The Rebuilding of Military Medicine

It is the neglect of timely repair that makes rebuilding necessary.
Richard Whately, economist and theologian (1787-1863)

Cynthia M.A. Geppert
Editor-in-Chief and Senior Ethicist Veterans Affairs National Center for Ethics in Health Care and Consultation-Liaison Psychiatrist, New Mexico Veterans Affairs Health Care System
Correspondence: Cynthia Geppert (fedprac@mdedge.com)

Fed Pract. 2024;41(9).
Published online September 16.
doi:10.12788/fp.0514

US Congressional inquiry and media attention are so frequently directed at the trials and tribulations of the US Department of Veterans Affairs (VA) that we forget the US Department of Defense (DoD) medical system also shares the federal practitioner space. The focus of the government and press recently has shifted to examine the weaknesses and woes of military medicine. This editorial reviews what that examination discovered about the decline of the DoD house of medicine, why it is in disrepair, proposals for its rebuilding, and reflects on what this trajectory can tell us about maintaining the structure of federal practice.

My father never tired of telling me that he and his medical colleagues returned from the Second World War with knowledge and skills gained in combat theaters that, in many respects, surpassed those of the civilian sector. Though he was biased as a career military physician and combat veteran, there is strong evidence backing the assertion that from World War I to Operations Enduring Freedom and Iraqi Freedom, American military medicine has been the glory of the world.[1]

A November 2023 report from the DoD Office of the Inspector General (OIG) warned that military medicine was in trouble. The report's emphasis on access and staffing problems that endanger the availability and quality of health care services will likely strike a chord with VA clinicians. The document is based on data from OIG reports, hotline calls, and audits from the last several years; however, the OIG acknowledges that it did not conduct on-the-ground investigations to confirm the findings.[2]

When we hear the term military medicine, many immediately think of active duty service members. However, the patient population of DoD is far larger and more diverse. The Military Health System (MHS) provides care to > 9.5 million beneficiaries, including dependents and retirees, veterans, civilian DoD employees, and even contractors. Those who most heavily rely on the MHS are individuals in uniform and their families are experiencing the greatest difficulty with accessing care.[3] This includes crucial mental health treatment at a time when rates of military suicide continue to climb.[4]

The lack of access and dearth of health care practitioners (HCPs) spans both military facilities and the civilian clinics and hospitals where current and former service members and their dependents use the TRICARE beneficiary insurance. Reminiscent of recent challenges at the VA, DoD members are encountering long wait times and the frustrating bureaucracy of inefficient and, at times, inept referral networks. Additionally, many institutions and HCPs will not accept TRICARE because it pays less and has more paperwork than other insurance plans. What is worse, there is currently no governmental leverage to compel them to participate.

As with both the VA and civilian health care spheres, rural areas are the most impacted. Resource shortfalls adversely affect all aspects of care, especially the highly paid specialties like gastroenterology and urology, as well as primary care practitioners essential to ensure the health of military families. The deficits are widespread—all branches report similar obstacles to providing responsive, appropriate care. As if this was not enough to complete the mirror image of the VA's struggles, there is a rising tide of complaints about the military's electronic health record system.[5] How did the preeminent MHS so rapidly decay? Experts in and out of uniform offer several explanations.

As with most forms of managed care, the need to cut costs drove the Pentagon to send military members and dependents to civilian health care systems to have their medical needs addressed. However, this outsourcing strategy was based on a false assumption that the community had enough capacity to deliver services to the many beneficiaries needing them. Nearly every sector of contemporary American medicine is experiencing a drastic shortage of HCPs. Though the resource allocation problems began

before the pandemic, COVID-19 only exacerbated and accelerated them.[6]

This downsizing of military hospitals and clinics led to another predictable and seemingly unheeded consequence. A decrease in complex cases (particularly surgical cases) led to a reduction in the skills of military HCPs and a further flight of highly trained specialists who require a reasonable volume of complicated cases to retain and sharpen their expertise. The losses of those experienced clinicians further drain the pool of specialists the military can muster to sustain the readiness of troops for war and the health of their families in peace.[7]

The OIG recommended that the Defense Health Agency address MHS staffing and access deficiencies noted in its report, including identifying poorly performing TRICARE specialty networks and requiring them to meet their access obligation.[2] As is customary, the OIG asked for DoD comment. It is unclear whether the DoD responded to that formal request; however, it is more certain it heard the message the OIG and beneficiaries conveyed. In December 2023, the Deputy Secretary of the DoD published a memorandum ordering the stabilization of the MHS. It instructs the MHS to address each of the 3 problem areas outlined in this article: (1) to reclaim patients and beneficiaries who had been outsourced or whose resources were constrained to seek care in the community; (2) to improve access to and staffing for military hospitals and clinics for active-duty members and families; and (3) to restore and maintain the military readiness of the clinical forces.[8] Several other documents have been issued that emphasize the crucial need to recruit and retain qualified HCPs and support staff if these aims are to be actualized, including the 2024 to 2029 MHS strategic plan.[9] As the VA and US Public Health Service know, the current health care environment may be a near impossible mission.[10] Although what we know from the history of military medicine is that they have a track record of achieving the impossible.

Disclaimer

The opinions expressed herein are those of the author and do not necessarily reflect those of *Federal Practitioner,* Frontline Medical Communications Inc., the US Government, or any of its agencies.

References

1. Barr J, Podolsky SH. A national medical response to crisis - the legacy of World War II. *N Engl J Med*. 2020;383(7):613-615. doi:10.1056/NEJMp2008512
2. US Department of Defense, Office of the Inspector General. Management advisory: concerns with access to care and staffing shortages in the Military Health System. November 29, 2023. Accessed August 26, 2024. https://www.dodig.mil/reports.html/Article/3602650/management-advisory-concerns-with-access-to-care-and-staffing-shortages-in-the/
3. Management advisory: concerns with access to care and staffing shortages in the Military Health System. News release. US Department of Defense, Office of the Inspector General. November 29, 2023. Accessed August 26, 2024. https://www.dodig.mil/In-the-Spotlight/Article/3602662/press-release-management-advisory-concerns-with-access-to-care-and-staffing-sho
4. US Department of Defense. Annual report on suicide in the military: calendar year 2022. Accessed August 26, 2024. https://www.dspo.mil/Portals/113/Documents/ARSM_CY22.pdf
5. American Hospital Association. Strengthening the Health Care Work Force. November 2021. Accessed August 26, 2024. https://www.aha.org/system/files/media/file/2021/05/fact-sheet-workforce-infrastructure-0521.pdf
6. Ziezulewicz G. DOD watchdog report warns of issues across military health system. *Military Times.* December 6, 2023. Accessed August 26, 2024. https://www.militarytimes.com/news/your-military/2023/12/07/dod-watchdog-report-warns-of-issues-across-military-health-care-system/
7. Lawrence Q. It's time to stop downsizing health care, the Pentagon says. This couple can't wait. *National Public Radio.* April 3, 2024. Accessed August 26, 2024. https://www.npr.org/transcripts/1240724195
8. Mincher R. Military Health System stabilization: rebuilding health care access is critical to patient's well-being. January 22, 2024. Accessed August 26, 2024. https://www.defense.gov/News/News-Stories/Article/article/3652092/military-health-system-stabilization-rebuilding-health-care-access-is-critical/
9. US Department of Defense, Defense Health Agency. Military Health System strategy fiscal years 2024-2029. Accessed August 26, 2024. https://www.health.mil/Reference-Center/Publications/2023/12/15/MHS_Strategic_Plan_FY24_29
10. Jowers K. Pentagon plans to fix 'chronically understaffed' medical facilities. *Military Times.* January 25, 2024. Accessed August 26, 2024. https://www.militarytimes.com/news/your-military/2024/01/25/pentagon-plans-to-fix-chronically-understaffed-medical-facilities/