

February 2011

MILITARY PERSONNEL

DOD Addressing Challenges in Iraq and Afghanistan but Opportunities Exist to Enhance the Planning Process for Army Medical Personnel Requirements



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Why GAO Did This Study

For ongoing operations in Afghanistan and Iraq, military medical personnel are among the first to arrive and the last to leave. Sustained U.S. involvement in these operations has placed stresses on the Department of Defense's (DOD) medical personnel. As the U.S. military role in Iraq and Afghanistan changes, the Army must adapt the number and mix of medical personnel it deploys. In response to Congress' continued interest in the services' medical personnel requirements in Iraq and Afghanistan, GAO evaluated the extent to which (1) DOD has assessed its need for medical personnel in theater to support ongoing operations, (2) the Army has adapted the composition and use of medical units to provide advanced medical care, and (3) the Army fills medical personnel gaps that arise in theater. To do so, GAO analyzed DOD policies and procedures on identifying personnel requirements, deploying medical personnel, and filling medical personnel gaps in Iraq and Afghanistan, and interviewed officials.

What GAO Recommends

GAO recommends that (1) DOD clarify the level of routine medical care that deployed DOD civilian employees can expect in theater and (2) the Army update its doctrine and the organizational design of split medical units. In response to a draft of this report, DOD generally concurred with the recommendations.

View [GAO-11-163](#) or key components. For more information, contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov.

MILITARY PERSONNEL

DOD Addressing Challenges in Iraq and Afghanistan but Opportunities Exist to Enhance the Planning Process for Army Medical Personnel Requirements

What GAO Found

Medical officials in theater continually assess the number and the types of military medical personnel they need to support contingency operations in Iraq and Afghanistan and analyze the risks if gaps occur. Given congressional interest about deployed civilians, DOD reported to Congress in April 2010 that with each new mission, the need for new civilian skills has resulted in an increase in deployed civilians and that these civilians are not immune to the dangers associated with contingency operations. Although GAO did not learn of any DOD deployed civilians turned away for care in theater during this review, it is unclear the extent they can expect routine medical care in theater given that a DOD directive and theater guidance differ with regard to their eligibility for routine care. By clarifying these documents, DOD could reduce uncertainty about the level of routine care deployed DOD civilians can expect in theater and provide more informed insights into the military medical personnel requirements planning process.

Army theater commanders have been reconfiguring or splitting medical units to cover more geographical areas in theater to better provide advanced emergency life-saving care quicker, but Army doctrine and the organizational design of these units, including needed staff, have not been fully updated to reflect these changes. Studies show that for those severely injured or wounded, 90 percent do not survive if advanced medical care is not provided within 60 minutes of injury. Officials in theater told GAO they are using specialized personnel documents to staff these medical units with more up-to-date personnel requirements to address gaps caused by splitting medical units, and that current doctrine and organizational design were not sufficient to address the capability needed for splitting medical units. According to an Army regulation, it maintains its lessons learned program to systematically update Army doctrine and enhance the Army's preparedness to conduct current and future operations. By updating Army doctrine and organizational documents for the design of medical units that could be used in other theaters, the Army could benefit from incorporating its lessons learned, where appropriate, and be better assured the current practice of splitting medical units to quickly provide advanced life-saving emergency medical care to those severely injured or wounded does not lead to unnecessary staffing challenges.

Army commanders have used two approaches—cross-leveling and backfilling—to fill medical personnel gaps that arise in theater due to reasons such as illnesses, emergency leave, and resignations of medical personnel. When these gaps in needed medical personnel occur, the Army's 90-day rotation policy—while intended to ease the financial burden of deploying reserve medical personnel and help retain them—has presented some challenges in quickly filling these gaps in theater with reserve medical personnel when a medical provider is not able to deploy. However, Army data show the magnitude of these unfilled gaps or late arrivals for the reserve component medical providers ranged from about 3 percent to 7 percent from January 2008 to July 2010.

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United States Government Accountability Office
Washington, DC 20548

February 10, 2011

Congressional Committees:

When contingencies such as Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom arise, military medical personnel¹ are among the first to arrive and the last to leave. Sustained U.S. involvement in Iraq, Afghanistan, and elsewhere has placed stresses on the Department of Defense's (DOD) medical personnel, particularly for certain high-demand specialists such as psychiatrists and physician assistants. DOD medical personnel have dual responsibilities to provide medical care at health care facilities in the United States and abroad to servicemembers, former servicemembers, and other beneficiaries, and, when called upon, to provide urgent, lifesaving medical care on the battlefield and medical support to U.S. armed forces.

Providing military medical care for ongoing operations in Iraq and Afghanistan presents other challenges. For instance, as the number and mix of medical personnel specialists decreases in Iraq, in line with the theaterwide reduction of forces, the military must continue to provide medical support while adapting to reduced numbers of medical personnel. At the same time, medical units deployed to Afghanistan face logistical challenges created by geography and the lack of physical infrastructure such as roads and utilities that complicate their ability to provide advanced medical care to warfighters.

In our past reports, we have highlighted several issues concerning military medical personnel requirements. For example, in September 2006, we reported that some combat support and combat service support skills, including medical, were in particularly high demand to meet requirements for operations in Iraq and Afghanistan.² That report also found that medical and other support skills, which reside primarily in the Army's

¹For purposes of this report, we use the term "medical personnel" to refer to U.S. military health care officers including physicians, dentists, nurses, and others, as well as enlisted personnel such as medics, hospital corpsmen, and dental technicians.

²GAO, *Force Structure: DOD Needs to Integrate Data into Its Force Identification Process and Examine Options to Meet Requirements for High-Demand Support Forces*, [GAO-06-962](#) (Washington, D.C.: Sept. 5, 2006).

reserve components,³ were in increasingly short supply due to restrictions on the length and frequency of reserve deployments. In April 2009, we noted that DOD faced challenges in accessing and retaining medical officers, such as the limited supply and high demand for qualified medical professionals; the lower pay generally offered to them by the military compared to the private sector; the stress, length, and frequency of deployments; and the length of required service commitments.⁴ In July 2010, we reported that the services' collaborative planning efforts regarding requirements determination for medical personnel working in fixed military treatment facilities have been limited.⁵ We also noted that the services' requirements processes are not always validated and verifiable, as DOD guidance requires.

In response to the congressional committees' continued interest in the medical and dental personnel requirements of the military services, including their reserve components, needed to, among other things, meet their medical missions in support of contingency operations and deliver high-quality health care to eligible beneficiaries, we agreed to undertake additional work on issues related to DOD's medical personnel. For this report, we focused on military medical support for contingency operations in Iraq and Afghanistan, and as such, we evaluated the extent to which (1) DOD has assessed its need for military medical personnel to support ongoing operations, (2) the Army has adapted the composition and use of its medical units to provide advanced medical care, and (3) the Army fills medical personnel gaps that arise in theater.

For our first objective, we analyzed DOD's policies and processes that govern the medical personnel requirements determination process and compared DOD guidance and theater-level guidance regarding medical care for deployed DOD civilians and noted how they differed. For our second objective, we evaluated Army doctrine and the organization of medical units and assessed the extent to which they capture current

³DOD's reserve components are the Army National Guard of the United States, the Army Reserve, the Naval Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, and the Coast Guard Reserve.

⁴GAO, *Military Personnel: Status of Accession, Retention, and End Strength for Military Medical Officers and Preliminary Observations Regarding Accession and Retention Challenges*, [GAO-09-469R](#) (Washington, D.C.: Apr. 16, 2009).

⁵GAO, *Military Personnel: Enhanced Collaboration and Process Improvements Needed for Determining Military Treatment Facility Medical Personnel Requirements*, [GAO-10-696](#) (Washington, D.C.: July 29, 2010).

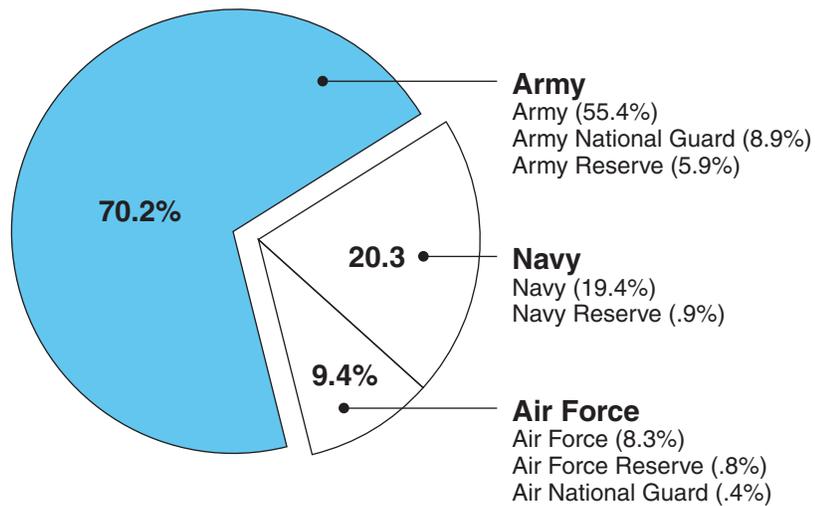
practices in Iraq and Afghanistan regarding the use and composition of these units. For our third objective, we reviewed the approaches used by Army theater medical commanders to meet medical personnel requirements when gaps in needed personnel coverage occurred in Iraq and Afghanistan. We also analyzed Army guidance for deploying medical personnel in its reserve components and assessed Army data to determine the extent to which medical units of the Army reserve components had their authorized numbers of medical personnel from January 2008 to July 2010, given this is the time period in which the Army had data. We assessed the reliability of the data by interviewing the agency official responsible for collecting and summarizing the data and determined that the data were sufficiently reliable for the purposes of this report. For all three objectives, we augmented our document analysis by interviewing DOD and service officials, including officials from United States Forces-Iraq and United States Forces-Afghanistan; U.S. Central Command; Joint Forces Command; Joint Staff; Office of Secretary of Defense for Health Affairs; Offices of the Surgeons General for the Army, the Navy, and the Air Force; and U.S. Marine Corps Headquarters. Throughout the engagement we relied upon our staff in Baghdad, Iraq to conduct extensive field work and interviews with officials in Iraq. For details on our scope and methodology, see appendix I. We conducted this performance audit from August 2009 through January 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

At the end of July 2010, over 10,000 military medical personnel were deployed to Iraq and Afghanistan, 70 percent of whom were Army servicemembers. Of that number, about 4,000 medical personnel were in Iraq and about 6,000 were in Afghanistan. The United States' military presence in Iraq is scheduled to end no later than December 31, 2011, and, according to administration estimates, as of September 2010, about 104,000 U.S. military personnel were deployed in Afghanistan.

Figure 1 shows the breakdown of all military medical personnel in Iraq and Afghanistan by service at the end of July 2010.⁶

Figure 1: Breakdown of Military Medical Personnel in Iraq and Afghanistan by Service as of July 2010



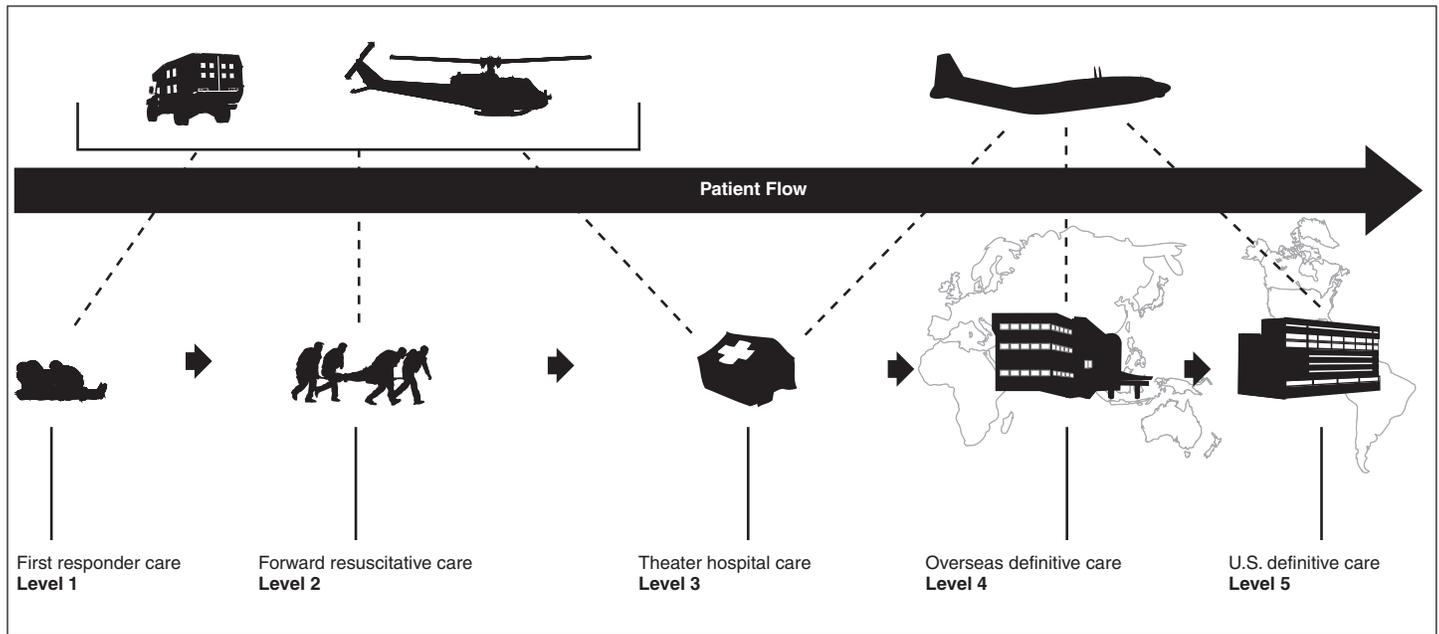
Source: GAO analysis of Defense Manpower Data Center's Contingency Tracking System.

Levels of Medical Care in Iraq and Afghanistan

DOD has established five levels of medical care to treat injured or sick military personnel, extending from the forward edge of the battle area to the continental United States, with each level providing progressively more intensive treatment. Over the course of operations in Iraq and Afghanistan, the military has integrated more advanced medical care into the first three levels of care, which are typically provided in theater, in order to provide the most comprehensive care possible closest to the point of injury. Figure 2 illustrates the different levels of medical care that may be provided to U.S. servicemembers who become ill or injured while in theater.

⁶This figure excludes Army, Navy, and Air Force active and reserve component medical personnel deployed to U.S. military medical facilities in nearby countries, such as Kuwait, Bahrain, and Qatar. Navy medical personnel support the Marine Corps, and Navy medical personnel within Marine Corps units are included in the Navy totals.

Figure 2: Levels of Military Medical Care That May Be Provided to U.S. Military Personnel



Source: GAO analysis and Art Explosion; (clipart).

- **Level 1 – First responder care.** This level provides immediate medical care and stabilization in preparation for evacuation to the next level, and treatment of common acute minor illnesses. Care can be provided by the wounded soldiers, medics or corpsmen, or battalion aid stations.
- **Level 2 – Forward resuscitative care.** This level provides advanced emergency medical treatment as close to the point of injury as possible to attain stabilization of the patient. In addition, it can provide postsurgical inpatient services, such as critical care nursing and temporary holding. Examples of level 2 units include forward surgical teams, shock trauma platoons, area support medical companies, and combat stress control units.
- **Level 3 – Theater hospital care.** This level provides the most advanced medical care available in Iraq and Afghanistan. Level 3 facilities provide significant preventative and curative health care. Examples include Army combat support hospitals, Air Force theater hospitals, and Navy expeditionary medical facilities.
- **Level 4 – Overseas definitive care.** This level provides the full range of preventative, curative, acute, convalescent, restorative and rehabilitative care, most typically outside of the operational area. An example of a level 4 facility is Landstuhl Regional Medical Center in Germany.

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- Level 5 – U.S. definitive care. This level provides the same level of care as a level 4 facility, but most typically is located in the continental United States. Examples include Walter Reed Army Medical Center in Washington, D.C.; National Naval Medical Center in Bethesda, Maryland; and Brooke Army Medical Center at Fort Sam Houston, Texas.

Not all patients progress through all five levels of care, and patients being evacuated may skip one or more levels of care as appropriate. In addition, joint and service definitions for each level of care vary marginally due to service-specific support requirements, but they essentially align with one another. For purposes of this report, we focused primarily on level 2 and level 3 facilities and their personnel, which provide the most comprehensive and advanced medical care in Iraq and Afghanistan.

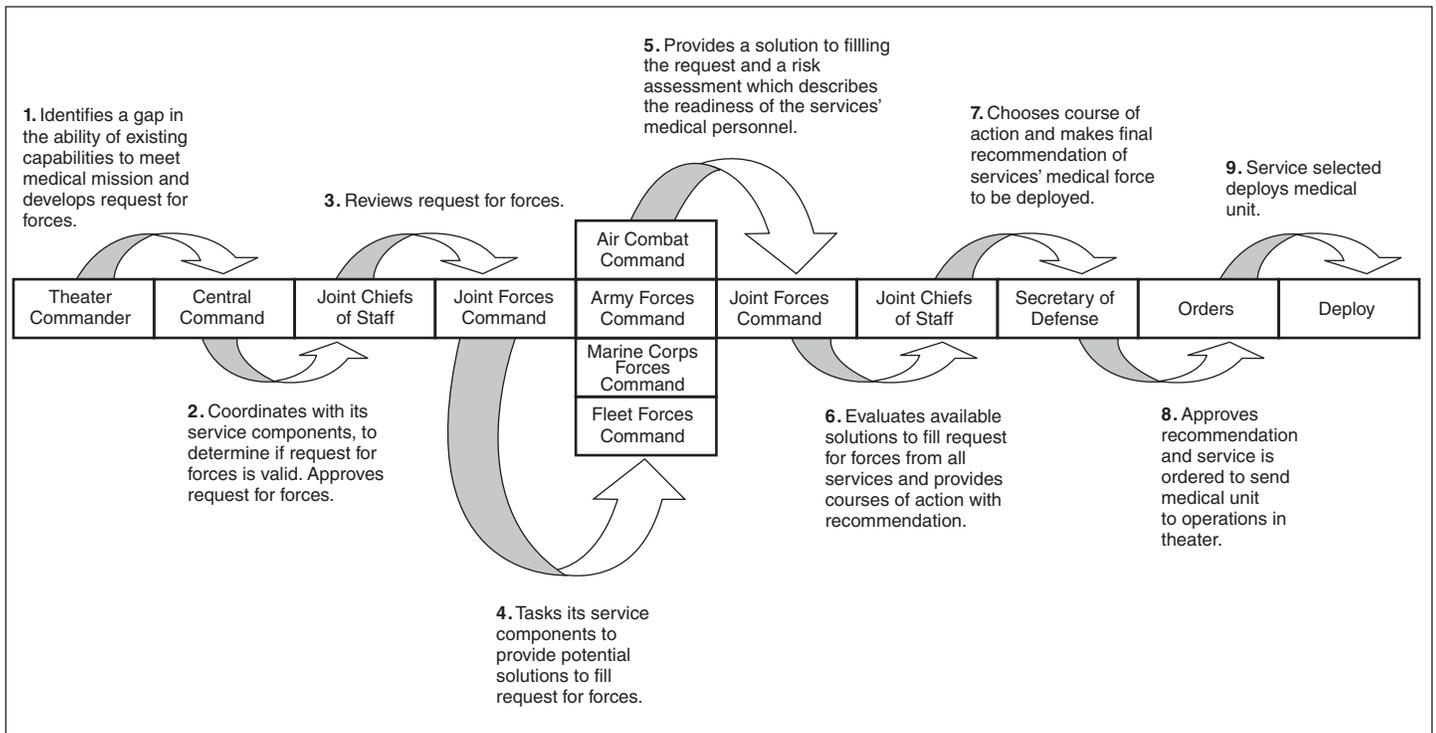
Organizational and Command Structure of Medical Forces in Iraq and Afghanistan

The U.S. command structure in Iraq and Afghanistan has evolved over time. In 2009, the designation of U.S. troops in Afghanistan became United States Forces-Afghanistan. In 2010, the designation of U.S. troops in Iraq became United States Forces-Iraq. The commanding generals of United States Forces-Iraq and United States Forces-Afghanistan both are advised by a lead surgeon on medical policy and procedures, according to theater medical officials. Each theater also has a medical task force—the Task Force 1st Medical Brigade and its successor, the Task Force 807th Medical Brigade in Iraq and the Task Force 30th Medical Command and its successor, Task Force 62nd Medical Command in Afghanistan—that, according to theater medical officials, consist of professional staff members who coordinate care in theater and directly command medical-only units in theater, such as forward surgical teams and combat support hospitals. The theater surgeon and medical task forces command mostly Army medical facilities. According to a DOD official, the other services maintain and operate additional medical facilities in theater that may be outside the direct command of the medical task force but under the direction of United States Forces-Iraq and United States Forces-Afghanistan. For example, the Air Force operates a theater hospital in Balad, Iraq but coordinates closely with the task force medical brigade in Iraq. The United States Forces-Iraq Surgeon and staff collaborate closely with the task force medical brigade commander and staff in Iraq to coordinate medical policy and care. The positions of United States Forces-Afghanistan Surgeon and the commander of the task force medical command in Afghanistan are filled by the same individual.

DOD Uses Its Global Force Management Process to Meet Medical Personnel Requirements

According to DOD officials, DOD meets theater medical personnel requirements through its Global Force Management process. DOD designed the Global Force Management process to provide insight into the availability of U.S. military forces to deploy, including medical personnel. Figure 3 depicts the process and the key participants in Global Force Management.

Figure 3: DOD's Process to Meet Personnel Requirements in Support of Operations in Iraq and Afghanistan



Source: GAO analysis.

Once the Secretary of Defense designates a service to meet a medical requirement, that service identifies and selects units and personnel to fill the requirement. While the procedures and systems used by each service to select medical personnel vary, the services' processes for filling

requirements⁷ all result in units and personnel deploying to an operational theater to carry out a mission.

Identifying and selecting medical personnel and units to fill requirements can often be challenging due to shortages⁸ of medical personnel, but DOD officials told us they have been able to fill almost all medical personnel requirements since the Global Force Management process was established in 2005. More information on the Global Force Management process and the services' personnel filling processes can be found in appendix II.

Theater Commanders Continually Assess Medical Personnel Requirements, but DOD's Directive on Routine Medical Care for DOD Deployed Civilians Is Not Consistent with In-theater Guidance

Medical officials in theater continually assess the number and the types of military medical personnel they need to support ongoing contingency operations in Iraq and Afghanistan. Theater officials also analyze gaps in medical care and the associated risks given different potential scenarios. However, it is unclear what level of care deployed DOD civilian employees can expect in theater because a DOD directive governing medical care for DOD deployed civilians is inconsistent with in-theater guidance with regard to eligibility for routine medical care for deployed DOD civilian employees. In response to congressional interest about deployed civilians, the Secretary of Defense reported to Congress in April 2010 that with each new mission, the need for new civilian skills have resulted in an increase in the number of deployed civilians and that these civilians are not immune to the dangers associated with contingency operations. Although we did not learn of any DOD deployed civilians turned away for care in theater during the period of our review, officials in theater did say this could be a concern if the number of civilians increased, and at that time they would assess the impact of a civilian increase on the need for more medical personnel. At the conclusion of our audit, an Army official agreed that if there is an inconsistency between departmental guidance and theater guidance, it should be clarified. Thus, by examining inconsistencies in departmental guidance compared to theater guidance on the level of routine medical care, DOD could reduce the uncertainty about the level of routine care these deployed civilians can expect in

⁷These processes include the Army's Professional Filler System; the Navy's Health Services Augmentation Program; and the Air Force's Air and Space Expeditionary Force methodology for deployment. The Navy provides medical personnel to support the Marine Corps through the Navy's Health Services Augmentation Program.

⁸Shortages of medical personnel occur when the level of available personnel is below the service's authorized medical personnel levels.

theater. In response to a draft of this report, DOD mentioned to us that its operating units have sufficient organic medical support and the medical needs of deployed civilians are being met. DOD also agreed that the Commander of U.S. Central Command should revise its guidance to clarify the level of care that deployed civilians should receive.

Theater Officials Analyze Mission Plans and Medical Data to Assess Their Need for Medical Personnel

Theater operational and medical officials determine how many and the types of medical personnel needed to support operations in Iraq and Afghanistan through an ongoing assessment, which includes an evaluation of the operational mission and other planning factors, such as historical injury statistics and medical workload data. In their assessment, theater officials also analyze gaps in medical care given different potential scenarios and the associated risks. This ongoing assessment takes place in theater and allows theater officials to identify new medical personnel requirements and regularly reevaluate existing medical personnel requirements. Further, theater operational and medical officials also consider operational limitations when developing their medical personnel requirements, including the limit on the total number of forces in theater and shortages of and high demand for certain medical personnel.

In determining the number of military medical personnel and the medical specialties needed, theater operational and medical officials told us that they begin by evaluating various mission planning factors, such as the number and dispersion of U.S. forces, the expected intensity of combat, capabilities of the adversary to inflict harm, geography, and climate. Officials said that this information allows them to determine the level and structure of medical care they expect to need to support missions throughout the theater of operations. For example, in planning for the increase of U.S. forces in Afghanistan beginning in early 2010, officials with the U.S. Central Command requested additional medical personnel to provide medical care to the increased number of U.S. military personnel in theater, including a theater hospital and a preventative medicine unit. In addition, during the offensive in Bastion, Afghanistan, officials with the Task Force 30th Medical Command told us that they relocated some mental health providers in Afghanistan to Bastion for the duration of the heightened operational tempo so this type of care could be better provided in the area experiencing hostilities.

To further assess the need for specific types of medical specialists in a given unit and across the theater, medical officials analyze data from the Joint Theater Trauma Registry, the Joint Medical Work Station, and service and joint data on disease and non-battle injuries to determine

trends in medical workload. Officials use this information to increase or decrease the number of medical personnel in line with demand for medical services. For example, DOD medical officials conducted an analysis to determine the need for cardiovascular specialists in Iraq and Afghanistan based on, among other variables, the volume of cardiovascular-related medical evacuations in theater. Officials also analyze gaps and risks in the medical care structure under different possible scenarios. For example, the Task Force 1st Medical Brigade in Iraq conducted an analysis that identified possible requirements for additional medical personnel with certain specialties, such as general surgeons, at locations in northern Iraq given the possibility of adverse weather conditions that would prohibit medical evacuation of patients to more advanced medical care facilities. Further, when confronted with a need for additional medical personnel, the theater commanding general can submit a request for forces through DOD's Global Force Management process. For example, we learned of two Army sustainment brigades—the 82nd and the 43rd Regional Support Commands—that deployed to Afghanistan with their authorized medical personnel but did not have enough medical personnel to provide full support to their convoys and forward locations. In response, Task Force 62nd Medical Command in Afghanistan requested additional forces for these two brigades. Officials told us that DOD met this requirement by deploying 22 Air Force medics to Afghanistan.

Additionally, medical officials in Iraq and Afghanistan told us that they must consider two operational limitations which affect how many medical personnel they formally request. First, the cap on the total number of U.S. forces allowed in Iraq and Afghanistan requires theater commanders to balance the number of medical personnel they request with many other types of forces needed to conduct and support ongoing operations. For instance, officials in Afghanistan told us that when they initiate requests for additional personnel, the requesting unit is asked to offset the increase in forces on a one-to-one basis within the unit. If they are unable to do so, operational and medical officials determine if the request for additional medical forces takes precedence over the need for other types of personnel already in theater, and if so they decide which personnel will redeploy out of theater to stay within the authorized force cap. Second, shortages of and high demand for medical personnel in certain specialties also plays a role in decisions about whether to request medical forces. For example, officials in Iraq determined that 16 additional veterinary food inspectors were needed for food safety inspections, but they did not formally initiate that request due to the current shortage of these specialists.

The Level of Care That Deployed DOD Civilian Employees Can Expect in Theater is Unclear

Although DOD primarily provides both emergency life-saving medical care as well as routine medical care to U.S. military personnel in Iraq and Afghanistan, it is unclear what level of routine medical care deployed DOD civilian employees can expect in theater. DOD relies on its own deployed civilians to carry out or support a range of essential missions, including logistics support, maintenance, intelligence collection, criminal investigations, and weapon systems acquisition. About 2,600 DOD civilian employees were deployed to Iraq, and about 2,000 DOD civilian employees were deployed to Afghanistan according to DOD's April 2010 report⁹ to Congress on medical care for injured or wounded deployed U.S. federal civilians. In response to congressional interest, DOD reviewed the department's existing policies for medical care for DOD deployed civilians and federal civilian employees that might be injured or wounded in support of contingency operations and reported to Congress on the results in April 2010. DOD noted in its report that with each new mission, the need for new civilian skills has resulted in an increase in the number of deployed civilians and that these civilians are not immune to the dangers associated with contingency operations, since they too incur injuries or wounds in their efforts to support the missions in Iraq and Afghanistan.

Although DOD guidance clearly provides that deployed DOD civilians will receive life-saving emergency care, it is unclear to what extent DOD civilians can expect routine medical care in theater because a DOD directive and theater guidance differ with regard to their eligibility for routine medical care. Specifically, DOD Directive 1404.10¹⁰ states that the department's civilian employees who become ill, are injured, or are wounded while deployed in support of U.S. military forces engaged in hostilities are eligible to receive health care treatment and services at the same level and scope provided to military personnel. However, theater guidance for Iraq and Afghanistan,¹¹ which provides detailed information on medical care to deployed civilians, among others, states that DOD civilians are eligible for emergency care but most routine care for them is subject to availability. This differs from the DOD directive that states care should be at the same level and scope provided to military personnel.

⁹Department of Defense, *Report to Congress, Medical Care for Department of Defense and Non-Department of Defense Federal Civilians Injured or Wounded in Support of Contingency Operations*.

¹⁰DOD Directive 1404.10, *DOD Civilian Expeditionary Workforce* (Jan. 23, 2009).

¹¹U.S. Forces-Iraq Operational Order 10-01, Annex Q, Appendix 2, Tab A (Jan. 1, 2010) and Task Force 62nd Medical Base Order 10-02, Annex Q, Appendix 4, Tab D (Aug. 5, 2010).

In addition, we found that the theater guidance document for care in Afghanistan¹² provided additional guidance that is inconsistent with both the DOD directive and with guidance provided elsewhere in the document as to the level of care to be provided to DOD deployed civilians. Specifically, one section of the guidance stated routine care for all civilians was to be provided subject to availability while another section of the same guidance stated routine care was to be provided for deployed DOD civilians in accordance with a previous issuance of DOD Directive 1404.10.¹³ The previous version of DOD Directive 1404.10 indicated that civilians designated as emergency essential employees would be eligible for care at the same scope provided to military personnel, while the current January 2009 DOD directive extends the provision of routine medical care to a much wider group of DOD deployed civilians.

Medical officials in Afghanistan told us that they provide routine medical care to U.S. federal civilians on a space-available basis, and that they would not turn away any person with injuries that presented a danger to life, limb, or eyesight, regardless of the employment status of an individual. This issue has received continuing congressional interest. For example, in April 2008 the House Armed Services Committee Subcommittee on Oversight and Investigations issued a report on deploying federal civilians and addressed the medical care provided to them when they are wounded, ill, or injured while in a war zone.¹⁴ Furthermore, DOD's report to Congress on deployed DOD civilians stated that the department believes it is imperative that each federal civilian understands where, when, and how they can receive medical treatment in theater. Although we did not learn of any deployed DOD civilians being turned away from receiving routine care in theater during the time of our review, officials in theater said it could be a concern if the number of DOD civilians that deploy increases, and that theater medical officials would assess the impact of any increase on the planning process for determining medical personnel requirements. However, if theater officials concluded that they needed more medical personnel due to increases in numbers of

¹²Task Force 62nd Medical Base Order 10-02, Annex Q, Appendix 4, Tabs B and D (Aug. 5, 2010).

¹³DOD Directive 1404.10, *Emergency-Essential (E-E) DOD U.S. Citizen Civilian Employees* (Apr. 10, 1992).

¹⁴U.S. House of Representatives, Committee on Armed Services, Subcommittee on Oversight and Investigations, *Deploying Federal Civilians to the Battlefield: Incentives, Benefits, and Medical Care* (April 2008).

DOD deployed civilians, we recognize that an increase in medical resources would have to be balanced against other high-priority needed resources due to the force cap limiting the overall numbers of military personnel that can be in theater. For example, the former commander who oversaw military medical units in Afghanistan noted to us that while there is no medical-specific force cap, including a limit on the number of medical personnel within the larger force cap, any additional military personnel needed in theater must be balanced by the loss of other military personnel in other areas, such as a transportation unit, and that the force cap has played a role in their decisions in determining medical personnel requirements. Additionally, the current commander who oversees military medical units in Afghanistan stated that local base commanders can request additional medical personnel if they believe that the number of U.S. soldiers or civilians merits an increase. The official stated that an increase of about 800 to 1500 civilians would have to occur before they would consider revising military medical personnel requirements. At the conclusion of our audit, an Army official agreed that if there is an inconsistency between departmental guidance and theater guidance, it should be examined. As long as theater guidance differs from the requirements of departmental directives, uncertainty about deployed civilians' eligibility for routine care in theater will remain and the military medical personnel requirements planning process may not be fully informed by department-level expectations.

Medical Units Are Being Reconfigured to Provide Advanced Emergency Care More Quickly and Over Broader Geographical Areas, but Army Doctrine Does Not Fully Reflect These Reconfigurations

Theater commanders in Iraq and Afghanistan are providing quicker access to advanced emergency medical care by placing more medical units in more geographical areas to save lives. However, Army doctrine,¹⁵ which is the starting point for defining and planning a unit's capabilities, has not been updated fully to reflect these changes in theater. Also, the organizational design¹⁶ of these medical units used in theater, which indicates the number and mix of skilled medical personnel these units should have, has not been updated to reflect current practice in theater. Specifically, commanders in Iraq and Afghanistan have been splitting or reconfiguring medical units typically designed to operate in one location into multiple smaller units to cover a wider geographical area. For example, as of December 2009 the Task Force 28th Combat Support Hospital in Iraq—a field hospital typically designed to be in one location—was split to be at three separate sites in Iraq—Baghdad, Tallil, and Al Kut—to better cover this large operational area. Theater medical commanders split these units because they found that the field hospital's standard design configuration was no longer suitable for the model of care that has evolved in Iraq, which requires access to more advanced medical care—particularly surgical care—over large geographical distances to better save lives.

Splitting medical units, such as level 3 combat support hospitals and level 2 forward surgical teams, in order to locate them in more areas increases the opportunities to provide advanced emergency care quicker and could save more lives. According to documents from the 28th Combat Support Hospital, the number of surgical sites has increased due to the emphasis on providing troops access to surgical care within 60 minutes of being injured. DOD has stated that by providing advanced life-saving emergency medical care quicker, generally within 60 minutes of injury, survival rates increase significantly. In fact, studies show that for those severely injured or wounded, 90 percent do not survive if advanced medical care is not provided within 60 minutes of injury, thus creating urgency for rapid access to the wounded.

¹⁵Doctrine describes how DOD fights, trains, and sustains its forces and is generally the starting point for assessing capabilities. According to an Army official, doctrine includes publications such as Field Manuals and Tactics, Techniques, and Procedures.

¹⁶Organization refers to the design of units—how many and what types of personnel and materiel (equipment) a unit needs to provide a specific capability—and is defined by their Table of Organization and Equipment.

Medical officials in Iraq acknowledged that Army doctrine and the organizational design of medical units were top issues that needed to be updated to better reflect the current practice of splitting medical units such as combat support hospitals. For example, in a December 2009 Mid-Tour Report, the Task Force 1st Medical Brigade—the medical unit that provided oversight over medical units in Iraq before being replaced by Task Force 807th Medical Brigade—noted that the organization for combat support hospitals, including the list of needed medical specialties, should be redesigned to reflect the actual use of combat support hospitals across multiple locations and that certain lessons learned could be considered in the redesign. Specifically, Task Force 1st Medical Brigade reported that splitting full-sized combat support hospitals into smaller parts can create medical personnel gaps in certain specialties, including those related to the operation of pharmacies, laboratories, and patient administration. The medical brigade’s report also went on to note that personnel with these smaller combat support hospitals are spread so thinly that when personnel take leave or are evacuated out of theater due to injury, the medical brigade has to make difficult decisions on where to find needed personnel to mitigate coverage gaps. Given these lessons learned, officials with the Task Force 1st Medical Brigade told us that they were concerned about outdated policies, guidance, doctrine, and field manuals related to the determination of medical personnel requirements in theater and stated specifically that the current design of combat support hospitals is not flexible enough to accomplish what they are now being asked to do. As such, they now have to continuously use what is referred to as specialized personnel documents to manage staffing rather than staff as indicated in established doctrine and the organization design of these units. Specifically, officials with the Task Force 1st Medical Brigade noted to us that staffing of medical units is now done in a “very non-doctrinal fashion” and that they had similar concerns about splitting area support medical companies and using them in theater in a non-doctrinal fashion, given these area support medical companies now function as two separate level 2 troop medical clinics when they are staffed to function as one. Finally, the Task Force 1st Medical Brigade report went on to recommend that the organizational composition of combat support hospitals be redesigned to include redundant capability to accommodate expected attrition in staff.

Additionally, officials with the U.S. Forces-Iraq Surgeon Office told us in a separate interview that medical doctrine, specifically the organizational design for both personnel and equipment, should be assessed and updated given the current experience in Iraq. These officials said that the splitting of combat support hospitals and forward surgical teams has gained

acceptance over time but should be examined given how counterinsurgency doctrine is implemented in Iraq. These officials with the Surgeon Office in Iraq also said that flexibility in the doctrine is critical, but that doctrine needs to reflect the realities of operations on the ground and the degree to which current practice of splitting medical units has filtered into medical doctrine has been limited.

Recognizing these lessons learned in an environment that is continuing to evolve to provide advanced medical care to save more lives, officials with the Army Medical Department Center and School who are responsible for updating medical doctrine and the organizational design of medical units recently updated the forward surgical team field manual, noting that changes in the number and mix of specialists that make up a forward surgical team might be necessary if such teams are to operate as smaller stand-alone units. However, the updated manual did not specifically suggest what those changes in the number and mix of medical specialists that make up a forward surgical team should be if the team is providing advanced emergency care as a stand-alone unit. We were told that Army planners have adjusted medical personnel requirements for forward surgical teams to account for changes in these smaller nonstandard medical unit reconfigurations by increasing the number of personnel assigned to those units, but the updated field manual still does not specify what the number and mix of medical specialists should be. Furthermore, by splitting or dividing the standard traditional design for combat support hospitals, DOD has also had to adjust the number and mix of medical personnel in those units as well. Instead of relying on the standard traditional doctrine design for medical units in theater, Army medical officials have been developing specialized personnel documents to staff these medical units to identify the medical skill sets now needed to operate split medical units across multiple locations for counterinsurgency operations. Specifically, officials with the Task Force 1st Medical Brigade told us these specialized personnel documents allow for more up-to-date establishment of personnel requirements to address gaps caused by splitting medical units. However, the process is difficult and it came about because current doctrine and organizational design were not sufficient to address the capabilities needed for splitting medical units such as combat support hospitals and area support medical companies.

Although the Army medical officials we spoke with said that they believe splitting and reconfiguring units in theater is necessary and helps to increase survival rates by providing advanced life-saving emergency medical care generally within 60 minutes of injury, the Army has not fully

incorporated these current practices into Army doctrine and organizational documents, which ordinarily determine the size, composition, and use of these units. In response to a draft of this report, DOD explained to us that Army leadership has recognized that split hybrid operations and the dispersed environment in the theater of operations have generated a requirement for additional medical structure. According to an Army regulation, the Army maintains a lessons learned program to, among other things, systematically update Army doctrine to enhance the Army's preparedness to conduct current and future operations.¹⁷ By updating Army doctrine and organizational documents for the design of medical units that could be used in other theaters, the Army could benefit from incorporating its lessons learned, where appropriate, and be better assured the current practice of splitting medical units to quickly provide advanced life-saving emergency medical care to those severely injured or wounded does not lead to unnecessary staffing challenges.

Theater Commanders Have Used Two Approaches for Filling Medical Personnel Gaps

When medical personnel gaps unexpectedly arise in Iraq or Afghanistan, Army commanders have used two approaches to fill those gaps, according to medical officials in theater. Gaps in medical capabilities can occur when medical providers do not deploy as expected for reasons such as resignation, or a medical provider is determined to be medically nondeployable. Medical personnel gaps can also occur when individual medical personnel need to leave the unit for reasons such as an emergency situation at home or if they become seriously sick or injured in theater. According to medical officials in theater, when these gaps occur, Army commanders have used two approaches to fill these gaps: backfilling and cross-leveling.

- Backfilling involves the identification and deployment of medical personnel into theater from the United States or elsewhere who were not originally scheduled to deploy overseas at that time, according to medical officials in theater. For example, a dentist assigned to a brigade combat team in southern Iraq was evacuated out of theater for medical reasons. Given the backlog of needed dental work, commanders expressed concern about losing a dentist. In response, Army Forces Command initiated an effort to identify another dentist not in Iraq who was eligible to deploy to fill this need. DOD officials

¹⁷Army Regulation 11-33: *Army Lessons Learned Program* (Oct. 17, 2006).

told us that selecting and deploying an active component medical provider to backfill a position typically takes about 45 days.

- Cross-leveling involves the temporary relocation of personnel from one unit in theater to another, according to DOD officials. Medical officials in theater told us that cross-leveling is often used as an interim measure to minimize risk when a gap in medical personnel coverage occurs. For example, an operating room nurse assigned to a forward surgical team in Iraq had an unexpected medical situation and was evacuated out of theater. It was critical that this personnel requirement be filled in a timely manner, given that the forward surgical team was staffed with only one operating room nurse. Theater officials requested a replacement from U.S. Army Forces Command and U.S. Army Reserve Command, but the individual identified as a replacement could not deploy for at least 30 days. Recognizing the high priority need for a forward surgical team to have an operating room nurse, Task Force 1st Medical Brigade identified an operating room nurse that it could borrow from another unit in theater until the replacement arrived. After the replacement nurse arrived in theater, the operating room nurse on loan returned to the unit the individual came from.

Personnel gaps that occur in theater cannot always be prevented and when gaps do occur, theater commanders assess the risk associated with the gap and decide on an appropriate course of action, according to officials with Task Force 1st Medical Brigade. Cross-leveling in particular requires the assessment of risk associated with the personnel gap and the gap that would be created by the relocation of a medical provider from another unit. According to theater commanders we spoke with, cross-leveling, while temporary, is not an ideal solution and can present risk to medical operations in theater, especially when conducted on a recurring basis. We recognize that risk cannot be eliminated; it can only be managed. Army officials told us that they are willing to accept some risks in order to mitigate other risks they believe are higher.

According to medical officials, when medical personnel gaps in an Army reserve component medical unit occur, it can be challenging to fill the gap

before the start of the next 90-day rotation,¹⁸ given it can take around 120 to 180 days to identify, notify, and then mobilize an Army reservist to fill an unfilled requirement by which time the next expected 90-day medical provider has already arrived. The Army's 90-day rotation policy—while intended to ease the financial burden of deploying reserve medical personnel and help retain them—has presented some challenges for the Army in quickly filling these gaps when a medical provider is not able to deploy. For example, the 915th Forward Surgical Team—an Army reserve medical unit—was authorized to deploy to Iraq in September 2009 with three general surgeons, according to theater medical officials. Instead, it deployed with only one surgeon for the first 90-day rotation, despite efforts to identify two other deployable general surgeons. The Army Reserve identified a doctor to fill one of the two vacancies; however this individual could not deploy due to an inability to be credentialed as a general surgeon. The Army Reserve then identified another surgeon for deployment, but this individual had educational requirements issues, and yet a third identified surgeon resigned. By the time the Army Reserve was able to identify a surgeon who could deploy, the 915th Forward Surgical Team had been in Iraq for a month out of its first 90-day rotation. Further, the Army was unable to identify the third authorized surgeon for the 915th Forward Surgical Team before the end of that 90-day rotation given another identified surgeon scheduled for deployment resigned, and the replacement surgeon turned out to be nondeployable for medical reasons. In fact, the 915th Forward Surgical Team did not have one out of its authorized three general surgeons for the first three 90-day rotations—approximately 270 days. Moreover, the 915th Forward Surgical Team was expected to operate as two smaller units at two separate locations in southern Iraq, but it was unable to provide surgical capabilities in both locations as expected without three authorized general surgeons. As a result of the personnel gaps, Task Force 1st Medical Brigade temporarily relocated medical personnel already in theater from other medical units to the 915th Forward Surgical Team so it could meet its mission.

¹⁸Personnel in the Army reserve component medical corps, dental corps, and nurse anesthetists are to be deployed in theater for no longer than 90 days at a time unless the individual volunteers for a longer deployment, according to the Army's 90-day rotation policy (Assistant Secretary of the Army (Manpower and Reserve Affairs) Memorandum, *Army Medical Department Reserve Components' 90-day Rotation Policy*, Oct. 2, 2003). This policy was developed after a DOD study found that physicians could deploy for up to 90 days without substantial financial impact to their civilian medical practices. Typically, the Army would need to deploy four different reserve component medical providers for successive 90-day rotations to fill a single 1-year personnel requirement.

Although we found examples of the 915th Forward Surgical Team not having all of its medical personnel before the end of each 90-day rotation, Army data show the magnitude of these unfilled gaps or late arrivals for the reserve components ranged from about 3 percent to 7 percent from January 2008 to July 2010. Specifically, Army data showed that about 4 percent of mobilized Army reserve component 90-day medical rotators (21 medical providers out of 594) did not deploy to theater or arrive in theater on time for 2008. In 2009, that figure reached 7 percent (38 medical providers out of 519) and through the first 6 months of 2010, this figure was over 3 percent (8 medical providers out of 236).¹⁹ Unfilled reserve component personnel requirements can have serious consequences depending on the needed medical specialty. Therefore, medical commanders in theater typically cross-level to fill short-term temporary personnel gaps, although medical officials in Iraq we spoke with said cross-leveling is a less than ideal approach to fill these medical personnel gaps.

Conclusions

DOD has continued to assess its need for medical personnel in theater based on the requirements of the mission and a variety of medical data and has made adjustments to meet specific theater needs to achieve the goal of providing advanced life-saving care quickly. DOD has noted that, increasingly, deployed civilians also face dangerous circumstances in ongoing contingency operations. While DOD has stated that deployed civilians will receive emergency care whenever needed, the extent of routine medical care available to DOD deployed civilians is unclear due to inconsistent guidance. Inconsistent guidance could potentially impact the medical personnel requirements planning process if medical officials in theater are uncertain about deployed DOD civilian employees' access to routine medical care. While we did not learn of any deployed DOD civilians being turned away for medical care in theater during the time of our audit, DOD could still benefit by assessing the implications the inconsistencies in guidance could have if there were a sizeable increase in the number of DOD deployed civilians in theater.

Conducting counterinsurgency operations in often uncertain, dangerous environments such as Iraq and Afghanistan, Army theater commanders have reconfigured the composition of field hospitals and forward surgical

¹⁹These figures include deployments to Iraq and Afghanistan, as well as deployments to Kuwait, Kosovo, and Africa.

teams by breaking them down into smaller stand-alone units to better position them to give the severely wounded or injured, such as the casualties of blast-type injuries, the advanced emergency medical care needed to save lives. By being in more geographical areas, these critical life-saving medical units are better able to achieve their goal of providing advanced emergency medical care within 60 minutes of injury to increase survival rates. Acknowledging the current practice of splitting medical units, the medical brigade that provided oversight over medical units in Iraq reported that one of its top issues was advocating for updates to the doctrine and organizational redesign of these split units that govern its use and personnel allocation. By leveraging lessons learned collected from this practice, especially the needed number and mix of medical personnel, the Army could benefit from integrating these lessons systematically into Army doctrine and the design of these medical units. Updating doctrine and organizational design of these split medical units used in theater could help to assure that these units will be resourced with the needed number and mix of medical personnel to continue providing critical life-saving capabilities for counterinsurgency operations in other theaters and in the future.

Recommendations for Executive Action

To better understand the extent to which deployed DOD civilian employees have access to needed medical care, as appropriate, we recommend that the Secretary of Defense direct the Combatant Commander of U.S. Central Command to clarify the level of care that deployed DOD civilian employees can expect in theater, including their eligibility for routine care.

To enhance medical units' preparedness to conduct current and future operations given the changing use of combat support hospitals and forward surgical teams in Iraq and Afghanistan, we recommend that the Secretary of the Army direct the Army Medical Department to update its doctrine and the organization of medical units concerning their size, composition, and use.

Agency Comments and Our Evaluation

In written comments provided in response to a draft of this report, DOD generally concurred with our findings and recommendations. DOD fully concurred with our first recommendation that the department clarify the level of care that deployed DOD civilian employees can expect in theater. DOD partially agreed with our second recommendation that the Army Medical Department update its doctrine and the organization of medical units concerning their size, composition, and use. DOD noted that there is an unquestionable need to formally update doctrinal publications. DOD

also noted that the Army is constantly reviewing and assessing medical capability, the use of those capabilities and the organization of medical units, and updating doctrine to evolving staffing requirements. As an example, DOD mentioned in its official response that a recent review of medical capability indicated the need for additional medical personnel, and the Army responded with guidance to increase the number of enlisted health care specialists assigned to Army Brigade Combat Teams. The department also noted that the Army continues to capture lessons learned and input from commanders to ensure use of medical personnel meets requirements. We recognize that the Army continues to capture lessons learned and input from the commanders, and we noted in our report that the Army Medical Department Center and School has updated its forward surgical team field manual although updates to this field manual did not specifically note changes in the number and mix of medical specialists that make up a forward surgical team if the team is providing advanced emergency care as a stand-alone unit. Thus, we still believe the Army would benefit by fully updating the organization of medical units concerning their size, composition and use, as applicable, to incorporate current practices of splitting and reconfiguring deployed medical units in theater. DOD also provided technical comments that we incorporated as appropriate.

We are sending copies of this report to the Secretary of Defense, the Secretary of the Army, and appropriate DOD organizations. In addition, this report will be available at no charge on GAO's Web site at <http://www.gao.gov>. If you or your staffs have any questions about this report, please contact me at (202) 512-3604 or by e-mail at farrellb@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to the report are listed in appendix IV.



Brenda S. Farrell
Director, Defense Capabilities and Management

List of Committees

The Honorable Carl Levin
Chairman
The Honorable John McCain
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Daniel K. Inouye
Chairman
The Honorable Thad Cochran
Ranking Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

The Honorable Howard P. McKeon
Chairman
The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

The Honorable C.W. Bill Young
Chairman
The Honorable Norman D. Dicks
Ranking Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

Appendix I: Scope and Methodology

We examined the Department of Defense's (DOD) efforts to identify and fill its military medical personnel requirements in support of operations in Iraq and Afghanistan. Specifically, we evaluated the extent to which (1) DOD has assessed its need for military medical personnel in Iraq and Afghanistan, (2) the Army has adapted the composition and use of its medical units to provide advanced medical care, and (3) the Army fills medical personnel gaps that arise in theater. During our evaluation, we contacted DOD and service officials, including officials from United States Forces-Iraq and United States Forces-Afghanistan; U.S. Central Command; U.S. Joint Forces Command; Joint Staff; Office of Secretary of Defense for Health Affairs; Offices of the Surgeons General for the Army, the Navy, and the Air Force; and U.S. Marine Corps Headquarters.

For the first objective—to evaluate the extent to which DOD has assessed its need for military medical personnel in Iraq and Afghanistan to support ongoing operations—we analyzed DOD and service policies and processes that govern the determination of medical personnel requirements, including service doctrine, DOD guidance, and current theater-level guidance regarding medical care in Iraq and Afghanistan. Specifically, we compared a current DOD directive regarding medical care for DOD civilian employees and theater-level guidance regarding medical care for U.S. federal civilians, including DOD civilian employees, and noted how they differed. To augment our analysis, we interviewed officials, including representatives from the theater medical task forces and Surgeons' offices in Iraq and Afghanistan about how they assess their military medical personnel needs in Iraq and Afghanistan and possible effects of differences in guidance that govern medical care in theater.

For the second objective—to evaluate the extent to which the Army has adapted the composition and use of its medical units to provide advanced medical care in Iraq and Afghanistan—we reviewed reports from the medical task forces in theater, Army documentation of the composition of medical units in Iraq and Afghanistan, theater-level publications regarding medical care in Iraq and Afghanistan, Army medical doctrine, and Army field manuals for medical units. We interviewed officials, including officials with the medical task forces and Surgeons' offices in Iraq and Afghanistan about the current use and composition of medical units in theater, and the extent to which they are captured within official Army documentation of doctrine and the organization of medical units. In addition, we interviewed representatives from the Army Medical Department Center and School, Directorate of Combat and Doctrine Development about the relevance of doctrine and the organization of medical units and the role lessons learned in Iraq and Afghanistan might

play in any plans to update doctrine and the organization of medical units in the future.

For the third objective—evaluate the extent to which the Army fills medical personnel gaps that arise in Iraq and Afghanistan—we reviewed the approaches used by Army theater medical commanders to meet medical personnel requirements when gaps in needed personnel coverage occurred and interviewed officials with the theater-level medical task forces and Surgeons’ offices in Iraq and Afghanistan regarding reasons why unexpected medical personnel needs arose and the approaches used to address those needs in theater. When possible, we obtained and reviewed supporting documentation, and interviewed other officials involved in these efforts, including officials with the U.S. Army Forces Command, to fill unexpected medical personnel needs in theater. We also reviewed policies and guidance for meeting medical personnel needs that arise in theater for both the active and reserve components, specifically the Army’s 90-day deployment policy for reservists applicable to physicians, dentists, and nurse anesthetists. To determine the extent to which the Army’s reserve component medical units deployed their authorized medical personnel in 2008, 2009, and through the first 6 months of 2010 to Iraq and Afghanistan, we reviewed Army’s deployment data on late deployments of medical providers from the reserve components. We assessed the reliability of the data by interviewing the agency official responsible for manually collecting and summarizing the data. We determined that the data were sufficiently reliable for the purposes of this report.

Additionally, to better understand how military medical personnel requirements are met, we obtained information on DOD’s Global Force Management process and how the services identify medical units and personnel to fill these requirements. We interviewed officials with the Joint Staff, U.S. Joint Forces Command, and the military services’ force providers to include U.S. Army Forces Command, U.S. Fleet Forces Command, U.S. Air Combat Command, and U.S. Marine Forces Command, as well as officials with the Army Medical Command, the Navy Bureau of Medicine and Surgery, and the Air Force Personnel Center about their processes for filling in-theater military medical personnel requirements. For a more comprehensive listing of the organizations and offices we contacted, see table 1.

Table 1: Organizations and Offices Contacted During Engagement

Name of organization or office	Location
Air Force	
Air Combat Command Headquarters	Langley Air Force Base, VA
Air Force Office of the Surgeon General	Washington, D.C.
Air Force Medical Service	Washington, D.C.
Air Force Personnel Center	Washington, D.C.
Air Force Central Command	Washington, D.C.
Air National Guard	Washington, D.C.
Army	
Army Central Command	Fort McPherson, GA
Army Forces Command	Fort McPherson, GA
Army Medical Command	San Antonio, TX
Army Medical Department	San Antonio, TX
Army Office of the Surgeon General	Falls Church, VA
Army Reserve Command	Fort McPherson, GA
Army Reserve Office of the Chief	Washington, D.C.
Army National Guard	Arlington, VA
Marine Corps	
Marine Corps Forces Command	Norfolk, VA
Marine Corps, Headquarters	Washington, D.C.
Navy	
U.S. Fleet Forces Command	Norfolk, VA
Navy Office of the Surgeon General	Falls Church, VA
Navy Bureau of Medicine and Surgery	Washington, D.C.
Office of the Chief of Naval Operations	Washington, D.C.
Office of the Secretary of Defense	
Office of the Assistant Secretary of Defense, Health Affairs	Washington, D.C.
Office of the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness	Washington, D.C.
Other Department of Defense Organizations	
Central Command Office of the Surgeon General	Tampa, FL
Joint Chiefs of Staff	Washington, D.C.
Joint Forces Command	Norfolk, VA
Task Force 1 st Medical Brigade	Iraq
Task Force 807 th Medical Brigade	Iraq
Task Force 30 th Medical Command	Afghanistan
Task Force 62 nd Medical Command	Afghanistan

Source: GAO.

We conducted this performance audit from August 2009 through January 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: The Global Force Management Process and Service Processes to Identify and Select Medical Personnel to Fill Requirements for Deployment to Iraq and Afghanistan

The Department of Defense (DOD) uses its Global Force Management process to meet its requirements, including those for medical personnel and units. For ongoing operations, this process periodically examines requirements for rotational forces as well as emerging requirements as they arise. In addition, the services each use unique yet similar processes to identify and select medical units and personnel to fill requirements for Iraq and Afghanistan.

DOD's Global Force Management Process

DOD designed the Global Force Management process to provide insight into the global availability of U.S. military forces. For the rotational force management process, requirements are identified 2 years in advance. The rotational force management process is facilitated through Global Force Management Boards, which are typically held on a quarterly basis. The Global Force Management Board brings together general officers from interested parties—Office of the Secretary of Defense, the Joint Staff, the combatant commanders, the services, and the joint force providers—to specifically lay out known requirements, review and endorse sourcing recommendations and associated risk and risk mitigation options, and then to prioritize and meet the requirements as appropriate. The product of these Global Force Management Boards is the Global Force Management Allocation Plan, a document that is approved by the Secretary of Defense, which authorizes force allocations and deployment of forces in support of combatant commander rotational requirements. In both Iraq and Afghanistan, medical personnel and unit requirements are included in the Global Force Management Allocation Plan, which provides an approach for U.S. Central Command, the services, and the services' force providers¹ to manage the sourcing of rotational requirements, including requirements for medical personnel and units, such as the Balad Theater Hospital in Iraq or a combat support hospital in Afghanistan.

For requirements, including medical personnel and units, that are not known in advance, DOD used the emergent force management process extensively to meet requirements through requests for forces. Generally, the parties involved in this process have separate, sequential roles in the process. Requests for forces are generated by combatant commanders and

¹Army Forces Command, Air Force Air Combat Command, Navy Fleet Forces Command, and Marine Corps Forces Command are the force providers for medical personnel and units.

submitted to the Joint Staff for validation,² and then to the joint and service force providers³ to identify potential sourcing solutions to fill requirements before being transmitted to the Secretary of Defense for approval. In sourcing requests through the emergent process, requirements are prioritized according to a force allocation decision model.⁴ While emergent requirements are considered within the model's general framework, each request for forces is individually evaluated as it is received, meaning that officials focus on whether or not forces are ready and available to fill the request rather than trying to determine the relative priority of the request, as is done at the Global Force Management Boards for rotational requirements. As part of providing and evaluating potential solutions for the request for forces, the services' force providers often conduct risk assessments to provide information on the availability and readiness of both active and reserve forces. These risk assessments include violations of the services' rotation policies regarding the required time at home for servicemembers and the impact to current missions and operations, such as the staffing of U.S. military treatment facilities in the case of medical personnel, if a service is selected to meet the requirement. In addition, each of the services maintains a list of specialties that are in high demand relative to available personnel. All of the services identified critical care nurse, physician assistant, psychiatry, and clinical psychology as high-demand specialties.

²According to the Global Force Management Implementation Guidance for FY 2010-2011, validation may include the following: (1) prioritization of requirements in relation to other existing priorities; (2) capability and/or force availability guidance on alternate sourcing strategies to include coalition, DOD, or other options; (3) any required legal and policy review; (4) latest arrival date feasibility assessment; and (5) sourcing method suitability including evaluating alternative sourcing processes.

³The President has designated U.S. Joint Forces Command as the primary joint force provider for conventional forces. As such, it is responsible for identifying and recommending sourcing solutions in coordination with the military departments and other combatant commands. U.S. Joint Forces Command service components are responsible for identifying and recommending their respective service's sourcing solutions to the Joint Forces Command and serve as the primary contact for all service sourcing matters. While Joint Forces Command is the primary joint force provider for conventional forces, U.S. Transportation Command, U.S. Strategic Command, and U.S. Special Operations Command are also joint force providers.

⁴In 2008, DOD issued its Guidance for Employment of the Force, which attempted to balance the competing priorities of ongoing operations with other validated needs, including the needs for homeland defense and rapid response capabilities.

Service Processes to Identify and Select Medical Personnel to Fill Requirements

The services use unique yet similar processes to identify and select medical units and personnel to fill requirements for Iraq and Afghanistan.⁵ Once the Secretary of Defense designates a service to meet an emergent or rotational requirement, the service's force provider then begins the process of filling the requirement with personnel. While the procedures and systems used by each service to select the appropriate medical personnel vary, the services' processes for filling requirements all result in a unit and its personnel deploying to an operational theater to carry out a mission. The identification of individual medical personnel to fill the requirements is important because medical personnel across the services typically are assigned to fixed military treatment facilities caring for active duty personnel, their dependents, and retirees. However, in wartime, each service's medical personnel processes allow for the deployment of medical personnel from fixed military treatment facilities to support contingency operations, such as Iraq and Afghanistan, while considering potential impacts on the medical mission of the fixed military treatment facilities. In addition, the processes attempt to distribute the burden of deployments within and across medical specialties (e.g., orthopedic surgeons, critical care nurses, and psychiatrists), to comply with service guidelines, such as required time at home for servicemembers, to maintain a healthy inventory of medical specialists.

⁵These processes include the Army's Professional Filler System, the Navy's Health Services Augmentation Program, and the Air Force's Air and Space Expeditionary Force methodology for deployment. The Navy provides almost all medical personnel to support the Marine Corps through the Navy's Health Services Augmentation Program.

Appendix III: Comments from the Department of Defense



HEALTH AFFAIRS

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

Ms. Janet St. Laurent
Management Director
Defense Capabilities and Management
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

JAN 26 2011

Dear Ms. St. Laurent:

This is the Department of Defense (DoD) response to the GAO Draft Report, "GAO-11-163C, "MILITARY PERSONNEL: DoD Addressing Challenges in Iraq and Afghanistan but Opportunities Exist to Enhance the Planning Process for Medical Personnel Requirements," dated January 2011 (GAO #351393).

Thank you for the opportunity to review the draft report and provide comments. Overall, I concur with the findings and recommendations. My specific comments on the draft report recommendations are attached. I would like to specifically address that the title and scope of this report does not agree. The report title and opening comments state "DoD" and "medical personnel requirements" yet the focus of the report is clearly on Army (and Army Reserve) medical personnel requirements. Recommend the verbiage in the report more accurately reflect the actual scope and remove references to "DoD" in favor of "Army" or "Army Reserve."

My points of contact on this issue are Mr. Mike Hopper (Functional) who can be reached at (703) 681-3900 or Mr. Gunther Zimmerman (Audit Liaison) who can be reached at (703) 681-4360.

Sincerely,

A handwritten signature in black ink, appearing to read "George Peach Taylor, Jr.", written over a horizontal line.

George Peach Taylor, Jr., M.D.
Acting Principal Deputy

Enclosure
As stated

GAO DRAFT REPORT DATED JANUARY 2011
GAO-11-163C (GAO CODE 351393)

**“MILITARY PERSONNEL: DoD Addressing Challenges in Iraq and Afghanistan but
Opportunities Exist to Enhance the Planning Process for Medical Personnel Requirements,”**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATION**

RECOMMENDATION 1, DOD RESPONSE: Concur.

RECOMMENDATION 2, DOD RESPONSE: Partially concur. The Army is constantly reviewing capability and doctrine to evolving manpower requirements. As an example, a recent review of medical capability indicated the need for additional medical manning and the Army responded with guidance to increase the number of enlisted Health Care Specialists assigned to Army Brigade Combat Teams. It is unnecessary to direct such a review, as the Army continues to capture lessons learned and input from commanders to ensure employment of medical assets to meet requirements. There is however, an unquestionable need to formally consolidate and update doctrinal publications. The following suggested is offered to replace the current recommendation: “...we recommend that the Secretary of the Army direct the Army Medical Department to continue to assess medical capabilities, employment of those capabilities and the organization of medical units; updating doctrine as warranted.”

Appendix IV: GAO Contacts and Staff Acknowledgments

GAO Contact

Brenda S. Farrell, (202) 512-3604 or farrellb@gao.gov

Acknowledgments

In addition to the contact above, Laura Talbott, Assistant Director; John Bumgarner; Susan Ditto; K. Nicole Harms; Stephanie Santoso; Adam Smith; Angela Watson; Erik Wilkins-McKee; Michael Willems; and Elizabeth Wood made major contributions to this report.

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