



# Don't Get Wounded

## Military Health System Consolidation and the Risk to Readiness

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Absent some advance in material sciences, physics, or metaphysics, the infantrymen of the future will have to cease their habit of becoming wounded due to enemy action, disease, or nonbattle injury. In the future, the best medical advice available to the medical planner 2028 for the infantryman 2028 will be “don’t get wounded.” The reason is simple. The direction of military health system (MHS) consolidation is proceeding according to policy preferences, reports, and guidance derived from a past operational environment, not from the high-intensity operational environment anticipated in large-scale combat operations (LSCO), and not as directed by the 2017 *National Defense Strategy* and accompanying *Defense Planning Guidance*. As a result, the medical capability to meet high-demand casualty requirements will not be in place in the event of a LSCO.

This article argues that MHS consolidation must be placed into a strategic pause in order to allow service, department, and congressional stakeholders an opportunity to relook current consolidation efforts and the underlying assumptions and objectives that guide these efforts, and then refocus reform on readiness. By basing planning on lessons from recent small-scale combat operations, we are at risk of shaping the medical force out to 2028 in ways that will make LSCO medically unsupportable.

To address this issue, this article will look at the political and operational environment that generated MHS consolidation efforts, keying in on the 2015 *National Security Strategy*. Next, it will situate MHS consolidation within the broader policy objective of creating a form of nationalized healthcare system. It will then pivot to the 2017 *National Security Strategy*: the return to competition, the change it requires on how we conceptualize medical support to LSCO, and the risk we will cause if we fail to do so.

**Previous page:** The third floor ward of the 49th General Hospital at the Manila Jockey Club in Manila, Philippines, during World War II. The hospital began in Manila 1 March 1945 and was able to take over treatment of numerous casualties at a time when the Leyte hospitals were full and the Sixth U.S. Army installations were lacking medical capacity. This photo is indicative of the greatly increased medical requirements for large-scale combat operations. (Photo courtesy of the Army Medical Department Center of History and Heritage)

## The 2015 National Security Environment

Multiyear policy preferences are not contained in a single document or statement. Therefore, it is important to understand how policy is made within the federal government. The executive branch sets the strategic direction for the majority of the federal government (especially those parts within the executive branch) and performs its duties in consultation and negotiation with the coequal legislative branch. Through Congress, the executive branch seeks to resource the strategy, develop new laws, or find relief from past laws. Congress expresses intent through legislation and appropriations, conference reports, congressional delegation and staff visits, and engagement with department leaders. This communications process, occurring in an ever-changing milieu, is inherently iterative. The executive branch, in consultation with the departments within the branch, establishes the *National Security Strategy*. The Department of Defense (DOD), in response, produces the *National Defense Strategy* and its partner, the *Defense Planning Guidance*. The services take that guidance and produce strategies. This collection of documents then drives processes like Programming, Planning, Budgeting, and Execution; the Future Year Defense Program; and the Army Structure Memorandum.

MHS consolidation efforts began within the idea of a smaller military force operating out of secure bases on predictable rotations. This milieu is best described by the *National Security Strategy* of 2015. This strategy called for a drawdown of military end strength concurrent with the goal of modernizing the military.<sup>1</sup> The 2015 *National Security Strategy* also set a strategic direction for the force, placing the emphasis on homeland defense and wide-area security operations.<sup>2</sup> Reflecting these desires, the U.S. defense budget went from approximately \$748 billion in 2010 to \$609 billion in 2017 where it stabilized.<sup>3</sup> The active Army went from 560,000 soldiers in 2010 and was heading to 460,000 at the beginning of 2017.<sup>4</sup> Of note, there were nearly 60,000 soldiers in the nondeployable category for the year 2016.<sup>5</sup> A smaller, better-equipped Army was the goal. That Army would focus on defense of the homeland and counterterrorism operations abroad; both operations occurring out of installations in the continental United States or relatively secure bases abroad. Under this concept, centralizing support services, like

medical, would logically produce cost benefits and efficiencies. So, from the perspective of an Army operating out of fixed bases, the homogeneous, indistinct provision of medical services from a consolidated agency to the Army was entirely rational.

## Consolidation in Context

Further understanding the strategy of consolidation requires an examination of its underlying strategic logic. Dr. David J. Smith (DOD health reform leader) and Vice Adm. Raquel C. Bono (director, Defense Health Agency), lead writers for the *Journal of the American Medical Association* article “Transforming the Military Health System,” cited Sen. John McCain as providing the “strategic logic” for MHS consolidation efforts.<sup>6</sup> McCain, reflecting the national security environment of 2015, stated, “The United States now faces a series of transregional, cross-functional, multi-domain, and long-term strategic competitions that pose a significant challenge to the organization of the Pentagon and the military, which is often rigidly aligned around functional issues and regional geography.”<sup>7</sup> McCain’s terminology does not (nor does it have to) map neatly to DOD or military terms, a point he notes in additional floor remarks.<sup>8</sup> The term “transregional” implies a threat (such as terrorism) crossing national and regional boundaries. This is very different than near-peer threats with definable boundaries and fixed infrastructure/populations that opposing forces can strike. The senator describes cross-functional teams as being “focused on a discrete priority mission. It includes members from every functional organization in the bureaucracy that is necessary to achieving that mission.”<sup>9</sup>

Military medicine, seen in this context, is a function amenable to the application of the cross-functional team concept or further consolidation. In the author’s opinion, McCain’s cross-functional approach also brings to mind the related joint concept of cross-domain synergy. While the cross-functional approach is aimed at Office of the Secretary of Defense staff functions, the cross-domain approach targets warfighting. Both are very similar. Both trend toward the centralization of resources and authority toward Washington, D.C. Both were developed under a national security environment focused on small-scale combat operations. Both seek to address perceived barriers (functional and domain) in the post-Graham-Nichols organization of the DOD. And both require “essentially transcending service and

combatant command ownership of capabilities and assuming a global perspective on military operations to achieve globally integrated operations.”<sup>10</sup> This transcendent language will come up again as we look at normative efforts within MHS consolidation.

We will focus on two decisions driving MHS consolidation that were made in the context of the 2015 *National Security Strategy*. Those decisions are the continued evolution and growth of the Defense Health Agency and the decision to deploy an MHS-wide electronic health record.

## Military Health System Consolidation Efforts

While policy implementation is multiyear and executed through a number of documents, policy concepts are often described in fewer documents. In 2009, the Institute for Alternative Futures produced the *AMEDD Futures 2039 Project: Phase*

*2 Final Report*, which provides a testable blueprint for both MHS consolidation and consolidation objectives beyond the DOD. The purpose was “to develop a capacity for futures thinking within the Army Medical Department (AMEDD), and to explore major trends impacting the AMEDD over the next 30 years.”<sup>11</sup> Noting cost as the driving factor, the report suggested, “The economic realities of the cost of health will prompt national governance that integrates the MHS, VA [Department of Veterans Affairs], Health and Human Services, and civilian health organizations. The key stakeholders go beyond combatant commanders and DOD leadership.”<sup>12</sup>

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The 212th Combat Support Hospital setting up and training in a thirty-four-bed field hospital 7 November 2017 during the Guard-Ex Field Training Exercise at Breitenwald training area in Landstuhl, Germany. (Photo by Oliver Sommer, U.S. Army Visual Information Specialist)

In going beyond the combatant commanders and DOD, the report's authors envisioned "a consolidated healthcare system 'beyond jointness,' a system that involves the Joint Military Healthcare System (JMHS) and at least the Department of Veterans Affairs (DVA), could extend to all levels of government in the form of National Healthcare Insurance and a National Health System."<sup>13</sup> This transcendent language mirrors thinking within cross-domain synergy concepts. But while cross-domain concepts are largely applicable within the DOD, the cross-functional approach described in *AMEDD 2039* breaches containment as it seeks to address problems outside the department's purview.

Finally, the report describes how "one scenario that can be envisioned is based on escalating costs or OSD/COCOM/JS/service senior leaders growing frustration with having to continually deal with medical issues across multiple organizations. A scenario could play out that results in all medical activities coming under a single organizational structure. That single structure could easily be a [Defense] Health Agency (DHA) framework using the Defense Logistics Institute (DLA) Defense [*sic*] as a model."<sup>14</sup>

The *AMEDD Futures 2039* report points to the ultimate objective of a form of nationalized healthcare system. In this report, we can see the attempt to use consolidation within the MHS as a means to a larger end. Written in 2009, the report had a pessimistic view of healthcare within the United States and saw the drive toward a national health system as a potential solution. This became a policy objective.

To that end, cost is often cited as the driver toward MHS consolidation. Military healthcare costs were projected to hit \$66.6 billion in 2016 and trend beyond \$70 billion in later years, so the need for spending economies was apparent, particularly when compared to the 2009 expenditures of \$46.3 billion. From fiscal year (FY) 2001 to FY 2009, military healthcare expenditures grew at an average annual rate of 11.8 percent with a projected FY 2009–FY 2016 projected growth

rate of 5.3 percent. However, the Budget Control Act of 2011 arrested the projected growth and the MHS expenditures rationalized to a 1.6 percent actual growth, or around \$50 billion dollars a year, from FY 2009 to FY 2016.<sup>15</sup> Following the Budget Control Act of 2011, the DHA came into being.

The March 2012 deputy secretary of defense memorandum “Implementation of Military Health System Governance Reform” established the DHA as a combat support agency, gave them responsibilities for TRICARE (a DOD healthcare program), established multiservice markets, and authorized the placement of military treatment facilities (MTFs) within the National Capital Region under the authority, direction, and control of DHA.<sup>16</sup>

The MHS saw further integrative efforts with the passage of National Defense Authorization Act (NDAA) of 2017. Signed into law by President Barack Obama on 23 December 2016, it became Public Law No. 114-328.<sup>17</sup> In his signing statement, Obama noted,

Beyond these provisions, I remain deeply concerned about the Congress’s use of the National Defense Authorization Act to impose extensive organizational changes on the Department of Defense, disregarding the advice of the Department’s senior civilian and uniformed leaders. The extensive changes in the bill are rushed, the consequences poorly understood, and they come at a particularly inappropriate time as we undertake a transition between administrations. These changes not only impose additional administrative burdens on the Department of Defense and make it less agile, but they also create additional bureaucracies and operational restrictions that generate inefficiencies at a time when we need to be more efficient.<sup>18</sup>

In the context of this article, the key features of the law fall into one of two broad areas. Sections 703 (facilities) and 721 (manpower) required force structure reductions. Sections 702 and 706 required consolidation at different levels within the system. Under Section 702, DHA was given administration of the “benefit.” Through department policy positions and later NDAA-19, the “benefit” became defined as healthcare delivery, veterinary and dental services, public health, education and training, and research and development. Section 706 (of

NDAA-17) directed the secretary of defense to establish “military-civilian integrated health delivery systems through partnerships with other health systems.”<sup>19</sup> An initial read would seem to indicate broad systemic change, but the clarifying language directed the secretary to accomplish this consolidation through “memoranda of understanding or contracts between military treatment facilities [MTFs] and [other health systems].”<sup>20</sup> Instead of a broad, systematic military-civilian consolidation, we see law directing actions at the unit (MTF) level; actions that were already ongoing at medical facilities like U.S. Army Medical Department Activity, Fort Drum, New York.

NDAA-18 did not require further changes in the MHS but is interesting for language proposed, but not passed, in the conference report. In this language, the 2017 Senate Armed Services Committee proposed an amendment “that would require the Secretary of Defense, within 1 year of the date of the enactment of this Act, to conduct a pilot program of not less than 5 years duration to establish integrated healthcare delivery systems among the military health system, other federal health systems, and private sector integrated health systems.”<sup>21</sup>

This proposed language, had it passed, would have lifted military, other governmental agencies, and civilian consolidation from an action at the unit (Section 706) level to the MHS as a whole. In the absence of this language, the statutory authority used within the MHS for system-wide consolidation with other governmental agencies and civilian health systems remains the MTF specific authority in section 706.

A review of recent news articles demonstrates how this section 706 authority is driving consolidation outside of the DOD. DHA released an announcement, which reportedly stated “that an initiative known as DOD VA Health Care Staffing Services has reached the ‘strategy development stage.’”<sup>22</sup> In a video report on the development, Bloomberg Government described the report as an effort “to merge the healthcare both agencies provide.”<sup>23</sup> Francis Rose (anchor for Government Matters), Rob Levinson (senior defense analyst for Bloomberg Government), and Megan Howard (congressional reporter, Bloomberg Government) noted, “This thing seems to be moving forward,” and “This has really operated under the radar screen,” and “The broad conversation on this is how to combine the military health system with ... the VA’s Veteran’s Health Administration ... that seems like something both the HVAC [House



Veterans Affairs Committee] and the Senate Veterans Affairs committee would be very, very interested in ... am I missing something?"<sup>24</sup> After the airing of the report, the VA issued a statement that "the initiative is not a proposal to merge healthcare systems."<sup>25</sup>

This confusion is understandable if we consider direction and timing. The move toward a whole of government approach to healthcare is coming from within the MHS, as indicated in the article accompanying the video. Second, using the blueprint provided by the *AMEDD Futures 2039* report, ten years in, we are at the point of MHS consolidation but before the planned point of integration with the VA, Health and Human Services (HHS), and private partners.

Previously, we discussed the proposed but not passed NDAA-18 language directing the secretary of defense toward and integrated healthcare delivery system beyond the DOD. In the Senate Armed Services Committee chairman's markup for NDAA-2020, we find remarkably similar language reemerging and now recommending

a provision that would authorize the Secretary of Defense to conduct a pilot program for no more than 5 years to establish partnerships with public, private, and nonprofit health care organizations, institutions, and entities in collaboration with the Secretaries of Veterans Affairs, Health and Human Services, Homeland Security, and Transportation.<sup>26</sup>

In the author's view, we must dispense with the idea that the Federal Government is monolithic, united and moving in concert toward some goal. In policy development, competing interests negotiate, sometime clash, and always ebb and flow.

These structural integrative efforts, conceived in a now outdated strategic environment of small-scale combat operations, seek to combine, at some point, the MHS and the VA. The complement to this structural effort is electronic.

## Electronic Health Records

By linking electronic systems, future structural integrative efforts become more plausible, both within DOD and without. The 2014 decision to deploy a consolidated electronic health record (EHR) within the MHS saw the implementation of a facilities-based EHR beginning in 2017. As with MHS consolidation, the deployment of the EHR sought to consolidate

disparate health records systems by integrating inpatient and outpatient records, providing data access and decision support, and sharing data between DOD, the VA, and commercial providers.<sup>27</sup>

In the FY 18 review of the DOD Healthcare Management System Modernization (DHMSM), the director, operational test and evaluation, referred to the new EHR as currently "not operationally effective because it did not demonstrate enough workable functionality to effectively manage and document patient care, ... not operationally suitable because of poor system usability, insufficient training and inadequate help desk support," and "not survivable in a cyber-contested environment."<sup>28</sup> Even within the national security environment of 2015, we experienced large-scale data breaches like the 2015 Office of Personnel Management hack.<sup>29</sup> Consolidated systems can deliver efficiencies but also single points of failure.

These problems are likely solvable, but what they point out is the risk in the pace of change. DOD, DHA, and the vendor need time to evaluate the risks to force and mission. The advantages of an EHR, moving from a documenting system to a care coordination tool, are great. But the deployment of inadequate tools could nullify the advantage. Despite problems, the continued employment of the EHR remains a high priority within the MHS.<sup>30</sup> When seen in the context of further systematic consolidation, that decision becomes understandable.

## Toward a National Health System

An MHS that moves "beyond combatant commanders and DOD," merges with the VA, and includes Health and Human Services (HHS) would not, in itself, constitute a national health system. The literature within the MHS is unclear on how this hybrid system would become a national healthcare system. However, we can envision this nationalization occurring through the concept of monopsony, "the term for a commodity market that includes numerous sellers and a single buyer."<sup>31</sup>

The DOD has a monopsony in the purchase of certain goods and services. In the healthcare space, the MHS, which is an insurance plan and a direct care system, does not. But an MHS moving beyond the DOD as an MHS/VA, and in combination with strategic partners and alliances, could conceivably achieve what Pauly describes as a "partial monopsony."<sup>32</sup> In this scenario, a single buyer could exert enough influence over



the market to drive standards and pricing. A recent Kaiser Health News article asked, “What if huge health insurance companies could push down prices charged by hospitals and doctors in the same way [as Wal-Mart]?” It then noted, “Accepting Wal-Mart logic for healthcare might bolster arguments for an even bigger, more powerful buyer of medical services: the government. A single-payer, government health system ... would be the ultimate monopsony: one buyer, negotiating or dictating prices for everybody.”<sup>33</sup>

This monopsony could also drive industry standards. The president of government services at Cerner (the EHR vendor for the DOD and VA), testifying before Congress, indicated as much when he noted, “The power of the DOD and VA to make that choice [choose a common standard] to move forward will influence the commercial marketplaces.”<sup>34</sup> A combined MHS/VA, in combination with strategic partners and alliances like HHS, could, potentially, act as a partial monopsony in dictating input prices. This hybridized system would represent more than 56,000 beds out of a total U.S. capacity of over 931,000 beds (all types)

Soldiers with the 131st Field Hospital, 528th Hospital Center, assess a mock patient 15 August 2018 during a simulated emergency as part of a week-long exercise at Fort Bliss, Texas. The exercise was designed to test capabilities, build rapport, and increase efficiency at the Army’s second-ever updated, modular-design field hospital. (Photo by Marcy Sanchez, William Beaumont Army Medical Center)

and a combined beneficiary population of over 19 million people.<sup>35</sup> From a partial monopsony position, a combined MHS/VA/HHS health system could drive toward a national healthcare system.

Of course, the construction of a national health system is a multiyear policy objective. Within the context of that policy objective, we can see NDAA-17 as a recognizable waypoint. This fits in with the road map laid out in the *AMEDD Futures 2039* report. We have seen the establishment of the DHA, the consolidation of shared services and the National Capital Region, and now the consolidation of the MHS under a single authority. The next waypoint would be the consolidation of the MHS, VA, HHS, and other strategic partners and alliances.



These final steps would place the MHS on a path toward “a Consolidated Federal Healthcare System, a system that would function as a National Healthcare System.”<sup>36</sup>

In the end, policy preferences are just that—policy preferences—and presidentially appointed, Senate-confirmed officials have the authority to pursue them. As part of the process, military planners at all levels must continue to balance perceived advantages in a single

The Army had a readiness challenge and needed to respond. It responded to the new *National Security Strategy* and 2018 *National Defense Strategy* with a doctrinal focus on multi-domain operations and LSCO fought at the levels of theater armies, corps, and divisions. Inevitably, LSCO will come with large-scale casualties.

It is difficult to produce unclassified casualty estimates tested against validated operation plans;

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policy preference with straightforward assessments of risk to mission or risk to force. The necessity of military doing so is even more important in today’s environment as the 2018 *National Defense Strategy* notes that “(U) Our institution [the Department of Defense] has biased processes to manage low-end limited conflicts versus high-end, large-scale combat.”<sup>37</sup> The focus on low-end limited conflicts makes the status quo consolidation of the MHS, beyond the DOD, possible.

### **Readiness within the 2017 National Security Environment**

With the 2017 *National Security Strategy*, great power competition, and the potential for large-scale combat operations, returns. President Donald Trump directed, “To retain military overmatch, the United States must restore our ability to produce innovative capabilities, restore the readiness of our forces for major war, and grow the size of the force so that it is capable of operating at sufficient scale and for ample duration to win across a range of scenarios.”<sup>38</sup>

Army Chief of Staff Gen. Mark A. Milley, reflecting on the Army’s posture in 2015, noted, “If you go back to 2015, I think we were on a downward slope of readiness relative to the tasks required to be able to fight near-peer competitors. Our readiness was probably okay for counterinsurgency and counterterrorism but not for the higher end of warfare. At that time, we really only had two or three brigades at the highest levels of readiness; today we’re in excess of 20.”<sup>39</sup>

however, we can examine historical plans and planning models. From a date range of 11 September 2001 to 31 December 2012, approximately 15,740 service members required Role 4 or Role 5 hospitalization.<sup>40</sup> That averages to approximately 118 soldiers per month, or four casualties per day. By comparison, U.S. Transportation Command, the combatant command responsible for patient distribution within the continental United States, provides planning factors in support of LSCO that range from 250 to one thousand casualties per day returning to the United States.<sup>41</sup> The 2019 Army Campaign Plan notes, “Warfare will become more violent, lethal and swift, creating more consequential risks in terms of casualties, cost, and escalation.”<sup>42</sup> This casualty stream is at the heart of the readiness challenge for military medical forces.

In the author’s view, military readiness is not a priority in MHS consolidation given that consolidation efforts really serve as a means to a larger administrative end unrelated to the return to competition and the large-scale combat operations that implies. As a result, readiness is poorly understood and not properly considered at the enterprise level of the MHS, with its continued focus on discreet, individual tasks such as clinical knowledge, skills, and abilities (KSAs).<sup>43</sup>

In the military services, readiness is more clearly defined. At the DOD level, readiness is “the ability of military forces to fight and meet the demands of assigned missions.”<sup>44</sup> As the term comes through the secretary and the chief of staff of the Army, readiness is sharpened



and refined until it becomes clear guidance. Army Surgeon General Lt. Gen. Nadja West, in her role as the commanding general of U.S. Army Medical Command, provides this commander's assessment:

As directed by the Chief of Staff of the Army, our top priority is Readiness. The Secretary of the Army defines readiness as "ensuring the Total Army is ready to deploy, fight and win across the entire spectrum of conflict, with an immediate focus on preparing for a high-end fight against a near peer adversary." Further, he directs "improving Readiness is the benchmark for everything we do; it should guide our decision-making."<sup>45</sup>

Readiness is without a limiting clause. Readiness is not just individual tasks, like discreet clinical KSAs currently in use as a force-shaping metric (in accordance with section 703). Medical readiness is the ability of the entire medical force to respond to LSCO. Readiness requires military attention at the strategic, operational, and tactical levels. From a military perspective, readiness must remain the overriding focus, not efforts aimed at consolidation for administrative ends that may actually be an impediment to readiness.

Readiness is not a focus in MHS consolidation. Instead, the focus is on a limited system "that will have civilians providing the majority of care to beneficiaries and a slimmed-down uniform staff focusing primarily on operational medicine."<sup>46</sup> This is the very definition of an MHS bias that anachronistically focuses on managing "low-end limited conflicts versus high-end, large scale combat" that the *National Defense Strategy* cautions against. Logically, an MHS not focused on military requirements is just a health system. And those military requirements far exceed the current focus on discrete, individual-level tasks like KSAs, individual soldier readiness, and soldier readiness processing; a complete understanding of medical readiness must include the number of collective tasks required in LSCO. Understanding the task required means abandoning the view of distant, small-scale combat operations appearing occasionally in public view as a CNN chyron and understanding that a theater war will inherently involve the strategic support area in the continental United States. In the event of a theater war, U.S. Navy medical personnel will board ships and slip over the horizon; U.S. Air Force medical personnel will support from bases and build

the vital strategic aeromedical evacuation bridge; and the AMEDD Regiment will leave cantonment with the deploying formations or expand medical capacity within the strategic support area.

Responsibilities of the Army health system at war include

- ◆ displacing assigned personnel working in MTFs;
- ◆ transferring "the benefit" to the purchased care network in order to provide personnel support to soldier readiness processing;
- ◆ receiving multiple U.S. Army Reserve medical support units and troop medical clinic personnel to support mobilization force generation installations;
- ◆ executing installation medical supply activities or master ordering facility tasks;
- ◆ reception, staging, onward movement, and integration of medical backfill battalions, blood support detachments, and veterinary service detachments;
- ◆ initiating bed expansion packages (execution of indefinite delivery/indefinite quantity and medical Q-coded service contracts);
- ◆ operating federal coordination centers;
- ◆ providing patient reception teams to aeromedical evacuation hubs;
- ◆ receiving casualties (250–1,000 per day) who meet the sixty-day hold policy (conserving fighting strength);
- ◆ regulating the DOD-VA contingency hospital system;
- ◆ providing case management/discharge services for service members within the DOD-VA contingency hospital system using the warrior transition battalions;
- ◆ monitoring decision points like reducing graduate medical education to regenerate Army health system capacity lost through attrition; and finally,
- ◆ reversing these processes through demobilization tasks.

Is the MHS ready today to execute this wide array of necessary activities? An external evaluation would suggest it is not. U.S. Transportation Command Base Plan 9008 calls for an almost immediate access (on a cost reimbursable basis) to the National Disaster Medical System (NDMS). Access to the NDMS is contingent on "a military health emergency declared by the ASD (HA) [Assistant Secretary of Defense for Health Affairs]," which "is deemed to be a public health emergency for purposes of the NDMS statute."<sup>47</sup> Put in perspective, at

a cost to the American people of some \$50 billion a year, the MHS will be in a state of public health emergency in the first days of war. Unless we refocus.

Broadly speaking, Army medicine faces the same challenges as the Army writ large. Army challenges in strategic deep fires, air defense artillery, and logistical support to LSCO become Army medicine challenges in war-time expansion, casualty reception, and combat power regeneration. The additional complexity Army medicine faces is MHS consolidation efforts. The structure, the engine, of Army medical readiness is in place. But instead of turning it back on, consolidation is pushing us to bolt the M1A2 engine of readiness into the Model T of pre-2017 MHS consolidation efforts in a way that will, predictably, fail. The bitter irony is that we are now changing medical warfighting structure at the exact moment we are directed to return to LSCO planning efforts.

## Conclusion

The status quo development of a consolidated MHS and the continued development of a health system that

grows beyond the DOD clearly increases military readiness risk as we continue to transition from small-scale combat operations and return to LSCOs. The assumptions that drove MHS consolidation are likely no longer valid in an environment characterized by great power competition. However, there is time within congressionally mandated timelines, to refocus.

We are at a fork in the road. Down one path is a focus on the “benefit.” We see the MHS following the blueprint of the *AMEDD Futures 2039* report: increasingly civilianize, detach from the DOD, and merge with the VA/HHS/civilian strategic partners and allies to become the nucleus of some form of nationalized healthcare system. Down the other path is readiness, properly understood. Down this path, we go into the future; we see America’s worst day—where her wounded stretch across battlefields measured in thousands of kilometers—and we make a plan for them. If we choose the “benefit,” then the best medical advice to America’s fighting sons and daughters will be “don’t get wounded.” ■

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## Notes

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