Chapter Five

OTHER ASSESSMENTS OF THE MHS ORGANIZATION

To complement our reviews of health plan organization in the civilian managed-care sector and readiness issues in the military sector, we reviewed past reports on the MHS and interviewed senior DoD officials and others who are knowledgeable about military health issues. The past studies revealed a debate on military health system organization that has continued intermittently for five decades. Interviewees focused on many of the same issues that motivated the earlier investigations.

PREVIOUS STUDIES OF MILITARY HEALTH SYSTEM ORGANIZATION

The question of how best to organize military medicine first arose after World War II, when the establishment of a large standing military force necessitated a sizable permanent medical system. The first decision the DoD faced in this regard was whether to create a separate medical service for the Air Force.

In 1947, the Army—both the Surgeon General and the Chief of Staff—strongly favored a unified medical system, but the Navy and the Air Force disagreed. In 1949, the Joint Chiefs of Staff (JCS) urged formation of a completely unified and amalgamated (that is, a single) Medical Service.

Since the late 1940s, at least 13 studies have addressed military health-care organization (see Table 5.1). All but three studies have

Table 5.1

Previous Studies of Military Health-Care Organization

		Recommendation		
Year	Name	Create Unified Service	Add to Central Authority	Keep Separate Services
1948	Hawley Board		✓	
1949	Cooper Committee		✓	
1949	First Hoover Commission	✓		
1955	Second Hoover Commission		✓	
1958	Consultant to President			✓
1970	Presidential Blue Ribbon Panel		✓	
1975	Military Health-Care Study			✓
1979	Defense Resource Management Committee			✓
1982	Grace Commission	✓		
1983	Systems Research and Applications Corporation Report to Congress	✓		
1990	ASD/HA Report to Congress		✓	
1991	OSD/HA Joint Working Group		✓	
1991	OSD Office of Administration & Management	✓		

favored either a unified system or recommended a stronger central authority to improve coordination among the services.[1] The first Hoover Commission in 1949 went even further and recommended a

[1]Information on the studies before 1975 comes from Hunter and Baker (1983).

United Medical Administration for almost all federal health-care activities. The second Hoover Commission in 1955 reiterated its concern about duplication and competition in the military health programs, but was more cautious in its recommendation for greater coordination. In 1958, when President Eisenhower asked Dr. Fred Coller of the University of Michigan to evaluate military medicine, Coller concluded that coordination between the medical departments would be adequate without a unified system and focused instead on the development of teaching programs as a means of ensuring quality of care.

Anticipating the move to a volunteer force, in 1970 a Presidential Blue Ribbon Panel recommended that coordination be enhanced by assigning responsibility for reviewing health budgets and manpower to a Director of Medicine and Health. Likewise, a major 1975 Military Health Care Study suggested (without specifics) that system efficiency and effectiveness would improve with the establishment of a central entity to coordinate medical planning and regional authorities to oversee operations.

Several years later, the Defense Resource Management Study team decided not to consider consolidation, concluding, "It is difficult to show that either regional commanders or a central DoD agency would improve efficiency or effectiveness, or to show that they would not (Rice, 1979)." However, the study also suggested that if its other recommendations led to inadequate improvement in the system, then the question of consolidation should be reopened. Three years later, in 1982, the Grace Commission again recommended the creation of a centralized health agency.

In 1983, the Systems Research and Applications Corporation (SRA) prepared the most detailed of these organizational studies in response to a request from the Senate Armed Services Committee (Hunter and Baker, 1983). The committee requested a study of the feasibility of and benefits to be gained by creating a defense health agency modeled after existing defense agencies. The SRA report created a detailed blueprint for such an agency, with a hierarchical management structure including a headquarters reporting to the ASD/HA, and including regional commanders in the U.S. and over-

seas theaters, and the MTFs and Office of CHAMPUS[2] at the operating level.

Under this scheme, the surgeons general would focus on medical readiness, including mobilization planning, research and development, combat support doctrine, and career development of military medical personnel. The draft of the SRA report drew negative comments from the Joint Staff and the services, who focused on potential difficulties in coordinating medical activities and resource management during peacetime and deployment. Senior DoD officials clearly doubted the ability of defense agency leadership to develop effective relationships with the services and manage the medical system efficiently. The authors of the SRA report disagreed and concluded that a health agency could be both beneficial and feasible if it is well-managed and fully supported by the medical departments. Their arguments in favor of a health agency were based on expected benefits from separating the management of the two missions—improved readiness from having the surgeons general focus on the medical readiness mission and, more efficient management of the MTFs and better integrated health-care delivery from the benefits mission.

The result of all these studies was the establishment of an Assistant Secretary of Defense for Health Affairs, or ASD/HA, and a gradual increase in the authority vested in that office. The current MHS organizational structure evolved in response to a study prepared by the Director of Administration and Management in the OSD, at the request of the Deputy Secretary (U.S. Department of Defense, 1991a).

The OSD study postulated three alternative organizational structures: (1) strengthening the role of the ASD/HA in overseeing a unified medical budget; (2) a unified U.S. medical command; and (3) a defense health agency. The report concluded with a matrix of advantages and disadvantages to each alternative. The study's authors expected that strengthening the role of the ASD/HA would be less disruptive than the other two options and improve the OSD's ability to make tradeoffs across the MHS, but leave the system without the single authority needed for integration of the peacetime and wartime missions and high performance.

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[2]The Civilian Health and Medical Program of the Uniformed Services is widely known by simply its acronym.

A medical command would create a strong central authority at the cost of a reduction in the role of the military services in taking care of their personnel. A defense agency would be similar to a medical command, but it would reduce military involvement in medical readiness planning and operations. The Deputy Secretary chose the first alternative, stating, "establishment of such an agency could create organizational turmoil in medical affairs at a time when the Department cannot afford it." He specifically cited the implementation of managed care and a concern that disruption of the medical program would affect retention and recruitment during the drawdown (Deputy Secretary of Defense, 1991).

PAST REORGANIZATION OBJECTIVES

Over the decades, proponents of a unified medical structure have cited many of the same objectives, including the following:

- Improve medical readiness through better planning, training, and operational systems
- Ensure quality of care
- Control costs through better coordination of resource management decisions and service delivery
- Establish clear command and control of the medical system.

Sharp increases in health-care costs motivated many of the reviews of the MHS. For example, total MHS costs (including personnel costs) rose between 1979 and 1989 at an annual rate of 12 percent in nominal dollars and 5 percent in constant dollars (Congressional Budget Office, 1995). As a result of these increases, the share of the defense budget allocated to the MHS increased from less than 4 percent to 6 percent or higher. The fact that civilian employers were experiencing similar cost increases was of little consolation as DoD officials and the Congress watched funding shift from other defense programs to the MHS. Annual shortfalls in the funding for civilian health care raised questions about the ability to forecast costs and develop meaningful budgets.

Complaints about unclear command and control and inadequate MHS management systems developed as the Congress and DoD

leadership looked for ways to control costs. The same issues are raised in just about all the studies: duplication of effort and even competition for business by the medical departments, lack of coordination in the allocation of personnel and other resources, poor coordination and continuity of care across MTFs and with civilian providers, inadequate data systems and costing methods, and minimal communication of lessons learned within the system.

Since the possibility of a large conflict with the former Soviet Union has been eliminated, there has been less concern about acquiring adequate personnel and equipment to provide operational medical support, although determining requirements for the new era has been difficult and contentious (U.S. General Accounting Office, 1995). A continuing need also exists to reshape deployable units, training, and medical doctrine for the wider array of missions experienced in the 1990s and to support evolving combat structures and strategies.

INTERVIEWS WITH CURRENT OFFICIALS

To update the viewpoints on the military health system contained in earlier studies, we interviewed senior DoD officials. A list of the interviewees can be found in Appendix C. They include members of the DMOC and senior leadership in the MHS. We also interviewed members of the congressional staff, the General Accounting Office, the Joint Staff, and several former DoD officials who served in recent years. Finally, we made a site visit to TRICARE Region 11 in the Pacific Northwest where we interviewed staff from the regional (lead agent) office and staff at the three MTFs in the Seattle-Tacoma area.

The interviews were based on a short list of open-ended questions that were designed to prompt discussion. The questions and relevant congressional language were provided to respondents prior to the interviews. The questions included the following:

- Why do you think interest in reorganizing military health care has reemerged? What are the problems with the system today?
- Setting aside whether or not a joint command is a good idea, how would you structure such a command?
- Are there other organizational changes to consider?

- What are the advantages and disadvantages to organizational alternatives?
- Which approach do you favor, if any?

Responses to the first question resulted in a summation of what objectives might be met by a reorganization. The interviews did not result in an exhaustive list of organizational alternatives, but they did provide some insight about the alternatives discussed earlier in this report.

Reasons for Considering Reorganization

In its report accompanying the Senate FY 2000 authorization bill, the Senate Armed Services Committee referred to the changing environment for military medicine:

> The committee is concerned that the current Defense Health Program (DHP) organizational structures are unnecessarily complex and unwieldy. The military health care environment continues to evolve and new variables affect the DHP's ability to accomplish the mission. Examples of this mission evolution are increased frequency of deployment, force protection issues, and the emphasis on prevention rather than intervention. All of these variables demand rapid decision-making, effective communication, and reevaluation of priorities and resource allocations. The committee is concerned that current structure may not facilitate rapid responses or flexibility. (U.S. Senate Armed Services Committee, 1999).

Several officials indicated that earlier readiness problems, such as some identified by the General Accounting Office (GAO) following Operations Desert Shield and Desert Storm, have been addressed. However, some officials also suggested that interoperability of the services' deployable units in supporting increasingly joint operations remains deficient, and they expressed some concern that medical readiness has again become overshadowed by the peacetime managed-care mission.

However, most of the problems identified in recent years lie in the delivery of peacetime health care, and not in readiness. TRICARE, which was phased in between 1993 and 1998, is the culmination of years of effort to introduce managed care in the MHS. Officials in the

Congress and DoD perceive that TRICARE functions better in West Coast regions, which were the first to implement the program and tap into a mature civilian managed-care industry, than in other regions. Many of the officials we interviewed for this study cited similar concerns about TRICARE:

- Inaccurate budget estimates, which some officials relate to an ill-defined benefit
- Escalating costs
- Beneficiary dissatisfaction with access to care and administrative procedures[3]
- Civilian provider dissatisfaction, especially with the timeliness of claims processing and payment[4]
- Problems in contracting for the civilian component of TRICARE, including successful challenges to past contract awards.

These are essentially the same problems that plagued the MHS before TRICARE. Frustrated at the apparent lack of progress, at least in some regions of the country, the most common concern expressed was over the lack of a single authority for the MHS who could be held accountable for improving TRICARE performance.

Region 11 interviewees provided us with valuable perspectives from the regional and local levels.[5] Most expressed frustration with the multiple chains of command in the current organizational structure. It often happens that guidance from the TMA and the service's intermediate commands conflict, making it difficult to integrate health-care delivery across the MTFs and civilian providers. Without exception, Region 11 managers believed they had established good relationships locally and could manage TRICARE effectively as a team if given the necessary authority. Most were skeptical about a joint command for two reasons: (1) They feared it would add another

[3]Recent beneficiary surveys show a noticeable increase in satisfaction, however.

[4]Recent data from TMA indicate that claims processing has recently improved dramatically.

[5]Our visit occurred as Region 11 was beginning to discuss how to execute the "strong lead agent" test. See Chapter 6 for more on this test.

management layer. This concern would be mitigated if the service's intermediate commands were replaced by a single intermediate command; and (2) MTF managers worried about maintaining their relationships with local line commanders, which they feel are critical for readiness.

Opinions on MHS Organization

Although the majority of officials we interviewed cited concerns about the current MHS organization including its effectiveness, fewer offered specific or comprehensive recommendations for reorganization. However, approximately two-thirds of the officials supported some type of reorganization. The organizational alternatives that were discussed included the following:

- A joint command
- Increased service responsibilities for both MHS missions—military readiness and benefits
- Increased responsibility and authority to regional lead agents (similar to the "strong lead agent" test currently underway in TRICARE Region 11)
- A defense health agency.

Of those who supported some type of MHS reorganization, most sought to correct the perceived lack of a single authority and clearly defined responsibilities among subordinates.

Approximately one-half of the officials suggested reorganization similar to a joint command with service components. These suggestions generally resemble a joint medical command with service components, with some variation. For example, some officials suggested that TRICARE would be a staff function of a joint command, but others placed this role in service component commands. Finally, one official suggested a novel variation—a component command for a joint medical operations task force in addition to service components. The task-force component would organize and tailor joint medical forces for deployment to operations such as small-scale contingencies. These forces would then be made available to a com-

batant CINC for employment, through coordination with the command surgeon of the geographic command.

Among those officials who did not favor a joint command, some were uncertain about the best course to follow, and others appeared to endorse the status quo. A third group advocated devolving all medical activities to the services—in effect establishing three medical programs. In all cases, the key concern about a joint command was its effect on the relationship between the medical units in a service and the supported line units.

We found only minimal support for separate organizations for the two missions (for example, a joint command with readiness and TRICARE components). Almost all of the individuals we interviewed suggested that unity of medical command is a requirement for success, particularly in ensuring that the requirements of operational medicine are recognized in day-to-day activities. However, a distinctly minority view held that the two missions are very different and frequently conflict, and should therefore be housed in separate organizations. A suggested benefit of organizations segregated by missions is that there would exist clearly defined responsibilities and authorities for the leadership of each resulting organization. On the other hand, opponents of separate organizations cited greater bureaucracy and more difficult or decreased coordination across the missions.

A large majority of officials were opposed to the establishment of a defense health agency. Many of those opposed to an agency suggested that this option would make the coordination necessary to support readiness too onerous. Similarly, others were concerned that civilian leadership of the large peacetime mission would detract from the military readiness mission. However, proponents of this option (a distinct minority) cited the benefit of clearly defined responsibilities and authorities for each of the two missions. They suggested that a defense health agency run by civilian leadership experienced in health-care management would be best suited to provide peacetime health care.

An underlying theme of several of the interviews we conducted was the perceived unpopularity of defense agencies in recent years. Overall, most officials who opposed the establishment of a defense

health agency cited the lack of a single authority over both missions of the MHS as a primary reason for their opposition.

Other Organizational Issues

The interviews we conducted were intended to invite officials to raise issues related to a possible reorganization of the MHS. Although only a portion of those interviewed strongly endorsed one organizational alternative over others, many provided comments about issues that they felt should be considered regardless of potential organizational alternatives.

Many interviewees expressed an opinion regarding the type of officer who would lead a joint command, if one were established. They were divided in their preferences for a line officer (with a medical officer as deputy) or a medical officer as commander. Those recommending a line officer stressed the experience in managing large organizations that most of these officers acquire, their likely objectivity on medical matters, and their likely credibility with other line officers. Those recommending a medical officer felt that medical expertise would be essential for an effective command and the advice of a deputy could not be substituted for the directives from a medical officer. They noted that other large combat service support organizations are typically commanded by an officer with extensive experience in the support function.[6]

Some officials questioned the value of the Region 11 test (see Chapter Six) and, more generally, the notion of testing new organizational concepts. Regarding the Region 11 test, these officials believed that reorganization at the regional level would fall short because central management authority continues to be fragmented. Several officials also pointed out that it will be impossible to generalize the results of a test in Region 11 because it is the smallest and most effectively managed in the system. A few officials questioned whether reorganization can be tested at all.

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[6]Similarly, most CEOs of large civilian managed-care organizations are health administrators or physicians with management experience. A review of eight of the largest civilian managed-care organizations showed that only one CEO had no prior health experience. Most CEOs and other top managers had spent their entire careers in health management. Four of the eight CEOs are physicians.

ASSESSMENT OF MHS ORGANIZATION OVER TIME

Comparing the perspectives advanced in past studies with attitudes expressed in interviews today, it appears that the reasons for considering MHS reorganization have changed little. They continue to include the following:

- Improved cost management
- Better integration of health-care delivery
- More-effective administrative processes
- Sustained attention to readiness.

Although there remains considerable uncertainty regarding the benefits of specific organizational alternatives, including a joint command, the interviews conducted in this study suggest more support for reorganization and present a greater variety of alternatives than in previous studies.