

SYNCHRONIZING USG EFFORTS TOWARD COLLABORATIVE HEALTHCARE POLICY MAKING IN IRAQ

BY

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**SYNCHRONIZING USG EFFORTS TOWARD COLLABORATIVE
HEALTHCARE POLICY MAKING IN IRAQ**

by

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ABSTRACT

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A primary pillar to achieving strategic aims in Iraq is through the reestablishment of a functional healthcare system. Currently, no set corporate solution exists including all agencies pertaining to a universally acceptable strategic health policy in support of this objective. Healthcare is an elemental component of basic human needs and should be accessible, affordable, and capable. Following combat operations and phasing into stabilization operations, basic healthcare infrastructure and systems have often been either disrupted or degraded altogether. To address this situation, the U.S. Government (USG) requires a coordinated interagency approach to formulate a strategic healthcare plan. Incorporating all relevant players into this goal will promote sound organizational design, unity of effort, and a culture favorable to synchronization. This proposal submits specific recommendations and advocates a renewed effort toward addressing these requirements. The primary constructs under review are USG organization, leadership, and culture as they relate to a strategic healthcare policy. This approach reduces redundant efforts, conserves resources and augments the legitimacy of the new Government of Iraq while supporting U.S. national strategic aims.

SYNCHRONIZING USG EFFORTS TOWARD COLLABORATIVE HEALTHCARE POLICY MAKING IN IRAQ

...strategy is defined as the systematic, integrated, and orchestrated use of various means to achieve goals.

—Brad E. O’Neal¹

A primary catalyst to achieving our strategic ends in Iraq is through the formulation of a consolidated and cooperative strategic healthcare policy to enable the operability of their healthcare system. An often cited criticism of U.S. policy, however, is that, after the relative end of hostilities and transfer into stabilization operations, we fall short in post-conflict planning and execution.² Rationales for this repeated predicament abound: nevertheless, the failure to adapt and leverage our current systems along a seamless continuum impedes the achievement of functional outcomes.³ A key tenet on the list of stabilization requirements in a theater of operations is reestablishing a system which supports the basic human need of health care.⁴ An operational healthcare system can then quickly become the “long pole” of the strategic ends, in this case, a legitimate, self-securing and sustainable Iraq.⁵ As LTG David Barno (Retired) states from his experiences as the Commander, Combined Forces Command – Afghanistan (CFC-A) in 2005, “healthcare is one of the most critical components to ensuring a reduction in insurgency while likewise having an immense long-term positive impact.”⁶

Relieving populations from undue suffering caused by a disrupted or degraded health care system ameliorates negative perceptions and promotes the legitimacy of government.⁷ The final element of promoting a functional health policy is the eventual transition of these systems from U.S. agencies to host nation authorities. Effective transition requires a more synchronized approach between all agencies involved.⁸

Establishing a sound healthcare policy for Iraq requires a collaborative effort on a scale not yet exercised in the history of the conflict. The challenges we face in planning, implementing and sustaining a viable health care policy in Iraq are multifaceted and ominous at best. These are compounded by an overall strategy for healthcare that fails to fully appreciate the favorable effect a full synchronization of effort would have on achieving a desirable end state.⁹ The desired end state is the complete and sustainable management and operation of the Iraqi healthcare system...by the Iraqis.¹⁰ With a host of opinions from international members as well as divergent views amongst our own departments and agencies charged with reviving the preexisting healthcare system in Iraq, the challenge of seamless civil-military operations and de-conflicting of priorities and strategies is significant.¹¹

The following analyses relay some of the impediments and subsequent recommendations to achieving a more coordinated, functional, and thereby synchronous strategic healthcare policy. Initially, the history and present state of the problem is defined. Secondly, discussion turns to organization, leadership, and culture as the core constructs of a synchronized healthcare policy. Finally, as with any applicable use of research, recommendations are provided for negotiating new or amended civil-military healthcare design, training, leadership and cultural change mechanisms. These elements will enable the USG to address health policy operations in stabilization and transitional phase contexts currently and in the future.¹²

Literature Review

The development of a more streamlined and effective planning model of healthcare operations, regardless of context, begins with nesting the strategic

healthcare plan within the goals of the overall national strategic and joint campaign plans.¹³ The current joint campaign plan, for example, emphasizes the overall goals of the national strategic plan which include political, security, economics and diplomatic as the critical components.¹⁴ The diplomatic component is designed to build confidence in the Government of Iraq (GOI) which a synchronized healthcare policy can significantly enable. This provides the foundation for designing metrics and assigning groups to tackle the most difficult challenges faced in the stabilization phases of contingency operations. The phases of stability operations in general terms are initial response, transformation and fostering sustainability.¹⁵ While many phase requirements can be identified and developed prior to entry into theater, more often than not, the rapid progression of hostilities and projection of fighting forces in pre-deployment phases may not allow for the significant resources necessary to work through these issues and formulate a strategic plan initially.¹⁶

Typically the elements (or tenets) of stabilization operations in a theater are based on previous, often erroneous, conclusions of a former campaign.¹⁷ To counteract this effect, the relevant players should establish plans in a synchronized matrix fashion so as to determine organizational structure, lead agent elements, and specific context dependent strategic healthcare tenets to pursue.¹⁸ The baseline membership should include, at a minimum, the key representative agencies on the ground that can readily affect operations of local health systems. Historically these teams have been incomplete: several pronounced examples illustrate the results of these shortfalls and lend suggestions for organizational, leadership and cultural changes.

History. The first lesson in reviewing the strengths and weaknesses of previous attempts at a functional strategy formulation is through examination of history. Through past examples, whether specific to healthcare, or indirectly from other pillars of stabilization such as water, sanitation, or infrastructure reconstitution, one can consider all available elements in the development of new synchronous policy.¹⁹ This becomes increasingly relevant as future departmental and interagency functions will need to be aligned and implemented with the same level of flexibility as asymmetric warfare presently mandates.²⁰ Health operations in the present contemporary operational environment include vulnerabilities, uncertainties, complexities and ambiguity (VUCA) in the application of organizing, planning, and training requirements.²¹ These VUCA elements require great flexibility in application from all players involved.²² Regardless of the ability to address strategic health plan tenets early on, the USG must be prepared for future operations that closely mirror “national assistance” type stabilization plans and approach them with an interagency cooperative focus.²³

The history behind interagency cooperation is a mixed bag of personalities, conditions on the ground, and the capabilities of the host nation involved.²⁴ Although not all challenges are exactly alike between contexts, they similarly shed light on previous shortcomings in the ability to work seamlessly along differing lines of authority. This may be tolerable in environments where interdepartmental differences do not require immediate remedy, but it can be debilitating on the battlefields and mortar pocked suburbs of nations where we are currently engaged in contingency operations.²⁵

Varying levels of civil-military cooperation in previous conflicts exist and provide a foundation for future effective healthcare policy and planning. One example from the

1989 Panama Campaign (Operation Just Cause) represents a failed coordination of effort to reestablish a stable and functional government after the deposing of General Manuel Noriega.²⁶ The overall lack of synchronization led to immense challenges on the ground as agencies across the spectrum failed to implement their plans in tandem with other partners resulting in disjointed and ineffective outcomes.²⁷ Conversely, Operation Uphold Democracy in Haiti in 1994 demonstrated a significant improvement. The inclusion of an interagency plan demonstrated a need for more synchronized civil-military planning (in the form of the Haitian Interagency Working Group).²⁸ The rationale was to form a strategy with established outcome metrics used to measure the success of stabilization operations at the conclusion of hostilities.²⁹ Although there were still deficiencies in full coordination, the creation of this group was the first in a modern operational scenario.³⁰ This organization developed from the recent experience in Panama from after action reviews of organization, leadership and processes.³¹ These lessons, along with those of other operations, resulted in several updates to policy, ending with the implementation of Presidential Decision Directive (PDD-56) in 1997, *Managing Complex Contingency Operations*. This established mandates for the interoperability and functioning of interagency processes.³²

Although historically many military planners have shied away from stabilization type operations, they are uniquely skilled in certain areas. They are particularly adept in healthcare and civil engineering, which have experienced administrators and managers who practice their skill in peacetime as well as during times of conflict.³³ The military arm of the nation's power will continue to be heavily involved with civil-military cooperation

and planning and should incorporate previous lessons into organizational designs, doctrine, leadership training and cultural adaptations.³⁴

Interagency cooperation continues to evolve: the Bush administration has since superseded PPD-56 in favor of the new National Security Presidential Directive (NSPD) 44, in 2005.³⁵ This new directive outlines responsibilities of the agencies involved; however it does not provide the required structure, matching doctrine, and especially the resources to allow flexibility in application.³⁶ Currently USG is addressing some of these shortfalls via proposals for a deployable agency structure.³⁷

The Army likewise has specifically highlighted stability operations support of USG plans through five primary tenets: establish civil security, establish civil controls, restore essential services, support governance and support economic and infrastructure development. These precepts are manifested in current doctrinal mediums and leadership promotion of the topic.³⁸ These mediums, however, are defined only generally as they relate to healthcare and do not detail strategy, planning or indoctrinate civilian agencies to collaborate in activities under any specific authority.³⁹ Even with the movement toward a deployable organizational design at the national level, and template at the Army level, the healthcare community has a responsibility to address shortfalls in the interim.⁴⁰ As a Department of Defense (DOD) component that practices peacetime and wartime missions simultaneously, the military medical community has certain resources capable of supporting nation building, stabilization, humanitarian assistance and peacekeeping operations, most specifically as they relate to the “restore essential services” tenet.⁴¹ In contexts such as Iraq and Afghanistan, the medical communities

have an implied obligation to work through planning, training and leveraging joint assets in manpower and experience.⁴²

Interagency and interdepartmental challenges, coupled with the lack of an organizational structure to support coordinated activities, present obstacles to synchronized planning.⁴³ A prime source example specific to healthcare policy coordination, was shown during a meeting at the Al Rashid Hotel in Baghdad in the spring of 2007 about the transportation of medications from a warehouse by Iraqi Security Forces (ISF). The meeting included leadership from the Department of Health and Human Services (DHHS) (representing the Department of State (DOS) and Health Attachés Office), Multi National Security and Training Command-Iraq (MNSTC-I) Health Affairs, the Ministry of Health (MOH), the Ministry of Defense (MOD) and select members of the Multinational Forces-Iraq Surgeons office (MNF-I Surg).⁴⁴ Differing agendas and lack of a unified front resulted in the inability to come to a consensus among the USG representatives present. Having differences in theory and application amongst disparate institutions is not uncommon and often understandable. The failure to present a united front in formal negotiations, however, displays dysfunction that organizational change alone will not fully address.⁴⁵ It requires a review of leadership training, planning and resourcing as well as doctrinal and cultural changes in application to bridge the gap.⁴⁶

These challenges between agencies and departments in the current context are similar to those experienced during the Vietnam era. During that time attempts to pacify populations and “win the peace” took the form of Medical Civil Action Program (MEDCAP) where medical personnel would venture into a village and administer

immunizations and basic healthcare to the populace.⁴⁷ Similar to present day Iraq, these were “feel good” stories for the Soldiers involved, but they were not tied into an overall strategy and did not account for the effect on those communities that did not receive this benefit. As one previous medical researcher states, “...MEDCAPs accomplished little except to possibly improve the American image.”⁴⁸ Following this perception and as testimony to the need for a consolidated approach, another Vietnam analyst illustrates,

...commanders did not have the resources to develop health care systems, solve sanitation dilemmas, dig wells, and change lifestyles that had evolved over the centuries. Such activities required a comprehensive strategy and assistance plan beginning with overhauling the health care delivery system of the host nation...⁴⁹

Even with the introduction of the Civil Operations and Revolutionary Development Support (CORDS) group, which was designed to address the interagency challenges and synchronize the approach, the medical element was poorly measured for true effect.⁵⁰ This was reflected in another account of medical operations in 1970, “...increases in the amount of our own military efforts are measured, and this is called progress.”⁵¹ Progress, then, was measured in more altruistic and humanitarian terms as well as a means of providing intelligence, versus true medical capacity building and enabling any sustainable aspects for the Vietnamese health system.⁵²

Based on the historical and current examples provided, the USG must continue efforts to address present challenges. Ongoing analyses should highlight models, training and cultural change to align joint and interagency processes. These organizational processes in turn would promote a singular strategic medical vision which supports overall national policy aims. Therefore, achieving a new state of functionality in strategic healthcare policy for Iraq requires a review of organizations, leadership and culture.

Organizational Structure. The current structures of the agencies under review are the results of decades in the making. Thus the challenge of breaking down barriers to change within and between these agencies can be substantial. Changing the organizational structure of many of these entities demands executive level focus and a joint vision from all parties. Stove-piped systems thinking coupled with parochial organizational characteristics and values requires surgical like policy changes and direction to indoctrinate change.

The first element to address is the present overall structural layout, specifically as it pertains to healthcare systems. For example, the relevant players in this system in the Iraqi theater of operations includes at a minimum, the DOS, DOD, DHHS, United States Agency for International Development (USAID), Non-Governmental Organizations (NGO), International Organizations (IO), MNF-I Surgeon, Multi National Corps-Iraq Surgeons (MNC-I Surg), MNSTC-I, MOH and complementary agencies, and the Medical Brigade Headquarters (MED BDE HQ) that manage the U.S. military medical assets in theater. This list is not exhaustive as there is also a Central Command Surgeon (CENTCOM Surg) and several consultant agencies that are available through “reach back” systems stateside. Nonetheless, the aforementioned “on the ground” representatives form the core working group in theater. Once these organizations and their roles are more clearly articulated and placed in a framework which follows design, planning and training goals, the military official, diplomat or Foreign Service officer can better appreciate their utility.

For stabilization missions, one proposal for a new DOS organization calls for the creation of a Civilian Reserve Corps, to address the need for a coherent organization to

plan stabilization phases in contingency operations.⁵³ From the healthcare perspective, DOD medical resources and expertise would be a valuable consultant to any such entity. Stabilization environments that have experienced disruption to healthcare systems require subject matter experts in policy, strategy and medical infrastructure to adequately address the need for rebuilding. Although DOD is familiar with executing civil-military operations, each context requires a flexible and adaptive approach. In the case of Iraq, the Provincial Reconstruction Team (PRT) is an example of one such design attempt to incorporate several different professional elements across the spectrum of stabilization operations at tactical and operational levels.⁵⁴

PRTs were initially introduced in Afghanistan as Joint Reconstruction Teams (JRTs) where they achieved some successes and elucidated challenges in the form of interagency cooperation.⁵⁵ The PRTs promoted improvements to reconstruction and restoration of essential service operations based on availability of personnel. The teams were designed to include experts in several key areas such as economics, governance, and infrastructure development from the other agencies. However PRTs often had poorly developed mission statements, unclear roles, and in many cases, limited representation outside the DOD.⁵⁶ In 2005 the PRT concept was implemented in Iraq, yet continued to be afflicted by several of the previous shortcomings. The primary shortfall for health policy promotion was the absence of healthcare personnel in the early PRT diagrams. However, in conjunction with the “surge” in Iraq in 2007, a new concept of Embedded Provincial Reconstruction Teams (ePRT) surfaced as the next phase in promoting stabilization efforts.⁵⁷ These teams now included medical personnel, but with one major shortfall.⁵⁸ The vast majority of medical personnel assigned to these

teams had little experience in health policy, health planning or management of health care systems across international or interagency systems.

Organizational Training. As one might expect, disadvantages from lack of training, experience and political acumen to negotiate on behalf of the larger system, can hamper initial efforts in synching health policy with overall strategic healthcare plans. Although we could not immediately make up for lack of experience, some training opportunities quickly emerged. This included training and medical orientation for PRTs and ePRTs in country through a medical orientation plan meeting conducted weekly out of the Health Attaché Office. This training, however, was not part of doctrine or standing operating procedure, or any established strategic healthcare policy. Although not the focus of this paper, critical orientation topics included defining the strategic health plan map for Iraq as outlined by the MOH, the cultural sensitivity component of the Iraqi population for gender specific medical concerns, and public and private healthcare options just to name a few. Had the orientation not taken place, however, their efforts would not be completely in line with strategic health policy needs of the central MOH or the USG.⁵⁹ To adequately address this challenge we require an upfront synchronized healthcare strategy, created through updates to current doctrine and improved organizational and cultural relationships among the USG structures.⁶⁰

Investing in orientation and training of PRTs and ePRTs promotes our strategic healthcare tenets locally via providing some basic skills training and management consultation to the local authorities; they could then rapidly become a catalyst for health policy application.⁶¹ The ePRTs could then act as the “eyes and ears” of local health operability in the 18 provinces which make up Iraq and could therefore provide updates

and provincial level medical intelligence to enable any adjustments to strategic level planning variables via the Health Attaché Office.⁶² This promotes a singular common operational picture (COP) to supplement a strategic vision for all agencies to work from.

A vital component of a strategic vision includes assessing the current training available in healthcare administration. This training element illuminates programs designed to increase knowledge of health policy and strategy. Training programs must incorporate scenarios and other tools capable of improving leadership competencies as well as relationships.⁶³ One such program, the U.S. Army Baylor University Graduate Program in Health and Business Administration provides training for health care administrators in the Army, Navy, Air Force, Coast Guard and Veterans Administration.⁶⁴ Within the last few years, this program opened slots for Civil Service personnel and expanded the focus to include Business Administration.⁶⁵ The separate services and agencies transfer funds to supplement their staff participation in the program. Training includes didactic and residency phases providing students, regardless of background, the ability to gain experience in healthcare system challenges across contexts.

If the training components and assets, along with several other key health policy promotion tenets, are defined in doctrine and policy, medical elements on the ground will become integral to overall strategic policy goals. These assets would complement the design of metrics and asset distribution requirements for a given context. Metrics used to measure effectiveness of health policy operations at all levels would then follow the same strategic vision.⁶⁶

As the renowned business consultant and organizational analyst John Naisbett purveys, “strategic planning is worthless – unless there is first a strategic vision.”⁶⁷ The organizational components necessary for coordinating and collaborating on a strategic medical vision and plan in Iraq include, at a minimum, the MNF-I Surgeons Office, the MNC-I Surgeons Office, the MNSTC-I Surgeon, and the Medical BDE HQ from the DOD and the Health Attaché Office (DHHS), DOS, USAID, and NGOs from the civilian agency lanes. These interagency players have distinctly different missions and strategies, but the same goal--an operable health care system.⁶⁸ While executive order NSPD 44 places the DOS as the overall responsible agent for stabilization operations, the military medical community may contribute substantively to the goal, as it has certain resources and competencies already built into their structures to augment health systems planning, logistics and construction.⁶⁹ Filling civilian agency billets is not the overall intent; collaboration toward a common goal is. The Army Action Plan for Stability Operations promotes the ability to share assets on a consultant basis to achieve mutual national policy goals (supporting organization roles).⁷⁰

Organizational Resources. Developing new approaches to organizational design and incorporating flexibility in application requires a review of roles. Findings indicate that in certain operations DOD may need to assume roles that are inherently a part of another agency to support an overall USG healthcare strategic policy. Supplementing this position in the literature is a recurring theme of significant resource shortages in personnel, training and experience for civilian agencies such as DOS, DHHS and USAID.⁷¹ These deficiencies are also pervasive in the healthcare arena. For example, for more than eight months in 2007 there was only a single staff member from DHHS in

the Health Attachés Office in the US Embassy in Iraq. Unfilled billets included the Health Attaché, Deputy Health Attaché (new requirement), Facilities and Engineering Officer and an assistant. For nearly three months of this time, the only billet filled was the liaison officer position from the MNF-I Surgeons Office. This situation has been more the norm than the exception and for the foreseeable future any change to structure that requires a manning commitment is likely to encounter this same fill rate.

In response to these manning shortfalls, the services all have varying degrees of capacity to fill positions. This is based on present inventories and skill sets. Leveraging this “joint” billet maximizes the utility of Air Force, Navy and Army medical service officer personnel. Many of these assets have training or currently hold positions as planners for health policy applications and strategic development.⁷² Should the USG adopt greater flexibility in positions via doctrinal or organizational change, it will attain a “whole-of-government” approach and achieve solidarity in application of strategic healthcare intent.⁷³ Perhaps LTG Barno (Retired) stated this best in a discussion of interagency working relationships and unity of effort, “...same goals, different uniforms...”⁷⁴

Temporarily filling inherently civilian positions due to a dearth of manpower and experienced personnel on the ground can confer some distinct advantages for the USG. Resourcing certain billets allows knowledgeable personnel from DOD with experience and training in healthcare operations to have a voice and permits consideration of valid opinions. These are not diplomatic roles, per se, as those are best held by DHHS and DOS representatives more versed in these lanes. DOD has core competencies and could adopt roles such as Acting Chief of Facilities Construction and Planning for the Iraq Reconstruction and Management Office (IRMO) [now reestablished by another

Presidential Executive Order as the Iraq Transition Assistance Office (ITAO)], the Deputy Health Attaché (who can also serve as the Chief of Health Policy for DOD via the MNF-I Surg Office), and the Chief Logistician for healthcare planning.⁷⁵ These elements can then blend skills developed stateside into common planning and training scenarios with DHHS elements into goal alignment and decision making strategies.⁷⁶

Decision making in a multi-national, multi-cultural and multi-forces environment is complex and requires mechanisms to ensure compliance. Poor decision-making can result in agencies defining goals along different metrics and thereby applying redundant solutions to challenges, resulting in wasted resources and extending the timeline to reach a desired end state.⁷⁷ Although the literature posits that the military should not “own” the civilian healthcare mission, it could provide a supporting role.⁷⁸ The position that the civilian healthcare mission in these contexts belongs solely to the DOS via the DHHS weakens the USG ability to reach strategic aims.

Planning and Implementation. In addition to resource solutions, it is also necessary to coordinate plans and strategies for implementation. Historically, planning a seamless policy for post-conflict operations has been insufficient and therefore execution has been poor.⁷⁹ Planning has been lacking due to a combination of effects of disparate organizational structures, leadership, and culture exacerbated by the challenges of context and time. The planning of the various agencies has been approached from several viewpoints. Civilian agencies typically do not focus on the implementation of plans as much as diplomacy and the creation of objectives to achieve ends. One example of their focus on objectives is the development of the Essential Task Matrix from the Office of the Coordinator for Reconstruction and Stabilization

(S/CRS) for the DOS.⁸⁰ The DOD typically focuses on Joint Planning guidance along with the tenets published in the new Stability Operations Field Manual.⁸¹ Because civilian agencies do not arrive with the same resources and capabilities as DOD, the DOD has assumed these additional missions in an ad hoc fashion, resulting in poor performance in stabilization tasks (at least initially).⁸² Emphasizing a need to rectify this shortcoming, Dr. Conrad Crane, a leading researcher on insurgency operations, best states the implied mission, “the inadequacies of civilian organizations insure that the army will not be able to avoid such missions in the future.”⁸³ The complexities involved in deciphering these challenges and implementing solutions lies in effective leadership.

Leadership. As with any other organization, the structure of the civil-military operations is often perceived via prisms and paradigms of the prior experiences of their stakeholders. LTG Barno (Retired) states in an interview describing organizational leaders as “often prisoners of their own experiences.”⁸⁴ The leadership of the host nation affected is often just as entrenched. Optimally, the leadership construct will be the catalyst to a whole of government approach in future policy application.⁸⁵

Leadership is the key to promoting unity of effort. Meetings involving governmental agency representatives at the central ministry level in Iraq for example, require the presence of the Health Attaché (DOS representative) as well as an MNF-I representative (augmented by other USG assets based on the context of the discussion). This provides a united front from the USG perspective. In order for the leadership involved in negotiations to exercise strategic intent, they must understand the plurality of paths available in healthcare policy. Appreciating other agency approaches, leadership competencies and implementation processes leverages those

differences to strategic advantage.⁸⁶ We often fail to take these intricate details and characteristics into account and create unity of effort. In failing to promote a united front, implementation suffered in Iraq as USG agencies left the table thinking they understood each other's position, yet they executed completely different plans.⁸⁷

Similarly, in Iraq, the MOH leadership does not maintain seamless or collaborative relationships with the other ministries and are often at odds with separate party affiliations. The challenges inherent in this leadership culture impede forward progression. As an enabler, MOH leadership requires capacity development via consultation and a united focus from all USG players to increase their ability to sustain the Iraqi health system for the future. To do so, these officials need to be included in relevant training on healthcare management and other critical facets that enable them to sustain their healthcare system. This objective of ministerial capacity development is a key component of strategic healthcare policy implementation. Additionally, the MOH in Iraq operates under different methods of healthcare application and these subtleties are relevant if we expect them to sustain the training and planning provided.⁸⁸

The leadership element also correlates directly to cultural considerations. Breaking down the barriers to success by gaining a better understanding of the cultural differences in strategic healthcare planning is essential (i.e. Iraqis define healthcare and democracy (its application) differently than Western counterparts).⁸⁹ As such, some aspects of Western based systems need to be excluded in planning for Iraqi health policy. For example, certain managed care imperatives, insurance systems, and geriatric care facilities are all tenets that are either vastly different or absent altogether in their system. Even the conduct of negotiations with the Iraqis and the relevant parties

needs to be exercised in tandem with their norms. To appropriately educate our medical practitioners and policy makers through orientations therefore, we cannot use our Western lens to evaluate their system; we have to use their lens. Lastly, not only do we need to take leadership and cultural elements into consideration in synchronized health policy planning, we also need to review our “interior lines” to identify the organizational culture shifts necessary to promote a singular strategic medical vision within the USG.

Organizational Culture. Any organization, whether military, civilian, volunteer or international, possesses a set of values, goals and understanding representative of their culture.⁹⁰ The elements of leadership and culture are highly correlated and allow for initial predictions about working relationships. Culture highlights differences in priorities and an organization’s ability to work in tandem with other agencies.⁹¹ Stereotypes and prejudices are often grounded in historical examples of failed cooperative efforts between agencies and departments. Leadership has the responsibility to shift away from cultural stereotyping and move toward establishing solid foundations for future cooperation.⁹² Clearly there are shortfalls from both lanes in understanding the differences in culture between these often disparate organizations. Addressing these challenges is necessary for future performance and unified vision construction.⁹³

Often cited in the literature is the perception that civilian organizations are significantly under-resourced and poorly structured for post conflict operations.⁹⁴ This requires certain resource and training solutions. The DOD possesses the resources to ameliorate this situation in certain contexts, but may not be appropriate for other environments. Although this seems to couch significant responsibility on DOD, there is some logic for arguing this position. Namely, there is the notion of “best fit.”⁹⁵ This idea

relates to the fact that the military conducts the vast majority of contingency operations including everything from disaster relief and hurricane response to nation building and stabilization operations.⁹⁶ Even with the “jointness” of operations, we still need to “fit” the mission to the agency best able (through resources, training and experience) to perform roles.⁹⁷ Best fit also applies to different time contexts (phases) of operations which may necessitate mixing of agency resources or changes in leadership elements. Lack of a best fit is often exacerbated by conditions on the ground, leadership personalities, cultural stigmatism, resource constraints and sometimes simple absence of a functional relationship. Perhaps the single greatest challenge is to improve understanding of each organization and to effectively leverage their cultural differences.

The Iraq health care environment requires particular attention to the cultural dimension. Our previous paternalistic promotion of western medicine, as well as ignorance of preexisting governmental structures and cultural components of Middle Eastern systems of management, stymied initial efforts at health policy planning.⁹⁸ Many who arrive in Iraq, to include myself, have preconceived notions of healthcare delivery and other biases that do not fit the Iraqi model. Particularly in healthcare, perhaps the simplest instructions should read; “please check western ideals and views at the door.”⁹⁹

The essential element here is not limited to simply understanding the institutions that define healthcare in our domestic environment, but also appreciating subtle and overt differences in healthcare on the international stage. Iraq has a socialized healthcare system during the day and a privatized system through the afternoon.¹⁰⁰ There is currently no tax system to fund this socialized type system (funded previously on oil revenues and the private system).¹⁰¹ Physicians and staff often have different

roles in this environment as well as the location of where healthcare is provided (most healthcare is provided in Primary Health Clinics (PHC) versus inpatient facilities). Already the view of healthcare delivery in this context is very different from typical experiences of US healthcare facilities. As such, we would be wise to enjoin the host nation medical authority into discussions on the intricacies of their system and how best to address their shortfalls and thereby enable their successful reconstitution.¹⁰² The cultural elements of our systems as well as those of the host nation transcend into recommendations for future organizational, training, planning and cultural adaptations.

Recommendations

After close examination of the literature and discussion with experts, specific themes emerge in the form of organizational, leadership and cultural strategies for enabling future synchronization of healthcare policy. Critical analysis of these core constructs requires an approach that promotes creative and critical thinking imperatives, allowing for revisions and paradigm shifts in application to different contexts.¹⁰³ Specific recommendations were identified via prime source interviews, literature review and personal account information. These recommendations make suggestions for creating new organizational structures (or amendments to old ones), addressing the challenges of disparate leadership and personalities in the process, and considering the cultural elements which affect both organization and leadership challenges.

New Organizational Design. An appropriate organizational structure is essential to executing collaborative health policy operations. Currently, DOS through the DHHS requests personnel to attend to healthcare policy issues. When these billets go unfilled or are filled by personnel lacking health policy writing or international healthcare

experience for example, we risk the viability and efficacy of healthcare policy. To address potential shortfalls, this paper proposes a flexible approach coupled with the establishment of professional training and identification of experience in this area to form the most capable team to create synchronized healthcare policy applications.

Leadership roles of this team can first be visualized by phases (see Figure 1).¹⁰⁴ The initial conflict stage, where security is not yet fully established, requires the emergent operational management and leadership of the DOD system.¹⁰⁵ Once the phase transitions to the stabilization element of healthcare operations, the ownership of the process begins to transition to the DHHS element in theater with DOD assuming a more supporting role (security dependent).¹⁰⁶ The next phase is a transitional phase in which the stabilization phase has entered a mature stage and DHHS assumes complete responsibility and resourcing for this element. This allows time to field the DHHS resources necessary to complete the mission. The final phase is the sustainment of a healthcare system for that particular context. This should be the host nation medical authority assuming full control and DHHS assuming more of a consultant role (if any).

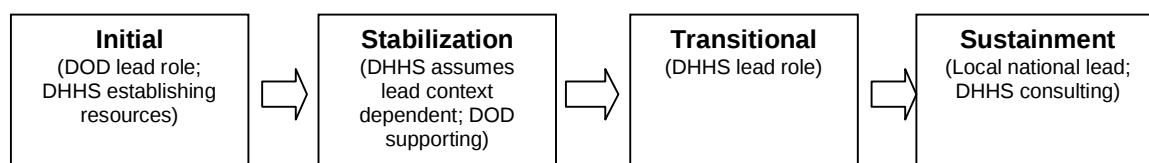


Figure 1. Phases of Medical Stabilization Support Operations (Proposed)¹⁰⁷

From a phased method approach, members of both agencies (DHHS and DOD) could then combine into one framework to create a new organizational “design” (see Figure 2).¹⁰⁸ This design is a physical manifestation of the idea of promoting organizational change and collaboration of efforts. Although currently not a part of any

manning document available in the DOD inventory, the separate services medical departments possess skill sets, assets and other capabilities to perform certain health planning missions. These roles would form the core elements of a flexible medical model within the DOS structure that allows for a new approach to strategic healthcare policy planning in contingency operations.¹⁰⁹ Regardless of the composition of the model, the strategic aim is the same; to establish a new, more streamlined, effective, and efficient system for contingency operations and healthcare policy decision making.

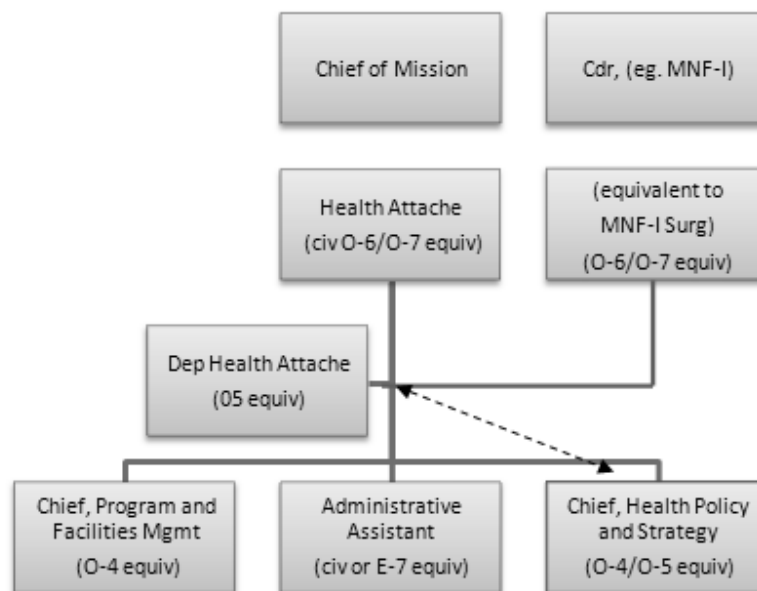


Figure 2. Flexible Medical Model (Proposed)

Selection of the model membership must be made according to established criteria and vetting amongst their peers to choose the most experienced and capable representatives. This would then be supplemented by training programs which all elements of the medical leadership (civilian and military) would be required to complete.¹¹⁰ In this proposal, the lead in emergent healthcare issues and Phase I requirements is the MNF-I Surgeon (or equivalent). In Phase II-IV, the Health Attaché

(from DHHS) assumes the lead on local civilian health policy initiatives. As the most vulnerable phase, Phase II (Stabilization) requires close collaboration between the Health Attaché and the MNF-I Surgeon (or equivalent) and their staffs, depending on the context. To assist the Health Attaché in Stabilization phases and beyond, DHHS requires a deputy versed in health policy operations and capabilities achieved through advanced civil training. At the operational and strategic levels, the military healthcare administrator is the most likely agent as they are often immersed in civilian agency healthcare theory and application during peacetime.¹¹¹ This individual can then perform the role as Chief Health Policy and Strategy or as the Deputy Health Attaché or both depending on the complexity of the current phase (rationale for the dashed lines of authority in the proposed model).

As shown, these DOD assets, if utilized appropriately, have the potential for pronounced and immediate effects on the “healthcare battlefield” at the strategic level.¹¹² Additionally, this new design provides for different skills or billets to augment the module based on context. In the case of Iraq, for example, you would want the services of a military health facilities expert to consult with DOS and DOD leadership on the Iraqi healthcare reconstruction and rehabilitation program (Chief, Program and Facilities Management). There should also be an Administrative Assistant element, considering the amount of planning, briefings and coordination required.¹¹³ These same roles, initially filled by DOD, would eventually be filled by DHHS as it stands up to take full authority and leadership over the civilian healthcare policy mission. The final model for this organization would be a more flexible design allowing for augmentation and later reduction based on context and time.¹¹⁴ This small investment upfront eliminates

redundant efforts, promotes a united effort, and expedites transition to host nation medical authorities.¹¹⁵ A new consolidated training program would define how this module would function, who would lead by phase, and how to plan collectively.

Organizational Training Program. One way to leverage strengths of disparate institutions is through collaborative practical application in training scenarios. Training scenarios could incorporate case studies, table top exercises, and planning sessions, which are all critical elements for understanding cultural differences and appreciating the strengths of different organizations.¹¹⁶ For example, DHHS functions more as a policy agent negotiating through diplomacy and political acumen with local national healthcare administrators and leadership. DOD, on the other hand, maintains resources with specific healthcare core competencies designed to implement goals established at the national level. Part of organizational training should also include other partners such as USAID, NGOs and IOs. Utilizing the strengths of all systems allows optimization of robust healthcare expertise. Promoting, training and developing action plans through these applications creates a type of knowledge management. This knowledge management creates off the shelf solutions (action plans) for potential scenarios in contingency environments. Creation of these plans should become a significant component of any new leadership training program.¹¹⁷ Although some training programs exist currently, none are doctrinally mandated to combine all the relevant healthcare personnel in a united effort.¹¹⁸

Organizational Planning. Included in the organizational construct is the element of set action plans, as detailed in the proposed training program. This allows for practiced off the shelf type remedies for operations, based on a long list of context

dependent variables to include security, threats, opportunities, weaknesses and strengths.¹¹⁹ Currently, the Joint Campaign Plan describes the components of desired end state and nests in general terms the elements of “essential services” reconstitution and the part they play in the overall effort (desired effects). The medical planning subcomponent of this larger plan is primarily the work of DOD elements on the ground with consultation from CENTCOM as well as parties stateside.¹²⁰ This works well for their initial post-conflict missions, which are emergent in nature, and may include emergency healthcare, humanitarian relief, and immediate logistical support. As the DHHS does not have adequate resources or the deployment capability to match the DOD medical community, prior to conflict, DHHS and DOD leadership should plan for different phase leadership and future partnerships to support the overall national strategy (see Figures 1 & 2). The manpower and fiscal resources from civilian institutions need to plan for balanced fiscal responsibility and their ability to assume required missions with DOD.¹²¹ Whatever the source, the doctrinal inclusion of all players will foment cultural adaptation and lead to collaborative planning exercises accentuating their respective strengths.¹²²

The planning element includes the topics not only presented in a relevant leader training course or regulations, but also planning in tandem with the assets we are most likely to have in theater. For example, exercises can be conducted at a myriad of sites around the U.S. and even in theater where the DOS, USAID, DOD and other relevant players would work together through scenarios.¹²³ A common application of scenario based training used in military contexts is called Training Exercise Without Troops (TEWT).¹²⁴ Some potential TEWT topics include managing a medical resupply mission,

coordinating security for medical infrastructure, medical training with host nation personnel, and planning asset distribution with multinational partners to include NGOs and IGOs as well as the host nation medical leadership.¹²⁵ More complex scenarios may also involve global issues such as emergency response planning for a pandemic.

As part of the model application process, the relevance of the medical mission on the ground requires a foundation in research and prioritization of planning.¹²⁶ Strategic healthcare planning can then incorporate the latest data for cogent decision making. Currently a multiagency working group is defining the medical related essential tasks required in a theater and which USG agency is most appropriate to address the need.¹²⁷ These essential tasks should be included in training exercises. In spite of design, training, and planning recommendations, without a combined strategic medical vision fomented by leadership, synchronized planning will remain only a possibility.¹²⁸

Leadership. Leadership is the linchpin for any successful organizational change.¹²⁹ This leadership construct is key to recognizing the strengths of all relevant parties, applying logical methodology to problem solving on the national level, and working effectively with multinational partners, host nations, and USG counterparts. To support a unified strategic medical vision, leadership competencies are required to mold organizations and shift parochial or entrenched thinking into more effective and efficient systems.¹³⁰ Some of the strategic leadership competencies include negotiating, communicating (cross cultural savvy), interpersonal maturity, complex decision making (where not all parties fall under the same authority for process) and “futuring” (exploring other possible scenarios).¹³¹

At this crucial stage of USG organizational cultural adaptation, the addition of transformational leadership skills to current basic leadership competencies is essential.¹³² These promote strategic leadership thinking, and employ embedding and reinforcing elements.¹³³ For transformation, leadership will need to use these specific embedded tools to change, adapt or adjust organizational culture and “sell” the concept to constituents.¹³⁴ Some of the embedding tools include communication of a unified vision, promotion of dual agency thinking, allocation of appropriate resources, selection of personnel to fill key billets, ensuring that these personnel are retained, incorporating external interests into strategic planning, seeking mid-level leaders to continue to promote the vision (champions), and setting up joint training and planning exercises.¹³⁵ Following the use of embedding concepts, reinforcing criteria are needed to sustain changes and adaptations.¹³⁶

Reinforcing elements include several different possibilities yet to be explored in full spectrum medical operations. Reinforcing elements aimed at aligning efforts include promoting an interagency (medical oriented) philosophy with a collaborative leadership vision, creating organizational design to match new mission outlines (and resources), and building structures that support personnel promotion and selection of “champions,” establishing training programs and publishing new doctrinal principles. Considering the VUCA environment where leaders operate currently, both DHHS and DOD must focus on incorporating these cultural adaptations and proactive mechanisms, including resourcing and vision from executive levels.¹³⁷

Assessment of current leadership competency in both healthcare communities requires close scrutiny.¹³⁸ This will ensure the most developed and capable leadership,

with the desired skill sets, assumes the lead in strategic roles in complex environments. Careful selection is crucial considering that leaders will need to utilize collaborative strategic communications to send the correct message to the nation, deter insurgent activity, and support the legitimization of the government in keeping with national policy goals.¹³⁹

Leadership competencies, transformative leadership through embedding and reinforcing principles, and careful leadership selection emboldens the ideal of mutual assistance and collaboration along all facets of medical stabilization support operations.¹⁴⁰ Training modules and programs would ensure assimilation of this cultural change into the organization.¹⁴¹ In the case of healthcare, the ramifications for failing to promote these elements and competencies could result in confusing and inefficient doctrine which fails to shift organizational culture along a necessary path.

Organizational Culture Change. The medical community, a significant component of stabilization operations, requires an organizational shift toward greater collaboration and synchronization between visions, doctrine, design, training, leading and most especially...culture. One of the basic aims of this research toward a more synthesized healthcare policy for Iraq is to change the present culture. This cultural conflict, as detailed in the literature review, has been a persistent problem since the outset of these types of operations.¹⁴² The cultural construct is not only relevant to the civilian elements but likewise the military contingent, which uses different skills, planning guidelines and operational principles.¹⁴³

Promoting vision through strategic leadership principles and corporate buy in from all the constituents is required for lasting cultural change.¹⁴⁴ One significant

component of leadership involves identifying the needs of senior, middle and junior management, specifically training and development in areas of flexible adaptation to changing conditions (culture). This perception of leadership and support of change through cultural adaptation is instrumental in creating a new organizational environment that integrates the values, heritage, and voice of the members.¹⁴⁵ As correlative components, doctrine changes, organizational design, and training programs also help determine the necessary elements to support culture change.

Doctrinal components, if appropriately vetted by leadership for concurrence within and between the agencies described, can assist in realigning perceptions, decision making and overall cultural adaptation of organization(s). As the S/CRS is the DOS representative for coordination of efforts on stabilization operations, and the DHHS is the DOS representative for health policy, the National Security Council (NSC) could then direct the DHHS as the lead executive authority.¹⁴⁶ The DHHS could then task the Office of the Secretary of Defense for Health Affairs (OSD/HA) to create a unified medical doctrine incorporating components from both agencies (DOS/DOD). Using this methodology, the collaboration would be solidified through doctrinal components synchronizing the effort. Currently, the absence of any unifying doctrinal component creates certain significant gaps in operational collaboration.¹⁴⁷ This is reflected in the Iraq context. Absence of synchronous approaches, unity of effort and doctrine led to frequent duplication of efforts and greater expense in resources at the national level.¹⁴⁸ This is not to say that advances have not been made; in fact, several have.¹⁴⁹ Previous advances, however, were typically not synchronized with other agency elements and did not follow a singular medical strategic plan.¹⁵⁰ To function effectively, the players

involved require doctrinal guidelines beyond the current language provided in joint campaign plans or equivalent S/CRS task matrices.¹⁵¹ These guidelines must be supported and propagated by leadership who can address the subtle subculture differences of these institutions.

Cultural understanding aimed at aligning goals and driven by leadership, doctrine and training, will permit greater power in leveraging whole of government medical assets.¹⁵² While each of the agencies fall under different lines of authority and approach issues from different perspectives (through organizational values and other cultural perceptions), these differences can also serve as strengths in the right context. DHHS and DOD cultural specific elements provide them with capabilities that complement one another well. To wit, the DHHS has access to political venues, understanding of domestic public health sector planning and diplomatic training.¹⁵³ DOD in turn maintains medical resources available early on in contingency operations as well as a cadre of trained experts.¹⁵⁴ These assets would take considerable time and effort to grow within the other organizations and should be embraced as enablers to facilitate healthcare operations. A combined DOD/DHHS approach, utilizing these cultural elements, is in a better position to address specific strategic healthcare policy tenets necessary to reconstitute healthcare systems.

Strategic Healthcare Policy Tenets (Accessible, Affordable, Capable)

The primary elements of a functional health system are well documented in RAND publications, international health journals, Morbidity and Mortality Weekly Updates, certain Essential Task Mission listings (ETM) from DOD as well as S/CRS and other sources.¹⁵⁵ The specific healthcare policy tenets for stabilization operations in Iraq

will require further refinement from these more all encompassing listings as they should be based on context, threat and time available. Although defining each of the basic health policy tenets for stabilization operations is beyond the intent of this research, these are briefly provided to enable follow on analysis for new system designs in organization, leadership, training, planning and culture.

These elements also include parallel systems necessary to be operational in order to promote overall health of populations.¹⁵⁶ A primary concern from a parallel basic human need support system is potable water and adequate sanitation systems. Functional water and sewage systems help avoid the onset of pandemics or other communicable disease proliferations. For disease outbreaks, nations require a planned and rehearsed pandemic response system.

Other vital strategic health policy and planning considerations include displaced persons support, detainee healthcare policy, contractor healthcare, basic medical and pharmaceutical supply systems management, Emergency Management Systems (EMS), healthcare infrastructure, health education and promotion, and funding mechanisms to enable sustainment of systems.¹⁵⁷ Additionally, fiscal support of any healthcare system includes a review of insurance mechanisms, salaries, and affordability for the general population.¹⁵⁸ Health system structure involves calculating and rating the facilities of a particular system, evaluating construction needs, accessibility and function. To operate this system, it is necessary to explore the available pool of health system human resources. This element also relates to training, retaining and recruiting of health care staff. A final key element of health systems' functionality is the availability of versed healthcare administrators. Training personnel in

healthcare administration principles is a vital component of any strategic health policy plan. These specific healthcare tenets make up the building blocks of health policy for any nation.¹⁵⁹

Conclusions

Healthcare operations, a primary enabler of stabilization operations, require greater focus by leaders for future contexts.¹⁶⁰ Synchronizing a strategic health policy requires new models, leadership training and cultural adaptation. Preparing now, even if through historical case studies and scenario driven elements, will begin cultural transformation and engender greater cooperation among organizations involved.¹⁶¹ In international contexts the sole authority representing the President of the United States is the Ambassador. The DOS is the authority for managing stabilization operations in international settings. DOS designated DHHS as the agent for managing the healthcare mission abroad. Although the DHHS is selected as the lead agent to address the healthcare capability of a host country, they often lack resources and experience to address all the unique challenges.¹⁶² In order to address the specific strategic healthcare tenet requirements in policy and planning, the ambassador and combatant commander also rely on the expertise and forthright appraisal of those strategic leaders who share the mission. These leaders, whether within the organizational components of an embassy structure or with the military authority, must analyze situations, supply courses of action, and implement solutions together to achieve desired ends.¹⁶³

One suggestion is to build a model that redefines the current system in design, leadership and culture. Having a unified vision and complementary organizational design guided by leadership competencies is paramount to a coordinated effort.¹⁶⁴

Although this “unity of effort” definition is often viewed differently based on the specific organizational culture, the proposed model and phased application incorporates the Health Attaché Office with both military and civilian membership (see Figure 1 & 2).¹⁶⁵

Adjusting to a renewed focus on stabilization operations (contingency operations of the future) presents significant challenges to leaders in the medical community. These challenges will prove to be critical elements to consider in planning for strategic goals in other future contexts.¹⁶⁶ Using techniques such as embedding and reinforcing mechanisms to complement leadership, doctrine, training and planning models, we can reassess the external environment along a continuum of possibilities. Incorporating partners from both institutions into the cultural change model is imperative to achieve lasting organizational change and buy in from all the relevant players.¹⁶⁷ Strategic medical leadership is the key to promoting the vision of effective interagency collaboration and coordination.

As stated by Conrad Crane, “the army’s involvement in stabilization phase operations has been particularly demanding and has pushed the services to perform numerous unwanted nation building tasks.”¹⁶⁸ Stabilization operations have become more the norm; hence USG medical assets have an obligation to design, plan and train together to support national goals. This has recently been described in Field Manual 3-07, *Stabilization Operations*, but detailing strategy and planning for translation of this suggestion into application requires more granular introspection.¹⁶⁹ Additionally, there has recently been a move within the Peace Keeping and Stabilization Operations Institute (PKSOI) to bring on board a DHHS representative who has served in a healthcare delivery role in Iraq. Incorporating this representative may enable their future

efforts and provide valuable insight into the DHHS processes abroad.¹⁷⁰ It is clear that a more streamlined and functional health policy model for healthcare strategic operations is essential to effective and efficient application in these contexts. This follows the Army recommendations for 21st century counterinsurgency operations; to institutionalize new methods for a unified interagency approach, redefine leader training and development, and refine plans and doctrine to complement efforts in counter insurgency efforts.¹⁷¹

Although Iraqi leadership in the healthcare sector may not require the U.S. to manage their system, they do require some specific resources and training in order to enable their efforts. This capacity building approach promotes greater long-term sustainability, more effective policies and assists in the nation building process.¹⁷² Agencies in Iraq, as well as those supporting from stateside and other international entities, can accomplish this mission through a more refined roadmap via structure, leadership, culture and comprehensive strategic healthcare plan.¹⁷³ Harmonizing the relationships via these changes to the critical elements needed for sustainable change enhances current civil-military operations within the healthcare arena.¹⁷⁴

A final thought on the remodeling and synthesizing of health policy planning would be to utilize the flexible model design proposed here, as well as training and other cultural adaptations. The flexible nature of this model should allow for use in other theaters of operation such as Afghanistan, or even the relatively recent African Command (AFRICOM) context.¹⁷⁵ As members representing the same government, we should utilize all the elements of national power along the same continuum to better achieve an overall desired end state. Failure to do so may cause divergence from campaign objectives and thereby deviate from national goals. Regardless of the

context, synchronizing effort in international healthcare policy would continue to be one of the most powerful tools available to the USG in the execution of national strategic objectives in stabilization operations.

Endnotes

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²⁴ Nora Bensahel, *International Perspectives on Interagency Reform*, (Santa Monica, CA: RAND Corporation, January 2008), 6-9; see also Crowther, "Tailoring a U.S. Embassy," 221-226.

²⁵ Crane, "Landpower and Crisis," 45; even in Kuwait after Operation Desert Storm "neither the Army nor DOD had an adequate plan for Post War operations to rebuild Kuwait and civilian agencies were even more unprepared." The implied task from this and similar examples is the need to have an overall plan to address these ongoing shortfalls in synchronization.

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³² Crane, "Landpower and Crisis," 53; William J. Clinton, PDD/NSC 56: Managing Complex Contingency Operations, <http://www.fas.org/irp/offdocs/pdd56.htm>, (accessed November 2, 2008); see also John F. Troxell, "Presidential Decision Directive-56: A Glass Half Full," in *The Interagency and Counterinsurgency Warfare: Stability, Security, Transition, and Reconstruction Roles* eds., Joseph R. Cerami and Jay W. Boggs (Carlisle Barracks, PA: Strategic Studies Institute, 2007), 25-46; see also Amanda Smith, "Strategic Communication: Interagency Rhetoric and Consistent Interpretation," in *The Interagency and Counterinsurgency Warfare:*

Stability, Security, Transition, and Reconstruction Roles eds., Joseph R. Cerami and Jay W. Boggs (Carlisle Barracks, PA: Strategic Studies Institute, 2007), 361.

³³ David Mangelsdorff, "The Army-Baylor Program in Healthcare Administration," *U.S. Army Medical Department Journal*, (Jan-Mar 2005). "Making Rank," *Baylor Magazine* 5, no. 1 (Summer/Fall) <http://www.baylormag.com/story.php?story=005952> (accessed Oct 29, 2008); see also U.S. Army Corps of Engineers Home Page, Missions, <http://www.usace.army.mil/> (accessed October 31, 2008); see also U.S. Army Corps of Engineers, Gulf Region Division, <http://www.grd.usace.army.mil/index.asp> (accessed October 31, 2008); see also "Iraqi Health Care's Revival and what it Can Teach U.S. Hospitals," *Hospitals and Health Networks* 82, no. 9 (September 2008): 5; paid advertisement in leading healthcare journal on military healthcare administrators.

³⁴ Crane, "Landpower and Crisis," 24; see also U.S. Department of the Army, "Army Action Plan for Stability Operations: Strategy, Plans and Policy, Army Campaign Plan Decision Point 105," Washington DC, (August 2007) 2.

³⁵ National Security Presidential Directive 44, (NSPD-44), released December 7, 2005, Subject: Management of Interagency Efforts Concerning Reconstruction and Stabilization; superseding Presidential Decision Directive/NSC 56 dated May 20, 1997; see also Hammes, *The Sling and the Stone*, 231.

³⁶ National Security Presidential Directive 44, Management of Interagency Efforts, December 7, 2005; see also Douglas C. Lovelace, Jr., "Foreword" in *Stability Operations and State-Building: Continuities and Contingencies*, ed. Greg Kaufmann (Carlisle Barracks, PA: U.S. Army War College, Strategic Studies Institute, October 2008), v.

³⁷ LTC Lisa Forsyth of the Stabilization Office, Pentagon, interview by author, Washington, D.C., October 3, 2008; referenced planning meetings on the Essential Medical Tasks that must be completed in order to address stabilization operational tenets (draft document) and the new agency proposed. Also included discussions of working groups with DHHS and the Office for Construction, Stabilization and Reconstruction (S/CSR) to work through present challenges; see also Metz, *Learning from Iraq*, 74-75; part of the approach to reorganization of the military role in stabilization type operations is to create a joint "Stabilization and Construction Command" which would be positioned in DOD and complemented by special forces assets. The optimal method is to stand up a special interagency corps with a mission outline mirroring that of stabilization oriented command.

³⁸ U.S. Department of the Army, *Stability Operations*, Chapter 3; see also U.S. Department of the Army, "Army Action Plan for Stability Operations," (August 2007), 3-4; see also U.S. Department of Defense, Joint Operations, Joint Publication 3-0 (Washington, DC: U.S. Department of Defense, February 13, 2008).

³⁹ U.S. Department of the Army, *Stability Operations*, Chapter 3.

⁴⁰ Redmond, "AAR – Medical Support to Stability Operations," 10 July 2008.

⁴¹ U.S. Department of the Army, "Army Action Plan for Stability Operations," (August 2007).

⁴² *Ibid.*, 6.

⁴³ Steven R. Miles, *Reconstruction under Adversity: Rebuilding Iraq – Lessons for the Future*, (Carlisle Barracks, PA: U.S. Army War College, March 30, 2007), 4-6.

⁴⁴ Metz, *Learning from Iraq*, 48; MNSTC-I was created to assist the Iraqis as an enabler of their security forces development; see also Spring 2007, Health Attaché meeting in Baghdad Iraq: Meeting held to discuss transportation requirements for operations in Iraq where leadership (USG) failed to reach consensus. Lacking accountability at this level through a single organization to dictate policy, the operations became fragmented and disparate resulting in redundant efforts and wasted resources; see also Thomas Donnelly and Frederick W. Kagan, *Ground Truth: The Future of U.S. Land Power*, (Washington D.C.: American Enterprise Institute (AEI) Press, 2008), 2-42.

⁴⁵ Michael J. Metrinko, *The American Military Advisor: Dealing with Senior Foreign Officials in the Islamic World*, (Carlisle, PA: U.S. Army War College, Strategic Studies Institute, August 2008), 37, 63, 66; in a context where the military or civilian agency is to interact with international organizations, agencies, NGOs, etc, we should be cognizant of divergent agendas and take care to promote a united approach among the disparate groups.

⁴⁶ Vicki J. Rast, *Interagency Fratricide: Policy Failures in the Persian Gulf and Bosnia*, (Maxwell AFB, AL: Air University Press, 2004); discusses the interagency gap between the diplomats and military in the execution of a sustainable peace and some previous failures.

⁴⁷ Robert J. Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, (Lubbock, TX: Texas Tech University Press, 2004), 115.

⁴⁸ *Ibid.*, 127.

⁴⁹ *Ibid.*

⁵⁰ James H. Embrey, *Reorienting Pacification: The Accelerated Pacification Campaign of 1968* (Lexington, KY: University of Kentucky, 1997) 24-25; see also Ross M. Coffey, *Improving Interagency Integration at the Operational Level: CORDS – A Model for the Advanced Civilian Team*, monograph (U.S. Army Command and General Staff College, Fort Leavenworth, KS: School of Advanced Military Studies, 2006); CORDS established to promote unity of effort and a revolutionary conceptualization of cooperation.

⁵¹ Brian M. Jenkins, "The Unchangeable War," RM-6278-ARPA (Santa Monica, CA: Rand Corporation Paper, November 1970), 1.

⁵² Wilensky, *Military Medicine*, 42-47.

⁵³ Steven Metz and Raymond Millen, "Intervention, Stabilization, and Transformation Operations: The Role of Landpower in the New Strategic Environment," *Parameters* 35, no. 1, (Spring 2005): 49-50; see also Hans Binnendijk and Stuart E. Johnson, *Transforming for Stabilization and Reconstruction Operations*, (Washington, DC: National Defense University Center for Technology and National Security Policy, 2004), 53-69; see also L. Farrel, "Stability, Reconstruction Skills Key to Long Lasting Security," *National Defense* (January 2008).

⁵⁴ Seth Cropsey, "An Odd Prescription: Old Medicine Won't Solve Pentagon Woes," *Armed Forces Journal* 145, no. 11 (June 2008): 27; see also John Koivisto, *Increasing Effectiveness of*

Interagency Provincial Reconstruction Teams, Strategic Research Project (Carlisle Barracks, PA: U.S. Army War College, March 30, 2007), 11; see also Steven Mains, *PRT Playbook: Tactics, Techniques, and Procedures*, No. 07-34 (Fort Leavenworth, KS: Center for Army Lessons Learned, September, 2007); see also U.S. Department of the Army, *Stability Operations*, F-1 to F-6.

⁵⁵ Carlos Hernandorena, "U.S. Provincial Reconstruction Teams in Afghanistan, 2003-2006: Obstacles to Interagency Cooperation," in *Interagency and Counterinsurgency Warfare: Stability, Security, Transition, and Reconstruction Roles*, ed. Joseph R. Cerami and Jay W. Boggs (Carlisle, PA: U.S. Government Publication, 2007), 121; see also Office of the Special Inspector General for Iraq Reconstruction, "Status of the Provincial Reconstruction Team Program Expansion in Iraq," SIGIR-07-014, July 25, 2007, ii-iii.

⁵⁶ Koivisto, *Increasing Effectiveness of Interagency*, 8.

⁵⁷ Office of the Special Inspector General for Iraq Reconstruction, "Status of the Provincial Reconstruction Team," 6-7.

⁵⁸ Mains, *PRT Playbook*, 66.

⁵⁹ "Iraqi Health Care's Revival and what it can teach U.S. Hospitals," *Hospitals and Health Networks* 82, no. 9 (September 2008): 14; implies a need to understand the desires of the Ministry of Health (MOH) more readily.

⁶⁰ Gary Felicetti, "The Limits of Training in Iraqi Force Development," *Parameters*, (Winter 2006-07): 81; discusses the issue of institutionalized training resistance which has come about in literature surrounding our National Strategy for *Victory in Iraq*. If training imperatives are emplaced into our community for "nation-building" for example, we may avoid some of the previous pitfalls experienced with training forces in Iraq.

⁶¹ Jane Ward, Kerrie Lindberg, Daniel McNulty and Mona Ternus, "A Global Engagement Enhancer: The International Health Specialist," *Air & Space Power Journal* (Fall 2002); training similar to that of the Air Force medical components in international settings is an option.

⁶² Raymond Millen, *Managing Provincial Reconstruction Activities*, (U.S. Army War College, Carlisle Barracks, PA: Strategic Studies Institute, December 2007), 237.

⁶³ Carafano, "Learning from the Past," 171; leadership competencies for these roles should include familiarity with diverse but related disciplines, crisis action planning experience and understanding of other forces affecting operations.

⁶⁴ U.S. Army-Baylor University Graduate Program in Health and Business Administration, <http://www.baylor.edu/graduate/mha/index.php?id=44639>, (accessed November 12, 2008).

⁶⁵ Ibid.

⁶⁶ Metz, *Learning from Iraq*, 61; the relevance of doctrine that followed the 2005 National Defense Strategy and Secretary Rumsfeld reinforcement of stability operations as a core competency was an effort to integrate all activities across the department for organization,

resources, education, training and doctrine; see also U.S. Department of Defense, *National Defense Strategy* (Washington, DC: U.S. Department of Defense, June 2008), 17-18.

⁶⁷ John Naisbitt: International Best-Selling Author of Megatrends and Megatrends 2000, <http://www.naisbitt.com/home.php> (accessed Nov 3, 2008); see also John Naisbitt Biography, http://www.naisbitt.com/biography_print.htm (accessed Nov 3, 2008); see also Thinkexist.com quotations, <http://thinkexist.com/common/print.asp?id=363708"e=strategic-planning-is-worthle...> (accessed Nov 3, 2008).

⁶⁸ Steven Metz, *Rethinking Insurgency*, (Carlisle, PA: U.S. Army War College, Strategic Studies Institute, June 2007), 41-42.

⁶⁹ Bradford A. Lee, *Winning the War but Losing the Peace? The United States and the Strategic Issues of War Termination* (n.p., 2003) 259; see also U.S. Department of the Army, "Army Action Plan for Stability Operations," (August 2007), 5-6; see also Redmond, "AAR – Medical Support to Stability Operations," 10 July 2008.

⁷⁰ U.S. Department of the Army, "Army Action Plan for Stability Operations," (August 2007), 5-6; Redmond, "AAR – Medical Support to Stability Operations," 10 July 2008.

⁷¹ Crane, "Landpower and Crisis," 37; see also Brian Friel, "The Powell Leadership Doctrine." *Government Executive*, (1 June 2001): 257; resource abundance and DOS are not synonymous; see also U.S. Congress, House of Representatives, Committee on Armed Services, Panel on Roles and Missions, Initial Perspectives, January 2008 (USAWC Foundations of Military Power, Selected Readings) 2-3; see also U.S. Department of Defense, *Health Capabilities in Stability Operations*, 8; see also Bensahel, *International Perspectives on Interagency Reform*, 7.

⁷² Mangelsdorff, "The Army-Baylor Program," (accessed Oct 29, 2008).

⁷³ Redmond, "AAR – Medical Support to Stability Operations," 10 July 2008.

⁷⁴ Barno, interview by author, Sept 12 2008.

⁷⁵ Redmond, "AAR – Medical Support to Stability Operations," 10 July 2008.

⁷⁶ Leonard Wong and Don M. Snider, *Strategic Leadership of the Army Profession in The Future of the Army Profession*, 2d ed, Don M. Snider and Lloyd J. Matthews, (Boston, MA: McGraw Hill Custom Publishing, 2005), 604-607.

⁷⁷ Isaiah Wilson, "Thinking Beyond War: Civil-Military Operational Planning in Northern Iraq," (paper prepared for delivery at the Annual Meeting of the American Political Science Association, Chicago, IL, September 2-5, 2004), 15.

⁷⁸ Metz, *Learning from Iraq*, 80; see also U.S. Joint Chiefs of Staff, "Interagency, Intergovernmental Organization and Nongovernmental Organization Coordination During Joint Operations", Joint Publication 3-08, Vol I, (Washington, DC: U.S. Government Printing Office, March 17, 2006).

⁷⁹ Crane, "Landpower and Crisis," 24, 34, 45; see also Carafano, "Learning from the Past," 167.

⁸⁰ Redmond, "AAR – Medical Support to Stability Operations," 10 July 2008; see also National Defense University, *Interagency Management of Complex Crisis Operations Handbook*, (Washington DC: National Defense University, January 2003).

⁸¹ U.S. Department of Defense, *Joint Operation Planning*, II-6 to II-12; see also U.S. Department of the Army, *Stability Operations*; U.S. Department of Defense, *Health Service Support*, Joint Publication 4-02, (Washington, DC: U.S. Department of Defense, October 31, 2006).

⁸² Crane, "Landpower and Crisis," 24.

⁸³ Crane, "Landpower and Crisis," 56.

⁸⁴ Barno, interview by author, Sept 12 2008.

⁸⁵ David W. Major, *Regional Initiatives: Eliminating the Causes of Terrorism*, Strategic Research Project (Carlisle Barracks, PA: U.S. Army War College, March 15, 2008), 4.

⁸⁶ Dr. S. Stevenson and Dr. Marybeth Ulrich, "Civil-Military Relations Panel," briefing slides with scripted commentary, Carlisle Barracks, PA, U.S. Army War College, November 13, 2008.

⁸⁷ Spring 2007, Baghdad, Iraq, Meeting took place where the MOD, MOH, MNSTC-I and Health Attaché elements negotiated a training program for clinical staff at one of our military medical facilities for a specific number of applicants and although all agreed, participation was non-existent in the first attempt. The Iraqis assumed we were to meet several more times and agree several more times until implementation occurred; different cultural norms came into play.

⁸⁸ For background on Ministry of Health efforts to analyze their healthcare system and capacity development needs, see Mohammed J Hawail, *Guideline for Concise outlook for Health Approaches in Iraq: In Response to the Sixtieth Word [sic] Health Assembly Meeting*, (Baghdad, Iraq, May 2007); see also U.S. Department of Defense, *Health Capabilities in Stability Operations*; see also Thomas S. Bundt, *Healthcare Policy Operations—A Formulary for Effective Transition in Iraq*, Policy Paper for Health Attaché Operations (June 2007).

⁸⁹ Bundt, *Healthcare Policy Operations*, 4-5.

⁹⁰ Tyrrell, *What To Know Before*, 131.

⁹¹ Chris Cline, "The Influence of Stability Operations on the Army Profession and Public Management," in *The Interagency and Counterinsurgency Warfare: Stability, Security, Transition, and Reconstruction Roles*, ed. Joseph R. Cerami and Jay W. Boggs (U.S. Army War College, Carlisle, PA: Strategic Studies Institutes, December 2007), 465-509.

⁹² Colin S. Gray, *Modern Strategy* (New York: Oxford University Press Inc., 1999), 60; see also Crane, "Landpower and Crisis," 24.

⁹³ H.R. McMaster, "Graduated Pressure: President Johnson and the Joint Chiefs," *Joint Forces Quarterly* 34 (Spring 2003): 86; differences in agency culture, values and processes concluded in a flawed strategy; see also George R. Mastroianni and Wilbur J. Scott, "The Politics of Blame and Civilian-Military Relations," *Military Review* 88, Issue 4, (Jul/Aug 2008): 54; see also U.S. Department of Defense, *Military Support to Stabilization, Security, Transition, and Reconstruction Operations Joint Operating Concept*, (Norfolk, VA: Joint Forces Command, December 2006), D-5.

⁹⁴ Crane, "Landpower and Crisis," 24.

⁹⁵ Metz, *Learning from Iraq*, 80; in reference to designing a flexible medical module for the future, for example, there is truly "no one size fits all" as the Iraqi theater demonstrates.

⁹⁶ U.S. Congress, Committee on Armed Services, January 2008, 2-2 to 2-3.

⁹⁷ Crane, "Landpower and Crisis," 28; best "fit" for the Army in contingency operations; see also "Stochastic Analysis," U.S. Army Program Analysis and Evaluation Directorate, *America's Army...into the 21st Century*, Washing, DC: HQDA, 1997, 5; see also U.S. Department of Defense, *National Defense Strategy* (Washington, DC: U.S. Department of Defense, June 2008) 17-18; see also U.S. Department of the Army, *Stability Operations in an Era of Persistent Conflict*, (Washington DC: U.S. Department of the Army, June 1, 2008), 7.

⁹⁸ U.S. Department of Defense, *Health Capabilities in Stability Operations*, 5.

⁹⁹ Stephen J. Gerras, "Thinking Critically about Critical Thinking: A Fundamental guide for Strategic Leaders," (December 2007): 49-77, in U.S. Army War College, Department of Command, Leadership, and Management, *Selected Readings*, AY 2009, Strategic Thinking [DCLM Issue]; references leaving rank at the door and replacing this with synonymous thought on leaving egos and perceptions at the door to avoid bias and misreading intent.

¹⁰⁰ Jones, et al., *Securing Health: Lessons*, 221-273.

¹⁰¹ U.S. Department of Defense, *Health Capabilities in Stability Operations*.

¹⁰² *Ibid.*

¹⁰³ Meinhart, "Leadership and Strategic Thinking," 40-48; emphasizes the use of strategic thinking for leadership to integrate all the possible perspectives and challenges of complex systems which requires greater fidelity and processing of information and outcomes; see also Gerras, "Thinking Critically about Critical Thinking," 49-77.

¹⁰⁴ See Figure 1: Phases of Medical Stabilization Support Operations

¹⁰⁵ Flavin, "Planning for Conflict Termination," 107.

¹⁰⁶ Christopher E. Housenick, "Winning Battles but Losing Wars: Three Ways Successes in Combat Promote Failures in Peace," *Military Review* (September-October, 2008), 95-96.

¹⁰⁷ U.S. Department of the Army, *Stability Operations*, 2-13; the general phases of stabilization operations are initial response, transformation and fostering sustainment, however

this proposed model is an intentional modification to align specifically with health policy applications in a stabilization type scenario.

¹⁰⁸ Flavin, “Planning for Conflict Termination,” 46; Flavin states, “...typically culture is rooted in history, held collectively and is of sufficient complexity to resist many attempts at direct manipulation.” This tenet is critical to understanding the barriers that exist to sustaining and implementing an effective organizational culture as well as trying to change it. Figure 1: Phased Stability Operations for Medical Lead Agent; Figure 2: Proposed Medical Module Model (Flexible Application)

¹⁰⁹ Currently the requirement for a Health Attaché is not a permanent structure in Embassy operations and therefore not organic to the DOS or DHHS. This has implied flexibility inherent to a more (whole of government) system to provide assets tasked specific to a set mission. For example, if specific health policy subject matter expertise is not available in DHHS (not as robust as Joint medical manpower assets), this identifies the need to establish a module complimented by manpower from all agencies and departments to leverage our full medical potential; see also U.S. Congress, Committee on Armed Services, January 2008, 1-13 to 1-16; the relevance of seeking to align structure and assets parallels the need highlighted by the Committee on Armed Services to note the gaps and reduce the duplication of effort across the different departments within DOD. We should seek to review those elements that are regarded as the core competencies of that organization and align resources accordingly; see also Metz, *Learning from Iraq*, 66; it is essential to design operations tailored around the strengths (core competencies) of its membership.

¹¹⁰ Mangelsdorff, “The Army-Baylor Program,” (accessed Oct 29, 2008); slots in the US Army Baylor program are made available to other services and the VA which then transfer funds from their departments to finance their students.

¹¹¹ B. J. Weiler, “Corps of Engineers Assisting in Building Health Clinics in Iraq,” American Forces Press Service New Articles, <http://www.defenselink.mil/news/newarticle.aspx?id=16714> (accessed August 13, 2008); Mangelsdorff, “The Army-Baylor Program,” (accessed Oct 29, 2008).

¹¹² Mangelsdorff, “The Army-Baylor Program,” (accessed Oct 29, 2008).

¹¹³ Putting together briefings for the Minister of Health and providing a consultative element to their tasks will enable them to defend their needs to the GOI and thereby continue to gain resources and appropriate attention from the government toward the healthcare sector. One personal example of this was a power point slide show provided to Minister Dr. Ali Alshamari depicting a new retention and allowance plan for certain skills sets in an effort to curb their emigration (significant exodus of healthcare staff from Iraq). As a result of the briefing that Dr. Ali then provided with this slide package, the Ministry of Finance in concert with the Deputy Prime Minister initially granted him the necessary funding to recapture these personnel which was advertised in Iraq as well as in Jordan to strategically convince others to return.

¹¹⁴ See Figure 1

¹¹⁵ Dallas W. Homas, *Strategic Medical Leadership in the Global War on Terrorism*, Strategy Research Project (Carlisle Barracks, PA: U.S. Army War College, March 15, 2008), 2; see also Millen, Managing Provincial Reconstruction Activities, 238-244.

¹¹⁶ Donald F. Kettl and James W. Fesler, "The Politics of the Administrative Process," in *Decision Making*, (Washington, DC: CQ Pres, 2005), 111-143.

¹¹⁷ Duane R. Ireland and Michael A. Hitt, "Achieving and Maintaining Strategic Competitiveness in the 21st Century: The role of Strategic Leadership," *Academy of Management Executive* 19, no. 4 (Nov 2005): 48.

¹¹⁸ U.S. Department of the Army, "Army Action Plan for Stability Operations," (August 2007), 5-6; Redmond, "AAR – Medical Support to Stability Operations," 10 July 2008; these references define current efforts to promote cooperative planning efforts.

¹¹⁹ Peter M. Ginter, Linda M. Swayne and W. Jack Duncan, *Strategic Management of Healthcare Organizations*, 3d ed., (Malden, MA: Blackwell, 1998), 175; 562-576; 506-523; see also Thomas L. Wheeler and J. David Hunger, *Strategic Management and Business Policy*, (Upper Saddle River, NJ: Prentice Hall, 2002), 1-23; see also U.S. Department of the Army, *Stability Operations*.

¹²⁰ U.S. Department of the Army, *Full Spectrum Operations*, Field Manual 3-0, "Stability Operations," (Washington DC: U.S. Department of the Army, February 27, 2008) Chapter 9; see also Metz, *Learning from Iraq*, 83; see also U.S. Department of the Army, *Peace Operations Field Manual (FM) 100-23*, (Washington DC: U.S. Department of the Army, December, 1994); see also U.S. Joint Chiefs of Staff, *Interagency, Intergovernmental Organization and Nongovernmental Organization*, II-16.

¹²¹ For assuming a mission not typically under the auspices of that agency or department a commensurate funding line needs to be created to recognize and adequately support the supporting agency/department.

¹²² Ireland and Hitt, "Achieving and Maintaining Strategic," 47; organizational controls, can be powerful tools to place boundaries on interests, while simultaneously granting flexibility in application allowing for the leveraging of other entities (agency resources in this case) to address a specific problem.

¹²³ Andrew S. Natsios, "The Nine Principles of Reconstruction and Development," *Parameters* 35, no. 3 (Autumn 2005): 4; USAID began to see weaknesses in their training programs and has been refocusing efforts to work in tandem with other agencies.

¹²⁴ Flavin, "Planning for Conflict Termination," 107.

¹²⁵ Metz, *Learning from Iraq*, 1; NGOs at one time in the planning process were expected to provide resources and personnel to reestablish society and essential services following conflict, this plan likewise was left wanting; see also U.S. Department of Defense, *Health Capabilities in Stability Operations*, 7-8.

¹²⁶ Ginter et al., *Strategic Management of Healthcare Organizations*, 506-523.

¹²⁷ Forsyth, interview by author, October 3, 2008; discussions regarding DHHS personnel participation on new interagency working groups; see also Conrad C. Crane and W. Andrew Terrill, *Reconstructing Iraq: Insights, Challenges, and Missions for Military Forces in a Post-*

Conflict Scenario (Carlisle, PA: U.S. Army War College, Strategic Studies Institute, February 2003), 63-73.

¹²⁸ Warner W. Burke, "Organization Change: Epidemics, Integration, and Future Needs," in *Organization Change: Theory and Practice*, (Thousand Oaks, CA: Sage Publications, Inc., 2002), 68; see also Stephen J. Gerras, Leonard Wong and Charles D. Allen, "Organizational Culture: Applying a Hybrid Model to the U.S. Army," (Carlisle Barracks, PA: U.S. Army War College, June 2008), 245; one of the first components of a "reinforcing mechanism" for embedded elements to support organizational change is organizational design and structure.

¹²⁹ Wong and Snider, *Strategic Leadership of the Army Profession*, 602.

¹³⁰ Ireland and Hitt, "Achieving and Maintaining Strategic," 39; see also Burke, "Organization Change," 68; references challenges of being "locked into" a present culture. Depicts carrying out organizational tasks and missions that may be in direct contrast to the methodologies of other organizations with like missions; see also Wong and Snider, *Strategic Leadership of the Army Profession*, 607-621; see also Thomas S. Szayna, Derek Eaton and Amy Richardson, *Preparing the Army for Stability Operations: Doctrinal and Interagency Issues*, (Santa Monica, CA: RAND Corporation, 2007), 115; emphasizes influencing the direction of interagency collaboration and the need for a unified strategic vision; see also Darrell L. Jenkins, *Phase Four: Applying History's Successful Nation Building Lessons in Iraq*, Strategic Research Project (Carlisle Barracks, PA: U.S. Army War College, March 30, 2007), 2.

¹³¹ Ireland and Hitt, "Achieving and Maintaining Strategic," 38; see also "The Future Belongs to Those Who...a Guide for Thinking About the Future," Institute for Alternative Futures, <http://www.altfutures.com/docs/FuturesTechniques.pdf>, (accessed November 5, 2008); see also Wong and Snider, *Strategic Leadership of the Army Profession*, 611-619.

¹³² Peter W. Chiarelli and Stephen M. Smith, "Learning from our Modern Wars: The Imperatives of Preparing for a Dangerous Future," *Military Review* 87, no. 5 (September-October 2007): 439; transformational leadership will enable the Army in the next evolution of modern conflict and will help in understanding a very dangerous future through a different lens; see also Ireland and Hitt, "Achieving and Maintaining Strategic," 46; leadership is key to reshaping the organizational culture of entities and so many components work in tandem to enable this effort.

¹³³ Gerras et al., "Organizational Culture," 226-255; see also U.S. Department of the Army, *Army Leadership*, Field Manual 6-22, (Washington DC: U.S. Department of the Army, October 2006), 25.

¹³⁴ Burke, "Organization Change," 59; see also Stephen A. Shambach, ed., *Strategic Leadership Primer*, 2nd ed., (Carlisle Barracks, PA: U.S. Army War College, 2004); to complement these new skills, strategic level leadership needs to understand the intricacies of all the elements of national power such as diplomacy, information, and military and economic, (DIME) to be truly effective.

¹³⁵ Shambach, *Strategic Leadership Primer*, iii, 21-23, 30, 34: communication skills are one of the most important competencies that strategic leaders employ to change culture and adapt organizations to new environmental realities. They require vision, future focus and an understanding of institutional values, history and experiences of the organization to best embed

changes and complement with reinforcing mechanisms; see Kettl and Fesler, "The Politics of the Administrative Process," 114, 120; strategic planning involves the concept of idea generation, an essential parallel to leadership vision. This article portends that strategic planning on the political levels is not likely to be successful, however for the purposes of agencies and departments, planning removes boundaries and creates a strong tie to vision and mission support as well as a vital component to guide rational decision making.

¹³⁶ Burke, "Organization Change," 53.

¹³⁷ Shambach, *Strategic Leadership Primer*, iii; a key feature to the "VUCA" environment as experienced by present day leadership is the speed at which changes take place and the mandate to be able to react within a very constrained timeline in order to adequately address challenges.

¹³⁸ U.S. Department of the Army, *Army Leadership*, 27; these core leadership competencies are the baseline elements of all leader attributes in complex organizations. These include leading, developing and achieving specific aims. These are the baseline variables that form the leadership construct complemented by character, presence and intellectual capacity.

¹³⁹ Chiarelli and Smith, "Learning from our Modern Wars," 445-447; see also Metz, *Learning from Iraq*, 27; by showing a greater American presence, you can actually work to alienate the population. In the promotion of strategic communication by renewed emphasis on these strategic leadership tenets we can understand a methodology where the Iraqis are represented as providing for their citizens, advertise this element, and thereby increase the legitimacy of their government; see also U.S. Department of Defense, *Joint Operation Planning*, II-2 to II-3.

¹⁴⁰ Burke, "Organization Change," 291.

¹⁴¹ Gerras et al., "Organizational Culture," 242.

¹⁴² Crane, "Landpower and Crisis," 56.

¹⁴³ Metz, *Learning from Iraq*, 66; see also U.S. Department of the Army, *Full Spectrum Operations*, Appendix A.

¹⁴⁴ Ireland and Hitt, "Achieving and Maintaining Strategic," 38; see also Dennis C. Jett, "Challenges in Support and Stability Operations: Why each one is different," in *The Interagency and Counterinsurgency Warfare: Stability, Security, Transition, and Reconstruction Roles* eds., Joseph R. Cerami and Jay W. Boggs (Carlisle Barracks, PA: Strategic Studies Institute, 2007), 15.

¹⁴⁵ Michael L. Gibler, *Shotgun Wedding: Interagency Transformation for the 21st Century Security Environment*, Strategic Research Project (Carlisle Barracks, PA: U.S. Army War College, March 15, 2008), 21.

¹⁴⁶ Alan G. Whittaker, Frederick C. Smith and Elizabeth McKune, "The National Security Policy Process: The National Security Council and Interagency System," in *Affairs of State: The Interagency and National Security*, ed. Gabriel Marcella (Carlisle Barracks, PA: U.S. Army War College, Strategic Studies Institute, December 2008), 97-170.

¹⁴⁷ Susan E. Koger-Hill, "Team Leadership," in *Leadership: Theory and Practice* 3rd ed Peter G. Northouse, (Thousand Oaks, CA: Sage Publications, Inc., 2004), 297; see also Forsyth, interview by author, October 3, 2008; reference planning meetings on the essential tasks that must be completed in order to address stabilization operations tenets (draft document); see also Metz, *Learning from Iraq*, 47; see also Szayna et al., *Preparing the Army*, 132-226; see the Post Conflict Essential Tasks Matrix (ETM).

¹⁴⁸ Flavin, "Planning for Conflict Termination," 102; see also Office of the Special Inspector General for Iraq Reconstruction, "Status of Ministerial Capacity Development in Iraq," SIGIR-06-045, Jan 30, 2007, 18-20; U.S. Department of Defense, *Health Capabilities in Stability Operations*, 6.

¹⁴⁹ Advances in promotion of healthcare systems in Iraq are short term and individualized efforts (ie., providing clinics in rural communities, establishing MEDCAP exercises to promote capabilities and addressing individual population concerns), however when these are not part of the overall strategy (i.e., nested within the Ministry of Health (MOH) strategic map), then the host nation is not part of the plan nor is able to sustain systems once the USG withdraws from this support role. We require long term and sustainable solutions.

¹⁵⁰ Office of the Special Inspector General for Iraq Reconstruction, "Key Recurring Management Issues Identified in Audits of Iraq Reconstruction Efforts," SIGIR-08-020, July 27, 2008, ii-v; see also Gene Bonventre, *Health Issues in Stability Operations*, Position Paper (21 Sept 05).

¹⁵¹ Metz, *Learning from Iraq*, 24; we should not repeat the mistakes of the failure to plan for phase IV operations in Iraq by not promoting a collaborative planning effort; see also Redmond, "AAR – Medical Support to Stability Operations," 10 July 2008.

¹⁵² Ireland and Hitt, "Achieving and Maintaining Strategic," 39.

¹⁵³ Metz, *Learning from Iraq*, 66; see also Robert K. Mendenhall, *Pre-War Planning for a Post-War Iraq*, Strategic Research Project (Carlisle Barracks, PA: U.S. Army War College, February 18, 2005), 12.

¹⁵⁴ Redmond, "AAR – Medical Support to Stability Operations," 10 July 2008.

¹⁵⁵ Jones, et al., *Securing Health: Lessons*, 221-273; see also Forsyth, interview by author, October 3, 2008; see also U.S. Department of the Army, "Army Action Plan for Stability Operations," (August 2007), 5-6; see also Redmond, "AAR – Medical Support to Stability Operations," 10 July 2008.

¹⁵⁶ Jones, et al., *Securing Health: Lessons*, 230-234; see also Wheeler and Hunger, *Strategic Management and Business Policy*, 1-23.

¹⁵⁷ Tyrrell, *What To Know Before*, 137; failure to address the health of a population effectively can have deleterious effects.

¹⁵⁸ Jones, et al., *Securing Health: Lessons*, 224-225.

¹⁵⁹ Ginter et al., *Strategic Management of Healthcare Organizations*, 175; 562-576; 506-523.

¹⁶⁰ "The Future Belongs to Those Who...a Guide for Thinking About the Future," Institute for Alternative Futures, <http://www.altfutures.com/docs/FuturesTechniques.pdf>, (accessed November 5, 2008); it is critical for organizations, and in this case, primarily healthcare supporting institutions, to evolve due to the changes in the environment and cues of uncertainty and other VUCA elements mentioned. "Thinking about the future ... does in fact increase the probability of success in the future."

¹⁶¹ Flavin, "Planning for Conflict Termination," 107; Ross Coffey, "Revisiting CORDS: The Need for Unity of Effort to Secure Victory in Iraq," *Military Review* (March-April 2006): 24-34; emphasizes the need to use our lessons learned to avoid repeating mistakes in future contexts.

¹⁶² Friel, "The Powell Leadership Doctrine," 257; provides an example that resource abundance and DOS are not synonymous; see also U.S. Congress, Committee on Armed Services, January 2008, 2-3; see also U.S. Department of Defense, *Health Capabilities in Stability Operations*, 8; see also Bensahel, *International Perspectives on Interagency Reform*, 7.

¹⁶³ Coffey, "Revisiting CORDS," 24-34.

¹⁶⁴ Mendenhall, *Pre-War Planning*, 11; see also Special Inspector General Iraq Reconstruction, *Iraq Reconstruction: Lessons in Program and Project Management*, available from www.sigir.mil/reports/pdf/Lessons_Learned_March21.pdf, p. 16; Carafano, "Learning from the Past," 173; the lack of a coordinated effort is typically a result of failing to plan as well as exercising plans together prior to conflict.

¹⁶⁵ See Figure 1 & 2; see also Carafano, "Learning from the Past," 176; ensuring unity of effort provides for single overall command authority for each phase.

¹⁶⁶ Chiarelli and Smith, "Learning from our Modern Wars," 437-450; authors go into great detail on how to address future full-spectrum operations and provide significant stabilization tenets to discussions, changing roles for the military and encouraging developing cultural mindsets that support this transformation.

¹⁶⁷ Richard L. Daft and Karl E. Weick, "Toward a Model of Organizations as Interpretation Systems," *The Academy of Management Review* 9, no. 2 (1984): 187; the basis for organizational change is often widely believed to be caused solely by the external environment and the organization will suddenly move to address the exogenous issue(s). However an this can occur only if the members of an organization actually interpret the specific signals in the same way that higher management does. This also depends on what specific type of organizational change model they may prescribe to; see also Friel, "The Powell Leadership Doctrine," 260; a key catch-phrase introduced by "the Powell Leadership Doctrine" principles include this idea of "encouraging change, empowering people and fighting for resources."

¹⁶⁸ Crane, "Landpower and Crisis," 24.

¹⁶⁹ U.S. Department of the Army, *Stability Operations*.

¹⁷⁰ COL Rick Megahan, Chief, Governance Division, PKSOI, interview by author, Carlisle Barracks, PA, Oct 30, 2008.

¹⁷¹ Metz and Millen, *Insurgency and Counterinsurgency*, 35-36; see also U.S. Congress, Committee on Armed Services, January 2008, 2-2 to 2-3; see also Office of the Special Inspector General for Iraq Reconstruction, "Key Recurring Management Issues," ii-v; see also Special Inspector General Iraq Reconstruction, *Iraq Reconstruction: Lessons*, 16; report stated that the ad hoc nature of organizations and operations consumed excess time, resources and lacked appropriate staff, procedures and systems to effectively direct the effort; see also Flavin, "Planning for Conflict Termination," 106; see also Petraeus, MNF-I Commander's COIN Guidance, 2-4.

¹⁷² Natsios, "The Nine Principles," 8; see also L. Mori, D. Meddings, and D. Bettcher, "Health, Human Security and the Peace-Building Process," in *Conflict and Human Security: A Search for New Approaches of Peace-Building*, *English Research Report Series* no 19, 176.

¹⁷³ Metz, *Rethinking Insurgency*, 57; recommendations for improved outcomes in insurgent contexts depends on the ability to develop greater interagency efforts in strategy, doctrine, training and leader development.

¹⁷⁴ Flavin, "Planning for Conflict Termination," 105-106; see also Jeffrey B. Clark, *Lesson Relearned: The Urgent Need to Replace Post-Conflict Improvisation with Policy*, Strategy Research Project (Carlisle Barracks, PA: U.S. Army War College, March 18, 2005) iii, 2.

¹⁷⁵ Farrel, "Stability Reconstruction Skills."