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ARMY FORCE STRUCTURE

Plans to Restructure and Reduce Medical Corps

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Madam Chairman and Members of the Subcommittee:

We appreciate the opportunity to be here today to discuss the Department of the Army's process for restructuring and reducing the number of reserve medical support units from its force. During the past 2 weeks, we have discussed this issue with Army officials from the Deputy Chief of Staff's Operations and Plans Office, the Office of the Surgeon General, the Army's Forces Command, the National Guard Bureau, and the Office of the Chief of Army Reserve. We have also held discussions with Department of Defense officials from the Offices of Health Affairs, Reserve Affairs, and Force Management and Personnel. We obtained documentation on the Army's current inventory of medical units and its estimate of future requirements.

RESULTS IN BRIEF

The Army plans to reduce its medical force structure from 786 units to 555 units by 1995. While the number of active units is expected to increase slightly, the number of units in the reserve components will be reduced by 105 units. According to the Army, this equates to a reduction of about 30,000 authorized positions. The Army plans to begin these reductions about October 1992.

Based on its experiences in the Gulf war and its Medical Force 2000 initiative, Army officials have decided that the medical force should be less dependent on reserve forces, particularly in its contingency force, which must deploy quickly. As a result, the Army's future medical force will be less reliant on reserve units. The Army's Office of the Deputy Chief of Staff for Operations and Plans directed Forces Command and the National Guard Bureau to identify which reserve medical units to eliminate. In making their decisions, these organizations sought to achieve several objectives, including the retention of needed critical skills and an increase in unit readiness.

The Army is attempting to retain critical medical specialists in part by dispersing the components of its hospital units throughout the United States and by adding specialists from units scheduled to be eliminated to its Individual Mobilization Augmentee program. However, the Army's plans to decentralize its reserve medical force may not allow it to fully achieve its objectives of retaining critical skills and achieving higher unit readiness. For example, with the deactivation of Army medical units, the Army has no assurance that it will be able to retain personnel with critical medical skills, and it has no plan describing how it will keep them. In addition, we have seen no plans describing how the Army expects to achieve unit cohesion and training for the reserve units under its planned decentralized hospital system. This is particularly important because units lacked collective unit training prior to Operation Desert Shield/Desert Storm. Further,

while the Army Reserve and National Guard have coordinated their plans to avoid competing for the same resources, we believe that including an assessment by the Office of the Secretary of Defense would provide an opportunity to coordinate plans among the military services.

CHANGES IN THE SIZE OF THE MEDICAL FORCE

The Army plans to reduce its combat forces from 28 divisions to 20 divisions by 1995. To determine the number of combat support and combat service support forces (including medical units) needed to support the fighting force, the Army uses a process known as "Total Army Analysis." The results of the latest analysis, which projects requirements for 1999, are shown in table 1. This table shows the Army's 11 medical functional areas and the number of units currently within them. The unresourced columns in this table represent the number of required units that the Army has determined to be unaffordable.

Table 1: Current and Planned Army Medical Units

	Current program					Future plan				
		National					National			
Functional area	Active	Guard	Reserve	Unresourced	Total	Active	Guard	Reserve	Unresourced	Total
Hospitals	33	17	82	9	141	31	7	50	20	108
Area Support	2	2	0	5	9	6	3	1	2	12
Command and Control	7	6	18	13	44	10	3	16	1	30
Evacuation	33	40	21	37	131	28	23	18	1	70
Dental	23	11	40	31	105	24	7	29	12	72
Medical Logistics	8	2	8	5	23	9	1	8	3	21
Specialty Teams	19	0	52	102	173	25	0	39	61	125
Veterinary	21	1	14	10	46	15	0	18	5	38
Combat Stress	8	3	13	22	46	10	0	14	4	28
Preventative Medicine	20	18	15	12	65	22	9	13	4	48
Laboratories	1	1	1	0	3	2	0	1	0	3
Total force	175	101	264	246	786	182	53	207	113	555

Source: Department of the Army.

As shown in table 1, the number of active force units has increased by 4 percent, while the number of Reserve units has decreased by 22 percent and the number of National Guard units has decreased by 48 percent. This equates to an overall medical force reduction of about 30,000 authorized positions--about 20,000 positions within

the Army Reserve and about 10,000 positions within the Army National Guard.

In addition to reducing the medical force, the Army initiated an effort to restructure its medical force in support of the AirLand Battle doctrine. Medical Force 2000 has created changes throughout the Army's medical force. For example, Medical Force 2000 eliminates two types of hospitals and changes the bed capacities of the rest.

All the hospitals will have new personnel and equipment configurations. With the exception of the Mobile Army Surgical Hospitals, all hospitals will consist of a base component that is clinically similar and one or more of what the Army refers to as "mission-adaptive components."

IMPLEMENTATION OF THE DRAWDOWN OF UNITS

The Deputy Chief of Staff for Operations and Plans provided guidance to Forces Command and the National Guard Bureau for structuring and selecting reserve component units for deactivation. According to Army officials, their objectives were to configure medical units to support the Army's AirLand Battle doctrine, retain critical skills, and increase the readiness of the units.

Forces Command, with the help of the U.S. Army Reserve Command and the Office of the Chief of Army Reserve, selected the Reserve medical units to retain and reconfigure. They first reviewed units by geographical regions to determine the feasibility of consolidating "broken" units (or units with low readiness ratings) within reasonable distances into reconfigured "whole" units (or units with higher readiness ratings). Then they reviewed the Unit Status Reports to identify both good and bad units based on personnel readiness rates. Next, they reviewed, as necessary, Reserve Medical Management Information System reports to confirm the personnel readiness ratings and identify how many people were actually qualified. This information enabled Forces Command to establish the makeup of a new unit and to decide on the location or locations of the new unit's components.

Other considerations used in making unit selections included the distribution of all Reserve and National Guard units so competition for recruits would be minimized, the ability to recruit in certain geographical areas, and budgetary and training impacts.

After considering the various criteria, Forces Command developed a medical force structure and a stationing plan for the Army Reserve that fit the Total Army Analysis requirements. It then sent the plan to the Army Reserve Commands, asking them to review and comment on the structure and provide suggested changes for the force structure in their geographical areas of concern. Forces Command has incorporated many of these changes and has forwarded

its proposed medical force structure to the Army Deputy Chief of Staff for Operations and Plans.

The National Guard Bureau followed similar procedures as the Forces Command, except the Guard's plan was not sent to the states for review and comment before it was forwarded to the Deputy Chief of Staff for Operations and Plans.

OBSERVATIONS

We offer the following observations:

-- Active medical units represent 23 percent of all medical units. This percentage will increase to 33 percent under the Army's plan for the future. As a result, the Army's future medical force will be less reliant on reserve units.

-- The impact of the restructuring and the drawdown on the Army's medical unit readiness is uncertain. According to the Army, the total number of available medical personnel appears adequate to staff the reduced number of units. However, many factors could affect medical readiness, such as the current shortage of critical specialists, the Army's ability to retain these specialists, and the geographical dispersion of the units.

-- Due to the deactivation of Army medical units, there is a concern that critical medical specialists will be lost. The Army has a number of methods to try to retain these critical specialists. These include the Individual Mobilization Augmentee program and the geographical dispersion of hospital components. However, a formal plan has not been developed to facilitate and manage the retention of essential medical personnel.

-- Army officials with whom we spoke believed that a decentralized medical force had advantages over the current structure, including an enhanced capability to retain critical medical specialists and improved readiness. A potential disadvantage is an adverse impact on unit training. The distance between the elements of a hospital under Medical Force 2000 may be several hundred miles. Consequently, the ability to drill as a unit may be lost. One of the lessons learned during Operation Desert Shield/Desert Storm was that medical units lacked the collective unit training necessary to support combat operations.

-- Office of the Secretary of Defense officials stated that they did not review the Army's plans for the drawdown and restructuring of its medical forces. Including the Office of the Secretary of Defense in the review process affords an opportunity to coordinate plans among the military services. Within the Army, the Reserve and National Guard components

Our May 1991 report on the Forest Service's monitoring performance presented strikingly similar findings.[5] Our findings in these two reports as well as those in a number of other GAO reports on both BLM's and the Forest Service's range management programs are linked by a common thread: the performance weaknesses we have observed are in large measure a result of resource constraints; the agencies do not have sufficient staffing and funding to perform all the management tasks necessary to effectively administer the current level of grazing activity. If the agencies' performance is to be demonstrably improved, our reports concluded that a better balance between the level of grazing activity and the resources available to administer it is needed.

In this context, our February 1992 report asked the Congress to consider (1) reducing the scope of the existing grazing program or (2) funding an increase in BLM's range management resources. Among the options for offsetting the additional required appropriations would be to increase federal grazing fees.

GRAZING ON BLM LAND IN THE HOT DESERTS

In our November 1991 report on grazing activity on the public land in the hot deserts of the Southwest, we reached a similar conclusion.[6] Livestock grazing occurs on almost 20 million acres of BLM land in America's hot deserts--some of the most unproductive, yet environmentally fragile, land in the country. We found that current livestock grazing activity risks long-term environmental damage while generating minimal economic benefits and grazing fee revenues that are not sufficient to provide for adequate management. We found evidence of damage caused by livestock grazing on BLM land as well as evidence of livestock grazing's adverse impacts on several wildlife species. Some damaged land may take decades to recover if it recovers at all.

We also found that BLM lacks the staff resources needed to collect and evaluate data measuring the impact of livestock grazing on many desert allotments. Without these data, BLM is not in a position to assess livestock usage of desert allotments and change usage as needed. Overall, because livestock grazing on BLM's hot desert land poses a high risk to the environment and costs more to manage than it returns to the federal government, we questioned the merits of the activity as it is currently conducted. Our report offered several options for the Congress to consider if it chooses

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[5]See Rangeland Management: Forest Service Not Performing Needed Monitoring of Grazing Allotments (GAO/RCED-91-148, May 16, 1991).

[6]The "hot deserts" encompass the Mojave, Sonoran, and Chihuahuan deserts. BLM manages land in these deserts in portions of California, Nevada, Utah, Arizona, and New Mexico.