

NAVAL WAR COLLEGE

Newport, R.I.

DoD Medical Unification:

A Necessity for the Combatant Commander and Homeland Defense

by

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A paper submitted to the Faculty of the Naval War College in partial satisfaction of the requirements of the Department of Joint Military Operations.

The contents of this paper reflect my own personal views and are not necessarily endorsed by the Naval War College or the Department of the Navy and are not likely to get me promoted.

Signature: \_\_\_\_\_

13 May 2002

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**REPORT DOCUMENTATION PAGE**

<b>1. Report Security Classification:</b> UNCLASSIFIED			
<b>2. Security Classification Authority:</b>			
<b>3. Declassification/Downgrading Schedule:</b>			
<b>4. Distribution/Availability of Report:</b> DISTRIBUTION STATEMENT A: APPROVED FOR PUBLIC RELEASE; DISTRIBUTION IS UNLIMITED.			
<b>5. Name of Performing Organization:</b> JOINT MILITARY OPERATIONS DEPARTMENT			
<b>6. Office Symbol:</b> C		<b>7. Address:</b> NAVAL WAR COLLEGE 686 CUSHING ROAD NEWPORT, RI 02841-1207	
<b>8. Title (Include Security Classification):</b> DOD MEDICAL UNIFICATION: A NECESSITY FOR THE COMBATANT COMMANDER AND HOMELAND DEFENSE (UNCLASSIFIED)			
<b>9. Personal Authors:</b> Commander Jack R. Rumbaugh, MSC, USN			
<b>10. Type of Report:</b> FINAL		<b>11. Date of Report:</b> 13 MAY 2002	
<b>12. Page Count:</b> 23 <b>12A Paper Advisor (if any):</b> Professor Paul St. Laurent			
<b>13. Supplementary Notation:</b> A paper submitted to the Faculty of the NWC in partial satisfaction of the requirements of the JMO Department. The contents of this paper reflect my own personal views and are not necessarily endorsed by the NWC or the Department of the Navy.			
<b>14. Ten key words that relate to your paper:</b> Military Health System, TRICARE, Medical Department, Defense Health Agency, U.S. Medical Command			
<p><b>15. Abstract:</b> Since the end of WWII, there have been no less than two dozen formal audits, boards, studies and reviews all questioning the efficiency and effectiveness of the three Services maintaining their own Medical Departments. For a variety of reasons, the Service Medical Departments have remained arguably unchanged by Goldwater-Nichols DoD Reorganization Act and the "jointness" it intended.</p> <p>Contrary to some initial expectations, TRICARE has evolved into an effective mechanism for providing healthcare to our active duty personnel, retirees, and their respective families. The remaining piece of the puzzle seems to be the effective and timely delivery of operational medical support to the true primary customer, the Combatant Commander. This can be resolved through the establishment of a unified Defense Health Agency.</p> <p>For CONUS and OCONUS support missions, the Combatant Commander is best served by a single, effective, and mission oriented voice for medical. For example, Presidential Decision Directives have established two Federal Lead Agencies that will oversee the response to a WMD attack on the homeland are the FBI (crisis management) and FEMA (consequence management). A cursory review of FEMA's Federal Response Plan, has the DoD as a primary supporting Agency with more support tasks as any other Agency; all of these tasks requiring coordination with Service medical organizations. The Combatant Commander is better served with having one voice, one chain of command, and one expert that can be relied upon to provide the necessary medical support, where when it is needed.</p> <p>The era of looking out for what is best for the individual Service medical departments is past. By looking out for the needs of the Combatant Commander, the needs of the Nation are also best served.</p>			
<b>16. Distribution / Availability of Abstract:</b>	Unclassified  X	Same As Rpt	DTIC Users
<b>17. Abstract Security Classification:</b> UNCLASSIFIED			
<b>18. Name of Responsible Individual:</b> CHAIRMAN, JOINT MILITARY OPERATIONS DEPARTMENT			
<b>19. Telephone:</b> 841-6461		<b>20. Office Symbol:</b> C	

## Abstract

### DOD MEDICAL UNIFICATION: A NECESSITY FOR THE COMBATANT COMMANDER AND HOMELAND DEFENSE

Since the end of WWII, there have been no less than two dozen formal audits, boards, studies and reviews all questioning the efficiency and effectiveness of the three Services maintaining their own Medical Departments. For a variety of reasons, the Service Medical Departments have remained arguably unchanged by Goldwater-Nichols DoD Reorganization Act and the "jointness" it intended.

Contrary to some initial expectations, TRICARE has evolved into an effective mechanism for providing healthcare to our active duty personnel, retirees, and their respective families. The remaining piece of the puzzle seems to be the effective and timely delivery of operational medical support to the true primary customer, the Combatant Commander. This can be resolved through the establishment of a unified Defense Health Agency.

For CONUS and OCONUS support missions, the Combatant Commander is best served by a single, effective, and mission oriented voice for medical. For example, Presidential Decision Directives have established two Federal Lead Agencies that will oversee the response to a WMD attack on the homeland are the FBI (crisis management) and FEMA (consequence management). A cursory review of FEMA's Federal Response Plan, has the DoD as a primary supporting Agency with more support tasks as any other Agency; all of these tasks requiring coordination with Service medical organizations. The Combatant Commander is better served with having one voice, one chain of command, and one expert that can be relied upon to provide the necessary medical support, where when it is needed.

The era of looking out for what is best for the individual Service medical departments is past. By looking out for the needs of the Combatant Commander, the needs of the Nation are also best served

**DoD Medical Unification:  
A Necessity for the Combatant Commander and Homeland Defense**

I hold the care of the sick and injured  
and a sacred trust...

to be a privilege

from the Hospital Corps Pledge<sup>1</sup>

Change--it is to be expected, however, the form it will take is often far less predictable. In general, individuals and institutions deal with change in four basic ways: by choosing to seek it out, by quickly acting upon it, by learning to adapt to it, or by denying and resisting it.<sup>2</sup> Since World War II (WWII) the Department of Defense (DoD) Military Health System (MHS) has been quite effective in countering over two-dozen studies<sup>3</sup> suggesting the MHS seek out, act upon, or adapt to change in a positive manner rather than succumbing to the institutional and bureaucratic bias to deny or resist it. The mission of the Military Health System (MHS) - to "provide health support for the full range of military deployments and to sustain the health of members of the Armed Forces, their families, and others to advance our national security interests" is certainly broad enough to seek out, build upon, and adapt to change in order to better support the Combatant Commander.<sup>4</sup>

The thesis of this paper is that it is now time to embrace change to the MHS. The Nation has justifiably set high standards for the Department of Defense and as such, the Service Medical Departments; it expects DoD to be the experts in the business of national defense. Therefore, the three Service Medical Departments must seek out change that will better serve the Combatant Commander while still ensuring the highest healthcare industry standards are applied to the care and treatment of the individual patient. It is time for the three medical departments and the TRICARE Management Activity to become joint in concept, to embrace change and be transformed into the Defense Health Agency.

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<sup>1</sup> "The Hospital Corps Pledge." Lkd. U.S. Navy Hospital Corps. 10 March 2002. <<http://www.kcatech.com/corpsman/pledge.htm> > 18 April 2002.

<sup>2</sup> Spencer Johnson and Kenneth Blanchard, Who Moved My Cheese?: An Amazing Way to Deal With Change in Your Work and in Your Life (New York: Putnam's Sons, 1998) 25 - 75.

<sup>3</sup> Colonel David Wehrly, "Military Medicine Focused for Joint Warfighting," (Unpublished Research Paper, U.S. Army War College, Carlisle Barracks, PA: 1993), 45-51.

In the following pages I will argue that a unified medical organization is required to provide the leadership and centralized coordination to support the Combatant Commander. Not only is this sound fiscal policy, it also leverages resources to their best possible use while ensuring that the Combatant Commander has the medical resources necessary to address the challenges of patient care, operational medicine, homeland defense, and weapons of mass destruction.

With the rising cost of healthcare under the TRICARE program for purchasing healthcare from outside of the MHS (and its predecessor CHAMPUS), the primary focus of the MHS has shifted from a healthcare delivery system that exists to support the needs of the Combatant Commander to a system that has embraced civilian healthcare delivery models - often at the expense of the Combatant Commander. The result was an effective transition to an accreditation driven civilian health care organization and the health maintenance organization (HMO) support structure adapted for DoD requirements. In an era of austere budgets and downsizing, it is not surprising that when hard choices had to be made, the MHS found itself challenged to adequately meet the demands to both the Combatant Commander and the civilian health care model. Due to the resource limitations of the last few decades, the message was conveyed that the Combatant Commander needed to choose between medical support for the operational forces and the medical support for the families, retirees, and active duty personnel remaining at home. As is often the case when faced with multiple priorities, the issue that is most important (i.e. supporting the Combatant Commander) is ultimately sacrificed upon the proverbial altar of addressing the immediate crisis at hand (i.e. the financial and quality assurance improvements promised by application of healthcare industry standards). Improved efficiencies and effectiveness through consolidation of the MHS offers another choice.

The additional demands of Homeland Defense should encourage the MHS to develop metrics and models that will successfully apply healthcare industry standards to the business of supporting the Combatant Commander. To meet this challenge, the three Service Medical Departments need to be joint in concept, planning, and practice. The threat to the United States homeland will require the MHS to effectively interact

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<sup>4</sup> "Mission Statement." Lkd. Office of Assistant Secretary of Defense for Health Affairs. 03 April 2002. <<http://www.ha.osd.mil/>> 18 April 2002.

with all levels of homeland medical support--on a local, state, federal, and possibly international level. The Combatant Commander now requires a consolidated medical organization that will provide both the quality patient care and operational support elements in a myriad of defense related missions.

### **Is there a need for change?**

Since the completion of WWII, Department of Defense and Congressional leadership have often been in quandary over the requirement, efficiency, and effectiveness of maintaining three separate medical departments for the Services.<sup>5</sup> Regardless of perspective, the Service Medical Departments have been successful in fending off official inquiries into the requirement for what has been perceived as apparent overlap, redundancy, and Service specific medical practices. It is beyond the scope of this paper to address each of these studies, however Colonel David Wehrly presented an overview of these inquiries in his paper entitled Military Medicine Focused for Joint Warfighting. It was his analysis that:

the number one priority for current medical programs is garrison-oriented peacetime healthcare delivery... This priority has compromised the go-to-war medical capability available to support our military forces through traditional military medical endeavors... much of the operational health service support (HSS) that is available occurs in spite of senior medical leadership, not because of it.... **A single Defense Health Service Support Agency should replace the three currently separate medical departments** (emphasis mine).<sup>6</sup>

Furthermore, it is not the purpose of this paper to propose detailed wire-diagrams for a unified medical organization; there is no shortage of wire-diagrams within DoD. None-the-less, some general guidelines in designing a unified medical organization will be presented later in this paper. Again, the focus of this paper is to argue that a unified medical organization with an operational focus is required if the MHS is to truly focus on providing optimal medical support for the Combatant Commander. It is primarily the Combatant Commander who will be served or thwarted by the unity of command and unity of effort provided by the medical support structure, for better or for worse, the impact upon homeland defense will be an obvious, secondary result.

A terrorist attack upon the United States has been of utmost concern following the events of September 11<sup>th</sup> 2001. Yet it is not against airplanes, bombs, or even biological attacks that the United States must defend.

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<sup>5</sup> When added to the three Service Medical Departments, the TRICARE Management Activity adds a fourth dimension to DoD MHS.

<sup>6</sup> Colonel David Wehrly, "Military Medicine Focused for Joint Warfighting," (Unpublished Research Paper, U.S. Army War College, Carlisle Barracks, PA: 1993), 45-51.

A primary goal of terrorism is to produce terror in order to effect change. According to the Federal Bureau of Investigation (FBI), the purpose of terrorism is "to intimidate or coerce a government, the civilian population, or any segment thereof, in the furtherance of political or social objectives."<sup>7</sup> In a large part, the agenda of today's international terrorists seems to be to instill fear in the population at large in order to foster a loss of trust and faith in the government's ability to protect it. Terrorists use fear, confusion, and distrust in their arsenal of weapons in order to destroy the will of the people and thereby weaken the effectiveness of the government.

Numerous studies, including the FBI's 1999 Report on Terrorism, indicate that unconventional weapons (i.e. chemical, biological, radiological, cyber, radio frequency, and pulse weapons) may become more attractive to terrorists.<sup>8</sup> Many of these unconventional weapons (e.g. nuclear, chemical, and biological) seem to add an extra element of terror than their conventional counterparts, and therefore may become the weapon of choice in a strike on America's homeland. Of these, biological weapons would produce a most formidable public health challenge. In a letter to Governor Gilmore in his role as the Chairman, Advisory Panel to Assess Domestic Response Capabilities for Terrorism, the Director for the Center for Bio-Terrorism Response emphasized that:

...In a chemical attack, decontamination is the major containment issue... Biological terrorism is considered a low probability, high consequence event... The silent and secretive nature of a bio attack and the delayed onset of illness following a bioterror attack results in victims being seen some days later by primary care physicians, clinicians, and infectious disease specialists and in emergency rooms... containment in a bioterror attack requires infection control in medical facilities, contagious disease precautions and identifying a large population at risk.<sup>9</sup>

## **The Role of the Combatant Commander**

Why is any of this of interest to the Combatant Commander? After all, the Federal Government has established a primary plan of action for any such WMD (Weapon of Mass Destruction) attack. The government has a two-fold plan, and during the first stage the FBI is designated as the Lead Federal Agency in charge prior to and during the initial crisis management of the incident. The FBI's concept of operations focuses on the

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<sup>7</sup> "Terrorism in the United States, 1999 Report" Lkd. Federal Bureau of Investigation. 18 April 2002. < <http://www.fbi.gov/publications/terror/terroris.htm> > 18 April 2002.

<sup>8</sup> *ibid.*

<sup>9</sup> Samuel J. Watson III, personal letter of 31 October 2000 to the "The Advisory Panel to Assess Domestic Response Capabilities for Terrorism involving Weapons of Mass Destruction" of 15 December 2001. Lkd. The Gilmore Commission. 17 April 2002. < <http://www.rand.org/nsrd/terrpanel/> > 18 April 2002.

initial stages of a WMD incident; during which it will exercise Crisis Stage command and control through its National Domestic Preparedness Office.<sup>10</sup>

However, critical to the success of the FBI's plan is the reliance upon other federal agencies for support. This is of particular interest to the Combatant Commander since the plan relies heavily upon on DoD. Designated as a support agency for crisis management functions and technical operations, DoD provides an impressive degree of tactical, operational, and strategic support, including:

... threat assessment; DEST [domestic emergency support team] participation and transportation; technical advice; operational support; tactical support; support for civil disturbances; custody, transportation and disposal of a WMD device; and other capabilities including mitigation of the consequences of a release.<sup>11</sup>

Once the FBI has determined that the event is no longer in the Crisis Stage, the Consequence Management Stage begins with the Lead Federal Agency shifting from the FBI to FEMA (Federal Emergency Management Agency) under the Department for Health and Humans Services (HHS). Of the federal agencies that support the FEMA at this stage, DoD is again tasked with a significant degree as either the Primary or Secondary Agency for twelve Emergency Support Functions with numerous tasks in each function. If successful, a terrorist attack will result in casualties, and the medical tasks assigned to DoD will be broad and resource intensive--ranging from initial triage and treatment to ground and air medical transportation.<sup>12</sup>

To provide the necessary medical support to respond to such a threat as expected by the FBI or FEMA, the Combatant Commander is best supported by a medical structure that provides a centrally led, well coordinated research and development program for the detection, mitigation, and consequence management of weapons of mass destruction. This requires a strong medical infrastructure; not just for the testing, reporting, and evaluation of disease and medically-related threats as provided by the Center for Disease Control (CDC), but for coordination of rapid deployment and employment of direct medical support at all levels (i.e. local, county, state, and federal).

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<sup>10</sup> "CONPLAN - U.S. Government Interagency Domestic Terrorism Concept of Operations Plan" Lkd. Federal Bureau of Investigation. 18 April 2002. <<http://www.fbi.gov/publications/conplan/conplan.pdf> >18 April 2002.

<sup>11</sup> "CONPLAN - U.S. Government Interagency Domestic Terrorism Concept of Operations Plan" Lkd. Federal Bureau of Investigation. 18 April 2002. <<http://www.fbi.gov/publications/conplan/conplan.pdf> >18 April 2002.

It becomes clear that the Combatant Commander for Homeland Defense is likely to have significant support role in both the Crisis and Consequence Management Stages of a WMD attack on the United States. This will require profession planning for, evaluation of, and response to FBI and FEMA requests for the medically-oriented support tasks. Like any mission, operational factors of time, space, force, and information will be critical to contain the crisis and minimize the medical impact of the agent(s) used.

Should a WMD attack be directed against a ship or a military base overseas, the Combatant Commander's requirement for a clear, focused, medical response will be further compounded. Regardless of the location of the WMD incident, the Combatant Commander will need a consolidated, unified, medical support organization. This organization will be required to coordinate with other agencies or governments in order to direct the medical aspects of personnel augmentation, scientific, technical, and logistics necessary to support crisis response and consequence management tasks associated with military bases and operational units around the world.

### **The need to change the Medical System**

So why is it time to change? For all its perceived shortfalls (i.e., expensive, apparent redundancy, arguable lack of focus on the combatant commander), the MHS provides quality medical care that consistently results in patient satisfaction rates well above national averages.<sup>13</sup> TRICARE has exceeded expectations in many regards, so why change the MHS and risk making things worse?

When Congress enacted Goldwater-Nichols Department of Defense Reorganization Act in 1986, there was no reference to the medical departments applying joint concepts to their mission or their participation in joint professional military training.<sup>14</sup> An argument has been made that although a joint focus might be of value for the war-fighters, it has little practical use to non-combatant medical personnel who have little need to understand the principles of war. On the converse, others argue that this type of thinking explains the lack of

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<sup>12</sup> "Federal Response Plan" Lkd. Federal Emergency Management Agency. 16 June 1999. < <http://www.fema.gov/fema/fed1.htm> > 18 April 2002.

<sup>13</sup> "2002 TRICARE Stakeholder's Report: Our Promise Kept, Our Nation Calls." Lkd. TRICARE Management Activity. 18 April 2002. < [http://www.tricare.osd.mil/stakeholders/downloads/stakeholders\\_2002.pdf](http://www.tricare.osd.mil/stakeholders/downloads/stakeholders_2002.pdf) > 18 April 2002.

<sup>14</sup> "U.S. Code title 10 Subtitle A, Part 1, Chapter 5" Lkd. Goldwater-Nichols Act of 1986." Undated < [http://www.dtic.mil/jcs/core/title\\_10.html](http://www.dtic.mil/jcs/core/title_10.html) > 18 April 2002.

progress in establishing common operating procedures, staff integration and interoperability between the Service Medical Departments.

Certainly the intent of Goldwater-Nichols was to encourage and support improved interoperability among the Services.<sup>15</sup> Few would argue that the Services have not benefited from this legislation inasmuch as it has improved coordination and communication in other service sector areas. The Defense Intelligence Agency, Defense Logistics Agency, and the U.S. Transportation Command are several examples of service sector areas within DoD that have been successful in expanding their emphasis from beyond the Service level to the joint focus of the Combatant Commander.

Yet, maybe the practice of military medicine is truly unique. Perhaps the distinctive models used by the individual medical departments best serve the Services. What if the adoption of a joint warfare mindset only served to further distance the medical department provider from the war-fighting customer? After all, if Congress has not mandated the Service Medical Departments to fully embrace Goldwater-Nichols, then there is no reason to do so.

Fortunately, a quick review of the operational concepts for medical support makes it clear that such thinking it without true merit. In concept and practice, when the medical departments provide direct support to the Combatant Commander or Joint Task Force Commander it is in the form of a senior medical officer assigned to serve on the Commander's staff as the Surgeon<sup>16</sup> to help select, employ and integrate the appropriate medical resources from any or all of the Services in order to ensure mission accomplishment.<sup>17</sup> If the common adage of "train as you fight and fight as you train" has proven successful in other aspects of military operations, it is time to also apply it to the Service Medical Departments, whether or not Congress specifically mandates it.

### **What has this to do with Homeland Defense?**

Much of the doctrine and emphasis for change within DoD is based upon the results of exercises and war-games. During the summer of 2001, a major, senior-level war-game examining the "national security,

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<sup>15</sup> *ibid.*

<sup>16</sup> The term Surgeon applies to the senior medical department representative on the Commander's staff, it does not require the officer to be a physician skilled in surgery as is the modern use of the term.

intergovernmental, and information challenges of a biological attack on the American homeland".<sup>18</sup> For exercise purposes, during a period of rising tension in the Far East, an outbreak of smallpox was discovered in Oklahoma City. The exercise, entitled Dark Winter, lasted thirteen days, during which time the smallpox outbreak had spread to twenty-five states and fifteen countries. Many of the challenges for decision makers involved the "public health response, lack of an adequate supply of smallpox vaccine, roles and missions of federal and state governments, civil liberties associated with quarantine and isolation, the role of DoD, and potential military responses to the anonymous attack."<sup>19</sup>

The results of the exercise were consolidated into five major learning points, to include (quoted in entirety):

- 1) **An attack on the United States with biological weapons could threaten vital national security interests.** Massive civilian casualties, breakdown in essential institutions, violation of democratic processes, civil disorder, loss of confidence in government and reduced US strategic flexibility abroad are among the ways a biological attack might compromise US security.
- 2) **Current organizational structures and capabilities are not well suited for the management of a BW attack.** Major "fault lines" exist between different levels of government (federal, state, and local), between government and the private sector, among different institutions and agencies, and within the public and private sector. These "disconnects" could impede situational awareness and compromise the ability to limit loss of life, suffering, and economic damage.
- 3) **There is no surge capability in the US health care and public health systems,** or the pharmaceutical and vaccine industries. This institutionally limited surge capacity could result in hospitals being overwhelmed and becoming inoperable; could impede public health agencies' analysis of the scope, source and progress of the epidemic, the ability to educate and reassure the public, and the capacity to limit casualties and the spread of disease.
- 4) **Dealing with the media** will be a major, immediate challenge for all levels of government. Information management and communication (e.g., dealing with the press effectively, communication with citizens, maintaining the information flows necessary for command and control at all institutional levels) will be a critical element in crisis/consequence management.
- 5) Should a contagious bioweapon pathogen be used, **containing the spread of disease will present significant ethical, political, cultural, operational and legal challenges** (emphasis mine).<sup>20</sup>

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<sup>17</sup> Joint Chiefs of Staff, Doctrine for Health Service Support in Joint Operations, Joint Pub 4-02 (Washington DC: 30 Jul 2001), GL-8.

<sup>18</sup> "DARK WINTER: Bioterrorism Exercise - Nunn, Hamre to Testify on Lessons Learned" Lkd. Center for Strategic and International Studies. 19 July 2001. <<http://www.homelandsecurity.org/darkwinter/index.cfm>> 18 April 2002.

<sup>19</sup> *ibid.*

<sup>20</sup> *ibid.*

In summary, the United States is not prepared for an attack of this sort upon its homeland and would quickly turn to the FBI and FEMA to take charge of the Crisis and Consequence Management Stages. They in turn would call upon DoD and other federal agencies to assist in implementing their plans. DoD would task a Combatant Commander who would need a strong, professional, and operationally-oriented medical support organization capable of providing immediate advice, technical support, and rapid deployment of DoD medical resources.

### **What type of medical organization is best?**

There has been much discussion among the policy makers about what type of medical department consolidation would best serve DoD. Broad in scope, suggested models for DoD medical organizational reform range from status quo (i.e. no change), to a joint Medical Command (similar to the U.S. Transportation Command or Special Operations Command which provides direct support the other Combatant Commanders), to a Defense Health Agency (e.g. similar to the Defense Intelligence Agency or Defense Logistics Agency), to a Federal Health System (e.g. to strengthen VA and HHS coordination), as well as several hybrid models in between.

Of these main alternatives, some are easy to dismiss. On the one extreme, maintaining status quo will not meet the full spectrum of challenges and threats to the Combatant Commander nor is it responsive to the Homeland Defense mission. On the opposite end of the spectrum is the idea of establishing a Federal Health System. Although visionary in concept, the DoD medical community needs to learn to work together before it reaches out to embrace other missions and federal agencies such as FEMA and the Department of Veterans Affairs. Both of these options can be dismissed as unrealistic options to address the foreseeable threats.

This leaves two viable options for developing a model to provide medical support to the Combatant Commander. Both the U.S. Medical Command and Defense Health Agency are workable models with distinct advantages and disadvantages, in either case; some basic premises for this unified medical organization would remain the same.

First, DoD medical support is broadly divided into four or five echelons of care depending on Service model. In general, Echelons I and II describe care and treatment provided at the front lines.<sup>21</sup> These echelons incorporate the individuals and units that are trained and equipped to deploy immediately with the war-fighter. Starting with basic first-aid principles taught to recruits, Echelon I progresses on to the individual corpsman or medic assigned to the combat unit and ranges up to the Echelon II mobile medical units able to keep pace with tactical level operational forces (e.g. surgical companies, medical battalions, etc). Regardless of whether a Defense Health Agency or U.S. Medical Command is established, this level of treatment and support must remain embedded in Service-specific training and doctrine to ensure Service confidence, camaraderie, as well as familiarity with Service- specific applications of operational art at the tactical level of war.

It is at the Echelon III - V level where the Combatant Commander begins to see the true benefits of medical consolidation. It is at this level where large, but relatively immobile deployable medical units or fixed medical treatment facilities are encountered. Units at this level include fleet hospitals (e.g. and Army and Air Force equivalents); the Hospital Ships, overseas and U.S. based military hospitals and research facilities.<sup>22</sup> In general, medical personnel at these units are not involved in direct combat support and are less interested in operational art of the operational or theater-strategic levels of war (e.g. directly serving the Combatant Commander), they are more interested in the art and science of medicine, medical research, and long-term treatment and patient rehabilitation. When not assigned to an operational unit, medical personnel at this level could be keeping up with changes in the medical practice by serving at a medical treatment facility or a medical research unit under the centralized auspices of a unified medical organization.

These Echelon III - V facilities would be joint warfare oriented in theory and practice, similar in concept to a Geographic Combatant Commander. Medical personnel assigned to these units would be assigned based on medical specialty or expertise, not upon the color of their uniform--at this level, medical research, economies of scale, and unity of effort and command would pay the largest dividends to the Combatant Commander, Homeland Defense, and DoD. It would be at this level that planning and exercising for operational and

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<sup>21</sup> Joint Chiefs of Staff, Doctrine for Health Service Support in Joint Operations, Joint Pub 4-02 (Washington DC: 30 Jul 2001), II-2 thru II-3.

<sup>22</sup> *ibid.*

homeland defense medical support, coordinated WMD research, and interagency coordination with other local, state, federal, foreign, or multi-national medical response facilities would initially take place. By integrating the Echelon III - V medical support into a unified command structure (U.S. Medical Command or Defense Health Agency model), medical personnel would still have "shore" duty assignments where they could train, practice, and serve while not deployed with operational forces.

Secondly, the role and structure of TRICARE should remain more or less as it exists today. The TRICARE Management Activity has established a regional concept for medical support to non-deployed active duty members, retirees and both their families.<sup>23</sup> As the system matures, TRICARE would need to realign TRICARE regional support contracts to coincide with those of the geographic Combatant Commanders thereby improving communication and understanding of the medical support costs, limitations, and capabilities within each geographic Combatant Commanders area of responsibility.

### **U.S. Medical Command Model**

A primary advantage to the U.S. Medical Command model is that Combatant Commanders are familiar with the concept. Since Combatant Commanders operate under this model, they are more likely to understand the strengths and weaknesses, capabilities and limitations of this model. Combatant Commanders may have a natural bias towards this model, believing that a fellow general or flag officer experienced in the operational environment would be of better service on important operational, theater strategic medical issues. Subordinate medical units would be assigned much as they are now, allowing for some consolidation based on requirements and regional expertise. Similar in concept to the U.S. Transportation Command, the U.S. Medical Command would strengthen Service integration while becoming more effective and responsive in nature. The Services would retain the mission for recruitment and training, while the U.S. Medical Commander would be responsible for medical resource policy, budgeting, and employment.

### **Defense Health Agency Model**

A primary advantage to the Defense Health Agency model would be in areas such as improved organizational and managerial continuity, more experience and effectiveness in dealing with DoD's civilian and political leadership, budgetary and planning oversight. This model has proven successful in fourteen other defense agencies.<sup>24</sup> In part, it was created to bridge the gap between the Combatant Commander and other elements of national infrastructure. A Defense Health Agency would build upon MHS expertise while facilitating long term relationships and improving interagency coordination with other federal agencies such as Health and Human Services, Federal Emergency Management Activity, Department of Veterans Administration, National Institutes of Health, and the U.S. Public Health Service, just to name a few.

Another issue in favor of the Defense Health Agency Model is the view of the leadership within President George W. Bush's administration. Although many things have changed since the 11<sup>th</sup> of September 2001, it is interesting to note Secretary of Defense Rumsfeld's remarks to the audience gathered at the Pentagon on the day before the September 11 attack. While serving as a guest speaker for the DOD Acquisition and Logistics Excellence Week Kickoff, the Secretary of Defense spoke on a topic entitled "Bureaucracy to Battlefield" during which he shared his own thoughts and ideas on the need for medical department unification, as follows:

Department headquarters are hardly the only scenes of redundant bureaucracy. Health care is another. Each service branch has its own surgeon general and medical operation. **At the department level, four different agencies claim some degree of control over the delivery of military health care.**

Consider this snapshot. **One out of every five officers in the United States Navy is a physician.**<sup>25</sup> That's not to single out the Navy or to suggest that too many doctors wear uniforms. The Navy and Marine Corps' forward deployments generate unique medical needs. Rather, it's to say that some of those needs, especially where they may involve general practice or specialties unrelated to combat, might be more efficiently delivered by the private sector. **And all of them would likely be more efficiently delivered with fewer overlapping bureaucracies.**

We've begun to consolidate health care delivery under our TriCare (i.e. TRICARE) management activity. Over the next two years we will reform the procurement of care from the private sector. I've

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<sup>23</sup> "TRICARE Regions at a Glance" Lkd. TRICARE Management Activity. 18 April 2002.

<<http://www.tricare.osd.mil/regionalinfo/>> 18 April 2002.

<sup>24</sup> National Defense University. The Joint Staff Officer's Guide 2000. "DoD Organization (June 2000)" figure 1-3. JFSC Pub 1 (Washington DC: 2000) 14.

<sup>25</sup> Secretary Rumsfeld's statistical source was not cited. Term "physician" likely reflects all Navy medical department officers, to include nurses, scientists, and healthcare administrators--not just medical officers.

asked the military departments and Personnel and Readiness organization to complete a revamping of the military health system by fiscal year 2003 (emphasis mine).<sup>26</sup>

## **Recommendation**

In light of all the above, it is time to for the MHS as an organization to embrace systemic organizational change. The most effective model to use to reorganize, revitalize, and integrate the three Service Medical Departments and the TRICARE Management Activity into a unified organization that more fully supports the Combatant Commander is the defense agency model. A Defense Health Agency will establish a fifteenth defense agency with a clear mission to support both the Combatant Commander and the individual patient. Doing so will re-energize the role of operational medicine, maintain the advances made in the realm of quality assurance, and streamline elements of the multi-service bureaucracy required by the current medical organizational structure.

## **Conclusion**

In conclusion, establishing either a consolidated U.S. Medical Command or a Defense Health Agency would be major step forward towards improving medical support to the Combatant Commander and the homeland defense mission without sacrificing the gains made in applying health industry standards to the MHS. The final decision for any proposed consolidation will certainly be made based on a variety of issues--with large, powerful constituencies weighing-in to ensure that the outcome is to their benefit. But fear of making difficult decisions is no reason to continue to settle for status quo. The Combatant Commander and the Nation require a unified medical organization capable of meeting the opportunities, challenges, and the emerging threats of the twenty-first century. The Defense Health Agency is the best available model for the consolidation of the three medical departments; the time for transformation is at hand.

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<sup>26</sup> Secretary of Defense Rumsfeld, "Bureaucracy to Battlefield," Lkd. 10 September 2001. [DOD Acquisition and Logistics Excellence Week Kickoff](http://www.defenselink.mil/speeches/2001/s20010910-secdef.html). < <http://www.defenselink.mil/speeches/2001/s20010910-secdef.html> > 18 April 2002.

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