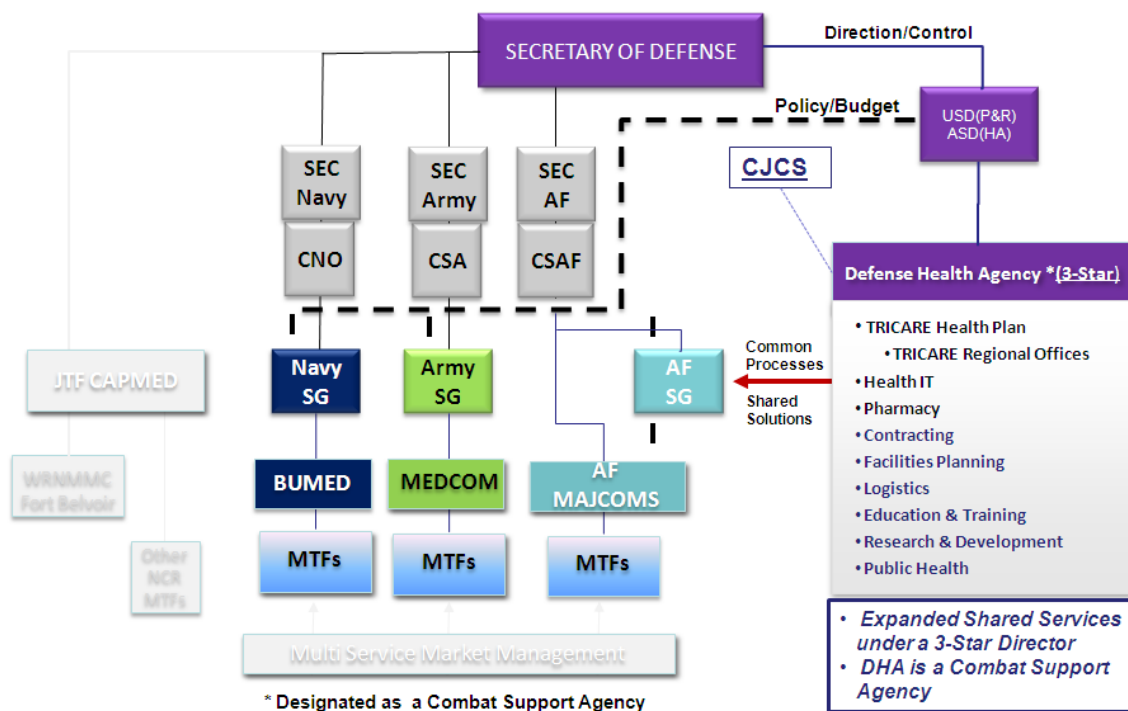


Figure 1 Overall Model of Governance of the MHS (Current)

*Source:* Department of Defense, *Task Force on Military Health System Governance* (Washington, DC: Government Printing Office, September 2011), 34.

During the celebration of the two-year anniversary and the achievement of full operating capability of the DHA in 2015, Assistant Secretary of Defense for Health

Affairs Dr. Jonathan Woodson stated: “No single service in the future will have all of the capabilities that are necessary. It requires the combined efforts of all services, and to have an integrating agency that can provide those platforms going forward is going to be essential.”

At the time of his statement, Dr. Woodson did not know how prophetic he would be. Over the last two years, the combatant commands have utilized the Global Force Management Allocation Process in order to fill emergent force allocations Requests for Forces (RFF)—“A request from a CCDR . . . for units or capabilities . . . generated because (either) the unit or capability is not resident in existing assigned or allocated forces or the unit or capability is not available due to current force commitments with other ongoing requirements in the CCDR’s AOR”<sup>9</sup>—for surgical capabilities. This process asks each service if they can meet this need with their forces within the 120-day standard from RFF to Latest Arrival Date.

The U.S. Joint Chiefs of Staff (JCS) has received “14 emergent requests for surgical capabilities totaling 21 surgical teams.”<sup>10</sup> The emergent requests were from only two of the six combatant commands. Those commands were U.S. Africa Command and U.S. Central Command with four and 10 requests respectfully. Of the 14 requests, the JCS was able to source nine of the requests, the combatant commands were able to source three requests due to internal mitigation and the JCS is currently staffing two requests. Of

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<sup>9</sup> U.S. Marine Corps, Marine Corps Order 3120.12, *Marine Corps Global Force Management (GFM) and Force Synchronization* (Washington, DC: Headquarters United States Marine Corps, February 2015), 11-20.

<sup>10</sup> Cory J. Plowden, e-mail message to author, March 22, 2017.



the requests that the JCS were able to meet, the JCS was unable to meet the RFF to Latest Arrival Date 120-day standard.

General Dunford stated:

The American military must stay ahead of this pace because the United States will not have time to marshal the immense strength at its command as it did in World War I and II and during Korea. Today, the ability to recover from early missteps is greatly reduced. The speed of war has changed, and the nature of these changes makes the global security environment even more unpredictable, dangerous and unforgiving. Decision space has collapsed and so our processes must adapt to keep pace with the speed of war.<sup>11</sup>

#### Current Situation

The NDAA for Fiscal Year 2017 has called for another change in the governance of the MHS but like the other recommendations over the last 60 years, it provides no model of governance for the MHS that provides forces to speed decision-making for the combatant commander. The language within the NDAA 2017 was a House-Senate compromise that gave management responsibility of the more than 400 military hospitals and clinics, currently owned and operated by the Army, Navy, and Air Force, to the DHA effective October 2018. Each service will retain the position of surgeon general but what surgeons' general roles will be is unclear. It appears, military departments will continue to own all military personnel and be responsible for organizing, training, and equipping their deployable military medical forces.

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<sup>11</sup> Jim Garamone, "Dunford: Speed of Military Decision-Making Must Exceed Speed of War," *DoD News*, January 31, 2017, accessed May 7, 2017, <https://www.defense.gov/News/Article/Article/1066045/dunford-speed-of-military-decision-making-must-exceed-speed-of-war/source/GovDelivery/>.



into a high-performing integrated health system that gives beneficiaries what they need and deserve: the right care, in the right time, at the right place.”<sup>13</sup>

Moving the military treatment facilities (MTFs) under the control of DHA does not increase the speed of decision-making spoken of by General Francis Dunford, Jr. By retaining the service medical departments, the bill does not change the Global Force Management allocation process that asks each service if they can provide a medical resource to the combatant command thus further reducing the speed of decision-making of the geographic commander.

In the U.S. Africa Command 2017 Posture Statement, General David M. Rodriguez, Commander, U.S. Africa Command, stated:

Africa’s security environment is dynamic and complex requiring innovative solutions. . . . While the command has been able to succeed in multiple efforts, our mission is impacted by inconsistent resourcing of key requirements and capabilities. These constraints risk our Soldiers, Sailors, Airmen, Marines, Coast Guardsmen, and Civilians executing activities on the African continent. . . . Integrating personnel recovery and surgical stabilization/medical sustainment capabilities are a moral obligation and essential for the proper care of U.S. service members who risk their lives to protect our nation.<sup>14</sup>

General Rodriguez’s statement is a clear message that he will not be able “to produce plans for the employment of the armed forces to execute national defense

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<sup>13</sup> Serbu, “Defense Health Agency Poised for Huge Growth under Just-Passed Defense Bill.”

<sup>14</sup> David M. Rodriguez, *AFRICOM 2017 Posture Statement* (Washington, DC: U.S. Department of the Army, March 9, 2017), 23.

strategies and respond to significant military contingencies”<sup>15</sup> under the current model of governance.

### Purpose and Significance of the Study

For over 60 years, it has been suggested by agencies external and internal to the DOD and Congress that the state of the MHS is of high concern albeit for different reasons—high costs of care and operational readiness. Numerous reports along with statements by congressional and strategic military leadership attest to that there is a concerning divide between the expectations of the MHS conducting its benefits and readiness missions; furthermore, a traditional and ideological divide between the House and Senate Armed Services Committees and the services’ surgeons general exists concerning the correct manner which the MHS should decrease costs in the benefits mission and still maintain adequate capabilities to support the readiness mission. The main issues that the MHS is currently facing are: a severe lack of resources, a negative organizational culture and outdated and unaligned service medical doctrine.

During the last call for transformation in 2017, the NDAA gave control of the MTFs currently under the control of the Army, Navy and Air Force to the DHA. In accordance with the *Joint Concept for Health Services (JCHS)*, the basic component of capabilities designed to support globally integrated operations across the range of military operations (ROMO) is with globally integrated health services (GIHS). With the violent, uncertain, chaotic, and ambiguous operational environment and the budget-

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<sup>15</sup> 10 US Code SS 164 (b)(3)(A), *Commanders of Combatant Commands: Assignment; Powers and Duties*.

constrained landscape that the DOD is forced to operate within a thorough capabilities based analysis to determine the capabilities required to have an overall model of governance of the MHS that can manage and provide “joint operational health services that are sufficiently modular, interoperable, and networked to enable . . . [quick] and [efficient combination] and [synchronization of] capabilities”<sup>16</sup> is needed. The product of that analysis should produce capabilities across the doctrine, organization, leadership and education and policy domains of Doctrine, Organization, Training, Materiel, Leadership, Personnel, Facilities and Policy (DOTMLPF-P). This research, when considered by congress, should serve as a starting point for the future transformation of governance of the MHS.

Presently, a Joint Force Surgeon (JFS) is “appointed by the joint force commander to serve as the joint force special staff officer responsible for establishing, monitoring, or evaluating joint force health service support.”<sup>17</sup> The JFS is “responsible for coordination and integration of support among the services” and “integrates what . . . is given from the services to accomplish the mission.”<sup>18</sup> The JFS establishes relationships with those that exercise command authority over medical forces to synchronize activities.

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<sup>16</sup> Joint Chiefs of Staff, *Joint Concept for Joint Operations: Joint Force 2020*, ii.

<sup>17</sup> Joint Chiefs of Staff, Joint Publication 4-02, *Health Service Support* (Washington, DC: Government Printing Office, 2012), GL-9.

<sup>18</sup> Darwin D. Kumpula, “Joint Medical Command-Do It Now” (Strategy Research Project, U.S. Army War College, Carlisle Barracks, PA. March 2005), 8.

What must be noted is that the JFS is a staff officer that has no command authority nor a robust staff to truly synchronize the integration among the services.<sup>19</sup>

The purpose of this study is to determine a set of capabilities needed by an overall model of governance of the MHS and inform the chief decision maker—Congress—to call for further study to codify the doctrine, organization, leadership and education and policy changes needed to provide the model of governance that will enable the combatant commander to expedite decision-making processes to maintain the initiative of the joint force during globally integrated operations (GIO) and to support the service-specific needs of operational and tactical commanders.

#### Primary and Secondary Research Questions

The expectation of this study is to produce criteria, capabilities and tasks that can be applied to determine the future model of MHS governance. The criteria developed from the Terms of Reference outlined in a memorandum from former Secretary of Defense Ashton Carter and the determination of the task force developed to determine the appropriate model of governance of the MHS led to the DHA as the overall model of governance to “provide a pathway to a stronger and enduring governance model for the system, while maintaining the incredible performance of a military health system whose primary mission is to prepare for and go to war.”<sup>20</sup> This study should result in the

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<sup>19</sup> Ibid.

<sup>20</sup> Department of Defense, *Task Force on Military Health System Governance*, 10.

capabilities needed by the MHS in order to support the primary missions to prepare for and go to war.

Therefore, the primary research question is:

What should be the capabilities of the future overall model of governance of the MHS?

To determine the answer, a set of secondary research questions must be answered:

1. What capabilities were identified in the last major transformation of the MHS?
2. What capabilities and tasks of the MHS are identified in doctrine?
3. What were the capabilities required by the MHS identified in national strategic documents?
4. What are the needed capabilities of the MHS identified in the professional body of knowledge?

### Assumptions

The relevancy of the recommendations above have been predicated on several assumptions:

1. That a process of determining a model of governance can be derived through study of the last major transformation of the MHS;
2. That there are concepts of the last major study of overall governance of the MHS that can be applied to the future transformation;
3. That the capabilities globally integrated health services (GIHS) outlined in the *JCHS* are reasonable to meet the needs of the joint force in the future; and,

4. That a joint model of governance will not affect the readiness or benefits missions of the MHS.

### Limitations

One of the most significant limitations is a lack of available literature regarding a force management process to develop command structures. An additional limitation is that the *National Security Strategy* has not been updated with the change in President. The transition from the Obama Administration to Trump Administration occurred on January 22, 2017 and in accordance with Public Law 99-433, SS 603/50 U.S.C Subsection 3043, President Trump “Not later than 150 days after the date on which” he took office “shall transmit to Congress a national security strategy report.”<sup>21</sup> The last limitation is that the JCS only has two years of data regarding the Combatant Command (CCMD) submissions for emergent allocation of RFFs.

### Scope and Delimitations

The research does not analyze all reports and studies related to the call for transformation of the MHS from service-centric medical departments alone to the addition of the combat support agency—DHA. The focus will be to analyze only those reports and studies that produce an actual accepted and implemented model of governance.

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<sup>21</sup> Nathan J. Lucas and Kathleen J. McInnis, *The 2015 National Security Strategy: Authorities, Changes, Issues for Congress* (Washington, DC: Congressional Research Service, April 2016), 1.



The research will focus on the readiness mission and not the benefits mission defined as—health care to active duty personnel, retirees, and dependents—of the MHS and support to U.S. Africa Command.

The methodology used will be based upon the DOTMLPF-P applied within the capabilities-based assessment (CBA) will only be evaluated across the doctrine, organization, leadership and education (D-O-L) domains.

### R1: Initial Personal Recommendation

This study is applied professional case study research. The research methodology is explained in chapter 3. This section provides an initial personal recommendation (R1) for capabilities needed by the future model of governance for the MHS. The research is a “reasonable professional standard” to assess the existing professional bodies of knowledge that are persuasive and relevant to design R1.<sup>22</sup> Research over the last 10 years focused on determining a model of governance “that is both more efficient in terms of headquarter size, but more importantly, that is more agile, [and] has greater unity of effort” but there has been no consensus regarding doctrine, organization, leadership and education and policy.<sup>23</sup> For the most part, the models of governance identified have been: As is, parallel commands, unified commands, and single service provider commands.

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<sup>22</sup> Kenneth Long, “Case Studies in Action: A Practical Method for Gaining Useful Insights in the Military Masters of Arts and Sciences Program,” in *Developments in Business Simulation and Experiential Learning*, vol. 43 (Proceedings of the Forty Third Annual Conference of the Association for Business Simulation and Experiential Learning (ABSEL), New Orleans, LA, ed. Alex Smith).

<sup>23</sup> Department of Defense, *Task Force on Military Health System Governance*.

The capabilities of each of these various models is further described in chapter 2 through the literature review. Each of these capabilities eliminate the “redundant commands and parallel tracks for mission support” that exist in the current system.<sup>24</sup>

Since 2013, Congress and the DOD have called for reductions in size of military services’ headquarters and general and flag officers as a solution to reduce operating costs of the DOD. In the professional opinion of the researcher, the overall model of governance—Initial Personal Recommendation (R1)—should be a single service provider model equivalent to the Army, Navy, and Air Force.

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<sup>24</sup> Arthur B. Eisenberry, “Unified Medical Command: An Old Idea Whose Time Has Come,” *Armed Forces Journal* (June 2013), accessed May 13, 2017, <http://armedforcesjournal.com/unified-medical-command-an-old-idea-whose-time-has-come/>.

## CHAPTER 2

### LITERATURE REVIEW

#### Introduction

The *JCHS* describes the challenges of health care operations in support of joint forces in a future operating environment that is volatile, uncertain, complex, and ambiguous. In order to meet those challenges, the joint force must develop non-materiel solutions with the appropriate capabilities. However, the doctrine that the joint force operates under is largely outdated. The arrival of the DHA signals a commitment to confronting the flaws in the Military Health System, but it does little to address the balance between the benefits mission that supports more beneficiaries and retirees and the readiness mission that supports the strategic, operational and tactical levels of war.

This study fills the capability gaps needed to determine the requirements for an overall model of governance by closely examining the history of the Military Health System, the transformation of the Military Health System, and the military doctrine, national strategic documents, joint concepts and professional body of knowledge that address the Military Health System. These topics serve as natural dividers for the sections of this literature review and the topics will help to answer the secondary questions:

1. What capabilities were identified in the last major transformation of the MHS?
2. What capabilities and tasks of the MHS are identified in doctrine?
3. What were the capabilities required by the MHS identified in national strategic documents?

4. What are the needed capabilities of the MHS identified in professional body of knowledge?

### The Beginnings of the Military Health System

At the urging of General Washington in 1775, the Continental Congress called for:

[T]he establishment of an hospital for an army, consisting of 20,000 men, the following officers and other attendants be appointed . . . then proceeded to the choice of officers for the Hospital, when, Benjamin Church was unanimously elected as director of, and chief physician in, the hospital . . . the appointment of the four surgeons and the Apothecary be left to Doctor Church . . . the Mates be appointed by the Surgeons . . . the number do not exceed twenty; and . . . the number be not kept in constant pay, unless the sick and wounded should be so numerous as to require the attendance of twenty . . . one Clerk, two storekeepers, and one nurse to every 10 sick, be appointed by the Director.<sup>25</sup>

The establishment of this hospital was the beginning of the formalized medical structure that would become antecedent to the Army Medical Department. From 1783 to 1784, the fledgling medical department shrank to a single surgeon and four surgeon's mates.<sup>26</sup> Until 1789, there was no formal military medical department and states were responsible for healthcare of the soldiers and militia serving within their borders.

From 1775 through 1842 when the "Bureau of Medicine and Surgery" was established, the Department of the Navy did not have a distinct medical organization.

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<sup>25</sup> The Library of Congress, *American Memory, Journals of the Continental Congress, 1774-1775*, accessed March 26, 2017, [https://memory.loc.gov/cgi-bin/query/r?ammem/hlaw:@field\(DOCID+@lit\(jc00265\)\)](https://memory.loc.gov/cgi-bin/query/r?ammem/hlaw:@field(DOCID+@lit(jc00265))).

<sup>26</sup> Larry J. Godfrey, "A Unified Medical Command: The Next Step in Joint Warfare Development" (Strategy Research Project, U.S. Army War College, Carlisle Barracks, PA, April 2001), 3.

Between these periods, the Navy posted surgeons on ships and their services focused almost entirely on shipboard care and relied on civilians or the Continental Army treatment facilities once the sailors were on shore.<sup>27</sup> This sharing of services could be construed as the first example of medicine being joint or multi-service. In his 1808 proposal, “Observations on the Means of Preserving the Health of Sailors and Soldiers, with Remarks on Hospitals and their Internal Administration,” Dr. Edward Cutbrush, U.S. Navy Surgeon 1799 to 1829, proposed the organizational design for a Navy Medical Department.<sup>28</sup>

The Civil War saw two distinct medical departments, Army and Navy, with “clearly delineated hierarchical structures” led by a “surgeon general with dedicated staff and administrative divisions supporting a loose structure of hospitals, clinics and pharmacies.”<sup>29</sup> Further reorganization of the Army Medical Department occurred with the implementation of “Congressional Act 12, Statute 379” in 1862.<sup>30</sup> This act greatly expanded the staff and role of the Army Medical Department within the War Department and established the precedence of a service surgeon general being a general officer.<sup>31</sup>

As in the American Revolution, the medical departments advanced conceptually and scientifically to meet the needs of the sick and wounded. The medical advances of

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<sup>27</sup> Ibid.

<sup>28</sup> Ibid.

<sup>29</sup> Ibid., 4.

<sup>30</sup> Ibid.

<sup>31</sup> Ibid.

the civil war are considered by some to be the “first real RMA for American military medicine.”<sup>32</sup> By the end of the Civil War, the Army and Navy Medical Departments had distinguished themselves as a necessity but at this point their activities were still service-specific.

From 1903 to 1947, some form of the Joint Army and Navy Board existed. Initially, the board was tasked to take plans developed by the service secretaries, formulate joint operating concepts, and “resolve any problems arising from dissimilar approaches between the services.”<sup>33</sup> These concepts had little impact on the War Plans for WWI and did not reflect thoughtful consideration regarding medical planning. At the insistence of the service secretaries following WWI, the Joint Army and Navy Board was reactivated and expanded by adding the Chief of the War Plans Division of the Army and the Director of Plans for the Navy to the board and creating the Joint Planning Committee. This second version of the Joint Army and Navy Board was as ineffective as the one prior to WWI and for this reason was disbanded in 1947.

All was not lost in medicine during this period. Military medicine continued to “Conserve the Fighting Strength” of the force. Scientific advances in medicine were challenged to keep up with the lethality and destructive nature of weapons introduced during this period. Military medicine advancements led to a decrease in deaths due to disease and to greater survivability due to wounds received during combat.

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<sup>32</sup> Godfrey, “A Unified Medical Command,” 4.

<sup>33</sup> Ibid., 6.

The precursor to the Air Force Medical Service was instituted in World War II. The Army had an Air Surgeon, Major General David Grant, and combat physicians that established the medical support programs for the aircrews operating within the Army Air Corps. The Medical Service, U.S. Air Force was established by Air Force General Order No. 35, June 8, 1949<sup>34</sup> in order to provide the medical care support function to the Air Force. The Air Force Medical Service contained six officer personnel components with a contingent of enlisted medics. Air Force General Order (GO) 35 stated, “corps shall consist of those personnel transferred from corresponding corps of the Department of the Army, and personnel subsequently commissioned in the respective corps of the Medical Service, United States Air Force.”<sup>35</sup>

The establishment of the Air Force Medical Service did not come without opposition. One year after the creation, House Resolution 8889 was introduced during the 81st Congress, “Air Force Organization Act of 1950,” Section 305(a). This resolution called for the abolishment of the Air Force Medical Service and the transfer of care for its force to the Army and Navy. The spirit of this resolution was met with vigorous opposition from the Office of the Air Force Surgeon General. Then Surgeon General, Major General Harry G. Armstrong, pointed out the need for a medical service that would be able to “adapt flying personnel to the deleterious effects and hazards” associated with

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<sup>34</sup> Air Force Medical Service, “Report of the Medical Service 1 July 1949-30 November 1949,” accessed May 6, 2017, <http://www.airforcemedicine.af.mil/Portals/1/Documents/History/Historic-Documents/AFD-130529-028.pdf>.

<sup>35</sup> Air Force Medical Service, “Creation of the Air Force Medical Service,” accessed May 6, 2017, <http://www.airforcemedicine.af.mil/AFMSHeritage/>.

“extremes of velocity, altitude and engineering performance” and that would be sympathetic to the Air Force, unlike the Army Medical Department.<sup>36</sup> Ultimately, the establishment of the Air Force Medical Service prevailed but the service-specific, medical allegiance displayed by Major General Armstrong became commonplace.

### Transformation of the Military Health System (2011-2018)

Military transformation simply stated is a “profound change in military affairs.”<sup>37</sup> Paul Davis stated military transformation “need not imply rapid . . . across-the-board change, nor the discarding . . . which continues to work well . . . however, should be dramatic rather than mere improvements on the margin” because the process has “no simple end point.”<sup>38</sup>

Success is not always guaranteed with any transformation but it will definitely not be successful if the service medical departments continue to “embrace concepts too strongly and uncritically.”<sup>39</sup> Congress has continuously called for changes to the overall governance of the MHS but as displaced in the most recent changes called for in NDAA

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<sup>36</sup> Air Force Medical Service, “The Necessity for an Organic Medical Service within the United States Air Force,” accessed May 6, 2017, <http://www.airforce.medicine.af.mil/Portals/1/Documents/History/Historic-Documents/AFD-130529-035.pdf>.

<sup>37</sup> Paul K. Davis, *Military Transformation? Which Transformation, and What Lies Ahead?* (Santa Monica, CA: RAND Corporation, 2010), 11, accessed May 14, 2017, [http://www.rand.org/content/dam/rand/pubs/reprints/2010/RAND\\_RP1413.pdf](http://www.rand.org/content/dam/rand/pubs/reprints/2010/RAND_RP1413.pdf).

<sup>38</sup> *Ibid.*, 1.

<sup>39</sup> *Ibid.*, 11.



2017, they are making only marginal improvements—the DHA manages the MTFs—in an attempt to correct a problem that spans a much greater spectrum of challenges.

On June 14, 2011, an internal DOD task force consisting of representatives from the Military Departments, the Joint Staff, and the Office of the Secretary of Defense (OSD) was established by the Deputy Secretary of Defense. The task force was given Terms of Reference and charged “to evaluate options for long-term governance of the MHS . . . report within 90 days . . . detailing the relative strengths and weaknesses of each option evaluated as well as recommendations for governance.”<sup>40</sup> The task force developed five organizational models: a unified medical command, a Defense Health Agency, management by one or more Military departments, a hybrid model incorporating elements of the other models and an “As Is” option.

The task force took the original Terms of Reference and expanded them to consist of the following criteria:<sup>41</sup>

1. Sustain a medically ready Active Duty—Reserve Component through high quality integrated health care;
2. Maintain a trained and ready deployable medical force;
3. Provide high quality, integrated medical care to non-Active Duty—Reserve Component beneficiaries;
4. Achieve significant cost savings through reduction in duplication and variation;

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<sup>40</sup> Department of Defense, *Task Force on Military Health System Governance*, 3.

<sup>41</sup> Ibid.

5. Afford dispute resolution process and clear decision authority with clear accountability;
6. Offer ease of implementation; and
7. Enhance interoperability.

Table 1. Overall Criteria for Governance Options for MHS

Criteria	Weighting
<b>1*</b> Sustain a medically ready Active Duty (AD)/Reserve Component (RC) through high quality integrated health care. The alternative should maintain or enhance the ability to provide medically ready warfighters.	<b>25%</b>
<b>2*</b> Maintain a trained and ready deployable medical force. The alternative should sustain the training necessary to meet all clinical and other requirements needed to provide a fully trained and current deployable medical force.	<b>23%</b>
<b>3*</b> Provide high quality, integrated health care to non-AD/RC beneficiaries. The alternative should maintain or enhance the ability of the system to sustain the current high quality of health care that it provides at the current levels of integration between the Services as well as the private sector.	<b>21%</b>
<b>4*</b> Achieve significant cost savings through reduction in duplication and variation. The alternative should result in a reduction of the system operating costs.	<b>17%</b>
<b>5</b> Provide dispute resolution process and clear decision authority with clear accountability. The alternative should provide clear decision authority and dispute resolution at the lowest appropriate level, including clear lines of accountability.	<b>6%</b>
<b>6</b> Ease of implementation. The alternative should be implementable taking into account Title 10 equities, short term costs and long-term savings, and decisions required inside and outside of the DoD.	<b>5%</b>
<b>7*</b> Enhance interoperability. The alternative should facilitate interoperability among the Services.	<b>3%</b>

Source: Department of Defense, *Task Force on Military Health System Governance* (Washington, DC: Government Printing Office, September 2011), 23.

The task force delivered its report on September 15, 2011 with the recommendation for a Defense Health Agency with the MTFs remaining with the Military Departments.

Unlike previous recommendations, former Secretary of Defense Ashton B. Carter directed:

[I]mplementation of the Military Health System governance reform . . . the establishment of a Defense Health Agency (DHA) to assume responsibility for shared services, functions, and activities of the MHS and other common clinical and business processes . . . with initial operating capability . . . achieved by October 1, 2013, and full operating capability within two years.<sup>42</sup>

The DHA celebrated its second anniversary and the achievement of full operating capability on October 2, 2015. Assistant Secretary of Defense for Health Affairs, Dr. Jonathan Woodson, stated:

The readiness of the force is of paramount responsibility. As we go forward into the future . . . we have to achieve greater jointness and efficiency for sustainability . . . enable our service [surgeons general] to present medically ready forces and medical forces to the service chiefs and combatant commanders. No single service in the future will have all of the capabilities that are necessary . . . to support combatant commanders.<sup>43</sup>

#### Professional Body of Knowledge Identified Requirements

Transformation for the medical arm of the DOD will most certainly mean looking at the new environment in which the military health system operates and taking

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<sup>42</sup> Carter, “Planning for Reform of the Governance of the Military System.”

<sup>43</sup> Shannon Collins, “Defense Health Agency Achieves Full Operating Capacity,” *DoD News*, October 2, 2015, accessed May 1, 2017, [https://www.defense.gov/News/Article/Article/621722/defense-health-agency-achieves-full-operating-capability/keepThis/true/TB\\_iframe/true/height/650/width/800/?caption=DoD+News+Feed](https://www.defense.gov/News/Article/Article/621722/defense-health-agency-achieves-full-operating-capability/keepThis/true/TB_iframe/true/height/650/width/800/?caption=DoD+News+Feed).

responsive action in order to implement change for the greater good of the DOD.<sup>44</sup> Transformation will radically alter the way we fight and the speed at which we can support significant combat with casualties, thus requiring the capability to provide combat casualty care more quickly than in the past. Care for early casualties is critical to the success of operations thus becoming the center of gravity—the source of power that provides moral or physical strength, freedom of action, or will to act. The friction of war causes forces to develop redundancies and ad hoc capabilities that may not seem efficient. For this reason the medical support construct must be carefully reevaluated. Despite our vast improvements in medicine and our ability to save lives in combat, the uncertainty and friction of war that Clausewitz emphasized has not been abolished and never will be right.<sup>45</sup>

A “four-star medical force commander” would lead the model of governance.<sup>46</sup> The model of governance will “remove all manner of inter-service administrative impedimenta that . . . go through the several levels of command and administration through the Service chiefs down to the medical departments” in order “to find out if support of the kind . . . might be available, either right now or in the future for planning purposes, let alone trying to actually get names and faces assembled and en route to his

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<sup>44</sup> Bruce W. McVeigh, “A Joint Medical Command--Is It Needed to Enhance Medical Interoperability in the Modern Warfight” (Paper, Naval War College, Newport, RI, May 2006), 2.

<sup>45</sup> Ibid.

<sup>46</sup> David A. Lane, “The Military Health Systems: Separate but Equal,” *Joint Force Quarterly*, no. 44 (1st Quarter, January 2007), 90, accessed May 13, 2017, <http://ndupress.ndu.edu/portals/68/Documents/jfq/jfq-44.pdf>.

area of need, as well as spending time figuring out who's paying for it.”<sup>47</sup> “The Service Surgeons General would cease to exist in their present form . . . to reduce redundancy, improve resource allocation and management, and overlay each military functional vice service specific organizational structure.”<sup>48</sup> The service surgeons general retain their responsibility for advising their respective secretary and chief on the medical readiness of their force. The medical command would have Title X responsibilities and support the Combatant commanders.<sup>49</sup>

The model “would have overall [combatant commander's] vision and authority to plan, prioritize, and deploy the necessary assets”<sup>50</sup> and the “professional, centralized source would have both the oversight and the insight to further balance and enhance the package . . . providing a tailor-made solution . . . based on the mission requirements.”<sup>51</sup> “With complete control of the assets, it is much easier and quicker to prioritize the

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<sup>47</sup> Paul E Casinelli, “The Joint Medical Command: Boon or Bane for the Supported CINC?” (Paper, Naval War College, Newport, RI, May 2001), 7.

<sup>48</sup> Dennis D. Doyle, “Tri-Service Medical Transformation—Time for a Unified Military Medical Command (USAMEDCOM)” (Strategy Research Project, U.S. Army War College, Carlisle Barracks, PA, April 2003), 14.

<sup>49</sup> Kelvin B Owens, “Transformation of the Military Health System” (Strategy Research Project, U.S. Army War College, Carlisle Barracks, PA, January 2006), 8.

<sup>50</sup> Rey Conard, “A Joint Medical Command and Transformation” (Paper, Naval War College, Newport, RI, May 2003), 13.

<sup>51</sup> Casinelli, “The Joint Medical Command,” 8.

requests”<sup>52</sup> and “be able to mass the health services assets more quickly by having an overview of all the military medical assets available.”<sup>53</sup>

“The new structure should be founded on a regional basis that supports the Unified Command Plan (UCP) geographic areas of responsibility rather than simply maintaining an air, sea and land medical component configuration”<sup>54</sup> In this model, the command 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.”<sup>55</sup> Furthermore, this model of governance “would [allow the medical commander to] exercise command and control of all medical forces and resources through subordinate regional medical commanders”<sup>56</sup>

The regional medical commander would “maintain responsibility and accountability for both peacetime and wartime health care delivery and readiness throughout his area of responsibility”<sup>57</sup> This regional medical command “enhances the ability of the combatant commander to ensure medical readiness and support to the forces and all DOD beneficiaries during the full spectrum of operations”<sup>58</sup> A “regional medical

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<sup>52</sup> Ibid.

<sup>53</sup> Conard, “A Joint Medical Command and Transformation,” 13.

<sup>54</sup> Doyle, “Tri-Service Medical Transformation,” 14.

<sup>55</sup> Lane, “The Military Health Systems,” 94.

<sup>56</sup> Doyle, “Tri-Service Medical Transformation,” 14.

<sup>57</sup> Ibid.

<sup>58</sup> Owens, “Transformation of the Military Health System,” 11.

commander with total visibility of available resources . . . facilitates formal resource sharing agreements between subordinate field organizations and fixed treatment facilities within his area”<sup>59</sup> This command would serve as “a single point of contact for health services in the theater and provide potential economies of scale savings through consolidation,”<sup>60</sup> “facilitate the use of military medical assets by a geographic commander,”<sup>61</sup> and most importantly, “be available for integrated joint planning by the geographic combatant commanders and the other commands.”<sup>62</sup>

The theater medical command would “streamline medical support,”<sup>63</sup> “ensure unity of command,”<sup>64</sup> “increase responsiveness to operational requirements,”<sup>65</sup> “add flexibility in tailoring medical units to the task,”<sup>66</sup> and “enhance our ability to cross-level capability.”<sup>67</sup> “Assets from one area of the . . . theater of operations or . . . another theater

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<sup>59</sup> Doyle, “Tri-Service Medical Transformation,” 14.

<sup>60</sup> Ibid.

<sup>61</sup> Conard, “A Joint Medical Command and Transformation,” 12.

<sup>62</sup> Ibid., 13.

<sup>63</sup> Godfrey, “A Unified Medical Command,” 14.

<sup>64</sup> Ibid.

<sup>65</sup> Ibid.

<sup>66</sup> Ibid.

<sup>67</sup> Ibid.

can be used to supplement . . . HSS elements and immediately be effective, without any need for equipment familiarization or reworking.”<sup>68</sup>

The joint medical command would assume direction of all reserve medical forces. These forces would be allocated to each theater medical command in order to increase available resources. The “seamless integration of the reserve medical forces into the active component” to “[synchronize] . . . training schedules . . . the depth of personnel . . . the appropriate mix of personnel, or ‘package’ would be assembled, whether for routine backfill or even to complement the Theater Engagement Plan (TEP).”<sup>69</sup>

The theater command would allow “a coordinated system of medical readiness exercises” that “can not only build good will in his theater, but can actually improve the level of medical readiness of our allies.”<sup>70</sup> “Properly coordinated medical missions in both the civilian and military sectors, executed within the construct of the TEP, will greatly improve the scope and effectiveness of . . . TEP.”<sup>71</sup>

In order to create a greater level of interoperability the medical capabilities from the first responder capability to the theater hospitalization capability, “all levels of care are built out of common standard ‘building blocks’ or modules. Support packages of increasing capability are built out of combinations of these modules to fit the medical

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<sup>68</sup> Casinelli, “The Joint Medical Command,” 10.

<sup>69</sup> Ibid., 12.

<sup>70</sup> Ibid.

<sup>71</sup> Ibid., 13.



mission. Should a module be destroyed, lost, or depleted, another of the same module can be sent to replace it (this includes the personnel who man the module).”<sup>72</sup>

Training would become more centralized. “With standardized training and procedures all HSS personnel would know how to handle all administrative actions and all procedures from road marches to theater medical evacuation, no matter to which Service component medical unit they were assigned.”<sup>73</sup> “After enlisted basic training at any service’s basic training station” personnel “would lose any semblance of service specific affiliation and instead be fully integrated into the USMEDCOM during their advanced individual training or officer basic course.”<sup>74</sup>

“Military medical culture must take the time to expose medics to all service specific tasks and demand common protocols and standards in execution.”<sup>75</sup> “The slogan ‘train as you fight’ is also true for a new bumper sticker, and that is ‘train as you treat.’ The medics and medical technicians in DOD operate in a joint environment.”<sup>76</sup> “DOD must transition to medics as an integrated system and not a single minded section of one type of service.”<sup>77</sup>

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<sup>72</sup> Ibid., 10.

<sup>73</sup> Ibid.

<sup>74</sup> Doyle, “Tri-Service Medical Transformation,” 15.

<sup>75</sup> Darlene A. McCurdy, “Beyond Joint Medical Training” (Strategy Research Project, U.S. Army War College, Carlisle Barracks, PA, March 2012), 11.

<sup>76</sup> Ibid., 18.

<sup>77</sup> Ibid.

“For real world missions and interoperability, we must teach Air Force medics to load a ground ambulance, Army medics to transfer a patient onto a ship for treatment or evacuation, and a Navy Corpsman to evacuate a casualty by loading a litter on a UH-60 MEDEVAC.”<sup>78</sup> “We can’t teach every possible battle field scenario, but we must teach our medics the basic medical treatment and evacuation protocol across all services. The goal is to know the algorithms and react instinctively in combat, every minute counts.”<sup>79</sup>

For ease of logistical support and standardization the joint medical command should be implemented. Joint medical logistics would “lead to cost savings through the economies of scale”<sup>80</sup> and “save money by ending needless duplication.”<sup>81</sup> There would be savings generated by having a singular entity conducting contract services not only due to “volume bargaining, but the contracts would be reviewed by one agency instead of several across the DoD.”<sup>82</sup> A “centralized body responsible for planning and acquisition would . . . increase the flexibility of HSS, but also decrease response time, cost, and size of the logistics tail, to include maintenance requirements.”<sup>83</sup>

“All equipment would be budgeted for and bought . . . much the same as USSOCOM procures its own [specialized] equipment from its own independently

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<sup>78</sup> Ibid.

<sup>79</sup> Ibid.

<sup>80</sup> Conard, “A Joint Medical Command and Transformation,” 15.

<sup>81</sup> Ibid., 16.

<sup>82</sup> Casinelli, “The Joint Medical Command,” 8.

<sup>83</sup> Ibid., 10.

submitted budget” to “aid in the standardization of equipment, but overall it would increase the capability . . . through increased agility, flexibility, and speed of response, not to mention an ultimately decreased logistics tail” because “medical has its own separate class of supply (Class VIII) specifically to avoid the long lag times inherent in the normal supply system.”<sup>84</sup>

The joint command would “unite the responsibility for both health appropriations and medical manpower under one entity.”<sup>85</sup> “Resource allocation would be further enhanced by the incorporation of the DOD sizing model to compare workload with requirements across the force.”<sup>86</sup> The command would “evaluate the efficiency of the health care delivery system by region and redistribute personnel wherever needed based on this common, relevant operational picture and his future vision.”<sup>87</sup> Furthermore, “regional medical commanders would routinely (quarterly) justify their workload and productivity metrics against manpower and budget allocations” and “present an annual combat health service support plan, designed in concert with the theater operational plan.”<sup>88</sup> “Direct care providers would be recruited for the USMEDCOM and not for any

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<sup>84</sup> Ibid., 11.

<sup>85</sup> Doyle, “Tri-Service Medical Transformation,” 14.

<sup>86</sup> Ibid.

<sup>87</sup> Ibid.

<sup>88</sup> Ibid.

particular service”<sup>89</sup> and “Personnel management, to include promotion, education, and assignments, could be consolidated under the Deputy Surgeon General (Personnel).”<sup>90</sup>

A USMEDCOM “with its own budget would be more proactive in developing . . . plans and equipment . . . to be in synch with the DOD near term and future visions.” In order to “more efficiently and effectively support a geographic commander,” the regional medical commander will “[keep] a greater percentage of his people in theater and therefore truly being a force multiplier.” Furthermore, the commander will be “matching the communications and movement strategies and capabilities of the supported commanders.”<sup>91</sup> The Assistant Secretary of Defense (Health Affairs) (ASD (HA)) would establish policy and serve as the medical advisor to the Secretary of Defense.<sup>92</sup> The ASD (HA) would no longer submit the Defense Health Program Budget to the Services to execute medical care and training, except for Service unique requirements.<sup>93</sup>

### Globally Integrated Health Services

As defined in the *JCHS*, GIHS is “the strategic management and global synchronization of joint operational health services that are sufficiently modular, interoperable, and networked to enable the joint force commander to quickly and

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<sup>89</sup> Ibid., 15.

<sup>90</sup> Ibid.

<sup>91</sup> Casinelli, “The Joint Medical Command,” 11.

<sup>92</sup> Doyle, “Tri-Service Medical Transformation,” 14.

<sup>93</sup> Owens, “Transformation of the Military Health System,” 8.

efficiently combine and synchronize capabilities.”<sup>94</sup> GIHS will allow medical forces to mitigate their possible attrition by selectively aggregating and disaggregating capabilities across battlespace geometry that is no longer linear but more multidimensional.<sup>95</sup> The model of governance must be able to rapidly apply “the right medical capabilities . . . at the right place and right time.”<sup>96</sup> The model of governance within the GIHS will need to have the following capabilities: joint medical planning; joint theater directed coordination, synchronization, and medical situational awareness; medical mitigation of the environment; MTFs management; patient evacuation; patient management; joint medical leader development; medical intelligence coordination; joint medical research and development; medical logistics coordination and synchronization; and global health services networked.<sup>97</sup>

#### *National Security Strategy*

The 2015 *National Security Strategy* calls for the United States to “lead with purpose” as a “global force for good.”<sup>98</sup> The U.S. military is grounded in enduring national interests of “security of the United States, its citizens, and U.S. allies and partners” and “A rules-based international order advanced by U.S. leadership that

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<sup>94</sup> Joint Chiefs of Staff, *Joint Concept for Health Services (JCHS)*, 5.

<sup>95</sup> *Ibid.*, 6.

<sup>96</sup> *Ibid.*, 7.

<sup>97</sup> *Ibid.*, 19.

<sup>98</sup> Barrack H. Obama, *National Security Strategy* (Washington, DC: The White House, February 2015), 2.

promotes peace, security, and opportunity through stronger cooperation to meet global challenges.”<sup>99</sup> In order to advance these interests we must “allocate resources accordingly,” remember that “our resources will never be limitless,” and make “policy tradeoffs and hard choices.”<sup>100</sup> The U.S. *National Security Strategy* states “we will continue to insist on reforms and necessary investment in our military”<sup>101</sup> and this means our medical capabilities also.

*Quadrennial Defense Review—National Defense Strategy*

The 2014 *Quadrennial Defense Review* focuses on the future defense of the U.S. “by rebalancing our defense efforts in a period of increasing fiscal constraint.”<sup>102</sup> The 2014 *Quadrennial Defense Review* is focused on three initiatives: a defense strategy that protects and advances U.S. interests and sustains U.S. leadership; a description of the DOD’s responsible and realistic steps to rebalance major elements of the joint force given the changing environment; and an intent to rebalance in order to control internal cost growth that is threatening to erode our combat power in this period of fiscal austerity. The DOD placed a priority on protection of the All-Volunteer Force while working towards reform.

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<sup>99</sup> Ibid.

<sup>100</sup> Obama, *National Security Strategy*, 2.

<sup>101</sup> Ibid., 7.

<sup>102</sup> Department of Defense, *Quadrennial Defense Review* (Washington, DC: Government Printing Office, 2014), IV.

The national defense strategy in the *Quadrennial Defense Review* states, “we will preserve the expertise gained during the past ten years of counterinsurgency and stability operations in Iraq and Afghanistan . . . protect the ability to regenerate capabilities that might be needed to meet future demands . . . invest in new systems and infrastructure but also continue to develop innovative operational concepts that confound adversary strategies.”<sup>103</sup> The pillars of the defense strategy are: protect the homeland, build security globally, and project power and win decisively. The DOD is committed to identifying new presence paradigms to find creative, effective, and efficient ways to achieve goals and assist strategic decision-making. The DOD cites innovation as the “central line of effort.”<sup>104</sup>

#### *National Military Strategy*

The Chairman of the Joint Chiefs of Staff publishes the U.S. *National Military Strategy*, which in the 2015 version “describes how we will employ our military forces to protect and advance our national interests.”<sup>105</sup> We must be able to rapidly adapt to new threats while maintaining comparative advantage over traditional ones. Increasingly, success will depend on how well our military instrument can support the other instruments of power and enable our network of allies and partners. The 2015 *National Military Strategy* continues the call for greater agility, innovation, and integration. It

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<sup>103</sup> Ibid., 19.

<sup>104</sup> Ibid., VI.

<sup>105</sup> Joint Chiefs of Staff, *The National Military Strategy of the United States of America* (Washington, DC: The White House, June 2015), i.

reinforces the need for the U.S. military to remain globally engaged to shape the security environment and to preserve our network of alliances. “The U.S. Joint Force combines people, processes, and programs to execute globally integrated operations and achieve our National Military Objectives [NMO].”<sup>106</sup> The *National Military Strategy* provides an integrated approach composed of three National Military Objectives: to deter, deny, and defeat state adversaries; to disrupt, degrade, and defeat violent extremist organizations (VEOs); and to strengthen our global network of allies and partners. The U.S. military pursues these objectives by conducting globally integrated operations, implementing institutional reforms at home, and sustaining the capabilities, capacity, and readiness required to prevail in conflicts that may differ significantly in scope, scale, and duration. The U.S. requires a “military with the capacity, capability, and readiness to simultaneously defend the homeland; conduct sustained, distributed counterterrorist operations; and, in multiple regions, deter aggression and assure allies through forward presence and engagement.”<sup>107</sup>

“If deterrence fails, at any given time, our military will be capable of defeating a regional adversary in a large-scale, multi-phased campaign while denying the objectives of . . . another aggressor in a different region.”<sup>108</sup> In an effort to disrupt VEOs, the military is “widely distributing U.S. military forces and leveraging globally integrated

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<sup>106</sup> Ibid., 13.

<sup>107</sup> Ibid., 6.

<sup>108</sup> Ibid.



command and control processes to enable transregional operations.”<sup>109</sup> We must “preserve our alliances, expand partnerships, maintain a global stabilizing presence, and conduct training, exercises, security cooperation activities, and military-to-military engagement”<sup>110</sup> in order to “increase the capabilities and capacity of partners, thereby enhancing our collective ability to deter aggression and defeat extremists.”<sup>111</sup>

The ability to quickly aggregate and disaggregate forces anywhere in the world is the essence of global agility. We are striving to increase our agility by improving campaign planning, sustaining a resilient global posture, and implementing dynamic force management processes that adjust presence in anticipation of events, to better seize opportunities, deter adversaries, and assure allies and partners.

#### *Capstone Concept for Joint Operations*

The *Capstone Concept for Joint Operations* was developed to serve as a guide for the development of Joint Force 2020 and describes potential operational concepts to defend the nation against a wide range of security challenges.<sup>112</sup> The security environment is characterized by: the proliferation of weapons of mass destruction, the rise of modern competitor states, violent extremism, regional instability, transnational

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<sup>109</sup> Ibid., 8.

<sup>110</sup> Ibid., 9.

<sup>111</sup> Ibid.

<sup>112</sup> Joint Chiefs of Staff, *Capstone Concept for Joint Operations: Joint Force 2020*, 1.

criminal activity, and competition for resources.<sup>113</sup> The joint force should utilize Globally Integrated Operations (GIO) to prepare only for the future security environment.<sup>114</sup> In order to accelerate and expand how the joint force musters decisive force, the *Capstone Concept for Joint Operations* identified eight elements of GIO but this paper refers to the following six: requires a commitment to the use of mission command; provide the ability to seize, retain and exploit the initiative in time and across domain; enable and are premised upon global agility; place a premium on partnering; provide for more flexibility in how joint forces are established and employed; and leverage future joint forces to better integrate and improve cross-domain synergy. Globally integrated operations will enable commanders to: cope with uncertainty, complexity and rapid change; improve their ability to tailor the force to the situation; aid their ability to scale military force as required; and help the lowest echelons to exercise initiative and coordinate locally while maintaining broader situational awareness.<sup>115</sup> GIO will allow stakeholders to bring differing perspectives and capabilities to bear on complex challenges.<sup>116</sup> Finally, enhancing military effectiveness, as the U.S. forces grow smaller, will allow for better stewardship of fiscal resources as we defend the nation and its interests.<sup>117</sup>

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<sup>113</sup> Ibid., 2.

<sup>114</sup> Ibid., 4.

<sup>115</sup> Ibid., 8.

<sup>116</sup> Ibid.

<sup>117</sup> Ibid.

### *Joint Concept for Health Services*

The *JCHS* describes the provision of health-care services in support of Globally Integrated Operations (GIO) to joint forces.<sup>118</sup> GIO will place stress upon the joint force's ability to provide health services for deployed forces and mission partners.<sup>119</sup> The *JCHS* applied lessons learned from recent combat experiences propose a joint concept to shape future solutions to the health care challenges the joint force will face when conducting GIO.<sup>120</sup> The *JCHS* states that "To take advantage of these insights, the Department of Defense must better synchronize policies, procedures, and investments in health services to sustain the current quality of care while ensuring the joint force can support GIO."<sup>121</sup>

### *Military Doctrine*

Joint Publication 4-02 states that health service support in joint operations is "conducted as part of an interrelated military health system that shares medical services, capabilities, and specialists among the service components and partners with multi-agencies and nations to implement a seamless unified health delivery effort within joint command and control (C2)."<sup>122</sup> "Although the MHS is an interrelated system which may share medical services, capabilities, and specialties among the U.S. service components, it is not a joint mission command system. Each service component develops its medical

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<sup>118</sup> Joint Chiefs of Staff, *Joint Concept for Health Services (JCHS)*, 1.

<sup>119</sup> *Ibid.*

<sup>120</sup> *Ibid.*

<sup>121</sup> *Ibid.*

<sup>122</sup> Joint Chiefs of Staff, Joint Publication 4-02, I-1.

resources to support its service-specific mission. This results in the development of different types of organizations with varying levels of capability, mobility, and survivability. Although joint medical resources may have similar nomenclature to describe the unit, they are not usually interchangeable.”<sup>123</sup>

A Joint Force Surgeon (JFS) is appointed for each combatant command, subunified command and joint task force. He is a staff member with no assigned forces. The JFS establishes relationships with theater MTF commanders and others who exercise command authority over medical forces to synchronize activities. The JFS is supported by a staff that should be “reasonably balanced in experience and rank among the services concerned and should be of sufficient size to effectively coordinate support.”<sup>124</sup> The JFS supported by the staff coordinate:

1. Joint health service support (HSS) and force health protection (FHP) initiatives;
2. Deployment health surveillance;
3. HSS and FHP operations that sustain collaborative joint planning;
4. Standardization and interoperability of medical capabilities and materiel;
5. Development of the medical plan and course of action analysis;
6. Review of subordinate plans and operations;
7. Joint coordination of intratheater patient movement;
8. Reachback support;

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<sup>123</sup> Ibid., 1-02.

<sup>124</sup> Joint Chiefs of Staff, Joint Publication 4-02, II-1.

9. HSS and FHP planning and operations to include: hospitalization; patient movement; service component transportation assets; medical logistics (MEDLOG) support; blood management; intelligence support to joint health operations; preventive medicine (PVNTMED), medical surveillance, and intelligence; patient area reception; medical aspects of reintegration; impacts of the law of war and medical ethics; medical aspects to support personnel recovery; and medical repatriation of partner nations; and

10. The collection of medical lessons learned data that provides operational documentation and results in recommendations for change to current plans and policy.

All services share the need for the same military medical capabilities: first responder capability; forward resuscitative care capability; theater hospitalization capability; definitive care capability; and en route care capability (patient movement from point of injury through successive capabilities of care to MTF) (see figure 3).

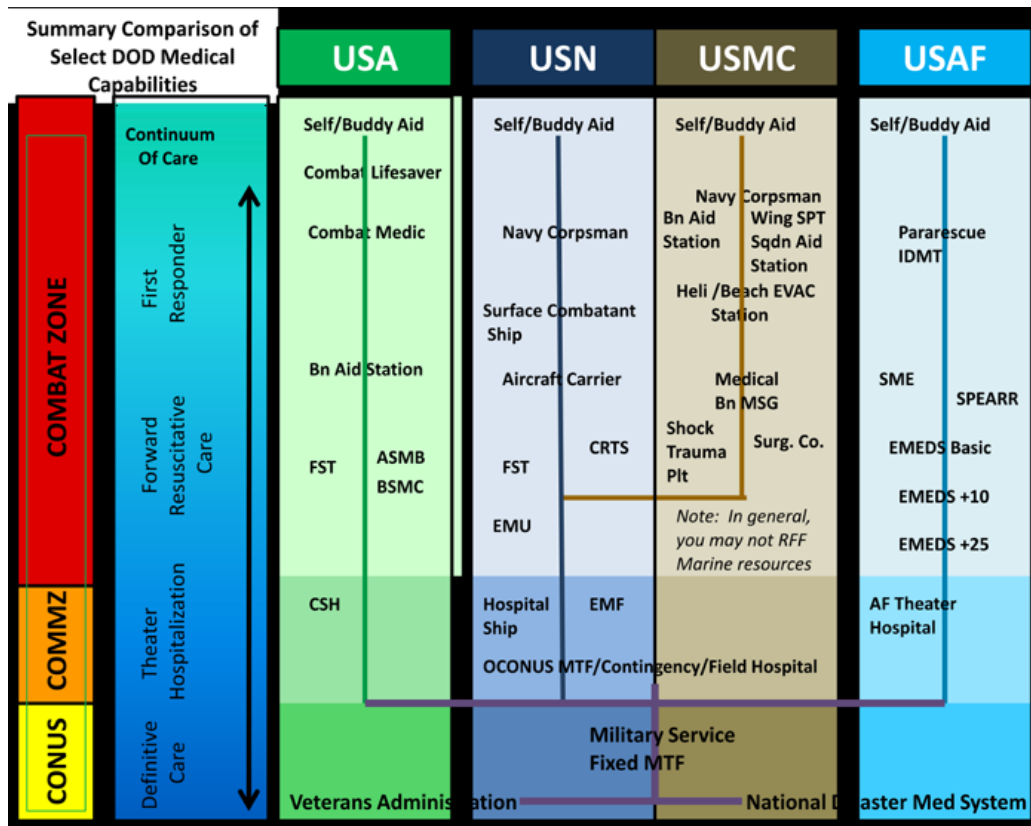


Figure 3 Summary Comparison of US Medical Capabilities

Source: Defense Medical Readiness Training Institute, "JOMMC Handbook Version 14.0" (Joint Operations Medical Managers Course (JOMMC), JBSA, Sam Houston, TX), 46.

Each of these elements is ultimately geared to support the major combat unit of each service such as Army brigade combat teams (BCT); Marine Corps marine air ground task force (MAGTF); Air Force squadrons; and Navy aircraft carrier strike groups. Each service has some degree of medical mission command and first responder to theater hospitalization capability.

The Universal Joint Task List (UJTL) is developed by the joint staff for use by combatant commanders, subordinate joint force commanders, and functional or service

component commander. The UJTL is a list of “tasks in a common language, which serves as the foundation for joint operations planning across the range of military and interagency operations” and “supports DOD to conduct joint force development, readiness reporting, experimentation, joint training and education, and lessons learned.”<sup>125</sup> There are four levels of war of joint tasks:

1. Strategic-National: multiple theaters of war, headquarters (HQs) in the continental United States (CONUS);
2. Strategic-Theater: Theater of War Operations;
3. Operational: Theater of Operations or Joint Operational Area; and
4. Tactical: Area of Operations, battlespace

The levels of war are described by tasks organized around the major joint tasks performed at that level of war. The following is a list of UJTL subtasks required by the joint force:

1. Provide Patient Movement (SN 1.2.8): Evacuate injured and sick personnel with appropriate en route care;
2. Provide Medical Intelligence (MEDINT) (SN 2.2.3.5): Produce medical intelligence (MEDINT) resulting from collection, evaluation, analysis, and interpretation of foreign medical, bio-scientific, and environmental information;

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<sup>125</sup> Joint Chiefs of Staff, *Joint Mission Essential Task List (JMETL) Development Handbook* (Washington, DC: Government Printing Office, September 2002), 18.

3. Supply Medical Materiel (Class VIII) (SN 4.12.4): Maintain the necessary level and duration of medical (Class VIII) supplies and services to achieve national and multinational objectives;

4. Coordinate Health Services (SN 4.3.3): Coordinate medical health services that promote, improve, conserve, and restore the mental and-or the physical well-being and performance of individuals and-or groups;

5. Coordinate Health Service Support (HSS) (ST 4.2.2): Coordinate health service support (HSS) including, but not limited to, first responders, forward resuscitative surgery, theater care, en route care, preventive medicine, mental health, dental, and veterinary services, in preparing and sustaining theater forces;

6. Coordinate Patient Movement (ST 4.2.2.2): Coordinate the movement of patients within and from theater. Designate MTFs by matching existing medical capabilities with reported patient needs; scheduling and arranging movement of DOD patients and authorized beneficiaries; establishing procedures regulating the evacuation of patients; determining eligibility for others, such as United Nations (UN) personnel and foreign national; and making special arrangements for enemy prisoners of war (POW);

7. Manage Medical, Dental, and Veterinary Services and Laboratories (ST 4.2.2.3): Provide medical, dental, and veterinary services programs;

8. Coordinate Medical Surveillance (ST 4.2.2.4): Implement a military medical surveillance program that includes collection and analysis of health status and threat information;



9. Conduct Patient Evacuation (OP 1.6): Conduct patient evacuation and provide transportation of patients by any means to enhance the capability of medical care;

10. Provide Health Services (OP 4.4.3): Perform, provide, or arrange all services to promote, improve, conserve, and-or restore the mental or physical well-being of personnel;

11. Manage the Joint Blood Program (OP 4.4.3.1): Plan and coordinate the handling, storage, and distribution of whole blood and consolidate and forward resupply requirements;

12. Manage Medical Evacuation (MEDEVAC) (OP 4.4.3.2): Organize and control the medical evacuation (MEDEVAC) system; and

13. Manage Health Services Resources in the Joint Operations Area (JOA) (OP 4.4.3.3): Manage the joint operations area (JOA) medical resources to provide effective and consistent treatment of wounded, injured, or sick personnel so as to return to full duty or evacuate from the JOA.

### Chapter Summary

The literature review focused on earlier transformation of the MHS. Transformation that resulted in the establishment of the DHA. The review of the documents leading up to, as well as the analysis of the MHS governance transformation, provide the foundation for a future organization within the DOD. The DOD will have to conduct a thorough analysis of the required capabilities, which will then guide the design of the overall governance of the MHS. Once the DOD has proven a concept to be effective, can the model of governance be instituted in the DOD organizational structure

via a transformation of armed forces. To reduce cognitive bias, the researcher conducted the literature review by analyzing literature produced by other members of the professional body that are more senior and with different experiences. The review analyzed previous attempts at Military Health System transformation and the documentation regarding those.

## CHAPTER 3

### RESEARCH METHODOLOGY

#### Purpose of the Research and the Research Questions

In order to answer the primary research question, three secondary questions were developed. Each secondary question will be answered in chapter 4 after research and analysis based upon an applied professional case study method. The sources used were national strategic documents, doctrine, concepts, studies, publications, and additional sources.

#### Research Methodology

In his presentation during proceedings of the Forty-Third Annual Conference of the Association for Business Simulation and Experiential Learning (ABSEL), Dr. Kenneth Long (2016), Command and General Staff Officer Course Department of Logistics and Resource Operations (DLRO) instructor, describes the practical application of the case study method within the Masters of Military Arts and Science (MMAS) program over a five-year period. He provides a set of critical decisions that can guide a case study design to satisfy the purpose of either informing or persuading policy decision makers.<sup>126</sup> By addressing each of the key points of that design model the MMAS case study makes a systematic, consistent and aligned argument for the research design.<sup>127</sup> The method used for this research was applied professional case study methodology. This

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<sup>126</sup> Long, “Case Studies in Action.”

<sup>127</sup> Ibid.

study began with the researcher's professional opinion regarding the initial overall model of governance (R1). After examination through a literature review and CBA analysis—the analysis portion of the Joint Capabilities Integration and Development System (JCIDS) process that provides materiel or non-materiel solutions for an identified capability gap that meets an established capability need, the researcher provided revised professional opinion (R2) and stakeholder analysis resulted in an improved final recommendation (R3) that will go to the chief decision maker (CDM). The conceptual R1, R2, R3 construct acknowledges that professionals have opinions formed from experience, education and reflection, and that these opinions are informed by the body of knowledge and evolve through time and through research. The stakeholder analysis requires the researcher to step out of his perspective and examine his R2 proposal from different professional viewpoints, and provides evidence to examine to make sure that the research was not done as a way to reinforce original bias and opinion. This stakeholder analysis is part of the professional process, because CDMs will insist that the perspectives of those affected by proposals must be incorporated into any study.

### Criteria

Within the Joint Operational Planning Process (JOPP), joint forces test the validity of tentative courses of actions and reject all tentative courses of action that do not meet all of the following criteria: adequate, feasible, acceptable, distinguishable, and complete. The researcher posits the criteria of adequate, acceptable and feasible against the models of governance for the MHS in order to analyze them through the lens of various stakeholders whom the changes may affect. An adequate model will “accomplish the

mission within the commander's guidance."<sup>128</sup> A feasible model will "accomplish the mission within the established time, space, and resource limitations."<sup>129</sup> An acceptable model will "balance cost and risk with the advantage gained."<sup>130</sup>

### Process

This research is an applied qualitative professional case study with a modified CBA that takes into account the professional body of knowledge. The product of the CBA is a non-materiel approach, with DOTMLPF-P.<sup>131</sup>

The model of governance was analyzed through the lens of the Joint Capabilities Integration and Development System (JCIDS) CBA in order to ensure that it is communicated in actionable plans that adhere to joint processes. Prior to 2008, the CBA consisted of three sequential components: the Functional Area Analysis (FAA), the Functional Needs Analysis (FNA), and the Functional Solutions Analysis (FSA). In 2008, the CBA was revised because "phases created artificial decision points" and "to use the CBA to both identify gaps and help advise which particular gaps require action . . . not attempt to dictate detailed solutions."<sup>132</sup> The researcher chose to utilize the pre-2008

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<sup>128</sup> Joint Chiefs of Staff, Joint Publication 5-0, *Joint Operation Planning* (Washington, DC: Government Printing Office, 2011), IV-24.

<sup>129</sup> Ibid.

<sup>130</sup> Ibid.

<sup>131</sup> Joint Chiefs of Staff, *Capabilities-Based Assessment (CBA) User's Guide* (Washington, DC: Government Printing Office, 2009), 9.

<sup>132</sup> Ibid.

version because it provides clearly delineated steps that have clearly defined outputs. This study will use the FAA, FNA, and FSA in order to access the recommended models to determine the appropriate model that meets the capability needs outlined in *JCHS*. Using the national strategies, the *Capstone Concept for Joint Operations*, and the *JCHS*, the FAA “arrives at a prioritized list of capabilities . . . that must be accomplished . . . to achieve these military objectives.”<sup>133</sup>

The first analytical phase of the CBA process is the Functional Area Analysis (FAA) in order to determine the operational tasks, conditions, standards to meet the objectives outlined in strategic documents. FAA describes how the force will operate, the timeframe and environment in which it must operate, its required capabilities (in terms of missions and effects), and its defining physical and operational characteristics.

The second phase of the CBA process is the FNA and assesses “capabilities of the current and programmed” models of governance to identify “if there is a capability gap,” “overlaps or redundancies,” and to “characterize [the] capability gaps” to meet objectives identified in the FAA.<sup>134</sup> The primary input in the FAA and the output analysis create a list of capability gaps, redundancies, shortfalls, and an estimate of the timeframe in which a solution is required.

The last phase of the CBA is the FSA. It is “the operationally based assessment of potential doctrine, organization, training, materiel, leadership and education, personnel, facilities and policy (DOTMLPF-P) approaches to solving one or more of the capability

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<sup>133</sup> AcqNotes, Home Page, accessed May 14, 2017, <http://www.acqnotes.com>.

<sup>134</sup> Ibid.

gaps identified in the FNA.”<sup>135</sup> For the purpose of this research, the potential solution was evaluated only for doctrine, organization, leadership and education, and policy changes within the DOTMLPF-P approach. The solutions were further tested for acceptability through the following criteria: adequacy, feasibility, and acceptability.

### Stakeholders

In chapter 4, the initial position (R1) will be evaluated through the lenses stakeholders to produce the informed position (R2). Stakeholders are identified as:

1. Tactical Stakeholders: prioritize mission support in a unique environment with full acknowledgement of service unique requirements;<sup>136</sup>
2. Operational Stakeholders: prioritize interoperability, shared common operating picture, common practices, and the flexibility to reallocate interchangeable assets in response to shifts in campaign priorities;<sup>137</sup>
3. Strategic Stakeholders: value deployability, adaptability, definitive care placed at strategic locations to support warfighters, support to long-term holistic needs and Title X (recruiting, organizing, supplying, equipping, training, servicing, mobilizing, demobilizing, administering, maintaining and construction of the force) compliance;<sup>138</sup> and

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<sup>135</sup> Ibid.

<sup>136</sup> Kenneth E. Long, e-mail message to author, March 27, 2017.

<sup>137</sup> Ibid.

<sup>138</sup> Ibid.

4. Political Stakeholders (CDM): value cost-saving, efficiency, readiness, decreased headquarter size, reduced number of GO—FO. The key concerns of Congress can be expressed in the recent words of the House and Senate, “that a single agency . . . would best improve and sustain operational medical force readiness and the medical readiness of the armed forces . . . the current organizational structure . . . paralyzes rapid decision-making and stifles innovation in producing a modern health care delivery system.”<sup>139</sup>

Analysis of the stakeholder positions and expectations will result in the final recommended position (R3); a position that has been evaluated through the lens of the stakeholders and the chief decision maker (CDM).

### Chapter Summary

This chapter provides the background and description of the applied professional case study methodology used by the researcher to answer the primary and secondary research questions. The intent of this applied professional case study research methodology is to analyze the models identified by the researcher in order to recommend a singular model supported by evidence and analysis, that the DOD can implement. Using the lenses of CBA and DOTMLPF-P ensures that the final recommendations are submitted in terms that make sense to congressional decision makers in the House and Senate Armed Services Committees. Finally, each model is considered from the viewpoint of various stakeholders affected by the changes to ensure the validity of the

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<sup>139</sup> Serbu, “Defense Health Agency Poised for Huge Growth Under Just-Passed Defense Bill.”



recommendations. This process ensures a thorough analysis of each recommendation in an effort to arrive at valid solutions to current capability gaps in the MHS. Finally, this chapter lays out the framework used for Analysis, chapter 4.

## CHAPTER 4

### ANALYSIS

#### Introduction

The purpose of this study is to determine what the basic requirements for the model of overall governance for the Military Health System (MHS) should be. Per the *JCHS*, a globally integrated health system has to be capable of “the strategic management and global synchronization of joint operational health services that are sufficiently modular, interoperable, and networked to enable the Joint Force Commander to quickly and efficiently combine and synchronize capabilities.”<sup>140</sup>

The purpose of this chapter is to first answer the secondary questions through the analysis of the literature review presented in chapter 2. Then, the Initial Personal Recommendation (R1), introduced in chapter 1, will be evaluated with consideration to analysis of the literature review and according to the Research Model presented in chapter 3.

#### What Capabilities were Identified in the last major Transformation of the MHS?

The criteria identified in the 2011 study, to determine the overall governance of the MHS, are still applicable today. This criteria was a combination of the original Terms of Reference supplied in the memorandum from the Secretary of Defense (SECDEF) references, and additional criteria from the task force. The Defense Health Agency was a

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<sup>140</sup> Joint Chiefs of Staff, *Joint Concept for Health Services (JCHS)*, ii.

product of this research and still considered the standard in evidence by the NDAA 2017. The NDAA 2017 gave more of a management role of day-to-day operations of the medical treatment facilities to the DHA by placing the MTFs under their direct leadership. For that reason, these criteria remain a good starting point for all future study and analysis:<sup>141</sup>

1. Sustain a medically ready Active Duty—Reserve Component through high quality integrated health care;
2. Maintain a trained and ready deployable medical force;
3. Provide high quality, integrated medical care to non-Active Duty—Reserve Component beneficiaries;
4. Achieve significant cost savings through reduction in duplication and variation;
5. Afford dispute resolution process and clear decision authority with clear accountability;
6. Offer ease of implementation; and
7. Enhance interoperability.

What Capabilities are needed by the MHS in or due to Support National Strategic Documents?

United States enduring national interests provide the framework for the military to develop national security interests (NSIs) in order to prioritize its missions. Military services are then able to provide recommendations regarding the type and degree of military force required to defend our nation, at what cost and at what risk?

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<sup>141</sup> Department of Defense, *Task Force on Military Health System Governance*, 3.

The national military objectives are the pillars to the integrated approach proffered in the *National Military Strategy*. These objectives are achieved through globally integrated operations, institutional reforms, and the sustainment of capabilities, capacity, and readiness in order to win our nations wars. The 2014 *Quadrennial Defense Review* called for the military through capacity, capability, and readiness to be able to simultaneously defend the homeland; conduct sustained, distributed counterterrorist operations; and, in multiple regions, deter aggression and assure allies through forward presence and engagement. If and when deterrence fails, the military has to be able to fight a large-scale, multi-phased campaign with actors in one region while defeating another aggressor in another region. The ultimate duty of the military is to be able to provide forces that can fight multiple conflicts. To do this will require a MHS that can support that need.

In order to be able to support these types of globally integrated operations, the *JCHS* called for globally integrated health services to provide strategic management and global synchronization of joint operational health services that are sufficiently modular, interoperable, and networked and that can quickly and efficiently combine and synchronize capabilities. This will be important if the other instruments of war—diplomacy, information, and economic—fail to deter adversaries. the future organizational design of governance for the MHS should be to provide: joint medical planning; joint theater directed coordination, synchronization, and medical situational awareness; medical mitigation of the environment; MTFs; patient evacuation; patient

management; joint medical leader development; medical intelligence; joint medical research and development; medical logistics; and global health services network.<sup>142</sup>

What MHS Capabilities and Tasks  
are Identified in Doctrine?

The basic mission of the MHS in an operational environment is to foster, protect, sustain, and restore health. Mission essential tasks in accordance with the Joint Publication 4-02 that support the mission of MHS are:

1. Joint HSS and FHP initiatives;
2. Deployment health surveillance;
3. HSS and FHP operations that sustain collaborative joint planning;
4. Standardization and interoperability of medical capabilities and materiel;
5. Development of the medical plan and course of action analysis;
6. Review of subordinate plans and operations;
7. Joint coordination of intratheater patient movement;
8. Reachback support; and
9. HSS and FHP planning and operations.

These tasks were further codified by the universal joint task list (UJTL) tasks. The UJTL tasks are the tasks that a joint forces commander must ensure that they are able to conduct during their mission. The UJTL tasks are:

1. Provide Patient Movement (Strategic National 1.2.8);
2. Provide Medical Intelligence (MEDINT) (Strategic National 2.2.3.5);

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<sup>142</sup> Joint Chiefs of Staff, *Joint Concept for Health Services (JCHS)*, 19.

3. Supply Medical Materiel (Class VIII) (Strategic National 4.12.4);
4. Coordinate Health Services (Strategic National 4.3.3);
5. Coordinate Health Service Support (HSS) (Strategic Theater 4.2.2);
6. Coordinate Patient Movement (Strategic Theater 4.2.2.2);
7. Manage Medical, Dental, and Veterinary Services and Laboratories (Strategic Theater 4.2.2.3);
8. Coordinate Medical Surveillance (Strategic Theater 4.2.2.4);
9. Conduct Patient Evacuation (Operational 1.6);
10. Provide Health Services (Operational 4.4.3);
11. Manage the Joint Blood Program (Operational 4.4.3.1);
12. Manage Medical Evacuation (MEDEVAC) (Operational 4.4.3.2); and
13. Manage Health Services Resources in the Joint Operations Area (JOA) (Operational 4.4.3.3).

What MHS Capabilities are Identified in  
the Professional Body of Knowledge?

The professional body of knowledge analyzed during the research had common themes. The literature addressed four versions of governance: as is, dual command, unified command and single service. The unified command—a command, with a broad continuing mission, composed of significant components of two or more services under a single commander with the services retaining Title X functions and responsibilities—model of governance was the predominate model chosen throughout the research. It was determined that a four-star general should be the commander. The professional body of knowledge introduced the theater medical command as a means to provide direct support

to the GCC. The theater medical commander serves as the much-needed face of medicine, unlike the joint force surgeon (JFS), that can advise the joint force commander and provide planned and emergent medical capabilities.

### Application of the Research Model

In this section, the initial personal recommendation (R1) of a single service model of governance equivalent to the Army, Navy, and Air Force will be evaluated through the national strategic documents in terms of national interests, military objectives, transformation criteria, and current joint capabilities and tasks that the author reviewed in chapter 2.

Evaluation of R1 begins through the lens of the national military objectives. The first objective—Deter, deny, and defeat state adversaries—can be achieved based upon R1. The MHS still provide the force with the required medical capabilities but at a faster rate due to the removal of the impedimenta of having to ask multiple services for resources that are not currently in theater. The second objective—Disrupt, degrade, and defeat violent extremist organizations—can be achieved by R1 as described in the first objective. The third objective—Strengthen our global network of allies and partners—would be less effective with R1. R1 would maintain our current level of support to build capacity of our allies and partners because we do not have a theater level medical commander with assigned medical capabilities that could work with our partners and allies in order to increase the capacity and capability prior to conflict but most importantly to make them more self-sufficient. Therefore, with its design, R1 can achieve the first and second NMO completely but not the third.

Second, the *JCHS* identifies capabilities that need to be met in order to support the joint force. These capabilities support the three national military objectives. R1 with a combined headquarters that covers all of the combatant commanders is capable of joint medical planning, joint theater directed coordination, synchronization, medical situational awareness, medical mitigation of the environment, MTFs, patient evacuation, patient management, medical intelligence, and global health services network with each of the CCMDs but with a degree of difficulty. The span of control would be too great considering that each combatant command has its own unique plan and crises. Through R1 a single command would be responsible for joint medical leader development, joint medical research and development, and medical logistics. Having a location for all medical leaders to be educated would ensure that each understands all of the capabilities available to them in support of the force. Research and development conducted by a singular command would increase interoperability and drive cost savings through the development or usage of the same equipment and processes. This would give greater buying capacity to logistical contract services. The storage space needed to maintain materiel would be decreased due to this synchronized buying. Furthermore, materiel would more readily available due to a more accurate determination of usage based one version of product over time.

Third, the evaluation of R1 through doctrine requires that military personnel are cared for by applying prevention, protection and treatment capabilities. This is achieved by these five capabilities: first responder care capability, resuscitative care capability, theater hospitalization capability, definitive care capability, and en route care capability.



R1 is capable to conduct all of these required capabilities in support of the joint force. R1 has to be able to carry out these identified mission essential tasks:

1. Provide Patient Movement (SN 1.2.8),
2. Provide Medical Intelligence (MEDINT) (SN 2.2.3.5),
3. Supply Medical Materiel (Class VIII) (SN 4.12.4),
4. Coordinate Health Services (SN 4.3.3),
5. Coordinate Health Service Support (HSS) (ST 4.2.2),
6. Coordinate Patient Movement (ST 4.2.2.2),
7. Manage Medical, Dental, and Veterinary Services and Laboratories (ST 4.2.2.3),
8. Coordinate Medical Surveillance (ST 4.2.2.4),
9. Conduct and Manage Patient Evacuation (OP 1.6),
10. Provide Health Services (OP 4.4.3),
11. Manage the Joint Blood Program (OP 4.4.3.1),
12. Manage Medical Evacuation (MEDEVAC) (OP 4.4.3.2), and
13. Manage Health Services Resources in the Joint Operations Area (JOA) (OP 4.4.3.3).

R1 is capable of providing capabilities 1 through 4 (strategic-national) and capabilities 5 through 12 (strategic-theater and operational) with a limitation in execution. The size of the command needed to support all of these capabilities would be counterproductive and hard to control. R1 would deny the CCMDs a medical capability that is responsive to their individual needs.

## R2: Informed Recommendation

R2 is an informed recommendation derived from the evaluation of R1 in accordance with the Research Model presented in chapter 3. Furthermore, the researcher analyzed literature from various contributors in the field, with different approaches to the problem, to reduce the potential for cognitive bias. The first major concern with R2 would be the size of the command required to maintain all of the capabilities needed to support the CCMDs. Doctrinally, an effective leader can exercise control over a maximum of six subordinate elements. With R1, the medical commander would have to deal with all of the service chiefs and combatant commanders but we do violate and are still effective. Even though there are exceptions, it is a good planning factor. The informed recommendation allows a commander to exercise effective command and control, provide direct support to each combatant command, and decrease headquarter size. Therefore, the R2 informed recommendation is that the overall model of governance should be a single service provider. Regional medical commanders should be added to support each CCMD in a manner similar to the current service component commands within each CCMD.

## Chapter Summary and Conclusions

At first sight, there is no significant difference between R1 and R2. However, through the analysis, the author determined that R2 needs to add a theater regional commander. The main reason is that the regional command would “maintain responsibility and accountability for both peacetime and wartime health care delivery and

readiness throughout his area of responsibility”<sup>143</sup> to “[enhance] the ability of the combatant commander to ensure medical readiness and support to the forces and all DoD beneficiaries during the full spectrum of operations.”<sup>144</sup> This command would serve as “a single point of contact for health services in the theater and potential economies of scale savings through consolidation,”<sup>145</sup> “facilitate the use of military medical assets by a geographic commander,”<sup>146</sup> and most importantly, “be available for integrated joint planning by the geographic combatant commanders and the other commands.”<sup>147</sup>

Through the analysis, the author has established that the MHS with theater medical commands can achieve national military objectives that support national interests. Furthermore, it can successfully accomplish the MHS basic mission prescribed by the doctrine consistent with doctrinal span control principles.

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<sup>143</sup> Doyle, “Tri-Service Medical Transformation,” 14.

<sup>144</sup> Owens, “Transformation of the Military Health System,” 11.

<sup>145</sup> Doyle, “Tri-Service Medical Transformation,” 14.

<sup>146</sup> Conard, “A Joint Medical Command and Transformation,” 12.

<sup>147</sup> Ibid., 13.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

#### R3: Recommended Solution

R3 is the R2 evaluated through the lens of the chief decision maker and the stakeholders. The chief decision maker is congress and the stakeholders are the strategic, operational and tactical leaders. No fewer than one-third of the expressed powers in the constitution relate to the military. Article 1, Section 8 of the constitution gives congress the power “to raise and support armies . . . to make rules for the Government and Regulation of the land and naval forces . . . and to make all laws which shall be necessary and proper for carrying into Execution the foregoing Powers.” Congress has always been deeply involved in affairs concerning the nation’s armed forces, and has a legitimate role to play.<sup>148</sup>

When considered through the lens of the chief decision makers (CDM), the majority of the requirements identified in R2 are feasible, acceptable and-or suitable if joint is adequate; however, there is one requirement that is of concern—four-star rank of the commander. The NDAA 2017 contains a provision that would reduce the number of general and flag officers by 25 percent. The Senate Armed Services Committee (SASC) bill went further and called for a reduction from the current 41 four-star billets to 27. The four-star billets will be for “the Chairman, Vice Chairman, and other members of the Joint Chiefs of Staff, including the head of the National Guard Bureau; the Combatant

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<sup>148</sup> Frederick H. Black, “The Military and Today’s Congress,” *Parameters* (December 1987): 48.

Commanders; the Commander of U.S. Forces–Korea; one additional joint billet for which the President could nominate for advice and consent by the Senate an officer for a four-star joint command (such as the current mission in Afghanistan); and three additional four-star billets each for the Army, Navy, and Air Force to be filled as they choose.”<sup>149</sup>

Each stakeholder has a different perspective based on echelon of command and force employment. Through the lens of the strategic stakeholder—GCC—R2 would meet their needs: a medical advisor, designated medical units and MTFs, medical force pool to meet emergent needs.

Through the lens of the operational stakeholder—Joint Task Force—R2 does not discuss the same needs required by the GCC.

Through the lens of the tactical stakeholder—brigade or equivalent—R2 would still provide organic capabilities to the command that would be able to train and support.

Therefore, after evaluation through the lens of the CDM and the stakeholders, the R3 Recommended Solution is an overall model of governance that is equivalent to the services in command concept. The commander would be a lieutenant general and each service will still maintain a surgeon general. The current staffs would be decreased to a level that would be suitable to provide information to the service chief. The remainder of each staff would be redistributed throughout the medical command. Furthermore, each surgeon general would be dual-hatted as the director of a medical service line of care under the medical command.

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<sup>149</sup> U.S. Senate Armed Services Committee, *National Defense Authorization Act for Fiscal Year 2017*, accessed May 14, 2017, <http://www.armed-services.senate.gov/imo/media/doc/FY17%20NDAA%20Bill%20Summary.pdf>, 3.

The command would have a subordinate theater medical command commanded by a brigadier general. The theater medical commanders would also serve as the medical adviser to the combatant commanders. Each theater medical command would have three subordinate medical groups that are responsible for an area equivalent to one-third the size of the combatant command. The medical groups would serve as the commanders responsible for oversight of their respective area of operation (AO) and when identified will serve as a wartime medical advisor to a joint force commander.

In order to meet the needs of the tactical level commander, the current medical positions would remain but be coded joint to maintain current support relationships of each service. Furthermore, the command would be commanded by a brigadier general that is responsible for training and education, medical research, public health and medical materiel.

The R3 Recommended Solution implementation would be controversial because of service parochialism. It requires significant analysis and professional debate on how it effects changes in doctrine, organization, and leadership and education.

#### Recommendations for the Chief Decision Maker

Public Law 113-291 replaced the *Quadrennial Defense Review* with the *Defense Strategy Review (DSR)*. The *DSR* is a comprehensive examination of the “national defense strategy, force structure, modernization plans, posture, infrastructure, budget plan, and other elements of the defense program and policies of the United States with a view toward determining and expressing the defense strategy of the United States and

establishing a defense program”<sup>150</sup> by the Secretary of Defense in consultation with the Chairman of the Joint Chiefs of Staff.

The *DSR* is completed “every four years, during a year following a year evenly divisible by four”<sup>151</sup> and submitted to the Committees on Armed Services and the House of Representatives not later than March 1 of the following year. The *DSR* is to consist of three timeframes: near-term (associated with FYDP); mid-term (10 to 15 years); and far-term (20 years).

The following is a recommendation for an implementation plan to determine and activate a new overall model of governance for the MHS. The implementation should utilize the same timeframes as the *DSR* because the *DSR* will provide the CDM with “force size and structure, capabilities, posture, infrastructure, readiness, organization, and other elements of the defense program that would be required to execute the missions called for in the strategy” and “an assessment of the significant gaps and shortfalls between the force size and structure, capabilities, and additional elements.”<sup>152</sup>

Transition to a new overall model of governance would be conducted in three terms and each term divided into three phases. The phases are as follows:

1. The planning phase. This phase will begin upon distribution of the planning directive. Although much of the planning initiated in this phase will envelop the entire

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<sup>150</sup> *Carl Levin and Howard P. ‘Buck’ Mckeeon National Defense Authorization Act for Fiscal Year 2015*, PL 113-291, *U.S. Statutes at Large* 128 (2014): 3512.

<sup>151</sup> *Ibid.*

<sup>152</sup> *Ibid.*

transition, the emphasis during this first phase will be on formulation of objectives; assignment of functions; and establishment of interior organizational arrangements required to implement the concept. Concurrent consideration will be given to programing, budget and funding needs; manpower and materiel requirements; establishment of communications and control systems; and site planning, to include selection and preparation.

2. The activation phase. This phase begins with the activation of the new commands or agencies and-or the major realignment of functions within existing agencies or commands. This phase envisions continuation of planning begun in the earlier phase and will highlight procedures, methods and directives required for the effective functioning of the internal organizational elements and the organization as a whole. Assignment of personnel and movement to the permanent location will be initiated during this phase.

3. The modification phase. This phase of the transition will be devoted to the necessary modification or adjustment of procedures and organizational structure to achieve full operational effectiveness within each organization.

Each phase will have three priorities: Priority A (Must Do); Priority B (Should Do); and Priority C (Would Like to Do) (see table 2).



Table 2. Implementation Plan for MHS Transformation

Event	Priority	Near-Term	Mid-Term	Long-term
Detailed planning begins.	A	X		
Identify nonessential functions and activities and the personnel associated with them.	A	X		
Initiate detailed planning for transfer and assumption of responsibility by functional area; personnel, training and materiel.	A	X		
Initiate study for the purpose of simplifying systems and procedures.		X		
Initiate site planning for commands.	A	X		
Initiate planning for personnel matters in support of the reorganization.	A	X		
Initiate planning for budgets and funding programs.	A	X		
Initiate planning for acquisition of office spaces.	A	X		
Provide planning groups guidelines on personnel matters.	A	X		
Provide planning groups guidelines on financial management.	A	X		
Submit complete plan for allocation of office space.	A	X		
Submit preliminary implementation plan for review to include: Overall concept of organization, internal operations, staff and command relationships and communications, including any areas of disagreement regarding missions and functions. Proposed schedule for specific actions required to implement the organization, the schedule to be as detailed as practicable at this time. Estimate of overall personnel requirements with an indication of sources.	A	X		
Completion of plan for personnel matters and plan for budgeting and funding.	A	X		
Sites approved.	A	X		
Designate subordinate commanders and key staff officers of major subordinate commands.	A	X		
Develop necessary cost estimates including funding requirements for movement of sites.	A	X		
Submission of final type detailed implementing plan for CDC.	A	X		
Submission of final type detailed implementing plan for OPO.	A	X		
DODMED commences assumption of new responsibilities.	A	X		
MHS realignment completed.	A	X		

Source: Created by author.

### Potential Solution for Chief Decision Maker

A potential initial solution (figure 5) called U.S. Medical Command (USMEDCOM) would be equivalent to the services (Army, Navy, and Air Force). The Assistant Secretary of Defense (Health Affairs) (ASD (HA)) would be the service department secretary. The ASD (HA) would be responsible for the following functions: recruiting, organizing, supplying, equipping, training, servicing, mobilizing, demobilizing, administering, maintaining, and construction of the force.

Each of the service surgeons general will remain the medical advisor to their respective service chiefs. They would maintain an administrative staff large enough to provide day-to-day information to the chiefs of staff as needed. The surgeons general would each be dual-hatted as directors of service lines of treatment such as terrestrial medicine, aerospace medicine, and maritime medicine.

The current U.S. Army Medical Research and Materiel Command (USAMRMC) would remain the single-source medical materiel developer and responsible agent for medical research, development, and acquisition and medical logistics management. All of the similar resources from the Navy and Air Force would become part of the current Army command and be called the Medical Research and Materiel Command.

The current Medical Education and Training Campus (METC) in San Antonio would remain the single university-style administration of enlisted medical training but would now provide training for officers as well. METC would become a command and assume control of all residency and fellowship locations currently within the MTFs and the Uniformed Services University of Health Sciences. An O-7 would command the METC.

The current Army Public Health Center (APHC) at Aberdeen Proving Ground, MD would be reorganized with all equivalent personnel from the other services and would enhance DOD readiness by identifying and assessing current and emergent health threats, developing and communicating public health solutions, and assuring the quality and effectiveness of the DOD. The APHC would become the Public Health Command (PHC). An O-8 would command the PHC.

A theater medical command would support each geographic combatant command like the current service component commands of the Army, Navy, Air Force, and Marines. The theater medical commands would contain the forces assigned to support the combatant command. Global Force Management Implementation Guidance (GFMIG) will maintain the identified forces that support each theater medical command. The theater medical commands would align with the current Army Regional Health Commands (RHCs) because the Army RHCs align with major medical centers (MEDCENs) that would serve, as locations where units allocated to each theater could train. RHC-P (Pacific) would become Theater Medical Command-Pacific (TMED-Pacific) and support U.S. Pacific Command. The RHC-E (Europe) would become Theater Medical Command-Europe (TMED-Europe) and support U.S. European Command. RHC-C (Central) would become Theater Medical Command-South (TMED-South) and support U.S. Southern Command and RHC-A (Atlantic) would become Theater Medical Command (TMED-North) and support U.S. Northern Command. An appropriate location would have to be determined for Theater Medical Command-Africa to support U.S. Africa Command. An O-7 would command the theater medical

commands. Each command would consist of 188 personnel (79 officers, eight warrant officers, and 101 enlisted personnel)

To decrease the span of control of the theater medical commander, three medical groups will support each theater medical command. Each medical group will support one-third of the combatant command area of operations. The medical group commander will make recommendations to a joint force commander on the employment, task organization, and command relationship of those forces under his control. An O-6 would command the medical groups. Each group would consist of 105 personnel (35 officers, five warrants officers, and 65 enlisted personnel).

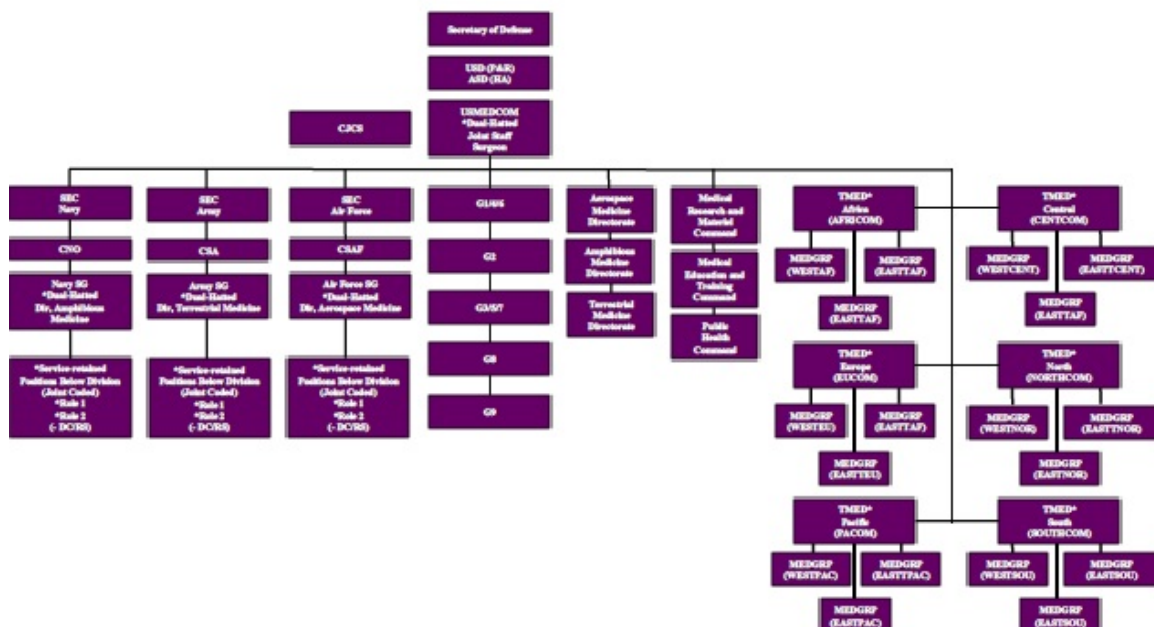


Figure 4 Potential Solution (USMEDCOM)

Source: Created by the author.

### Recommendations for Further Study

With the combination of the three services' personnel, equipment and capabilities, there needs to be further study to determine number of personnel per level of command, effectiveness of a functional combatant command—exercises transregional combatant command authority of all assigned Active Component and mobilized Reserve Component forces—model against the requirements, the standard models of medical units that support each level of war, and the standardization of medical materiel.

The number of personnel needed to support each level of command needs to be researched to reduce duplication and redundancy of personnel and positions namely flag and general officers. Once the appropriate manning levels are determined the subsequent cost-savings need to be captured in order to be placed back into the MHS, potentially in the benefits mission. The reduction of general and flag officers would support the current call for 25 percent reductions in general and flag officers contained in the NDAA 2017.

The functional combatant command model of governance needs to be considered against the requirements because this model is one that has been successfully implemented and would have the least amount of impact on the services. The lessons learned from the implementation of USSOCOM could be used during a premortem to correct identified deficiencies prior to initial operating capability of the medical command.

The current medical capabilities of each service need to be analyzed to determine the appropriate model or models that need to be developed to support the joint force. Each model will have to be able to aggregate and disaggregate in a manner that would allow each unit to provide either health service support or force health protection to any

unit. Once the units are determined, further study needs to be conducted to determine how each of the units should be distributed amongst the geographic combatant commands. The cost to move each of the required units needs to be captured for potential transfer of savings to the benefits mission.

There is an abundance of medical materiel currently being used within the DOD. All of the current materiel that is being used is being used because it is the preference of a particular person or body of people. All materiel needs to be evaluated to find commonality and where there is none then industry and profession standards should be the deciding factor. By standardizing materiel, cost-savings can be achieved that can be transferred back into the benefits mission.

#### Personal Learning Reflection

I obtained practical support regarding various aspects of my research during my meetings with my committee that led to a decrease in the cognitive bias that I had developed. I found that the advice that I was given regarding the applied professional case study research methodology by my committee member Dr. Long was very helpful in increasing the quality of my thesis. The research methodology serves as a creative way to conduct effective research through the lens of the CBA without a large research group. Each member of my committee highlighted the deficiencies in my thesis but provided detailed feedback to explain why these changes were necessary. By conducting this research, I have gained a more critical mindset when it comes to the operation of the MHS. This study gave me a greater appreciation for the work of force managers.

## GLOSSARY

Annual: CCDR force and Joint Individual Augmentation (JIA) requirements for the FY.

Benefits Mission: provides health care to over 9 million beneficiaries, including active duty personnel, retirees, and dependents worldwide.<sup>153</sup>

Combatant Command: A unified or specified command with a broad continuing mission under a single commander established and so designated by the President, through the Secretary of Defense and with the advice and assistance of the Chairman of the Joint Chiefs of Staff.<sup>154</sup>

Combatant Command (Command Authority): Nontransferable command authority, which cannot be delegated, of a combatant commander to perform those functions of command over assigned forces involving organizing and employing commands and forces; assigning tasks; designating objectives; and giving authoritative direction over all aspects of military operations, joint training, and logistics necessary to accomplish the missions assigned to the command. Also called COCOM.<sup>155</sup>

Command and Control: C2 encompasses the exercise of authority and direction by a commander over assigned and attached forces to accomplish the mission. Command includes both the authority and responsibility to use resources to accomplish assigned missions. Control is inherent in command. To control is to manage and direct forces and functions consistent with a commander's command authority. Control provides the means for commanders to maintain freedom of action, delegate authority, direct operations from any location, and integrate and synchronize actions throughout the operational area (OA).<sup>156</sup>

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<sup>153</sup> Government Accountability Office, GAO 08-122, *Defense Health Care: DOD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure* (Washington, DC: Government Accountability Office, October 2007).

<sup>154</sup> Joint Chiefs of Staff, Joint Publication 1-02, *Department of Defense Dictionary of Military and Associated Terms* (Washington, DC: Government Printing Office, 2016), 37.

<sup>155</sup> Ibid.

<sup>156</sup> Joint Chiefs of Staff, Joint Publication 3-0, *Joint Operations* (Washington, DC: Government Printing Office, 2017), xi.

Cross-Domain Synergy: the complementary vice merely additive employment of capabilities across domains in time and space.<sup>157</sup>

Emergent: CCDR emerging or crisis-based force, JIA and exercise requirements.

Global Force Management Allocation Process: Department of Defense process to align force apportionment, assignment, and allocation methodologies to support joint force availability requirements, enable comprehensive insight into global availability of U.S. military forces, and provide senior decision makers a vehicle to quickly and accurately assess the impact and risk of proposed allocation, assignment, and apportionment changes.

Globally Integrated Operations: globally postured Joint Force to quickly combine capabilities with itself and mission partners across domains, echelons, geographic boundaries, and organizational affiliations.<sup>158</sup>

Health Services: Health services promote, improve, preserve, or restore the behavioral or physical well-being of personnel. Health services include, but are not limited to, the management of health services resources, such as manpower, monies, and facilities; preventive and curative health measures; medical evacuation and patient movement of the sick, wounded, or injured; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat and operational stress control; and medical, dental, veterinary, laboratory, optometric, nutrition therapy, and medical intelligence services. Medical logistics, included within health services, includes patient movement, evacuation, and hospitalization. CCDRs are responsible for health services of forces assigned or attached to their command and should establish health services policies and programs.<sup>159</sup>

Military Health System: The Military Health System (MHS) within the Department of Defense (DOD) that serves almost 10 million Americans entitled to health care coverage. The MHS is a global healthcare system that has over 50 hospitals, 600 clinics staffed with 150,000 military and civilian personnel and has an operating cost of \$52 billion dollars. Today, the MHS has a dual health care mission—readiness and benefits.<sup>160</sup>

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<sup>157</sup> Joint Chiefs of Staff, *Capstone Concept for Joint Operations: Joint Force 2020*, 7.

<sup>158</sup> *Ibid.*, iii.

<sup>159</sup> Joint Chiefs of Staff, Joint Publication 3-0.

<sup>160</sup> U.S. Department of Defense, *Military Health System Review* (Washington, DC: Government Printing Office, 2014), accessed December 23, 2016,



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.<sup>161</sup>

Service Retained Forces: AC and RC operational forces under the administrative control of respective Secretaries of the Military Departments, and not assigned to a CCDR. These forces remain under administrative control of their respective Services and are commanded by a Service-designated commander responsible to the Service unless allocated to a CCDR for the execution of operational missions.

Unassigned Forces: Forces not assigned to a CCDR IAW Title 10 USC, section 162 and instead retained under Service control in order to carry out function of the Secretary of a Military Department IAW Title 10, USC, section 3013(b), 5013(b), and 8013(b).

Unified Command: A command with a broad continuing mission under a single commander and composed of significant assigned components of two or more Military Departments that is established and so designated by the President, through the Secretary of Defense with the advice and assistance of the Chairman of the Joint Chiefs of Staff.<sup>162</sup>

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[http://archive.defense.gov/pubs/140930\\_MHS\\_Review\\_Final\\_Report\\_Appendices.pdf](http://archive.defense.gov/pubs/140930_MHS_Review_Final_Report_Appendices.pdf).

<sup>161</sup> Government Accountability Office, GAO 08-122, 1.

<sup>162</sup> Joint Chiefs of Staff, Joint Publication 1-02, 250.

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