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Enhancing the US Military Health System's global health engagement strategy

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Introduction

The US Department of Defense (DOD) released the 2022 National Defense Strategy (NDS) fact sheet in March 2022.[1] The document highlights priority areas including the need for strengthening deterrence against strategic competitors and transboundary threats such as pandemics. The DoD acknowledges they cannot accomplish these tasks alone. The fact sheet states, "mutually beneficial Alliances and partnerships are an enduring strength for the United States and are critical to achieving our objectives…". The Military Health System (MHS) supports the NDS objectives providing a medically ready force, a ready medical force, and enhancing alliances and partnerships. These alliances and partnerships are established, enhanced, and employed through global health engagement (GHE) efforts. GHE is one of four MHS areas of impact and was codified in DoD policy in 2017.[2,3] Despite the increased demand for GHE and direct connection to the new NDS, **there are gaps impacting policy implementation and support to whole of government global health and global health security efforts.**

> "Mutually beneficial Alliances and partnerships are an enduring strength for the United States and are critical to achieving our objectives…"
>
> —2022 National Defense Strategy Fact Sheet

US DoD GHE as a capability has been enhanced over time, but shortfalls span the doctrine, organization, training, materiel, leadership and education, personnel, facilities, and policy (DOTMLPF-P) spectrum. These shortfalls prevent the US DoD from having the interoperable GHE capability required by today's defense challenges and expected by current GHE policy.[4]

The Services, Commands, and Defense Agencies are primarily impacted by personnel and funding constraints. In the US Central Command,

U.S. Army Reserve photo by Master Sgt. Michel Sauret. The appearance of U.S. Department of Defense (DoD) visual information does not imply or constitute DoD endorsement.

GHE human capital was inadequate to support all headquarters policy requirements. Despite conducting 169 GHEs from 2014-18 (9% of the security cooperation engagements), partner nation requests for engagement were declined due to the shortfall in personnel and funding to plan and execute.[5] Within the Indo-Asia Pacific Command, a Service Component Command experienced a modest 2% approval rate for GHE funding proposals. All 37 proposals submitted during the annual planning cycle linked Service health capabilities to partner nation gaps and were vetted and approved by the Component Command, Combatant Command, and Individual Country Teams including the US Agency for International Development.[6] Unfortunately, resourcing was not adequate to support the demand. Other shortfalls were documented in a 2019 DOTMLPF-P Change Recommendation (DCR) submitted to the Joint Requirements Oversight Council of the Joint Staff. Some action items were addressed while others such as personnel, funding, and centralized knowledge management continue to impact effective GHE policy implementation.

Notwithstanding these ongoing shortfalls, the MHS finds ways to enhance alliances and partnerships to support integrated deterrence, campaigning, and actions that build enduring advantages. First, the MHS supported a Secretary of Defense initiative with the United Arab Emirates by embedding a US military trauma, burn and rehabilitative medicine team in a new 750 bed facility (joint venture between the Mayo Clinic and the Abu Dhabi Health Services Company). The US military partners with UAE military and civilian counterparts to enhance medical capabilities, support interoperability, provide a venue for US military providers to generate readiness, and create a possible in-theater state of the art referral facility for ongoing and contingency operations.[7,8] Second, the US partnered with Vietnam and other Allies including Australia and the United Kingdom to build a Level 2 field hospital capability that deployed in support of United Nations Peace Keeping Operations in South Sudan. Third, the US supported the development of an African Peacekeeping Rapid Response Partnership Level 2 field hospital capability in Ghana, Rwanda, Senegal, and Uganda.[9] These hospitals were deployed by all nations during their national COVID-19 response.[10]

There are other examples where the MHS supported interagency partners such as the US Agency for International Development as seen in Bangladesh. A military medicine team provided fistula repair assistance in support of the US Ambassadors integrated country plan.[11] And examples of working directly with partner nation Ministries of Health to provide direct clinical care to support unmet needs as seen in Palau leveraging capability from the Tripler Army Medical Center located in Honolulu, Hawaii. These examples directly fit into the deterrence and campaigning "ways" in the new NDS. The US DoD is not alone in conducting GHE. Many nations are doing the same in support of their national defense and security strategies.[12]

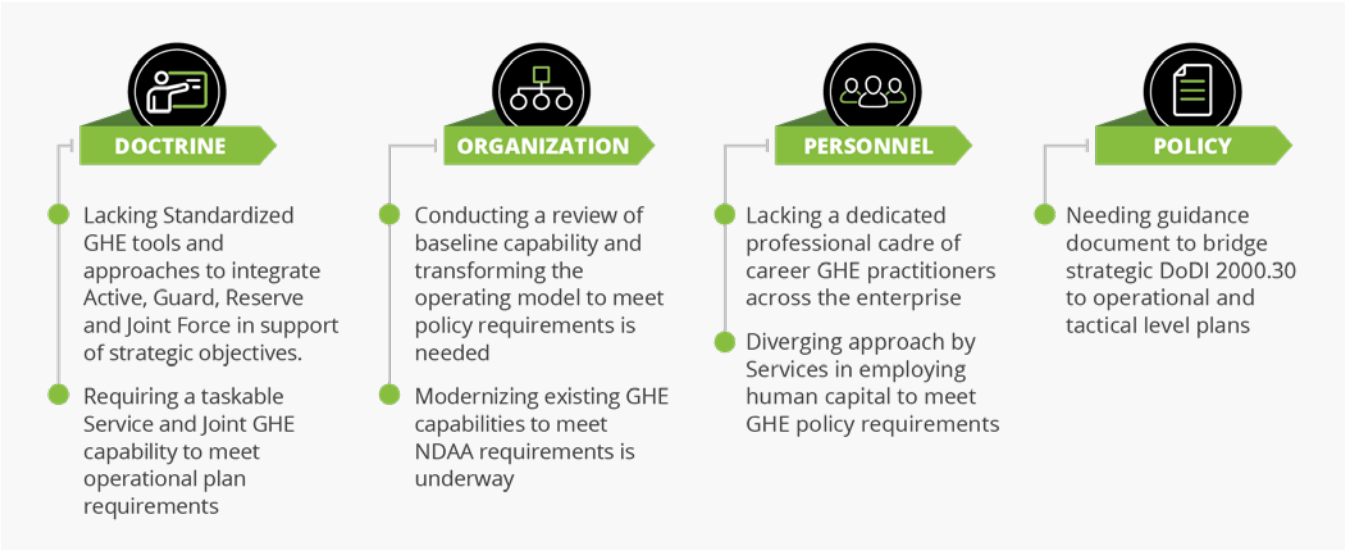
The COVID-19 pandemic highlighted for the world the need to double down on global health to mitigate future threats. This includes the threat to international order and the balance of power as societies emerge from the pandemic and look to the US for leadership.[13] The current administration reinvigorated investments in global health and global health security to address shared problems and lead in crisis response overseas.[14] **It is fundamental the US DoD follow their lead and create a more interoperable GHE capability to support the NDS, Joint Force, and our Allies and partners.**

Current State Description

The DoD implements the currently unfunded DoD GHE policy given existing authorities and appropriations dispersed across various accounts and agencies while managing risk to operational and garrison health requirements. Using the DOTMLPF-P framework, a few key areas highlighting the current situation are outlined below.

USNS Comfort, pictured during Operation Unified Response near Port-au-Prince, Haiti. The appearance of U.S. Department of Defense (DoD) visual information does not imply or constitute DoD endorsement.

Figure 1. *DoD GHE Current State*



1. **Doctrine.** Despite ongoing GHE operations, activities, and actions across all Combatant Commands (CCMDs), the DoD would benefit from standardized tools and approaches that bring together joint military medical functional capabilities across the Active, Guard, Reserve and Joint Force in support of the various strategic objectives.[15] Some efforts are underway to close this gap and include creating standardized tools such as medical functional area playbooks covering ten doctrinal areas (**Figure 2**) within the health service support and force health protection domains and designing adaptive force packages to be tasked and execute GHE missions.[16]

2. **Organization.** A comprehensive review and transformation of the current GHE ecosystem within the DoD and how it supports the interagency, Allies, and partners is warranted. This could further enable the DoD to achieve their interoperability goals set forward in the GHE policy. Evolution is occurring within the DoD GHE community and is driven primarily by the National Defense Authorization Act of 2017. Exploring the role of the Defense Health Agency (DHA) has and should play in GHE is necessary. Examination should include which organizations, authorities, and appropriations within the DHA contribute to the DoD GHE capability (e.g., the Armed Forces Health Surveillance Division and

Joint Trauma System) and the potential need for an integrating program management office to expand support as an enabling and delivery organization to the Services, Joint Staff, CCMDs and Component Commands.

3. **Personnel.** The DoD could benefit from a dedicated professional cadre of career GHE practitioners across the Active, Guard and Reserve forces. Individuals who received additional training in global health, diplomacy, and security cooperation such as the Air Force International Health Specialist and Navy Health Security Cooperation Officer currently serve as part-time practitioners as they transition between their primary profession and what may be considered an additional duty assignment to support GHE. The way these practitioners are employed diverges by Service and there does not appear to be a central workforce strategy nor joint human capital development framework for requirements across the DoD and in support of interagency partners.

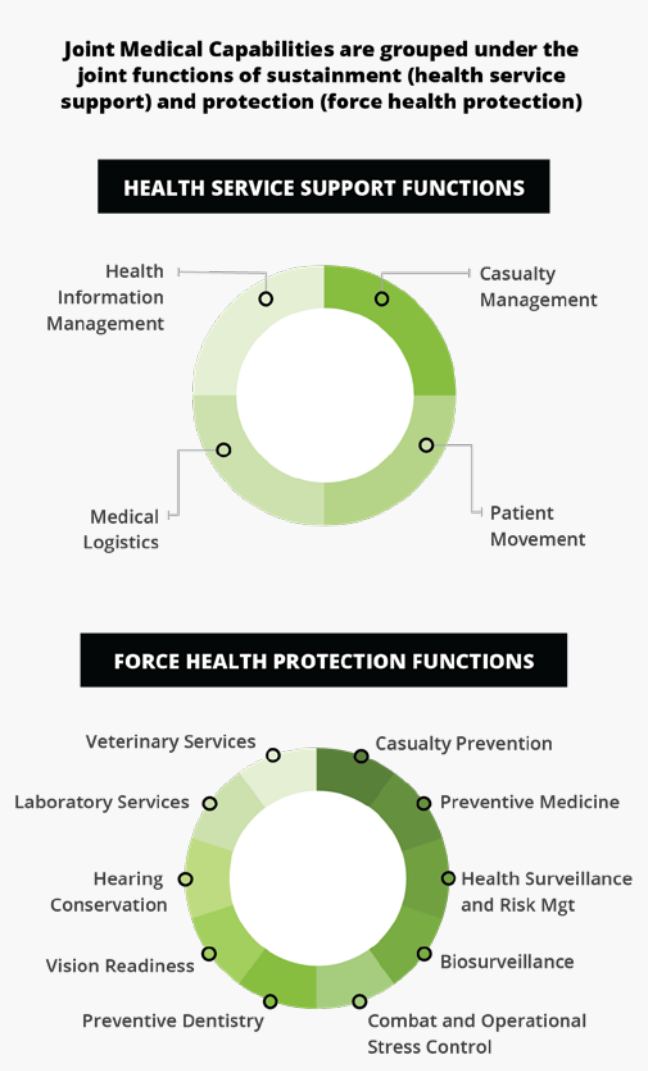
4. **Policy.** An Office of the Under Secretary of Defense for Policy reorganization in 2022 changed how the DoD leads GHE. The GHE policy authority shifted from the Assistant Secretary of Defense (ASD) for Special Operations and Low Intensity Conflict to the ASD Strategy, Plans and Capabilities driving the need for a Department of Defense Instruction (DoDI) 2000.30 Global Health Engagement Activities refresh. Additionally, the DoD could potentially benefit from a formal GHE guidance document bridging the strategic policy to operational and tactical level plans developed by the Combatant Commands and Component Commands.

Additional factors challenging GHE Policy implementation include:

5. **Variance.** The techniques CCMDs implement GHE varies by ends, ways, and means. This includes who is engaged (military or civilian entities), how (using MHS functional areas or civilian health system frameworks), and where (bilaterally or in multilateral arrangements). A consistent approach to policy implementation, while acknowledging the need for some flexibility based on unique CCMD requirements, would better enable all levels of the enterprise to quantify impact for leaders and elected officials.

6. **Technology.** There is a gap in GHE systems and processes for guiding, directing, assessing, and assuring inputs across the enterprise achieve strategic objectives. Closing this gap would enable various organizations to project the needs of partners and integrate capabilities to meet requirements within the DoD, across the interagency, and in conjunction with Allies and partners. Enabling Assessment Monitoring and Evaluation (AM&E) in support of GHE would also be enhanced to assure requirements in the DoD policy for AM&E are achieved.[17]

Figure 2. *Joint Medical Functional Areas*



U.S. Air Force photo by Staff Sgt. Adam R. Shanks. The appearance of U.S. Department of Defense (DoD) visual information does not imply or constitute DoD endorsement.

Point of View

DoDs current state highlights three challenges:

1. **Inconsistent approach to "why" and "how"** DoD GHE policy is implemented in support of the NMS, NDS, and NSS
2. **Insufficient capability across the enterprise** to meet DoD GHE policy requirements
3. **Lack of a DoD GHE information technology system, processes, and integration** with interagency and international partners

To address these limitations, we propose a structured approach to enable strategic transformation. This would require the DoD to commit, translate, and transform. The DoD should determine what GHE transformation is needed to achieve the new NDS objectives. They should specify how the organization will transform while managing risk. And finally, the DoD will need to execute, deliver return on investments, and achieve the desired future state of the GHE capability. An abbreviated ends, ways and means perspective is provided to highlight how DoD could optimize, grow, and reinvent GHE.

1. **Ends.** Update the DoD GHE policy, develop an institutional GHE strategy, and create associated plans. Updating the DoDI 2000.30 and setting the strategic outcomes by incorporating lessons learned since original publication in 2017 and aligning with interagency and international global health and global health security efforts would enhance implementation. Developing a Defense wide GHE strategy with associated strategic objectives, initiatives, activities, KPIs, and targets to support system wide performance management and integration with the MHS strategy. Developing implementation plans including, but not limited to, CCMD GHE Appendices to Annex Q of Combatant Command Campaign Plans, Component Plans, and inputs to Ambassador country plans where appropriate. These plans should be standardized to support performance monitoring, inform decision making, and lead to a greater return on investment while acknowledging the need for flexibility driven by unique CCMD requirements.
2. **Ways.** Design and detail a target operating model (TOM) for the GHE capability. The method used to achieve the strategic GHE objectives should include a TOM framework designed around four pillars: A. people, B. process, C. technology and D. governance. The approach should be applied to the strategic headquarters elements including the OSD and the Joint Staff with options to activate similar efforts in support of Services, CCMDs, Components, Defense Agencies, and other organizations phased over time. The TOM informed by interagency and international benchmarks would better enable the strategic headquarters in providing advice, guidance, direction, policy, and assurance in line with the NDS and NMS and the Services to generate a force for employment by the CCMDs.
3. **Means.** Large government transformations are typically multi-year journeys. They deliver impact by working with clients to set a clear vision and execute a path forward to transform the organization. Transformation efforts should leverage various resources to include convening groups of relevant stakeholders, facilitating working sessions, consolidating outputs, validating findings, and updating documentation to improve performance over time. This includes alignment with DoD policy and strategy validated by Subject Matter Experts who could establish the organization foundations, build capacity, and oversee performance to achieve the strategic objectives.

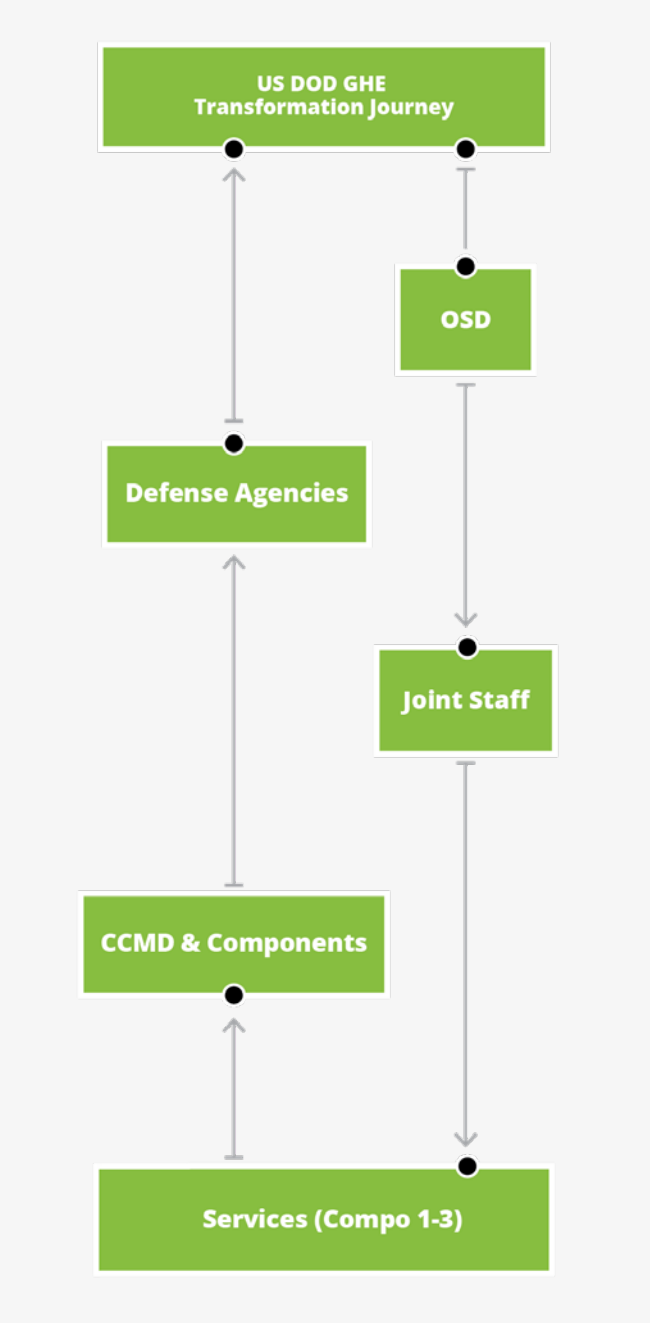
Potential Benefits

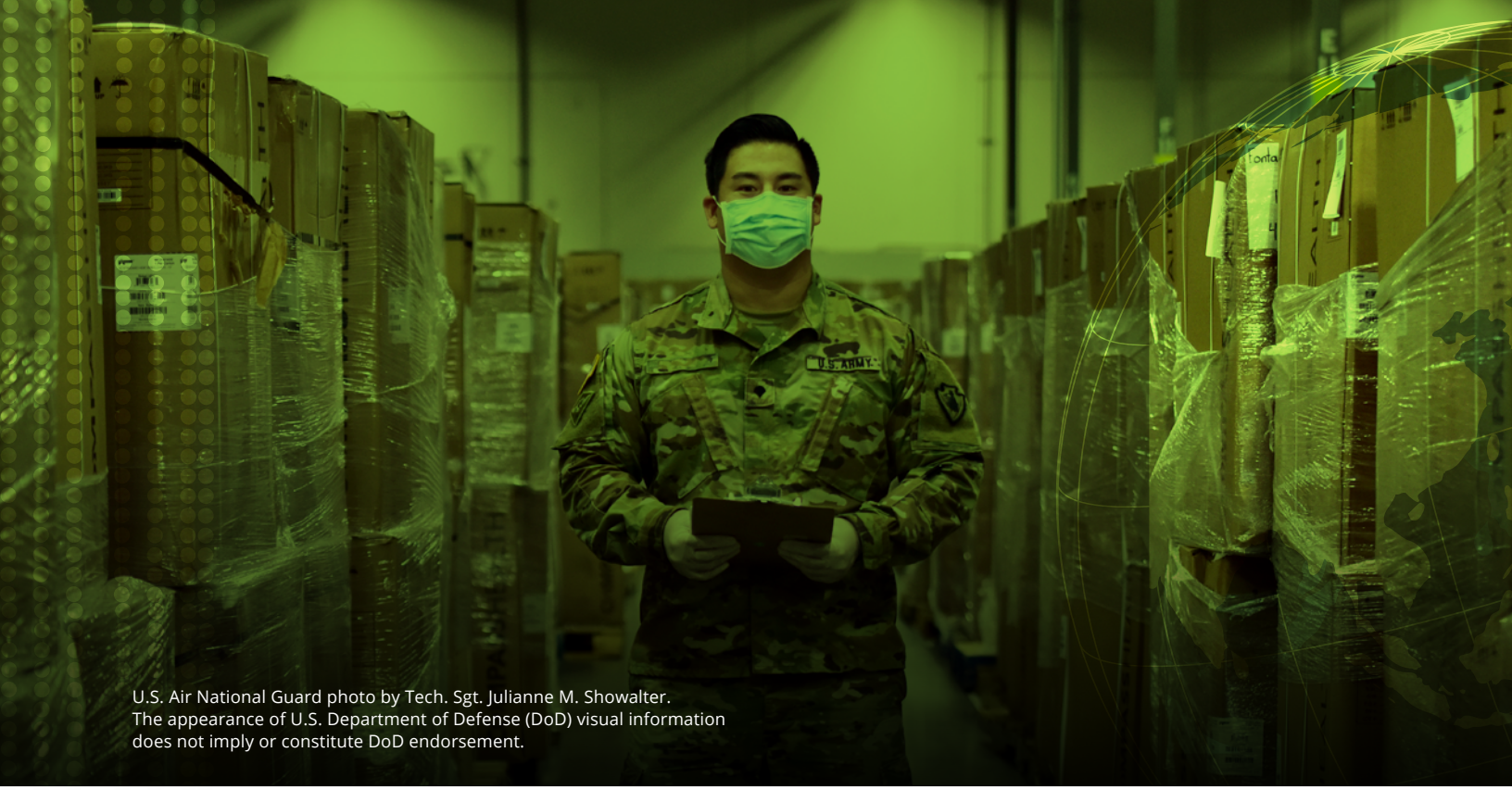
The transformation would help **ensure the DoD is able to modernize the GHE policy in support of the new NDS objectives and translate the validated GHE model into action.** The comprehensive GHE model should effectively link all elements within the DoD from the strategic to tactical levels in a single point of view. The model would leverage efficient and effective principles to drive improvement in readiness and operations while maximizing the return on investment of resources to deliver strategic outcomes. This includes enhanced decision making leveraging a comprehensive governance structure with clear lines authority and accountability. All organizations, units, and individuals leading and supporting GHE are aligned to requirements that meet strategic objectives. The new model built around greater interoperability would help enhance collaboration within the DoD and lead to better integration across the interagency in support of national security strategies—specifically global health and global health security programs and priorities.

Future State

The DoD GHE capability is transformed and resourced with a clear policy, strategy, and associated plans to support efficient and effective implementation across the enterprise and in conjunction with interagency and international partners. Support to this effort will assist the DoD and MHS in moving from incremental GHE change to transforming the capability and delivering breakthrough value. This type of strategic transformation will truly support national defense objectives, improve the health and safety of our warfighters, and provide enhanced readiness of the medical force.

Figure 3. *Transformation Journey*





U.S. Air National Guard photo by Tech. Sgt. Julianne M. Showalter.
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