

The Army Medical Department in the 1970s: adapting to peace and new budgets

As US involvement in Vietnam dwindled, the military shrank, both in numbers of people and budgets. For the Army Medical Department (AMEDD) there would be competing pressures requiring painful choices. However, it was not all cuts: where a new program was clearly necessary it was funded. As the Army moves forward into a complex security environment with both baseline and OCO funding under question, it behooves us to see what sort of cost-cutting worked and how push-back was framed.

Preemptive strike

Even before the drawdown, the AMEDD argued persuasively that it needed to expand. With the AVF coming, the CSA pro-actively sought to address factors that would undermine it, and the AMEDD argued that long hospital waiting periods and poor facilities would be detrimental both to the AMEDD and the whole Army. In early 1971 the VCSA approved a 10.6% increase in AMEDD manning. It is not clear if the AMEDD achieved this personnel growth, but even empty authorizations presumably cushioned somewhat against real personnel cuts later.

Replace expensive/scarcely personnel

The drawdown would change the number of AD patients, but there would be less change in overall patient numbers since beneficiaries (ADFM, RET and RETFM) would actually increase. However, the number of doctors available dropped sharply, from 7000 in 1969 to just over 4000 in 1977, many of whom were interns and residents with practice limitations.

So the AMEDD found lots of ways to substitute non-physicians. Sanitary engineers replaced about 40% of preventive medicine doctors; some occupational health departments were headed by community health nurses rather than docs. MSC and VC officers were used in some medical research and development positions. A few docs were replaced with MSCs in command and staff positions. Psychologists and Social Workers were used where possible for psychiatrists.

Occupational Therapists also saw some mental health patients. Physical Therapists were used to screen (and treat) some back pain and many orthopedic patients rather than first sending them to an orthopedic surgeon. PAs were used in maneuver battalions, seeing patients in the TMCs and some working in the clinics and hospitals, from 0 in 1973 to 92 in 1979; more were in TMCs. Nurse Practitioners were used in increasing numbers, from 69 in 1973 to 203 in 1979.

Some positions were left empty. TO&E units had go-to-war docs, but in garrison those docs worked in the hospitals. This cut unit readiness but sustained personnel readiness in the units and kept the docs clinically up-to-date. Civilians also replaced uniformed personnel. HSC went from 200 GS physicians in 1973 to 453 in 1979; contractors went from 10 to 55. Enlisted personnel were also replaced with civilians, up to a point. At the 39:61 ratio (39% military) HSC said that civilianization was affecting the mobilization capability: “the decision maker who decides to further reduce AMEDD manpower resources must be willing to warn the combat soldier that appropriate health care services in all probability will not be available to him on the next field of battle.”

Now, one function was wholly civilianized. Medical inspection of recruits of all services at Armed Forces Entrance and Examination Stations had been conducted by AMEDD personnel. The physicians were civilianized with no apparent problems.

Headcount was reduced administratively. Several recruiting programs that counted against end-strength were ended. These included one that commissioned medical students while they were in school, and the Walter Reed Army Institute of Nursing. Replacement programs did not count against end-strength.

Use cheaper personnel, or use expensive ones efficiently

A few commissioned officer positions were replaced with warrants or enlisted. GAO recommended cutting the number of officers, especially at O-6. OMB wanted to trim grade inflation government-wide by 0.15 GS grade, when positions came empty. I don't think that's lasted if it ever happened.

With dentists also scarce as hen's teeth, efficiency was needed – and seen as increasing dentist morale and retention. Dental assistants were trained better and used more, and facilities were upgraded to improve efficiency. This worked: dental workload was up 77% between 1975 and 1979 despite a 9.5% reduction in dental personnel.

Use reservists

From its earliest days, Health Services Command tried to use reservists doing their weekend and annual training as well as inactive duty training. This was claimed to improve training in the Reserve while providing workers for Health Services Command. Instead of all of a unit doing two weeks training at once, they could spread it out over a year, sacrificing unit training for individual training. 11,000 reservists were used in 1975. Members of the Individual Ready Reserve were also used starting with 100 in 1975 and quadrupling through 1979.

Reduce demand

There were substantial health promotion efforts. These included anti-smoking campaigns, anti-drinking campaigns, advice on nutrition, advice on exercise, warnings about atherosclerosis, and advice on avoiding loud noises/hearing conservation. These could be blunt, as in a cartoon with the caption “Fat + Smoking = Heart Attack” and include headlines common today such as “Many U.S. children overweight.” Clearly, effectiveness has been limited but we don’t know what costs might have been.

An entire category of civilian employees, Community Health Dental Hygienists, was approved by HQDA to encourage dental hygiene and prevent clinic visits. However, the need for personnel in clinics was so pressing that these positions were gradually converted into ordinary hygienists.

The AMEDD proposed raising medical and dental standards for recruits. This would reduce the amount of healthcare they would need. There is no indication if this was adopted, but it ran counter to the broader recruiting problems of the 1970s.

Administrative requirements could be managed. Instead of annual physical examinations, the AMEDD argued for periodic examinations. (This succeeded, becoming an examination every five years.) It also sought to reduce documentation and expedite EPTS separations. DA (presumably with OTSG support) submitted several requests to DoD for legislation that would shift both disability determinations and 13,000 annual Temporary Disability Retirement List examinations to the VA. The military would perform MEBs, but the VA would be wholly responsible for PEBs. This proposal was studied to death in the DoD.

Facility cutbacks

Obviously, where posts were closed the medical facilities could be closed. Numerically the biggest number was 30 Nike-Hercules bases. Some hospitals were cut back to clinics, facilitated by the shift from inpatient care to outpatient care. Valley Forge General Hospital was closed, but this was balanced by upgrading the hospital at Fort Gordon to a medical center.

Smaller cutbacks were also made. Research, dental, veterinary, and environmental health laboratories could be cut. It is not clear how much of this was related to the smaller Army reducing workload, how much to closing/down-sizing posts changing the distribution of work, and how much to accepting increased costs in TDY of personnel and shipping of samples in order to reduce numbers of personnel and facilities. Hospital trains for use in CONUS were discontinued.

The Army examined contracting healthcare at certain posts, up through small hospitals. This was an open-ended idea, with civilian hospitals, medical schools, group practices, or individual providers agreeing to provide services. 35 posts were considered. The process was lengthy, but ultimately two posts (Dugway Proving Ground and White Sands Missile Range) were selected. However, commercial offers substantially exceeded audited government costs and the proposal was halted in January 1977. Another effort to contract healthcare at a post began in 1979; DoD and the House Appropriations Committee both directed a test. HSC looked at five facilities but dragged things out into FY1982 and nothing happened.

Government sharing

Major efforts went into sharing DoD medical facilities and personnel. "Triservice regionalized health services" were started in four CONUS areas on 1 July 1972 for efficiency, economy, and improved delivery of services. Three regions had one service in the lead and other-service sub-

regions; the fourth had a rotating lead. This was extended to Europe and Japan then all of CONUS in FY 1974. “The system worked as a give-and-take low key consortium of administrators interested in providing professional health care by the best use of their pooled assets. It helped formalize a process which had operated on an *ad hoc* basis for several decades.” Some personnel were shared, and it appears specialized treatment centers were considered.

Working on a tri-service basis led to greater standardization of terms and policies. These had to be implemented on a DoD basis, which meant the ASD (Health Affairs) was involved. In the mid-1970s a government-wide study looked at Federal healthcare, including the Department of Health, Education, and Welfare; the DoD; and the VA. This led to calls for DoD-wide standardization in manpower methods, performance standards, staffing methodology, and accounting. A Defense Health Agency was also recommended. In the 1970s, the GAO reported on wide variances in federal healthcare and that sharing had been “inhibited by cumbersome or inequitable reimbursement mechanisms, the lack of economic incentives, or agencies’ and hospitals’ desires to maintain autonomy and ready access to a full range of health services.” A Federal Health Resources Sharing Committee was chartered in February 1978 from DoD, service Surgeons General, VA, and PHS. It largely avoided costs (e.g. multiple cancer centers in one place) and could only point to the legal problems of conflicting reimbursement mechanisms. There was recognition of common items and training. For instance, spectacle fabrication was better shared, with a test program to support the VA as well. Some training programs began taking personnel from multiple services.

DoD also centralized approval of items over \$100,000, as well as beginning, ending, or curtailing medical services. In 1979 planning began to consolidate veterinary support. This would roll out over FY80-85 (later accelerated to 80-82), with the Army taking over all veterinary support to

the Armed Forces. Officer manpower was cut, with both warrant officers and enlisted personnel substituted. Some positions were civilianized, and some converted from VC to other officer corps. (This would generally avoid specialty pay.) This preserved force-structure in the AMEDD, at the expense of expanding the AMEDD's mission. However, food-plant inspections were turned over to the USDA, saving some 20 officer and 120 enlisted spaces.

There were mobilization repercussions. Reducing the number of facilities available reduced mobilization and casualty care capacity for potential major wars. DoD responded to this by working within the government (i.e. with the VA) and the civilian sector to establish what is now the National Disaster Medical System but started as the National Defense Medical System.

Better management

This is a perennial goal, and goes hand-in-hand with centralization to get apples-apples data. The various joint or government-wide sharing was an effort to manage better. Creating the Medical Expense and Performance Reporting System was an effort to manage better. DoD also sought to adopt HMOs (for beneficiaries, not military) when those were the rage in civilian healthcare. CHAMPUS was also centralized instead of being managed by the three services. In a few places duplication was reduced – the Army hospital on Okinawa was turned over to the Navy.

Pass the cost

Cutting AMEDD manpower and budget caused increased referrals to the CHAMPUS network. Along with inflation, this caused the CHAMPUS budget to more than double in five years (up 142% over FY1969-1974). While arguably a rational decision for the AMEDD, this did not help the US Government overall, and Congress held hearings in 1974. Late in FY1974, SecDef Schlesinger restricted some practices that had become customary but were not authorized in law.

Since CHAMPUS was more of an insurance program than TRICARE is, the changes meant co-payments from individuals and were a deterrent to care.

Increased spending

- I want to end by looking at some expensive things that got funded in a period of tight budgets. Since the doctor draft was ending, there was a need for volunteer doctors. Congress spent lots of money on this: USUHS and the HPSP were approved. These were (and remain) costly programs, but were judged necessary. Similarly, professional special pays, retention bonuses, and GME have been funded. The costs have been repeatedly investigated, but because the requirement is genuine it has been approved even when budgets were tight.
- In 1973 the Secretary of Defense recognized the services were not investing enough in medical facilities and not asking for enough resources. (It is not clear if the AMEDD was pre-reducing its requests or if DA was reducing AMEDD requests.) He directed the Surgeons General to re-evaluate their programs. The AMEDD received a 23% increase for FY1974, equivalent to some \$2 billion today, and an augmented 5-year plan to replace 11 hospitals and dozens of dental clinics.
- Drug testing (and treatment) was a new requirement in the early 1970s. It was funded because the President and Congress judged it necessary. It appears extra funds and some manpower (at least civilian authorizations) were provided for this.

So, lots of things were unique to the 1970s that don't provide any guidance for now – the Army can hardly go to an all-volunteer force again. But the pressure to manage efficiently has

continued, and purple pressure has continued. But if there's a no-nonsense reason for the Army to spend money on healthcare, it's shown a willingness to do the right thing.