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THE PUBLIC HEALTH SERVICE
COMMISSIONED CORPS:
STRENGTHENING ITS ROLE AND
MANAGEMENT

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Executive Summary

THE PUBLIC HEALTH SERVICE COMMISSIONED CORPS: STRENGTHENING ITS ROLE AND MANAGEMENT

Centralized management of the 5,500-member commissioned corps of the Public Health Service is the most effective and efficient way for PHS to administer its officers. Since the corps' personnel and compensation rules, regulations, and statutes differ from those of the Civil Service and Senior Executive Service, and since officers are to be found in relatively small numbers throughout the Department of Health and Human Services and other Federal agencies, centralized management of officer promotions, retention, rotations, and compensation provides control and economy. We recommend that it continue to be managed by its present organization, the Division of Commissioned Personnel.

We also recommend that the Surgeon General and the Assistant Secretary for Health (ASH) take action to better define the mission of the commissioned corps. While PHS agencies have their own clear missions (and use commissioned officers to help satisfy them), they do not share a common understanding of the mission of the commissioned corps within PHS. Nevertheless, the Surgeon General, as part of his commissioned corps revitalization program, has asked the agencies to make changes in the way they use their officers to sustain that mission. To be able to support the changes, the agencies must fully understand the mission. Once the mission has been defined, we recommend that the Surgeon General publish it, and seek legislation to add it to Title 42, United States Code.

To anticipate questions about the commissioned corps revitalization program, and reduce confusion about its implementation, we recommend that the Surgeon General develop and publish a clear statement of direction for that program.

Finally, we recommend that the commissioned status of the ASH be eliminated if the ASH and Surgeon General are to remain separate positions. The ASH is the final arbiter for many commissioned corps personnel issues. His subordinate, the Surgeon General, must, by statute, outrank all other commissioned officers. We believe the ASH's responsibilities and his commissioned status to be incompatible.

Action on our recommendations will require hard work and, probably, realignment of some officer positions. It will produce a commissioned corps with a more visible mission and more clear direction.

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CHAPTER 1

BACKGROUND, PURPOSE AND ORGANIZATION

BACKGROUND

The commissioned corps of the U.S. Public Health Service (PHS) is a uniformed service headed by the Surgeon General of the PHS. The corps is centrally managed by the Division of Commissioned Personnel (DCP) which is part of the Office of the Surgeon General, a staff activity of the Office of the Assistant Secretary for Health (OASH). The PHS is concerned about the size and scope of OASH and has asked whether the DCP belongs there. At the same time, the corps itself is undergoing a "revitalization" program which is intended "to make the corps more effective and efficient relative to the Nation's needs for a cadre of highly professional, flexible, health professionals -- needs expressed in large measure by the agencies of the PHS and certain other Federal agencies".¹ Revitalization has had the effect of making the corps more visible, better managed and more centrally controlled. The Surgeon General needs to know if DCP is using its full potential to support revitalization. This report addresses those concerns.

Our report responds to the following six questions posed by OASH and the Office of the Surgeon General:

1. What are the major functions and authorities of DCP?
2. What is the cost, including full-time equivalents (FTE), of the services provided by DCP?
3. How does DCP relate to each of the PHS agencies?
4. How does DCP compare to similar operations in the Department of Defense (DoD)?
5. What is the proper position for DCP in the organizational structure of PHS and what are the implications of each viable alternative?

¹The Surgeon General of the Public Health Service; Letter to the Deputy Assistant Secretary for Health Operations and Director, Office of Management; *Draft OASH Organizational Study*; Jan 25, 1989.

6. What actions can DCP take to strengthen the revitalization program?

The first four questions are addressed in this chapter, the fifth in Chapter 2, and the last question in Chapter 3.

THE PURPOSE AND CHARACTERISTICS OF THE COMMISSIONED CORPS

Purpose

The purpose of the commissioned corps is not defined by law. Unlike Title 10, United States Code (USC), which spells out the purpose of each military department, Title 42, USC (The Public Health and Welfare) does not specify **why** there is a uniformed service in the Public Health Service. The statute simply requires that there be a commissioned corps in PHS.

The Surgeon General views the purpose of the commissioned corps to be the provision of a highly mobile, expert and compassionate cadre of federal health-care providers, health engineers and health scientists who can be deployed on short notice and in adequate strength to respond to health crises within the United States. As an example of such a use of the corps, 268 commissioned officers were deployed to Florida to deal with the health crisis created by the Cuban refugees during the Mariel boatlift.² The Surgeon General and others who manage commissioned officers believe that it would not be possible to rely solely on large numbers of federal civilians to meet such health contingencies nor to contract for such services with the expectation of high quality health care.

Considerable difference of opinion exists among commissioned officers themselves as to the purpose of the corps. Most of the officers we spoke to considered their membership in the corps as a public service. Some even considered it to be a calling, a connection to the long history of health-care and scientific service to the United States. Most officers consider themselves to be distinct from their civilian middle-manager counterparts; many display their commissioning certificates in their offices, and they describe their oath of office as being an important statement of who they are. Their oath, described in Title 5, USC, is the same as that used in the military departments and other commissioned officer positions in the Federal Government.

²Civil servants were also involved in that, and other, mobilizations.

On the other hand, some commissioned officers we interviewed believe that the corps is merely a way to compensate health-care specialists at a higher rate than is allowed by other government pay programs. In fact, we found instances where officers had no idea they were in a uniformed service until the revitalization program directed commissioned officers to wear their uniforms periodically. Some officers in that group do not even own uniforms.

The PHS agencies, lacking direction on a PHS-wide mission for the corps, have used commissioned officers to satisfy their own mission needs. The attractive pay scale and extra benefits of the commissioned corps have been used to attract personnel that the agencies believe could not have been obtained through the Civil Service or Senior Executive Service. Officers are frequently assigned to positions that are very similar to other positions held by civilians. Many officers' careers have been spent in a single agency and, particularly in research positions, many have gained such specialized experience that they are considered irreplaceable by their agencies.

One element of revitalization has been very difficult for one agency, the National Institutes of Health (NIH), to accept. Title 42, USC provisions permit the Surgeon General to retire officers after 30 years in the corps to provide upward mobility in rank for more junior officers. Before the revitalization program, those provisions were not regularly enforced. Since revitalization, however, DCP has vigorously adhered to them. With the size of the corps and number and grade of flag officers (O-7, O-8, and O-9) set by congress, the Surgeon General believes that there are only limited spaces available and, without regular retirements, it would be difficult to give deserving officers the opportunity to be promoted.

The NIH believes that senior research scientists should be retained in the corps without impacting on the promotion potential of others. In response to the enforcement of mandatory retirement, the NIH has proposed a new civil service category, called the Senior Biomedical Research Service, for those senior officers that would be forced to retire. The prospects that such a category will be created are uncertain.

Characteristics

The role of the commissioned corps has changed over time. The PHS commissioned corps was formed in 1889 to create a career service for health care

providers for the merchant marine. Until recently, the corps operated a network of federal hospitals throughout the United States serving the merchant seamen and indigent citizens. That responsibility was eliminated in 1982 when those hospitals were turned over to other operators. The largest group of commissioned corps members now supports PHS's Indian Health Service, but officers are assigned throughout the PHS (Appendix A).

The commissioned corps also has statutory commitments and agreements to provide primary health care and public health advice to several other federal organizations. Full-time PHS officers are assigned to support the Federal Bureau of Prisons, the United States Coast Guard, the Environmental Protection Agency, the National Oceanographic and Atmospheric Administration's commissioned corps, and several other organizations. That commitment is substantial: at the end of FY88, over 16 percent of the corps was assigned to government activities outside the Department of Health and Human Services (DHHS) or detailed from PHS to other federal organizations. Appendix B lists those details.

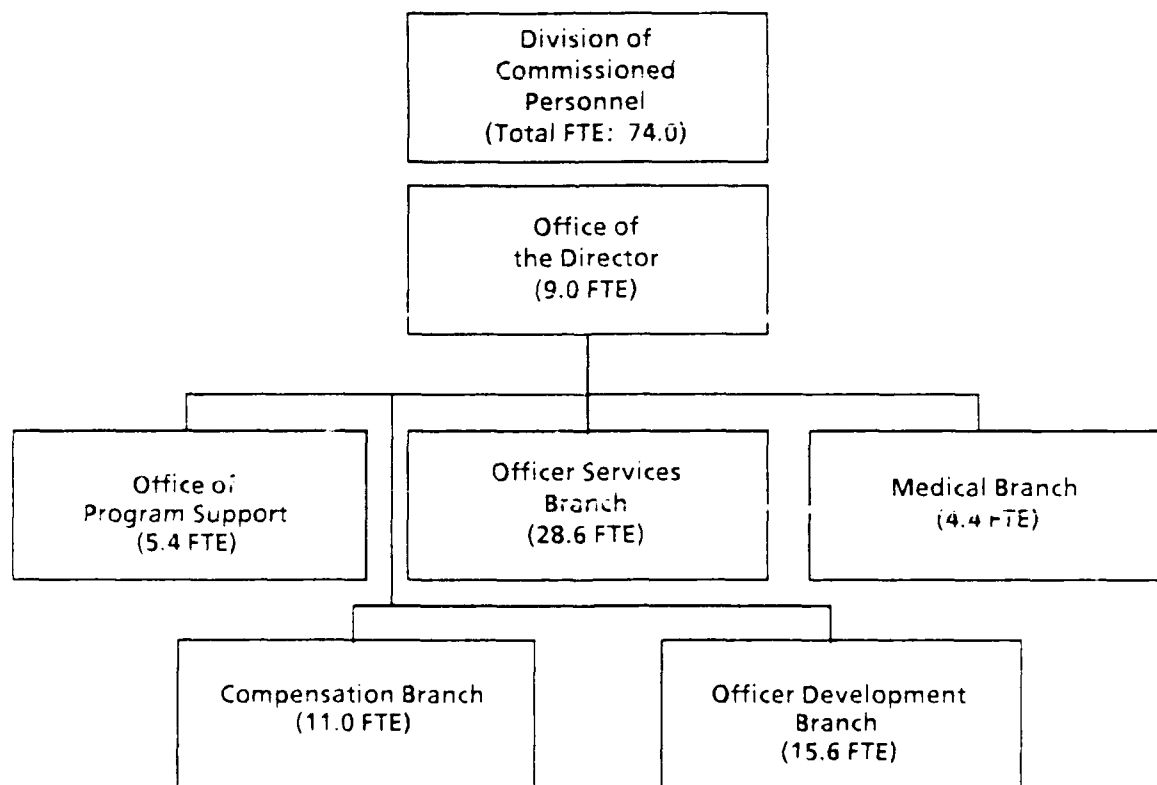
To satisfy its responsibilities, the corps has a mix of grades and 11 health-related specialties (Appendix A lists the number of officers by category and grade). The officer grade structure corresponds to the military structure of O-1 through O-9, although the names of the ranks are unique to the corps. The pyramid of ranks corresponds closely to a military medical department with the largest number of officers in the O-4, O-5 and O-6 ranks.

Although members of the commissioned corps are not covered by Title 10, USC, and therefore not subject to the Uniform Code of Military Justice (except when they are assigned to military positions), the statutes outlining officer selection, compensation, leave and retirement are the same for the PHS and the military departments. This means a PHS commissioned officer receives the same rights, privileges, immunities and benefits as do commissioned officers of the armed services; the same courtesies of the service and of their rank, Veterans Administration benefits, Soldiers' and Sailors' Relief Act, as well as use of military facilities such as commissary and post and base exchanges. In fact, commissioned officers of the PHS receive Department of Defense identification cards upon retirement.

THE DIVISION OF COMMISSIONED PERSONNEL

Organization, Functions, and Costs

DCP is part of the Office of the Surgeon General, an OASH staff activity. While the Assistant Secretary for Health (ASH) heads the U.S. Public Health Service, the Surgeon General, his subordinate, is the principal spokesperson for DHHS and the Federal Government on matters of public health. Under Title 42, USC, he is designated as the senior officer and head of the corps and is responsible for its personnel management. In practice, however, the Surgeon General has delegated operational control over commissioned officers to the agencies to which they are assigned. His major assistants in overseeing commissioned corps policies and programs are the Deputy Surgeon General (an O-8), a flag-rank acting chief of staff (an O-8) who provides day-to-day leadership and direction of commissioned corps activities, and DCP. DCP has six organizational elements with 74 Full-Time Equivalent personnel who manage personnel services for the commissioned corps. The organization of DCP (as of September, 1988) is shown in Figure 1.



Note: Appendix K-C provides details of the major functions of each part of DCP.

FIG. 1. ORGANIZATION OF THE DIVISION OF COMMISSIONED PERSONNEL

DCP has been under the Office of the Surgeon General since 1987. Until then, commissioned corps personnel management was under the control of OASH's Office of Personnel Management as the Commissioned Personnel Operations Division (CPOD). In 1982, the Surgeon General realized he had little control over the corps he headed and, believing that control of his personnel system was vital to corps management, he convinced the Secretary, DHHS and the ASH to move CPOD to his office. CPOD was moved in 1987 and reorganized as DCP. The Surgeon General believed such aggressive action was necessary to counter the feelings of neglect and decline in importance perceived by corps officers.

The personnel management activity of DCP has been substantial as it was when it was centralized in the OASH Office of Personnel Management. Table 1 shows the magnitude and variety of personnel actions performed by DCP in FY88.

DCP is funded from the PHS service and supply fund. Its total budget for the last three fiscal years is shown in Table 2.

DCP is a self-sufficient organization with one major exception. Its management information support is provided by the Commissioned Officers and Field Systems Division (COFSD) of the Assistant Secretary for Personnel Administration's Office of Human Resource Information Management in the Office of the Secretary, DHHS. COFSD provides *operational production support* by providing the computer software, hardware and personnel to prepare and distribute the monthly commissioned corps payroll. It performs *software support* and writes software programs to create ad-hoc reports from the automated commissioned officer personnel and payroll files. Finally, it provides *facilities management support* by maintaining the computer system used by DCP and helping DCP to select and purchase computer hardware and software for office-automation applications. There are 11.5 FTEs supporting these services for DCP. Two of the 11.5 FTEs are on loan from the Bureau of Health Care Delivery and Assistance within the PHS's Health Resources and Services Administration. The budget to pay for these services is borne by the Assistant Secretary for Personnel (ASPER).

The DCP sources we interviewed were satisfied with COFSD support and COFSD managers were pleased with the support arrangement.

TABLE 1
DCP ACTIVITY (FY88)

Major DCP Output	Example of Effort
Process	
Commissioned corps applications	2,000
Personnel orders	9,526
Routine payroll actions	38,000
Honor and service awards	950
Review and process	
Training applications	2,841
Promotion and assimilations	3,600
Retirements, probation and limited tours	417
Commissioned officer effectiveness reports	5,600
Develop and distribute	
Recruitment publications	20,000
Publish	
DCP Bulletin (monthly)	12 issues, 13,500 copies
Policies and regulatory issuances (average 2 monthly)	24 issuances, 6,000 copies
Policy and regulatory publications	10 publications, 10,000 copies

TABLE 2
DCP FUNDING

Fiscal Year	Budget
'986	\$2,943,000
'987	\$3,306,000
'988	\$3,858,000

Authorities

The authorities for the commissioned corps and its management are found in the following titles of the United States Code.

- Title 42, for organization and personnel management
- Title 37, for pay and allowances
- Title 38, for veterans' benefits
- Title 5, for oaths and grade relationships to federal civilians.

How DCP Relates to the PHS Agencies

Title 42, USC, assigns the responsibility for officer recruitment, selection, use and retention to the Surgeon General, but in practice these duties are assumed by the directors of the PHS offices, branches and agencies. Responsibilities to ensure officers adhere to the customs, courtesies and regulations governing the commissioned corps are shared jointly between DCP, the agencies and the officers. Officer retention and promotion are determined by boards of officers convened by the Surgeon General and managed by DCP. Ultimate authority for retention has been delegated by the Secretary, DHHS and the ASH to the Surgeon General. The President, with the advice and consent of the Senate, makes promotions. This practice is the same as the other uniformed services, and like their promotions, is kept free of minor political influence. The relationship between DCP and most agencies is amicable.

The ASH and the Surgeon General are commissioned officers. Most agency directors are also commissioned officers, and that provides a bond with the commissioned corps.³ On the other hand, PHS is the only uniformed service in which non-career Presidential appointees are found in uniform.

DCP policy is promulgated throughout PHS by senior commissioned corps Agency Representatives. Policy implementation requires about one-fourth of each representative's time (0.25 FTE). PHS commissioned officer administrative tasks

³The Administrator of the Alcohol, Drug Abuse and Mental Health Administration was the only non-commissioned agency head as of January, 1989.

are handled by Agency Liaison Staffs in each PHS agency.⁴ The positions required in each agency to perform these DCP activities are shown in Table 3.

TABLE 3
AGENCY LIAISON STAFFS

PHS Agency	FTEs
Alcohol, Drug Abuse and Mental Health Administration (ADAMHA)	1.2
Food and Drug Administration (FDA)	5.0
Health Resources and Services Administration (HRSA)	3.0
Indian Health Service (IHS)	3.8
National Institutes of Health (NIH)	4.4
Centers for Disease Control (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)	<u>2.2</u>
Total	19.6 FTEs

Note: As of September 30, 1988

DCP writes the regulations for the Surgeon General and publishes them in the two-volume Commissioned Corps Personnel Manual (CCPM), the official publication for policies, procedures, standards, instructions and personnel management information. DCP uses the Office of the Surgeon General's monthly Commissioned Corps Bulletin to notify the corps of impending policy changes before they appear in the CCPM.

Under the revitalization program, commissioned corps force development is managed by DCP. The agencies are asked to respond to DCP questions concerning agency requirements so that DCP can determine the number of billets requiring commissioned officers and the necessary skills required. These are critical questions, for the answers DCP receives to its inquiries get at the central issue of the purpose of the corps.

Keeping track of position requirements and overseeing the placement of qualified officers in those positions, which we call force management, is handled by

⁴Although there is no common structure for such staff offices, the liaison with DCP is normally found in the office that manages civilian personnel for each agency.

DCP's Officer Services Branch (OSB) through several programs. DCP is attempting to manage more closely the use of commissioned officers within the agencies to ensure they work in positions appropriate to their rank and category. To accomplish this goal, DCP monitors the program called Vacancy Announcement Tracking System (VATS) that announces health-related position vacancies throughout the PHS. When OSB determines that a potential position requires a commissioned officer, it negotiates with the agency that has the open position, with the officer who could fill the position, and with the agency losing the officer. DCP works hard to ensure that health-care assignments requiring commissioned officers are filled with them. The Commissioned Officer Student Training and Extern Program (COSTEP) recruits students in health-related disciplines to work for PHS during free periods of the academic year to learn about PHS and to allow PHS to evaluate them for future employment.

Most PHS agencies are satisfied with personnel management by DCP. Two, the National Institutes of Health and the Centers for Disease Control (which together are assigned 25 percent of the commissioned corps), believe that the agencies should manage the careers of commissioned officers as they now manage their civilian employees. That is, policy would be provided by OASH but recruitment, placement, promotions and retention of individual officers would be managed within the agencies. In a mobilization, OASH would "tax" each agency to provide the appropriate number of officers by specialty. The agencies would select individual officers to respond. The agencies argue that such an arrangement would give them the freedom they desire to most effectively use officers in support of their missions and would reduce the present cost of operating separate personnel offices for corps and civil service personnel.

RELATIONSHIP OF THE SURGEON GENERAL, PHS, TO THE SURGEONS GENERAL OF THE DEPARTMENT OF DEFENSE

The Surgeon General of the PHS is one of four executive department-level Surgeons General in the Federal Government; the others are the Surgeons General of the Army, Navy, and Air Force. They all work together on matters of mutual interest and meet periodically for executive-level coordination. As an example, in mid-1988, they agreed that during emergencies the PHS commissioned corps will replace military health-care providers that are sent overseas from U.S. military hospitals.

Each of the four Surgeons General gives direction to his service on matters of health. The Surgeon General of the PHS has the additional responsibility to speak to the nation on matters of public health. The most obvious examples are the Surgeon General's public comments on the effects of smoking, nutrition and AIDS on public health. Because the Surgeon General of the PHS provides health care in support of the Coast Guard and the National Oceanographic and Atmospheric Administration Corps, he is in fact the Surgeon General for those services as well.

The personnel management systems of the military medical departments and of DCP are comparable, but there are two important differences. First, the Surgeon General of the PHS is in full control of his personnel system on matters of customs, courtesies and retirements, areas over which the other Surgeons General have less control. Second, the armed services' Surgeons General control their personnel by using billet systems: designating positions that are to be filled by commissioned officers and assigning individual officers to each position. The PHS commissioned corps has identified billets for some of its commissioned officers, but has a far less sophisticated billet system than the armed services. Otherwise, the similarities between DCP and the military medical departments are striking. In fact, the DCP Director has been in close coordination with the Navy's Military Personnel Center to ensure that the commissioned corps personnel system is congruent on matters of mutual interest.

The cost of personnel management for the commissioned corps (in FTE) appears to be similar to that of a military service. We computed the total cost of personnel management for the PHS commissioned corps to be 102.6 FTEs (74.0 FTEs in DCP, 1.5 FTEs for the six Agency Representatives, and 19.6 FTEs in agency liaison staffs). With 5,498 officers in the PHS commissioned corps, that results in a ratio of 53.6 commissioned officers per FTE of personnel management support. That figure compared favorably to statistical staffing standard model results for a similar workload for one of the military services. Thus, with the exceptions already noted, the scope and cost of PHS commissioned corps personnel management is quite comparable to medical personnel management in the Department of Defense.

CHAPTER 2

ORGANIZATIONAL ALTERNATIVES

This chapter responds to the question, "What is the proper position for DCP in the organizational structure of PHS and what are the implications of each viable alternative?" We analyzed these organizational alternatives:

- Remain centralized in the Office of the Surgeon General
- Remain centralized and return to its former location in the Commissioned Personnel Operations Division of OASH/OPM
- Remain centralized, but re-locate within a PHS agency
- Decentralize by adding a sufficient number of FTEs within each agency to assume the personnel functions currently managed by DCP.

In determining whether DCP should be centralized or decentralized, we have based our argument on the centralized organization. We have done so to emphasize that the purpose of personnel management services is to assist the Surgeon General in achieving the objectives of the PHS commissioned corps (and the agencies in satisfying their personnel requirements), and to provide the best, most cost effective and efficient management of the commissioned corps personnel system.

There are several good reasons that personnel management should be centralized:

To Take Advantage of Specialization. Civilian agency personnel offices concerned with a system operating under a different set of rules may not have the tools or skills necessary to handle specialized personnel actions required for the commissioned corps.

To Aid in Coordination. A central organization formed specifically to provide personnel management can bring different functional specialists together to focus their efforts, better than staff members located in different agencies.

To Facilitate Control. Centralizing personnel management can aid senior management to ensure adherence to policy and to quickly modify those policies when conditions change.

To Secure Adequate Attention. A centralized personnel unit is a larger, more visible organization. It can maintain emphasis on personnel programs that might be overlooked in a decentralized unit.

To Reduce Expenses. Centralized services can realize economies of scale.

To Level Workload. Centralized personnel management can satisfy peak demands while wasting fewer resources during slack periods, especially if the peak workload for one agency happens to correspond to a slack period for others.

To Provide Professional Compatibility. A centralized personnel office consolidates workers with similar skills and thus provides opportunities for personnel managers to increase proficiency in a shared professional environment.

To Gain Organizational Depth. If personnel management were consolidated each agency is less susceptible to the departure or illness of a key person.

To Maintain Organizational Flexibility. Most personnel services remain the same even if the organization being served changes. In the commissioned corps and PHS environment where constant change is the norm, centralizing those relatively stable services can provide continuity. The centralized services would better serve the 12 percent of officers that work in agencies outside of DHHS.

The centralization of commissioned corps personnel management can provide definite advantages to PHS. Centralization also carries with it some disadvantages that may offset these advantages:

Loss of Control by Agencies. A centralized personnel system may not be as responsive to each agency as its own personnel department.

Centralized Personnel Policies at Variance with Agency Operating Philosophy. A centralized personnel system is in control of the policies it manages. These policies may conflict with agencies' use of their commissioned officers. The result may not be resolvable.

Organizational Inertia. A centralized personnel organization may become less responsive over time, as the organizational inertia that comes with size takes hold. As the service providers become more interested in satisfying the desires of the personnel organization management, they may become less interested in meeting the needs of agencies. This can result in bureaucratic delays, reduced levels of service, decreased tolerance for unusual requirements and an adversarial attitude toward the sponsoring agencies.

CENTRALIZED - REMAIN IN THE OSG

We recommend retaining commissioned corps personnel management in its current centralized location in the Office of the Surgeon General (OSG). This allows for centralization of essential personnel decisions such as promotion, retention, rotation, and compensation and provides the greatest management economy. In addition, centralization in the OSG facilitates the Surgeon General's revitalization initiatives.

The complexities of Federal statutes that need to be complied with by commissioned corps personnel managers almost mandate a centralized system. Title 42, USC; Title 37, USC, Pay and Allowances of the Uniformed Services; and Title 38, Title USC, Veterans' Benefits, as well as the companion statutes written in the Code of Federal Regulations all require centralized interpretation and coordination. Commissioned corps personnel management has never been decentralized, at least in the present memory of the PHS. In fact, few with whom we spoke suggested this as a viable alternative. Agency Representatives and Agency Liaison personnel spoke of the need for a centralized system to act as an arbitrator to sort out conflicts between two agencies competing for a single officer.

There are drawbacks to this recommendation, but they have not proven serious. There is no longer a single PHS manager for personnel issues as there was when the commissioned corps was managed by OASH/OPM. Thus, any inconsistencies between the two systems must be resolved by a higher level manager, namely the ASH. That has not been necessary to date. Also, personnel policies are sometimes at variance with agency operating philosophies. With the exception of the ongoing problem with NIH researchers, this problem is usually minor. The NIH problem cannot be resolved by reorganizing DCP.

Centralized personnel management is necessary because of the commissioned corps' apparent mission. As discussed in Chapter 1, both NIH and CDC would like to control the personnel management of their corps members, with policy being provided by DCP. If the mission of the corps is the provision of a deployable cadre of federal health-care providers, as the Surgeon General defined it to us, it seems likely that inter-agency reassignments would be necessary for officers to gain the experience needed for that role. Without centralized personnel management, we believe it unlikely that agencies would volunteer their better officers for such moves.

Under this option, DCP must coordinate its force development activities with those of the PHS Office of Personnel Management, the civilian-personnel managers. In many cases, commissioned officers occupy positions that could be filled by either uniformed or non-uniformed personnel. Close coordination in these areas of mutual interest will improve the personnel support of both offices. A significant first step was taken when DCP and OPM jointly defined those positions in PHS that are Senior Executive Service or flag-rank positions.

Finally, people with whom we spoke note that as the revitalization program develops, writing and activating revitalization initiatives must come from a single high-level source. The program would be seriously hampered without centralized initiative and a centralized focus.

CENTRALIZED-RETURN TO FORMER LOCATION AS THE COMMISSIONED PERSONNEL OPERATIONS DIVISION IN OASH/OPM

We recommend against returning personnel management to its former location in the PHS organizational structure.

Although all of the benefits of centralization accrue to this option as to the option to centralize within the OSG, it is the Surgeon General's opinion that the return to its former location will not provide him the freedom to promote his revitalization program as it is currently constituted. It is worthwhile to repeat that revitalization is little more than a program to reinforce already existing laws and regulations found in Title 42, USC, and the CCPM. These rules were in existence under the former organization, but it was not until the Surgeon General gained control of the personnel system and designated an acting chief of staff to oversee

policy changes that the corps began its revitalization program in earnest. Revitalization would not be as powerful if control reverted to its former status.

CENTRALIZED-PLACE UNDER A SINGLE PHS AGENCY

We recommend against centralizing the commissioned corps personnel function under a single agency.

This option is certainly possible. The Indian Health Service has over 40 percent of PHS officers and could be a prime location for a centralized personnel management system. No one to whom we spoke was favorable to this. There are two primary arguments against it. First, it is not favored by the Surgeon General. He feels he has greater control over the success of the revitalization program and as a result, has greater control over the continued existence of the commissioned corps with the function in OSG. Second, conflict resolution between competing agencies is easier to accomplish under the present centralized option. Also, having DCP under an agency would lead to the perception that the Indian Health Service or other agency would receive favored treatment.

Finally, revitalization initiatives written and managed from a single agency would not carry the same emphasis as they do now under a centralized system at a higher level in PHS. The Surgeon General and senior managers of commissioned officers would lose control of their personnel system.

DECENTRALIZED

We recommend against decentralizing commissioned corps personnel management.

It is possible for each agency to completely manage the personnel system for its commissioned officers. Basically, the agencies now recruit, select (with DCP's regulatory concurrence), develop (and recommend to DCP for promotion), discipline, and release officers before retirement. DCP processes the paperwork and ensures that the statutes, implementing regulations and policies of the Surgeon General are adhered to. Additionally, it is possible for each agency to manage the commissioned corps compensation system, now handled centrally by DCP.

Decentralizing personnel management, however, sacrifices the benefits which accrue to a centralized system. Each agency would need to expand its present small

staff to a much larger staff of qualified personnel experts in each of the areas managed by the centralized DCP. Commissioned corps personnel managers within the agencies would have a clearer understanding of the agencies' needs, but would lose the PHS-wide perspective that the corps' PHS mission would demand. Decentralization would be costly, and produce few benefits.

CHAPTER 3

THE REVITALIZATION PROGRAM

When we reviewed the support of the revitalization program by DCP, we did so at three levels: for the individual officer, for the PHS agencies, and for the Public Health Service as a whole.

DCP's service to the individual officer is excellent. DCP understands the statutes, rules and regulations imposed on the uniformed service and it guides and supports the commissioned officers well. In servicing the PHS agencies, we recommend DCP allow them more time to respond to revitalization initiatives and that it provide them with a clear statement of direction for the revitalization program. And, in support of PHS, DCP should promulgate a statement of purpose for the commissioned corps as an important step in planning a corps structure that will satisfy the real needs of the PHS.

RECOMMENDATIONS TO STRENGTHEN THE REVITALIZATION PROGRAM

Publish a Statement of Purpose for the Commissioned Corps

We recommend the Secretary, DHHS, the ASH and the Surgeon General write a statement of purpose for the PHS commissioned corps and define the mission of a commissioned officer compared to other professionals in the same discipline within PHS. We could find no clear statement of purpose for the commissioned corps. In fact, people we interviewed invariably did not agree on a present-day purpose for a uniformed service within PHS.

Having a clear statement of purpose for the corps will allow the Secretary, the ASH, the Surgeon General, DCP and the agencies to identify assignments for which commissioned officers are required and to justify those assignments (and the substantial retirement and veterans benefits which accrue to officers) to oversight activities of the Government. Additionally, a clear statement of purpose will improve relations between officers and those they serve. Any statement of purpose for the commissioned corps must be distinct from similar statements for PHS civilians performing similar functions. We further recommend that the Surgeon

General seek legislation to amend Title 42, USC to include the language of the purpose.

Title 42, USC, also lacks a statement of the purpose of PHS. Although addition of such a statement would be helpful to the commissioned corps, it is not a requirement that should prevent the Surgeon General from creating a statement of purpose for the commissioned corps.

The process of creating and publishing a purpose statement can be done at several levels ranging from the ASH alone declaring the purpose, to full participation by the commissioned corps. We recommend a process that includes senior executives in PHS such as the ASH, the Surgeon General and agency directors with the DCP director as an observer and advisor. Off-site high-level strategic management conferences have proven to be highly successful for senior federal government decision-making. Such a conference would be appropriate for this effort.

In establishing the commissioned corps mission, we recommend the Surgeon General consider creating a formal commissioned corps Ready Reserve component as part of his purpose statement. It is likely that some of the missions and roles he selects for the commissioned corps, particularly those that call for deployments to support emergencies, can be satisfied by a Ready Reserve similar to those in DoD.

Publish a Statement of Direction for the Revitalization Program

We recommend the Surgeon General and DCP collaborate on a clear statement of direction for the revitalization program. Our discussions with the Surgeon General and senior managers in DCP convinced us that revitalization initiatives are well thought-out and are being vigorously pursued. We also understand that rapid and large-scale changes are difficult to manage so that everyone in the process knows where the program is headed. In researching a definition of revitalization, we reviewed several documents, each with different, more detailed descriptions of the program initiatives. One, the official policy on how often the uniform should be worn, is published by a private association, the Commissioned Officers Association of the U.S. Public Health Service. We prepared our own understanding of the program and asked DCP to review it for completeness. The results of our study are presented in Appendix D.

We often found confusion over revitalization in the PHS agencies. Many of the people we interviewed knew about revitalization and were familiar with many of its initiatives; however, few had a sense of its scope. For them, revitalization is a series of activities with the generalized goal of improving the corps. But, without clear statement of purpose for the corps, the direction of the revitalization program can never be as clear as it should be. The Surgeon General should ensure that there is a single source of easily available information about revitalization.

Give the Agencies More Time to Respond to Proposed Revitalization Initiatives

We recommend DCP be more realistic about the time required to respond to proposed revitalization initiatives. We sensed some frustration among Agency Representatives and Agency Liaison personnel at the short suspense dates which often accompany proposals on which they are asked to comment. As an example of the problem, CDC is headquartered in Atlanta and the Agency Representative, an Assistant Surgeon General, grade O-7, is located at DHHS headquarters in Washington, D.C. A proposal from DCP is sent to the Agency Representative in Washington who then forwards it to CDC in Atlanta. Once the CDC comments are appended, they are returned to the Agency Representative who then forwards them to DCP. The proposed initiative may spend more time in transit than DCP allowed for the entire action.

Another facet of the problem is found in the proposal on wearing the uniform sent to the Indian Health Service (IHS), the agency with 41 percent of the commissioned corps. This proposal would have been evaluated better had there been input from the field. Field responses to the proposed uniform policy would have revealed that some Indian tribes find federal uniforms offensive reminders of previous oppression. The DCP did not allow enough review time to elicit this kind of response.

Examine Personnel Compensation Alternatives

Finally, we recommend as a revitalization initiative that OSG and OASH/OM work together to examine compensation techniques that would provide alternatives to the commissioned corps for attracting talent to the PHS. For some, the motivation to become a commissioned officer and remain one is strictly monetary and has little or nothing to do with the public-service responsibilities one would expect of commissioned officers in a uniformed service. Agencies have used the corps in the

past as little more than a recruiting tool, and many officers are in positions that cannot be justified by the purposes of the corps that we have discussed. The ideal situation would be to use commissioned officers only in positions that directly contribute to the mission of the commissioned corps.

Once the purpose of the commissioned corps is published, we believe that DCP should identify the present positions and officer categories that are not required to satisfy that purpose. With OASH/OPM, it should determine if there are special compensation requirements necessary to retain personnel who would be affected by eliminating those commissioned positions. By doing so, PHS can eliminate awkward situations in commissioned corps personnel management such as those that now confront it with medical research scientists. It also will be better able to justify the commissioned corps itself.

THE COMMISSIONED STATUS OF THE ASH

If the Assistant Secretary for Health (ASH) and the Surgeon General continue as separate positions, we recommend the position of the ASH be removed from the commissioned corps. This is a major change to the existing structure, but we believe that the present commissioned status of the ASH:

- Creates a confusing and contradictory hierarchy and lends credibility to the argument that the commissioned corps is simply an alternative pay system. By statute, the Surgeon General is the highest ranking officer in the PHS commissioned corps. He is supervised by the ASH, however, who has a subordinate rank in the commissioned corps. That rank structure not only creates confusion, but it results in the impression that the ASH's commissioned status is only meant to put him in a higher pay scale.
- Gives the appearance of a conflict of interest in the personnel appeals process. By statute, the ASH is the final arbiter on questions of officer retention; he is the appellate authority of the PHS commissioned corps. As a commissioned officer himself, the role gives the ASH the appearance of having a conflict of interest. In no other uniformed service is the appellate authority a uniformed service member.
- Reduces the degree of civilian oversight that is prevalent in the other uniformed services. With the ASH a commissioned officer as well as a Presidential appointee, the constitutional preference for civilian-controlled uniformed and armed services is contradicted. The commissioned corps is the only uniformed service of the seven with a ranking member as high in the political structure as an executive department Assistant Secretary.

We believe that the ASH's status as a commissioned officer is nearly impossible to defend, and that it could jeopardize the future existence of the corps. We recommend that it be eliminated.

APPENDIX A

COMMISSIONED CORPS DATA

TABLE A-1

COMMISSIONED OFFICER ASSIGNMENTS (As of September 30, 1988)

Officer Categories	Total	OS/DC	HCFA	OASH	HRSA	CDC/ATSDR	FOA	IHS	ADAMHA	NIH	EPA
Medical	1,630		8	47	204	339	52	571	64	346	4
Dental	597			15	216	4	5	210		27	
Nurse	786	2	33	40	101	20	23	473	21	76	
Engineer	563	1		17	5	72	70	224	2	26	146
Scientist	263		5	4	15	98	64	5	12	45	15
Sanitarian	288			9	13	49	51	138	1	9	18
Veterinarian	93			2		23	17		2	44	5
Pharmacist	562	1	4	21	53	2	101	341	6	36	2
Dietitian	63		8	4	3		4	23		21	
Therapist	93		5	2	21	2	6	37	1	15	1
Health Services	576	10	23	66	72	63	72	145	26	59	39
Total	5,498	14	86	227	704	672	405	2,266	135	699	230

Notes: OS = Office of the Secretary, Health and Human Services

DC = Office of Human Development Services

HCFA = Health Care Finance Administration

OASH = Office of the Assistant Secretary of Health

HRSA = Health Resources and Services Administration

CDC = Centers for Disease Control

FOA = Food and Drug Administration

IHS = Indian Health Service

ADAMHA = Alcohol, Drug Abuse and Mental Health Administration

NIH = National Institutes of Health

ATSDR = Agency for Toxic Substances and Disease Registry

EPA = Environmental Protection Agency (Independent Agency)

TABLE A-2

COMMISSIONED OFFICER RANKS AND CATEGORIES
(as of September 30, 1988)

Category	Rank									
	Total	0-1	0-2	0-3	0-4	0-5	0-6	0-7	0-8	0-9
Medical	1,630			222	453	406	516	15	17	1
Dental	577			134	136	198	107	1		
Nurse	198	3	105	215	254	124	79	2	1	
Engineer	563		52	69	32	179	179	1	1	
Scientist	263			18	49	90	116			
Sanitarian	288		28	31	76	73	90			
Veterinarian	33			14	21	21	37			
Pharmacist	567		51	59	151	217	38	1		
Dietitian	63		1	4	21	26	11			
Therapist	90		5	9	19	27	30			
Health Services	576	24	16	36	137	225	138			
Total	5,498	32	258	311	1,399	1,576	1,381	20	20	1

Notes: 0-1 = Junior Assistant
 0-2 = Assistant
 0-3 = Senior Assistant
 0-4 = Full
 0-5 = Senior
 0-6 = Director
 0-7 = Assistant Surgeon General
 0-8 = Assistant/Deputy Surgeon General
 0-9 = Surgeon General

APPENDIX B

COMMISSIONED OFFICER DETAILS

TABLE B-1

COMMISSIONED OFFICER DETAILS
(As of September 30, 1988)

Agency detailed to	PHS Sponsor	Number of officers on detail to others
U.S. Coast Guard	HRSA	161
National Oceanographic and Atmospheric Administration	HRSA	4
Bureau of Prisons	HRSA	178
Immigration and Naturalization Service	OSG	10
Department of Defense	OS	2
	FDA	1
National Park Service	CDC	10
World Health Organization	CDC	4
Agency for International Development	CDC	8
	OS	1
U.S. University of the Health Sciences	NIH	3
	HRJA	1
	ADAMHA	1
Pan-American Health Organization	CDC	3
St. Elizabeth's Hospital	ADAMHA	32
The White House	OS	1
TOTAL		420

APPENDIX C

**ORGANIZATION AND FUNCTIONS OF THE DIVISION OF
COMMISSIONED PERSONNEL**

**ORGANIZATION AND FUNCTIONS OF THE DIVISION OF
COMMISSIONED PERSONNEL**
(As of September 30, 1988)

The organization of DCP is shown in Figure C-1. A list of each organizational element's responsibilities is shown below.

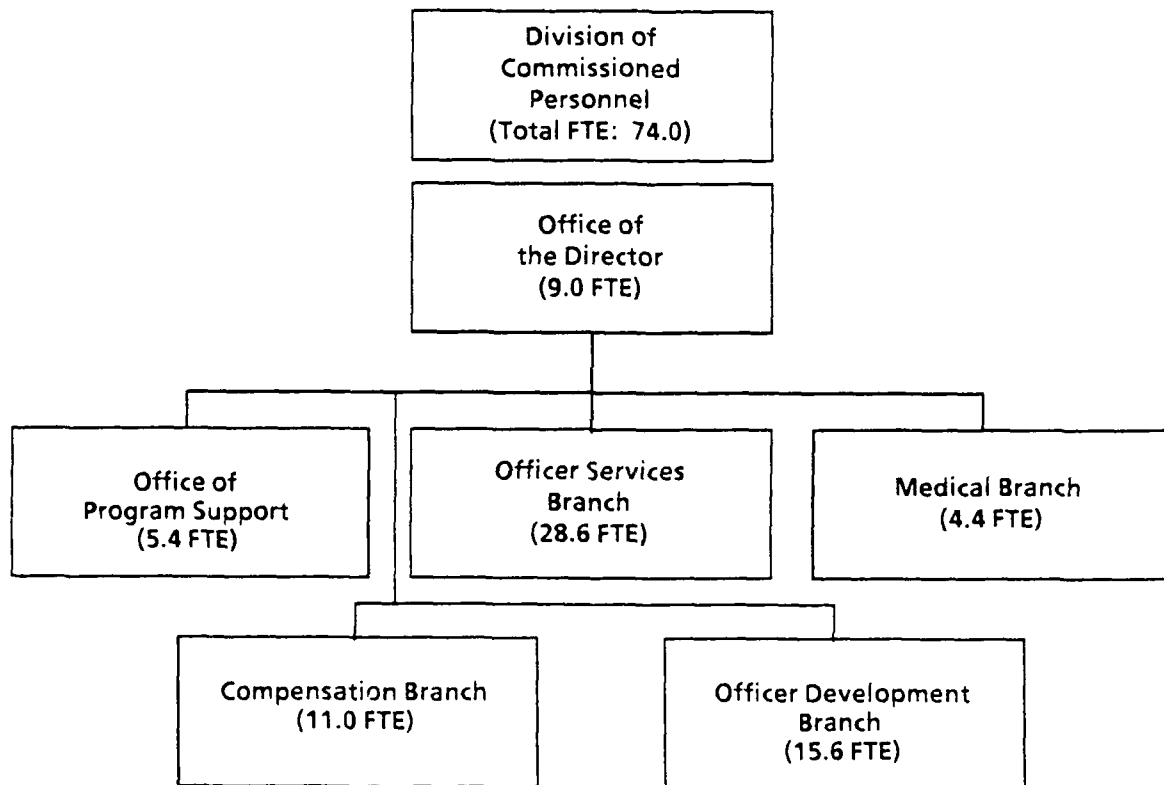
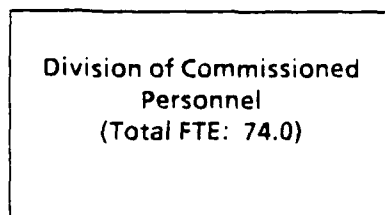


FIG. C-1. ORGANIZATION OF THE DIVISION OF COMMISSIONED PERSONNEL

RESPONSIBILITIES



Reviews and processes:

- Commissioned corps accession applications
- Personnel orders
- Routine payroll actions
- Honor and service awards
- Training applications
- Promotion and assimilation recommendations
- Retirements
- Probationary and limited tours
- Commissioned officer effectiveness reports.

Develops, publishes and distributes

- Recruitment publications
- Commissioned Corps Bulletin*
- Regulations and personnel policies.

Office of
the Director
(9.0 FTE)

Plans, evaluates and develops:

- Legislative and regulatory proposals and policies
- The Commissioned Corps Personnel Manual*
- Related publications, pamphlets and circulars.

Provides guidance and direction to the commissioned corps personnel system.

Administers revitalization actions for the commissioned corps.

Office of
Program Support
(5.0 FTE)

Provides administrative management function for:

- DCP and DSG
- Mail management, copy machine operator, filing messenger.

Manages commissioned corps forms and printing functions.

Administers:

- Commissioned corps performance appraisal system

Officer Services
Branch
(28.6 FTE)

Commissioned corps awards program
Bimonthly meeting of Agency Representatives
Vacancy Announcement Tracking System (VATS)
ADEPT
Retirement system
Billet system
Assimilations
All boards and hearings
Official personnel files
Freedom of Information Act requests
Applications for appointment.

Processes:

Travel and grade calculations
Distribution of personnel orders.

Represents PHS on Uniformed Services Per Diem, Travel and Transportation Allowance Committee (PDTTAC).

Medical Branch
(4.4 FTE)

Establishes, maintains and monitors:

Central medical files of commissioned officers
Ensures medical standards are established and set for appointment retention and retirement.

Initiates and/or reviews physical exams to determine qualifications for appointment.

Administers disability retirement program.

Interprets policy, authorizes, and processes all pay actions for:
Active duty officers

Compensation Branch
(11.0 FTE)

Retirees and annuitants
Former spouses of retirees.

Interprets policy on:
Survivor Benefit Plan (SBP)
Veterans Administration compensation
Dual compensation.

Officer Development
Branch
(15.6 FTE)

Administers:
Inactive reserve program
Officer assignments outside PHS
Assistant Surgeon General appointments
Commissioned Officer Student Training and Extern Program (COSTEP)
Services and benefits programs (i.e., DEERS, ID cards, VA benefits)
Placement of officers for assigned categories and programs.

Processes long-term applications and manages related data.

APPENDIX D

COMMISSIONED CORPS REVITALIZATION PROGRAM

COMMISSIONED CORPS REVITALIZATION PROGRAM

The Public Health Service Public Health Service (PHS) has undertaken several initiatives to revitalize the Commissioned Officer Corps. The following documents describe those initiatives:

- *Commissioned Officers Association Bulletin*. U.S. Public Health Service Mar, Apr/May, Sept, and Oct 1987. (The descriptions in these periodicals are key to understanding the revitalization initiatives.)
- Letter; Surgeon General to All Active Duty Commissioned Officers; April 6, 1987.
- Letter; Surgeon General to All Active Duty Commissioned Officers; July 6, 1987.
- Letter; Surgeon General to All Flag Officers; October 9, 1987.
- Letter; Surgeon General to All Commissioned Officers; June 6, 1988.
- Speech; HS Director David Callagy, DCP, to Commissioned Officers Association, Public Health Service; Scottsdale, AZ; May 25, 1988
- Speech; Surgeon General at Commissioning and Induction Ceremonies; Centers for Disease Control, Atlanta, GA; July 12, 1988.

The Surgeon General has said that he is aware of the urgent need to restore the Commissioned Corps to its traditional role at the forefront of the health programs of the United States. He wants to restore the corps' effectiveness as a uniformed service and its vitality and effectiveness in carrying out its historic mission (and by so doing overcome any criticisms that have been leveled at it). The Surgeon General reported the Revitalization Plan is a Secretarial Initiative (Secretary, DHHS). It focuses on four key activities: reorganization, commissioned corps billet system, career development, and usage.

REORGANIZATION

The Office of The Surgeon General was established in 1987 as a staff office under the Assistant Secretary for Health and assumed direct responsibility for commissioned personnel policy and functions, including the administration and management of the Division of Commissioned Personnel. The mission was taken

from the Office of Personnel Management in the Office of Management under the Assistant Secretary for Health, and:

- An acting Chief of Staff was appointed
- A Director, Division of Commissioned Personnel was appointed
- A senior officer was appointed in each agency to represent the agency's programs and management of the agency to the Office of the Surgeon General
- Fourteen work groups were formed to examine specific issues and make recommendations
- The 11 category-specific professional advisory committees (PACs) were strengthened as was the role of corresponding Chief Professional Officers (CPOs). The following actions revised the basic charter of the PACs:
 - ▶ Establishment of a goal of fostering broad participation by limiting terms of appointment, and increasing participation of both junior officers and officers in field positions.
 - ▶ Selection of new PAC members.
 - ▶ Establishment of criteria for selecting CPOs and steps to limit their terms of appointment.
- The *Commissioned Corps Bulletin* was reinstituted and sent to each officer (6,000 active duty, 2,000 retired and 5,000 inactive). It was made more informative and attractive.

COMMISSIONED CORPS BILLET SYSTEM

The commissioned corps billet system is being updated and revised with special emphasis on:

- Career tracks
- Consistency between billets and grades
- Maintaining ranks and strengths consistent with established billets, categorical need, and available assignments.

The commissioned corps is trying to open up more opportunities for officers to make the corps a career by providing for upward mobility. To facilitate this, DCP is accepting appointments of new officers at grades no higher than temporary O-3 (T-O-3) for most categories and T-O-4 for highly trained specialties. Some

agencies are recruiting even lower-graded officers for entry-level professional positions.

DCP is making an "objective determination" of virtually all flag grade billets and of the process used to promote officers to those billets. Flag officers must be members of the regular component. Reserve flag officers may still be appointed to such roles as the Assistant Secretary for Health (ASH), agency heads and The Surgeon General.

CAREER DEVELOPMENT

To respond to the rapidly changing health needs of Americans, the commissioned corps career development system, under development, will emphasize training and mobility.

Competitive Training Boards

Are established at DCP-level for all disciplines.

Commissioned Officer Individual Training Plans

Each officer will have an individual training plan developed and updated at regular intervals to facilitate the officer's career development and to maintain commissioned corps readiness.

Mobility

As a basis for professional growth and career development, each officer will be given the opportunity to compete for assignments. An officer should expect three to five geographic and/or professional rotations during a 20-year career. The inherent readiness of officers to move and meet changing or one-time needs is considered to be one of the major factors differentiating commissioned officers from civil servants.

Equal Opportunity

Work groups and promotion boards are established to ensure that the commissioned corps represents both genders, members of minority groups, and officers serving outside the Washington, D.C., area. The corps is adding women and minorities at a much higher rate than before revitalization; three in eight new

accessions are women (one in four in total active force) and one in four are minorities (1 in 7 in total active force). The Surgeon General wants to improve those rates.

Career-Track Work-Group

Fourteen work-groups were established during the summer of 1987 to analyze current approaches to career development and commissioned corps management, making suggestions about opportunities and identifying how to eliminate obstacles in the system. Of the 94 members, 40 percent came from the field. The five career development work groups will develop model career tracks and propose an implementation plan. Their recommendations will provide the foundation for planning and management of career tracks and assignments for individuals. The work groups will develop career tracks that include a series of specific and planned assignments of increasing responsibility and professional growth over a planned 30-year career. The 14 work groups are as follows:

- Career Development Work-Groups
 - Regulatory Affairs
 - Research
 - Management
 - Epidemiology-Public Health
 - Clinical
- Specialty Work-Groups
 - Uniform
 - Training, Awards and Recognition
 - Recruitment
 - Automated Officer Profile System
 - Orientation
 - Medical Standards
 - Medical Services
 - Boards (Promotion, Appointment and Assimilation)
 - Billets

DCP As Commissioned Officer Advocate

The "realignment" of DCP will ensure that all officers have the opportunity for input to and participate in their own career planning and development. DCP will actively identify and bring to officers' attention, newly available positions and billets throughout the DHHS and other agencies. DCP will assist officers in planning appropriate rotational assignments to satisfy their career plans. Those assignments are expected to foster professional growth, provide the opportunity to participate in expanded training and personal development and provide officers the opportunity to assume increasingly responsible positions.

Assignment Preference and Professional Licensure and Educational System (APPLES)

The APPLES was introduced to all officers in August 1987, in order to allow officers to communicate their career and geographic preferences to DCP. It is an automated personnel recordkeeping system that contains historical and licensing information on each officer. Licensing applies to about 3,900 officers.

PROMOTION AND RETIREMENT POLICIES

The Commissioned Corps had 2,000 fewer officers in 1987 than it had in 1980; 0-5 and 0-6 promotions have slowed for a few years before 1987. The following actions are being taken in response to those changes:

- Active recruiting of junior, rather than mid-grade, officers.
- Working with agencies to open positions currently held by 0-6s beyond their 30-year retirement date.
- Proposing to the Secretary, DHHS, an alternative pay system for PHS research scientists modeled after an academic faculty. (An NIH initiative.)
- Proposing to the Secretary, DHHS, improved special and comparability pays to encourage conversion of 30-year officers to the Civil Service.
- Providing agency heads with option to retain up to 15 percent of the 30-year retirement eligible officers (with no effect on other promotions). Agencies may keep additional officers above the 15 percent benchmark on a case-by-case basis; this, of course, slows other promotions, one-for-one in the affected agencies.

- Including reserve component officers and senior grade officers on promotion boards. The boards are following new precepts.

The Surgeon General personally wrote to each officer being affected by the 30-year retirement policy in 1988.

Officer Information Summary (OIS)

The OIS is a synopsis of each officer's succession to progressively responsible positions. It is an officer's personnel history – call to duty, promotions, changes in duty station, other transfers, awards and special skills. It does not include publications.

IMAGE

The Surgeon General has made the point that commissioned corps image and morale are basic to the recognition of PHS officers as leaders in the nation's health initiatives. Each commissioned officer must pursue and maintain the highest standards of personal and professional conduct, and each commissioned officer must live up to the mission and philosophy of the PHS commissioned corps.

In order to maintain the corps' identity as a uniformed service, all officers were directed to own and wear the appropriate uniform not later than May 1, 1987. The Surgeon General's policy is that each agency will set its own policy on the frequency its officers will wear the uniform but it will not be less than once a week. Guidelines for frequency of wearing the uniform were outlined in the April/May, 1987 issue of the *COA Bulletin*.

Improving *officer quality* by limiting all new calls to active duty to a specific 3- or 4-year period. Six months before end of a 3- or 4-year tour for all officers, a board of officers reviews the officer's record and assesses the officer's prospects for growth and career progression.

The assimilation of each officer into the regular component is under greater scrutiny. DCP is asking the agencies to encourage the best reserve component officers to apply for assimilation. There are two assimilation boards – one for O-3 and below, one for O-4 and above.

The COSTEP program has been increased from an average of 200 people in recent years to 400 in 1988.

An informal "ready reserve" program is active. Approximately 300 inactive reserve officers are enrolled in short tours programs (*in locum tenens* – a medical term meaning another health-care provider is temporarily taking patients for the absent primary health-care provider).

APPENDIX E

PREVIOUS STUDIES

PREVIOUS STUDIES

There have been three significant reports published on the Commissioned Corps in the past 30 years.

- U.S. Department of Health, Education, and Welfare. *Report of the Advisory Committee on Public Health Service Personnel Systems* (referred to as the "Folsom Study"). 1962.
- U.S. Department of Health, Education, and Welfare. *Report of the Secretary's Committee to Study the Public Health Service Commissioned Corps* (referred to as the "Perkins Study"). 1971.
- Ninety-seventh Congress. *History and Use of Public Health Service Commissioned Corps*, Hearing Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce (referred to as the "ASPE Study"). 1982.

UNCLASSIFIED

SECURITY CLASSIFICATION OF THIS PAGE

REPORT DOCUMENTATION PAGE

1a REPORT SECURITY CLASSIFICATION Unclassified		1b. RESTRICTIVE MARKINGS	
2a SECURITY CLASSIFICATION AUTHORITY		3. DISTRIBUTION / AVAILABILITY OF REPORT "A" Approved for public release; distribution unlimited.	
2b DECLASSIFICATION / DOWNGRADING SCHEDULE			
4. PERFORMING ORGANIZATION REPORT NUMBER(S) LMI-PH802R2		5. MONITORING ORGANIZATION REPORT NUMBER(S)	
6a NAME OF PERFORMING ORGANIZATION Logistics Management Institute	6b OFFICE SYMBOL (if applicable)	7a. NAME OF MONITORING ORGANIZATION	
6c ADDRESS (City, State, and ZIP Code) 6400 Goldsboro Road Bethesda, Maryland 20817-5886		7b. ADDRESS (City, State, and ZIP Code)	
8a NAME OF FUNDING / SPONSORING ORGANIZATION HHS	8b OFFICE SYMBOL (if applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER MDA903-85-C-0139	
8c ADDRESS (City, State, and ZIP Code) U.S. Public Health Service/DASH 200 Independence Ave. S.W. Washington, DC 20201		10. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO PROJECT NO TASK NO WORK UNIT ACCESSION NO	
11. TITLE (Include Security Classification) The Public Health Service Commissioned Corps: Strengthening Its Role and Management			
12. PERSONAL AUTHOR(S) Carl F. Stout, John B. Handy.			
13a TYPE OF REPORT Final	13b. TIME COVERED FROM _____ TO _____	14. DATE OF REPORT (Year, Month, Day) February 1989	15. PAGE COUNT 47
16. SUPPLEMENTARY NOTATION			
17. COSATI CODES FIELD GROUP SUB-GROUP		18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)	
19. ABSTRACT (Continue on reverse if necessary and identify by block number) Centralized management of the 5,500-member commissioned corps of the Public Health Service is the most effective and efficient way for PHS to administer its officers. Since the corps' personnel and compensation rules, regulations, and statutes differ from those of the Civil Service and Senior Executive Service, and since officers are to be found in relatively small numbers throughout the Department of Health and Human Services and other Federal agencies, centralized management of officer promotions, retention, rotations, and compensation provides control and economy. We recommend that it continue to be managed by its present organization, the Division of Commissioned Personnel. We also recommend that the Surgeon General and the Assistant Secretary for Health (ASH) take action to better define the mission of the commissioned corps. While PHS agencies have their own clear missions (and use commissioned officers to help satisfy them), they do not share a common understanding of the mission of the commissioned corps within PHS. Nevertheless, the Surgeon General, as part of his commissioned corps revitalization program, has asked the agencies to make changes in the way they use their officers to sustain that mission. To be able to support the changes, the agencies must fully understand the mission. Once the mission has been defined, we recommend that the Surgeon General publish it, and seek legislation to add it to Title 42, United States Code.			
20. DISTRIBUTION / AVAILABILITY OF ABSTRACT ☒ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT ☐ DTIC USERS		21. ABSTRACT SECURITY CLASSIFICATION	
22a. NAME OF RESPONSIBLE INDIVIDUAL		22b. TELEPHONE (Include Area Code)	22c. OFFICE SYMBOL

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To anticipate questions about the commissioned corps revitalization program, and reduce confusion about its implementation, we recommend that the Surgeon General develop and publish a clear statement of direction for that program.

Finally, we recommend that the commissioned status of the ASH be eliminated if the ASH and Surgeon General are to remain separate positions. The ASH is the final arbiter for many commissioned corps personnel issues. His subordinate, the Surgeon General, must, by statute, outrank all other commissioned officers. We believe the ASH's responsibilities and his commissioned status to be incompatible.

Action on our recommendations will require hard work and, probably, realignment of some officer positions. It will produce a commissioned corps with a more visible mission and more clear direction.

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