EYE ON WASHINGTON

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the future of military health care

During 2007, I had the privilege of serving as the co-chair of a congressionally mandated task force on the future of military health care.

The task force was established by the FY07 National Defense Authorization Act and directed to make recommendations to Congress about a broad range of measures, including those needed to sustain the military healthcare services, the appropriate cost-sharing structure between the government and beneficiaries, wellness initiatives, health promotion and disease management programs, alternative initiatives to manage patient behavior and costs, the ability of the military to account for true and accurate costs, and the adequacy of the military healthcare procurement system.

The task force comprised 14 individuals—seven from inside the military and seven from outside the military. It included such familiar names in the world of health policy as Carolyn Clancy, MD, director of the Agency for Healthcare Research and Quality; Larry Lewin, founder of the Lewin Group; and Robert Galvin, MD, director of global health benefits for GE. Military members included Lt. Gen. James Roudebush, the current Air Force surgeon general; Rear Adm. John Mateczun, formerly Navy deputy surgeon general and now commander of the joint task force of the national capital region; Gen. Richard Meyers, the former chair of the Joint Chiefs of Staff; Shay Assad, the head of procurement and my co-chair; and Gen. John Corley, initially vice chief of staff of the Air Force and currently commander of Combat Air Command. The task force issued its report to the Department of Defense just before Christmas. The final report will be forwarded to Congress no later than March 31, 2008.

Some Strengths of Military Health Care

Military health care is provided by a combination of direct care, delivered at military treatment facilities, and purchased care, obtained through a network of three national contracts. As a system of care, the direct care portion of military health care has many of the advantages of other "systems of care," including the use of clinical guidelines and protocols, increased focus on preventive care, at least some use of electronic medical records (currently available for portions of outpatient care and in development for inpatient and other types of care), and a broad range of healthcare personnel providing care.

The use of direct care combined with purchased care is a great strength of military health. It provides the military with substantial "surge" capability and with increased flexibility to respond to changes in demand that result from geographic shifts in its active duty and retiree populations. This combination also allows the military to provide access to specialists who might otherwise be hard to recruit or justify on a full-time basis.

Military health care has been responsible for a variety of advances, particularly in aspects of surgical care, largely reflecting the results of medical breakthroughs during times of war. The military's active involvement in both undergraduate medical education at Uniformed Services University of the Health Sciences and graduate medical education at some of its larger installations has also helped keep military medicine at the forefront of medical advances.

Because military health care is funded in large part by direct appropriation, it has had to develop within a fiscally constrained environment. By most measures, the military has been able to

provide good-quality care at what appears to be "reasonable" or at least comparable rates of cost increase compared with the private sector. Satisfaction rates are regularly measured and reported in the military and indicate general high rates of satisfaction and the value of providing a feedback system of information and rewards to units based on their performance.

Challenges

Despite these substantial strengths, the military healthcare system is facing a number of challenges. Some are primarily a reflection of the challenges facing health care in the United States, such as greater use of services, increasingly expensive technology, and the aging of the retiree population. Others relate primarily to military health care. These reflect the dual mission of military health and the substantial expansion of benefits and users in a system that has otherwise not been altered since TRICARE was introduced in 1995.

The first mission of military health care is to meet the military's medical readiness needs. This puts an obligation on the system in terms of training and requires the medical system to be ready to respond to any military challenges that may arise. The need to meet the readiness mission influences how, where, and by whom care may best be provided and may, in turn, distort decisions about what would otherwise be the most efficient way to provide care to active duty members, their dependents, and retirees.

The use of direct care combined with purchased care, while a great strength of military health care, also raises challenges regarding the proper integration between the two systems of care and challenges in terms of aligning incentives that optimize the best use of each type of care.

The current pressures from a sustained military conflict in Iraq and Afghanistan have stressed the medical personnel needs of the military and emphasized the importance of finding ways to introduce greater flexibility in responding to future deployments with less disruption to training programs and to the delivery of care of active duty and dependents remaining in-country. These issues not only relate to traditional concerns regarding recruitment and retention, but also raise questions of undergraduate and graduate training programs as well as the potential for the increased use of medical reserve forces.

The most serious challenges are financial. The growth in healthcare spending by the military is hard to compare with private sector growth in part because of the importance of the readiness mission and in part because of different accounting systems used more generally by the Department of Defense (DoD)—an issue that the GAO has raised on a number occasions. One thing is clear, however: The enrollment fees, deductibles, copays, and other financial attributes of TRICARE have not been changed in more than 12 years. The DoD therefore not only is being challenged by the nation's overall growth in healthcare spending—the result of an increasing number of people using an increasing number of services as eligibility and benefits continue to expand—but also is paying for an increasingly larger share of the total spend.

Changing the military health benefit during an election year while the country is at war is a political challenge that Congress is unlikely to take on. The financial issues, however, are not going away. At some point soon, Congress will have to decide if it is willing to fund an increasingly larger share of a substantially growing military health budget and, if not, what changes it is willing to consider. The task force just concluded has given the Congress several options to consider. Stay tuned … ●

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During 2007, Gail Wilensky co-chaired the Department of Defense Task Force on the Future of Military Health Care and served as a commissioner on the President's Commission on Care for America's Returning Wounded Warriors. From 2001 to 2003, she co-chaired the President's Task Force to Improve Healthcare Delivery for Our Nation's Veterans.

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