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The Public Health Service Commissioned Corps' Role in Disaster Response

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Abstract

As one of the seven Uniformed Services, the Commissioned Corps of the U.S. Public Health Service is a national health care asset. The Corps' rich history is filled with examples of a strong relationship with the Armed Forces. Current national emergency response planning documents strengthen this relationship. At the same time, there is a noticeable lack of coordinated mobilization planning for the use of Public Health Service officers to meet these operational plans. This document explores the various relationships established between the Public Health Service Commissioned Corps and the other organizations, and the lack of apparent mobilization policy and planning.

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"The policy of the United States is to have sufficient capabilities at all levels of government to meet essential defense and civilian needs during any national security emergency. A national security emergency is any occurrence, including natural disaster, military attack, technological emergency, or other emergency, that seriously degrades or seriously threatens the national security of the United States. Policy for national security emergency preparedness shall be established by the President. Pursuant to the President's direction, the National Security Council shall be responsible for developing and administering such policy. All national security emergency preparedness activities shall be consistent with the Constitution and laws of the United States and with preservation of the constitutional government of the United States.[1]"

President of the United States
Executive Order 12656
November 18, 1988

INTRODUCTION

The government of the United States has established roles for all of its operating components during national emergencies. This paper focuses on the role of the Department of Health and Human Services (DHHS), its Commissioned Corps of the United States Public Health Service (PHS), its relationships with other operational units within the government, and the impact of reduced Federal budgets in the current weak economy. In particular, we shall look at the areas of primary responsibility for the DHHS as outlined in various statutes, executive orders, memoranda of understanding (MOUs), Department of Defense Directives (DoDD), and operational plans. We will look at the implications of Executive Order 12656 of November 18, 1988: Assignment of Emergency Preparedness Responsibilities, The

Federal Response Plan annex concerning Public Health and Medical Care, and CINCFOR CONPLAN 7300-90, Integrated Conus Medical Mobilization Plan of 1 July, 1990.

A review of the specific role of the Commissioned Corps of the PHS in meeting these mobilization needs will be conducted. The Corps is a unique organization that crosses PHS Agency boundaries within DHHS. Current plans for use of the Corps as differentiated from DHHS as an entity, as well as proposals for future involvement will be discussed.

It should become clear to the reader that, although there are many relationships established for the use of officers of the PHS Commissioned Corps, there are minimal plans for implementation. Possibilities for needed actions to remedy this situation are presented.

HISTORY

Basic Authorities

Other government authorities in addition to Executive Order 12656 exist for emergency mobilization; each identifies the inter-relationships between and among various federal agencies. These include:

The Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 93-288, as amended)

The Federal Response Plan (For Public Law 93-288, as Amended)

The Public Health Service Act, Title 42 USC

DODD 3020.36, Assignment of National Security Emergency Preparedness Responsibilities to DOD

DODD 3025.10, Military Support to Civil Defense (Defines Military Support to Civil Authorities (MSCA))

DODD 3025.12, Military Assistance for Civil Disturbances (MACDIS)

The role of each of these authorities will be explored as appropriate in following sections.

The Department of Health and Human Services

As a cabinet level agency of the U.S. government, DHHS has overall responsibility for the health and welfare of the population of this country. The principal components of DHHS include: 1) The Administration on Children and Families, 2) The Public Health Service, 3) The Health Care Financing Administration, and 4) The Social Security Administration. Most of the direct functions associated with the health of the U.S. population, both in direct care and health research, fall under the purview of the PHS. Responsibility for the operation of the PHS lies with the Assistant Secretary for Health.

The Public Health Service

Establishment of the PHS may be traced to July 16, 1798, when President John Adams signed An Act for the Relief of Sick and Disabled Seamen[2]. The organization was established to provide health care to sailors and merchant marines when no such care existed. Thus, a relationship with the military forces of this country was established from the beginning of the United States. A similar relationship has existed with the U.S. Coast Guard since 1879 during its days as the Revenue-Cutter Service[3].

Today the PHS has over 45,000 employees, both civilian and commissioned, working in its various agencies and operational components. These include: 1) The Office of the Assistant Secretary for Health, 2) the Food and Drug Administration, 3) the National Institutes of Health, 4) the Indian Health Service, 5) the Agency for Toxic Substances and Disease Registry, 6) the Health Resources and Services Administration, 7) the Centers for Disease Control, 8) the Alcohol, Drug Abuse and Mental Health Administration and, 9) the Agency for Health Care Policy and Research.

"The mission of the Commissioned Corps of the Public Health Service is to provide highly-trained and mobile health professionals who carry out programs to promote the health of the Nation, understand and prevent disease and injury, assure safe and effective drugs and medical devices, and deliver health services to Federal beneficiaries, and who furnish health expertise in times of war or other national or international emergencies. As one of the seven uniformed services of the United States, the Commissioned Corps is a specialized career system designed to attract, retain, and develop health professionals who may be assigned to Federal, State, or local agencies or international organizations to accomplish its mission."[4]

Assistant Secretary for Health
December 11, 1989

A Corps of Health Professionals

A commissioned corps was established within the PHS on January 4, 1889, when President Grover Cleveland signed An Act to Regulate Appointments in the Marine Hospital Service of the United States[5]. At that time only graduates of medical schools were eligible for a commission within the corps. The Supervising Surgeon General who campaigned for the establishment of the corps was John B. Hamilton. At the time there were approximately fifty officers on active duty in the corps[6]. The mission of the corps was to radically change from one of meeting the needs of the merchant marines and sailors to one of providing wide ranging programs that would touch on every aspect of American life.

Today the PHS commissioned corps has approximately 6500 officers on active duty in 11 health profession categories (Table 1).

Category	Active	Reserve	Retired	Total
Medical	1815	2336	751	4902
Dental	688	557	236	1481
Nurses	960	292	293	1545
Health Srv	812	337	212	1361
Pharmacist	709	229	156	1094
Engineers	576	529	351	1456
Sanitarian	332	143	169	644
Scientists	276	131	225	632
Vets	110	47	85	242
Therapists	102	49	65	216
Dietitians	80	41	52	173
Total	6460	4691	2595	13746

Table 1. PHS Corps Strength by Category

These officers are assigned to the 9 agencies/offices of the PHS, and 11 other government or international organizations. The other organizations are staffed by PHS officers as the result of Federal statutes or interagency agreements. PHS provides clinical services to: The Federal Bureau of Prisons, the Immigration and Naturalization Service, the U.S. Coast Guard, and the National Oceanic and Atmospheric Administration. Other types of professional services are provided by members of the other categories to the Environmental Protection Agency, the Peace

Corps, the Health Care Finance Administration, the Agency for International Development (State Department), the Pan American Health Organization, the World Health Organization, and the Department of Defense.

As may be implied by the professional categories and the organizations to which the officers are assigned, the activities of the officers of the PHS are diverse, both in location and function. In the discussion of the Federal Response Plan, we will see where the PHS actually maintains the sole expertise to meet the responsibilities assigned to other federal agencies.

History and the PHS

Both DHHS and the PHS have a long history of responding to national emergencies, both domestic and international. Most recently, the agencies and officers of the PHS participated in Operation Desert Shield/Desert Storm. Although the roles played were not in the public eye, they were very important. PHS participated in providing support during several repatriation airlifts of U.S. citizens and dependents, including U.S. citizens detained by the Iraqis. Several government work groups related to mitigating the threat of potential Iraqi-sponsored terrorist attacks directed toward American targets at home and abroad were conducted with DHHS participation. In particular, work group activities led to a broadening of the scope of the Federal

Natural Disaster Response Plan to include technological incidents, and terrorism. The reworked plan was subsequently named The Federal Response Plan[7].

In the area of pharmaceuticals, the Food and Drug Administration worked to insure the availability of drugs, biological products, and medical devices required by DoD. PHS also assumed leadership responsibility for the National Emergency Blood Program. Once Desert Storm was completed, PHS convened a meeting of pharmaceutical and medical supply/equipment industry representatives to provide a forum for discussion of issues and problems encountered during the operations. The possible occurrence of similar problems during or following a major domestic disaster or emergency was assessed[8].

Officers of the Commissioned Corps were used in various capacities. Several nurses were deployed after the war as part of the humanitarian response. Additionally, officers assigned the Federal Bureau of Prisons filled in for over 200 civilian reservists called to active duty. Other officers whose duty stations are in proximity to military treatment facilities voluntarily participated in clinical care activities at those facilities. A PHS officer was assigned to the 352nd Civil Affairs Unit of the U.S. Army and accompanied the unit to Saudi Arabia and Kuwait[9].

In the past, officers of the PHS have been involved in such activities as providing medical care during the Cuban influx of 1981, Vietnam duty, militarization during World War(WW) II which continued until after the Korean War, and providing for the training of most of the nurses graduated in this country during WW II[10].

ROLES AND RESPONSIBILITIES

The National Disaster Medical System

Several references exist which explain the National Disaster Medical System in detail. For purposes of completeness, a limited review of its history will be included as a foreword to current relationships and system status.

In 1980, DoD began organization of the Civilian-Military Contingency Hospital System (CMCHS) to help remedy the shortfall between available military medical care capacity and predicted numbers of casualties for overseas conventional conflicts. This system was intended to establish a pre-commitment of non-Federal acute care hospital beds for care of military personnel[11].

At the same time, the lack of a national medical response capability in the event of a major domestic disaster was noted by Federal civilian planners. As a result of this need, a concept paper was prepared in August, 1981, which described a single national medical system to serve as a backup for DoD and to respond to domestic disasters. In December, 1981, the President established the Emergency Mobilization Preparedness Board (EMPB) to make recommendations for improvement of U.S. mobilization capability during major disasters and emergencies. The Principal Working Group on Health (PWGH), the medical subgroup of the EMPB recommended the creation of a National Disaster Medical System (NDMS)[12].

The principal government agencies designated for involvement in the NDMS are DoD, DHHS, the Federal Emergency Management Agency (FEMA), and the Department of Veterans Affairs. Management responsibilities for the overall system rest within the Office of Emergency Preparedness (OEP), DHHS. When a domestic disaster situation is determined, the Assistant Secretary for Health, DHHS has responsibility for activation and control of the NDMS. In a military contingency, the Assistant Secretary of Defense (Health Affairs) has authority to request activation of the NDMS[13].

The basic concept of the NDMS is to provide a coordinated system that combines medical care at a disaster site (domestic emergency), a transportation system for casualties that must be evacuated from the domestic disaster site, a receiving system at designated locations for stabilization and local transport co-ordination, and acute care at pre-committed treatment facilities. The main functional blocks for providing remote medical care are the Disaster Medical Assistance Teams (DMATs). Each team is expected to be self-sufficient for a period of 72 hours. Plans call for 150 of these DMATs to be identified and trained throughout the country[14].

The Federal Response Plan

The Federal Response Plan outlines the specific emergency mobilization responsibilities of the Federal agencies. The Plan is designed to address the consequences of any disaster or emergency situation in which there is a need for Federal response assistance under the authorities of the Stafford Act (Public Law 93-288 as amended by Public Law 100-707). It is applicable to natural disasters such as earthquakes, hurricanes, typhoons, tornadoes and volcanic eruptions, technological emergencies involving radiological or hazardous material releases, and other significant events. The Federal responsibilities have been broken into 12 Emergency Support Functions (ESF). Each ESF has a lead agency assigned to ensure implementation[15].

The 12 ESFs and associated lead agencies are[16]:

1	Transportation	Department of Transportation
2	Communications	National Communications System
3	Public Works and Engineering	U.S. Army Corps of Engineers
4	Fire fighting	Department of Agriculture
5	Information and Planning	Federal Emergency Management Agency
6	Mass Care	American Red Cross
7	Resource Support	General Services Administration
8	Health and Medical Services	Department of Health and Human Services
9	Urban Search and Rescue	Department of Defense
10	Hazardous Materials	Environmental Protection Agency
11	Food	Department of Agriculture
12	Energy	Department of Energy

Although DHHS is the assigned lead agency for implementation of ESF #8, it also has assigned support roles in other ESFs. Outside of the formal Plan, an MOU exists between the PHS and the Army Corps of Engineers (ACE) for PHS assistance in meeting the requirements of ESF #3 concerning public works and potable water supplies[17]. This is in line with the requirement of the Plan that the various Federal agencies agree to develop and maintain the headquarters and regional interagency planning that must be done to establish a coordinated Federal response capability.

Implementation of the Plan is assumed to occur after a State's capability to respond to an emergency situation is overwhelmed. Either the Governor(s) of the affected state(s) or the President can declare an emergency situation which may require activation of the Plan. Such activation, not unlike the

mobilization of the armed forces described in following sections, can be phased to meet the level of response required. A full mobilization of all the ESFs would occur only in a catastrophic national emergency[18].

Emergency Support Function 8

Purpose:

> The purpose of this Emergency Support Function is to provide U.S. Government coordinated assistance to supplement State and local resources in response to public health and medical care needs following a significant natural disaster or man-made event. Assistance provided under ESF #8 - Health and Medical Services, is directed by the Department of Health and Human Services through its Executive Agent, the U.S. Public Health Service. Resources will be furnished when State and local resources are overwhelmed and medical and/or public health assistance is requested from the Federal Government[19].

The major functional areas are: 1) assessment of health/medical needs; 2) health surveillance; 3) medical care personnel; 4) health/medical equipment and supplies; 5) patient evacuation; 6) in-hospital care; 7) food/drug/medical device safety; 8) worker health/safety; 9) radiological hazards; 10) chemical hazards; 11) biological hazards; 12) mental health; 13) public health information; 14) vector control; 15) potable water/waste water and solid waste disposal; and 16) victim identification/mortuary services[20].

The ability to meet many of these functional responses is contained within the PHS. Specific agencies within the PHS are assigned lead responsibility for areas within this ESF that require their expertise. Additional resources are available upon activation of the NDMS.

Emergency Support Function 3

Purpose:

> The purpose of this Emergency Support Function is to provide Public Works and Engineering support to assist the State(s) in needs related to lifesaving or life protecting following a major or catastrophic disaster[21].

PHS engineers and sanitarians have an interest in the requirement of providing emergency restoration of critical public services and facilities, especially supplying adequate amounts of water for a variety of uses. It is because of this requirement and the unique skills of PHS engineers that the MOU was signed in January 1991, between the PHS and the ACE for engineering support. Under the terms of the MOU the PHS will assign engineer and sanitarian officers to the ACE division and district offices for the purpose of providing public health engineering and sanitation input to emergency response plans[22].

Why the use of PHS officers? The ACE has limited experience in the areas mentioned above. The PHS, in particular those engineers and sanitarians assigned to the Indian Health Service (IHS), regularly deals with such activities. Often the conditions for providing water and sewage on reservations are very austere, a set of conditions similar to those expected after a major disaster.

A pilot project was undertaken late in 1991 to test the feasibility of this MOU. Officers from the PHS (2 sanitary engineers, 2 sanitarians, all from the IHS) were sent to work with members of the ACE's Louisville KY district office, members of the Kentucky State Emergency Operations Center, and the Paducah/McCracken County Emergency Operations Center staff. Initial response to this project has been very favorable[23].

Relationship with the Department of Defense

The relationship of DHHS and the commissioned corps of the PHS to DoD is varied and extensive. The Public Health Service Act, Title 42, USC, defines the role of the commissioned corps in national emergencies. The several federal response plans, both those established by Executive Order and DoD Directives, outline the formal relationships and responsibilities of all federal agencies. They do not, however, establish the operational plans for cross use of assets. In addition, several memoranda of

understanding exist between the PHS commissioned corps and the other uniformed services.

Integrated CONUS Medical Mobilization Plan

(CINCFOR CONPLAN 7300-90)

As stated in the opening page of this plan, the CONPLAN has the following purpose:

> The Integrated CONUS Medical Mobilization Plan (ICMMP) will ensure the integration of the appropriate portions of the Services' mobilization plans, the Department of Veterans Affairs (DVA)/ Department of Defense (DOD) Contingency Hospital System and the National Disaster Medical System (NDMS). The plan will ensure the effective and efficient use of residual CONUS military medical resources to expand the CONUS medical base for providing health care to the mobilizing force and casualties resulting from a national security emergency or other applicable contingencies. The plan will incorporate an orderly, efficient and effective transition from peacetime to wartime military medical operations that can also be responsive to disasters or national security emergencies[24].

There are two sets of conditions under which the plan may be implemented: support to military wartime operations (including contingencies); support to civil authorities (MSCA) in disaster or national emergency situations[25].

In the first condition, which may range over the entire spectrum of armed conflict from Low Intensity Conflict (LIC) to global war, the plan may be implemented in three phases. It is in phase III (global war) that the PHS/NDMS might be used, for this is when total mobilization would occur[26].

Under the conditions of a major disaster or emergency which, in the determination of the President, requires Federal assistance to state and local government efforts to save lives and protect property, MSCA plans may be implemented. The Director of FEMA, in compliance with the provisions of 42 USC 5121, may direct any Federal agency to provide assistance. If DoD assets are needed, the Secretary of the Army, as the DoD Executive Agent, through the Director of Military Support (DOMS), will provide policy and direction for the military support within CONUS. DOMS may, within established policy, task appropriate DoD components for use of military resources[27].

In reviewing the operations to be conducted under this plan several important features, or lack thereof, stand out. There are no designated specific medical forces/resources in anticipation of execution of this plan. The National Command Authority (NCA) may direct the allocation of resources in support of MSCD/LDC missions. Prior to such an allocation, commanders may, after assessment of their own mission priority needs, provide medical forces/resources to support ICMMP missions. This

support is temporary and may be withdrawn to meet higher priority military missions[28].

The plan ensures effective and efficient use of CONUS residual military medical resources by focusing on four broad areas and tasks. Two of these tasks may have direct implication on the interaction with DHHS. In particular, providing care for returning casualties (including those generated in CONUS) may require use of the NDMS. The second task of import is the provision of military resources in support of MSCA operations. This will require the development and maintenance of plans, programs, and mechanisms to ensure effective mutual support between and among the military, civil government, and the private sector.

One of the important assumptions of the ICMMP is that insufficient military medical resources will exist during mobilization to satisfy the total demand of the military services. Additionally, the Military Services and all other health care agencies will draw from the same limited medical resource base. It is assumed that all residual CONUS military medical resource assets will be potentially available, to include aeromedical evacuation and blood assets. Finally, ICMMP can be used in support of any national security emergency[29].

Military Mobilization of the PHS Commissioned Corps

DHHS has been established as the lead Federal Agency concerned with the health of the nation throughout this document. The ICMMP recognizes this fact and outlines the possible mobilization of the PHS commissioned corps to meet the needs of DoD. Militarization and mobilization of PHS Commissioned Corps members takes place when a determination is made by the President that these manpower resources are required to meet a national emergency. If the President declares the PHS Commissioned Corps a military service, PHS commissioned officers will fall under the Uniform Code of Military Justice (UCMJ). Otherwise, PHS operations would continue as in peacetime under the DHHS/PHS administrative organization (unless the President directs otherwise).

There are alternative levels of implementation which include:

1. Selective mobilization of active duty PHS Commissioned Corps officers to augment military medical requirements.

2. Total mobilization of active duty PHS Commissioned Corps officers to augment military medical requirements.

3. Selective mobilization of members of the PHS inactive reserve.

4. Mobilization of all available PHS inactive reservists.

Current policies and plans call for minimum impact on active duty officers of the PHS Commissioned Corps in wartime. The pool of officers available for detailing to DoD would be increased by mobilizing inactive PHS Commissioned Corps reservists before reassigning active duty officers.

Use of the inactive reserves, unless there is Presidential mobilization, is not the same in the PHS as in the military services. Once an officer has left active duty his/her continued relationship with the PHS Commissioned Corps is voluntary. There is no obligated period of follow-on reserve service. Additionally, there is no retirement credit or annual training commitment for officers of the PHS inactive reserve. Legislation forwarded to Congress in September 1991, is currently under consideration to strengthen the ties of the PHS inactive reserve. If enacted, officers would require periods of annual training in medical facilities or other appropriate health profession

activities (e.g. work on an indian reservation for civil engineers).

Military Support to Civil Authorities

The role of the military in support of civilian disasters is important, especially since many of the resources needed by DHHS to meet its responsibilities belong to DoD. When MSCA operations occur, military medical resources may be deployed and employed under DOMS direction. The CONUSA/JRDC (Disaster Control Officer (DCO)/Regional Military Emergency Coordinator (RMEC)), as appropriate, will coordinate with DHHS representatives for medical matters via the FEMA Federal Coordinating Officer (FCO). The following partial listing of the sequence of events in a domestic emergency indicates the role of DHHS in activating MSCA activities[30].

1) DHHS, through FEMA, notifies DOMS that a catastrophic event that may require a medical response has occurred.

2) DHHS, through FEMA, forwards specific validated requirements to DOMS for action.

3) DOMS designates CINCFOR as the supported CINC for anticipated MSCA operations.

4) CINCFOR assigns a lead CONUSA, and if necessary, a supporting CONUSA.

The rest of the outlined steps establish the temporary nature of the military assistance provided and the fact that such assistance will be withdrawn if required to support higher priority military functions. Additionally, the need to ensure continuity of operations, troop survival, and rehabilitation of essential military bases over implementation of CONPLAN 7300-90 is established[31].

The DHHS/PHS - DoD Memorandum of Understanding

The MOU between DoD and the DHHS/PHS was signed in July, 1988, and amended in December 1989. The basis for this MOU rests in the Public Health Service Act, as amended, specifically 42 U.S.C. 204, 212, 213, 215, 216, and 217 [Appendix A]. This MOU established a contingency planning relationship between the departments for the mobilization and employment of PHS commissioned officers in DoD health care activities. Before this MOU there had been no agreement defining the mechanism and plans to mobilize the PHS corps. The ICMMP described in a preceding

section states that assets of both the NDMS and PHS commissioned corps may be activated depending on the nation's response level to a military contingency. However, the ICMMP does not detail the ongoing relationship between the services to ensure a smooth meshing when needed.

Under the MOU, various responsibilities are spelled out to assist in the process of integrating PHS officers into the military services when required. Both parties are to undertake cooperative initiatives concerning the mobilization and employment of PHS officers in such health care activities as the Joint Medical Mobilization Office (JMMO) and other areas of interest in health care planning, operations, and training[32].

The responsibilities of DoD include the peacetime planning for and, upon Executive Order of the President, integration of designated PHS officers in DoD health care activities to the maximum extent possible under existing law. This action would provide an immediate capability previously degraded by the rapid and early deployment of active duty and reserve military health care personnel to overseas theaters. Additionally, when theater health care manpower requirements dictate, PHS officers may be deployed to theater facilities[33].

Provisions are included for the assignment of a PHS officer to the JMMO for the purpose of assisting in the preparation of a general plan for the mobilization and employment of designated PHS officers in DoD health care activities. The plan will establish priorities for employment, time-phased requirements and availability, command and control responsibilities, and requirements for definitive plans[34].

Through the Secretaries of the Military Departments, each of the military departments is tasked to identify the requirements, by health care specialty and priority, that can be filled by PHS officers. Each service is to prepare definitive plans to implement the general mobilization and employment plan for PHS officers in their department[35].

DHHS maintains responsibility to develop and promulgate internal policy regarding the mobilization and employment of PHS officers. This includes policy for the recall of retirees for transfer to DoD after DHHS/PHS meets its mandated domestic responsibilities. The general plan will include the time-phased availability of PHS officers. Steps will be taken to ensure that definitive plans are prepared at agency/program levels to implement the general plan. Any initiatives that might result from the general and definitive plans that require funding are to be planned for in Agency/Program budgets[36].

Personnel issues are generally spelled out insofar that PHS officers will meet DoD physical and credential requirements. Additionally, PHS personnel assigned to Military Services will be eligible for DoD and Service specific training and awards programs on the same basis as assigned commissioned officers of the Military Services. The overall caveat to this MOU is the availability of funds for these purposes[37].

RECENT INTERACTIONS AND USES OF THE PHS CORPS

Currently three PHS commissioned officers are assigned to DoD. Two of these officers have responsibilities directly related to implementation of the DoD - DHHS MOU. The senior officer is assigned to the Assistant Secretary of Defense (Health Affairs) and is tasked with developing the plans for the use of PHS officers by the Military Services as required by the MOU. Another officer is assigned to the CJCS staff, J-4 (Logistics Directorate) to serve as a liaison to the PHS concerning medical readiness activities. Both of these officers are assigned out of the DHHS, OEP.

Throughout this document the use of staff of DHHS and officers of the PHS commissioned corps have been described. As recently as December 1991, ESF #8 was activated to respond to mass destruction in the Republic of the Marshall Islands that resulted from a severe storm. Following hurricane Hugo in 1989, the NDMS was partially activated with teams of medical providers and a portable medical facility being sent to the island of St. Croix to replace the devastated hospital. The currently established ΓMATs maintain an annual training program. A major, multi-unit exercise is scheduled for the fall of 1992.

The role of the PHS during Desert Shield/Desert Storm, while out of the public eye, was extensive and of major import in meeting the mission of the U.S. government. At that time the inactive ready reserve and retired members of the PHS commissioned corps who are clinical providers were polled concerning deployment readiness to serve in domestic locations. This was done in response to the calling up of military reservists from understaffed rural areas of the country. While seeking to be responsive to the needs of the nation at home in difficult circumstances, there would have been a potentially greater negative impact on the nation's health if active duty officers had been reassigned in great numbers. One of the major standard clinical activities in the PHS is to meet the needs of under served citizens through both the Indian Health Service and the National Health Service Corps. Redirection of these already

limited resources would only exacerbate a chronic shortage of rural providers.

Future Trends and Roles

The United States Military Services are in a state of downsizing as a result of fiscal necessity (the huge national budget deficit), the end of the Cold War, and the demise of the Soviet Union. Although the medical departments of the Armed Forces will be the last to face reductions because of the continuing need to provide medical care to retirees, they eventually will[38]. Congressional budget makers have raised the possibility of reducing the levels of the military below the "Base Force" levels proposed by the Pentagon. The senior Executive Branch leadership has contended that we must remember the lessons of history and not return to the days of the hollow military that existed prior to the Korean War.

The nature of expected future wars has changed, however. No longer is the specter of global war something lived under on a daily basis. Regional conflicts such as Desert Shield/Desert Storm are believed to be the course for the immediate future. In fact, with the demise of the Soviet Union and the loss of the need for nations to align with the major players, the world is witness to an increase in the number of regional

interest/culturally motivated conflicts. The U.S. military is being shaped to respond quickly to such conflicts around the world. This is important because of the greater potential for reduced availability of military assets to meet domestic emergencies. Additionally, we must consider the greater need for outside DoD assets, such as the PHS Commissioned Corps, to meet short term health care needs in a military contingency as outlined in the DoD - PHS MOU.

Operations Provide Comfort and Provide Hope are but two of the humanitarian missions that DoD has participated in during recent years. There is an expectation that such missions will be part of the future role of the U. S. Government, including the Armed Forces[39]. At the same time, the nation's state of health care, both in terms of cost and accessibility, has become an issue of concern to the population. This is increasingly reflected as a campaign issue for the 1992 Presidential elections. Diseases, both old and new, are seeing new resurgences in cases among the population. Cases of tuberculosis, at one time under control and very infrequently seen in this country are on the increase. Control of HIV infection has been an item of great interest for some time and actions to find a cure are ongoing. The most recent information presented by the Secretary of Health and Human Services indicates that one in every 100 males and one in every 800 females in this country is infected with the HIV virus. All these, and many

other health issues, point to a continued need for the PHS to fulfill its domestic mission.

What of the need to respond to domestic national emergencies? Major earthquake faults in both the central and western United States are approaching points in their historical cycles when catastrophes may be expected. Are we ready and will we continue to be ready (if we now are) when the military assets are diminished?

The PHS Commissioned Corps' Potential

The historic role of the PHS Commissioned Corps has been one of a mobile cadre of health professionals. During the same period when DoD is downsizing, the PHS Corps, which has been constantly understaffed, is growing in size. The PHS mission has not changed with the changing world, health care and treatment needs continue both at home and abroad.

To continue to be able to respond as a uniformed service in times of national emergency requires new and continuing efforts to plan for the mobilization of the PHS corps. There is a difficulty based in the shared nature of control of the officers between the Surgeon General and the Agencies of the PHS to which they are assigned. While the Surgeon General maintains line control over the officers, actual designation of and funding for

positions rests within the Agencies. This dichotomy of command and control requires exceptional levels of coordination to employ commissioned officers for missions outside of their standard duties. It is in this area of expanded coordination and future planning that the role of the PHS Corps will be determined.

The efforts to fulfill the expectations of the DoD -- PHS MOU must continue. We do not need to determine which specific officer will be assigned to which specific task, but rather to establish the exact procedures to be used in all levels of a PHS call up. DoD should plan for the contingencies where PHS officers will be used and at what level of staffing. More importantly, the PHS should have an established policy and plan for the use of its officers in such a contingency. Such a central mobilization plan is imperative so that the domestic mission may be continued while providing to the needs of the military. The current perspective on future wars does not warrant a detailed officer by officer plan. We should, however, have institutionalized policy and plans to provide support as was done in Desert Shield/Desert Storm. We may not assume that the luxury of a several month time frame in which to prepare for war will exist in the future.

The additional MOUs discussed in this document (U.S. Coast Guard, Armed Forces Institute of Pathology, U.S. Army Corps of Engineers) represent commitments of PHS commissioned officers under a variety of circumstances. Evidence of a central accounting of these commitments and how they will be met is lacking. This should be resol ed.

The NDMS, when fully implemented and funded, will provide an asset to meet the needs of the nation in a domestic emergency and may serve as an important backup to DoD in a military contingency. Training and equipping of the team members will be critical to meeting the government's responsibilities under the Emergency Response Plan, ESF #8. The PHS Corps once again provides an asset that, through its daily activities, is relatively easy to prepare for NDMS type responses. With the vast majority of clinical services (medical, dental, engineering, etc.) currently being provided under somewhat austere conditions within the Indian Health Service, and actively training PHS DMATs, the resources are available.

"In the general sense, mobilization is government intervention in the national economic process to meet extraordinary national requirements. It is defined as the act of assembling and organizing national resources to support national objectives in time of war or other emergencies. It requires energization of the appropriate components of strategic logistics to respond to direct military attack (e.g., Pearl Harbor) by another nation or alliance, the emergence of a political or technological event (e.g., the Apollo moon program) that requires a unified national response or a significant national emergency or disaster (e.g. earthquake)[40]."

Basic National Defense Doctrine
Joint Pub 0-1
May 7, 1991

Conclusions

Mobilization is a process, one that can be planned for in times of peace or non-emergency. An office for mobilization planning within the PHS Commissioned Corps structure does not currently exist. Such an office is required to ensure proper utilization of the corps when responding to national emergencies. This office would coordinate all existing MOUs and serve as a focal point for future requests for commissioned officers, either in contingency planning or national responses. The office should have the responsibility for preparing policy and implementation agreements with the individual Agency authorities for temporary reassignment of officers to a PHS mission during an emergency. Planning can occur to cross Agency boundaries when compiling mission specific response teams. Such plans should determine which standard activities would fit the mission profile, which mission capabilities exist that are not part of an officer's

standard activities, which activities cannot be interrupted, and which can.

If the reserve components of the PHS corps are granted status equivalent to those of the other Uniformed Services, the potential for use of PHS assets without impacting on domestic responsibilities is increased. Many of the roles outlined for the NDMS call for two week deployments. If adequate advanced planning is conducted, officers, either active duty or reserve, could be mobilized without significant impact on ongoing programs.

The PHS Commissioned Corps exists to provide a cadre of mobile health professionals that are a valuable resource to the nation. Planning for their use within the framework of the ongoing mission of DHHS and the PHS is important to ensure continuity of domestic health services. As part of the PHS, officers could provide a timely uniformed response from the Federal Government that is not military in nature. This particular role could be of increasing importance in international health assistance activities.

Endnotes

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Appendix A

Applicable Sections of the Public Health Services Act

Section 204 establishes a Commissioned Regular Corps (currently limited by statute to 2400 officers) and, for the stated purpose of "securing a reserve for duty in the Service in time of national emergency," a Reserve Corps.

Section 212(c) provides for the involuntary recall of retired officers of either the Regular or Reserve Corps when the Commissioned Corps constitutes a branch of the U.S. land or naval forces.

Section 213 specifies the military benefits and rights accorded to PHS commissioned officers.

Section 215 authorizes the detail of PHS personnel to the Military Services.

Section 216(a) provides for the Presidential prescription and promulgation of regulations concerning the Commissioned Corps (PHS).

Section 217 provides that the President may, by Executive Order, declare the USPHS Commissioned Corps to be a military service, either in time of war, or upon a Presidential declaration of a national emergency.

In addition, section 802(a)(8) of Title 10 of the U.S.C. provides that PHS officers assigned to DoD are subject to the UCMJ.