STRATEGY RESEARCH PROJECT

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INTEGRATING MEDICAL SUPPLY AS PART OF THE ARMY'S SINGLE INTEGRATED MATERIAL MANAGER CONCEPT— WHY OR WHY NOT?

BY

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Integrating Medical Supply as Part of the Army's Single Integrated Materiel Manager Concept--Why or Why Not?

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ABSTRACT

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The U.S. Armed Forces of the 21st Century is predicted to be a more capable, agile, and power projection force. This prediction will radically change the way units are supported on the battlefield through an operational concept called " Focused Logistics." This concept will fuse information, logistics and transportation technologies to enable logisticians to deliver the right support at the right time and place on the battlefield. To achieve the goal of seamless logistics integration capabilities, one concept is to establish a Single Integrated Materiel Manager for the Army which envisions integrating all such functions as Quartermaster, Ordnance, Finance, and Medical Supply. The Single Manager Concept is the proposed primary means to achieve an efficient and effective integrated logistics and financial system to ensure combat readiness of the force at minimum cost to the Department of the Army. The consolidation of medical supply with the Standard Army Supply System has been a point of debate for many years due to opposing points of view on the missions of both functions. This paper examines the Single Manager Concept and the

and the implications of integrating medical supply as part of the concept.

TABLE OF CONTENTS

ABSTRACT iii

ACKNOWLEDGMENTS vii

LIST OF TABLES ix

INTRODUCTION 1

UNDERSTANDING ARMY LOGISTICS 3

THE IMPORTANCE OF THE MEDICAL MISSION 4

THE MEDICAL LOGISTICS (CLASS VIII) CONCEPT 6

THE UNIQUENESS OF THE MEDICAL COMMODITY 10

A SINGLE INTEGRATED MATERIEL MANAGER CONCEPT 16

ADVANTAGES OF A SINGLE INTEGRATED MATERIEL MANAGER CONCEPT..... 17

DISADVANTAGES OF A SINGLE INTEGRATED MATERIEL MANAGER CONCEPT...19

IMPLICATIONS OF A SINGLE INTEGRATED MATERIEL MANAGER CONCEPT .. 20

CONCLUSION 21

ENDNOTES 23-24

BIBLIOGRAPHY.....25

ACKNOWLEDGMENTS

I take this opportunity to thank Colonel Stuart Mervis, Director, Medical Logistics, Office of the Army Surgeon General and Roger Houck and Eli Toney, Logistics Integration Agency for providing timely information and support for this project.

LIST OF TABLES

Table 1: Prime Vendor Statistics in Europe 14

Table 2: Class VIII Support to Bosnia 15

INTRODUCTION

The end of the Cold War created new challenges for the U.S. military due to the absence of a major Soviet threat. Since 1985, America has responded to vast global changes by reducing defense budget by 38 percent, force structure by 33 percent, and procurement programs by 63 percent.[1] The Army is changing from a forward-deployed and Industrial Age Army trained, equipped, and postured to stop a Soviet advance in Europe, to an Information Age, power projection Army.[2]

In May 1997, the Secretary of Defense published the Quadrennial Defense Review(QDR) outlining our future defense. Building on the President's National Security Strategy, the QDR determined that the defense strategy for the near and long term must continue to shape the strategic environment to advance U.S. interests, maintain the capability to respond to the full spectrum of threats, and prepare now for the threats and dangers of tomorrow and beyond.[3] The result will be a force capable of carrying out today's missions with acceptable strategic risk, while allowing us to stabilize our investment program in order to achieve the future joint force capabilities described in Joint Vision 2010.[4]

Joint Vision 2010 is the template for how the U. S. military will achieve new levels of effectiveness in joint warfighting. Its tenets are four operational concepts:

dominant maneuver, precision engagement, full dimensional protection, and focused logistics.

Focused logistics integrates information superiority and technological innovations to achieve state-of-the-art logistics practices and doctrine.[5] This concept transforms the way units are supported on the battlefield from a supply-based system relying on mass into a distribution-based system exploiting improvements in logistics velocity and transportation. The end state of this transformation will be a fully integrated, seamless, wholesale-to-retail logistics system.

The Defense Reform Initiative(DRI) introduced by the Department of Defense(DOD) in November 1997. This initiative mandates the application of better business practices within DoD. Also, it centers on four pillars -- reengineering support activities, consolidating redundant organizations, competing more in-house functions, and eliminating excess infrastructure.[6]

Given DoD's thrust to streamline organizations and eliminate redundancy, critical questions are raised as it pertains to focused logistics. What are the means to achieve focused logistics? How will focused logistics affect the current Army logistics structure?

One concept introduced by the Combined Arms Support Command(CASCOM) is a Single Integrated Materiel Manager for the Army. The concept poses the integration of Ordnance (ammunition

supply), Finance, Quartermaster and Medical Supply functions under a Single Manager.

This paper examines the Single Integrated Logistics Manager concept and offers examples of why Medical Supply should continue to be managed by the Army Surgeon General.

UNDERSTANDING ARMY LOGISTICS

How does Army logistics work and who has overall responsibility? The basic mission of the logistics system is to support the soldier in the field and in garrison with what is needed, when, where, and in the condition and quantity required, at optimum expenditure of resources.[7] It also includes those activities that support the movement and sustainment of a combat force. The five functional elements of logistics are:

- Supply - the acquisition, distribution and salvage of supplies and equipment such as tanks, aircraft, ships, and medical supplies.
- Maintenance - sustainment of materiel in an operational status.
- Transportation - the movement of personnel and equipment to meet the Army, Navy, Marine and Air Force requirements.
- Services - functions such as food, laundry/bath, airdrop, property disposal and mortuary affairs support.

- Facilities - maintenance of real property as it pertains to the upkeep of buildings.

There are two levels of logistics which are determined by the type of work accomplished at each level. Two levels are: wholesale and retail. The wholesale level is characterized as relating to the management and sale of goods in large quantities. Examples of organizations with wholesale responsibilities include:

U. S. Army Materiel Command (USAMC), Defense Logistics Agency (DLA), and the General Services Administration (GSA). Based on a 1965 Board of Inquiry on the Army Logistics System, the Army Materiel Command was assigned responsibility for general logistics support worldwide except for medical, construction, and transportation.

The retail level involves two types of support: general and direct support. General support is generally performed in support of the theater-level logistics system. Direct support involves direct logistics support to a specified unit.

THE IMPORTANCE OF THE MEDICAL MISSION

The Army Medical Department (AMEDD) plays a vital role in the protection of combat troops by enhancing combat power.[8] In essence, the AMEDD serves as integral part of the Army's personnel replacement process.

The AMEDD's mission is to conserve the Army's fighting strength in both peace and war. Its goals are to: reduce the incidence of disease and non-battle injury through sound preventive medicine programs; provide medical care and treatment for acute illnesses, injuries, or wounds; expedite evacuees out of theater; and promptly return to duty those soldiers who have recovered.[9]

A vital necessity in the accomplishment of the AMEDD's mission is the timely receipt of medical materiel . Medical materiel are those items of supplies and equipment required for use by health care professionals that generally have no application beyond the diagnosis, care, and treatment of patients and the prevention of diseases.[10] Medical materiel range from a simple bandage to highly complex drugs; from wooden splints to x-ray apparatuses.

The vehicle for the management of medical supplies and equipment is the medical logistics system. Its mission is to provide quality supplies, equipment, support services, and facility maintenance. It is imperative to note that medical supply is a vital link within the total health care logistics system. For example, its support includes supplies for other health care functions such as optical fabrication, veterinary dental, and blood management. Therefore, the medical supply function should not operate separately from the entities it supports.

THE MEDICAL LOGISTICS (CLASS VIII) CONCEPT

The medical logistics system is both unique and dynamic because of its dual role of providing quality healthcare support during peace and war. In peacetime, medical supply support is an enormous enterprise generating approximately $2 billion annually amongst the Services.

The wartime medical supply (Class VIII) function is an important part of the combat health logistics system. It responds first and foremost to patient care. Consistent with military and logistical operations, combat health logistics support operates in a continuum across strategic, operational, and tactical levels.[11]

The combat health logistics mission is to provide:

- Class VIII supplies and equipment (medical materiel, to include medical-peculiar repair parts)
- Optical fabrication
- Medical equipment maintenance and repair
- A Single Integrated Medical Logistics Manager (SIMLM) for Joint Operations
- Blood management for Army, Joint, and/or Combined Operations.
- Contract support[12]

At the strategic level, the combat health logistics system is managed by the United States Medical Materiel Agency (USAMMA) and Defense Logistics Agency (DLA) depot system. USAMMA coordinates

Class VIII support in a theater of war through the Theater Medical Materiel Management Center (TMMMC). Support consists of procurement and shipment of pre-planned medical supply packages in support of deploying medical units. A Theater Medical Command is the senior medical headquarters exercising control of the TMMMC.

MEDCOM's TMMMC is responsible for centralized management of theater-level medical logistics activities to include the management of Class VIII materiel, medical equipment maintenance, optical fabrication and blood support . It provides interface between the strategic and operational logistics systems. The TMMMC maintains intransit visibility, redirects shipments, and directs theater wide cross-leveling of Class VIII assets in Joint and/or Combined operations.[13]

Additionally, the TMMMC coordinates the movement of Class VIII supplies with the senior movement control organization in theater. Resupply support is coordinated with USAMMA and the US Transportation Command.

Operational level medical supply support provided by the Medical Logistics Battalion (Rear) which comes with a unique capability to provide both general and direct medical logistics support. Its mission is to provide Class VIII support to Echelon Above Corps(EAC) units and the Medical Logistics Battalion (Forward). Supported medical units and hospitals are resupplied by line item requisitioning using standard medical automated

systems. Requisitions which cannot be filled from stocks on hand are submitted through the TMMMC to the strategic logistics system. Requisitions filled from the CONUS base are normally sent directly to the designated Medical Logistics Battalion (Forward).

At the tactical level, the Medical Logistics Battalion (Forward) is responsible for medical logistics support to divisional and nondivisional units operating in the supported corps. This unit provides direct support to units in the corps rear area.

MEDICAL SUPPLY MANAGEMENT HISTORICAL PERSPECTIVE

Since World War I, the AMEDD has for various reasons and to varying degrees, lost and regained control over the medical supply management function.[14] There were several attempts in the past to consolidate all supply commodities to achieve total asset visibility and coordination of logistics assets. In all cases however, the management of medical supply was returned to the control of the Army Surgeon General.

The Vietnam War provides an example of how changes to the medical supply system created significant delays in medical resupply support. In 1965, the Army established the Army Pacific Materiel Management Agency as the central control agency for the supply requisitions to eliminate multiple pipelines for common items and to create shorter lines of communication. By the fall of 1965, the Pacific Materiel Management Agency's demand

satisfaction rate for medical requisitions (the percentage of requests for stocked items that it filled at 100 percent) was only 79 percent.[15] Demand satisfaction continued to drop to a dismal 12 percent by May 1966, well below the AMEDD's standard of 95 percent. As a result zero balances rose to 28% and dues-out increased to more than 9,000.[16] The reason cited for this problem was that the general supply system was unable to cope with a high demand of nonstandard items.

The situation prompted the Army Surgeon General at the time, Lieutenant General Leonard B. Heaton, to make the following comments, "It seems incredible that a mismanaged organization can continue to flourish and do more harm than good. When they meddle with medical supplies, they are playing with life and death and nothing could be more serious. medical supplies should and must remain in medical channels."[17] Consequently, when control was returned to medical supply personnel, demand satisfaction increased to 91 percent in July 1966 and climbed to 95 percent in September of that same year.

A Logistics Review study on Vietnam (1965-69), concluded that continuing emphasis should be placed on the concept which provides for management of the medical commodity by medical personnel.[18]

Concurrent with the consolidation attempt in Vietnam, similar problems were highly evident in healthcare management in Europe. Medical supply inventory control responsibilities were

given to the Supply and Maintenance Agency, Communications Zone(COMMZ). Within six months, demand satisfaction fell from 98 percent to below 65 percent.[19] Again the solution was to return the inventory control function to medical control.

THE UNIQUENESS OF THE MEDICAL COMMODITY

As the Army explores the ways and means of achieving a Single Integrated Logistics concept, careful consideration must be given to who controls the medical commodity due its distinct and sensitive nature.

Why is medical supply considered different from other commodities? First and foremost, it is the only commodity that has a patient as a customer of the process. Unlike other commodities, a due-out for a medical item may have life threatening implications. Consequently, medical supply personnel require technical knowledge and experience in the medical management of the commodity. The technical requirements that are involved in the management of the medical commodity will not allow the medical supply managers to make the decision, "if you don't have peas, feed them beans"(the age-old Quartermaster attitude).[20] Additionally, as stated by Eli Toney, Army Logistics Integration Agency representative, "medical supply is more than just processing boxes with labels from a source of supply to a customer. There is a requirements determination factor that

requires an expertise in the field of medicine and medical supply to ensure the customer receives the right item."[21]

Other reasons why the medical commodity is different include:

- Medical supply items are subject to change in technology, dictating a high usage of nonstocked items.
- Only 2 percent of medical items stocked in Army depots are military unique items as opposed to 80 percent in other commodities.
- The Food and Drug Administration(FDA) and the Drug Enforcement Agency(DEA)impose many statutory requirements on issue, storage, use, and disposal of many medical items. For example, the consolidation of storage locations for some medical and nonmedical supplies is a violation of FDA regulations.
- Unlike other commodities, medical supplies are afforded protection under the provisions of the Geneva Convention as follows: "Fixed medical establishments, vehicles, and mobile units of the medical service shall under no circumstances be attacked"(Article 19, para 1. GCI).[22]

VIEWS POINTS ON INTEGRATION

The AMEDD's position on total integration of medical supply with the Army's supply system has always been that medical supply is a vital resource of the total healthcare system and should be

controlled and managed by the Surgeon General. On the other hand, non-AMEDD arguments on control of medical commodities include:

- Supplies are no different from beans, nails, and tires.
- Centralization reduces management problems thereby improving management efficiency.
- An integrated system is more economical to operate.
- An integrated system standardizes operations.[23]

While it can be argued that these are significant advantages, there are also vital disadvantages of integrated management such as:

- Leads to the adoption of excessive regimentation or "conformity for conformity's sake".
- Eliminates the specialists from management of the items he/she knows best thereby reducing their influence over decisions.
- Reduces the relative importance of small commodities because intensity management is most often keyed to factors such as dollar value, sales, and inventory, shortage space required and number of customers.
- Minimizes the unique aspects of the commodity by the application of general rules.
- Creates duplicate stockage without adequate justification.
- Standardization of operational philosophy.[24]

While there are historical data and arguments for a dedicated medical supply system, there are also clear reasons emerging from today's operating environment which continue to support preservation of the system and the role of the Army Surgeon General in the process.

The AMEDD continues to make improvements in the conduct of soldier healthcare support based on lessons learned from the Gulf War and changing strategies in the way the Army fights.

In 1988, DoD published it's first Medical Readiness Strategic Plan with the intent of providing DoD with an integrated, coordinated and synchronized plan for achieving and sustaining medical readiness through the year 2001 and beyond. It focuses on several key medical logistics objectives which are:

- To ensure the medical structure has a robust, seamless and assured communications capability within the global communications architecture.
- To consolidate medical command and control requirements into a single interoperable capability to be part of the Global Command and Control System.(GCCS)
- To develop a seamless medical information system serving contingency support and beneficiary care across all echelons.[25]

Through the exploration of better business practices, medical logisticians have made substantial improvements in the timeliness of customer support. In 1992, a program called Medical Prime Vendor was implemented to support both fixed and

field hospitals worldwide. Prime Vendor today, is the fastest, most efficient distribution system of its kind, delivering orders in 24 hours for hospitals in CONUS and 1 to 4 days in OCONUS.[26] In addition, Prime Vendor has greatly enhanced the capability of field units to accomplish their mission by reducing the order-ship times(OST) from 30 to 4-6 days for overseas customers.

How does Prime Vendor work? It is a requirements based contract managed by the Medical Directorate of the Defense Supply Center, Philadelphia. It is a cooperative effort between industry and the medical logistics system to satisfy customers' medical needs. The current contract supports all pharmaceutical and medical/surgical type supplies provided by a single distributor.

One example of the effectiveness of Medical Prime Vendor is in the case of its implementation in Europe. The U.S.Army Medical Materiel Center serves as the Tri- service Class VIII distribution center for the entire European theater. Since implementation of Prime Vendor in 1992, customer support has improved drastically. The following improvements are reflected below:

PRE-PRIME VENDOR	PRIME VENDOR
OST 30-45 days from CONUS	4-6 days from CONUS
8-10% Zero Balance	2% Zero Balance
21 day customer OST	4 day customer OST
$8.8 Mil Requisitioning Objective(RO)	$3.3 Mil RO

Table 1: Prime Vendor Statistics in Europe[27]

Another example is to compare the Class VIII support to that of Class IX repair parts support provided during Operation Joint Endeavor(Bosnia). Class IX is the best class to compare Class VIII with because it is the most intensely managed general supply class and, like medical, it contains a large number of common use items. General supply logisticians measure their performance by OST for all requests and zero balances. The Department of the Army OST objective is 23 days. The following comparison follows:

OST FOR A SIX MONTH AVERAGE

Bosnia

Class VIII	9.5
Class IX	26.9

Hungary (Intermediate Staging Base)

Class VIII	9.2
Class IX	18.9

Table 2: Class VIII Support to Bosnia[28]

Another major achievement in Europe is the implementation of a computer software program called QuoCom which allows the distribution center total asset and intransit visibility of supplies. Items shipped to Bosnia could be tracked from the time supplies left the warehouse in Europe until destination in

Bosnia. Medical logisticians deployed in Bosnia could tell their customers not only when to expect their shipment but what specific items were being shipped also. These major improvements created the total asset visibility capability for medical assets in the European Theater. While Army logistician seek ways to implement total asset visibility, the AMEDD has already implemented the program.

Case in point, problems with lack of asset visibility were experienced in both Operation Restore Hope (Somalia) and Operation Support Hope (Rwanda), and initially in Operation Joint Endeavor(Bosnia), however technologies such as the Automated Manifest System, and radio frequency automatic identification technology are currently being tested to provide logisticians with total asset and intransit visibility so desperately needed for any future deployments.

A SINGLE INTEGRATED MATERIEL MANAGER CONCEPT

Could a Single logistics manager work for the Army? What functions should be consolidated? Perhaps a look inside the Royal British Army may provide some incite.

A similar trend of a single logistics concept has taken form in the British Army. On 5 April 1993, as part of a major reorganization, five combat service support elements of the British Army were combined to form a Royal Logistic Corps (RLC).[29] The combat service support elements include the Royal

Corps of Transport, the Royal Army Ordnance Corps, the Royal Pioneers, the Army Catering Corps and the Defense Postal and Courier Service of the Royal Engineers.[30] The reorganization resulted from three major logistics support reviews of the British Army since the end of World War II. Also, the Gulf war highlighted the need for an improved logistics system to meet the increased demands of changing doctrine.

The RLC is commanded by a two-star Director General. The RLC is primarily responsible for supplying, arming, fueling, feeding, clothing and transporting the field army.

In contrast, the new RLC does not provide maintenance and medical support to the British Army. These areas remain the responsibility of the Royal Electrical and Mechanical Engineers and the Royal Army Medical Corps, respectively.[31] In comparison with the U.S. Army, these organizations have separate chains of command parallel to the logistics support of the RLC. However, in a tactical scenario all support functions are combined to create a seamless combat service support system and as such, is commanded by a single entity.

ADVANTAGES OF A SINGLE INTEGRATED MATERIEL MANAGER CONCEPT

Support of ground combat forces require an integrated logistics system at all levels to successfully accomplish a mission. A Single Integrated Materiel Manager gives a Combatant Commander a single point of contact for all logistics matters by

merging all related supply functions currently divided among the Quartermaster, Ordnance, and the Medical Service Corps. Coordination of the movement of materiel assets would be easier to manage and to establish priorities by preventing multiple sources from competing for transportation assets. For example, as experienced during Operations Desert Shield and Desert Storm, all supply commodities suffered from a lack of corps and Echelons-Above-Corps transportation support because of competing requirements.

Assuming that all supply assets transactions are managed by one common automated system, it also affords the commander information on asset visibility of all classes of supply to assist in timely resource decisions. Lessons learned from Operation Restore Hope(Somalia), noted that "without a centralized theater logistics management system", we not only lose visibility of materiel in the pipeline and in storage at either end of it, but lack the ability to "cross-level" supplies in the theater.[32]

Finally, a Single Integrated Materiel Manager concept would streamline the number of logisticians needed to perform separate functions thereby saving spaces that could be used in other areas.

DISADVANTAGES OF A SINGLE INTEGRATED MATERIEL MANAGER CONCEPT

As it pertains to the integration of medical supply with the standard supply system, there are a several important issues. First, if lessons learned from history play a role in future decisions, we must take a close look at the past. The critical issue is who controls the process? Medical supplies are a life or death commodity and therefore must be managed by those who are technically trained to manage the process. Attesting to this fact, in 1955 the Hoover Commission recognized that medical materiel is a highly specialized category of supply and must be procured, stored, and distributed differently from other types of supplies.

The Vietnam War provides an example how changes to the medical supply system caused a degradation of medical support to wounded soldiers. If history is the best teacher, we must not allow that degradation to repeat itself.

As stated in 1855 by Surgeon General Thomas Lawson in his report to Secretary of War Jefferson Davis, "once medical supplies were out of medical control, they were subject to all manner of destruction from storekeepers and others who handle a box containing the choicest medicines as roughly and recklessly as if they were camp-kettles and mess-pans".[33] And as stated recently by a Quartermaster logistician, "although the Medical Service Corps is a part of multifunctional organizations, its unique

capabilities do not overlap the functional areas of the Transportation, Quartermaster, or Ordnance branches, so it should not be included in a logistics corps.[34] Secondly, in terms of achieving focused logistics, one would argue that medical supplies are currently managed and distributed in a highly precise and focused manner. Extensive application of asset visibility, tailored packages, and pinpoint distribution schemes currently characterize the Class VIII system. Although our medical supply system is under the operational control of the Surgeon General, the Army Deputy Chief of Staff for Logistics (DCSLOG) has policy oversight. As such, the medical logistics system as a whole is conducted in accordance with DA Deputy Chief of Staff for Logistics policies and procedures. In addition, medical logisticians work in various positions within the Army Staff. Therefore, a more fair assessment should yield a conclusion that medical logistics is not a separate system from the Army logistics system.

IMPLICATIONS OF A SINGLE INTEGRATED MATERIEL MANAGER CONCEPT

The capability to distribute supplies and materiel through a synchronized and seamless logistics system is a necessity for the Army of the future. Much of the difficulty experienced in Desert Shield and Desert Storm in supporting units logistically

stemmed from a lack of integration and optimal use of resources. The Single Integrated Materiel Manager concept offers perhaps the best way to achieve the goal of synchronized, seamless logistics, however, its specific functions and how they are to be integrated are not clearly defined. In terms of integrating medical supply with the Army standard supply system, the concept must be carefully designed to ensure uninterrupted support of patient care. If the Army adopts this concept, there should be a medical dimension that continues to recognize the value of the Army Surgeon General in directing medical supply support.

Additionally, consideration should be given as to how the concept will affect the Army's unique role as the Single Integrated Medical Logistics Manager (SIMLM) for all Joint Operations. Perhaps our focus should be directed at enhancing "jointness" as opposed to a Service unique perspective.

CONCLUSION

The DOD is committed to streamlining and eliminating redundancy. A Single Integrated Materiel Manager concept is one alternative to streamlining organizations while at the same time leveraging technologies to support our Army of the future.

As the Army explores a Single Integrated Materiel Manager concept, the vital role of the Army Surgeon General in the delivery of health care through quality medical logistics support must not go unnoticed.

As outlined in this paper, past attempts to redirect the management of medical supplies resulted in less than optimal medical supply support. Technical expertise is the one area that all logistics functional areas require and will be even more essential as the Army moves to a smaller, leaner logistics structure. Measures that may dilute this expertise in favor of a more general approach could compromise the quality of support required to support our soldiers. As medical materiel and other commodities expand their reliance on direct commercial sources such as Prime Vendor for day-to-day operations and contingency operations, the level of commodity expertise increases proportionately.

This paper has outlined the impact of a Single Integrated Materiel Manager Concept on medical readiness. Any concept that favors control of medical supply management outside of medical expertise, should consider lessons learned from history as well as recent achievements within the medical logistics community before pursuing a totally integrated logistics concept.

4,631

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