Dual Allegiance in Military Healthcare

US Air Force and Defense Health Agency Convergence

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Recent congressionally directed changes gave the Defense Health Agency authority, direction, and control of military treatment facilities. But limited authorities resulted in the agency's pursuit of capacity, typically measured via medical productivity standards. The Air Force maintains command authorities to organize, train, equip, and provide capabilities, including medical, to the combatant commander. These dual authorities converge at the military treatment facility, producing a conflict between capacity and capability. Tension, already present due to the dual nature of the mission to provide support and healthcare delivery to beneficiaries, has increased and threatens the Air Force's ability to medically support combat operations, generating risk to the operational mission. With the increasing likelihood and stakes of armed conflict, senior leaders can mitigate the risk to the operational mission by decreasing the tension and risk at Air Force MTFs.

The October 2022 US *National Security Strategy* identified the People's Republic of China (PRC) as "America's most consequential geopolitical challenge."[1] Framed as great power competition, the narrative in the strategy contends China has the ambition and intent to reshape the international world order.[2] Building upon the *National Security Strategy*, the US secretary of defense identified China as the "pacing challenge" in the October 2022 *National Defense Strategy*.[3] More specifically, the *National Defense Strategy* identified four priorities for the Department of Defense, one of which is "deterring

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1. Joseph R. Biden Jr., *National Security Strategy* (Washington, DC: The White House, October 2022), 11, https://www.whitehouse.gov/.
2. Biden.
3. Lloyd J. Austin, *2022 National Defense Strategy of the United States of America* (Washington, DC: Office of the Secretary of Defense (OSD), October 2022), 2, https://media.defense.gov/.

aggression, while being prepared to prevail in conflict when necessary—prioritizing the PRC challenge in the Indo-Pacific region."[4] In line with the strategic guidance, each US military department (MILDEP) is preparing for potential conflict.

Rapidly deployable and employable combat weapons systems form the backbone of the Air Force's ability to achieve strategic and operational objectives in support of a desired political end state. Yet combat weapons systems require combat support. Medical support is a crucial enabler of combat operations. As far back as the US Civil War, its purpose of supporting combat forces was considered essential yet underappreciated:

> A Corps of Medical Officers was not established solely for the purpose of attending the wounded and sick; the proper treatment of these sufferers is certainly a matter of very great importance, and is an imperative duty, but the labors cover a more extended field. The leading idea, which should be constantly kept in view, is to strengthen the hands of the Commanding General by keeping his army in the most vigorous health, thus rendering it, in the highest degree, efficient for enduring fatigue and privation, and for fighting.[5]

While this viewpoint from 1866 still applies, medical personnel perform additional functions such as aeromedical evacuation, radiological decontamination, water testing, and more in today's environment. The significance of their role in supporting combat forces is perhaps best exemplified in the operations in Iraq and Afghanistan early in the twenty-first century. In these operations, medical support achieved the greatest injury survivability rate in US history. This was largely due to relatively short distances to advanced medical capabilities, effective mission command, and robust communications. Even so, this was done in an uncontested air environment, which allows for quick access to such advanced medical capabilities. This may or may not be the case in future conflicts.

Military healthcare capability represents the ability to provide medical support in direct support of combat operations. Capability is "the ability to complete a task, perform a function, or execute a mission—under specified conditions and to specified standards of performance."[6] Thus, such capability is required for effectiveness. For example, radiological decontamination represents a specific healthcare capability. Conversely, military healthcare capacity measures the system's ability to provide care to a patient. Capacity is typically measured by productivity standards based on civilian healthcare benchmarks, such as the number of patients seen per week by each provider type.

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4. Austin, 7.

5. Jonathan Letterman, *Medical Recollections of the Army of the Potomac* (New York: D. Appleton and Company, 1866), 100–101.

6. Chairman of the Joint Chiefs of Staff (CJCS), *Joint Warfighting*, Joint Publication (JP) 1, Vol. 1 (Washington, DC: CJCS, March 25, 2013, incorporating change 1, July 12, 2019), 18.

Challenges Posed by Anticipated Near-Peer Conflict

Air supremacy, mission command, and communications will be challenged within the Indo-Pacific theater in a conflict with China. While this paper will focus on the Indo-Pacific region, its findings also apply to the European theater. The size of the Indo-Pacific area of operations will add tension and risk to combat operations, combat support, and mission command. Some levels of strategic tension and risk are acceptable and even generally preferred; however, as the tension between elements such as time, energy, resources, equipment, distance, information, and system inputs increase, greater volatility, uncertainty, complexity, and ambiguity (VUCA) result, increasing overall risk to the mission.

During combat operations, such tension, VUCA, and risk escalate, and this in turn can affect operational, strategic, and political objectives. Each component must manage risk to provide and while providing forces to the appropriate combatant commander. To help the Air Force manage or mitigate tension and risk to the greatest extent possible, successful combat operations and support "in a contested environment demand maximum delegation, trust, and empowerment of Airmen before the conflict starts."[7] One mitigation measure included in Air Force doctrine directs the organizing, equipping, and training of combat operations and combat support units as they will fight.[8]

Recent congressionally directed changes gave the Defense Health Agency (DHA)—the DoD combat support agency responsible for "fulfilling combat support functions for joint operating forces across the range of military operations" and health service support to the military community—authority, direction, and control over all military treatment facilities (MTFs), while the US Air Force retains command authority. Yet as great power competition increases the likelihood and stakes of armed conflict, because of DHA's new role, the Air Force must now resolve the increased tension and risk at the MTF level to prepare to support combat operations medically.

Background

Before 1993, the Air Force Medical Service (AFMS) did not have squadrons or a squadron commander, unlike its line of the Air Force counterparts.[9] Like civilian hospitals, functional leaders ensured clinical care and quality; the hospital commander retained command authority and responsibility. This changed in 1993 when the US Air Force chief of staff directed the surgeon general to adopt the Objective Wing Model to focus on operational readiness.[10]

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7. Charles Q. Brown Jr., *Accelerate Change or Lose* (Washington, DC: Department of the Air Force [DAF], August 2020), 6, https://www.af.mil/.

8. DAF, *The Air Force*, Air Force Doctrine Publication (AFDP) 1 (Washington, DC: DAF March 2021), https://www.doctrine.af.mil/.

9. Merrill A. McPeak, *Selected Works: 1990–1994* (Maxwell AFB, AL: Air University Press, August 1995).

10. Wade B. Adair, *The Objective Medical Group Next Gen: Outdated or an Overhaul?* (research report, Air War College, Air University, Maxwell AFB, AL, February 22, 2018), https://apps.dtic.mil/.

The Objective Wing Model organized the Air Force around a functional unit, the squadron. The model remains in place today to include within the AFMS. A commander leads the squadron and is empowered by law with the authority, accountability, and responsibility to execute the mission, lead people, manage resources, and improve the unit to provide the geographical combatant commander with the appropriate capabilities and capacity to launch their respective operational plans.[11]

The squadron commander, typically a lieutenant colonel, is given these authorities via G-series orders from the next higher-level commander, typically a group commander. Each medical group (MDG) continues to have functional leaders—the chief medical officer, administrator, chief nurse, chief dentist, and the biomedical science corps executive—that focus primarily on clinical care and quality. Some squadron commanders are dual-hatted as functional leaders, providing them with additional responsibilities.

In 2013, the Defense Health Agency arose from the TRICARE Management Activity, a government entity responsible for managing healthcare benefits for active-duty personnel, retirees, and family members. In 2017, via the annual National Defense Authorization Act and due to ever-increasing healthcare costs within the DoD's budget, Congress required the military health system of the three military departments to move under the DHA's authority, direction, and control.[12]

The law's original intent included consolidating all MTFs within the continental US (CONUS) under DHA to deliver efficient and standardized healthcare; those MTFs outside the continental US (OCONUS) would remain with the military departments.[13] Military treatment facilities exist on OCONUS bases to enable a forward force presence in support of the respective combatant commanders, with a real possibility of supporting combat operations in place, especially in South Korea or Japan, but also at European bases, as was done during the 2011 Operation Odyssey Dawn in Libya. Business efficiencies are needed at these locations, but not at the sacrifice of their capability to support operational plans. Yet the Department issued a directive in September 2021 that placed all MTFs under DHA.[14]

Like the Air Force Medical Service organization before 1993 and the current organization of the US Navy and the US Army Medical Services, the functional unit within the Defense Health Agency is the military treatment facility. In the Indo-Pacific theater, a director leads each MTF and reports to the DHA regional director, who in 2023 is an Army two-star general. A similar relationship exists in Europe, but within CONUS, an intermediary organization called the market might be present between each MTF and the region. The region director then reports to the director of the DHA. The markets and

11. DAF, *Commander's Responsibilities*, Air Force Instruction (AFI) 1-2 (Washington, DC: DAF, 2014).
12. National Defense Authorization Act for Fiscal Year 2018, Pub. L. 115-91 (2017).
13. Joseph Heck (Nevada state representative), personal communication with authors, April 12, 2022.
14. Heck; and Department of Defense (DoD), *Defense Health Agency (DHA)*, DoD Directive 5136.13 (Washington, DC: DoD, March 2, 2022), https://www.esd.whs.mil/.

regions are all new organizations with new and additional human resources, budgetary, and infrastructure requirements.

The DHA director delegates authorities and the responsibility for administering and managing patient care to the MTF director.[15] Additionally, the MTF director leads an executive staff commensurate with the size of the facility and must be a colonel or someone of greater rank.[16] The executive team most commonly consists of leaders such as the chief medical officer, administrator, chief nurse, and chief dentist, who advise the MTF director from their functional lane. Squadron commanders, or a squadron, are not part of the DHA lexicon or structure.

Except for several facilities, the military treatment facility is generally equivalent to a medical group within the Air Force. A dual-hatted colonel leads both and is designated the MTF director and MDG commander. While MTFs and MDGs may appear synonymous, they differ in their authority sources. An MTF director has DHA authorities, while the MDG commander has MILDEP-specific authorities. While there is some delineation of DHA and Air Force authorities, roles, and responsibilities that may appear supportive of each other at a superficial level, at a deeper level, because the two sources fundamentally prioritize capability and capacity differently, they are in direct conflict with each other, increasing the tension and risk that converge at the squadron and group commander level.[17]

Recent contamination in an installation's water supply highlights this conflict.[18] Line of the Air Force leadership sought medical expertise to ensure public safety and to maintain deployment medical capabilities while adjusting the expectations of medical personnel over the three-month emergency. The Defense Health Agency initially deemed the emergency an environmental concern before eventually recognizing the possible medical impacts. Yet DHA continued to seek justification for the lost capacity, or productivity, throughout the emergency when the facility did not have drinkable water for more than three months. The conflict between capability and capacity increased tension, producing increased risk at the facility.

Capacity versus Capability Tension and Risk

The combatant commander's operational plans levy requirements on the military departments, and they build their structure to provide forces with specific capabilities to the combatant commander to execute their plans. In the Air Force, the squadron commander organizes, equips, and trains their squadron to provide forces and capabilities to the combatant commander. To do this, the Air Force recently approved a new force generation

15. DoD, *DHA* .

16. DoD.

17. DoD; and DAF, *Commander's Responsibilities*.

18. "Drinking Water Incident Response at Joint Base Pearl Harbor-Hickam, Honolulu, Hawai'i (November 2021–March 2022)," Environmental Protection Agency (website), accessed July 7, 2023, https://www.epa.gov/.

model.[19] Still, the AFMS must determine how the model will apply to medical forces. This adversely affects the AFMS because the narrative is externally defined and driven. Conversely DHA does not provide forces to the combatant commander.

With Congress' charge to gain healthcare efficiencies and standardization, DHA focused on military healthcare capacity rather than capability. As mentioned above, healthcare capacity is a measurement of the system's ability to provide care to a patient and is typically measured by productivity standards set by civilian healthcare benchmarks. Capacity lies within the DHA's authority. Thus, the agency set productivity standards as the benchmark, utilizing civilian healthcare productivity standards as the model.

At the same time, DHA is attempting to equate patient care with capability to maintain its relevance to the combatant commanders. For example, a patient visit to their primary care provider is typically viewed as meeting a productivity standard or capacity. The DHA interpreted the meaning of this visit to fit the definition of capability, which is outside the authorities given by Congress. This would be appropriate if the medical provider and team only provided healthcare. During daily operations or in contingency environments, however, Air Force medics are held responsible for many more capabilities.

The DHA's emphasis on capacity over capability increases the tension and risk within the Air Force Medical Service MTFs because of improper staffing models. Before the DHA assumed authority, direction, and control, staffing models historically gave the Air Force commander flexibility to balance capacity and capability locally. Unfortunately, staffing models within the AFMS now create greater tension and risk due to the DHA's emphasis on capacity over capability, directly impacting the MTF budget.

The Army and Navy are in less jeopardy for tension and risk as their civilian personnel within their MTFs (approximately 76 percent and 45 percent, respectively) can provide capacity while their active-duty personnel balance the pursuit of capabilities with capacity. The AFMS manning model relies upon a more significant percentage of active duty to civilian personnel (approximately 83 percent and 17 percent, respectively) to provide care in their respective MTFs.[20] While some civilian personnel within the Air Force Medical Service provide home-station medical capabilities, all active-duty personnel provide both home-station and deployed medical capabilities, requiring additional initial and sustainment training and repetitions.

In establishing productivity standards based on civilian healthcare productivity to measure capacity, the Defense Health Agency used civilian standards that came from clinics that maximized productivity and did not have a military-specific healthcare capability mission to meet. Thus the DHA standards are blanket standards without any local requirement considerations. For example, a provider in Osan, South Korea, is expected to

19. David W. Allvin, "Key Terminology for USAF Force Presentation and Employment Approaches," official memorandum, 2022.

20. Alfred K. Flowers Jr., "Strategic Landscape" (Presentation, AFMS Senior Leader Workshop, National Conference Center, Leesburg, VA, December 6, 2022).

meet the same productivity standards as a provider in Columbus, Mississippi, even though the readiness training requirements are vastly greater in Osan.

In addition, DHA calculates the fiscal year budget for a facility based on its projected productivity given their respective staffing like a for-profit civilian healthcare organization. If productivity is not met for any reason, including capability requirements, the facility will have money taken from its budget. By the DHA linking capacity to an annual budget, the AFMS' current staffing models have shifted to the emphasis on capacity, inserting stress into daily operations and risk to future combat military support because of the lack of emphasis on capabilities.

Differing Authorities

Differences in higher headquarters' command and control (C2) due to different authorities also increase tension and risk. As with all MILDEP components, the US Air Force's primary mission is to provide capabilities to the combatant commander to support operational plans, including medical. Capacity plays a role, but not at the cost of the capability. Commanders at and above the squadron level are empowered to balance capability and capacity by assuming risk via mission command. At the same time, they are held accountable for their decisions.

Risk is well-defined in Air Force instruction; every line item must list a waiver authority, forcing commanders to process *how* they should think about risk rather than *what* to think about risk.[21] Mission command culture allows the squadron commander, or a commander at any level, to pursue a waiver via the appropriate authority for any requirement by justifying the local environment that warrants the waiver. This mission command culture allows risk to be defined and assumed at the proper level, which enables the commander room to operate and make decisions based upon the identified risk and local conditions.

It also ensures guidance is nonproscriptive and helps capability and capacity remain balanced. Ultimately, this prepares commanders for the dynamics of combat operations and combat support operations through mission command or centralized command, distributed control, and decentralized execution, especially in the Indo-Pacific theater where communication will likely be degraded or absent in the event of a conflict.[22]

Conversely, because DHA emphasizes capacity over capability due to the limitations of its authorities, the agency's guidance and instructions provide proscriptive centralized command, centralized control, and centralized execution. Instructions tell the reader *what* to think rather than *how* to think about operations. This centralized command,

21. DAF, *Publications and Forms Management*, AFI Instruction 90-160 (Washington, DC: DAF, April 14, 2022).

22. DAF, *Command and Control*, AFDP 3-30 (Washington, DC: DAF, 2020).

control, and execution is evident in the comparative number of instructional publications. The AFMS has 91 current publications, while DHA has 270.[23]

These mission command differences between the AFMS and DHA force the group and squadron commander to determine where the authority arises. During the coronavirus (COVID-19) pandemic response peak, DHA produced central guidance to be used within several days after any Centers for Disease Control and Prevention updates. Such guidance offered little room for local interpretation or application.

Conversely, the Air Force encouraged quick adoption, leaving the medical group commander to determine with their local line of the Air Force leadership how best to apply and implement any updates for the installation. This resulted in two policies, one for the MTF and one for the rest of the installation, creating tension and risk. The military departments' secretaries and service chiefs highlighted this risk and its implications to the mission.[24] Proscriptive command, as DHA currently provides, does not prepare the unit commander for mission command in a conflict.

Readiness Requirements

Every Air Force MTF must maintain a contingency medical response capability at the home station and in a deployed environment for activation in an emergency or natural disaster requiring medical capabilities.[25] The other MILDEPs maintain similar capabilities. These response capabilities may contain different clinical care teams, such as a disaster mental health team. A larger facility may have more robust capabilities, such as surgical and inpatient care teams.

In three primary roles, military training and exercises are required to train, practice, and refine for noncombat and combat medical support. First, every Air Force active-duty medic is assigned a position to fulfill in the event of a home station noncombat medical response. For example, a pediatrician may be assigned to a clinical or triage team. In a mass-casualty event or local disaster, the pediatrician would serve on this team until deactivation.

Secondly, based on their specific Air Force Specialty Code or job, every medic completes annual functional requirements to provide a job-specific capability for a combatant command operational plan. For example, a medical technician must maintain their National Emergency Medical Technician Certification to deploy in this role. Still, most medical technicians do not work in an emergency room or respond to emergencies in an ambulance, requiring additional time for sustainment training.

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23. DAF E-Publishing, "Publications and Forms," DAF, accessed January 5, 2023, https://www.e-publishing.af.mil/; and DHA, "DHA Publications Library," Health.mil, accessed January 5, 2023, https://www.health.mil/.

24. Ryan D. McCarthy et al., "Military Health System Medical Reform," official memorandum, August 5, 2020.

25. Air Force Surgeon General (AF/SG), *Health Services*, AFDP 4-02 (Washington, DC: AFMS, 2019).

Thirdly, a medic can be assigned to a functional team that deploys with a specific capability. For example, the pediatrician or the medical technician can be assigned to a team that, if activated by a combatant commander, deploys to a chemical, biological, radiological, or nuclear event to provide a decontamination capability.

These three examples represent separate scenarios, but the same individual can be tasked with all three responsibilities simultaneously or independently. The Air Force clearly defines and standardizes most functional initial, sustainment, and refresher requirements (example two). Yet home-station medical response (example one) and functional deployment team (example three) requirements must be better codified centrally.

For example, a home-station medical response capability is required, but the local commander determines initial, sustainment, and refresher training and exercise requirements are what is needed.[26] Nevertheless, the commander is still held to DHA's central productivity standards, or capacity. While some of the care provided would be like the performance of their regular duties, high-volume patient care does not ensure individual proficiency and capability for home-station or deployed readiness requirements. Individuals from across the facility are also brought together to form these teams. Highly reliable teams require time for training and repetition through exercises to be effective and safe. Lastly, the medic can be and is likely reassigned to different teams when they move every two to four years.

Medical Mission Command

Beyond the training and exercise requirements identified earlier in the paper, mission command is essential to maximizing an effective and safe response, regardless of the size and scope of the medical response capability. Mission command allows the commander to "identify and assess requirements, allocate means, and integrate efforts . . . to determine the status of organizational effectiveness."[27] At the broad level, mission command within an Air Force MTF during a contingency medical response typically involves the integration of four key personnel into two teams.

Two personnel, the medical group commander and one other individual—typically the deputy commander who is commonly a dual-hatted squadron commander at smaller facilities or a stand-alone deputy at a larger facility, or one of the squadron commanders—are part of the wing or installation crisis action team (CAT). The team brings together the senior leaders from the installation with an operations center to ensure effective C2 of the entire scope of the emergency among the fire department, security forces, medical, public affairs, and other agencies on the installation. In addition, this structure facilitates central communication with higher Air Force headquarters and organizations outside of the installation as needed.

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26. AF/SG.
27. CJCS, *Joint Campaigns and Operations*, JP 3-0 (Washington, DC: CJCS, June 18, 2022).

The other two personnel, typically squadron commanders, provide internal mission command into the medical group via a central node, the medical control center (MCC). The medical staff on the CAT and the MCC coordinate identification, assessment, allocation, and integration efforts but focus their efforts externally and internally on the military treatment facility.

More specifically, US Air Force MTF mission command, through a cyclical feedback loop, identifies and assesses medical threats to forces, advises senior military operational commanders on the medical threats, and allocates means while integrating efforts internal and external to the organization to reach maximal effectiveness. The DHA addition adds another input and output. While the Defense Health Agency could be integrated, the crisis action team is administered by nonmedical personnel who work for the installation commander, adding additional layers to reach the MTF director. If the medical control center were the integration source, it would force its internal focus to include external efforts. The integration of DHA still needs to be defined during contingency responses, creating tension and increasing risk to the mission.[28]

Air Force Combat Operations Medical Support

While the Defense Health Agency assumed authority, direction, and control of nearly every MTF in 2021, several notable exceptions exist. Air Force MTFs in the US Central Command theater, such as the 379th, 332d, and 386th Medical Groups, remain under the Air Force's authority, direction, and control due to their direct combat support of ongoing operational missions in the Middle East. Additionally, these facilities do not use Defense Health Program funding; their funding comes from the US Air Force. The MDG commander is not dual-hatted as the MTF director; the position does not exist at these facilities.

These military treatment facilities are 100 percent staffed by active-duty members who fall under the mission command of their squadron, group, and wing commander through clear lines of authority. Training and exercises occur with regularity to ensure highly reliable teams. Productivity standards, or capacity, are considered, but not at the expense of maintaining capabilities. The medical group commanders are integrated into the installation CAT, while the squadron commanders integrate the military treatment facility through the MCC.

In this environment, the focus is on capability over capacity to ensure the Joint warfighting operational function of protection is postured to support when and if needed.[29] For example, Operation Allies Refuge facilitated the evacuation of more than 100,000 people from Afghanistan. Because the above MTFs remained under Air Force authority, direction, and control, the MDG and squadron commanders shifted medical capabilities to support the operational mission without approval or input from DHA.

28. McCarthy et al., "Military Health System."
29. CJCS, *Joint Campaigns*.

The Air Force Medical Service will support combat operations through medical capabilities. Every Air Force MTF within the USINDOPACOM and USEUCOM theaters currently falls under DHA's authority, direction, and control. The current ambiguity of how the AFMS will support these operations generates tension at OCONUS MTFs. If a conflict arises, a mechanism or trigger does not exist to "flip" the MTFs back to service authority, direction, and control to operate like those within the USCENTCOM theater.

Recommendations

Recognition of the tension between the Air Force Medical Service and Defense Health Agency at the group and squadron commander levels is the first step to reducing risk. The US Air Force surgeon general recently acknowledged the tension publicly for the first time.[30] The second step is more complicated as it involves managing and mitigating the tension and risk within the military treatment facility. From the MTF perspective, minimal actions have occurred to do so.

At first glance, the removal of DHA's authority, direction, and control by Congress may appear to be the logical solution. Another possible solution may be the elimination of each of the separate medical services. This article, however, proposes a more nuanced approach. While the recommendations outlined below are not exhaustive, AFMS senior leaders, as well as MDG and squadron commanders, should "pursue until apprehended" to solve this problem in advance of possible conflict.[31]

Defining Capacity and Capability

The AFMS must define capability and capacity and develop a purposeful narrative with prioritization guidance to minimize risk based on combat operational medical support requirements. The definitions must support the current and future requirement that routine patient care may not be equitable to patient care or capacity. Additional training is likely required to gain, maintain, and build capabilities for requirements.

This narrative, guidance, and the associated costs must be communicated regularly and often up the chain of command, laterally to other organizations, and down the chain of command. Specifically, up the chain of command, within the Military Health System executive review meeting, chaired by the Under Secretary of Defense for Personnel and Readiness, an opportunity exists to advocate for Air Force equities.[32] At this meeting, the Military Health System lines of effort and plans are integrated with the Department of

30. Shireen Bedi, "Air Force Medical Leaders Discuss Future Operational Challenges, Solutions at Annual Workshop," AFMS, December 14, 2022, https://www.airforcemedicine.af.mil/.

31. Theresa Hitchens, "CSAF Brown Mulls Streamlining of Air Force Commands; Barrett Announces 'e' Aircraft," Breaking Defense, September 14, 2020, https://breakingdefense.com/.

32. John J. DeGoes, "Scene Setter . . . AFMS & Military Health System Transformation" (presentation, AFMS Senior Leader Workshop, National Conference Center, Leesburg, VA, December 6, 2022).

Defense.[33] The under secretary and US Air Force vice chief of staff represent and advocate for the AFMS by providing input, concerns, and recommendations.[34]

In addition, recurring conversations between the Air Force surgeon general, surgeon general's leadership team, medical group, and squadron commanders must occur to inform, obtain feedback, and clarify the conflict between capability versus capacity tension and risk narrative. Major command surgeons general and their respective staff should also be a part of this conversation as they are integral to planning and oversight, but the Air Force surgeon general and staff should have these conversations to obtain direct feedback from the field.[35]

Additionally, capability and capacity must be built into the medical vernacular and included in all foundational courses, such as officer technical, Basic Leader Airman Skills Training, Intermediate Executive Skills, and precommand training courses. While line of the Air Force group and wing commanders attend a precommand course that includes an overview of the AFMS, additional education is needed to expound the tension within the AFMS and the subsequent risk this poses to their operational missions. Ideally, this information should come from the Air Force surgeon general, but it must be reinforced locally by MDGs and squadron commanders.

Once the Air Force Medical Service defines capability and capacity, MTF staffing models must be studied to ensure the correct mix of staff are present to balance the tension and risk to the Air Force operational mission at each location. Home-station contingency response team requirements should be considered and centrally defined when addressing AFMS staffing models. Knowledge, skills, and abilities should be defined centrally to standardize operations across the Air Force. Additionally, home-station contingency response teams could be defined by Air Force Specialty Codes to gain training efficiencies through standardization, allowing for more time to conduct training and exercises.

Differing Authorities

The AFMS must advocate through senior leaders such as the secretary, chief of staff, and chief master sergeant of the Air Force to refine DHA authority, direction, and control over all MTFs to only those within CONUS. Due to their direct support of combatant command operational plans, MTFs within the Indo-Pacific and European theaters should be aligned to the respective military departments for command, authority, direction, and control authorities, like those in USCENTCOM. Realignment would sustain the law's original intent of standardizing MTF operations to gain fiscal efficiencies within CONUS.

Yet due to casualty projections, capacity will be needed in a conflict with a peer or near-peer adversary. Shifting DHA's authority, direction, and control to CONUS-only facilities focuses efforts to standardize operations and gain efficiencies, decreases the ca-

33. DeGoes.
34. DeGoes.
35. AF/SG, *Health Services*.

pability versus capacity tension, and decreases the overall risk to combat operation medical support at MTFs outside of the continental United States. MILDEP command and control of medical services during expeditionary operations is directed by Joint guidance but should be updated to reflect the current environment.[36] If DHA realignment is not accomplished, capability and capacity tension will remain at OCONUS military treatment facilities, thus increasing the risk that their personnel are unprepared to support combat operations.

The Air Force Medical Service must correct the dearth of senior medical representation from all corps—biomedical science, dental, medical, medical service, and nurse corps—within the Defense Health Agency. This can be done by ensuring the Air Force is adequately represented by an officer, enlisted member, and civilian personnel at all levels, especially leadership. Four out of 17 DHA leaders are from the Air Force; only three of the four have medical command experience.[37]

To accurately represent and advocate for Air Force equities and culture, command at the squadron and group level should be a prerequisite, as much as possible, so the tension and risk between capacity and capability can be articulated and represented. Some may consider a move from AFMS to DHA a lateral move; Joint credit should be established or granted in critical positions to overcome this.

Lastly, medical strategy and policy at all levels must be revamped to decrease tension and risk. Topics such as mission command, definitions of capability and capacity, command-and-control relationships, supporting and supported agencies, waiver processes, and waiver authorities must be included. Medical training facilities within CONUS should have a contingency redline, or tripwire, to switch from DHA authority, direction, and control back to the respective US military department to ensure the worldwide and local mission is met.

Readiness and Air Force Combat Operations Medical Support

The Air Force Medical Service must quickly update its deployment model to incorporate it into the new US Air Force Force Generation (AFFORGEN) model. While this work may have started centrally, communication and transparency with the rest of the AFMS do not yet exist, so local initiatives have begun at many locations. To overcome this, regular communication, with transparency, should occur with the medical group and squadron commanders. The AFMS must also determine the capabilities needed to build the team. For example, the Air Force is increasing the Indo-Pacific theater's critical care air transport teams.

While necessary, air transport can only occur infrequently in a contested air environment. This means patients may need prolonged care at or near the point of injury. Yet

36. CJCS, *Joint Health Services*, JP 4-02 (Washington, DC: CJCS, December 11, 2017).

37. Military Health System, "Our Leaders: Health Affairs Leaders," Health.mil, accessed February 3, 2023, https://www.health.mil/.

without air transport, the logistics of prolonged care will likely become an issue due to limited resources. This produces an ethical and moral dilemma. Is it better to save one or a few individuals but decrease resource availability for future casualties? Or to protect limited resources? The best decision may be to focus medical efforts primarily on mission regeneration or the return to duty of personnel while secondarily focusing on surgical, prolonged care, and critical care air transport to minimize the overall risks to the mission. These capability discussions and decisions must occur frequently and with transparency. Clear policy and guidance must follow to establish priorities and explain why.

Once this is defined, the AFMS must be part of every operational training and exercise at the local, wing, Joint, partner, and Allied levels to build and sustain the capability. This means AFMS must be a part of the planning, execution, and debriefing to ensure realism, learning, and accountability. It also reinforces the mission command structure that will be used in the event of a contingency. This develops the narrative of how AFMS supports combat operations and the cost of sustaining this capability.

It is also unknown how AFFORGEN will generate medical forces to meet Joint medical requirements. This is because Joint medical requirements are largely undefined. The Air Force Medical Service and Air Force should advocate through the chief of staff of the Air Force to the Joint Staff to codify the Joint requirements before codifying AFMS requirements within the AFFORGEN model. Ultimately, disparate thrust leads to an inconsistent narrative and vector, resulting in the symptoms, and not the problem being addressed.

Additionally, the AFMS must define home-station contingency response capabilities and training. Every Air Force installation and surrounding civilian community should be examined to define the local requirement. Once the requirement is identified, the MTF capability can be right-sized. Reexamination should occur with recurring frequency.

Medical Mission Command

To maintain its mission of supporting combat operations with medical capabilities, the Air Force Medical Service must latch itself into US Air Force command-and-control functions at the service, major command, numbered air force, wing, and detachment levels. These levels are already integrated into the combatant commander's component C2 structure, usually through the commander, US Air Force forces, or the Joint Force air component commander.

Mission command requires identification and analysis, and if the appropriate authorities exist, an assumption of risk when appropriate. Mission command also requires the employment of forces as the Air Force organizes, trains, and equips these forces to minimize risk. This can only occur if both medical group and squadron commander positions are maintained. The MDG commander must integrate the group externally while the squadron commander integrates internally within the MTF. If squadron commanders are removed, medical integration will be threatened externally and internally due to the tension of time and energy at the MDG commander level. The Air Force's lean MTF staff-

ing model requires some depth at the commander level. A noncommander may not fully understand the tension and risk of capacity versus capability and does not have the legal authority to assume the risk.

While there have been calls for a single medical department since the establishment of the Department of Defense, the AFMS must advocate against this, considering the current great power environment and the potential for conflict in the next 10 years. Integration of the Air Force, Army, and Navy medical systems could take place but would take years due to the different cultures, missions, and structures. In today's environment of great power competition, integrating now poses a real risk to each medical service's ability to support the combat operations of their respective military department and the Joint team. Instead, each MILDEP must maintain its responsibility as the force provider for their missions to the combatant commander to support operational plans and requirements. Additionally, each department must maintain the mission command of its medical forces.

While beyond the scope of this paper, the Air National Guard and Air Reserve have organic medical assets that should be assessed for tension and risk. Similar assessments should be undertaken as the Space Force considers its future medical capabilities.

Conclusion

As the likelihood and stakes of armed conflict increase, the Air Force Medical Service must prepare to support combat operations. Recent congressionally directed changes gave the Defense Health Agency authority, direction, and control over all military treatment facilities to gain fiscal efficiencies through the standardization of medical care. Considering this, DHA prioritized capacity. Yet the Air Force retains command authorities and is responsible for providing medical capabilities to the combatant commander to support operational plans and requirements. This creates a confluence of tension at the medical group and squadron commander levels within Air Force MTFs due to the conflict of capacity and capability priorities.

If the situation is left unaddressed or unmitigated, tension increases, and such an environment potentially worsens during combat operations. Increasing tension creates increased risk and decreasing unity of effort and command, whether at peace or in a conflict. If unaddressed, this risk can radiate upward to affect operational, strategic, and political objectives, and it can also spread downward to all medics. If tension and risk increase at the provider level, they will ultimately transfer to their patients. When lives are on the line, which in armed conflict they will be, the Air Force Medical Service must address and mitigate these issues by starting with the cause and not the symptoms. With the likelihood of conflict increasing, this must be solved now. Determining a solution while already under fire will cause deaths that could have been prevented. ✈