MOAA
Military Officers Association of America

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Don't Dismantle Military Medicine

Objective: To sustain military readiness.
At the heart of a lethal and ready military force lies a well-trained, fully capable cadre of medical professionals, the result of comprehensive training across a wide array of medical disciplines and specialties.

Issue: DoD's proposal to reduce medical capabilities.
DoD submitted a fiscal year (FY) 2020 budget calling for reducing military medical forces by nearly 18,000 billets, a force reduction of roughly 20%. It appears DoD has not analyzed the longer-term impact this will have on the medical training institutions that provide the very medical professionals who underwrite military readiness.

A 20% force reduction constitutes a qualitative change to the military health system that could cause unintended consequences impacting all types of medical care across America.

Background: DoD has the authority to reform the Military Health System significantly.
DoD, the Defense Health Agency (DHA), and three services are implementing vast Military Health System (MHS) reforms, per the 2017 and 2019 NDAAs. Reforms include transferring administration and management of military treatment facilities (MTFs) to the director of the DHA. According to DoD, the secretary will transfer authority through a "streamlined organizational model that standardizes the delivery of care across the MHS, with less overhead, more timely policy-making, and a transparent process for oversight and measurement of performance." As part of this restructuring, DoD plans to repurpose a significant number of uniformed medical positions for other efforts needed to support the National Defense Strategy.

CONSIDER THE CONSEQUENCES

Combat casualty care capabilities:

• Warfighters who lose confidence in combat care will hesitate in battle, degrading lethality.

• Future readiness will be jeopardized by any interruption of the Graduate Medical Education (GME) pipeline. It takes over a decade to restore a fully trained and capable medical force after interruptions in education.

Recruitment and retention:

• Cuts to obstetrics and gynecology will negatively affect recruitment and retention of women in service, and it will impact transition of care to the VA.

• Loss of pediatric care will affect retention.

• Cutting residency and fellowships in GME sends a negative signal to the competitive pool of current medical and nursing applicants considering a military medical career, sub-optimizing recruiting.

Retiree health care:

• TRICARE Prime retirees already are being pushed into civilian networks from MTFs, in some cases without assessing capacity or willingness for local health care providers to accept new patients.

Already taxed civilian sector health care:

• The civilian sector cannot absorb additional medical school graduates to train. Last year, more than 1,100 civilian medical student graduates were unable to find residency opportunities because of capacity issues.

• Civilian networks are lacking in rural areas where many installations are located.

• Civilian doctors who have not served likely will not fully understand the spectrum of medical needs facing the military community; this is especially concerning for mental health providers (who also face a shortage).

ACTION NEEDED

Congress, we need your help:

Include a directive in the FY 2020 NDAA instructing DoD to:

- **Halt any realignment of medical positions** pending a Congressional review
- **Develop metrics for long-term effects** on military readiness, combat casualty care capabilities, family member readiness, graduate medical education, and beneficiary care
- **Develop a phased implementation** of any medical force restructuring contingent on metric outcomes as reported to Congress and its approval via the FY 2021 NDAA and subsequent defense bills

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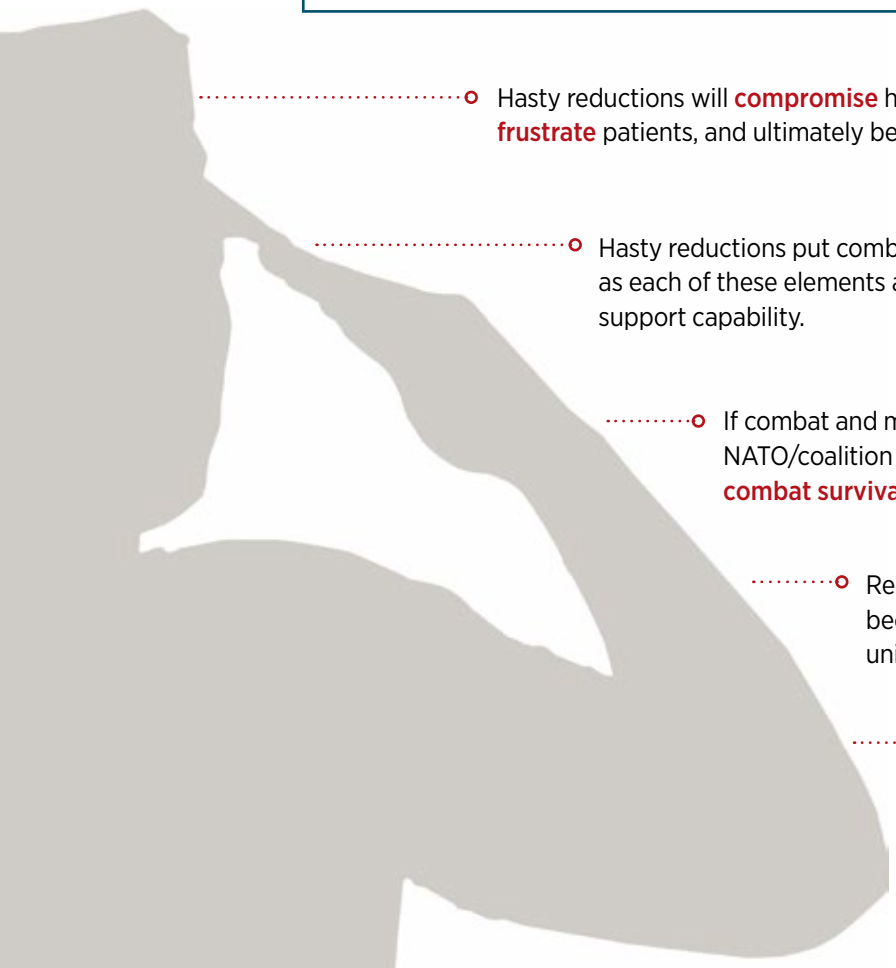
6 QUESTIONS EVERYONE SHOULD BE ASKING

1. Can military medical departments absorb these reductions and still support the following: operational plans, medical requirements, combat operations, and humanitarian aid and disaster relief missions? Can they do more than one of these simultaneously if required?
2. What are the stateside-to-overseas dwell ratios for deployments? Are they acceptable and at predictable levels, or will these reductions result in more frequent deployments and less time at home with families?
3. How will the reductions affect recruitment and retention of military medical professionals, including the reserve component?
4. What will be the effect on Graduate Medical Education programs (the physician pipeline)?
5. Will these reductions compromise the military health benefit to a point where there is no longer a benefit to joining or staying in the military?
6. What will be the effect on civilian medical communities associated with these reductions and the follow-on diminished or eliminated access at military treatment facilities?

BOTTOM LINE FOR THE MISSION, TROOPS, AND FAMILIES



- Hasty reductions will **compromise** health care, **frustrate** patients, and ultimately be **expensive**.
- Hasty reductions put combat, medical, and family readiness **at risk** as each of these elements are essential to maintain effective combat support capability.
- If combat and medical readiness are affected, U.S. and NATO/coalition forces will likely face significant decreases in **combat survivability**.
- Recruitment becomes more difficult – retention becomes even more difficult – leaving those in uniform **waiting for relief**.
- VA MISSION Act implementation could experience **significant challenges** as it depends on some facets of DoD health care and community partnerships to serve the nation's veterans.