
**ASSESSING THE ORGANIZATIONAL
ALTERNATIVES**

In Chapter Two, we identified five organizational alternatives for structuring an MHS organization (see Table 6.1 for a list of these alternatives). Each of these alternatives structures the chain of command somewhat differently.

Three of the alternatives (Numbers 2, 4, and 5 in the table) adopt the civilian-sector practice of separating health-plan management from health-provider management. The two alternatives based on the current structure (Numbers 1 and 2) leave overall command of medical activities to the services, but Number 2 restructures TRICARE's health-plan management. Of the three joint alternatives (Numbers 3 through 5), two of them (Numbers 3 and 4) maintain service-specific medical chains of command for both readiness and TRICARE, but break the command relationship between the medical departments and their service leadership. The other joint arrangement (Number 5) creates component commands for readiness and TRICARE and moves all TRICARE activities to a geographic structure. A variation on this alternative would move the TRICARE component to a defense agency.

EXAMINING THE ALTERNATIVES

To assess the alternatives, we kept in mind the lessons we learned from the civilian sector, as discussed in Chapter Three; readiness considerations, as outlined in Chapter Four and the issues raised in

Table 6.1
Management Structure in Organizational Alternatives

| | Current Structure: Number 1 | Modified Current Structure: Number 2 | MEDCOM Service Compo- nents: Number 3 | MEDCOM Service, TRICARE Compo- nents: Number 4 | MEDCOM Readiness, TRICARE Compo- nents: Number 5 |
|--|-----------------------------------|---|---|---|---|
| Single MHS authority | | | ✓ | ✓ | ✓ |
| TRICARE management organization | | ✓ | | ✓ | ✓ |
| Combined MTF and TRICARE management | | | ✓ | | |
| Service-based organization for readiness | ✓ | ✓ | ✓ | ✓ | ✓ |
| Service command of readiness, MTFs | ✓ | ✓ | | | |

past studies and the interviews we conducted, as discussed in Chapter Five.

These considerations suggest that the best MHS organizational structure would include the following:

- Clear assignment of responsibility within the MHS and possibly a single authority
- A coherent TRICARE health-plan management structure with designated local area managers
- Assignment of authority over resources and other decisions, consistent with the assignment of responsibility
- Strong accountability and incentives

- Mechanisms that ensure that the services have highly effective operational medical support and the medical-line relationships that this requires
- Clear assignment of responsibility, resources, and authority for readiness and mechanisms for coordinating with peacetime health-care delivery.

The last two elements in this list are what make the MHS an unusually complex health system. It must closely coordinate medical and non-medical functions within the services and integrate medical functions across the services and civilian contractors. The current structure is largely service-based, in the belief that it will maintain strong medical-line relationships within the services. Over time, the authority of the ASD/HA has been strengthened in an effort to also improve integration across services and the civilian provider community. The result is an organization that is neither service-based nor unified, and that fragments responsibility.

Implicit in the current organizational structure, and in most discussions on the subject, is an assumption that activities are most effectively coordinated when they belong to the same organization. However, the private sector has discovered that this may not be the case in very large organizations. The development of flexible contractual relationships has allowed effective coordination between individual companies, each of which focuses its expertise on a subset of activities. It is difficult to say whether the MHS, as a public organization, would be able to successfully adapt these practices .

Determining which MHS organizational alternative is “best” involves choosing which activities to organize under common management and which can be coordinated across organizational lines. The choice involves judgments on whether (1) focusing health-plan responsibility in a separate management structure would improve TRICARE performance without damaging the ability to coordinate peacetime health-care delivery and readiness; (2) the benefits of a joint command (or defense agency) would justify removing health care from the services’ command chains and potentially damaging service-specific competencies; and (3) within a joint command there should be a single chain of command for both missions or whether those missions should reside in separate organizations.

The clearest shortcoming in the current MHS organizational structure is the fragmented responsibility for TRICARE. Our four organizational alternatives attempt to correct this situation in different ways. Alternatives 2, 4, and 5 in Table 6.1 follow the standard approach in the private sector and even other public health systems (for instance, the Veterans Administration) by assigning health-plan responsibility to a single organization, which would be structured geographically in local and regional management units. TRICARE management would be separate from MTF management, consistent with the principle of separating health-plan management from health-provider management.

Whether this model would fit well in the MHS depends entirely on the development of effective coordination to ensure that TRICARE management practices do not impede readiness. It should be possible to encourage TRICARE-readiness coordination by monitoring and rewarding performance in both missions.

Alternative 3 in Table 6.1 takes a very different approach from the other alternatives, assigning health-plan responsibility to the services and, at the local level, to the MTF commanders. This structure may facilitate TRICARE-readiness coordination within the MTF, but it would create three TRICARE organizations and risk conflict of interest between health-plan and provider management.

Improved TRICARE management may be possible without establishing a joint command by restructuring the TRICARE Management Activity and giving it the responsibility and authority necessary for managing a health plan (as with Alternative 2). The current Region 11 test of a “strong lead agent” is a pilot of this approach. The test should show whether more-effective TRICARE management could be achieved without also establishing a single authority in the form of a joint medical command. Alternatively, merely establishing a joint command as an added management layer on top of the current structure (as in Alternative 3) is unlikely to provide an effective MHS organizational structure. Clarification of responsibility and appropriate assignment of authority, at least for TRICARE, are also needed.

As we describe in Chapter Two, the other way to unify MHS management is to establish a defense health agency. The Secretary of Defense has the authority to establish a defense agency when it is

determined that such an action would be a more effective, economical, or efficient means to provide for the performance of a support activity that is common to more than one military department (U.S. Code 10 §191).

The experience of civilian managed-care organizations, as described in Chapter Three, indicates that there are few economies or efficiencies of scale to be gained by such a consolidation. Therefore, the rationale for a defense health agency would have to be that the appropriate civilian leadership would add needed expertise in managed care. Most DoD officials appear not to believe that the expertise would be forthcoming.

With respect to readiness, unity of command is a principle of war, unity of effort is fundamental to joint warfare (U.S. Department of Defense, 1997), and interoperability “is the foundation of effective joint, multinational, and interagency operations” (Shelton, 2000).¹ However, it is not clear whether a joint command is necessary to optimize these principles for operational medicine and readiness, or whether current joint doctrine for health service support or other options would be sufficient if applied diligently.

In our interviews, we found very little support for separating management of the MTFs and deployable units, even within the integrating structure of a joint command (as with Alternative 5). Creating a defense agency for TRICARE was particularly unattractive to interviewees. Unity of medical command was thought to be necessary for ensuring that operational medicine requirements are recognized in day-to-day MTF activities. However, a distinctly minority view held that readiness and TRICARE are very different and frequently conflict. This view suggests that the peacetime care mission demands the greatest attention from the leadership of an integrated organization, posing a risk to the operational mission.

Although all the services have command and control over their deployable units and MTFs, only the Air Force currently integrates its

¹“Interoperability” is defined in Joint Publication 1-02 as “the ability of systems, units, or forces to provide services to and accept services from other systems, units, or forces and to use the services so exchanged to enable them to operate effectively together.”

command structure for non-deploying and deploying medical units. In the Army and Navy, the non-deploying units are organized in a medical command and the deploying units are assigned to the operational forces. Thus, coordination of peacetime care and readiness now requires coordination across organizations in these two services. It is not obvious that coordination would be more difficult across component commands within a joint medical command than it now is across commands within a service.

RECOMMENDATIONS

The experience to date in other managed-care organizations suggests that careful consideration be given to reorganizing TRICARE management. This would involve establishing a chain of authority responsible for overall TRICARE performance at the local, regional, and national levels. Careful consideration should be given to separating this TRICARE organization from the military services' medical management structures to minimize the conflict between health-plan and health-care provider management.

The strong lead-agent initiative now being tested in TRICARE's Region 11 provides an opportunity to examine the value of consolidating TRICARE management authority. However, this test will be meaningful only if the Region 11 managers are given the considerable authority and flexibility needed for effective health-plan management and if the short duration of the test does not preclude real change. If the Region 11 test suggests that reorganization of TRICARE will be sufficient, then we urge consideration of the more-extensive modifications envisioned in Alternative 2.

If the Region 11 test reveals that effective local management would be problematic without reorganization at higher levels, a joint command would be the obvious next step. Even with this course of action, the same organizational structure is unlikely to be optimal for all objectives.

Because each of the objectives for the best MHS organizational structure listed earlier in this chapter may be valued differently, and because non-organizational decisions will also affect their achievement, we recommend that DoD leadership consider the relative importance of these objectives in selecting a specific joint command

option. Also, for these reasons, we do not recommend one specific option in this report; however, we have described instances in which one option may better enable achievement of a specific objective.

Unless a joint command is established, it is impossible to know whether it would manage the system more effectively and maintain medical-line relationships important for medical readiness. There is no guarantee that a joint command would succeed in solving the persistent performance and cost problems that motivated the many studies of MHS organization, including this one. However, a joint command would “put someone in charge” of military health, a step most DoD senior officials advocated during the interviews conducted for this study.

MEASURING PERFORMANCE AND PROVIDING INCENTIVES

In Chapter Three, we describe how civilian managed-care organizations increasingly rely on quantitative measures to achieve accountability by evaluating ongoing performance and monitoring the progress of new initiatives. If the MHS is reorganized to clarify responsibility, a high priority should be given to implementing the same kind of performance evaluation system.

Consistent with the principle that all key outcomes should be measured, readiness performance measures appropriate for MTF and TRICARE managers as well as deploying unit commanders are needed. Complete and accurate data must be available much more quickly than they are today.

A balanced performance evaluation system including TRICARE and readiness measures would itself provide an incentive to achieve desired outcomes and a good “report card.” There are a number of ways to strengthen this incentive. The most obvious is to incorporate relevant health-care outcome measures in the personnel evaluations for MTF commanders, clinical service chiefs, TRICARE managers, and even individual providers.

Another approach is to develop group incentives, such as extra discretionary resources for MTFs that perform well.

These other organizational elements cannot be overemphasized. Without effective performance measurement and appropriate incentives, restructuring the organization chart will not be effective.

The reverse is also true. Without restructuring to clarify responsibility and authority for military medicine, current efforts to improve performance measurement will fail to achieve the desired improvements in management.