
**OPTIONS FOR ORGANIZING THE MILITARY
HEALTH SYSTEM**

The FY 2000 Defense Authorization Act requested that this report address the merits of making the MHS more unified and that it specifically consider reorganization to create a joint command or unify certain activities.¹ In this chapter, we describe options for organizing the system. The first option is the current structure. We then propose four options with alternative organizational structures: one that modifies the current structure to better unify the chain of command and budgeting for TRICARE and three options for structuring a joint command. In developing these four new options, we incorporated some principals drawn from the literature on organizational design and implemented in civilian managed-care organizations, as described in Chapter Three.

OPTION 1: CURRENT ORGANIZATIONAL STRUCTURE

Earlier in this report, we described the MHS's two missions: military readiness and the benefits mission. The MHS system includes organizations tailored to each of these missions: deployable medical units for the readiness mission and the MTFs and managed-care support contracts for the benefits mission. As we discuss further in Chapter Four, the MTFs also play an important role in readiness.

¹We considered the chain of command, financial management, and personnel management in analyzing organizational structure. A brief discussion on the more-specific topic of the training curriculum is in Appendix A.

The MHS organizational structure differs in some respects by service. The Army, Navy, and Air Force operate separate medical departments, established in accordance with Title 10 of the U.S. Code. The Navy Medical Department supports both the Navy and Marine Corps. The Army and Navy each have a medical command, headed by a Surgeon General, who manages the MTFs and other activities through a regional command structure. Deployable medical units are integrated with the Army, Navy, and Marine Corps organizations they support.

The Air Force imbeds both its MTFs and deployable units in its basic structure; the chain of command is from the MTF to the local line (for example, a wing) command to the major command to the Chief of Staff. At each level in this structure, there is a medical staff officer who advises on medical matters and, in reality, has considerable management authority. The Air Force Surgeon General, through his position as medical advisor to the Chief of Staff, exercises essentially the same authority as the other Surgeons General do.

Overseeing the DoD's medical mission is the Assistant Secretary of Defense for Health Affairs (ASD/HA). DoD Directive 5136.1 assigns considerable authority to the ASD/HA as the program manager for all medical resources, including

- establishing policies, procedures, and standards for DoD medical programs
- preparing a unified medical program and budget with funding for all accounts except military personnel
- presenting and justifying the medical program and budget in the DoD Planning, Programming, and Budgeting System and to the Congress
- co-chairing the committee that facilitates consideration of DoD biomedical research.

The ASD/HA reports to the Under Secretary of Defense for Personnel and Readiness (USD/P&R). The ASD/HA is the reporting authority for a number of DoD medical agencies, including the TRICARE Management Activity (TMA). TMA was established as a DoD field activity in 1998 to oversee the revamped military health benefits plan, TRICARE. Its responsibilities include TRICARE administration,

preparation and execution of the unified Defense Health Program appropriation, contracting for managed-care support services, and support to the services' delivery of TRICARE services.

Finally, the Defense Medical Oversight Committee (DMOC) was established in 1999. Its membership consists of the three service Under Secretaries; the Vice Chiefs of the Army, Navy, and Air Force; the Vice Commandant of the Marine Corps; the DoD Comptroller; the ASD/HA; and the USD/P&R. The Surgeons General are *ex officio* members. The DMOC's role has not yet been made explicit in a formal charter, and its activities have been varied.

MHS Organization for TRICARE

The organizational structure that implements TRICARE is shown in Figure 2.1. There are four hierarchies in this structure: the Office of the Secretary of Defense (OSD) and the three military services with medical departments. Each oversees a set of providers that deliver health care to TRICARE beneficiaries (represented by the darker-shaded boxes in Figure 2.1). Health plan responsibility for TRICARE resides in the OSD's Health Affairs office (represented by the lighter-shaded boxes). Not shown in the chart is DMOC, which as noted earlier consists of senior leadership from the OSD and the services.

MHS Organization for Readiness

Figures 2.2 through 2.4 display basic organization charts for each of the three military medical departments. The Surgeons General of the Army and Navy each lead a regionally organized medical command to manage MTFs and oversee medical activities, but they do not exercise direct authority over all aspects of medical readiness. Although these commands can control the readiness activities in the MTFs (such as individual skills training), many military-specific readiness activities, such as materiel maintenance and unit training, occur in deployable medical units. Furthermore, these units are often under the control of non-medical commanders. In these cases, there is no direct medical chain of command above the deployable medical unit, and the medical unit leader is evaluated by a line or support commander; however, the Surgeons General provide medical policy guidance through their respective service chiefs.

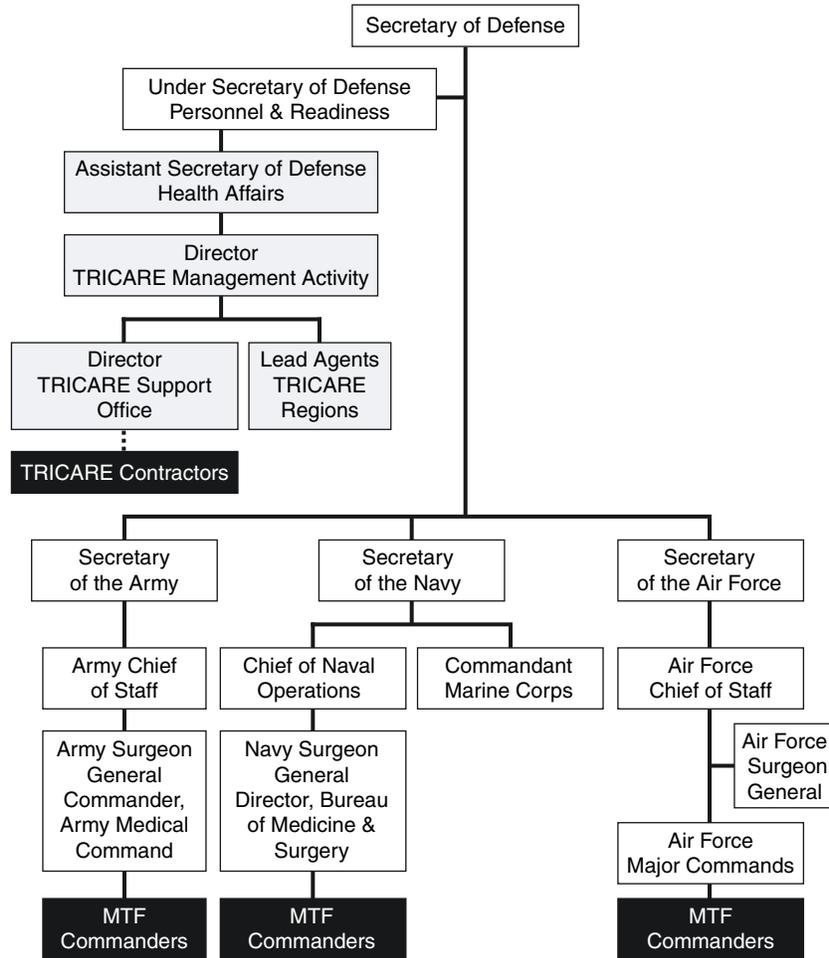


Figure 2.1—TRICARE Organization

The Air Force employs the most integrated medical system with regard to line command and control. As in the other services, the Air Force Surgeon General provides medical advice to the Chief of Staff of the Air Force and generally oversees all Air Force medical activities.

The Army's medical organization is less integrated with the line command structure than the other services. Army medical centers are organized under regional medical commands, which provide both command and control and resources. Smaller Army MTFs receive resources from the regional medical commands, but their commanders are often evaluated by responsible line commanders. Like the Navy, deployable Army medical units and "organic," or highly integral, medical components are controlled by the service component commands, for example the Army's Forces Command in CONUS, as shown in Figure 2.2.

Although these units are staffed in peacetime with some medical personnel to provide basic care to service members and to be maintained and trained as a deployable medical unit, active duty medical professionals (such as physicians or nurses) fill out these units for combat training and deployment, but are assigned to MTFs where they can maintain their medical skills. When these personnel deploy, they can be backfilled with reserve personnel.

Due to a restructuring a decade ago, the Navy's medical organization is less integrated with the line command structure than the Air Force,

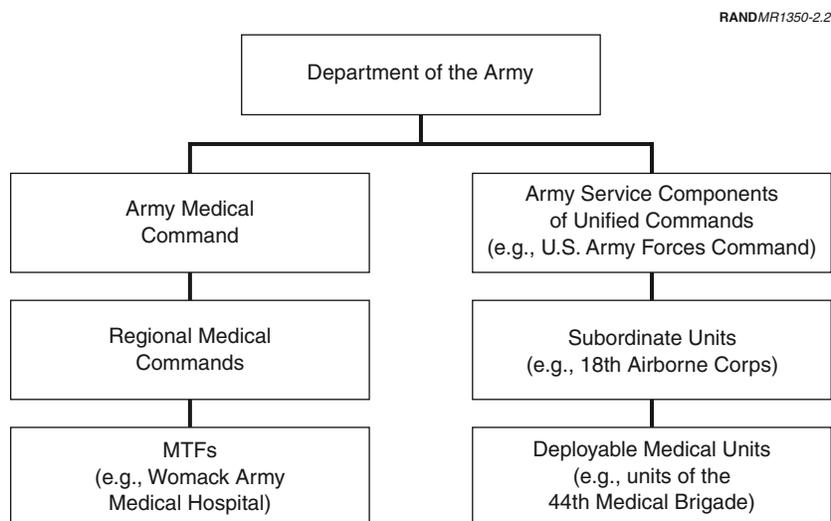


Figure 2.2—Army Medical Organization

but more so than the Army’s medical organization. The Navy Surgeon General is the Director of Naval Medicine and commands the Bureau of Medicine and Surgery (BUMED). BUMED provides policy and technical support for health-care delivery to deployed units and in shore-based MTFs. The Navy provides medical support elements for the Marine Corps. Navy MTFs receive policy and resources from BUMED, and military command and control from the Navy or Marine Corps line commanders.

The Navy medical structure directly links MTFs and deployable medical units. For example, the six mid-size naval hospitals with family-practice residency programs each staff a fleet hospital, which requires nearly all of the staff from the naval hospital. Sub-specialists not available at these “community” hospitals are assigned to the fleet hospitals from one of the three naval medical centers. Two of the naval medical centers, Bethesda and San Diego, are assigned to staff

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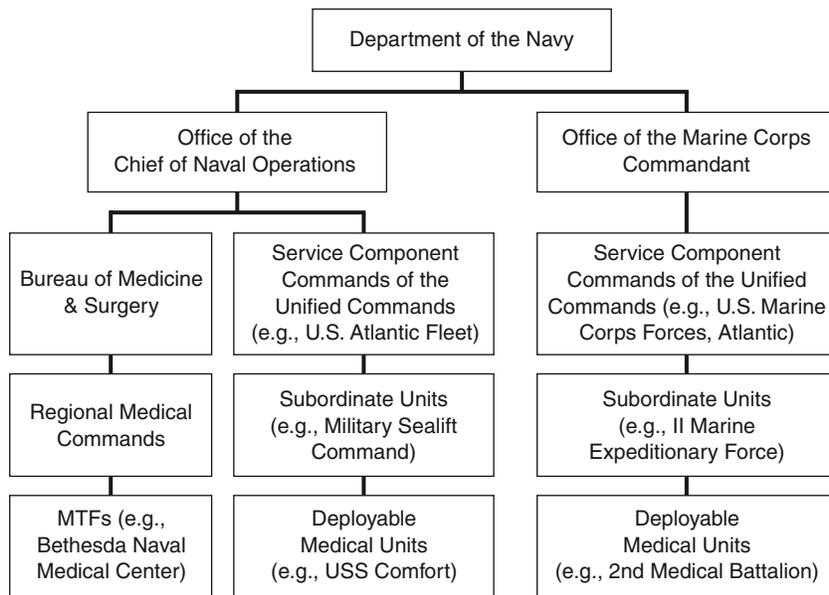


Figure 2.3—Navy Medical Organization

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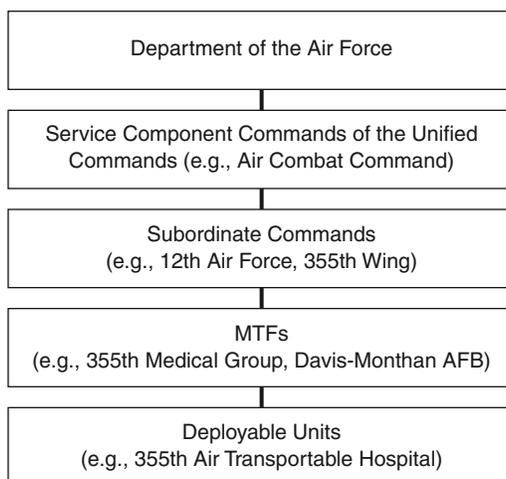


Figure 2.4—Air Force Medical Organization

the two hospital ships. Annually, personnel assigned to all these naval hospitals train together for two weeks at their fleet hospitals or hospital ships. Reserve personnel backfill the MTFs during this period. In contrast to the Air Force and Army, which are primarily MTF-based when providing peacetime care, naval medical units consistently provide support to deployed Navy and Marine Corps units on a rotational basis.

In the Air Force, peacetime and operational medical units are integrated under local command and control at each wing command, with the MTF commander reporting to the wing commander. Each major Air Force command (MAJCOM) employs a command surgeon who provides advice to the MAJCOM commander and exercises considerable management authority, but ultimately Air Force MTFs are commanded and controlled by the line command at the installation they serve.

Doctrinally, deployable medical units in the Air Force are staffed directly from the MTF of the supported line commander. In practice, the Air Force employs a “building block” approach for providing medical support to deploying units, whereby deploying medical

units are often constructed from various MTFs. Augmentation of these units with medical specialists needed for particular missions is usually accomplished from the larger MTFs.

When deployed, medical units are part of the service component commands of each geographic combatant command.² The Commander in Chief (CINC) of each geographic command is responsible for coordinating and integrating support provided by the services' medical units within his theater of responsibility (U.S. Department of Defense, 1995). This is accomplished through coordination between the medical units assigned to the geographic command and the command surgeon, who is a staff officer to the CINC. This structure is illustrated in Figure 2.5.

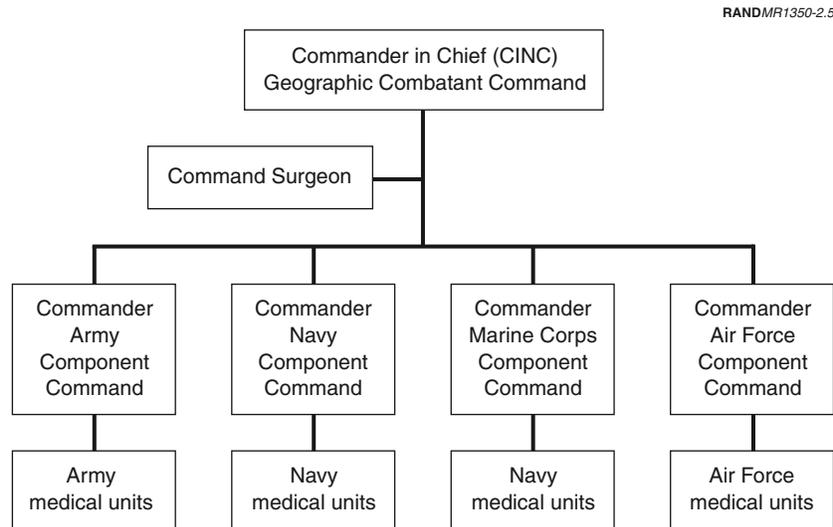


Figure 2.5—Organization of Deployed Medical Units

²Portions of the U.S. Coast Guard may also mobilize in support of large-scale operations. In these instances, their medical support is largely provided by the DoD Services, primarily the Navy.

MHS Resource Management

The flow of resources for both readiness and TRICARE is shown in Figure 2.6. Military-personnel authorizations and funding are included in the overall personnel accounts for each service. The services therefore have some discretion in allocating personnel resources to medical versus other activities, although the Congress has constrained the services' allocations at times.

Other operating funds for medical activities are provided in a single appropriation (the Defense Health Program, or DHP), which is included in the budget for the Office of the Secretary of Defense. The DHP pays for civilian personnel, equipment that is not included in the capital account, supplies, maintenance, information systems, and contract services. TMA is responsible for developing the budget each year and it allocates a share of the annual appropriation to each service and a share for "corporate" functions such as the TRICARE support contracts and information systems.

OPTIONS 2–5: ALTERNATIVE ORGANIZATIONAL STRUCTURES

Over the past decade or more, the MHS has reshaped military health-care delivery through TRICARE. The goal at first was to contain costs but has expanded to include population health and patient satisfaction. Achieving these goals requires a cost-effective allocation of health resources, efficient use of those resources within each component of the system, and integration across the components to ensure the best outcomes for patients. Allocating resources and integrating care can be difficult in a health system without integrated management and an integrated flow of resources.

In Chapter Three, we describe how civilian health-care organizations are structured to facilitate cost-effective health-care delivery. We have borrowed from their experience in identifying options for reorganizing the MHS.

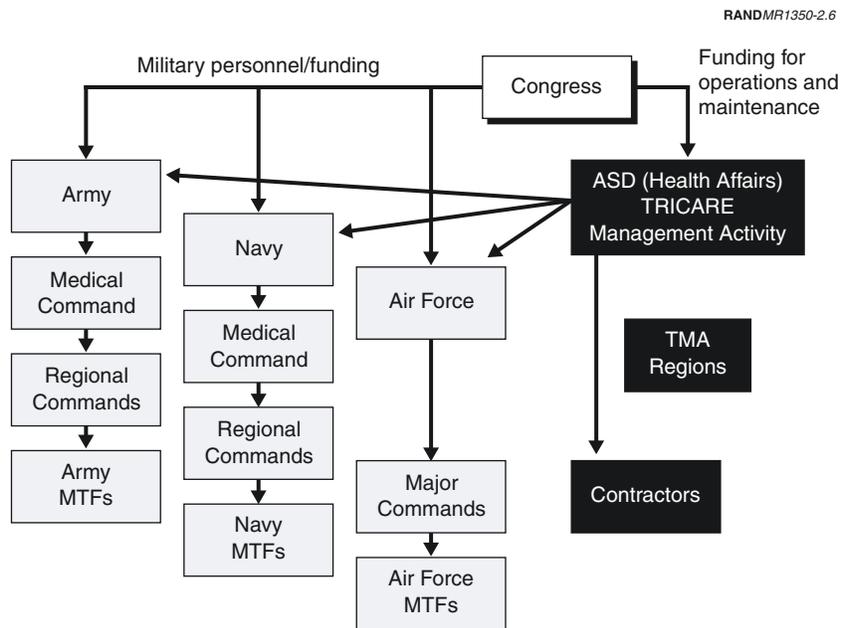


Figure 2.6—Flow of TRICARE Resources

Option 2: Modification of the Current Structure

The first of the four new options would retain much of the current organizational structure, but it would call for several changes designed to clarify management responsibilities for TRICARE and facilitate resource management and integration of health services. TMA would assume the responsibilities of administering a health plan, many of which it already handles—determining the annual budget, contracting for services from the private sector, and allocating the budget to the MTFs and the contractors that provide the care.

TMA would remain under the authority of the ASD/HA and it would keep its current regional structure. However, within each region would be local market managers, each responsible for one or more defined geographic areas. The areas would include the current MTF catchment areas, other areas with sizeable beneficiary populations,

and broader regions where beneficiaries are more dispersed. Wherever possible, these areas would be designed to co-exist with civilian health-care markets to facilitate management of civilian contract care. Areas with sizeable military populations might occupy a full-time TMA manager, but smaller areas would require only a part-time manager.³

Figure 2.7 illustrates the flow of funding within a modified organizational structure. The funding would be allocated to each area based on its eligible population (with appropriate health risk adjustments) and would reflect the total resources needed to care for the population in the MTFs and civilian sector. This means moving MTF military personnel funding from the service accounts to the DHP account. The TRICARE area managers would work with MTF commanders, the contractors, and local civilian providers to develop cost-effective programs. They would finance care provided by the MTFs and civilian providers. In the case of the MTFs, they would provide a budget based on an annual plan for providing care, MTF staffing, and utilization targets.

Civilian providers would be reimbursed on a fee-for-service or other basis through the contractors, as they are now. TRICARE managers would be accountable for overall TRICARE performance in their areas and MTF commanders would be accountable for performance in delivering care within their facilities.⁴

The services would remain fully responsible for recruiting, training, and managing medical personnel except where joint programs exist today or are determined to be more cost-effective in the future. However, the funding for military personnel would be provided through the TRICARE management structure to the MTFs, along with other operating funds. This would allow for greater visibility in resource use and accountability for financial outcomes, in addition to accountability for quality and service outcomes.

³These manager positions would replace some positions at the services' intermediate commands, whose resource management responsibilities would largely devolve to the TMA regions.

⁴In addition, the MTF commanders would continue to be responsible to their line commander(s) for such matters as the health of active-duty personnel, support of training and other military activities, and health care provided or managed by MTF personnel.

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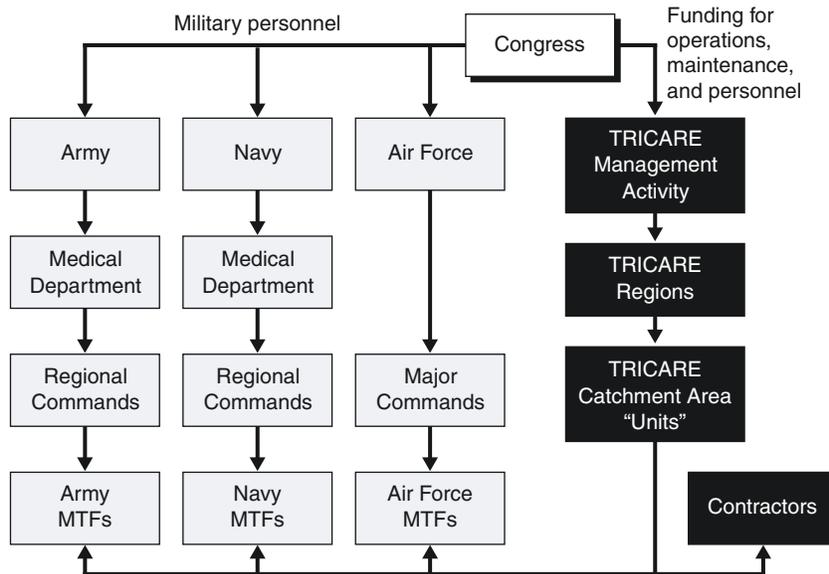


Figure 2.7—Flow of Funding in a Modified MHS Structure

As described earlier, the local TRICARE manager and MTF commander would negotiate an annual plan with targets for MTF Prime enrollment and MTF utilization by other beneficiaries. The plan can be adjusted as the year unfolds in response to unexpected changes in MTF staffing. If the MTF cannot meet its targets, it would receive less funding from the TRICARE manager. This could occur if military personnel are deployed; funding for deployed personnel would come from a medical readiness account, not from the TRICARE account. Developing workable financial mechanisms would be difficult, particularly with current data systems. Nevertheless, over the long run, strengthening the financial management in TRICARE should pay off in a more cost-effective program.

Under this scheme, the TRICARE manager has no command-and-control authority over the MTF commander. As purchaser for TRICARE services, the TRICARE manager should influence the MTF commander's decisions. TRICARE performance is monitored at each

TRICARE management level and MTF performance is monitored by the responsible service. Similarly, the relevant line commander or service medical commander evaluates the MTF commander. In both cases, it is essential that these evaluations be based on objective and balanced measures of the relevant outcomes.

Options 3–5: Joint Command Structures

A joint medical command would be a unified combatant command, as defined by Title 10, because it would have broad, continuing missions and be composed of forces from two or more military departments. Title 10 establishes the legal authority for unified combatant commands in general and a somewhat different legal authority for the Special Operations Command (SOCOM).

The SOCOM commander has an expanded set of responsibilities and authorities for special operations activities, whether or not they are carried out within the command. These include programming and budgeting, budget execution, acquisition of specialized assets, training, requirements determination and validation, and monitoring of the services' personnel management activities. Most, if not all, of these authorities and responsibilities were consolidated and assigned to the ASD/HA over the years. Therefore, we assume that a joint medical commander would be assigned the same responsibilities and authorities that are assigned to the SOCOM commander. In keeping with current practice, all DHP funding would go to the joint command instead of the services. This approach would also be most consistent with the objective of consolidating health-plan authority for TRICARE.

Numerous options exist for structuring a joint medical command. Here, we consider three options that illustrate important differences in organizational structure. The first organizes all medical activities in service component commands. The second option is similar to the first, but separates responsibility for health-plan management in a TRICARE component. The third option involves a more radical change in MHS organization. It organizes medical activities functionally under readiness and TRICARE components. Readiness activities are organized by service, but TRICARE activities are organized geographically. Under each option, the Surgeons General would con-

tinue their responsibilities for medical policy in their respective services. Their other responsibilities would differ, however.

The three options have some common elements. They would own the same medical units, have the same type of commander, and leave Title 10 responsibility for organizing, manning, and equipping medical units to the services. All options would assign deployable medical units to the joint command, although they could remain within their current line commands. We chose to assign them to the medical command to promote coordination between medical readiness and TRICARE management and encourage a unified approach to the readiness mission. This does not mean that all medical functions would move under the medical command. As we describe in Chapter Four, some of these functions are highly organic to non-medical units (for example, ships). Before a joint command could be established, the appropriate assignment of units and personnel would have to be determined.

We assume that a joint command of this size would be commanded by a four-star flag officer. Thus, the medical commander would outrank the Surgeons General, regardless of the role that they fill.

Following the SOCOM model, the joint medical commander would have responsibility for monitoring the services' management of medical personnel. Although the command could request that military personnel be assigned outside their services, the need to maintain service expertise and ensure good medical-line relationships would generally make this undesirable.⁵

Joint Command with Service Components. A joint command with service component commands is sketched in Figure 2.8. This is the standard organizational structure for unified combatant commands, employed even in SOCOM. In many respects, it carries forward the current organizational structure but assigns overall responsibility and authority to a single military commander. The Surgeons General are the most obvious candidates to command the component commands, but these positions could be filled by other flag officers if the

⁵Assignment to another service occurs in the current structure, although it is not a common practice. MTFs located in the same area also lend personnel on an informal basis.

services prefer to keep the component-command job separate from that of chief policy advisor within the service.

The joint medical staff would assume many of the responsibilities now assigned to the TMA, including contracting support. However, consistent with organization along service lines, the services would assume technical oversight of the activities performed by the managed-care support contractors in their catchment areas. This responsibility would be decentralized and thus assigned along with other aspects of health-care management to the MTF commander. Technical oversight for contractor activities outside the catchment areas would be handled either by the joint medical staff or assigned to the services as lead agents for different regions.

In Figure 2.8, we show the Air Force deployable units reporting to the Air Force MTFs and the Army and Navy deployable units reporting through separate chains of command. This maintains elements of the current service structures, but it involves a major change in Air Force command and control. MTFs and their deployable units (when

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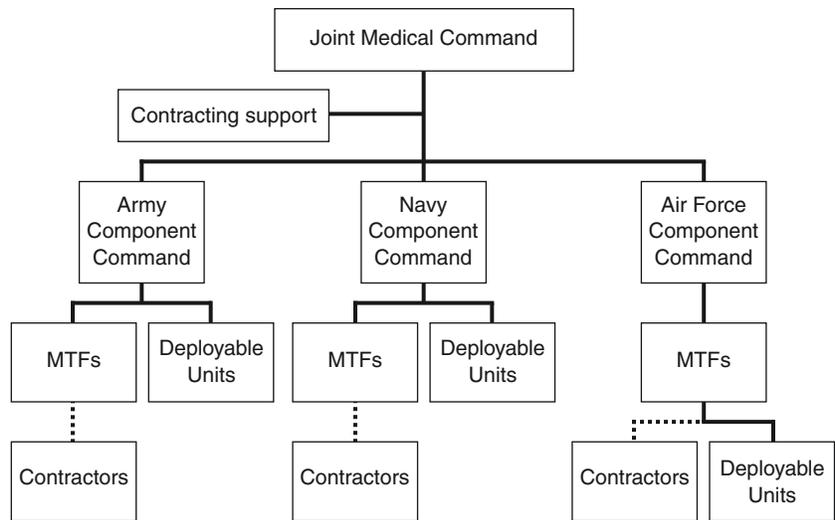


Figure 2.8—Joint Command with Service Components

they are not deployed) would no longer report to the Air Force line command they support. There is less change for the Army and Navy; the service component command is similar to the medical commands they have now. In all the services, the commander's performance evaluation could be prepared by the senior line commander, as is done now. If so, it will be important to ensure that the rating commander takes account of performance in both readiness activities and TRICARE management.

Joint Command with Service and TRICARE Components. This option, illustrated in Figure 2.9, is similar to the option just described except that it assigns responsibility for managing TRICARE to a separate component within the command. Essentially, it is the joint-command version of today's organizational structure, modified as we described earlier in the first alternative structure. However, the operational authorities now held by the ASD/HA would be held instead by the joint commander and TMA's functions would move to the TRICARE component command.

Joint Command with Readiness and TRICARE Components. As we indicated earlier in this chapter, this third option envisions the most

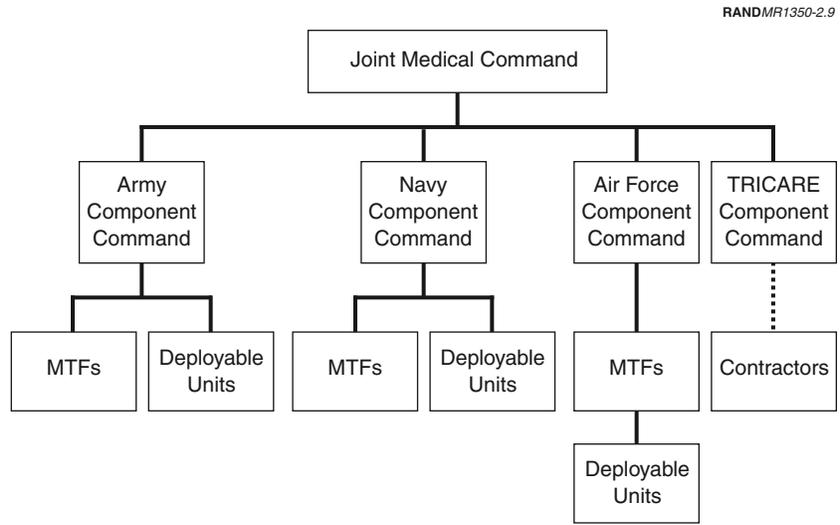


Figure 2.9—Joint Command with Service and TRICARE Components

radical reorganization of the MHS. It would create a separate chain of command for much of the readiness mission under the joint commander's overall authority (see Figure 2.10). All deployable units (other than those that remain organic to line commands) would report through service component commands to a deputy commander for readiness. The TRICARE component command would be structured according to a civilian-like model, with regional commands overseeing health care delivered by the MTFs and civilian providers in their assigned geographic areas.

Within the regional commands would be health-plan market managers with appropriate responsibility for overall TRICARE performance. Each market area would be assigned to a single manager, but one manager might handle more than one area.

Responsibility for health matters at an installation and for the health of all assigned military personnel would continue to be the responsibility of the MTF commander. The responsible line commander would rate the MTF commander's performance in these areas. The regional TRICARE commander would evaluate the MTF's TRICARE performance, with input from commanders at the installation.

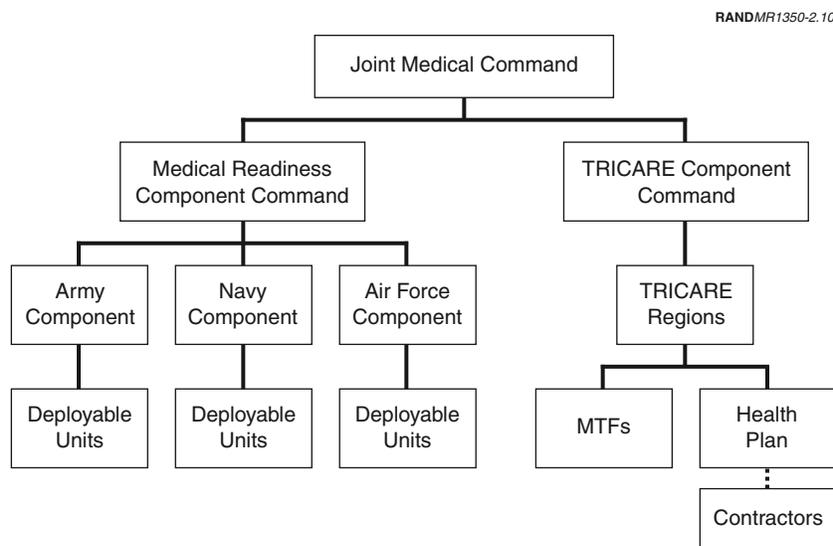


Figure 2.10—Joint Command with Readiness and TRICARE Components

In this joint-command alternative, the Surgeons General would most likely oversee medical readiness in their services, but they would no longer have authority over the MTFs. In their capacity as chief medical officer for their respective service, they would monitor the performance of the MTFs in maintaining the health of active-duty personnel, providing care to families, and supporting readiness training and deployment.

The resources needed for readiness activities would be identified and allocated to the readiness component. This would include personnel assigned to deployable units and preferably an allotment for personnel assigned to MTFs but available to the deployable units when needed. The TRICARE component would receive all TRICARE resources, including personnel assigned to the MTFs.

When personnel leave to man deployable units for training or operations, the readiness component would reimburse the TRICARE component from its allotment.⁶ Establishing these internal resource transfers would be a challenge, but if it can be done properly, TRICARE managers would quickly receive the funding they would need to refer patients to the civilian sector when the MTF loses staff.

Level of Consolidation of Operational Medicine

Medical care for deployed personnel may be provided by medical specialists who are either assigned to operational units or to medical units that are attached to operational units. Alternatively, patients may be evacuated to medical units that operate more independently of the operational forces. Examples of the former are medics in Army and Marine combat units, battalion aid stations, flight surgeons who remain with squadrons in the Air Force, or medical personnel assigned the Navy ships. Examples of the latter are field or fleet hospitals and the Navy's hospital ships.

If a joint medical command were created, it would include stand-alone operational medical units and exclude personnel assigned to operational units. More generally, medical activities determined to

⁶Or, the reimbursement would be in-kind in the form of reserve personnel.

be organic to the supported operational unit would most likely remain outside the medical command.

Joint Command Versus Defense Health Agency

An alternative to a joint command is a defense agency for health-care activities. This alternative embodies two options.

One option is to include all of the MHS in the agency. This option would result in both the peacetime and readiness medical structure reporting to the department's civilian leadership, and such an organization would be a significant departure from the current service-oriented posture for readiness.

The second option is a variation of the third joint command option presented earlier, in which the readiness and peacetime missions are housed in separate component commands. Were this joint command option extended to include a defense agency, the medical readiness mission would continue to fall under the purview of the services (possibly via a joint readiness command), and the peacetime mission would be managed by the defense agency. Because of the necessarily close association of medical support units and operational units, it is likely that such an agency would be designated a combat support agency. Such designation would require oversight by the Chairman of the Joint Chiefs of Staff with regard to the plans of the agency for its support of operating forces and related training (U.S. Code 10 §193).

Because medical personnel must be shared between the readiness and peacetime missions in order to maintain their medical and operational skills, the amount of coordination that would be required between a defense health agency and readiness activities would be considerable. For this reason, if a defense health agency is established, it is likely that a joint readiness command would be advantageous to facilitate this coordination through singular leadership of both missions.