
SUMMARY

The National Defense Authorization Act for Fiscal Year 2000 requested that the Secretary of Defense submit a study identifying areas of military medicine in 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.

The Under Secretary of Defense for Personnel and Readiness, whose responsibilities include health programs, asked RAND to conduct this study.

BACKGROUND

Since the end of World War II and the establishment of the Air Force, the question of whether to create a unified military health system (MHS) has arisen repeatedly. Over the years, the system has retained its traditional structure, with separate Army, Navy, and Air Force medical departments. However, in response to the many studies that recommended further consolidation, the Department of Defense (DoD) gradually enhanced the authority of the Assistant Secretary of Defense for Health Affairs (ASD/HA), particularly in the areas of resource management and civilian contract responsibility. The most recent change was made in 1992. At that time, the DoD was begin-

ning to implement managed care and the senior leadership was unanimous in their concern that reorganization might impede this significant implementation effort. Now that the new managed-care program, called TRICARE, is operational, the question of military health system organization has arisen again.

APPROACH

The military health system has two missions: (1) to provide TRICARE, a comprehensive health benefit, to eight million beneficiaries and (2) to provide, and maintain readiness to provide, medical support to military operations. We looked to the civilian managed-care experience for evidence on effective organizational structures for TRICARE. We then considered the activities and organizational structure for operational medicine, and the coordination required to carry out two missions at the same time. Drawing on organizational models from the civilian sector and within the DoD, we developed five organizational alternatives and assessed their strengths and weaknesses.

We draw on two sources of information to identify effective organizational practices in the civilian sector: (1) the literature on organizational structure, in general and specifically in the managed-care industry, and (2) the organization and management practices in four leading managed-care companies.

The four companies span the managed-care activities of the military system. TRICARE offers managed-care health plans, with health care delivered in military treatment facilities (MTFs) and through civilian managed-care contracts. Thus, the system includes a large integrated health-delivery system and a health plan based on this delivery system, but with a substantial component of contract care. We visited two health plans, one with its own integrated delivery system and one that contracts for all care, and two integrated delivery systems that contract to provide health services to various health plans. The four managed-care companies we studied are Kaiser Permanente, UnitedHealthcare, Sutter Health, and Tenet.

To address the more unique aspects of the military health system, we draw primarily on government studies and documents. These include, for example, the many studies of the military health system and documents describing its current structure and joint doctrine

and organization. We also interviewed current and recent senior government officials, including members of the Defense Medical Oversight Committee, senior medical officials, and congressional staff. Finally, we visited one of the 12 TRICARE regions, Region 11 in the Pacific Northwest, where we interviewed TRICARE management staff and military hospital and clinic staff. Region 11 has the most experience with TRICARE and is currently a test bed for some important management innovations.

RESULTS

Based on the experiences of civilian managed-care organizations, the unique requirements of operational medicine, and the perspectives of senior DoD officials, the military health system organization 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 this support requires
- Clear assignment of responsibility, resources, and authority for readiness and mechanisms for coordinating with peacetime health-care delivery.

In this report, we consider five alternative organizational structures:

- The current structure
- Modification of the current structure to unify health-plan management in TRICARE and separate it from MTF management

- Joint command with three component commands, responsible for the MTFs, TRICARE management, and medical readiness in each service
- Joint command with service and TRICARE components, with the service components responsible for the MTFs and medical readiness, and the TRICARE component responsible for the health plan
- Joint command with readiness and TRICARE components, with the readiness component responsible for medical readiness and the TRICARE component responsible for the MTFs and TRICARE.

Given the uniqueness of the MHS, it is impossible to determine how successful the alternatives would be, relative to each other and the current organizational structure. Nevertheless, the experience of other managed-care organizations argues for strengthening the TRICARE management structure and consolidating responsibility for TRICARE resources. A test of an approach that is similar to, although less ambitious than, the changes we consider is now underway in Region 11. The test should reveal whether reorganization of the current regional structure would improve TRICARE management without weakening the service ties that many believe are critical to medical readiness.

If the Region 11 test shows that reorganization at the regional level can be effective without any reorganization at higher management levels, we recommend the more extensive changes suggested in our second alternative—modification of the current structure to unify health-plan management in TRICARE and separate it from MTF management. Otherwise, a joint command should be considered. It is possible that both a joint command and a restructured TRICARE organization within the command would constitute the most effective organization.