
INTRODUCTION AND BACKGROUND

The National Defense Authorization Act for Fiscal Year 2000 requested that the Secretary of Defense submit a study identifying areas with respect to the Defense Health Program¹ for which joint operations might be increased, including organization, training, patient care, hospital management, and budgeting. The study team was asked to discuss the merits and feasibility of establishing the following:

1. A joint command
2. A joint training curriculum
3. A unified chain of command and budgeting authority.

This report, which fulfills the congressional request, is the latest in a long series of studies on this topic. Our objective is to develop organizational alternatives that appear to have some merit and outline the trade-offs inherent in choosing among the alternatives. We considered the experience of civilian health-care organizations in developing and assessing alternatives, but we also considered the unique missions and operations of the military system.

The remainder of this introductory chapter provides a brief overview of the current military health system (MHS). Chapter Two describes

¹The term *Defense Health Program* refers to the program element in the DoD program and budget that includes the operations and maintenance funds for medical activities. Not all medical activities are included in this program element and some resources for the included activities are in other program elements. To avoid confusion, we refer to the collection of all DoD medical activities as the “military health system.”

the organizational alternatives we identified. The organization of managed health care, drawing on experience in the civilian sector, is the subject of Chapter Three and the military-unique aspects of the MHS are discussed in Chapter Four. Chapter Five describes the insights we gained from the numerous past studies that address MHS organizational structure and our interviews with military health, Department of Defense (DoD), and congressional experts. Finally, in Chapter Six, we describe the issues that arise in choosing among organizational alternatives and recommend a general course of action.

OVERVIEW OF THE MILITARY HEALTH SYSTEM

The Department of Defense operates one of the largest and most complex health-care organizations in the nation. Including their overseas facilities, the Army, Navy, and Air Force operated about 465 military treatment facilities (MTFs) in 1999, including 91 hospitals and 374 clinics (U.S. General Accounting Office, 1999b).

The beneficiary population consists of approximately eight million active duty personnel, retirees, survivors, and their dependents. Their care is provided through a program called *TRICARE*, which offers both managed-care and fee-for-service options. TRICARE managed-care providers include the MTFs and a network of civilian providers administered through regional contracts with civilian managed-care organizations. The fee-for-service option also covers care provided by civilian providers who have not joined the network.

THE SYSTEM'S DUAL MISSIONS

On the surface, the military health system resembles a fairly typical U.S. managed-care organization. However, as a *military* health system, it has unique responsibilities arising from dual missions:

- 1. The Readiness Mission:** To provide, and to maintain readiness to provide, medical services and support to the armed forces during military operations.
- 2. The Benefits Mission:** To provide medical services and support to members of the armed forces, their dependents, and others entitled to DoD medical care (Deputy Secretary of Defense, 1991).

The uniquely military readiness mission involves deploying medical personnel and equipment as needed to support military forces throughout the world in wartime, peacekeeping and humanitarian operations, and military training. Activities that ensure the readiness of medical and other military personnel to deploy also contribute to the medical readiness mission. The benefits mission provides an employer health benefit (TRICARE) to military personnel and their family members, during active service and after retirement. MTFs supply about two-thirds of the health care used by TRICARE beneficiaries overall and almost all of the health care used by active-duty personnel. Civilian providers supply the rest of the care.

The two missions are linked in two ways. First, the health care provided under TRICARE also contributes to readiness; it keeps active-duty personnel at the peak health needed for military effectiveness and ensures their families are taken care of while they are away from home. Second, the same medical personnel are used for both missions. Active-duty physicians, nurses, and other health personnel staff the MTFs, where most of the health care for beneficiaries is provided. As needed, active-duty health personnel leave the MTFs to fill out the personnel assigned to deploying medical units. MTFs may also employ civilian medical professionals, who do not deploy, and deploying units often also employ reserve personnel, who spend little time in the MTFs.

So long as a large standing medical force is required for readiness, the active-duty personnel will need to be employed in regular patient care to sustain their skills. Making productive use of these personnel in TRICARE also keeps the costs of the DoD's employer health benefit reasonable. Although the two missions complement one another, joint production of readiness and benefits involves a complicated set of trade-offs and management challenges.