Focus On….Managing Health Services Support to Military Operations.

The Operational Context for Military Health Services Support.

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Abstract

This is the first of a series of monographs that describe some of the principles and factors involved in managing health services support to military operations. This paper will place planning military health services support in the context of wider planning for military operations. It starts be examining the Contemporary Operating Environment and the role of military forces within it. The paper then considers the generic military planning process and how the medical staff in a headquarters plan the medical support to military operations. The final element of the paper is a discussion of the composition of the personnel required within a medical branch in a military headquarters.

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Introduction

This is the first of a series of monographs that describe some of the principles and factors involved in managing health services support to military operations[1]. Health is not merely the absence of injury or disease, in its widest sense it includes physical and mental well-being. In a military operational context, health is the ability to carry out duties unimpeded by physical, psychological or social problems. The medical services make a major contribution to force protection, sustainability and the moral component of Fighting Power by the prevention of disease, the rapid treatment of the injured, wounded, or diseased, their medical evacuation, and eventual recovery and return to duty or discharge from Service. Effective medical support is fundamental to mission success and the provision of appropriate and visible medical support demonstrates both military resolve and the nation's commitment to its forces. Clearly, whilst medical care is an important element of maintaining health, the actions of many other agencies, led by the Chain of Command, also have important responsibilities in this area (1).

This paper will place planning military health services support in the context of wider planning for military operations. The second paper will consider the Estimate process in more detail and describe specific medical factors to be considered within this process. The third paper will examine the process of Casualty Estimation within the Estimate as a tool for forecasting demand for military medical capability and capacity. Future papers will consider subjects such as managing medical evacuation, assisting the development of

[1] The phrase 'health services support' is specifically chosen to encompass all aspects of the role of the military medical services in the prevention of disease, the evacuation of casualties and their subsequent clinical care. It is not yet UK or NATO endorsed doctrine.

health services support to indigenous security forces, governance of the deployed medical system and military medical involvement in wider national health sectors. These papers will build upon papers previously published in this Journal (2,3,4,5,6,7,8,9,10) but will concentrate on the contemporary operational environment (COE) described in the Future Land Operational Concept (FLOC) . This sees the nature of future land conflict across a spectrum of activities ranging from humanitarian activities through stability operations to major combat operations (11). These papers will be generic in nature in order to be suitable for an unclassified publication and are designed to assist the clinical readership of this journal to understand the role of the Command and Staff cadre of the Defence Medical Services.

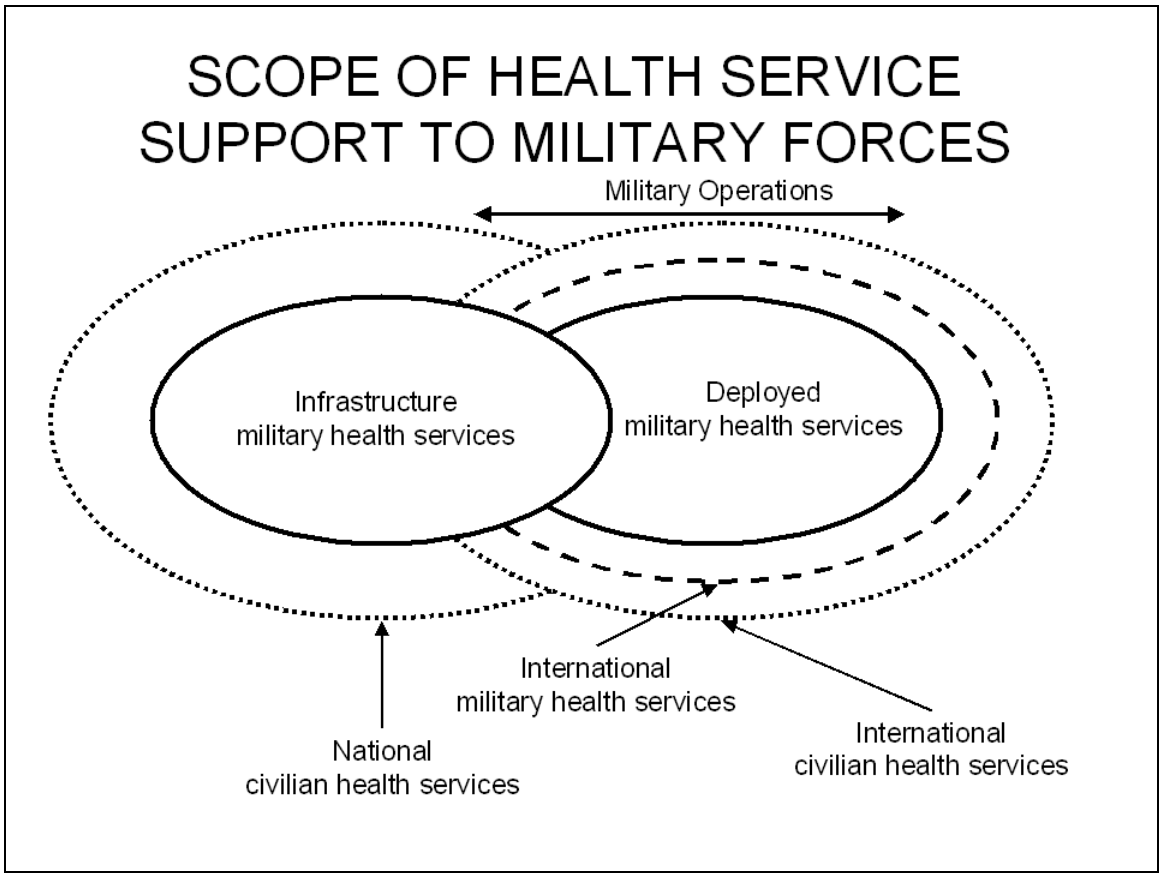
Military health services officers require an understanding of overall military context including the application of clinical practice within the COE. This introductory paper provides a brief review of military operations in the COE and then the nature of deployed military health services.

Military Operations In The Contemporary Operational Environment

Whilst many nations use military medical personnel for the provision of health services for military personnel in the home base, military medical organisations primarily exist for the relief of suffering on the battlefield though the provision of deployed military health services. Although nations have a moral and legal duty to provide health services support

for their own troops, not all nations can provide the full capability themselves. Thus there may be substantial multi-national collaboration to ensure sufficient deployed medical capability and capacity for a military force (possibly including the military forces of the indigenous country). The deployed military health services may also need to collaborate with national and international civilian health agencies in the host country. These relationships can be summarized in Figure 1 taken from UK Joint Medical Doctrine (1).

Figure 1



British Defence Doctrine describes the principles that underpin the employment of military power alongside the other two instruments of national power, diplomatic and

economic, to achieve national strategic objectives. The UK's approach to crisis management is always 'cross-government' and usually involves multi-national and multi-agency partners. The military component will inform the shared analysis of the situation. Collaborative planning will determine both the task and the purpose for each activity required to achieve the desired outcome. It will also direct the execution of military activities, and contribute to a shared assessment of progress.

There is widespread consensus that the focus for current military capability should shift from inter-state war to intra-state and trans-state conflict including counter-insurgency operations (COIN). The FLOC describes the military's role in crisis prevention and post conflict stabilization. This is achieved through promoting security and stability, building institutional capacity, Security Sector Reform (SSR) and development. These functions may require military forces to contribute to the delivery of essential goods and services if civilian agencies are either constrained or absent. The military contribution to supporting civilian development needs to be co-ordinated with local and international civilian agencies. It should be focussed on meeting basic needs (food, water, fuel) and providing essential services (health services, sanitation and education). This is mainly achieved through the provision of security to enable other actors to have access to the dependant civilian population but may involve direct delivery of services.

The military framework for command and control is based upon four levels of war (12). The highest level is the Grand Strategic and is concerned with inter-ministerial co-ordination to implement national policy in a comprehensive approach integrating all of

the instruments of state (diplomatic, economic and military activities). The Military Strategic Level is concerned with the allocation of military resources to support the Grand Strategic plan. The Operational Level is about the employment of military forces to achieve strategic goals through the design, organisation, integration and conduct of campaigns. The lowest level, the Tactical Level is the level at which actual combat is orchestrated and battles are fought. In the COE, particularly as a result of the speed of modern media communications, the separation of these levels has become blurred with the potential for small tactical events to rapidly become strategically important. Table 1 summarises the key medical planning and execution activities for each level.

Table 1. Medical Activities at each level of war

Level	Activities	Remarks
Grand Strategic	Balancing health resources between civil and defence requirements. Generating health manpower to support national requirements. Integrating military and civilian resources to care for military casualties at Role 4.	National health service resources are finite. In WW2 a national committee managed mobilisation of civilian medical staff in the Armed Forces to ensure balance between military and civilian requirements
Strategic	Allocation of resources to the medical function. Determining the medical support capabilities and capacities required to support campaigns. Balancing medical resources between active duty and reserve forces. Predicting the casualty load for campaigns.	The medical function has to compete will all other military functions for Defence resources.
Operational	Determining the medical resources required for specific operations'. Balancing medical resources between nations and between Army, Navy and Air Force medical services on operations.	This requires an understanding of the medical implications of operational design and balancing economy with risk. This is about allocation of medical resources (especially Role 2E and Role 3,

	Establishing and monitoring the medical evacuation chain from point of wounding to Role 4.	and MEDEVAC airframes) for a particular operation.
Tactical	Assigning missions and tasks to individual medical units. Planning for and managing casualty evacuation and care during and after battles. Responding to medical emergencies.	This requires an understanding of military and medical tactics and the potential casualty flows. This is about siting of Role 2E, Role 2LM units and managing MEDEVAC from point of wounding to the strategic evacuation hub.

Organisation Of Military Headquarters

Western military headquarters are normally organised into a series of discrete staff elements (13). The Commander is directly supported by his two principal staff officers (Chief of Staff and Deputy Chief of Staff) and specialist advisers (Political/Policy Adviser, Legal Adviser, Medical Adviser). The supporting staff are structured into 9 staff divisions (titles J – Joint, A – Air, N – Naval, G – Ground, C – Combined) dependant on the function of the headquarters). The staff branch functions are described in Table 2.

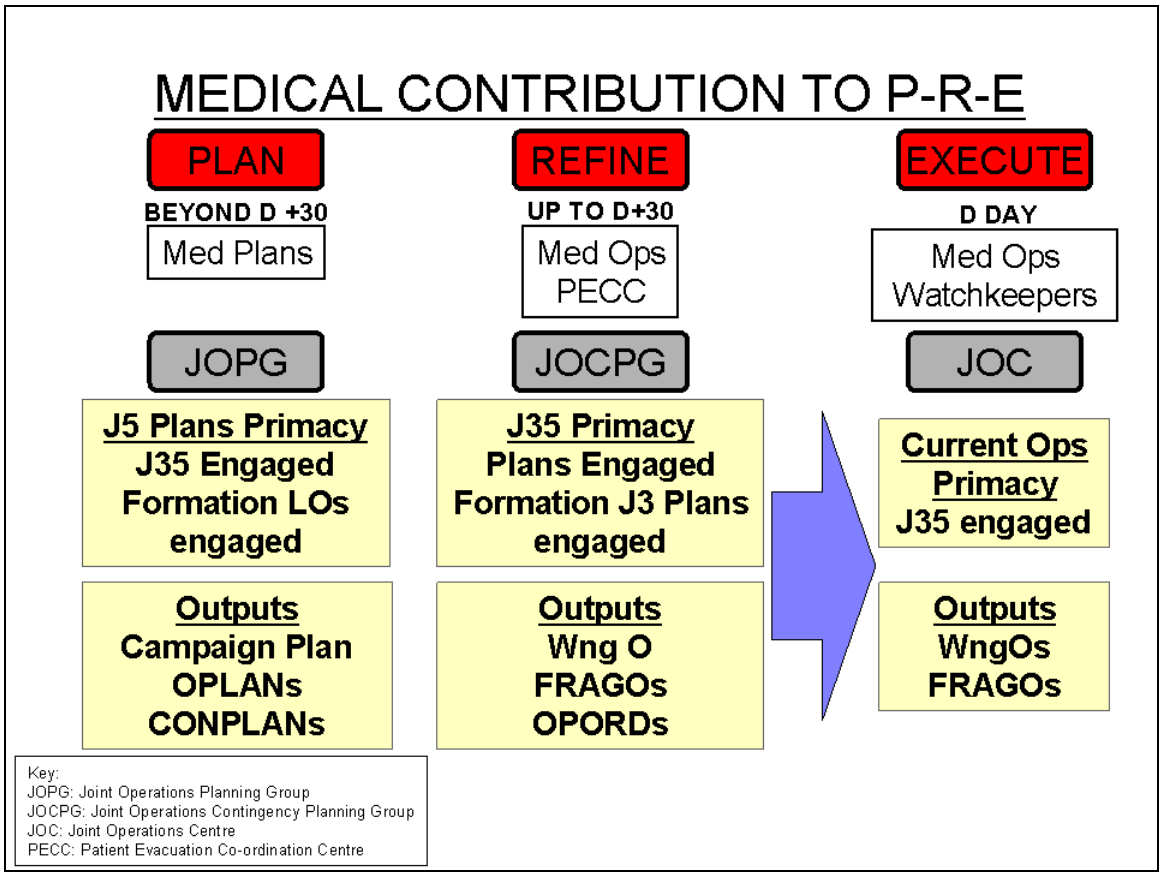
Table 2 – Staff Branch Functions

Number	Title	Function
J1	Personnel and Administration	Responsible for manpower planning and accounting, Prisoners of War policy, welfare, discipline and honours and awards.
J2	Intelligence	Responsible for the collection, analysis and presentation of information about the operational environment and actors.
J3	Operations	Responsible for monitoring and managing current operations in the operations centre and producing Operational Orders in the J3/5 cell.
J4	Logistics	Responsible for supply, movement, equipment support and medical support.
J5	Plans	Responsible for managing the ‘Estimate’ process and developing Operational Directives and Plans.

J6	Communications	Responsible for communications and information systems for the force.
J7	Doctrine and Training	Responsible for training and lessons identified. May be the focal points for development of indigenous forces.
J8	Financial	Responsible for all financial and contracting aspects.
J9	Civil-Military Liaison	Responsible for interfaces to non-military actors in the campaign.

The planning and execution of the military operation is managed by the J5, J3/5 and J3 staff branches as a multi-disciplinary activity that draws in representatives from all of the specialist branches. The shift in responsibility between these staff branches can be summarised as the Plan-Refine-Execute process. Military planning utilises the 'Estimate' which is a formal tool for structured problem-solving. The medical aspects of the Estimate will be considered in the second of these papers. A range of planning documents may be produced as a result of the Estimate including: Campaign Directive, Force Instruction Document, Operation Plans (OPLANS), Contingency Plans (CONPLANS) (J5), Operation Orders (OPORDs) (J3/5), and Fragmentary Orders (FRAGOs) (J3/5). Each of these will have a health and medical services component. The staff branches monitor the performance of the plan on behalf of the Commander using a range of tools including Reports & Returns, Operational Analysis, and formal assessments and reviews. These relationships and outputs are summarised in Figure 2.

Figure 2 Medical Contribution to Plan – Refine - Execute

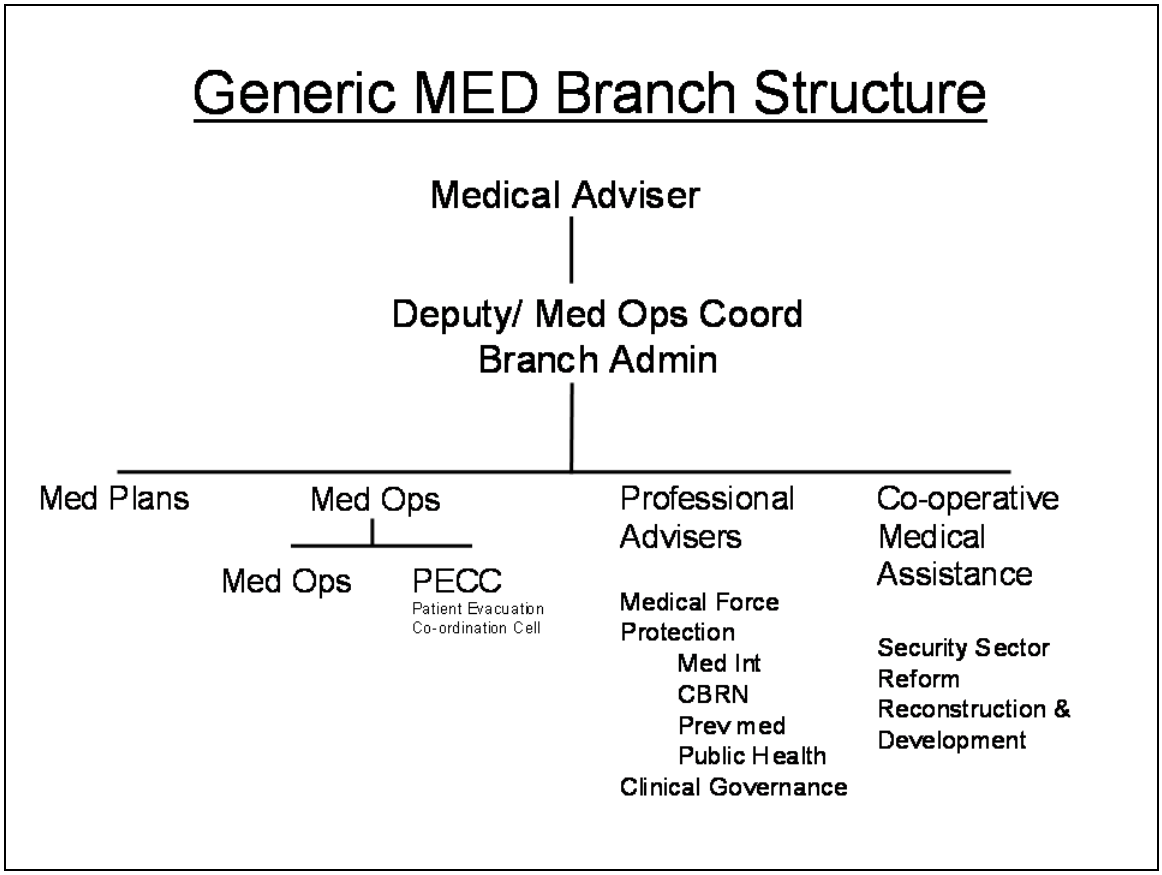


Managing The Medical Function Within Military Headquarters

There is considerable similarity between military medical planning and civilian emergency planning, but the military environment is about planning for the certainty of trauma casualties rather than the possibility of trauma casualties. In addition there are important differences in the nature of the environment, the type of injury and the organization of the medical system (14). NATO medical doctrine (15) lists the following as core outputs of a medical staff branch: medical support planning and execution, managing medical evacuation (MEDEVAC), maintaining medical situational awareness (monitoring, tracking, assessing and reporting medical capability and capacity), issuing

functional policies, implementing Clinical Governance, advising on Force Health Protection, co-ordination with other staff functions as shown in Table 2, and medical information management. The Medical Branch is usually organized into the functional areas shown in Figure 3.

Figure 3. Generic Medical Branch Structure



The senior medical staff officer is the Medical Adviser within the Commander's principal staff and controls subordinate medical units on behalf of the Commander. The medical staff branch is usually organised within the J1/J4 area under the Deputy Chief of Staff but

contributes to and is supported by staff outputs across the headquarters. Through his deputy he maintains oversight of the medical contribution to the P-R-E process to ensure that the medical estimate, plan and execution are coherent and effective. The Medical Plans cell provides medical advice to the J5. The cell co-ordinates with Operational Analysis for the production of the Casualty Estimate and the Air/Aviation cell to obtain and assign aeromedical evacuation resources. The Medical Operations cell is responsible for medical advice to J3/5 and J3 and may be divided into 2 functions the Medical Operations Cell and the PECC. The Medical Operations Cell works with J3/5 to plan medical support to specific tactical activities. It also maintains the current medical Situational Awareness picture through operational and medical Command Information Systems and manages Casualty Regulation across medical facilities. The Patient Evacuation Control Cell is responsible for the planning and execution of all medical evacuation (MEDEVAC) tasks by ground, Rotary Wing or Fixed Wing transport. The PECC co-ordinates with higher and sub-ordinate formations/units and internal staff branches of Aviation, Air and Movement. The PECC supports the J1 branch for Patient Tracking and Reporting. The PECC either works within Med Branch or in the Operations Centre dependant upon the precise structure of a HQ for a specific operation. It is usual for the PECC to be manned on a 24 hour basis and is the primary point of contact for the HQ Medical Branch.

The medical branch should be established for specialist health functions. Force Health Protection is the most important and would be led by a specialist in Environmental Health, Public Health or Occupational Medicine. This cell would supervise the collection

of medical intelligence, promulgate Force Health Protection instructions and act as the lead for investigating outbreaks of ill-health. There may also be an individual responsible for Clinical Governance (CG) across the medical system. This role would monitor the performance of MEDEVAC against clinical timelines, assure CG processes in medical units and investigate any concerns regarding clinical performance.

Military health services have an important role in the evolving operational concept of the 'Comprehensive Approach' that integrates military, pan-government and multi-agency sectors in conflict resolution (12). This would be led by a co-operative medical assistance cell which has two roles. The first is within Security Sector Reform (SSR) by supporting the medical services of the indigenous security sector (army, police, border police etc) and collaborating with the J7 staff branch. The second is engagement with the indigenous civilian health sector (ministry of public health, health aspects of ministry of education, health sector International Agencies (e.g. World Health Organisation) and health sector NGOs (e.g. ICRC, MSF) in order to support the health aspects of humanitarian assistance (HA) and reconstruction and development (R&D).

Conclusion

This article has summarised the current military context and the organisation and function of a deployed military headquarters. It describes the role of a medical branch within a military headquarters and the key interfaces both within the headquarters and across

wider stakeholders in a deployed military environment. The next article will describe the contribution of the medical function to the military planning process.

Word count: 1930

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