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SERVING THE UNDERSERVED IN THE 21ST CENTURY: THE NEED FOR A STRONGER, MORE RESPONSIVE PUBLIC HEALTH SERVICE COMMISSIONED CORPS

HEARING

BEFORE THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

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SERVING THE UNDERSERVED IN THE 21ST CENTURY: THE NEED FOR A STRONGER, MORE RESPONSIVE PUBLIC HEALTH SERVICE COMMISSIONED CORPS

THURSDAY, OCTOBER 30, 2003

HOUSE OF REPRESENTATIVES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 10:15 a.m., in room 2154, Rayburn House office Building, Hon. Tom Davis of Virginia (chairman of the committee) presiding.

Present: Representatives Mr. Davis of Virginia, Shays, Ose, Lewis, Mrs. Davis of Virginia, Duncan, Janklow, Waxman, Maloney, Kucinich, Tierney, Clay, Watson, Van Hollen, Ruppersberger, and Norton.

Staff present: David Marin, director of communications; Susie Schulte, professional staff member; Teresa Austin, chief clerk; Brien Beattie, deputy clerk; Corinne Zaccagnini, chief information officer; Leneal Scott, computer systems manager; Phil Schiliro, minority staff director; Phil Barnett, minority chief counsel; Karen Lightfoot, minority communications director and senior policy advisor; Sarah Despres, minority counsel; Josh Sharfstein, minority professional staff member; Earley Green, minority chief clerk; Jean Gosa, minority assistant clerk; and Cecelia Morton, minority office manager.

Chairman TOM DAVIS. The hearing will come to order. I want to welcome everybody to today's oversight hearing on the Department of Health and Human Services' proposed transformation of the U.S. Public Health Service Commissioned Corps. In light of new and emerging threats to our Nation's public health, this hearing will focus on proposed improvements to make the Commissioned Corps a more readily deployable force to respond quickly and effectively to emergency health needs around the country.

We are slated to have a journal vote at 10:30, so we'll move through opening statements, get the statements here and get in as much questioning as we can and then take it from there. Sometimes they end up not having the votes, but I just want to explain, if we have that, we'll recess, go over and vote and then come back.

The Commissioned Corps is one of the seven uniformed services of the United States. It is comprised of highly trained and mobile health professionals who carry out programs to promote good health and understand and prevent diseases and injury, assure safe and effective drugs and medical devices, deliver health serv-

ices to Federal beneficiaries and supply health expertise in time of war or other national or international emergencies. Corps officers have been providing health care to American citizens for over 200 years and are constantly adapting to changing demands and new challenges in the public health field.

However, currently the Commissioned Corps is underutilized and underdeveloped. As a result of this, HHS intends to strengthen the public health infrastructure by transforming the Corps to meet the challenges of the 21st century. The rationale behind the proposed transformation is deeply rooted in new emerging threats facing the country. If the United States continues to face uncertain threats, including possible terrorist attacks and infectious diseases, it's critical that the Secretary has well trained medical professionals who can respond immediately and appropriately to an emergency need. These proposed changes are essential to improving our Nation's public health and ensuring that the Commissioned Corps will be an effective and efficient force of health care professionals.

There are three main principles guiding the transformation proposal. The first is to expand and enhance the Commissioned Corps. The second initiative aims to improve and expand training and deployability of commissioned officers to areas where primary care services are lacking. The third initiative will improve the Commissioned Corps management and development structure.

Under the proposal, the Commissioned Corps' size, structure and response capabilities will evolve into a more accessible team of health care and public health professionals. The Corps will remain committed to traditional public health needs, including providing health care to underserved areas around the country, supporting the expansion of community health centers and strengthening the health care safety net for all Americans. These functions will be balanced with emergency response efforts to create a better equipped and more effective Commissioned Corps.

In closing, I think it's important to note these ideas for reorganization are not novel concepts. Deployability and fitness standards for Corps officers date back well over 100 years. Ultimately, the Commissioned Corps needs to be strengthened and its mission broadened to include traditional and evolving needs in the public health field. With these changes, the Commissioned Corps will be better equipped to protect, promote and advance our Nation's public health.

I understand that some of our witnesses this morning will express concerns about specific elements of the transformation plan and we welcome their comments. I look forward to a constructive dialog on these concerns. I know we all share the same goal at the end of the day, and that's a Commissioned Corps dedicated to and prepared for emerging 21st century challenges and needs.

We have a great selection of witnesses to provide testimony this morning. Surgeon General Carmona is here to provide the committee with an overview of the Commissioned Corps, and detail the need for reorganization of the Corps. Joining us on our second panel will be former Surgeon General Dr. C. Everett Koop, who will offer his opinions on the transformation policy. Former Assistant Secretary for Health and former U.S. Surgeon General Dr. Julius Richmond will also provide the committee with his expertise

in the area of public health. And finally, Captain Gerard Farrell, executive director of the Commissioned Officers Association will offer the perspective of officers in the Commissioned Corps.

[The prepared statement of Chairman Tom Davis follows:]

Statement of Chairman Tom Davis
Committee on Government Reform
Hearing on "Serving the Underserved in the 21st Century: The Need for a Stronger, More Responsive Public Health Service Commissioned Corps."
October 30, 2003

Good morning. I would like to welcome everyone to today's oversight hearing on the Department of Health and Human Services (HHS) proposed transformation of the U.S. Public Health Service Commissioned Corps. In light of new and emerging threats to our nation's public health, this hearing will focus on proposed improvements to make the Commissioned Corps a more readily deployable force to respond quickly and effectively to emergency health needs around the country.

The Commissioned Corps, one of the seven uniformed services of the United States, is comprised of highly-trained and mobile health professionals who carry out programs to promote good health, understand and prevent disease and injury, assure safe and effective drugs and medical devices, deliver health services to Federal beneficiaries, and supply health expertise in time of war or other national or international emergencies. Corps officers have been providing health care to American citizens for over 200 years and are constantly adapting to changing demands and new challenges in the public health field. However, currently, the Commissioned Corps is underutilized and underdeveloped. As a result of this, HHS intends to strengthen the public health infrastructure by transforming the Corps to meet the challenges of the 21st century.

The rationale behind the proposed transformation is deep-rooted in new emerging threats facing our country. As the U.S. continues to face uncertain threats, including possible terrorist attacks and infectious diseases, it is critical that the Secretary has well trained medical professionals who can respond immediately and appropriately to an emergency need. These proposed changes are essential to improving our nation's public health and ensuring that the Commissioned Corps will be an effective and efficient force of healthcare professionals.

There are three main principles guiding the transformation proposal. The first is to expand and enhance the Commissioned Corps. The second initiative aims to improve and expand training and deployability of Commissioned officers to areas where primary care services are lacking. The third initiative will improve the Commissioned Corps' management and development structure.

Under the proposal, the Commissioned Corps' size, structure, and response capabilities will evolve into a more accessible team of healthcare and public health professionals. The Corps will remain committed to traditional public health needs, including providing healthcare to underserved areas around the country, supporting the expansion of community health centers, and strengthening the health care safety net for

all Americans. These functions will be balanced with emergency response efforts to create a better-equipped and more effective Commissioned Corps.

In closing, I think it is important to note, these ideas for reorganization are not novel concepts; deployability and fitness standards for corps officers date back well over a hundred years. Ultimately, the Commissioned Corps needs to be strengthened and its mission broadened to include traditional and evolving needs in the public health field. With these changes, the Commissioned Corps will be better equipped to protect, promote, and advance our nation's public health.

I understand some of our witness this morning will express concerns about specific elements of the transformation plan. I look forward to a constructive dialogue on those concerns. I know we all share the same goal at the end of the day—a Commissioned Corps dedicated to, and prepared for, emerging 21st century challenges and needs.

We have a great selection of witnesses to provide testimony this morning. Surgeon General Carmona is here to provide the Committee with an overview of the Commissioned Corps and detail the need for a reorganization of the Corps.

Joining us on our second panel will be former Surgeon General, Dr. C. Everett Koop, who will offer his opinions on the transformation policy. Former Assistant Secretary for Health and Surgeon General, Dr. Julius Richmond, will also provide the Committee with his expertise in the area of public health. Finally, Captain Gerard Farrell, Executive Director of the Commissioned Officers Association, will offer the perspective of officers in the Commissioned Corps.

Chairman TOM DAVIS. I now recognize the distinguished ranking member, Mr. Waxman, for an opening statement.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

I want to thank Chairman Davis for agreeing to my request to hold this hearing today on the future of the Commissioned Corps of the Public Health Service. A bipartisan hearing on this issue is fitting. As administrations and Congresses have come and gone, the Commissioned Corps has steadily advanced public health for more than 100 years, saving millions of lives in the United States and around the world.

It's easy to overlook the critical contributions of the Commissioned Corps to our Nation's health and safety. Commissioned Corps officers review drug applications at the FDA, search for breakthrough cures at NIH, and staff the front lines of response to public health emergencies. The Corps responded to the disaster at the Three Mile Island nuclear plant in 1979, the measles outbreak of the late 1980's, and the emergence of SARS earlier this year. To date, the more than 6,000 members of the Corps fulfill critical functions in more than 20 science-based agencies and offices.

Today's hearing will focus on a plan proposed by Secretary Tommy Thompson to transform the Commissioned Corps. The plan has two main goals: to increase the preparedness of the United States for a public health emergency and to improve care for the medically underserved. Both of these goals are critically important, and there is widespread support for modernization of the Corps. The question we face is not whether the Corps should be altered to meet today's challenges, but how and by what process. Details matter. Unfortunately, the details of the plan put forth by Secretary Thompson have serious flaws.

I have written to Secretary Thompson expressing my concerns about the proposed transformation plan. The problems with his plan include the new physical fitness and deployment requirements that could drive many experienced and dedicated scientists and other health professionals out of public service. That's one big problem. The plan also leaves the Surgeon General with too little management authority over the Corps. I ask, Mr. Chairman, that the letter I wrote to Secretary Thompson be included in the record.

Chairman TOM DAVIS. Without objection, so ordered.

[The information referred to follows:]

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BERNARD SANDERS, VERMONT, INDEPENDENT

August 11, 2003

The Honorable Tommy G. Thompson
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Secretary:

I have just become aware of a draft policy circulating in the U.S. Department of Health and Human Services (HHS) that would require six thousand health professionals in the U.S. Public Health Service Commissioned Corps to meet weight limits, do push-ups, and agree to leave their home on short notice — or forego all promotions and face possible dismissal.

If implemented, this draft policy would risk an exodus of highly trained doctors, engineers, nurses, scientists, pharmacists, dentists and veterinarians from over 20 science-based agencies and offices. It also appears manifestly unfair to those health professionals who, upon their resignation, would lose all retirement benefits. While I support your goal to improve the ability of the Commissioned Corps to respond to public health emergencies, the new draft policy seems excessive. A more gradual approach would achieve your objective without draining needed scientific expertise from the government or mistreating employees.

I urge you to modify this draft policy to address these serious concerns.

I also ask that you justify all of your future plans for the Commissioned Corps to Congress, including your unusual decision to shift the responsibility for the Corps away from its historic leader, the U.S. Surgeon General, and to a more political appointee. It would obviously be unwise to inject politics into the science-based core, and I hope this issue will be examined by the House Government Reform Committee in the coming weeks.

Background

The U.S. Public Health Service traces its roots to a 1798 law that provided medical care to merchant seamen.[1] Since 1889, the U.S. Public Health Service has employed health professionals in a military-like model called the Commissioned Corps. Today, the Commissioned Corps includes about six thousand doctors, engineers, nurses, scientists, pharmacists, dentists and veterinarians working for more than 20 federal agencies and offices.[2]

Commissioned officers review drugs at the Food and Drug Administration, investigate outbreaks of infectious disease at the Centers for Disease Control and Prevention, conduct groundbreaking medical research at the National Institutes of Health, care for thousands of patients in the Indian Health Service, and perform many other essential services.

In addition to providing critical assistance to science-based agencies and offices, officers in the Commissioned Corps can volunteer for deployment in case of a public health emergency. About 2,000 health professionals are participating in this program.[3]

The New Draft Policy

On July 3, 2003, HHS launched a major effort to reorganize the Commissioned Corps in the "most sweeping transformation since . . . 1889."[4] Among other changes, this proposal sets the goal of "100 percent deployability."[5]

I have now obtained the draft policy circulating within HHS that is supposed to achieve this objective.[6] The policy would apply "deployment readiness standards" to <u>all</u>

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[1]Department of Health and Human Services, *The History of the Commissioned Corps* (online at http://www.usphs.gov/html/history.html).

[2]*Id.*

[3]*Medical Corps to Increase, Reorganize; New Office Will Oversee Force*, Washington Post (July 4, 2003).

[4]Department of Health and Human Services, *News Release: Secretary Thompson to Increase Numbers and Flexibility of Public Health Service Commissioned Corps* (July 3, 2003).

[5]*Id.*

officers in the Commissioned Corps, aside from students, who have worked more than 120 days. The standards, which now apply only to volunteers, include weight limits that vary with height, the ability to perform a certain number of push-ups in two minutes and the ability to run or walk 1.5 miles or swim 500 yards within a set period of time.[7] The standards require officers to remain current in their professional field, including 110 hours of clinical work per year. Officers must also agree to leave home on short notice and to make emergency arrangements for their dependents.[8]

Under the draft policy, officers who fail to meet "deployment readiness standards" would not be permitted to continue advancing in their careers in the Commissioned Corps. Instead, scientists and doctors who cannot do enough push-ups in two minutes or fail any of the other new requirements would face "disciplinary action, including, but not limited to a Letter of Reprimand and referral to a disciplinary board such as a Temporary Promotion Revocation Board."[9] The result could be demotion in rank or dismissal. There is no guarantee that officers who are dismissed or who resign from the Commissioned Corps would be employed in an equivalent capacity in the civil service.

This draft policy appears both unwise and unfair. Thousands of officers in the Public Health Service Commissioned Corps contribute immeasurably to the mission of science-based agencies and offices. It defies common sense to impose a new set of rules that could force many to leave government service. As just one example, drug reviewers at FDA use their expertise and experience to keep unsafe pharmaceuticals off the U.S. market, while at the same time ensuring that Americans have speedy access to potentially life-saving therapies. Forcing them out of their jobs because of their speed on the race track or in a swimming pool needlessly endangers the public.

From the point of view of officers in the Commissioned Corps, the draft policy represents a "bait and switch." Over the past two decades, thousands have joined the Commissioned Corps without any expectation that they would have to meet these standards for "deployment readiness." Some of these individuals may suffer from chronic diseases; others may have family obligations that prevent deployment. Many health

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[6]Department of Health and Human Services, *Public Health Service, Personnel Instruction 8 — PHS Deployment Readiness Standards, DRAFT FOR SERVICEWIDE NOTICE AND COMMENT* (July 28, 2003).

[7]U.S. Public Health Service, *Commissioned Corps Readiness Force* (online at http://oep.osophs.dhhs.gov/ccrf/).

[8]*Id.*

[9]*Id.*

professionals who might never have joined the U.S. Public Health Service had the draft policy been in effect at the time may now be demoted or forced to leave.

What makes this "bait and switch" particularly unfair is that those officers who leave government service early lose all their retirement benefits. Unlike federal employees in the civil service, health professionals in the Commissioned Corps do not receive any pension benefits until 20 years of service. Forcing them to resign from the Corps ahead of time could cause significant financial hardship and would be an unjustified breach of trust by the government.

Other Concerns with HHS Plan

The HHS plan to transform the Public Health Service Commissioned Corps raises other serious concerns. I have learned that the plan would shift responsibility for the Commissioned Corps away its historic leader, the U.S. Surgeon General. Instead, leadership would be concentrated in the office of the Assistant Secretary for Health, traditionally a more political appointment. Indeed, the draft policy gives the Assistant Secretary for Health authority to set additional requirements for the Commissioned Corps.

The shift in leadership raises the concern that the non-partisan core would be politicized. This shift is strongly opposed by the Commissioned Officers Association of the U.S. Public Health Service, representing 70% of active duty officers. The Association has commented that:

> An organizational structure which places force management responsibility under an authority other than the recognized uniformed commander of the force, the Surgeon General, appears to contradict efforts to improve force management and streamline the Corps. Removing the Surgeon General from direct line authority over force management clouds accountability for force employment decisions — a fundamental requirement for operating any uniformed force.[10]

I am also concerned that HHS has yet to fully justify its goal of "100 percent deployability." Officers in the Commissioned Corps fill key non-clinical jobs in numerous science-based agencies and offices that do not have any direct translation to public health emergency response. Many are program administrators and analysts who have not provided clinical care for years and may not have time to remain current in clinical practice. Turning the Commissioned Corps entirely into a mobile force may lead federal agencies to be reluctant to hire officers who could leave for extended periods at a

---

[10]Commissioned Officers Association, *COA Position Statement on DHHS Transformation Plan for the PHS Commissioned Corps* (July 14, 2003).

moment's notice. The result would be an end to a program that has effectively recruited top scientists and health professionals to the government for decades.

HHS does not appear to have considered a recent expert report on how to structure future promotions within the Public Health Service in making its plan.[11] Any major changes should be carefully planned and justified before being rushed into implementation.

Conclusion

I understand and share your desire to improve the ability of the Commissioned Corps to respond to public health emergencies. The pursuit of this goal, however, should not undermine the work of science-based agencies or mistreat valued health professionals in HHS. A more gradual and sensible approach would achieve your objective without these adverse consequences.

I therefore urge you to modify this draft policy substantially before implementation. I also ask that you provide answers to the following questions:

1. Who participated in the development of the draft policy?
2. What studies or analyses have been conducted on the impact of the draft policy on the mission of the science-based federal agencies and offices that currently employ Commissioned Corps members?
3. What is the justificiation for removing responsibility for the Corps from the U.S. Surgeon General?
4. What studies or analyses have been conducted on the need for and impact of switching to a 100% deployable Corps?
5. Will there be an opportunity for interested parties to comment on any major changes in the Commissioned Corps prior to implementation?
6. How many political appointees are officers in the Commissioned Corps? Please give the names and dates of service of these individuals. What are the rules regarding political activity by officers and how does HHS assure that these rules are not broken?

Because of the importance of the Public Health Service Commissioned Corps to our nation, I ask that you and the U.S. Surgeon General Vice Admiral Richard Carmona present justification for any major changes to Congress prior to proceeding. I am also asking Chairman Tom Davis to hold a hearing on the restructuring of the Public Health Service in the Government Reform Committee next month.

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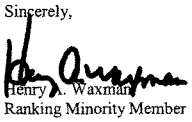
[11]Commissioned Corps Promotions Task Force, *Report of the Commissioned Corps Promotion Task Force — Draft* (Jan. 17, 2003).

I look forward to discussing these issues with you further. I request a reply to this letter by August 25, 2003.

Sincerely,



Henry A. Waxman
Ranking Minority Member

cc: Vice Admiral Richard Carmona, U.S. Surgeon General
The Honorable Tom Davis

Mr. WAXMAN. In fact, the current administration proposal has so many problems that it has raised serious concerns among those who should be its stronger supporters. For example, Commissioner Mark McClelland of the Food and Drug Administration has written to Secretary Thompson that the physical fitness standards could drive "extremely talented and committed officers" out of public service. Dr. Elias Zerhouni is the Director of the National Institutes of Health, where more than 400 officers serve in many leadership roles. Dr. Zerhouni told me at a recent Energy and Commerce Committee hearing that he has serious concerns about Secretary Thompson's proposal. He testified that he was willing to share a letter that he wrote to the Secretary about these concerns with the committee. I'm disappointed that the Department has blocked him from doing so.

Public health experts at the Centers for Disease Control and Prevention have also voiced serious concerns. According to a senior CDC bioterrorism expert, Dr. Charles LeBaron, this proposal could undermine public health preparedness. Dr. LeBaron is concerned that by emphasizing deployment and physical fitness, the transformation plan will produce a Corps that is long on mobility but short on expertise. Dr. LeBaron asks, if a dirty bomb were to explode in the United States, "would the Nation be better served and defended by experts in radiation or by a collection of persons whose primary credentials lie with the number of situps they could perform and their ability to align the seams of their upper and lower garments?" I ask that his written comments on the proposed transformation plan be included in the record.

Chairman TOM DAVIS. Without objection, so ordered.

[The information referred to follows:]

From: LeBaron, Charles
Sent: Tuesday, August 12, 2003 4:00 PM
To: Ccpm, None (PSC)
Subject: Comments on Proposed Personnel Instructions
FROM: CDR Charles W. LeBaron MD, PHS#56928
TO: Commissioned Corps Personnel Administation
RE: Proposed Personnel Instructions Concerning Promotions and Deployments
DATE: 13 August 04

Thank you for submitting these proposals for comment. The detailed critiques of the COA, the PPAC, and of individual officers are probably more than sufficient for you to evaluate your proposals' implications for individual members of the Corps and for group morale. My own commentary focuses on the public health impact of the proposed "transformation" of the Corps. In my opinion, the most likely outcome of this "transformation," as apparently contemplated, would be the unilateral disarmament of our public health defenses at a time when they are most needed.

In view of the seriousness of these statements, a quick biography is in order. I am a graduate of Princeton University, Harvard Medical School, and am board-certified in both Internal Medicine and Pediatrics. I have spent fifteen years in the Commissioned Corps and am one of CDC's many outbreak control specialist, but I spend my clinical time at an Indian Hospital that has experienced medical staffing shortages. Five out of the past six years, articles for which I was a co-author were published in the *Journal of the American Medical Association*.I Last year, an article in the *New England Journal of Medicine*, for which I was a co-author, won the Shepard Award, the prize for the best scientific paper published at CDC. I am currently assigned to the CDC branch responsible for recognition of and initial response to potential smallpox attacks. During the first two weeks of the Iraq War, as well as other periods before and since, I have carried the "smallpox phone" (i.e., the primary contact for evaluation of suspected smallpox) twenty-four hours a day. Two weeks ago I was nominated by my Center for an Outstanding Service Medal, and the group in which I serve was nominated for a Unit Commendation.

Early recognition and expert response is critical to containing any public health problem, whether arising from natural events or terrorism. For half a century, the taxpayers have funded the Centers for Disease Control and Prevention (CDC) to provide the nation with the capacity for such recognition and response, particularly for threats where states and localities are unlikely to to become expert through experience (e.g., smallpox, ebola) or where surveillance of large-scale trends is necessary for adequate response (e.g., HIV, diabetes). CDC is organized into units of experts dedicated to such recognition and response. Acquiring and retaining such highly trained personnel is difficult, particularly for physicians, since all the financial incentives lie in the private sector. The Commissioned Corps has functioned to attract such experts into public health by offering them salary and benefits which, if not competitive with the private sector, are at least not prohibitively less, while the Corps' 20-year retirement vestment aids in retention. In general, the leadership of CDC's disease recognition and response teams has been staffed through the Commissioned Corps.

The "transformation" of the Corps would appear to systematically disassemble such expert teams in favor of an all-purpose response force consisting of a "roster" of persons who may, or may not, have any expertise in the situation requiring evaluation and response. Recently, our unit dealt with a multi-state outbreak of monkeypox, a disease which mimics smallpox. One can imagine the national panic and subsequent uproar had this situation been mis-evaluated as a

smallpox attack. Is it plausible that the situation could have been correctly evaluated with a "duty roster" of occupational therapists, pharmacists, clinic nurses, and emergency room physicians from all over the nation, none of whom had any communication with each other prior to being "deployed"? In fact, in the midst of another smallpox evaluation, one of our highly-trained smallpox infection control staff was suddenly "deployed" away from smallpox to a tornado site where s/he and others apparently spent most of their time handing out Wal-Mart vouchers in a gym - a "deployment" that was proudly reported in the Commissioned Corps Bulletin. Had Richard Rodriquez succeeded in obtaining the materials for a "dirty bomb"in Afganistan and exploding it in Chicago, would the nation be better defended by experts in radiation or by a collection of persons whose primary credentials lie with number of sit-ups they could perform and their ability to align the seams of their upper and lower garments? We are currently sending an outbreak team to the Marshall Islands to evaluate, in part, whether their growing measles epidemic may have been the source of spread to a simultaneous outbreak in the US and, if so, how such spread can be controlled. Should we wait for a formal "deployment" with approvals all the way to the Surgeon General, obtaining a "roster" of persons familiar with handing out Wal-Mart vouchers -- or should we act? Public health is an ongoing war against disease. In contrast to military actions, major combat operations are never over, and public health workers are always in deployment status, even if they're at a computer examining the relentless rise of obesity in the United States.

We're told that the Commissioned Corps is "top-heavy" with Commanders and Captains. It should be. The purpose of the Commissioned Corps is not to provide services that are readily available through contract or temp agencies - it's to defend the public health using the best expertise at the nation's disposal. That expertise takes time to develop. Once lost, it may take another half-century to reacquire.

We're told that members of the Corps should be "mobile" -- which apparently means they should switch jobs every few years. If the CIA had ten persons in whom it had spent a decade training in the various dialects of Arabic, would it require that they leave off monitoring Al Qaida communications, and instead try to make sense of satellite photos of North Korea or blunder around doing cloak-and-dagger maneuvers in Vienna, while the experts in overhead imagery and covert operations were assigned to learn Arabic from scratch? An all-purpose Corps is a no-purpose Corps. My experience in Indian hospitals suggests that sudden deployments may be as injurious to the Corps clinical mission there as it is likely to be to the public health mission of CDC, but it's best for those persons to speak for themselves.

The military has learned from hard experience that modern wars are won not by large numbers of briefly-trained troops, but by the quality of intelligence, the nimbleness of the operations, and the precision with which force can be delivered. As best I can determine, the Commissioned Corps apparently proposes to proceed in the opposite direction. For the sake of the nation's health and the integrity of its defenses against bioterrorism, it's my hope that this course will be corrected.

Thank you for considering my comments and those of others.

Charles W. LeBaron MD

Mr. WAXMAN. I requested that Dr. LeBaron testify, and Chairman Davis invited him to this hearing. Unfortunately, the Department has said it would only let him testify as a private citizen, without his uniform and at his own expense.

Others who should support the plan to improve the Commissioned Corps include former leaders of the Corps. I have heard from several former Surgeons General and former Assistant Secretaries of Health. These distinguished public servants, two of whom are here today, are concerned that the transformation plan leaves the current Surgeon General with very little authority over the Corps. They believe that a splintered Corps management system threatens to undermine recruitment, morale and effectiveness.

A transformation plan should also be supported by commissioned officers themselves. In that regard, we will have the opportunity today to hear from Gerald Farrell of the Commissioned Officers Association, which represents 70 percent of active members of the Commissioned Corps. He has previously said that the proposal appears "crafted to destroy Corps morale" and "drive officers out of Government service."

A Corps reorganization plan requires the complete support of the current Surgeon General, who is the historic leader of the Corps. I welcome Vice Admiral Dr. Richard Carmona to this hearing. I hope this is an opportunity for him to speak frankly about what changes are needed to the Secretary's original proposals.

Let me conclude with an observation. There is simply too much at stake for a major Corps transformation to be bungled. I have spent my career in Congress fighting to expand access to care for the underserved and to improve our public health system. I would love to see a Commissioned Corps for the 21st century that is even more involved in these longstanding concerns. But if there is so much opposition among those who should be supporting this proposal, then it is time to take a step back. HHS should develop a clear process to make sure any changes to the Corps achieve their intended goals.

I want to thank you, Mr. Chairman, for holding this hearing, and the witnesses for coming, and I look forward to their testimony.

[The prepared statement of Hon. Henry A. Waxman follows:]

Statement of Rep. Henry A. Waxman, Ranking Minority Member Committee on Government Reform Hearing on Serving the Underserved in the 21st Century: The Need for a Stronger, More Responsive Public Health Service Commissioned Corps

October 30, 2003

I would like to thank Chairman Davis for agreeing to my request to hold this hearing today on the future of the Commissioned Corps of the Public Health Service. A bipartisan hearing on this issue is fitting. As administrations and Congresses have come and gone, the Commissioned Corps has steadily advanced public health for more than 100 years, saving millions of lives in the United States and around the world.

It is easy to overlook the critical contributions of the Commissioned Corps to our nation's health and safety. Commissioned Corps officers review drug applications at FDA, search for breakthrough cures at NIH, and staff the front lines of response to public health emergencies. The Corps responded to the disaster at the Three Mile Island Nuclear Plant in 1979, to the measles outbreaks of the late 1980s, and to the emergence of SARS earlier this year. Today, the more than 6,000 members of the Corps fulfill critical functions in more than 20 science-based agencies and offices.

Today's hearing will focus on a plan proposed by Secretary Tommy Thompson to transform the Commissioned Corps. The plan has two main goals: to increase the preparedness of the United States for a public health emergency and to improve care for the medically underserved. Both of these goals are critically important, and there is wide support for a modernization of the Corps.

The question we face is not whether the Corps should be altered to meet today's challenges, but how and by what process. The details matter. Unfortunately, the details of the plan put forth by Secretary Thompson have serious flaws.

I have written to Secretary Thompson expressing my concerns about the proposed transformation plan. The problems with his plan include new physical fitness and deployment requirements that could drive many experienced and dedicated scientists and other health professionals out of public service. The plan also leaves the Surgeon General with too little management authority over the Corps. I ask that that letter be included in the record.

In fact, the current Administration proposal has so many problems that it has raised serious concerns among those who should be its strongest supporters.

For example, Commissioner Mark McClellan of the Food and Drug Administration has written to Secretary Thompson that the physical fitness standards could drive "extremely talented and committed officers" out of public service.

Dr. Elias Zerhouni is the director of the National Institutes of Health, where more than 400 officers serve in many leadership roles. Dr. Zerhouni told me at a recent Energy and Commerce committee hearing that he has serious concerns about Secretary Thompson's proposal. He testified that he was willing to share a letter that he wrote to the Secretary about these concerns with the committee. I am disappointed that the Department has blocked him from doing so.

Public health experts at the Centers for Disease Control and Prevention have also voiced serious concerns. According to a senior CDC bioterrorism expert, Dr. Charles LeBaron, this proposal could undermine public health preparedness. Dr. LeBaron is concerned that by emphasizing deployment and physical fitness, the transformation plan will produce a Corps that is long on mobility but short on expertise. Dr. LeBaron asks: If a dirty bomb were to explode in the United States, "would the nation be better defended by experts in radiation or by a collection of persons whose primary credentials lie with the number of sit ups they could perform and their ability to align the seams of their

upper and lower garments?" I ask that his written comments on the proposed transformation plan be included in the record.

I requested that Dr. LeBaron testify, and Chairman Davis invited him to this hearing. Unfortunately, the Department has said it would only let him testify as a private citizen, without his uniform and at his own expense.

Others who should support a plan to improve the Commissioned Corps include former leaders of the Corps. I have heard from several former Surgeons General and former Assistant Secretaries of Health. These distinguished public servants, two of whom are here today, are concerned that the transformation plan leaves the current Surgeon General with very little authority over the Corps. They believe that a splintered Corps management system threatens to undermine recruitment, morale, and effectiveness.

A transformation plan should also be supported by commissioned officers themselves. In that regard, we will have the opportunity today to hear from Gerald Farrell of the Commissioned Officers Association, which represents 70% of active members of the Commissioned Corps. He has previously said that the proposal appears "crafted to destroy Corps morale" and "drive officers out of government service."

A Corps reorganization plan requires the complete support of the current Surgeon General, who is the historic leader of the Corps. I welcome Vice Admiral Dr. Richard Carmona to this hearing. I hope this is an opportunity for him to speak frankly about what changes are needed to the Secretary's original proposals.

Let me conclude with an observation: There is simply too much at stake for a major Corps transformation to be bungled. I have spent my career in Congress fighting to expand access to care for the underserved and to improve our public health system. I would love to see a Commissioned Corps for the 21st century that is even more involved in these longstanding concerns. But if there is so much opposition among those who should be supporting this proposal, then it is time to take a step back. HHS should develop a clear process to make sure any changes to the Corps achieve their intended goals.

I thank the witnesses for coming and look forward to their testimony.

Chairman TOM DAVIS. Thank you very much. Are there any other Members who wish to make opening statements? Hearing and seeing none, we have Vice Admiral Richard Carmona here. Would you rise with me, and I'm going to swear you in, it's our committee tradition.

[Witness sworn.]

Chairman TOM DAVIS. Thank you very much. We're pleased to have you with us. We have a light in front that will go orange after 4 minutes, red after 5. If you need to go over a little bit, do it, but your entire statement is in the record, and we'll base our questions on that. We're looking for votes in about 15 minutes. We may be able to get through questions and get out of here if we do it quickly.

STATEMENT OF VICE ADMIRAL RICHARD H. CARMONA, U.S. SURGEON GENERAL

Admiral CARMONA. Thanks for the opportunity for allowing me to come before you today. Secretary Thompson sends his greetings but also his regrets that he cannot be here today.

I appreciate the opportunity to address the Committee on Government Reform about the administration's efforts to transform the Public Health Service Commissioned Corps into a more mobile and responsive national resource for meeting some of our Nation's most important public health challenges. I am particularly pleased to have this opportunity to describe to you and the members of the committee the Department's vision of the transformation, to delve into the overall objectives and to clear up any of the misconceptions about the transformation and what it is and what it is not.

I want to start my prepared statement with a clear message: the Public Health Service Commissioned Corps has a long and proud history. I am proud of its service to this country and the officers who serve in the Corps are justly proud of their accomplishments. I have pride in the achievements of people such as Rear Admiral Craig Vanderwagen, whom Secretary Thompson deployed from the Indian Health Service to Iraq. There is no better way to illustrate his service than to quote from his recent e-mail message back to us. He wrote: "The Ministry of Health in Iraq has some marvelous professionals who are very happy to have the opportunity to do good things for their country after years of neglect. We will build a primary care system that has not existed here before to complement the improvements in public health systems. I am happy to be here and growing immensely in this environment and thankful every day for the opportunity to be part of this."

I applaud the work of commissioned officers like Captain Ken Martinez of the National Institutes for Occupational Health, a component of CDC and Commander Tim Cote of the Food and Drug Administration. Captain Martinez, an engineer who works in the field of industrial hygiene, was among the officers responding to the anthrax release on Capitol Hill. He was deployed from CDC and served 24/7 for several weeks. Commander Cote, who is currently the Chief of Therapeutics and Blood Safety at the Center for Biologics at the FDA, not only served during the anthrax release, when he was assigned to the NIH, but also volunteered to deploy for duty in Iraq. It is the dedication of individuals like Commander

Cote, Captain Martinez and Rear Admiral Vanderwagen that exemplifies the best of the Corps, past, present, but more importantly, future.

While the Corps has responded well during many public health emergencies, including most prominently the September 11th attack and the anthrax release on October 15th, Secretary Thompson and I believe that our capabilities will have to be broader, our resources deeper, and our flexibility enhanced if we are going to be ready to address the needs of our citizens when they are faced with future national emergencies. We need to be ready should local and State public health resources be overwhelmed by urgent public health needs, whether engendered by a terrorist attack, a natural disaster such as a significant earthquake, or a nationwide disease threat, such as would be created by an influenza pandemic. In fact, during the past few weeks, in preparation for and in response to the havoc created by Hurricane Isabel, Secretary Thompson deployed 176 commissioned officers to several communities, to seven State emergency operations centers and to six State health departments. These officers served with distinction and I am proud of what they have accomplished.

In addition to addressing public health emergencies, ongoing Corps deployments across the country are essential to protect public health. For example, the Indian Health Service is facing both significant recruiting problems and a large number of vacancies, half of them for nurses, in providing care for our American Indian and Alaska Native populations. Similarly, the President and the Secretary, from the beginning of this administration, have recognized that we need thousands of health care professionals to overcome shortages in health centers and National Health Service Corps placement sites where recruitment efforts have fallen short of expectations.

Secretary Thompson and I are equally concerned that we do not have a sufficiently large force, appropriately trained, suitably experienced, and readily deployable to address special needs, such as the critical issue of childhood immunization. Across our Nation, there are urban and rural areas where the percentage of children unprotected from critical diseases is a serious concern to us all. Further, we need to strengthen our national prevention effort. For example, early diagnosis of diabetes is important, particularly among some of the most needy members of our society. That public health professionals are attuned to the early signs of diabetes is crucial to controlling the progress of that disease, as well as controlling the cost of treatment and more serious conditions connected with progression of the disease. Another example is the need to respond to the difficult health care issues we face along the southwest border. The fact of the matter is that when it comes to national resources to address urgent and unexpected national public health demands such as these, there are too few readily accessible public health professionals at our disposal to deploy as needed.

Over the past several decades, ever since the public service hospital system was disbanded, the management of the Corps has become more and more decentralized and the structure of the Corps less and less distinguishable from the Civil Service. The require-

ments that were placed on the department during the events of September 11th and the anthrax attack underscore the importance of the Public Health Service Commissioned Corps, as well as the need for more direct responsibility exercised by the Secretary. Therefore, the Secretary has asked his principal health official, the Assistant Secretary for Health, to be responsible for policy and oversight of the Corps and the Surgeon General to implement these policies and be responsible for the operation of the Commissioned Corps.

To strengthen our Corps and broaden its mission to include new dimensions that are clearly necessary, we need to revamp and strengthen our recruitment efforts, use our promotion systems to reinforce and reward the best of qualities of a truly national, mobile public health force, bring our administrative management systems into the 21st century, and adapt the best DOD personnel practices for use in managing the Public Health Service Commissioned Corps.

For years, authority has existed in the Public Health Service Act to appoint warrant officers as part of the professional Public Health Service Commissioned Corps. Secretary Thompson now needs to use the authority to expand the capacity of the Commissioned Corps. We need to be able to access the clinical resources of registered associate degree-trained nurses that every State recognizes and licenses to provide clinical nursing services. Appointing them as warrant officers permits us to expand the service delivery capacity of the Corps. At the same time, we want to give them access to the education that would be required if they wanted to be commissioned officers after receiving a bachelor's degree in nursing. Likewise, we want to use the rank structure to add other members of the health care team such as laboratory assistants, physical therapy assistants and paramedics.

As part of this effort and at the direction of Secretary Thompson, I am already strengthening our Basic Officer Training Course to ensure that newly recruited officers are fully aware of our readiness standards and deployment systems when they first enter on duty. Also, as part of the transformation of the Corps, Secretary Thompson and I believe we should explore ways to strengthen and expand our reserves as a readily available source of additional officers, should we be required to respond to public health emergencies and other urgent requirements that exceed our active duty capacities. Therefore, the Secretary has asked me, working with the Assistant Secretary of Health, to look into options for that aspect of the transformation. Growing and maintaining a healthy, robust reserve could be instrumental in the pursuit of easing the maldistribution of public health professionals, without significantly adding to the size of the Federal payroll. These public health professional reservists could practice their professions within their communities all across the Nation and strengthen the capacity to respond to emergencies at a local level without the need for massive relocation of people and assets in times of an emergency.

There are several other reforms that we are developing as part of the transformation initiative. I have mentioned reforms directly affecting the lives of officers currently serving in the Corps. The continued dedication and commitment of commissioned officers to

the public health of this Nation is very important to both the Secretary and me. We will move to strengthen the development of those members of the Commissioned Corps who have devoted their careers to research in public health by establishing more formally structured career tracks. They will provide officers with clear growth opportunities to which they can aspire.

Our Nation asks much of these dedicated individuals, many of whom could migrate to the more lucrative private sector. Instead, these dedicated officers choose to serve in the Corps to the benefit of the entire Nation. In the past, the mission statement of the Commissioned Corps has been tailored to focus on supporting the activities of agencies that comprise the Department of Health and Human Services. Secretary Thompson and I believe that we need to revise that statement to better emphasize all of the values that have long been part of the Commissioned Corps: to protect, promote and advance the public health, science, and security of the Nation, domestically and globally, as America's uniformed service of uniquely qualified health professionals.

Because much has been speculated about the impact of this transformation on existing officers and the potential for disruption of their service, I want to conclude and emphasize what the transformation is not. Much information has been printed and, contrary to characterizations in the media and misconceptions elsewhere that have caused concern among officers, I would like to make two points. First with regard to deployment of officers, any deployments undertaken will be congruent with an officer's skills, competencies and physical capabilities. To be clear, sending officers such as bench scientists, FDA regulatory specialists or epidemiologists from CDC to achieve mission objectives that are not consistent with their specific training and physical capabilities makes no sense. The transformation contemplates no such thing.

Second, with regard to promotion standards, no system will be adopted that places undue demands on an officer with regard to training or physical strength. In fact, the three-tiered readiness standards we are proposing will impose no new physical fitness standards at the basic level through the calendar year 2004, and will establish, as other uniformed services do, a medical waiver provision. There will be phased-in incentives for officers to seek higher levels of training and deployment capability, but no officer will be disadvantaged for promotion by physical fitness standards in the 2004 promotion cycle.

Mr. Chairman, for over 200 years, the U.S. Public Health Service Commissioned Corps has served our country well. But today, faced with new challenges and new threats, transformation of the Commissioned Corps is a necessity. As envisioned, the transformed Corps will provide this and future Presidents with a more highly trained, capable and mobile cadre of public health professionals. We can accomplish this without disadvantaging any current members of the Corps, and we can accomplish this within the limits provided us by Congress for the size of the Commissioned Corps.

Mr. Chairman, that concludes my statement and I am ready to respond to any questions you may have. Thank you, sir.

[The prepared statement of Admiral Carmona follows:]

Testimony
Before the Committee on Government Reform
United States House of Representatives

Meeting Our Nation's Important Public Health Challenges: Transformation of the Public Health Service Commissioned Corps

Statement of
Richard H. Carmona, M.D., M.P.H., F.A.C.S.
Surgeon General
U.S. Public Health Service
Department of Health and Human Services

For Release on Delivery
Expected at 10:00 am
on Thursday, October 30, 2003

Thank you Mr. Chairman for this opportunity to address the Committee on Government Reform about the Administration's efforts to transform the Public Health Service (PHS) Commissioned Corps into a more mobile and responsive national resource for meeting some of our Nation's most important public health challenges. I am particularly pleased to have this opportunity to describe to you and the members of this committee the Department's vision of this transformation, to delve into the overall objectives, and to clear up many of the misconceptions about what the Transformation is, and what it is not.

I want to start my prepared statement with a clear message. The Public Health Service Commissioned Corps has a long and proud history. I am proud of their service to this country, and the officers who serve in the Corps are justly proud of their accomplishments. I have pride in the achievements of people such as RADM Craig Vanderwagen, whom Secretary Thompson deployed from the Indian Health Service to serve, currently, in Iraq. There is no better way to illustrate his service than to quote from his recent e-mail message back to us. He wrote:

> "The Ministry of Health [in Iraq] has some marvelous professionals who are very happy to have the opportunity to do good things for their country after years of neglect. We will build a primary care system that has not existed here before, to complement the improvements in public health systems. I am happy to be here and growing immensely in this environment, and thankful every day for the

opportunity to be part of this."

I applaud the work of Commissioned Corps Officers like Captain Ken Martinez, of the National Institutes for Occupational Health, a component of the Centers for Disease Control and Prevention (CDC), and Commander Tim Cote, M.D. of the Food and Drug Administration. Captain Martinez, an engineer who works in the field of industrial hygiene was among the officers responding to the anthrax release on Capitol Hill. He was deployed from CDC and served 24/7 for several weeks. Commander Cote, who is currently the Chief of Therapeutics and Blood Safety at the Center for Biologics at the FDA, not only served during the anthrax release, when he was assigned to the National Institutes of Health, but he also volunteered to deploy for duty in Iraq. It is the dedication of individuals like Commander Cote, Captain Martinez and RADM Vanderwagen that exemplifies the best of the Corps' past, and present–but more importantly, its future.

Why is the Transformation Needed?

While the Corps has responded well during many public health emergencies, including most prominently the September 11th attack, and the anthrax release on October 15th, Secretary Thompson and I believe that our capabilities will have to be broader, our resources deeper, and our flexibility enhanced if we are going to be ready to address the needs of our citizens when they are faced with future national emergencies. We need to be ready should local and state public health resources be overwhelmed by urgent

public health needs whether engendered by a terrorist attack, a natural disaster such as a significant earthquake or a nationwide disease threat such as would be created by an influenza pandemic. In fact, during the past few weeks, in preparation for and in response to the havoc created by Hurricane Isabel, Secretary Thompson deployed 176 Commissioned Officers to several communities, to seven state emergency operation centers, and to six state health departments. These Officers served with distinction and I am very proud of what they accomplished.

In addition to addressing public health emergencies, ongoing Corps deployments across the country are essential to protect public health. For example, the Indian Health Service is facing both significant recruiting problems and a large number of vacancies, half of them for nurses, in providing care for our American Indian and Alaska Native populations.

Similarly, the President and the Secretary, from the beginning of this Administration, have recognized that we need thousands of health care professionals to overcome shortages in Health Centers and National Health Service Corps placement sites where recruitment efforts have fallen short of expectations.

Secretary Thompson and I am equally concerned that we do not have a sufficiently large force, appropriately trained, suitably experienced, and readily deployable to address special needs, such as the critical issue of childhood immunization. Across our nation,

there are urban and rural areas where the percentage of children unprotected from preventable diseases is a serious concern to all of us. Further, we need to strengthen our national prevention effort. For example, early diagnosis of diabetes is important, and particularly among some of the most needy members of our society. That Public Health professionals are attuned to the early signs of diabetes is crucial to controlling the progress of the disease as well as controlling the cost of treatment of the more serious conditions connected with the progression of the disease. Another example is the need to respond to the difficult health care issues we face along our Southwestern border. The fact of the matter is that when it comes to national resources to address urgent and unexpected national public health demands such as these, there are too few readily accessible Public Health professionals at our disposal to deploy as needed.

Over the last several decades, ever since the PHS hospital system was disbanded, the management of the Corps has become more and more decentralized and the structure of the Corps less and less distinguishable from the civil service. The requirements that were placed on the Department during the events of September 11th and the anthrax attack underscored the importance of the PHS Commissioned Corps as well as the need for more direct responsibility exercised by the Secretary. Therefore, the Secretary has asked his principal health official, the Assistant Secretary for Health, to be responsible for policy and oversight of the Corps, and for the Surgeon General to implement these policies and be responsible for the operation of the Commissioned Corps.

To strengthen our Corps and broaden its mission to include the new dimensions that are clearly necessary, we need to revamp and strengthen our recruitment efforts; use our promotion systems to reinforce and reward the best of the qualities of a truly national, mobile public health force; bring our administrative management systems into the 21st century; and adapt the best of DOD personnel practices for use in managing the PHS Commissioned Corps.

For years, authority has existed in the Public Health Service Act to appoint warrant officers as part of the professional PHS Commissioned Corps. Secretary Thompson now needs to use that authority to expand the capacity of the Commissioned Corps. We need to be able to access the clinical resources of registered, associate-degree trained nurses that every State recognizes and licenses to provide clinical nursing services. Appointing them as warrant officers permits us to expand the service delivery capacity of the Corps. At the same time, we want to give them access to the education that would be required if they wanted to be commissioned after receiving a baccalaureate degree in nursing. Likewise, we want to use this rank structure to add other members of the health team such as laboratory assistants, physical therapy assistants, and paramedics.

As part of this effort and at the direction of Secretary Thompson I am already strengthening our Basic Officer Training Course to ensure that newly recruited officers are fully aware of our readiness standards and deployment systems when they first enter on duty. Also, as part of the transformation of the Corps, Secretary Thompson

and I believe we should explore ways to strengthen and expand our reserves as a readily available source of additional officers should we be required to respond to public health emergencies and other urgent requirements that exceed our active duty capacities. Therefore, the Secretary has tasked me, working with the Assistant Secretary for Health, to look into options for that aspect of the Transformation. Growing and maintaining a healthy, robust Reserve could be instrumental in the pursuit of easing the maldistribution of public health professionals without significantly adding to the size of the Federal payroll. These public health professional reservists, could practice their professions within communities all across this nation, and strengthen the capacity to respond to emergencies at the local level without the need for massive relocation of people and assets in times of localized emergency.

There are several other reforms that we are developing as part of this transformation initiative. I have mentioned reforms directly affecting the lives of officers currently serving in the Corps. The continued dedication and commitment of Commissioned Corps Officers to the public health of this nation is very important to both the Secretary and me. We will move to strengthen the development of those members of the Commissioned Corps who have devoted their careers to research and public health practice by establishing more formally structured career tracks. This will provide officers with clear growth opportunities to which they can aspire. Our nation asks much of these dedicated individuals, many of whom could migrate to the more lucrative private sector. Instead, these dedicated officers choose to serve in the Corps, to the benefit of the

entire nation.

In the past, the mission statement of the Commissioned Corps has been tailored to focus on supporting the activities of the agencies that comprise the Department of Health and Human Services. Secretary Thompson and I believe we need to revise that statement to better emphasize all of the values that have long been part of the Commissioned Corps - to protect, promote and advance the public health, science and security of the Nation domestically and globally as America's uniformed service of uniquely qualified health professionals.

Misconceptions

Because much has been speculated about the impact of this Transformation on existing officers and the potential for disruption of their service, I want to conclude, and emphasize what the Transformation is NOT. Much information has been printed, and contrary to characterizations in the media and misconceptions elsewhere that have caused concern among officers, I would like to make two points. First, with regard to deployment of officers, any deployments undertaken will be congruent with an officer's skills, competencies, and physical capabilities. To be clear, sending officers, such as bench scientists, FDA regulatory specialists, or epidemiologists from CDC, to achieve mission objectives that are not consistent with their specific training and physical capabilities makes no sense. This Transformation contemplates no such thing.

Second, with regard to promotion standards, no system will be adopted that places undue demands on an officer with regard to training or physical strength. In fact, the three-tiered readiness standards we are proposing will impose no new physical fitness standards at the basic level through the calendar year 2004, and will establish, as other uniformed services do, a medical waiver provision. There will be phased-in incentives for officers to seek higher levels of training and deployment capability, but no officer will be disadvantaged for promotion by physical fitness standards in the 2004 promotion cycle.

Mr. Chairman, for over two hundred years, the United States Public Health Service Commissioned Corps has served our country well. But today, faced with new challenges and new threats, Transformation of the Commissioned Corps is a necessity. As envisioned, the Transformed Corps will provide this and future presidents with a more highly trained, capable, and mobile cadre of public health professionals. We can accomplish this without disadvantaging any current members of the Corps and we can accomplish this within the limits provided us by Congress for the size of the Commissioned Corps.

That concludes my statement, Mr. Chairman, and I am ready to respond to your questions.

Chairman TOM DAVIS. Thank you very much. I have to tell you, before this I knew very little about it. This has not been a subject in my years that I've spent much time on. I know Mr. Waxman has spent a lot of time with this, so I'm learning my way through.

What distinguishes the Commissioned Corps from the Civil Service?

Admiral CARMONA. We are in uniform, sir. We are one of the seven uniformed services of the United States. Our function, our mission, as I stated, is to protect and advance the health of the Nation. As you know now, with the threats upon us, that has really increased somewhat to be more of a global responsibility. As you see, we have officers in Iraq helping to rebuild the Health Ministry.

Chairman TOM DAVIS. Being uniformed gives your superiors more ability to direct than civil servants, too, doesn't it? Isn't there more flexibility to direct the uniformed personnel?

Admiral CARMONA. Yes, sir, I think that is one element, just as our sister services, that it allows the leadership to direct those assets where they may be needed.

Chairman TOM DAVIS. OK. Secretary Thompson claimed in his announcement of the plan back in July that it would give the Surgeon General more authority over the Commissioned Corps than ever before. Do you agree that your position will receive added responsibility?

Admiral CARMONA. Sir, based on the plan that the Secretary has put forward, I think the Surgeon General will have unprecedented authority for the operations of the Public Health Service Commissioned Corps on a day to day basis. Working in concert with the Assistant Secretary and the Secretary who will develop the policy for administering the Corps, and in effect, the direction to the Surgeon General as to how to operate the Corps on a day to day basis.

Chairman TOM DAVIS. How do you interact, under the new management structure, how does it work with the Assistant Secretary for Health? Can you walk me through the new versus old, if there is a difference?

Admiral CARMONA. The way the system is proposed to be set up, sir, is that the Assistant Secretary, being the Secretary's chief deputy for public health matters, oversees the Office of Public Health and Science. The Surgeon General reports through the Assistant Secretary to the Secretary, and the Secretary, by delegation, delegates to the Assistant Secretary certain authority to generate policies and oversee the Commissioned Corps. In addition, I will have certain delegated authorities to operate the Corps on a day to day basis.

Chairman TOM DAVIS. OK. We learned after September 11, the anthrax scare, SARS, and other recent public health emergencies, that solid coordination between Federal, State, and local levels is key to handling emerging public health threats. We had testimony here last week on the Post Office, where some of the advice that was given, frankly, wasn't the right advice, it was something that was newly handled by CDC and the Postal Service. How will the new transformation improve coordination between Federal, State and local levels? Is that one of the goals of this, to improve that?

Admiral CARMONA. We are working on improving this right now through our Assistant Secretary for Public Health and Emergency

Preparedness, where we have Corps officers, CDC, NIH, we're really all partners in this preparedness. The threats that were thrust upon us on September 11 and then on October 15 are very new. Having to revitalize, reorganize ourEMS systems from the local to the State to the Federal level so that we have a seamless system that's able to deal with all hazards, that includes the every day things—the hurricanes, the earthquakes, the fires in California that are being experienced now—as well as the new threats where, quite frankly, who could have expected that planes would have been characterized as weapons, or pathogens characterized as weapons? It's a very new world, but I think we're making significant progress in moving in that direction.

Chairman TOM DAVIS. What's the communication been like? As this plan was being developed, what was the communication like from the bottom up ranks? Were there meetings and solicitations of ideas, or did this come in basically a top-down reorganization?

Admiral CARMONA. I don't think it was a top-down, sir. I think what occurred, and I will state that, prior to my becoming Surgeon General, this was an issue for the Secretary that he was bringing forward. In fact, as I went through my interviews, I was questioned about the Public Health Service structure, what I saw as the future of the Public Health Service, if I was in that position, how I would lead the Corps in this transformation. So it predated me.

Chairman TOM DAVIS. Right.

Admiral CARMONA. When I came in, there was already a structure in place by the Acting Surgeon General, who is my deputy now, who had formed committees to begin to discuss information within the troops and begin a dialog that would move up and down the chain of command on how the transformation should go forward.

Chairman TOM DAVIS. Has the dialog been satisfactory from your perspective?

Admiral CARMONA. The dialog has been a good one. It's been a vigorous one. There have been, as you can imagine, as many opinions as we have officers. So as you all in Congress have to deal with thousands of constituents who see the world differently, we have to work hard to develop a consensus and try and accommodate all of the input.

Chairman TOM DAVIS. Thank you. Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

Admiral Carmona, I want to welcome you to our hearing today.

Admiral CARMONA. Thank you, sir.

Mr. WAXMAN. To followup on that point about how this plan was put together, the Surgeon General is the historic leader of the Commissioned Corps. Were you the main author of the plan?

Admiral CARMONA. I think it was a team that put together the plan, sir. I could not take credit for it. It was all of us who worked on it.

Mr. WAXMAN. When it was announced on July 3, had you personally reviewed the plan and signed off with your approval?

Admiral CARMONA. The announcement that the Secretary brought forth on July 3rd I was fully aware of and fully supportive of. In his statement that was delivered, if that's what you mean,

on July 3rd, yes, sir. I had seen that and was fully supportive of his vision to transform the Corps.

Mr. WAXMAN. We know that FDA's Commissioner McClelland has written to the Secretary, critical of some parts of the proposal. And I heard from NIH Director Zerhouni who also had serious concerns about the plan. How is it that this plan was produced without finding some basic agreement with the directors of these critical public health agencies which employ hundreds of Corps officers?

Admiral CARMONA. Sir, if I might, I'm not sure that it was so much criticism as, for instance in Dr. McClelland's case, whom I was in contact with continually, as well as Dr. Zerhouni and Dr. Gerberding, who are my peers, he asked for input from his troops as to what the issues are. In fact, he assigned me two senior officers of our Commissioned Corps to work with me in getting that information. I viewed his letter more as a synthesis of the input he got that was then transferred to us to take appropriate action on. So we welcomed his input, as we did Dr. Zerhouni's and Dr. Gerberding's.

Mr. WAXMAN. I think they're reflecting a lot of unhappiness with members of the Corps, and I'm sure you've heard from people in the Corps as well, the draft proposal establishes universal fitness standards for all Commissioned Corps officers. Those who don't meet the standards would lose promotions and face dismissal from the Corps. I wrote to the Secretary in August that this could prompt an exodus of expertise from science-based agencies.

Can you explain how the proposed physical fitness standards, which include a minimum number of pushups, are relevant to experienced officers who are world class scientists or expert drug reviewers?

Admiral CARMONA. Yes, sir, I'd be happy to and I appreciate your asking the question, because certainly that's been the crux of some of the misconceptions. The proposal as we put it forth has a three-tiered system. In fact, only if you're going to be in the upper tiers, the advanced tier, where you'd have some more stringent physical requirements, would you be doing anything like pushups or timed runs. So the entry level or basic level really is for any one of our officers. Basically, it consists of a current physical exam on file that you're healthy, that you've got your vaccinations up to date, that you've got your basic CPR card on file, and the online modules of education that will bring you up to speed, so to speak, on emergency deployments and how our system works.

So in fact, there really is no intent to affect the officers as far as losing ability for promotion or for an exodus from the Corps. In fact, it allows the officers to gravitate to the level based on their skills, competencies and what they do, using the example of that lab researcher that you alluded to. There would be no intent to deploy that person to an environment that they could not work in. However, prior to September 11, or October 15, we never expected we'd have to deploy a lab scientist some place to figure out some complex issue, as we did with anthrax, for instance.

Mr. WAXMAN. Before you get into that, you're suggesting the policy is different than what I read in the draft proposal. Have there been changes in the draft proposal? For example, I wrote to Secretary Thompson and I asked him what will happen if an officer

cannot meet the fitness standards, for example, the weight limits or physical fitness requirements. Will promotions be withheld or not? And it seems to me that the answer I got back was, "Well, there can be a waiver, but still it's in place."

Admiral CARMONA. Sir, if I might, I think that maybe there's some confusion with the old Commissioned Corps readiness force. That is changing, the concept that the Commissioned Corps readiness force was always looked to be phased out. We have about 50 percent of our Corps qualified now as Commissioned Corps readiness force, which does meet physical standards of running or swimming and pushups and things like that.

Mr. WAXMAN. So only 50 percent has to meet these?

Admiral CARMONA. No, what I'm saying is that was the previous system. What we've done now in this proposal is to begin to phase-out CCRF where the whole Corps would be looked at as a deployable force, but with different standards within the Corps: an entry level, a middle level and an advanced level. And that entry level is, for instance, let's say a bench scientist who's not going to have to go out and do rescues or something that's highly physical, but we want to make sure that if they had to be deployed, which would be unlikely——

Mr. WAXMAN. Is there anything in writing about this?

Admiral CARMONA. Yes, sir.

Mr. WAXMAN. Other than the draft statement, draft proposal itself?

Admiral CARMONA. We have many things in writing, sir, that have been circulated as we were going through the dialog with all the authors and staff——

Mr. WAXMAN. Well, if there's been some change, I'd like to be sure we get it. But let me ask you——

Admiral CARMONA. We'll get with your staff, sir.

Mr. WAXMAN. Great. Just one, because my time is up and I hope we'll get a second round. You testified about the role of the Surgeon General and you say it's unprecedented authority. We're going to hear from two former U.S. Surgeons General, Dr. C. Everett Koop and Dr. Julius Richmond, both will testify that this reorganization plan does not give enough authority to the Surgeon General. The plan sets up a new Office of Corps Force Management that's responsible for training, recruitment and assignment of support, officer support, and the new office is separate from the Office of the Surgeon General and reports to the Assistant Secretary for Health. You said that you are going to have unprecedented authority day to day. But it sounds like some of your predecessors are saying when it comes to policy and recruitment, you as Surgeon General will have less authority than Dr. Koop and Dr. Richmond had. Do you agree with that?

Admiral CARMONA. Well, sir, first of all, I certainly respect the large shoes I filled following Drs. Richmond and Koop, who were certainly role models for all of us. So no question, I welcome their input. I have not seen specifically what they have said, though. But based on the plan that is before us, and understanding the history of the Corps from 1966, this plan proposes to give the Surgeon General the authority to operate and manage the Corps based on

policy that emanates from the Secretary and the Assistant Secretary.

Mr. WAXMAN. But the policy used to emanate from the Surgeon General, is that right?

Admiral CARMONA. I think if you go back historically, prior to 1966, when there was no ASH and there was a Surgeon General that really did both positions, that's a different issue. But I think if you look at the history over the last 40 years, the Surgeon General has had periods where he was strong and periods where he or she was not. I think this plan really does put some meat on the bones, so to speak, and gives the Surgeon General authority.

The issue of OCFAM is an interesting one, because I think there was a misconception. The Secretary has clarified that. OCFAM is a staff or an advisory group that the ASH will have at his or her disposal to be policy advisory. They are not going to be operating anything. The operation will be delegated to the Surgeon General for all functions of the Corps. That would include recruitment and that would include personnel functions. But the policy that would give instruction to the Surgeon General on how to operate the Corps would come from the Secretary and the ASH. That's the distinction, sir.

Mr. WAXMAN. Well, it's a, it's a distinction that disturbs many of us, because we have always seen the Surgeon General as the key person, and not the Assistant Secretary for Health. We think a lot of your prerogatives and responsibilities are being taken away and we don't see that as particularly a good idea. But I'll get back to you on the second round.

Admiral CARMONA. Thank you, sir.

Chairman TOM DAVIS. Thank you. I'm going to recess the hearing. Can you stay with us? We should be back in probably 20, 25 minutes.

Admiral CARMONA. Yes, sir, thank you very much.

Chairman TOM DAVIS. We'll take a break and reconvene in about 25 minutes. We have three votes over on the House floor. Committee is in recess.

[Recess.]

Chairman TOM DAVIS. The committee will come back to order.

Mr. Waxman, you are recognized for additional questions.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

Admiral Carmona, you can understand how there's a lot of anxiety out there by members of the Corps that they're going to have to go and pass some physical fitness test, even though they're working in something that has nothing to do with that. We'll want to look for some clarification on this whole point, because Dr. LeBaron, I mentioned in my opening statement, is a CDC bioterrorism expert. He's expressed concern that we're going to have a retrogression in our preparedness if we don't have the experts needed to lead our emergency response because they couldn't pass the physical fitness exam and do the requisite number of pushups.

We're hearing from people who are very anxious, because if they are commissioned officers and they have to leave the Corps prior to 20 years of service, they lose all their retirement benefits. When you change the promotion and other rules mid-stream, they're put in a terrible position. I'm sure you can understand why so many

of these officers are concerned about having the rules changed in the middle of their careers. They've given a lot to public health and it's imperative to avoid mistreating them and draining our science-based agencies of expertise.

I suppose it was a debate within the administration as to who's better able to handle the management structure and to set the actual policy for the Corps. On the one hand, it could be the Assistant Secretary of Health. On the other, it could be the Surgeon General. Give me the arguments for both sides, very briefly. Why would we want to have that management decision in the Assistant Secretary as opposed to the Surgeon General? It used to be one person, but now it's two.

Admiral CARMONA. It's a far more complex world now, and greater responsibility. But the Secretary encouraged us to have a vigorous debate about this issue. Because there is no right answer. But we were looking for a logical division of responsibility and authority and policy——

Mr. WAXMAN. Just give me the argument. If you were advancing the argument for giving it to the Assistant Secretary of Health, what would you say?

Admiral CARMONA. That the Surgeon General, in being the commander of the Corps every day, running the operation for the U.S. Public Health Service, as well as being an advisor to the President and the Secretary and being on the road quite a bit for public health issues around the country if not the world, probably has enough to do with just those components, and that policy might be much too much. Now, on the other side——

Mr. WAXMAN. Give me the argument the other way. Let's say you were making the argument, self-interested as it may be, but for the institution and the decision in general.

Admiral CARMONA. I never was on a debate team, but I'll play the game. [Laughter.]

The issue of the Surgeon General having it, really, if you argued for it, would be that, some would argue that, why would you divide management and policy, that they are intricately related and that we should probably consider having those together. Now, notwithstanding the fact that really the Secretary is the one that has the authority for the entire Health and Human Services, and delegates that authority for certain functions to the ASH or the Surgeon General. So really, the ASH doesn't have policy authority unless it's delegated from the Secretary.

Mr. WAXMAN. OK. You're a combat-decorated Vietnam war veteran, aren't you?

Admiral CARMONA. Yes, sir.

Mr. WAXMAN. You served in the military?

Admiral CARMONA. Yes, sir.

Mr. WAXMAN. As Surgeon General, what's your rank?

Admiral CARMONA. I'm Vice Admiral, 09 pay grade.

Mr. WAXMAN. And how many stars are associated with this rank?

Admiral CARMONA. That's a three star billet, sir.

Mr. WAXMAN. It's my understanding that if an Assistant Secretary for Health is a member of the Commissioned Corps and is not also the Surgeon General, this person becomes a four star gen-

eral. I also understand that Congress authorized this structure at a time when the Assistant Secretary for Health had more responsibility than today. Is it typical in other branches of the uniformed services that political appointees would be put in a uniform and take the rank of a general or admiral?

Admiral CARMONA. Well, sir, it's a good question. The system that we are proposing is parallel to that of the Department of Defense. My colleagues in the Army, Navy and Air Force are also three star billets, so either admiral or lieutenant general, vice admiral, lieutenant general at an 09 level. So Army, Navy, Air Force and myself, we are the four Surgeons General, if you will, of the country.

The Assistant Secretary in the Department of Defense that those Surgeons General report to is what you would call a four star equivalent, has the authority of a four star general or admiral, but doesn't wear the uniform because they are a civilian in an assistant secretary position. So your distinction between HHS and DOD is correct, that in the past, there was a change in statute that allowed for the Assistant Secretary to put on the uniform and not just be an equivalent of a four star.

Mr. WAXMAN. But would you recommend that an assistant secretary of health who was a political appointee put on the uniform of the Commissioned Corps and become a four star admiral over the Surgeon General? And would having too many political appointees in uniform pose any danger for the professionalism of the Corps?

Admiral CARMONA. That's a very tough question, sir. I've been involved in discussions and have had discussions with my colleagues at DOD as well as within the Corps and others as to should that be more of a DOD type position at Assistant Secretary. There are pros and cons, just as there were with the issues that you asked me to take both sides of just a moment ago.

I think that when you put a uniform on a person who hasn't come up through the ranks or understands, you do put them at a disadvantage because there's a certain culture that's engendered in that uniform that takes decades to get to. So I think that, unknowingly, that person is put at a disadvantage with their peers because they're, from everything from not being sure how to wear the uniform or salute or what the common courtesies are and the culture of the uniform. It makes it very difficult. So you'd have to propose an argument that would say, well, what is the benefit to putting the uniform on that person, rather than just having the equivalent and give them all of the graces that go along with the position, so to speak, but not the uniform itself.

Mr. WAXMAN. Do you feel like you're now becoming a lawyer because you're saying on the one hand and then on the other hand?

Admiral CARMONA. Almost. A little more practice I'll be OK.

Mr. WAXMAN. You're doing a good job.

One last question I want to ask, and then I know others have things they want to pursue. The transformation plan proposes to create a warrant officer rank within the Corps to hire hundreds of associate nurses. My understanding is that the Navy has tried and abandoned this approach and that it's drawn criticism from the Chief Nurse Officer. Have you studied the experience of associate

nurses and other services, and what is the logic for not proceeding more slowly with this plan?

Admiral CARMONA. Sir, that's a very good question. It's probably best to answer it in terms of why we even considered it. As you know, nationally, there's a nursing shortage, whether they're associate degree nurses or bachelor-trained nurses. It's certainly easier to access the associate degree nurses who are in a 2-year program than a 4. Now, I'm a former registered nurse. I understand the issues of nursing.

The reason that the Secretary chose to move in this direction was, we have huge unmet needs in the Indian Health Service and underserved areas around the country, and nursing is one of those biggest needs. So we were looking to be able to get nurses at the bedside, in the communities, to serve those underserved populations. In fact, I just got an e-mail last 24 hours, request for nurses specifically in Alaska and the Arctic Circle; for nurses to do OB/GYN as well as primary care, because the Eskimos have to travel over 500 miles if we can't get some people up there to fill the void.

In your area, sir, we got a request for nurses because of the forest fires.

Mr. WAXMAN. My question that I don't think you're answering, not that you don't have good intentions behind it, but there has been an attempt to do this and it didn't succeed. My question was, whether anybody studied the experience of associate nurses in other services and the fact the Navy tried it and abandoned it later should have been some lesson.

Admiral CARMONA. We did, sir, and in answer to your question directly, we did study those experiences and spoke to our colleagues in the other uniformed services. The driver for this was, we still have these huge, unmet needs. We looked at it as an opportunity to get nurses on the ground where they were needed to serve these underserved populations that are in desperate need of care.

Now, with that, we understand the concerns of all of the nursing leadership nationally who said, you know, the bachelor-trained nurse is more capable, has more experience, has more academic background. But why not put those together? And we looked at a continuum. So if we bring in associate degree nurses and put together an educational program that allows them to progress while they're working and become a bachelor trained nurse, under the supervision of our bachelor-trained nurses, to me that's a win-win situation for the Corps, it's a win-win situation for the communities that so desperately need those nurses.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

Chairman TOM DAVIS. Thank you very much. Just a couple of last questions. I'll put this under one big question.

Under the transformation proposal, I just wondered what type of emergencies would the Commissioned Corps respond to and are you planning on sending any Corps officers to respond to the California wildfires?

Admiral CARMONA. Thank you, sir. As I alluded to with Mr. Waxman, we just got a request, in fact I brought the e-mail with me, from the Red Cross in California to ask us to send five public health nurses for a 2-week deployment to assist them with public

health needs that are being unmet in those communities from the fires, and one of our liaison officers for our Commissioned Corps readiness force to support them through communications and should we need more resources there. We are in the process of deploying half a dozen nurses and a pharmacist up to the Arctic Circle now, because there are 10,000 Eskimos who have no care unless we can get those people there, because there is such a shortage of nurses and other health care professionals.

These come in on a daily basis from around the country and around the world sometimes, like Iraq. We do everything we can to meet that unmet need wherever it may be. So we really look forward to those opportunities to serve. We have a very robust 6,000 member Corps. We could probably use more, because sometimes we can't meet all the needs. But I'll tell you, we look forward to those challenges on a daily basis.

Chairman TOM DAVIS. That's why people go into it, to serve.

Admiral CARMONA. They do. We've got the most committed, hard working people I've ever worked with in my whole life. They subordinate their whole lives to serve others. So we would love to take in all the ones that we turn away because we don't have the billets for them. But we certainly have opportunities for them to serve if we could get them in.

Chairman TOM DAVIS. How much larger do you think the Corps ought to be to fulfill its mission?

Admiral CARMONA. How much larger should it be? Well, sir, to answer that——

Chairman TOM DAVIS. I know you're off script here. [Laughter.]

Admiral CARMONA. To answer that academically I'd have to ask you to give me some time to study it. Because we know that we have unmet needs throughout the country. We have community health centers where doctors aren't there, nurses aren't there, therapists aren't there. There's mental health needs in our underserved communities that are unmet. We could certainly look at that for you. But just generally, there is a large unmet need, as all of you know in this country, that public health officers could meet if we had those numbers.

Chairman TOM DAVIS. Thank you very much.

Any other questions? Mr. Van Hollen.

Mr. VAN HOLLEN. Thank you, Mr. Chairman. Thank you, Admiral. I think we all have a great interest in the future success of the Corps. It has a long and distinguished history, and we're all very interested in making sure that continues and we have a big stake in its reorganization. In addition, I also have many members of the Corps in my district. I represent a district right near our Nation's Capital here in Maryland, and many members of the Corps are at the FDA and NIH and other Federal agencies in this region.

I think you would agree, would you not, that it's important, whenever you undertake this kind of transformation and reorganization, that you get the support, the buy-in in this case, of the members of the Commissioned Corps and the officers of the Commissioned Corps in order for it to be successful in the long run? Would you agree with that?

Admiral CARMONA. Yes, sir.

Mr. VAN HOLLEN. Are you aware of any surveys that have been done to determine whether or not members of the Corps or members of the officers in the Corps, what their reaction is to this reorganization plan?

Admiral CARMONA. I'm aware of a lot of discussions and meetings that have taken place. I work through my colleagues, Dr. Zerhouni, Dr. Gerberding, Dr. McClelland, Dr. Duke, all the optive and staff within HHS. They then test their people to bring back information. I've gone to a number of all-hands meetings where I've asked for input from officers and that comes in and we take a look and see where the themes are developing. So there's been a number of ways that has been done. But really the input has come in various forms.

Mr. VAN HOLLEN. Would you agree that in a particular agency, if 72 percent of the members of the officer corps said that, as a result of this planned reorganization, they intended to leave after 3 years, that would be a problem, I assume?

Admiral CARMONA. Well, I'd certainly, if that was the case, I'd want to talk to them, first of all, to make sure that they understood what we were doing and that there was no misconception, misperception, of what the intent was, and find out specifically what are the issues.

Mr. VAN HOLLEN. Right. Well, I think that, one of the problems as I understand in talking to people, is that part of the cause for the misunderstanding may be a failure to communicate by the Department with members of the Corps. I have a survey that was done by the Commissioned Corps officers at the CDC, Centers for Disease Control. According to the results of that survey, 82 percent of the CDC officers who responded to the survey said they were considering leaving the Corps within 3 years because of the transformation. And of the physicians among them, 75 percent of the physicians said that as a result of the transformation plan, they were considering leaving the Corps. If that were to occur, you would agree that would be a significant degradation in the ability of the Corps to do its job, would you not?

Admiral CARMONA. Certainly, sir. If I might add, though, that as Mr. Waxman alluded to earlier, there were misperceptions at the time the survey was done. For instance, the physical requirements that people would have to, everybody's doing pushups and situps and being trained. That wasn't an issue. So when we heard about that, we did everything we could to correct those misperceptions that was not the intent, that there were three levels of physical ability. I think that was the biggest complaint that people pushed back on that: "Whoa, I'm a researcher, I shouldn't have to run miles and do pushups and situps." That wasn't the issue. I'm not sure how that got out there, but we've done everything we can to correct that misperception. Certainly, once the appropriate information is out, I'd love to see a survey done, once corrected, if that was still the opinion.

Mr. VAN HOLLEN. Well, 70 percent of the commissioned officers, I understand, are members of the Commissioned Officers Association. So would you agree it's a representative body, a body that represents them?

Admiral CARMONA. Yes, sir.

Mr. VAN HOLLEN. Don't you think it would be important to consult with them in coming up with this reorganization plan?

Admiral CARMONA. Well, as far as I know, I've spoken to Mr. Farrell many times, and the leadership, and I was not present at meetings, but I am told that there were two meetings with the commissioned officer directors, the COA director and leadership at HHS. But I was out of town those times and I don't know about those discussions.

Mr. VAN HOLLEN. Well, Mr. Farrell is here, but I just happened to see the October issue of the Commissioned Officers Association newsletter, this month's issue. In it, he says, "Over the last several weeks, I have presented COA's views on the transformation process in many different places. Capitol Hill, OMB, various journalists and to several COA branches. Interestingly, the one place I have not been invited to present our views is DHHS."

Now, if that's the case, and according to his testimony it seems to be, doesn't that suggest a very serious problem in how this plan was put together in the first place? You mentioned, what you're saying is confusion that hopefully we can sort out today. But it sounds to me like a lot of the confusion resulted from a failure to approach this reorganization in a way that makes sense, which is going to talk to the people who would be most affected. Doesn't that seem to—would you agree with that?

Admiral CARMONA. No, sir, respectfully I wouldn't in this case. I do agree with you that there has been some confusion and misperception. I have great respect for Mr. Farrell and the COA, I'm a member and have had many discussions with them over time. But there's a lot of venues to get to our officers. COA of course is a leadership group that is involved with our officers. But we've gone through the optive, the stafftivs, we've met with the leadership at CDC, NIH, FDA, SAHMSA. So it's not any one point of contact, it's multiple points of contact. And, certainly, I know personally, I rely on Mr. Farrell for input when I have questions, when I'm trying to learn the culture of the Corps and maybe the best course of action. He's got a little historical perspective that I don't have, and he's provided me great information since I've been in this position, which is only about 15 months.

Mr. VAN HOLLEN. Well, just in closing, Mr. Chairman, I think the results of the CDC survey where you've got 80 percent of the people surveyed suggesting they would leave the Corps as a result of this reorganization within 3 years and Mr. Farrell's statements that he has not really been included with respect to DHHS, thinking in this, suggests to me that if it's a question of confusion as opposed to significant substantive issues, then that confusion has clearly resulted from a failure to consult broadly with the people who would be most affected.

Thank you very much, Mr. Chairman.

Chairman TOM DAVIS. Thank you. Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman. Thank you very much.

I don't know whether to call you General or Admiral, so I'm going to call you Doctor. [Laughter.]

Doctor, what makes the Corps unique?

Admiral CARMONA. I think the most unique aspect of the Corps is that we are a uniformed service of health professionals, unlike

any other service in the world, that provides for the needs of public health to the United States and the globe now, on a daily basis, but also has the ability to respond to any contingencies that arise as far as emergencies.

Mr. SHAYS. I see it as, you don't follow the standard 40 hour work week.

Admiral CARMONA. No, sir.

Mr. SHAYS. You have that military kind of ethos, in a way. And it seems to me that if you are not fulfilling your unique responsibility then you need to say, "we need to change." It strikes me that change is going to make some people think, "Maybe this isn't the organization I want to be in." But if you're like any other health care organization in the country, there's really no point in your existing. That's kind of how I react. Obviously you want to interact with your employees and your employees need to buy into this organization. But if some people leave, that to me is not necessarily a bad sign. It's just a sign that they don't want to be part of what is unique about the Corps.

What are the new public health threats? I wasn't responding to my colleague from Maryland, it was something I wanted to say beforehand. Because I do think if you have a large number, it does say, "Hey, we're not communicating well, and we need to." But what are the new public health threats, and how are you responding to these new public health care threats?

Admiral CARMONA. The U.S. Public Health Service really is that anonymous backbone for public health in the United States. So when you turn on the water, when you take your medications, we all take for granted that those things are safe. But it's because we have this very robust public health service at FDA, CDC, NIH that does the research, does the work there.

The new threats really that are upon us began on September 11, because, prior to that, we characterized the emergencies we responded to as all hazards, hurricanes, earthquakes, and other types of disasters—chemical spills and so on—where we would assist communities in mitigating and recovering from disasters. But since September 11, we're dealing with issues of planes and weapons and pathogens as weapons, so it's an entirely new world. But the expertise that we have in the U.S. Public Health Service is very adaptable to those new threats. And whether it's bioterrorism or conventional weapons of mass destruction, that is bombs and bullets and fires and explosions, we are prepared to work with our colleagues throughout the country to be able to make our country a healthier and safer environment for all.

Mr. SHAYS. Someone sitting at this exact desk a few years ago, in one of my hearings on national security, a doctor of a noted major medical magazine, said his biggest fear was that a small group of dedicated scientists could create an altered biological agent that could wipe out humanity as we know it. This wasn't someone on the extremes, this was a pretty Main Street kind of personality and organization. Do you think that statement is worth being concerned about?

Admiral CARMONA. Absolutely, sir. We on a daily basis have intel briefings and look at the potential threats around the world. Certainly the bio threat is a very real one, from naturally mutating or-

ganisms as well as purposely creating mutations that could be more virulent. So we are very concerned.

Mr. SHAYS. Former Speaker Gingrich believes that bioterrorism is the greatest threat that we face. My subcommittee is concerned about botulinum toxins, more so than even smallpox and so on. Is this something that you have focused any attention on?

Admiral CARMONA. Our officers at CDC and NIH, you bet, would be doing the research on that, to develop appropriate mechanisms to respond should that occur. But botulinum toxin is a very real threat, especially as it relates to the food supply, its ability to be disseminated easily. So we are concerned about that, and there is active research going on right now.

Mr. SHAYS. As we speak, we don't really have a vaccine against it?

Admiral CARMONA. No, sir.

Mr. SHAYS. Which to me, Mr. Chairman, raises some gigantic concerns.

I want to conclude, because I know that we also have former Surgeons General. I just want to say that I view you as the chief spokesperson for health needs and health concerns. I believe that office is, and I believe in some ways there's almost been an attempt to downgrade the office. You are a moral authority that has to speak out. My view is that you sometimes may have to speak out when no one else in the administration agrees with you. I hope that you feel that you have that duty, because I believe you do.

Admiral CARMONA. I agree with you, sir, I do feel I have that duty. A day doesn't go by that I don't get up and really understand that term when people say the weight of the world is on your shoulders. I understand the immense responsibility I have and I take it very seriously. Thank you for your comments, sir.

Mr. SHAYS. Thank you. Thank you, Mr. Chairman.

Chairman TOM DAVIS. Thank you. We have another panel to get to, but I want to make sure if Members have questions they have an opportunity to ask them. Are there any other questions? Mr. Tierney.

Mr. TIERNEY. Just quickly, Admiral, thank you. Can you give us in 25 words or less what's the rationale for the Service being a uniformed service as opposed to a civil organization?

Admiral CARMONA. Twenty-five words or less. Well, professionalism, visibility, mobility, all of the issues we spoke a little bit earlier in some of the questions that I was posed. But not dissimilar from our sister uniformed services, that there is a command and control structure, there's an authority. And just like the Army and the Navy and the Air Force who have specific missions that they are tasked with, the U.S. Public Health Service also has those missions. We are proud to be seen as a uniformed, visibly fit, mobile service.

Mr. TIERNEY. Would you not function as well as a civil organization as opposed to military?

Admiral CARMONA. I think it would be much more difficult to do it as a civil servant, sir.

Mr. TIERNEY. Because?

Admiral CARMONA. Well, because you wouldn't have the control of the troops, you wouldn't have the training, you wouldn't have a

lot of the constraints of a uniformed service. As Congressman Shays just said, it's not a 40 hour week for us. We typically put in 60, 70, 80 hours a week, and we don't count the clock when we're deployed and we have to take care of those in underserved communities.

Mr. TIERNEY. I notice that amongst your physicians you have dieticians also serving in your force.

Admiral CARMONA. Yes.

Mr. TIERNEY. And we're talking about serving the underserved. What prospect if any does this reorganization have for any plans that you might have for addressing the issue of obesity as a national health concern, particularly amongst the underserved?

Admiral CARMONA. I am so happy you asked that question, because it is something that Secretary Thompson is passionate about, as I am. It is the fastest growing epidemic we have in this country, with 9 million children being obese or overweight, two-thirds of the American public being overweight or obese, huge costs, $117 billion a year. What we want to do is to be able to use this force for those reasons, to get out there and deal with this public health issue through education, through intervention. Our officers at NIH and CDC are doing research on it. It's a very big team approach. But we're already out there doing this.

Mr. TIERNEY. Are you going to make that a focal point of your——

Admiral CARMONA. It already has been, sir, as far as prevention. Prevention is one of the focal points of my portfolio as assigned by the President and the Secretary. And obesity is probably the key element within prevention right now.

Mr. TIERNEY. Thank you very much. I yield back, Mr. Chairman.

Chairman TOM DAVIS. Thank you, Mr. Tierney. The gentleman from Missouri.

Mr. CLAY. Just two quick questions.

Chairman TOM DAVIS. Sure.

Mr. CLAY. Thank you, Surgeon General Carmona, for being here. Good to see you again.

Tell me, what efforts are being made to recruit and train minority applicants wishing to become commissioned public health service officers?

Admiral CARMONA. As part of our transformation, we're looking at a scholarship program which we would like Congress to be involved in, where we would work with Congress to have Congressmen select worthy young men and women who could come into the Public Health Service and serve. We certainly would hope that would include a robust portion of underserved minorities, Native Americans, Black, Hispanic, etc. Because we recognized that, in fact, we need to have a more robust work force.

Now, with that said, of all the uniformed services, about a third of our officers identify themselves already as minority. So we are very proud of what we have achieved with diversity within our ranks already. But we don't want to stop there. We want more.

Mr. CLAY. I'd be interested in hearing more about the program that you want to develop.

Let me also ask you, what do you and Secretary Thompson envision to be the cost of the proposed transformation or reorganization plan, and how long will the implementation take?

Admiral CARMONA. The entire transformation is still being worked on, sir, as far as the specific details. Part of it, we're doing as much as we can through policy and just administrative changes within the Corps, which really there is very little cost associated with that, it's just a reorganization. Some of the issues that in the future we would like to bring before Congress as far as having an academy, having additional resources allocated to train minority doctors, nurses, dieticians, and others, have career pathways, we would like to engage in a discussion with Congress and other leadership to answer those questions because we feel that it will help us to meet the unmet need in many, many underserved populations in this country.

Mr. CLAY. OK, I thank you for your responses. Thank you, Mr. Chairman.

Chairman TOM DAVIS. Thank you. Any other questions?

Admiral, General, Doctor, nurse, I'm not sure what to call you—[laughter]—you've requited yourself well. Thank you very much. We appreciate your being here, and we'll take a 2-minute recess and get our next panel up. Thank you very much.

Admiral CARMONA. Thank you, Mr. Chairman. Thank you all.

[Recess.]

Chairman TOM DAVIS. Our next panel is a very distinguished panel; Dr. C. Everett Koop, who was U.S. Surgeon General from 1981 to 1989; Dr. Julius Richmond, who was Surgeon General from 1977 to 1981 and professor emeritus at the Harvard School of Public Health; and Captain Gerard Farrell, who is executive director of the Commissioned Officers Association.

It's our policy to swear you in, so if you would just rise with me and raise your right hands.

[Witnesses sworn.]

Chairman TOM DAVIS. Thank you very much.

You know the rules, the light will turn orange after 4 minutes and red after 5. You don't need to read your entire statement, because it's already in the record. You can highlight it. But we'll be generous, whatever you need to get your points across, and then we'll move to questions. I just want to thank all of you for being here. This is a really important issue that has not been highlighted at the congressional level much. We're very interested in your comments and your taking the time to be with us today. I'll start with Dr. Koop and move this way. Dr. Koop, thank you very much for being here.

STATEMENTS OF DR. C. EVERETT KOOP, FORMER U.S. SURGEON GENERAL; DR. JULIUS B. RICHMOND, FORMER ASSISTANT SECRETARY FOR HEALTH AND FORMER U.S. SURGEON GENERAL; AND CAPTAIN GERARD M. FARRELL, EXECUTIVE DIRECTOR, COMMISSIONED OFFICERS ASSOCIATION OF THE U.S. PUBLIC HEALTH SERVICE

Dr. KOOP. Thank you, sir. I will, because of the constraints of time, skip the niceties of introduction and ask you to refer to my prepared remarks.

I would like to say that I support Secretary Thompson's vision and initiative in recognizing the need for improvement in the Corps. The concerns I have are much more to do with organization and process, not the overall goal of strengthening the Corps.

I am the only living person who was Surgeon General and leader of the Public Health Service Commissioned Corps under two organizational concepts. One system worked well, but the other was inefficient, tied the hands of willing, competent experts and initiatives were stifled by bureaucrats with no real solutions. This system undermined the morale of the Corps.

The following changes I believe are important, sir. The Surgeon General and his staff must have complete and direct control over all aspects of the day to day administration, management and operation of the Corps. This is the system which worked after my revitalization of the Corps in 1987. The Corps needs to better define requirements, including personnel requirements—no small task. The Corps will then be able to move forward with its overall recruiting and assignment strategy.

The growing need for the Corps to respond to emergency situations demands some sort of a robust, ready reserve component, similar to the reserve components of the other uniformed services. The key to emergency response is the training, organization and exercising of the response force, well in advance of the emergency. This will require much thought before instituting change, as well as evaluation of trial and error, then reevaluation and, of course, funding.

Efforts to improve professionalism should include a continuum of educational opportunities from pre-commissioning through indoctrination through executive level management, administration, leadership and even officership for those selected for flag rank. The Corps has functioned best, in my opinion, when officers were rotated every 3 years through, say, Indian Health Service, Bureau of Prisons, public health service agencies, and then a period of refreshment in one of the public health service hospitals. The hospitals, except for those in the Indian Health Service, were closed in 1981, which severely impacted the opportunities to educate and re-educate our officers. There must be some alternate plan, which would include bioterrorism updates.

My concerns are that the plans do not support the important changes just mentioned. The system that did not work well for me was when personnel management of Corps officers was separated from control or direction by the Surgeon General. The new system I devised worked well. But in 1995, to my dismay, personnel management functions were moved again, this time under the HHS Assistant Secretary for Administration and Management. As a result, the Corps experienced difficulties in the recruiting and placement of officers, and has continued until very recently to slowly grow smaller. Hardly the system that would foster the desired increase in the size of the Corps.

We do not need a new office for day to day management and operation which reports to the Assistant Secretary for Health on a coequal basis with the Surgeon General. What then would be the role of the Surgeon General for leadership of the Corps, which is really one of the principal functions for which he is nominated in the first

place and then confirmed by the Senate? And leaving compensation and medical affairs under the authority of still another assistant secretary will add confusion and inefficiency where least needed.

The plans also appear to devalue the role of Corps officers in fundamental public health roles: research laboratory work, regulation activities. Clinical health care for underserved populations is not the only aspect of public health. Equally important is the work conducted by Corps officers in institutions like CDC, NIH, FDA. Let me remind you that the world relies on the standards of FDA, the NIH is the premiere source of medical research on this planet, and the CDC is preeminent in international health.

In the Department rush to fix one problem, they might well create two more if the process is not engineered critically. Mission drives requirements, tempered by resources. Then, after that, plans are developed to match resources against prioritized requirements. It appears to me we are beginning with the plans first.

Our public health infrastructure is not able to respond to the threat of bioterrorism. There are insufficient health care providers for some underserved communities, and improvements to our research capabilities are demanded by new diseases such as SARS. I would argue for an increased role for the Corps and the Surgeon General in leading the public health infrastructure at all levels. The Corps' role in emergency preparedness and response, especially organizational issues, should be carefully evaluated, as should be the relationship of the Corps and the Office of the Surgeon General to the new Department of Homeland Security.

In increasing the mobility of the Corps in emergent response, remember that these highly trained and experienced health professionals have day jobs. Their day jobs are critically important, whether they are clinicians on a remote Indian reservation or in Federal prison, or assigned as an epidemiologist or researcher at CDC. You cannot routinely deploy the only pharmacist on a reservation or in a prison without a plan for substitution.

Also, the lifelong researcher at CDC may not be the ideal choice to respond to an emergent situation where trauma skills will be the primary need. New responsibilities for the Corps must be carefully balanced against the still important role of the Corps in traditional areas of public health. This can only be successfully accomplished by using a strategic planning process which is organized, inclusive and based upon data. My impression of the current process is that none of these exist.

The Surgeon General is clearly recognized as the top public health professional in the country. The Office of the Surgeon General ought to be empowered to take charge of the infrastructure and develop the changes necessary to make it better. The Commissioned Corps is one logical tool already in place at the Surgeon General's disposal to make this happen. To do less, sir, I think, unnecessarily risks the public health of this great Nation. Thank you.

[The prepared statement of Dr. Koop follows:]

STATEMENT FOR THE RECORD

of

C. Everett Koop, M.D., Sc.D.
Surgeon General, 1981-1989

on

THE COMMISSIONED CORPS
OF THE
U.S. PUBLIC HEALTH SERVICE

Presented to the

HOUSE COMMITTEE
ON
GOVERNMENT REFORM

October 30, 2003

As a former Surgeon General of the U.S. Public Health Service I retain a deep and abiding respect for the dedication of the officers of the PHS Commissioned Corps. Accordingly, I appreciate the invitation of the House Committee on Government Reform to testify on the role and organization of the Corps as they continue their critically important work for the Nation.

There is little information available to the public concerning the details of the plan of the Department of Health and Human Services to reorganize or "transform" the PHS Commissioned Corps. My remarks will be based on what I have learned in discussions with others more familiar with the specifics of the HHS plans, and also on my experience over eight years as the Surgeon General.

Let me begin by stating my support for Secretary Thompson's vision and initiative in recognizing the need for improvements in the Corps. I endorse the need for change. The concerns I will express in this testimony have more to do with organization and process, matters I am sure the Secretary has left to subordinates; I am not here to criticize the overall goal of a strengthened Commissioned Corps and improved public health.

I am the only living person who was Surgeon General and leader of the PHS Commissioned Corps under two organizational concepts. One system worked well and the other was inefficient, tied the hands of the willing, competent experts where initiatives were stifled by bureaucrats with no real solutions in mind. The system undermined the morale of the Corps. I believe, therefore, that I am uniquely qualified to comment on what is in the best interests of public health as influenced by the Commissioned Corps.

For the Corps to reach its full potential in protecting and promoting the public health the following changes are important:

- The Office of the Surgeon General, that is the Surgeon General and his staff (OSG), must have complete and direct control over all aspects of the day-to-day administration, management, and operation of the Corps. This is the system which worked after the revitalization of the Corps which I undertook with the guidance and full support of the Secretary of Health and Human Services, Otis Bowen. Its models are and should be the other uniformed services as well as the organization of any successful business enterprise.
- The Corps needs to develop the ability to better define requirements, including personnel requirements. This is no small task. It was an important part of my efforts to revitalize the Corps, even though – in the three years available to me – we were not able to fully implement

the changes we sought. Once personnel requirements are documented, the Corps will then be able to move forward with improvements to its overall recruiting and assignment strategy.

The growing need for the Commissioned Corps to respond to emergency situations - whether natural disasters or the result of man made terrorist actions - seems to mandate a demand for some sort of robust ready reserve component, similar to the reserve components of the other uniformed services. This reserve force could function as either a backfill for officers deployed from clinical positions such as those in the Indian Health Service, or perhaps even as the response force itself. The key to emergency response, of course, is the training, organization, and exercising of the response force well in advance of any emergency. This will require considerable thought before instituting change, evaluation of trial and error and then re-evaluation, and of course, funding.

I fully support any initiative to expand the size and enhance the capability of the Corps, as well as any activity designed to improve its professionalism. In order to achieve an increase in size and capability the Corps must be able to relate such growth to a requirement. I believe the requirement exists, but it will take some effort to establish the data to support an expanded Corps. Mission must be matched to requirements which in turn must be assessed in terms of available resources. Efforts to improve professionalism should include a

continuum of educational opportunities from pre-commissioning through indoctrination in executive level management, administration, leadership and officership for those selected to flag rank.

- The Corps has functioned best when officers were rotated every three years through say, Indian Health Service, Bureau of Prisons, PHS agencies, and then a period of "refreshment" in one of the PHS hospitals. The hospitals, except for those in the Indian Health Service, were closed in 1981 which severely impacted the opportunities to educate and re-educate our officers. Attention must be given to some alternate plan which would include bioterrorism updates.

My concerns about the contemplated reorganization of the Commissioned Corps are that the plans do not support the important changes listed above. The system that did not work well for me from my confirmation in November of 1981 until revitalization in 1987 failed because personnel management of Corps officers was separated from any control or direction by the Office of the Surgeon General. From then until I left office at the end of my second four-year term in 1989, the new system worked well. In 1995, much to my dismay, personnel management functions were moved again, this time under the HHS Assistant Secretary for Administration and Management. As a result, the Corps has experienced difficulties in recruiting and placement of officers and has continued, until very recently, to slowly grow smaller - hardly

the system that would foster the desired increase in the size of the Corps.

The new plan appears to even further fragment the day-to-day administration and management of the Corps. I do not understand the need for a new office, responsible for day-to-day management and operation which reports to the Assistant Secretary for Health on a co-equal basis with the Surgeon General. What then, is the role of the Surgeon General for leadership of the Corps, which is one of the principal functions for which he is nominated and confirmed? Leaving the important functions of compensation and medical affairs under the authority of still another assistant secretary will add confusion and inefficiency where least needed. I used to call this the "onion syndrome", covering a mistake in organizational change with another layer to further confuse the issue - but like an onion, the outer layer neatly hides the layers below it.

The plans, as I understand them, appear to devalue the role of Corps officers in fundamental public heath roles - those who are engaged in research, laboratory work, and regulatory activities. Providing clinical health care to underserved populations is a critically important aspect of public health. But it is not the only aspect of public health. Equally important is the work conducted by Corps officers at institutions like

CDC, NIH and FDA. The growing importance of emergency response and deployability of Corps officers has the potential to cause conflict with the more traditional roles of Corps officers. The world takes on the standards of the FDA, and the NIH is the premiere source of medical research on this planet and the CDC is pre-eminent in international health. At any one time about 200 CDC personnel are abroad doing what no one else does better.

We forget, at our peril, the great synergy which the Corps brings to public health. The common identity and unity of purpose of these dedicated health professionals in their diverse assignments has been a key factor in the many successes wrought by our Public Health Service.

Failure to get the process right by which change is imposed on the Corps is bound to doom the outcome. My concern is that, in the Department's rush to fix one problem; they will create two more if the process is not engineered correctly. Mission drives requirements, which are tempered by resources. Plans are then developed to match resources against prioritized requirements, all consistent with the goal of achieving the mission. It appears to me, we are beginning with the plans first.

The PHS Commissioned Corps has been evolving and changing with emerging threats to public health ever since it was founded. Twenty

years ago, during my tenure, we were engaged in a revitalization of the Corps. Today there are new threats emerging. The confusion surrounding the anthrax episodes in the fall of 2001 pointed out some problems with the ability of our public health infrastructure to respond to the threat of bioterrorism. We have continuing problems with finding sufficient health care providers for some underserved communities. The increasingly rapid spread of new diseases, such as SARS, demands improvements to our research capabilities. All of these things point to the need to continually improve the forces at hand to protect our public health.

We invested considerable resources in a revitalization of the Commissioned Corps during my tenure as Surgeon General. We conducted all manner of studies supporting the need for a stronger, larger, more capable Corps. Many of those studies would still, no doubt be valid today. But any new initiative to transform the Corps must first begin with a revalidation of the Corps' mission and role in public health. I would argue for an increased role for the Corps and the Surgeon General in leading the public health infrastructure at all levels. The Corps' role in emergency preparedness and response – especially organizational issues – should be carefully evaluated. The relationship of the Commissioned Corps and OSG to the new Department of Homeland

Security role in public health emergency response is also worthy of examination.

One of the greatest challenges in increasing the mobility of the Commissioned Corps in emergency response is the fact that these highly trained and experienced health professionals all have "day jobs." And their "day jobs" are critically important whether they are clinicians on a remote Indian reservation or federal prison or assigned as an epidemiologist or researcher at CDC, perhaps on domestic or foreign detail. You cannot routinely deploy the only pharmacist on a reservation or in a prison without a plan for substitution. Similarly, the life long researcher at CDC may not be the ideal choice to respond to an emergency situation where trauma skills will be the primary need. New responsibilities for the Corps must be carefully balanced against the still important role of the Corps in traditional areas of public health. This can only be successfully accomplished by using a strategic planning process which is organized, inclusive, and data based. My impression of the current process is that it is none of these things.

Future needs of the Corps will be determined and documented with a requirements-based system of billet identification as previously discussed. A requirements based system will drive end strength which,

in turn, will drive recruiting and other force shaping policies and programs such as promotions, bonuses, etc.

Much has been written in the past two years about the urgent need for improvement in the nation's public health infrastructure. The Surgeon General is clearly recognized as the top public health professional in the country. The Office of the Surgeon General ought to be empowered to take charge of the infrastructure and develop the changes necessary to make it better. The Commissioned Corps is one logical, in place tool at the Surgeon General's disposal to make this happen. It will require additional resources and it must be based, again, on a validation of the mission of the Corps.

To do less unnecessarily risks the public health of this great Nation.

Chairman TOM DAVIS. Thank you, Dr. Koop.

Dr. Richmond, thanks for being with us.

Dr. RICHMOND. Thank you very much, Mr. Chairman.

I do want to express my appreciation to you, Mr. Chairman and to Congressman Waxman and the other members of the committee for your interest in this very important topic, which is so important, as Dr. Koop and Dr. Carmona have already indicated, to the health of our people. I'll make my comments relatively informal and, I hope, quite brief, so that we will have maximum time for questions, Mr. Chairman.

I want to say at the outset that I think it is important not alone to have this hearing but, I would hope, Mr. Chairman, that this committee would continue its interest in this matter. I come currently from an academic community, and in our academic community, oversight committees become extremely important for our functioning. Committees, essentially from the outside, and I view the role of this committee as an oversight committee, and I think having to answer your questions is extremely important in terms of our pursuing the best pathways to the Nation's health.

As you've already heard from Dr. Carmona, in the context of history, we have great reason to be proud of the record of the U.S. Public Health Service and Commissioned Corps in responding to emergencies which threaten the health of our people. History tells us that this response to health emergencies has always been full and effective. I have never known a situation where that has not been true. But this reflects the matter of constant training for emergency preparedness. Let me just give some brief illustrations, Mr. Chairman. First, on September 11, 2001, I think it's very significant that, of all of the Federal officials, Secretary Thompson was the first one to go on national television after the crisis of that day to point out that the Public Health Service had already responded by sending support to the State and local health officials in New York City. Again, that was not fortuitous, that was because of the emergency preparedness of the Corps.

Let me just very briefly illustrate some anecdotal evidence of the responsiveness of the Corps that I had personal experience with when I was Surgeon General and Assistant Secretary. One, the Mariel boat refugees arriving on our shores from Cuba, hundreds of them, when Mr. Castro emptied his jails and prisons and sent those people to our shores. Within hours, our Public Health Service officers prepared the way for the appropriate dealing with that situation. That had to go on for an extended period of time.

Comparably, the Southeast Asian crisis of that time, in the late 1970's, when the boat people of Southeast Asia were in refugee camps in Asia and were being brought to this country to relieve the pressures on the camps over there, some were found to have tuberculosis. In consultation with the Secretary of HHS at that time, we agreed that the best policy would be to screen the refugees before they came. She asked me, Madam Secretary Harris, she said, "Well, how long will it take for you to get people over there?" I said, "Within 24 hours," and that's when our staff members from CDC appeared in Southeast Asia to do the screening.

But perhaps most significantly, Mr. Chairman, was the Three Mile Island nuclear plant disaster when, as we know, near Harris-

burg, there was a great threat of a nuclear reactor plant disaster. This was prior to any experience with Chernobyl. Nobody knew what was going to happen. We needed instant response. Our CDC officers were on the scene within a matter of hours and stayed there, and I might say in a very courageous way at great risk to themselves, because no one could predict what would happen. Fortunately, that pressure chamber never exploded. But the CDC staff gathered data, and to this day collect epidemiologic data so that we can learn from that experience.

I mention these events because these responses are not fortuitous. They result from cultivating a corps of highly competent professionals. I can't over-emphasize that, and Dr. Koop has emphasized it as well as Dr. Carmona. But the competence of these professionals is engendered in the agencies in which, to use the modern parlance, they are embedded, the NIH, the CDC, HRSA, the FDA. This is where their professional work and their professional competence is developed.

Now, what is combined with this high degree of professional competence is the matter of flexibility. Effective responses develop out of flexibility. No set of regulations, however well intended, including those for the proposed transformation, can replace the need for a high degree of flexibility.

So Mr. Chairman, my concerns over what I know about the proposed transformation are the following. The Surgeon General and the agency heads should constitute a governing council, as they now functionally do, for the deployment of officers. They would act in concert with the Surgeon General. The current proposals do not take into account the concerns of the leadership of the Public Health Service agencies and the need to maintain our public health infrastructure, particularly at the Federal level.

I think it's extremely important that we recognize that there has been an erosion, as an Institute of Medicine report not too long ago indicated, of our public health infrastructure at the State and local level. But it also can be eroded at the Federal level if we don't take cognizance of the importance of maintaining the important functions of those agencies. And Dr. Koop has said very eloquently how important that is.

Second, the Surgeon General should unequivocally be the leader of the Corps, including, I would say, Mr. Chairman, its planning, policy and management functions. The Corps is not so large that one commanding officer can't incorporate the direction of all of these functions. It violates any sound principles of management to propose, for an example, an Office of Commissioned Corps Force Management to assume functions that the Surgeon General has had and has executed effectively historically.

Last, I would say, Mr. Chairman, flexibility should prevail in the evaluation and assignment of officers. This should prevail as well in the physical fitness requirements. The important issue is whether an officer can perform assigned duties. Parenthetically, I would add that I served for 4 years in World War II as a flight surgeon. Had we held to arbitrary standards, we would have lost much very valuable person power. And I could illustrate with many examples.

So in summary, Mr. Chairman, it's not that I am opposed to change. We can always do better. And in Dr. Koop's day, I would

recall for you that we engaged in a revitalization of the Corps. But we didn't have to reorganize the Corps to revitalize it and enhance its functions. So our past performance is due to the sound organizational structure and, in my view, the leadership which the Corps has had. We should enhance its efforts and not engage in changes which might well impair its efforts by creating new problems. In other words, we must be aware of, particularly, unintended consequences.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Richmond follows:]

TESTIMONY

CONGRESS OF THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON GOVERNMENT REFORM
OCTOBER 30, 2003

Hearing on the proposed transformation of the U.S. Public Health Services Commissioned Corps

I am Julius B. Richmond, M.D. I served as Assistant Secretary for Health in the Department of Health and Human Services and Surgeon-General of the U.S. Public Health Service from 1977 to 1981. Prior to that I served as the first Director of the Head Start Program and the Community Health Centers Program of the Office of Economic Opportunity from 1965 to 1967. I currently am the John D. MacArthur Professor of Health Policy, Emeritus at Harvard University.

Mr. Chairman, your committee today addresses an important issue before the nation: our preparedness to deal with medical emergencies and the proposed transformation of the U.S. Public Health Service Commissioned Corps to deal with such emergencies. At the outset I would state that I am always in favor of self-evaluation and constant attention to improving functional capacity. But I also believe that changes should be based on history and past performance.

In the context of history, we have reason to be proud of the record of the U.S. Public Health Service and its Commissioned Corps in responding to emergencies, which threaten the health of our people. History tells us that its response to health emergencies has always been full and effective. This reflects its constant training for emergency preparedness. Let me illustrate briefly.

On September 11, 2001, our most significant health threat recently, Secretary Thompson was able to go on national television to tell our people how the U.S. Public Health Service was responding. Under the leadership of the then Surgeon-General, Dr. David Satcher, help to the people of New York—including mental health efforts—were provided as needed. We should all be proud of this demonstration of effectiveness.

I would add some examples with which I was personally involved:

- The Mariel boat refugees from Cuba. When the Cuban government sent hundreds of mental hospital patients and criminals to our shores, the Public Health Services responded with great ingenuity and care.

- The Southeast Asian crisis in the late 1970's when many refugees fled their country in boats, they were sent to the U.S. from camps in Southeast Asia. A concern over a possible epidemic of tuberculosis in the U.S. developed because of refugees arriving

with the disease. Within a 24-hour period Public Health Service officers were dispatched to the camps to set up a screening program.

- The Three-mile Island Nuclear Plant disaster may be the greatest public health threat this nation has experienced. Action was required instantly. Again under the leadership of the Surgeon-General's office, CDC officers were on the scene in Pennsylvania monitoring the crisis. The nation owes them a great debt for documenting events and carrying on studies of the exposed population. In a lifetime of professional experience, I have never witnessed a more courageous and competent effort.

I mention these events because these responses are not fortuitous; they result from cultivating a Corps of highly competent professionals. Their competence is generated from their assignments in the operating agencies of the Public Health Service. Combined with a high degree of flexibility, effective responses develop. No set of regulations, however well intended—including those for the proposed transformation—can replace the need for a high degree of flexibility.

My concerns over the proposed transformation are the following:

- The agency heads should constitute a governing council for deployment of officers, which could act in concert with the Surgeon-General. The current proposals do not take into account the concerns of the leadership of the Public Health Service agencies and the need to maintain our public health infrastructure under all circumstances.

- The Surgeon-General should unequivocally be the leader of the Corps—including its planning and management functions. It violates any sound principles of management to propose an Office of Commissioned Corps Force Management to assume functions that the Surgeon-General has had historically.

- Flexibility should prevail in the evaluation and assignment of officers. This should prevail as well in the physical fitness requirements. The important issue is whether the officer can perform assigned duties. Parenthetically, I would add that I served for four years in World War II as a flight surgeon. Had we held to arbitrary standards we would have lost much valuable person-power. I could illustrate with many examples.

In summary, we can always do better. But the Department of Health and Human Services and its Public Health Service has a stellar record in responding to the health needs of the nation. This is due to its sound organizational structure and excellent leadership. We should enhance its efforts and not engage in changes, which will impair its efforts by creating new problems. In other words, we must be aware of unintended consequences.

Chairman TOM DAVIS. Thank you very much.

We have 7 minutes left on our vote on the floor. Here's what I think I'd like to do if it's all right with you. Recess it now, we just have two quick votes, we'll get there for the end of one, the beginning of another. Then Mr. Waxman and I at a minimum will be back here to hear from you, Captain Farrell, and then we'll go to questions. Is that all right? Then I will recess the meeting and we will reconvene within the next 15 minutes. Thank you.

[Recess.]

Chairman TOM DAVIS. The committee will come back to order. Thanks for being with us and thanks for being patient.

Captain FARRELL. Mr. Chairman, the Commissioned Officers Association of the U.S. Public Health Service appreciates your interest in the important contributions to the health of the Nation by the Commissioned Corps of the U.S. Public Health Service. In the Corps' long and distinguished history to the service of the Nation, its role in defending and advancing the public health has never been more important than today, given the evolving and emerging new threats we face to public health.

COA represents the interests, as you know, of some 7,000 active duty, retired and reserve officers of the Commissioned Corps. Seventy percent of active duty officers are COA members. Our constituents are the officers who will be charged with implementing the changes to the Corps. We believe, therefore, that they also have a role to play in developing what those changes will be.

COA supports what is best for the Nation's public health, a most fundamental component of our national security. The threat of biological weapons in the war against terrorism demands an army of public health warriors to provide leadership in the Nation's public health defense. Leadership for the Corps and the Nation's public health community is and ought to be provided by the U.S. Surgeon General.

Along with improvements in emergency response, we must not forsake more traditional public health roles, however: research, laboratory and regulatory work. The Commissioned Corps has many strengths. Among those are its adaptability, its diversity, its cross-cutting relationships in public health, the dedication, commitment, and professionalism of its officer corps. But there is always room for improvement.

We therefore fully support the Department of Health and Human Services' strategic plan which calls for an expanded, enhanced and fully deployable Commissioned Corps, and we applaud Secretary Thompson's initiative to transform the Corps. Specifically, our association supports the restoration of authority over and responsibility for the Corps to the Office of the Surgeon General. This includes full budgetary and manpower authority. We support the implementation of a force requirements and management system, which is billet-based and resourced similar to the other uniformed services. We support an overall recruitment and assignment strategy, based on the validated requirements. These will lead to a fully deployable Corps, consistent with the needs and requirements of the operating divisions, agencies and departments in which officers are assigned. It will also lead to a robust, ready reserve. We support initiatives to expand the size of the Corps and enhance its readiness capabil-

ity, consistent with the Corps' mission and the goal of increased professionalism. Finally, we support improvements in ongoing education, including the establishment of a public health service academy designed to increase the Corps' professionalism.

We were very interested to hear Admiral Carmona's testimony earlier, because much of what the Admiral has discussed today is new. But our specific concerns with the organizational structure and planning process as we have understood them up to this point lead us to believe that they were not designed to, perhaps, but might undermine, the ability of the Corps to attain the goals that we all agree upon. As we understood the plan to be conceived, and according to its written record, it would effectively sideline the Office of the Surgeon General and marginalize any relationship between that office and the Corps it is supposed to lead. It further fragments the Corps when just the opposite is needed.

The Department's approach applied new roles and missions for the Corps, but does not specifically address them. Nor does the plan address existing roles and missions for the Corps, which seem to be devalued. Force-shaping policies have been introduced with no attempt to define the requirement to which the force is being shaped. The new policies, since they were decided without input from the operating divisions and agencies, including the non-HHS agencies where officers are assigned, have created a situation where officers are less likely to be employed in these vital public health institutions in the future.

The proposal to recruit 2 year degree nurses as warrant officers, as has already been discussed, has raised significant concerns in the public health community. Adequate funding for the transformation and its effective implementation does not appear to have been considered.

Corps officers look to the Surgeon General for leadership, just as members of the other uniformed services look to their respective service chiefs. In the present environment and under the proposed plans to transform the Corps, the Surgeon General is being prevented from exercising any meaningful leadership authority over the Corps. This situation contravenes the intent of the President in nominating him and the Senate in confirming him.

The unfortunate result of a poorly planned and communicated transformation is an alarming degradation of morale in the Commissioned Corps. We have received hundreds of comments from our members expressing their alarm and concern over the process and direction of transformation. One Corps officer, an eminently qualified medical epidemiologist assigned to CDC wrote, "In general, the leadership of CDC's disease recognition and response teams has been staffed through the Commissioned Corps. The transformation of the Corps would appear to systematically disassemble such expert teams."

Our recommendations are simple and straightforward. We would like to see this committee, in collaboration with the committees of jurisdiction in the House and Senate, take appropriate action to ensure that the planning process used by the Department is similar to that in use at the Centers for Disease Control and Prevention, where they have a futures initiative in place. Specifically, we urge a planning process which includes, at a minimum, input and par-

ticipation of all Health and Human Services operating divisions and non-departmental agencies, a process that is open and transparent throughout.

We would recommend a process which begins with the validation of the mission of the Corps and a set of core values to guide the way. The validated mission becomes the basis for and drives end strength requirements, recruiting plans and policies, training requirements, assignment, including deployability policies, promotion plans,and policies. In short, mission requirements shape the force. Requirements for Corps officers at the Federal, State and local levels of public health infrastructure must also be included.

We recommend establishing a billet-based system of requirements identification with the active participation of all affected operating divisions, departments, and agencies where Corps officers are assigned. This should include establishing requirements for a ready reserve component.

We recommend delaying implementation of the force shaping policies, including new promotion policies, until the profile of the future Corps can be defined by the requirements-based force management system previously discussed. We believe that it is important to confirm the role of the Office of the Surgeon General in providing direct leadership, policy administration, management, and operational control, including budgetary and personnel management for the Commissioned Corps. We recommend identification by the Department and appropriation by the Congress of funding to implement the key provisions of a transformed Corps, including its expansion where needed, a ready reserve component, and a training academy with scholarship opportunities.

Finally, we recommend clarification of the Surgeon General's role in regard to emergency preparedness within the Department. This is consistent with the Surgeon General's role in public health, especially as envisioned by the Department in the transformation process thus far.

Once again, sir, the Commissioned Officers Association very much appreciates this opportunity to submit our views, and we look forward to addressing further details of these and other issues with you and the committee staff, and in the future, to working with the Department on these important issues. Thank you, Mr. Chairman.

[The prepared statement of Mr. Farrell follows:]

STATEMENT FOR THE RECORD

of

THE COMMISSIONED OFFICERS ASSOCIATION of the U.S. PUBLIC HEALTH SERVICE

on

THE COMMISSIONED CORPS OF THE U.S. PUBLIC HEALTH SERVICE TRANSFORMATION

Presented to the

HOUSE COMMITTEE ON GOVERNMENT REFORM

Submitted by:

Captain Gerard M. Farrell, USN (Ret.)
Executive Director
Commissioned Officers Association
of the U.S. Public Health Service

October 30, 2003

Captain Gerard M. Farrell, USN (Ret)

Captain Farrell, a thirty-year career naval officer, retired from active duty on 1 July 2000 and was appointed Executive Director of the Commissioned Officers Association of the United States Public Health Service (COA) on 1 November 2001. A Surface Warfare Officer during his Navy career, Captain Farrell served at sea in cruisers and destroyers. He commanded the destroyer, *USS FLETCHER (DD 992)* and cruiser, *USS PRINCETON (CG 59).* Ashore, CAPT Farrell served in a variety of staff assignments including Chief, Operational Plans Branch, U.S. Pacific Command; Deputy Commandant of Midshipmen at the U.S. Naval Academy; and Commanding Officer, Naval Station Annapolis.

Captain Farrell is a 1970 graduate of the U.S. Naval Academy, and holds a Masters degree in National Security Affairs (Strategic Planning) awarded by the Naval Postgraduate School in 1981. In 1991 he attended the Program for Senior Officials in National Security at the John F. Kennedy School of Government, Harvard University. Captain Farrell's military decorations include the Legion of Merit with two gold stars and various other campaign, unit, and personal awards.

Commissioned Officers Association of the U.S. Public Health Service

The Commissioned Officers Association (COA) of the U.S. Public Health Service is a professional organization of almost 7000 active duty, reserve, and retired PHS Commissioned Corps officers dedicated to improving the public health of the United States; supporting Corps officers, and advocating for their interests through leadership, education and communication. 70% of active duty PHS Commissioned Officers are members of COA.

Introduction

The Commissioned Officers Association (COA) of the U.S. Public Health Service appreciates the interest of the House Committee on Government Reform in the important contributions to the health of the Nation by the Commissioned Corps of the U. S. Public Health Service. We thank the Committee for holding this hearing and providing the opportunity to discuss the facts with respect to needed changes for the Corps. In the long and distinguished history of the Commissioned Corps' service to the Nation, its role in defending and advancing the public health has never been more important than now given the evolving and emerging new threats to public health.

The issue under discussion today is the urgency of having a well-run Commissioned Corps due to the increasing severity of health threats to our national security. COA has long advocated for the enhancement of the Nation's public health infrastructure at all levels of government, including an increased role for the PHS Commissioned Corps.[1] Recognition of the need for an expansion of the responsibilities assigned to the PHS Commissioned Corps and the concomitant imperative to modernize the Corps' administration, management, and operation predates the tragic events in the fall of 2001. The Senate Armed Services

[1] Lord, Michael W., COA Statement for the Record, Testimony before the Senate Health, Education, Labor and Pensions Committee, Subcommittee on Public Health and Safety, March 25, 1999.

Committee, in the Committee Report that accompanied the Department of Defense Authorization Act for Fiscal Year 1999, stated "The Committee notes the efforts underway within the Department of Defense to develop the means to respond to acts of terrorism involving weapons of mass destruction. In this regard, the committee directs the Secretary of Defense to ensure the assessment of needs and capabilities including an analysis of the capabilities that exist within the Commissioned Officer Corps of the U.S. Public Health Service, who, as members of the uniformed services, might be easily integrated into Department of Defense plans to respond to emergencies involving weapons of mass destruction."

The Commissioned Corps has a history of deploying with the military that goes well beyond mobilization in times of war. In such instances the uniform and rank structure of the Commissioned Corps, as noted by the Senate Armed Services Committee, has facilitated the relationship among the services.

Also in 1999 the Senate Appropriations Committee came to a similar conclusion. In the report accompanying the Appropriations Bill for the Departments of Labor, HHS and Education for Fiscal Year 1999, the Committee stated: "In developing plans for bioterrorism countermeasures, the Committee notes the standing personnel and

reserves of the Public Health Service are a valuable resource that ought to be well-integrated."

In late 2000, then HHS Secretary Donna Shalala convened a meeting of former Assistant Secretaries for Health to assist in developing recommendations for her successor in the next Administration. Our understanding is those recommendations included a strengthened and expanded Commissioned Corps. That same group was reconvened in March 2001 by HHS Secretary Tommy Thompson at which time they renewed and updated their recommendations.

The terrorist attacks on September 11, 2001 and the subsequent anthrax attacks in October of that year gave a new urgency to improving the capability of the Corps to respond to these new public health threats. Studies calling for urgent improvements to the Nation's public health infrastructure include a report issued by the Institute of Medicine in November, 2001.[2] Citing the confusion inherent in the federal government's initial response to the anthrax episodes in October 2001, another study addressed the leadership role of the U.S. Surgeon General,

[2] "The Future of the Public's Health in the 21st Century, Institute of Medicine, Washington, DC, November 11, 2002.

which appeared underutilized.[3] Other studies and authors reached similar conclusions.[4] [5]

In a report accompanying the Departments of Labor, Health and Human Services, and Education Appropriations Bill for fiscal 2003, the Senate Committee on Appropriations again signaled support for improvements to the Commissioned Corps, earmarking $2M "for activities related to the transformation and modernization of the Public Health Service (PHS) Commissioned Corps."

The Commissioned Corps of the U.S. Public Health Service

The PHS Commissioned Corps traces its origins to 1798 when President John Adams signed an "Act for the Relief of Sick and Disabled Seamen." The Corps was formally established in 1871 during President Grant's administration to correct major management flaws in the hospitals and clinics administered by the Marine Hospital Service. The Marine Hospital Service became the U.S. Public Health Service in 1912. From its inception the Corps was intended as a centralized, mobile, uniformed personnel system whose highly-trained health professionals could be assigned where most needed to carry out the Service's mission. On January 4,

[3] Rosner, David and Markowitz, Gerald, "September 11 and the Shifting Priorities of Public and Population Health in New York," Milbank Memorial Fund, May 2003.
[4] Kott, Andrea, "Warning: The State of Public Health in America Not So Healthy", *Advances*, The Robert Wood Johnson Foundation, Princeton, NJ, Issue 1, 2002.
[5] Kluger, Jeffrey, "A Public Mess", *TIME*, January 21, 2002

1889, the Congress enacted legislation that formally authorized the Corps.

Throughout our Nation's history, challenges to public health have changed along with the needs of a growing and changing country. The PHS Commissioned Corps has demonstrated a unique adaptability to meet the evolving threat. From a service designed to prevent the importation of disease at our maritime borders, the Corps has progressed through a series of public health challenges including veterans' care following the Civil War and World War I, major public health initiatives incident to the war effort in World War II, and providing health care to Native American populations beginning in the mid-1950s. Along the way, Commissioned Corps officers led in establishing the great public health institutions in this Nation, including the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the National Institutes of Health (NIH), and the Indian Health Service (IHS).

As a uniformed service, the Commissioned Corps brings some unique capabilities to the public health and emergency response arenas, making these officers especially well-suited for the public health response required in the aftermath of a bioterrorism incident. A February 1998 Report prepared by a Special Advisory Committee of esteemed public health professionals headed by Former Surgeon General C. Everett Koop

noted, "... expertise which is resident in the Corps to deal with biological and chemical agents is a critical resource that can be called upon in the event of terrorist attack." Tab A briefly describes some of the important characteristics of the Commissioned Corps, among them:

- specialized public health training and experience;
- on call **24 hours a day**, like their military counterparts;
- available for assignment to accommodate changing public health needs and priorities;
- an exceptional track record in the area of emergency response;
- presence in all 50 states, with large concentrations of officers in nearly every region of the country, thereby allowing for an expedited response;
- a key role in global health including officers assigned to the World Health Organization and other international public health institutions

The Commissioned Corps is also a rich source of epidemiologists and other professionals whose expertise is critical as part of a bioterrorist response.

A particular strength of the Corps is its diversity. Some 45% of Corps officers are female. 36% of Corps officers are minorities. These percentages are even greater for officers with less than ten years of service reflecting an increasing trend of diversity. These numbers make the PHS Commissioned Corps one of the most diverse entities within the federal government and a role model for the Nation at large. This composition of the Corps reflects its commitment to what is best for the Nation and the Corps' unique ability to address the needs of the underserved.

One special component of the Commissioned Corps is the Commissioned Corps Readiness Force (CCRF), which was created by the Office of the Surgeon General in 1994 to improve the DHHS ability to respond to public health emergencies. The CCRF is a cadre of approximately 2000 active duty PHS officers who are uniquely qualified by virtue of their education, skills and experience to respond to public health emergencies, and who can be mobilized quickly for this purpose.

The Commissioned Corps is also a vital part of the Nation's emergency response capacity through its role with Disaster Medical Assistance Teams (DMATs), which consist of both federal and private sector personnel. One of these DMATs (PHS-1) is comprised primarily of Commissioned Corps Officers (95%). This team has been stationed at high profile national events including, for example, the annual State of the Union Address here in the Capitol to provide the initial public health response in the event of a bioterrorism or other public health incident.

Corps officers have responded to countless public health emergencies. Among the more recent are the Loma Prieta Earthquake (California, 1989), Hurricane Hugo (Virgin Islands, North Carolina, South Carolina, 1989), Hurricane Andrew (Louisiana, Florida, 1992), Milwaukee Water System (Wisconsin, 1993), Midwest Floods (Minnesota, Kansas, North Dakota, Nebraska, Illinois, Wisconsin, 1993-1994), Southwest Flood

(Texas, 1993-1994), Northridge Earthquake (California, 1994), Winter Ice Storms (Alabama, Tennessee, Mississippi, 1994), Haitian Immigration (Florida, 1994), California Floods (1994-1995), South East Floods (Georgia, 1994-1995), Oklahoma City Bombing (1995), Tropical Storm Allison (Texas, 2001), World Trade Center Attack (New York, 2001), Pentagon Attack (Virginia, 2001), Anthrax Attacks (Florida, New Jersey, Maryland, Washington D.C., New York, 2001), Avian Influenza Outbreak (Virginia, 2002), Immunization of 19,000 School Children (Washington D.C., 2002), Exotic Newcastle Disease Outbreak (California, Nevada, Arizona, 2003), Midwest Tornadoes (Missouri, Texas, 2003), Smallpox Vaccinations (Maryland, Virginia, 2003), and Hurricane Isabel (North Carolina, Virginia, Washington D.C., Maryland, 2003).

Additionally, Commissioned Corps officers were deployed in the first Gulf War in 1991 and they remain deployed today in Afghanistan and Operation Enduring Freedom in Iraq. Corps officers deployed around the world in response to the SARS outbreak earlier this year.

The Commissioned Corps Inactive Reserve Component has the potential to provide an additional response capacity, or a backfill capacity, as circumstances require, provided it gains the appropriate funding and administrative support.

While the PHS Commissioned Corps is currently the best available source of public health expertise, the organization, administration and operation of the Corps can and must be improved in order to meet the needs of a great variety of agencies, not all of which are even in the Department of Health and Human Services. In this environment, the Corps is not utilized to its full potential.

Commissioned Corps Transformation

COA supports what is best for the Nation's public health. We support a strengthened public health infrastructure with an unambiguous chain of command, control, and communications and a clear understanding of who is in charge in a public health emergency. The threat of biological weapons in the war against terrorism demands an army of public health warriors to provide leadership in the Nation's health defense - a most fundamental component of our national security. That uniformed force of health professionals is the PHS Commissioned Corps. Leadership for the Corps and the Nation's public health community is and ought to be provided by the U.S. Surgeon General. Along with improvements in emergency response, we must not forsake more traditional public health threats - many of which overlap with man-made threats emerging today.

There remains a need for public health research and laboratory work to identify, prevent when possible, contain and eventually control diseases. The recent and rapid spread of the SARS virus demonstrated the critical importance of an epidemiological service which can respond quickly and competently. Commissioned Corps officers were rapidly deployed to Asia to assist in efforts to trace the source of this epidemic and contain its spread. Research and laboratory work are inextricably tied to clinical field work in public health. One of the greatest strengths of our Public Health Service is the cross-cutting relationship among the various disciplines of health professionals in the Commissioned Corps. Another is their ability to move from field work in underserved populations, where the public health risks are greatest, to research work in the course of a career. The vital role of the Commissioned Corps goes beyond its role in the delivery of public health services at the federal level. The Corps is a key element in the Nation's public health infrastructure. The Commissioned Corps is the glue that holds the Public Health Service together.

COA fully supports the DHHS Strategic Plan calling for an "expanded, enhanced and fully deployable Commissioned Corps." We applaud Secretary Thompson's initiative to transform the Corps.

Specifically, COA supports:

- Restoration of authority over and responsibility for the Corps to the Office of the Surgeon General (OSG). This includes budgetary and manpower authority.
- Implementation of a force management system which is billet based and resourced similarly to the other uniformed services.
- An overall recruitment and assignment strategy - one based on the foregoing billet-based force management system. This strategy has as its goal a fully deployable Corps, with improvements to mobility and emergency response capability, consistent with the needs and requirements of the operating divisions, agencies and departments in which officers are assigned. This includes a robust ready reserve component organized, outfitted, equipped, trained and compensated along the lines of the reserve components of the other uniformed services.
- Initiatives to expand the size of the Corps and enhance its readiness and capability, consistent with the Corps' mission and the goal of increased professionalism.
- Improvements in on-going education including the establishment of a USPHS Academy, designed to increase professionalism.

There are two pillars upon which any organizational transformation, such as sought by HHS for the Corps, will take place. The first is the **organizational structure** itself and the second is the **process** by which the transformation is planned and implemented.

Unity of command is essential to any successful organizational endeavor, whether in the corporate business world or the Department of Defense. This is no less true in public health. For too many years, the headquarters element of the Commissioned Corps was fragmented with the Surgeon General removed from any day-to-day operational authority over the Corps he was supposed to command.

The DHHS plan, as announced by the Secretary and briefed within the Department[6] instead of consolidating the administration and management of the Commissioned Corps under the Office of the Surgeon General, appears to call for yet a further division of authority over the Corps to three separate offices reporting to two different assistant secretaries. The functions assigned to the OSG under this plan; Science and Communications, Commissioned Corps Field Affairs, Force Readiness and Deployment, and Reserve Affairs are either non-existent, undefined, unmanned, unfunded or some combination thereof. This plan effectively sidelines OSG and marginalizes any relationship between that

[6] USPHS Commissioned Corps Transformation Initiatives – Draft document (Power Point Presentation)– 8/12/03

office and the Corps it is supposed to lead. It further fragments the Corps when just the opposite is needed.

COA firmly believes that consistent with sound business practices and principles of efficient organization, **all** functions related to the administration, operation and management of the Commissioned Corps must be aligned under one command unit, and this is most appropriately the Office of the Surgeon General. Specifically, the functions of requirements identification and setting, recruiting, training, assignment, officer support, compensation, and medical affairs must report to the Office of the Surgeon General. Full budgetary and personnel management authority to staff and operate all these functional areas must be provided to OSG. Signature authority for Commissioned Corps Personnel Manual administrative instructions should be retained by the Surgeon General, as is the case with service chiefs in the other uniformed services. Broad regulatory policy should appropriately remain with the Office of the Secretary.

We are especially concerned that authority for the compensation and medical functions has been assigned to the Program Support Center in the office of the DHHS Assistant Secretary for Administration and Management. This separate authority, completely divorced from the rest of the Corps, brings no benefit to the organization and will unnecessarily

complicate policy development, force management, communications, and resource allocation. In fact, DHHS has recently proposed substantial changes in the manner by which active duty PHS officers will receive medical care. The proposed transition to a Tricare-based system is likely to have a major negative impact on officers in the Indian Health Service, Bureau of Prisons, and other agencies - including CDC - who are assigned to duty stations that are not near a military medical facility. COA is seeking to work with DHHS on this important issue which could have serious implications for the assignment and retention of officers. We feel strongly that the functions of compensation and medical affairs must come under the direct authority of the Office of the Surgeon General. These are essential components of force management and have a direct impact on the officers needed to carry out their important public health work.

The process by which a strategic transformation is planned and implemented will have direct and lasting impact on the outcome produced. A flawed process will produce a flawed outcome. Senior officials within HHS have expressed serious reservations about the process by which the transformation is being planned and implemented. COA agrees with these assessments. The reaction of Corps officers, the

leadership of our major public health institutions, and members of Congress is evidence enough of the flaws in these plans. A principal reason for this is that the process being used is exactly the reverse of what it should be.

DHHS began this process with a series of action plans - "Decision Orders" - aimed at meeting intuitive challenges. There were vague references to new or evolving roles for the Corps. There was no attempt made to define or determine requirements. COA agrees that the challenges identified by the Department must be addressed. The first step, however, must be a validation of the role and mission of the PHS Commissioned Corps in public health. This cannot be satisfactorily accomplished without including input from the stakeholders in public health. Thoughtful professionals throughout the country with deep commitment to the status of public health in our Nation are concerned about the cloistered development and lack of professional consultation on such a major move as is contemplated for this most valuable national human resource. Former Assistant Secretaries for Health and Surgeons General have expressed their concerns about the organization and process by which much needed changes to the Commissioned Corps are being planned and implemented.[8]

[8] Former ASHs Robert Windom and Julius Richmond and former Surgeon General C. Everett Koop. In a letter dated September 10, 2003 Dr. Windom wrote "The ASH and SG are impotent, placed aside by

In effect, the Department's approach to transformation resulted in a plan which addressed individual issues in isolation. The totality of the proposals was overlooked and the isolated and exclusionary manner in which decisions were reached led to extremely poor communications with the officers who were most affected. Not only has there been poor communication with Corps officers, but also with the many HHS operating divisions and non-HHS agencies to which officers are assigned. In particular, our understanding is that until recently, the Surgeon General was virtually excluded from the planning process with decisions made in his name during his absence by officials with neither the authority nor the approval of the Surgeon General.

The result is predictable. Plans developed in secrecy and isolation, failure to include or even communicate with those most affected by the outcome, and new policies with the clear intent of penalizing officers in research, laboratory and regulatory assignments and those transferring from other uniformed services have created confusion and discontent. Officers are questioning their career choice and there is growing concern that officers will leave the Corps in significant numbers taking with them the expertise that is so vital to the Nation's public health preparedness at a time when we can least afford to lose it.

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persons who have no interest in PHS. This incompetence must not be allowed to continue, and the PHS must be restored to its previous vitality."

Corps officers look to the Surgeon General for leadership just as members of other uniformed services look to their respective service chiefs. The Surgeon General makes every effort to be responsive to Corps officers. Try as he might, however, in the present environment and under the proposed plans to transform the Corps, the Surgeon General is being prevented from exercising any meaningful leadership authority over the Corps. This situation contravenes the intent of the President in nominating the Surgeon General and the Senate in confirming him.

COA's specific concerns with the results of this flawed process are as follows:

- The DHHS approach implies new roles and missions for the Corps but does not specifically address them. Nor does the plan address existing roles and missions for the Corps which seem to be devalued.
- Force shaping policies have been introduced with no attempt to define the requirement to which the force is being shaped. The promotion policies put forward by the Department will have exactly the opposite effect of intended and are likely to result in a smaller, less capable Commissioned Corps.
- The new policies, since they were decided without input from the operating divisions and agencies, including the non-HHS

agencies where officers are assigned, have created a situation where officers are less likely to be employed in these vital public health institutions in the future. One prominent agency head stated his objections to Secretary Thompson in just these terms.[9]

- The proposal to recruit two-year degree nurses as warrant officers has raised significant concerns in the public health community.[10]
- Adequate funding for the transformation and its effective implementation does not appear to have been considered.

Within the last two years, COA's affiliated Foundation has completed two study projects examining recruitment, selection, and assignment policies and procedures used by the Commissioned Corps. The general conclusions and recommendations of these efforts found that, while a Corps-wide recruiting focus is needed, the more urgent problem is in the selection and assignment process. For example, the DHHS transformation plan calls for the recruitment of 1000 two-year degree nurses, yet there are currently over 125 fully qualified and boarded four-year degree nurses seeking a commission in the Corps who are awaiting assignment. These and other force shaping problems can only be

[9] FDA Commissioner letter to DHHS Secretary dated August 15, 2003.
[10] Blakency, Barbara, President, American Nurses Association, in a letter to DHHS Secretary Thompson dated 1 August 2003.

resolved by instituting a billet-based requirements and force management process.

One of the challenges that the Department wishes to overcome with this plan is the oft repeated criticism, especially by the Office of Management and Budget, that the Corps is top-heavy. Perhaps the distribution is as it should be. The purpose of the Commissioned Corps is not to provide services that are readily available through contract or temp agencies - it is to defend the public health using the best expertise at the nation's disposal. That expertise takes time to develop. Once lost, it may take another half-century to reacquire. What is not considered in the superficial analysis which concludes the Corps is top-heavy is any notion of the mission of the PHS Commissioned Corps. Grades of officers must be appropriately matched to their responsibilities consistent with the defined requirements of the billets they occupy in support of mission success. This is not currently done. Once this is accomplished it may well be that the rank structure of the Corps is entirely appropriate. Where it is not, appropriately targeted corrections can be instituted.

We understand there is a draft of proposed legislation being developed within DHHS to implement the transformation. Our information is that the draft proposal contains a provision creating several additional O-9 (three star vice admiral; the rank of the Surgeon General) billets in the

Commissioned Corps. One cannot help but wonder why this is even being considered if the drafters of the plan think the Corps is already top heavy.

The unfortunate result of the poorly planned and communicated transformation is an alarming degradation of morale in the Commissioned Corps. COA has received hundreds of comments from members expressing their alarm and concern over the process and direction of transformation. One Corps officer, an eminently qualified medical epidemiologist assigned to CDC where he works in smallpox research was particularly eloquent. He wrote, "In general, the leadership of CDC's disease recognition and response teams has been staffed through the Commissioned Corps. The "transformation" of the Corps would appear to systematically disassemble such expert teams...." Many of the comments received were mirrored in an article in the New York Daily News on Sunday, October 12, 2003.[11]

This is clearly a crisis for public health at a time when the Nation can ill-afford it.

[11] Kates, Brian, "U.S. Bioterror Plans Ripped", *New York Daily News*, Sunday, October 12, 2003.

Recommendations

Transformation is the term also used in the current approach of the Pentagon to maximize the mobility and effectiveness of valued human resources. As in DoD, the approach must in the public health context as well, consider the broad mission of the Corps to both enhance current mission responsibilities such as health research, evaluation and regulation as well as to prudently prepare for future challenges such as national disaster. COA recommends, therefore, that DHHS adopt a planning process similar to that in use at CDC for its "Futures Initiative." Specifically, we urge:

- A planning process which includes at a minimum input and participation of all DHHS operating divisions and non-DHHS agencies, open and transparent throughout.
- A process which begins with a validation of the mission of the PHS Commissioned Corps and a set of core values to guide the way. The validated mission becomes the basis for and drives end strength requirements, recruiting plans and policies, training requirements, assignment (including deployability) policies, promotion plans and policies. In short, mission requirements shape the force. Requirements for Corps officers at the federal, state, and local levels of the public health infrastructure must be included.

- Establishing a billet-based system of requirements identification with the active participation of all affected operating divisions, departments and agencies where Corps officers are assigned. This should include establishing requirements for a ready reserve component.
- Delaying implementation of force shaping policies, including new promotion policies, until the profile of the future Corps can be defined by the requirements based force management system discussed above.
- Confirmation of the role of the Office of the Surgeon General in providing direct leadership, policy administration, management and operational control, including budgetary and personnel management, for the Commissioned Corps.
- Identification by DHHS and appropriation by the Congress of funding to implement the key provisions of a transformed Corps including expansion of the Corps consistent with requirements as defined above , a ready reserve component and a USPHS Academy with scholarship opportunities.
- Clarification of the Surgeon General's role in regard to emergency preparedness within DHHS. This is consistent with the Surgeon General's role in public health, especially as envisioned by the Department in the transformation process thus far.

Once again, the Commissioned Officers Association very much appreciates this opportunity to submit our views to this distinguished Committee. We look forward to addressing further details of these and other issues with you and the Committee staff.

TAB A

THE COMMISSIONED CORPS OF THE U.S PUBLIC HEALTH SERVICE

- Is an active duty force of approximately **6000 health care professionals** comprised of physicians, nurses, scientists, dentists, engineers, sanitarians, pharmacists, veterinarians, dieticians, therapists and health services officers who serve in all 50 states and more than 550 locations worldwide.

- Provides officers to serve in the **eight agencies of the Public Health Service**, plus non-PHS agencies including the **U.S. Coast Guard** (whose uniformed medical services are staffed exclusively by Corps officers), **the Federal Bureau of Prisons**, the **EPA**, the **Immigration and Naturalization Service**, and the **Department of Homeland Security**.

- Is one of the seven **uniformed services**, whose members can be called to duty **24 hours a day** to respond to public health crises and emerging needs, and can be **directed** to other duty assignments to accommodate changing public health needs and priorities. In recent years Commissioned Corps officers have been involved in:

  - **Leading** the successful **global campaign to eradicate smallpox;**
  - **Investigating** and **identifying** the emerging **AIDS epidemic**; and the **SARS virus;**
  - **Providing clinical services** for Haitian, Cuban, Southeast Asian, and Kosovar refugees;
  - **Identifying** and **isolating** three separate acute **hemorrhagic fever** viruses in Africa;
  - **Identifying** and **isolating** the infectious agent responsible for the **Hanta Virus** in the American Southwest;
  - **Providing** and **coordinating** emergency services: Oklahoma City bombing ('95); Alaska ('94), California ('94-'95), Southeast ('94-'95), Midwest ('93-'94), Southwest ('92, '93-'94), Northern Plains States ('97) an Ohio ('98) floods; following Hurricanes Hugo ('89), Iniki ('92), Andrew ('92), and Georges ('98); Loma Prieta ('89) and Northridge ('94) earthquakes; following the Northeast ice storms ('98); and in response to terrorist attacks ('01);
  - Providing health care support for the United Nations General Assembly, Secret Service, Capital Police, 2002 Olympic Games, and the Washington, DC public school system.
  - Serving in Afghanistan today and in the First Persian Gulf War in 1991 and in Operation Iraqi Freedom in 2003.

Chairman TOM DAVIS. Thank you very much.

Captain Farrell, do you feel you've been involved in the process to date? Have you shared these views with the people that are putting this reorganization together?

Captain FARRELL. We've done our best to do that, sir. I have had, as Admiral Carmona mentioned, two meetings, one several months ago with the then-Department Chief of Staff where we discussed very specifically the organizational issue. Unfortunately, that gentleman left office a week later, and we're not aware of any follow-through.

About 2 months ago, I was able to meet with the Acting Assistant Secretary for Health, Cristina Beato. But we discussed mostly issues relative to the Association and not anything substantive relative to the issues regarding transformation. Subsequent to that meeting, I have offered on three occasions my services or the services of our association to the Department and we have been rebuffed on all three of those occasions, sir.

Chairman TOM DAVIS. Rebuffed meaning?

Captain FARRELL. No answer at all.

Chairman TOM DAVIS. "Don't call us, we'll call you," that kind of thing?

Captain FARRELL. Yes, sir.

Chairman TOM DAVIS. So what's the morale of the men and women that you represent at this point?

Captain FARRELL. Pretty poor, sir. The one survey that was referred to earlier, they were able to use some metrics to define a 50 percent degradation in morale at their particular agency. I would say from the tenor of the input that I get from our members there is considerable concern about not so much that the Corps is being transformed, but that they may be asked in the transformation to take on additional requirements and obligations without the support structures being put in place to enable them to do that, both in terms of fulfilling their jobs in the agencies in which they work and in their ability to take care of their families if they're going to be deployed more often.

Chairman TOM DAVIS. Thank you.

Dr. Koop, thank you for your testimony as well. Ordinarily, you noted, the mission drives the requirements, tempered by resources. Are you concerned that in this case, maybe the process is going to drive the mission?

Dr. KOOP. I think it might be that way. Certainly, I think that the direction that we usually take when we undertake something like a transformation that's contemplated here, the cart now seems to be before the horse.

Chairman TOM DAVIS. One of the concerns that this committee constantly has is that Government becomes too bureaucratic and process-driven instead of mission-driven. One of our goals is to try to get out there and be able to be more mission-driven. I think the jury is still out on what the ultimate plan is going to be here. But I think I hear loud and clear your concerns and the concerns of Dr. Richmond in terms of the way this has unfolded to date.

Dr. KOOP. Well, this 100 year-old organization has been evolving for a long time. I think the two functioning words that make it possible are flexibility, as Dr. Richmond said, but also appropriate-

ness. I think proper leadership of the Corps, using those two guidelines, can accomplish a lot of things without having a tremendous reorganization, which is causing a lot of the disruption of morale and planning of many of the members of the Corps.

Chairman TOM DAVIS. Unlike a lot of organizations, this organization is driven by its membership, by its employees, because they are technical and they are professional. Recruiting and retaining them is critical. That's not true everywhere. But it's certainly true in this particular case. I know Mr. Waxman shares my concern here that this is an area where you talk about larger reserves and continuing to track top-quality people who are service-driven people. But we cannot allow a diminution in the morale at this point. I think that could have ramifications down the road. It's tough to get good people.

Dr. KOOP. It's comforting to hear you say that.

Chairman TOM DAVIS. It's always tough to get good people. And I'm not just saying that we can't move ahead with transformation, but I think, at this point, we don't have, we're not sure exactly, from my perspective, we don't even have all the information we've requested, I think. And I'm still trying to get comfortable with it, and if the workers are still getting comfortable with it, that gives us some concern.

I am going to turn the gavel over to Mr. Shays, but I'm going to recognize Mr. Waxman. And let me just say to all of you, thank you very much for being here. This has been very useful to us.

Mr. WAXMAN. Thank you very much, Mr. Chairman. Well, what we seem to see here is a reorganization where all the people who should have been consulted weren't consulted. And from what I hear from you, Captain Farrell, you don't feel that your members of the Corps were really brought into the development of this reorganization plan. That's one reason they don't feel comfortable with it. And second, they don't feel comfortable with it because they feel that their careers are going to be jeopardized, all the service may be lost in terms of their pension if they're forced to do things that were never expected of them in the past. Is that right?

Captain FARRELL. That's true, sir. One of the issues is that many of these officers joined the Corps under a different set of circumstances and a different set of rules. And there is no provision, at least as we understand it, for grandfathering the new rules. We don't really object to changing the rules as long as the people who joined the Corps under a different set of circumstances and understandings are somehow protected, don't lose their retirement benefits and their ability to continue to serve with the distinction that they have already exhibited.

As far as our participation in the planning process, it's not just the fact that we have been, I'll use the words shut out, but even those elements within the Corps itself that have been asked to provide input seem to have been ignored. For example, the Department convened a distinguished panel of Corps officers to look at promotion policies and make recommendations. Yet when the revised promotion policies were published at the end of August, the officers who served on that panel were not able to discern any of their input having any effect on the proposed new policies.

Mr. WAXMAN. One of the cries from members of the Corps is that they're going to have to go through this physical fitness standard that many of them won't be able to meet. Even though that's not required of them in their day-to-day activities, they feel they'll have to leave the Corps. Dr. Carmona gave us some assurance today, and we'll look forward to some written assurance as well, that the interpretation of the proposal that all of us have seen is not going to be quite as we have read it.

Have you been told that those physical fitness standards are going to be revised, and have you seen any of the revisions?

Captain FARRELL. No, sir. Most of what Admiral Carmona was reporting on this morning was news to me, and represents a completely different plan from the one that I've had the ability to examine thus far.

Mr. WAXMAN. Well, it's critically important for HHS to followup today's testimony with a clear and detailed policy that provides the assurances to people that they're not going to be put through some mindless set of tests on how many pushups they can do when that has nothing to do with their expertise. We wouldn't want to lose their expertise.

Captain FARRELL. No, sir.

Mr. WAXMAN. And have people who do good physical routines but don't have the expertise that's going to be required, as we heard from Dr. LeBaron, to deal with bioterrorism or at the FDA to deal with drugs, or CDC with other public health matters.

Dr. Koop, in the 1980's you were the representation to everybody of public health, and you spoke the truth whether it was tobacco or AIDS. You represented the service and dedication of the Commissioned Corps. You've raised a couple issues about this transformation plan. One is that the Surgeon General should be the leader. Do you feel that the changes that are being talked about to either take away the powers of the Surgeon General, give them to the Assistant Secretary of Health, or to split the authority makes any sense?

Dr. KOOP. I've never been asked to testify, Mr. Waxman, with so little real knowledge. A lot of the things that I have behind me are hearsay. And I have to say what Mr. Farrell has just said, and that is, what I heard from Dr. Carmona is not what I knew up until yesterday. So there seem to have been some major changes. But the way I saw it, I would say that the Surgeon General's powers had been emasculated. To have him co-equal with a Department that knows nothing about what he is supposed to be doing and reporting to somebody who is in a different division of HHS seems to me ridiculous.

Mr. WAXMAN. Well, I didn't get assurances from his testimony this morning that was changed. I thought he gave a good face to it by saying how the Surgeon General would deal with the day-to-day activities. But it sounded like the policies were no longer going to be the Surgeon General's policies, they were going to come from elsewhere.

Dr. KOOP. As I heard Dr. Carmona, I thought he was separating policy from day-to-day activity, but you can't.

Mr. WAXMAN. And Dr. Richmond, do you also agree with that position? You were Surgeon General and Assistant Secretary of Health.

Dr. RICHMOND. Yes. In my testimony I focused particularly on the importance of the Surgeon General having responsibility for the policy and management of the Corps. Now, that of course is under the rubric of the Secretary of the Department's overall responsibility. But having said that, all of the policy development and the management of the Corps, and particularly I would emphasize, Mr. Waxman, the extremely important functions of relating to the agencies where the professional expertise of the officers keeps being renewed. This is why we're the envy of all of the countries of the world and that's why we're often drawn upon, particularly our capacities in CDC, by countries all over the world, because of this matrix that we have of professional competence in the agencies and the Commissioned Corps and the Surgeon General as its commanding officer. That delicate balance, I think, should not be impaired. The minute one goes down the path of separating policy from management in an organization of that size, I think, is an invitation to disaster.

Mr. WAXMAN. Just one last question, I'll ask Dr. Koop, and Dr. Richmond, I want you to respond. You can look at the Corps as having to respond to a medical emergency, and that's important. But also what's important is the idea of having Commissioned Corps officers serve in agencies like FDA, NIH and CDC. These are science-based agencies and they're critical to the overall mission of the Corps. Is that your view, and do you feel that there's some suggestion people ought to be only in a medical response team and not the other side?

Dr. KOOP. That's where I stress flexibility and appropriateness, because the individual officer is sometimes caught between the demands of a medical emergency which require a Corps response and his day-to-day activities as well as responsibility to the agency where hi serves.

I'd like to call attention to one other thing I think Mr. Tierney mentioned: the difference between the civil service response to an emergency and the Commissioned Corps. It's another anecdote that was mentioned in part by Dr. Richmond just a minute ago. That is, when Castro did dump a lot of people on our shores from his prisons and his insane asylums and so forth, the Governor of Florida called Secretary Harris for help. She issued an immediate request to the civil servants in HHS to respond to that emergency, and not one person volunteered. When she inquired why, they said, "It's not my job description." In desperation, she turned to the Surgeon General, who said, "Go," and 268 people went and served between 2 weeks and 2 years at that very onerous job of sorting out those people which, you'll remember, ended in separating 6,000 criminally insane people from other refugees.

Mr. WAXMAN. All three of you made excellent points, and I'm persuaded by the testimony today that everybody we've heard from, and the Secretary himself, has the same goal in mind, making sure that we have a Commissioned Corps that serves the best interests of the public health and needs of the American people. I just wish the Department had gone through a process where everybody's

views might have been sorted through and digested and there could have been a greater consensus for the proposal. But it's not too late. And I hope this hearing will produce that kind of dynamic that I think is essential to getting a win-win for everybody, not something where people fear a plan and may find themselves with no other choice but to leave. Because, as Congressman Van Hollen pointed out, in that survey, if we have 70 or 80 percent of people leaving the Corps, leaving the Centers for Disease Control and Prevention, it's not in their interest and it's certainly not in our interest to have that happen.

I thank the three of you for coming and I appreciate your contribution today. I hope as a result of this hearing we can get to a good result for everybody.

Mr. SHAYS [assuming Chair]. I thank the gentleman.

In my previous life chairing—I chair now the National Security Subcommittee—I used to oversee the Departments of Health, HHS, CDC, and so on, in the 4-years that I chaired that subcommittee. I developed a tremendous appreciation for our health care institutions and all the folks associated with it.

I'm struck with this basic belief, that I think the administration has a lot of very intelligent people working for it, and I sense there are probably a lot of good ideas in this reorganization. But the one criticism that seems to be not just unique to HHS and so on has been the desire sometimes to just mandate without involving the employees. So what could potentially be really good ideas aren't bought into by the employees. And frankly, the administration's desire just sometimes not to disclose stuff to Congress and so on, it's an Achilles heel in my judgment. It's a view that I have that goes not just in health care but in a lot of others.

So I take that general bias, so it's very easy for me to accept, Captain, your criticism of this process, because we've heard it before in so many different ways. But having said that, it doesn't mean the ideas are wrong or the effort is wrong. And I'd like to ask you first, Dr. Koop, in your testimony, you stated that the Corps, to reach its full potential, the Surgeon General must have complete and direct control over all aspects of the day-to-day administration, management, and operation of the Corps. I'd like you to tell me what this means. Every manager wants to have as much control, but are you saying that it needs to be more complete and more direct over everything as opposed to some other type of management of individuals? And if so, why?

Dr. KOOP. The essential thing has been mentioned in several ways, and that is that every officer has two obligations: that to the agency which employs him for his day job, where he has many obligations, and when emergencies arise, he has the obligation to respond as a member of the Corps. And that's why I said that, at the present time, the flexibility and the appropriateness which guide the council that makes these decisions makes it more than just a one-man decision. It isn't that the Surgeon General is a dictator, but he is the orchestrator of a very highly-tuned group of experts, all of whom have a very definite understanding of their responsibilities, both to emergencies and to the day-by-day situations that occur; they vary from agency to agency.

In my day, high on the table of organization, I reported directly to the Assistant Secretary of Health. But that did not mean that I didn't consult almost every day with the agency heads, and it didn't mean that I bypassed the Assistant Secretary and spent a lot of time with Otis Bowen on the discussion of policy. So it was a collegial atmosphere, which is one of the things that always was attractive about the Corps. Nevertheless, the Corps itself and the agency heads looked for direction to the Surgeon General.

Mr. SHAYS. Dr. Richmond, would you amplify on anything? Would you disagree with anything?

Dr. RICHMOND. No, I think Dr. Koop has put this very well. But I would also emphasize, just in terms of management principles, one cannot have a Corps which brings together professional expertise as well as preparedness issues without having clear lines of command and authority. I think anything that creates any degree of ambiguity about the Surgeon General's capacity to be the commanding officer would be a step backward.

Mr. SHAYS. So when I intuitively look at people in uniform and see ranks, the analogy is much closer to the military than it would be to so-called civilian life?

Dr. RICHMOND. Yes, and I think the uniformed service component sort of exemplifies that. And I think that the differentiation in part from the military is this professional expertise that exists in the Corps. That can't be constantly renewed and reinvigorated without these officers being in the operating agencies where the professional skills and developments are, as I indicated earlier, bringing the resources of NIH, FDA, CDC, and all of the others, HRSA, to bear on the problems. If we don't have that constant refreshing, professionally, of these officers by virtue of their placement there, they won't have the competence really to do the job in emergency preparedness that we hope they have.

Mr. SHAYS. So putting in my words, qualification to the pure military model is that a lot of those in the Corps are highly educated, part of a profession of doctors who basically you then say somehow modifies this concept of pure military.

Dr. RICHMOND. That's correct.

Mr. SHAYS. It implies to me there has to be more consultation and so on. But you still want lines of authority and so on. Is that what you're saying?

Dr. RICHMOND. That's exactly right.

Mr. SHAYS. Dr. Koop.

Dr. KOOP. That's correct, because the command and control aspect that the military uses so well is what separates us from a civilian organization.

Mr. SHAYS. Otherwise, you might as well not exist.

Captain Farrell, anything you would disagree with, or how would you amplify it or where would you put your emphasis?

Captain FARRELL. No, sir, I think that both Dr. Koop and Dr. Richmond both can say it far more eloquently than I can. The model that the Corps likes to look at is the military model. And that is in terms of organization and operation. But they don't execute it the way the military does, because they'll never be able to, because their mission is different.

What the uniformed service brings to the Corps probably more than anything else is the perception that very uniform conveys. Because what that uniform conveys is a perception of order, a sense of disciplined organization, it brings with it identity, a sense of purpose, and a commitment and a confidence, not so much a confidence in the people wearing the uniform, but in the confidence of the general public and those who adopt the uniform and wear it. There have been countless surveys over the past number of years that ask the general public, "What is the institution in the country that you have the most confidence in?" They list them, they are judges or clergy or whatever. Uniformed services consistently rank in the top three. That is something that I think is essential in health.

Mr. SHAYS. You put the emphasis slightly differently. I don't mean to be splitting hairs, but I'd like the two Surgeons General to respond. You said what made it different, I was inferring that the difference was the education of the individuals and the focus on the individuals. You put the focus on the mission. Is this a difference without a meaning? Are they one and the same, Dr. Richmond or Dr. Koop?

Dr. KOOP. I don't think there's a gap in what we're thinking. The mission of the military is much more focused. That of the Public Health Service is very diffuse. And I think there's another thing that may sound silly to bring up, but of all the uniformed services in this country, we are the only one that is unarmed, also the only one that doesn't go by the principles of the Uniform Code of Military Justice. So we have certain flexibility in our ranks that the Army, Navy and the Air Force cannot exert.

Mr. SHAYS. Can an employee within the Corps be ordered to go into harm's way like they can be in the military? If there's an epidemic somewhere, can you basically, as the Surgeon General, basically say, you need to go there, your life is somewhat in danger but that goes with the uniform?

Dr. KOOP. That goes with the uniform. The difference comes where, if he says, "I'm not going," the Surgeon General doesn't have the right to court martial him.

Mr. SHAYS. No firing squads?

Dr. KOOP. Not yet. [Laughter.]

Dr. RICHMOND. Mr. Chairman, I don't think there is a difference between mission and the other issues we're talking about. But our mission is to promote the public's health. And the difference is that we have to have professional skills in order to do that, not just military skills.

Mr. SHAYS. This may seem a little trite, but it does interest me, because uniforms are worn. I'd love to know what the policy of yours, Dr. Koop, and Dr. Richmond were, if someone was, when would they be required to wear a uniform if at all? If they worked for the CDC or NIH, would they be in uniform? Tell me how you sorted that out. Was that up to each individual to decide?

Dr. KOOP. When I came, the rule was you had to wear your uniform at least 1 day a week. I decided, we had several things that happened to us that really lowered morale right after I got here. One was that the administration closed all the public health service hospitals. Morale was very low. We lost our educational compo-

nent. I announced to the troops that if they wore their uniform, they'd see that they had a lot of friends suffering the same way. And I tried to stress the wearing of the uniform more and more.

Then when the day came for the revitalization, we had a problem in the Corps that we inherited from the Vietnam war. As you'll recall, if one volunteered for the Public Health Service at the time of the draft, they were exempt from the draft. We got a number of people who joined the Public Health Service for reasons other than pursuing public health. And we were very unhappy to have the military refer to these people as the "Yellow Berets," and they were a relatively incorrigible group that did not like the military discipline. They are the first people that I was anxious to do something about. Revitalization was geared in such a way that would make life very uncomfortable for these people and we lost 400 of them almost immediately. So one of the rules was——

Mr. SHAYS. And that didn't disappoint you?

Dr. KOOP. Not one bit. After that, I would say that gradually, the uniform became something that was worn more and more, and we had very few officers at the time I left in 1989 that spurned the uniform for reasons that were never made clear.

Mr. SHAYS. Interesting. Dr. Richmond, talk to me about the uniform, and also Captain Farrell. I just want to know, what role does the uniform play?

Dr. RICHMOND. I think Dr. Koop has spoken to this point. I think it's an important morale issue. It gives the group a sense of identity. I think it conveys important messages to the public about the commitment. We haven't talked all that much about what the Commissioned Corps means.

Mr. SHAYS. I'd be happy to have you tell me.

Dr. RICHMOND. When people enter the Corps, they really have made a commitment. That really includes, as you suggested, Mr. Chairman, being ordered into harm's way. That is part of the oath that they take. So it does provide a sense of identity, and to the public, it certainly communicates the sense of commitment that people in the Corps have.

Captain FARRELL. I would agree with all that, Mr. Chairman. The uniform brings a sense of identity, a sense of shared common purpose, unity of purpose. It brings tremendous visibility.

To go back to your earlier question, the decision about uniform policy is essentially today left to the individual agencies in which Corps officers are assigned. For instance, in the Bureau of Prisons, officers that are assigned there are required to wear their uniforms. It is a matter of being able to sort out who are the good guys and who are the bad in the prison. In Indian Health Service, you will find that most of the officers wear their uniform most of the time. Just recently, within the past month, Commissioner McClellan at FDA issued an edict that from, I guess it was the beginning of October, henceforth, all FDA commissioned officers will wear their uniform every day. That is something that we support, because we think the uniform adds a tremendous amount to this shared sense of purpose.

Mr. SHAYS. Thank you. It looks like your oath is the same as the oath of Congress for the most part?

Captain FARRELL. That may be true. The oath is the same, exactly the same as the other uniformed services.

Mr. SHAYS. Right. It also says, "I will support and defend the Constitution against all enemies, foreign and domestic, that I will bear true faith and allegiance to the same, that I take this obligation freely, without any mental reservation or purpose of evasion, that I will well and faithfully discharge the duties of the office for which I am about to enter, so help me God." And then an affidavit as to service: "I am willing to serve in any area or position wherever the exigencies of the service may recall." And another affidavit as to striking against the Federal Government: "I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof." It's a fairly clear statement.

Before we adjourn this hearing, what would you like to put on the record? Whatever you'd like, I'd like you to put it on the record, however long you'd like to take to do that. Dr. Koop, is there anything that you would like to put on the record?

Dr. KOOP. No, as I've said, when you've been chairman of the committees before, sir, there are a lot of things you can do that we can't do. And I think that the guidance from your committee as to how this particular transformation should have been done is not too late to correct. I think corrected, and following the things you've heard from all of the witnesses here, it can be done in such a way that we get the kind of a Corps we want that doesn't change its character, but does put responsibility and leadership where it belongs.

Mr. SHAYS. I know that Mr. Davis tends to followup on this, with the very good staff that we have. So that will be done.

Dr. KOOP. Good.

Mr. SHAYS. Dr. Richmond.

Dr. RICHMOND. I would just reinforce that notion that this have continuity, and certainly, we admire the interest that the committee members have demonstrated.

But I think the central message that I would like to leave is that the Surgeon General needs to be the commanding officer of the Corps, and that needs to be very clear.

Mr. SHAYS. Free from politics.

Dr. RICHMOND. Including policy, yes. With the oversight of the Secretary.

Mr. SHAYS. Right, but I'm saying free from politics, the ability to say what needs to be said when it needs to be said. The irony is that when you have a Surgeon General that does that, he or she is a credit to the administration, besides protecting the health and welfare of all Americans. They also in a very real way give credibility to the administration when they do that, whatever administration.

It's a comfort to those of us who aren't in the health field to know that if something needs to be said, we know one person will do that, and that's the Surgeon General, that they will say whatever needs to be said. That's essential. I was under the reign of Dr. Koop, and I just appreciated it so much, Dr. Koop. I never felt that

you would be reluctant to say what needed to be said. You found a gentle way to say it in most cases, but you said it.

Captain Farrell, is there anything you would like to put on the record?

Captain FARRELL. Sir, I'd just like to add that our association I think is encouraged and heartened by what we've heard here today, and we certainly appreciate the committee's interest. I would agree with Dr. Koop and Dr. Richmond that the important thing here now is to follow through and to make sure that the changes that are apparently taking place and the details of the transformation plan are actually carried out, put in writing for us all to see so we can evaluate and make sure that the plan is moving in the direction that the Corps officers will be able to fully support.

Mr. SHAYS. Thank you all very much. With that, we'll adjourn this hearing. Thank you.

[Whereupon, at 1:05 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

[The prepared statement of Hon. Carolyn B. Maloney and additional information submitted for the hearing record follow:]

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Congresswoman Carolyn B. Maloney
Opening Statement
Government Reform Full Committee
"Serving the Underserved in the 21st Century: The Need for a Stronger, More Responsive Public Health Service Commissioned Corps"
2154 RHOG
October 30, 2003, 10am

Thank you Chairman Davis and Ranking Member Waxman for holding this important hearing today.

It is particularly timely because on Tuesday, Chairman Shays brought an important field hearing to my district to address the health effects of 9/11.

We heard from many of the workers who ran to Ground Zero to help, not thinking about the possible health problems that they themselves might face. These heroes are now victims of a public health disaster of grave proportions. We heard testimony from carpenters and firefighters who can no longer breathe without an oxygen tank, walk up a flight of stairs, and are still suffering from post-traumatic stress disorder.

It is for this reason that I am interested to learn about the HHS proposed new deployment standards for the Public Health Service Commission. I hope that PHS, if appropriately reorganized, could become an important element in our effort to improve not only emergency response to public health crises, but also efforts to expand public health to under-served areas.

I am concerned with the various criticisms of the transformation that could impact the number of well-qualified, much needed scientists, doctors, and nurses from entering and remaining in the Corps.

We must develop deployment standards that address the requirements of the job without risking our ability to recruit and retain the best public health specialists and without risking the security of our nation.

Finally, one of the recurring themes of Tuesday's hearing was the need for a focused, coordinated response to public health disasters. I hope to learn how the new plan will address this need.

I look forward to hearing from our witnesses today to learn more about the proposed

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restructuring of PHS and hope to hear how PHS will be posed to better respond to the health needs of the American public.

After all, this must be the ultimate goal of the Corps.

Thank you.

STATEMENT OF
EDWARD N. BRANDT, JR., M.D., PH.D.

BEFORE THE COMMITTEE ON GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

HEARING ON THE TRANSFORMATION OF THE COMMISSIONED CORPS
OF THE U.S. PUBLIC HEALTH SERVICE
October 30, 2003

Good morning Mr. Chairman, and distinguished members of the Committee. I am Dr. Edward N. Brandt, Jr. I am currently Regents Professor and Director of the Center for Health Policy at the University of Oklahoma Health Sciences Center. From May 1981 through December 1984, I served as the Assistant Secretary for Health, and was responsible for the oversight and line management of the agencies of the U.S. Public Health Service (PHS), including the Commissioned Corps. I, myself, served as a Commissioned Corps officer during my tenure.

The public health environment in which we live has changed, especially since the terrorist events of 9/11 and the series of anthrax releases that followed. We are now at war and are confronted with the specter of chemical and biological terrorism occurring on our own soil. This is in addition to the natural emergence of new infectious diseases (for example, West Nile virus and SARS); the persistent problems of lack of reasonable access to health care for many of our rural and urban citizens; problematic levels of under-immunization among our populations of both children and adults; and, other potential threats, such as an accidental or intentional adulteration of our food supply.

The proverbial "bottom line" is that the world has changed, threats have changed, and the Corps must change. Unlike past times where the Corps has slowly been reshaped, the horizons and time frames that we face today are immediate and urgent on one hand, and persistent on the other. We have no idea when or if a terrorist will unleash a biologic weapon on the American people, but we know that the technological capacity to do so exists and we must plan to respond for the sake of our security. We have pressing problems in the day-to-day functioning of our public health infrastructure, with barriers to access and service that are not dissimilar to those of several decades ago. I believe that the Secretary's transformation initiative will address these issues.

It is essential that transformation be kept in perspective and in context. Officers of the commissioned corps are expected to be able to function in dual capacities. Corps officers have a routine assignment to which they report on a daily basis, but also possess extremely valuable, high level health skills that can be brought to bear in the event of a national need. This flexibility is one of the key characteristics that makes the uniformed service system as it is implemented within the Corps so valuable. The Secretary has proposed training of officers to assure readiness and to complement their varied professional skills, and I agreement that such is needed. Many of the skills that officers bring to their routine assignment can be used to full benefit in the event of an emergency.

There are three specific additional areas of Secretary Thompson's transformation plan that I want to address: use of the Corps for non-emergency primary care; the organizational structure for management and oversight of the corps; and modernization of the reserve elements.

PRIMARY CARE MISSIONS

The transformation of the corps should not be, and to my understanding is not, driven solely by the new importance that readiness and response have taken since 9/11. It has been adequately shown that corps officers bring much to improve research, public health practice, and the provision of primary care. I believe that the nation needs more commissioned corps officers on active duty in the full range of professional functions that they now fulfill, I also believe that renewed emphasis on the use of corps officers to address primary care in underserved areas and among the Native American population is essential.

The Health Resources and Service Administration's web site lists approximately 3,000 vacancies in underserved areas that need to be filled. The President and the Secretary have announced their intention to expand the Community Health Centers program by some 1,200 new centers by 2007. And, the best estimates of the number of new health professionals required to serve in these centers is between 7,500 and 20,000. The Indian Health Service, when last I heard, was currently short approximately 175 physicians, 100 dentists, over 350 registered nurses, and is critically short of pharmacists and other health professionals.

In my view, the best method by which to attract and place new health professionals to help fulfill the President's vision is the commissioned corps system. Whether the new officers are brought into the service as scholarship recipients or volunteers makes no difference. What makes a difference is that they are commissioned officers. During my tenure as the Assistant Secretary for Health, I learned first hand the value of the uniformed system as I assigned officers to community health centers, rural clinics, free-standing National Health Service Corps sites, and migrant health delivery sites. Implementing a well planned system of career development in a transformed corps, as the Secretary envisions, will offer personal and professional career growth within the world's premier public health establishments, the Department of Health and Human Services and the agencies of the U.S. Public Health Service. The corps system, operating via orders for the good of the service, can be used to address many of our nation's maldistribution problems. My experience with students in today's environment suggests that there is fertile ground for a program that combines service to the country and professional opportunity, which is precisely what the transformed corps will offer.

ORGANIZATION AND MANAGEMENT OF THE CORPS

The Secretary calls for an organization and management approach for the commissioned corps that places policy responsibilities on the shoulders of the Assistant Secretary for Health, and assigns personnel administration functions, including the use of the corps in the field to the Surgeon General. I believe that this is precisely the right structure for the times for several reasons.

First, while the Secretary has the ultimate command and control of the Corps, the Assistant Secretary for Health (ASH) is his chief medical and public health advisor. An essential task that the ASH performs is to help formulate approaches or solutions to public health problems and to design initiatives. Typically, these are complex issues and require the involvement of several agencies, and frequently multiple divisions or units within agencies. The ASH pulls multiple components together to form a cohesive whole to drive an initiative or address a problem . The ASH needs to be responsible for policy and the planning of the initiatives that are developed, taking advantage of the enormous benefit that a mobile, highly trained, professional corps can offer. The ASH is the integrating point, the Surgeon General the implementing point. This frees up the Surgeon General to attend to the daily work necessary to maintain the corps in their assignments, or on field missions.

Second, the corps has seen several types of management structures over the last few decades. The question at hand is not how to reinvent the past, but rather to do what is appropriate now in today's environment. It is important to look for best practices in similar organization to determine what might be the best approach. Within government, one needs to look to the Department of Defense for inspiration, as they house and oversee all of the other uniformed service health systems. Public information that is available on the web site for the Assistant Secretary of Defense for Health Affairs (ASD/HA) is very informative.

Like the ASH, the ASD/HA is the principal staff assistant and advisor on health matters to the Secretary of Defense and his immediate office. With regard to policy development and program integration, the ASD has a function that closely parallels that currently invested in the ASH. This parallel extends to the commissioned corps policy and planning functions that are proposed for the ASH. The ASD exercises authority, direction, and control over medical personnel; establishes policies, procedures, and standards; directs deployment medicine policies; and, leads strategic planning. These are precisely the functions that the Secretary wishes to be placed in an office that directly supports the Assistant Secretary for Health. Of course, for carrying out these responsibilities the ASH would be supported by an appropriate policy making office. The proposed structure for the commissioned corps parallels the DoD approach but is being appropriately adapted to HHS' needs.

In sum, I believe that the Secretary has clearly chosen the right organizational structure, in fact perhaps the only one that makes sense in our current environment. It follows the proven good practices under which the other uniformed services medical establishments operate and creates a parallelism that will facilitate increased collaboration and cooperation between all of the uniformed medical services. Of great significance to the corps is that it creates parity with those services, a goal that has been articulated by the Surgeon General, as well as constituency organizations, as important to pursue.

MODERNIZATION OF RESERVE

Secretary Thompson has made it clear that he views the transformation as a major systems change for the commissioned corps. While today's discussions revolve around the active duty corps, it must be borne in mind that there is also existing legal authority to operate a reserve

element of the corps in a manner that is nearly identical to the other uniformed services.

Increasing the number of health professionals available to work on missions as "part time" reservists has numerous benefits to policy makers, program officials, and the corps itself. A well-managed, properly populated reserve will have the effect of expanding the capacities and the capabilities of the active duty component in a cost efficient manner.

Again, it is important to bear in mind that the Secretary's transformation is not centered only on emergency response. There are numerous public health problems that can be addressed by planned call ups of reserve corps officers. Some examples of where reserves can be used under conditions of planned initiatives are:

- relieve staffing shortages in Indian Health Service clinics where staffing dips too low or where it is not sufficient to meet extraordinary demands;
- working with states and local communities to improve immunization levels, either as individual officers or teams deployed to areas of targeted need;
- provide technical assistance to help local public health departments to improve their infrastructure;
- work in teams that do back-to-back rotations into boarder areas, or migrant camps, to improve health status.

And, of course, reserves can be called up to meet emergency needs. A beefed-up reserve in the corps will have numerous positive benefits. There will be a reduction of pressures on the active duty corps to be viewed as the only resource. Reservists can be used to either back fill for active duty officers away from their principal duty station for whatever reasons. called to be deployed, and will short the time that any one active duty officer may be away from his or her principal assignment. I can envision numerous occasions during my tenure as ASH when I could have used such a cadre of people, not the least of which would have been to assist highly impacted departments of public health as the horrors of the HIV epidemic began to unfold. I believe that for the sake of health security, the country needs not only a strong active duty corps, but a well developed and equally strong reserve.

Mr. Chairman and distinguished members, I would like to close by restating my support for Secretary Thompson's transformation initiative for the commissioned corps. Secretary Thompson has articulated a clear vision and several principles for his transformation, and it is now up to those that serve the department to operationalize them. I look forward to working with the Secretary and others to improve the health status and health security of the nation through a modernized and transformed commissioned corps.

WRITTEN STATEMENT

OF

THE AMERICAN NURSES ASSOCIATION

ON

PROPOSED CHANGES TO THE PUBLIC HEALTH SERVICE CORPS

HOUSE GOVERNMENT REFORM COMMITTEE

OCTOBER 30, 2003

2154 RAYBURN BUILDING
WASHINGTON, DC 20515

Mr. Chairman, thank you for the opportunity to submit a written statement on the U.S. Department of Health and Human Services' plan to transform the Public Health Service Commissioned (PHS) Corps.

The American Nurses Association is the only full service association representing the nation's 2.7 million registered nurses through its 54 constituent member associations.

The U.S. Public Health Service traces its roots to a 1798 law that provided medical care to merchant seamen. Since 1889, the U.S. Public Health Service has employed health professionals in a military-like model called the Commissioned Corps. Today, the Commissioned Corps includes approximately 6,000 doctors, engineers, nurses, scientists dentists and veterinarians working for more than 20 federal agencies and offices.

On July, 3, 2003, The U.S. Department of Health and Human Services announced a reorganization of the U.S. Public Health Service Commissioned Corps. Among other changes, is a proposal which would implement a warrant officer rank within the Corps designed for recruitment of registered nurses with associate degrees to serve in the PHS Commissioned Corps. Implementation of this proposal would set a precedent within the PHS Corps and would institute a program that has already been tried and abandoned in the armed services. Since the associate degree curriculum does not offer the opportunity to develop public health competencies, ANA is concerned that this proposal would neither strengthen the PHS Commissioned Corps nor expand the strong cadre of public

health leaders needed to respond to public health and emergency needs across the country and around the world.

ANA believes that baccalaureate nursing education is necessary at a minimum to prepare the nursing workforce for the challenges of leadership in a complex and changing public health care system. ANA has long supported increased accessibility to high-quality educational and career mobility programs that utilize flexible approaches to individuals seeking academic degrees in nursing. A major plank in ANA's legislative platform focuses on ensuring continued support for nursing education both at the baccalaureate and graduate level. A study published in September, 2003, in the Journal of the American Medical Association (JAMA) found that the educational level of Registered Nurses (RNs) working in hospitals has a significant impact on whether patient survive common surgeries. According to the researchers, raising the percentage of RNs with bachelor's degrees from 20 percent to 60 percent would save four lives for every 1,000 patients undergoing common surgical procedures.

ANA recommends an approach to nurse recruitment for the public health system during this time of nursing shortage that should include increased federal funding for scholarships and loan repayments to ensure the supply of adequately prepared registered nurses to expand and strengthen the PHS Commissioned Corps.

ANA stands ready to work cooperatively with the Department to assist in identifying recruitment and retention strategies for registered nurses and accomplishing the goals of the transformations plan.

Statement
of the
American Chiropractic Association
Submitted to
U.S. House Government Reform Committee
October 30, 2003

ACA Calls for Inclusion of Chiropractors in PHSC

The American Chiropractic Association (ACA) is the nation's largest professional organization representing Doctors of Chiropractic. There are over 65,000 practitioners in the United Sates. The ACA appreciates the opportunity to submit a statement before this committee, which will examine a draft proposal of the Department of Health and Human Services to revitalize the commission corps.

As the third largest doctorate level health care profession, behind only medicine and dentistry, chiropractic care can contribute greatly to the success of the Public Health Service Commissioned Corps by helping it advance its mission. Doctors of chiropractic are the only licensed profession not included in the PHSC.

Chiropractic services are part of most private and public insurance and health programs today. The Doctor of Chiropractic is an integral part of our nation's health care delivery system. Recent advancements include chiropractic care being integrated into both the Department of Defense and the Department of Veteran Affairs. In addition to receiving reimbursement for worker compensation service Doctors of Chiropractic also enjoy coverage by most insurance, including both Medicare and Medicaid.

With expertise in the neuromusculoskeletal function of the human body, doctors of chiropractic would be an ideal addition to the Public Health Service Commissioned Corps. Doctors of Chiropractic provided their services from Ground Zero to the Pentagon after 9/11. As the PHS seeks to strengthen its corps, chiropractors should be an integral part of the nation's health care plan.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
COMMISSIONED CORPS

APPOINTMENT AFFIDAVIT
RESERVE CORPS

I, _____, do solemnly swear (or affirm) that
(Name in full)

A. OATH OF OFFICE

I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely without any mental reservation or purpose of evasion; that I will well and faithfully discharge the duties of the office on which I am about to enter, SO HELP ME GOD.

B. AFFIDAVIT AS TO SERVICE

I am willing to serve in any area or position or wherever the exigencies of the Service may require.

C. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof.

D. AFFIDAVIT AS TO PURCHASE AND SALE OF OFFICE

I have not, nor has anyone in my behalf, given, transferred, promised or paid any consideration for or in expectation or hope of receiving assistance in securing this appointment.

_____ _____
(Type name of appointee) *(Signature of appointee)*

Subscribed and sworn before me this _____ day of _____, A.D. _____,

at _____ _____
(City) *(State)*

_____
(Signature of Notary Public or authorized PHS Commissioned Corps officer)

_____
(Title)

Appointment and Appointment Date are Established by Personnel Order.

NOTE -- The oath of office must be administered by a person specified in 5 U.S.C. 2903. If by a Notary Public, the date of expiration of commission must be shown.

Commissioned Officers Association
of the U.S. Public Health Service

Gerard M. Farrell
Captain U.S. Navy (Ret.)
Executive Director

20 November 2003

The Honorable Mark E. Souder
Chairman
Subcommittee on Criminal Justice, Drug Policy and Human Resources
House Committee on Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Mr. Chairman:

I am pleased to respond to your letter of November 10, 2003 containing three additional questions for the record incident to my testimony before the House Committee on Government Reform on 30 October 2003 regarding the Public Health Service Commissioned Corps. Enclosed please find my responses to your questions for the record.

Please do not hesitate to contact me if I may be of any further assistance in these important matters. We appreciate your interest in and continued support of the PHS Commissioned Corps.

Sincerely,

Gerard M. Farrell
Captain, U.S. Navy (Ret.)
Executive Director

Encl.

8201 Corporate Drive, Suite 560, Landover, Maryland 20785 • (301) 731-9080 • FAX (301) 731-9084

RESPONSE TO QUESTIONS FROM
CAPTAIN GERARD FARRELL

IN RE: "Serving the Underserved in the 21st Century: The need for a Stronger, More Responsive Public Health Service Commissioned Corps"

Question 1
"You recommend that the Surgeon General provide "direct leadership, policy administration, management and operational control, including budgetary and personnel management for the commissioned Corps.' What impact will this have on the current HHS operating agencies, such as CDC, NIH, FDA, etc.?"

Response
Under the current organizational structure, responsibility for administration of the Commissioned Corps is vested in three separate and distinct DHHS offices that report to two different Assistant Secretaries. We strongly believe that this is an unsound and imprudent management scheme that leads to overlapping authority as well as confusion in the execution of the Corps' personnel responsibilities.

Vesting the Surgeon General with full administrative, management and operational authority over the Commissioned Corps as Dr Koop and Dr. Richmond, both former Surgeons General, as well as the Commissioned Officers Association recommend, will have an immediate and positive impact on the ability of HHS operating divisions to carry out their public health responsibilities. This organizational structure provides a single point of contact for the agency heads in all matters pertaining to the Commissioned Corps including officer recruiting, assignment, training and education, support, and deployment.

Consolidating functional authority for the Commissioned Corps under the Office of the Surgeon General (OSG) is, however, only the first step in a much needed process to develop a workable human resource needs register. The Commissioned Corps must create what the other uniformed services call a "table of billet requirements." In order to effectively and efficiently plan, program and assign human resources and properly manage them to meet the nation's health needs, the Commissioned Corps must gain the capability to forecast personnel requirements in each HHS operating division and other agencies and departments where officers are, or ought to be assigned.

The Commissioned Officers Association strongly recommends that the Surgeon General, using his reinstituted authority as the Commissioned Corps commander, immediately undertake negotiations with the HHS operating division leaders to establish within each organizational unit, a minimum number of positions (billets) which are best filled by Commissioned Corps officers. We envision the operating divisions and OSG working collaboratively to establish requirements and qualifications for each billet. Submitted commentary made available to the committee by Agency heads supports that potential. Operating under the Surgeon General, the OSG can commit to providing a fully qualified officer for each such position.

Enabling a set of clearly defined and agreed upon requirements endorsed by the agencies of HHS will permit the OSG to improve and centralize recruiting, establish career paths and better professional training and education programs for officers, and improve the quality of officers assigned throughout HHS and to other federal agencies and health entities where the need is presented. Moreover, establishing agreed upon billet requirements will include deployability standards and requirements for each billet. This will give the operating division heads a practical way of optimizing their use of the Commissioned Corps officers assigned to them. That will represent a major improvement from the present operating situation.

The leadership of every major HHS operating division is on record with their desire to increase the number of Commissioned Corps officers assigned. One impediment to increasing the number of officers in each operating division is the increased deployment and physical standard requirements contemplated for officers by HHS. These requirements were developed in isolation from agency leadership, and in fact from the majority of Corps officers. It was also not done in consort with the OSG. This is the result of the current status of fragmented leadership for the Commissioned Corps.

COA's recommendations are designed to increase the collaboration among the operating divisions and a single commander of the Commissioned Corps – the Surgeon General. The result will be a Corps more responsive to the needs of the individual divisions and agencies as a valuable resource, better able to serve the nation in the pursuit of an improved public health status.

Question 2
"You testified that: 1) there is "an alarming degradation of morale" within the Commissioned Corps, and 2) "there are currently over 125 fully qualified and boarded four-year degree nurses seeking admission in the [Commissioned] Corps who are awaiting assignment." Why is there a waiting list to join the Commissioned Corps if morale is alarmingly low?"

Response
Since the Corps does not currently have a system of determining personnel requirements to which I referred in the previous question as a "Table of Billet Requirements", it cannot accurately project recruiting needs. Service recruiters have no clear way of determining if the number of applicants currently awaiting assignment is below, meets, or exceeds the need. We do know, however, that there are currently some 350 nurse vacancies in the Indian Health Service alone. The mechanism to pull the fully qualified applicants from the available pool does not work and the OSG cannot assign the qualified applicants against known vacancies under the current personnel system. This situation leaves one of our most vulnerable populations underserved. Given these facts, it is not difficult to conclude that morale issues indeed are having an adverse impact on recruiting.

There is, however, little or no *prima facie* correlation between the morale of currently serving Corps officers and applicants for a commission who may have been waiting months, or in some cases a year or more, for a commission. Candidates for a commission

make their application on the basis of what they have understood the values of the Corps to be. It is too early to judge the impact of recent events in the management of Corps on future recruiting.

The degradation of morale to which I refer in earlier testimony is a relatively new occurrence. Morale of Corps officers slipped in early 2003 with the submission of the FY 2004 President's Budget which proposed eliminating the pay parity between the PHS Commissioned Corps and the other uniformed services which has been in place for almost 100 years. Corps officers were dismayed that their service was characterized by an Administration budget document as "essentially civilian in nature" when clearly that is not the case.

In earlier testimony before this House Committee on Government Reform former Surgeon General C. Everett Koop underscored the importance and need for a uniformed Corps of health professionals in government service. Dr. Koop contrasted the complete inability of HHS to muster any civil servants willing to respond to the Mariel Refugee crisis with the Commissioned Corps' responsiveness in deploying some 260 officers to Florida within 24 hours. He noted that the Corps, under his direction, was able to meet the needs in a most professional manner.

The promulgation of new promotion policies and changes to medical benefits suggested by the Office of the Assistant Secretary for Health in August of this year had a further deleterious impact on Corps morale. These new policies disadvantaged certain categories of officers for promotion without explanation or justification and instituted new requirements for promotion eligibility without providing the requisite resources which would enable officers to meet the new requirements. Changes to procedures by which active duty officers receive medical care were perceived as reducing the level and quality of care available.

It is highly unlikely that serving officers' declining morale would have transported into the applicant pool so rapidly as to be evident by late October. What is equally certain, however, is that poor morale within the Corps will eventually impact on recruiting. Serving officers who are not happy will be less likely to urge good candidates to pursue a commission as a PHS officer. There is ample anecdotal evidence available at this point to demonstrate that unless the organization and process of transformation are realigned with a single command structure under the Surgeon General, Corps recruiting and retention will both suffer.

Question 3
"What comparisons, if any, have you made with health professional recruiting systems within other public health organizations and health systems?"

Response
In 2003, COA's affiliated PHS Commissioned Officers Foundation for the Advancement of Public Health completed two research projects on recruiting, selection, assignment, and retention of PHS Commissioned Officers including those in the clinical disciplines.

These projects included an in depth study of DoD health professional recruiting processes as well as obtaining a "supply side" view by interviewing representatives of leading schools of health professions and current and former officers at every level of rank and discipline. To our knowledge those reports have not been used in developing the current proposals on recruitment and retention accompanying the transformation plan.

The bottom line is that there are many models of successful recruitment systems in other organizations that could and should be utilized by a well-managed Commissioned Corps to help meet its professional staffing needs.

The study reports are provided at Tabs A and B.

FINAL REPORT
RECRUITMENT AND RETENTION OF HEALTH PROFESSIONALS IN THE COMMISSIONED CORPS

FOUNDATION RECRUITMENT AND RETENTION PROJECT

NOTE: THIS VERSION OF THE REPORT DOES NOT CONTAIN APPENDICES A THROUGH I. THEY MAY BE OBTAINED FROM THE PHS COMMISSIONED OFFICERS FOUNDATION FOR THE ADVANCEMENT OF PUBLIC HEALTH

March, 2003
PHS Commissioned Officers Foundation for the Advancement of Public Health
8201 Corporate Drive Suite 560
Landover, Maryland 20785
With funding support from the Division of Commissioned Personnel
U.S. Department of Health and Human Services

Final Report
Recruitment and Retention Project
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INTRODUCTION

The material in this report documents the conduct of a research project conducted for the Division of Commissioned Personnel of the Department of Health and Human Services by the **PHS Commissioned Officers Foundation for the Advancement of Public Health** during the period February 22, 2002 to March 31, 2003. The project examined the potential of using former PHS Commissioned officers on the faculties of schools of the health professions as auxiliary recruiters for the Commissioned Corps.

The project was conducted by a panel of retired PHS Commissioned officers with a background of experience in the academic community and in health professional organizations.

The material contained in this report includes an executive summary of the project's operations, specific comment on the contract requirements set by the Division of Commissioned Personnel, and a series of findings and recommendations which have evolved from the research effort.

Also included as appendices are copies of the project's publications ranging from a review of the literature on recruitment and retention of personnel in the Federal health service through focus group findings on that same subject and including listings of former PHS Commissioned Officers now serving on the faculties of schools of the health professions. The appendices also include a list of auxiliary recruiters from the "pilot" schools of the health professions which were part of the research study and a timetable for the project operations for each of the thirteen and one quarter months of the project.

Professor Jerrold M. Michael, George Washington University
Co-Principal Investigator
March, 2003

EXECUTIVE SUMMARY

Recruitment and Retention Project
PHS Commissioned Officers Foundation for the Advancement of Public Health
March, 2003

The project approach was based on the hypothesis that *former PHS Officers and their interested colleagues on the faculties of the health professions schools may be identified and then called upon to become recruiters for much needed health manpower in the Federal Health Services.*

The major focus of the project was designated as the faculty and administrators of the schools of the health professions, particularly those faculty members who had previously served as Commissioned Officers of the PHS. Individuals from a series of "pilot schools" were solicited to become auxiliary recruiters for Commissioned Officer candidates from their institutions. The purpose of that sampling was to determine the probabilities of other individuals at the other schools of the health professions serving in a similar volunteer role. The process used and the selected schools are noted below.

To assist in the process, the project investigators accumulated and reviewed PHS recruitment and retention relevant materials available in Federal agencies and with the assistance of panels of present and former officers made an assessment of those materials most appropriate for specific use at schools of the health professions by former PHS officers now serving on those faculties. That activity was completed in April of 2002 and the results put into pamphlet form. A copy of that document is included in appendix D of this report.

Further, in order to provide these volunteer recruiters with current information as to what factors motivate young health professionals to join and to remain in service, the investigators first did a literature search covering the past 30 years related to recruitment and retention in the Federal health services. That work was completed in May of 2002 and the results put into pamphlet form. A copy of that document is included in Appendix E of this report. To validate those findings the investigators also conducted a series of "focus Group" type seminars using faculty, and students as well as current and former PHS officers to make those assessments. That work completed in May of 2002 was published in pamphlet form. A copy of that document is included in appendix F of this report.

As noted above, in order to carry out a sampling of former officers now serving on the faculties of the schools of the health professions, and to examine other issues which were part of the project, several "pilot" schools in the categories of Medicine, Dentistry, Pharmacy, Public Health and Environmental Health Science were selected for study.

In order to conduct the evaluation of the selected institutions, special Faculty Seminars were held from August through October of 2002. These faculty seminars brought together the "anticipated" auxiliary recruiters from the "pilot" schools of the health professions.

The first such seminar was held on August 24' 2002 at the George Washington University. It brought together representatives of The School of Medicine, George Washington University; School of Public Health, George Washington University; Philadelphia School of Osteopathic Medicine; School of Public Health, University of South Carolina and School of Environmental Health Science, Eastern Kentucky University. The agenda for that faculty seminar is included in appendix A of this report.

The second seminar was held on September 17 2002 at The University of Maryland. It brought together faculty from the University of Maryland School of Dentistry and the University of Maryland School of Pharmacy.

Follow up sessions to accommodate faculty who could not attend those first two seminars were held at the Philadelphia School of Osteopathic Medicine on September 23, 2002; at the School of Public Health of the University of South Carolina on October 17, 2002; and at the Eastern Kentucky University on December 3 2002.

The overall objectives of those sessions were two fold. It was to provide the faculty members with special recruitment materials and special contact information and also to permit the sharing of ideas about the most academically appropriate approaches for exposing students to the opportunities available through service in the Commissioned Corps of the PHS. **All of the attendees at these sessions have agreed to participate as Auxiliary Recruiters for the Commissioned Corps of the PHS.** Their names appear in appendix B of this report.

Among the materials distributed to all of the auxiliary recruiters in a briefcase kit were discipline specific recruitment materials and a special power point visual set prepared for use by the former PHS officers on those faculties. In addition, interactive CDs, developed by the Division of Commissioned Personnel, were distributed. These CDs permit their potential applicant students to make a preliminary application to the PHS Commissioned Corps "on line." Those applications were "marked" with a special designator so that follow up on the "pilot schools" applicants is possible.

The project also developed lists of former PHS officers serving at schools of Public Health and Pharmacy. The listing for the Schools of Public Health was issued in pamphlet form on December 2, 2002. It contains the names of 76 individuals. The listing for Schools of Pharmacy was issued in pamphlet form on February 6, 2002. The framework for the listing of Schools of Dentistry was issued in pamphlet form on ----. Copies of these pamphlets are included as appendix G, appendix H, and appendix I of this report.

The findings and recommendations section of this report contains commentary on (1) Changes in the Recruitment and Placement process; (2) Appointment of auxiliary recruiters; (3) Use of recruitment material; and (4) "Teachable moments" for recruitment.

In one very important area of those findings and recommendations, namely the section on Changes in the Recruitment and Placement Process, the following key points are made:

- Redefine the personnel mission of DCP/OSG and the Corps to centralized force management.
- Reorganize and centralize the way in which recruiting and placement is done in DHHS and provide the necessary resources to make it function properly.
- Develop a cadre of former PHS officers and "Friends of the PHS" to act as auxiliary recruiters at the schools of the health professions so that they can share their experiences and knowledge throughout the academic training program
- Give all Commissioned Officer recruiters a marketing message they can sell and that captures the vision of the Corps; provides an identity that young health professionals want to be part of, and that outlines opportunities not available anywhere else.

COMMENTS ON SPECIFIC PROJECT REQURIEMENTS (Contract Language)

The numbered items below are noted as project contract requirements and the text in bold print reflect comment on those requirements.

1) Accumulate recruitment and retention relevant materials available from DCP analyzing and validating appropriateness for specific use at schools of health professions

This requirement is addressed In Appendix D in the document titled, *SUMMARY OF COMMENTARY ON PHS COMMISSIONED OFFICER RECRUITMENT MATERIAL RESULTING FROM PANEL SESSIONS HELD ON MARCH 14 AND APRIL 18, 2002.* In this document each unit of recruitment material is analyzed and recommendations made regarding its use by the auxiliary recruiters at the schools of the health professions.

2) Identify schools of health professions that are nationally accredited and establish relationships with faculty, career counseling and employment centers, and students of schools of health professions.

This requirement was met with the identification of "pilot" schools of the health professions at George Washington University (Schools of Medicine and Public Health); The University of Maryland (Schools of Pharmacy and Dentistry; the University of South Carolina (School of Public Health); Philadelphia School of Osteopathic Medicine and Eastern Kentucky University (School of Environmental Health Science).

All of the faculty members who attended the faculty sessions have agreed to serve as auxiliary recruiters for the PHS Commissioned Corps.

A copy of an illustrative agenda for one of the faculty seminars (Session held at The George Washington University on August 24, 2002) is attached as Appendix A in this report.

3) Familiarize school faculty, career counseling and school employment centers about the PHS Commissioned Corps utilizing current recruitment and retention materials developed by DCP and empower them to actively participate in recruiting students. The educational process could utilize various methods of instruction, such as campus TV stations and career fairs.

See response to item number 2 above.

4) Evaluate impact of recruitment materials on school faculty, career counselors, employment personnel and students.

Follow up sessions were held at all of the Universities which served as "pilot" schools. All of the selected schools are actively participating in recruitment efforts. They are using the recruitment materials supplied and are involving student services personnel in the process of recruitment.

Lists of former PHS officers and in one case, "Friends of the PHS" on the faculty and staff have been developed for Schools of Public Health and Schools of Pharmacy. These are contained in Appendix G and Appendix H of this report. A framework for the listing of faculty at Schools of Dentistry is contained in Appendix I. Preliminary results from "Computer identification" of the applicants who do a pre application "on line" indicate an increased number of recruits from the "pilot schools"

5) Conduct "focus Group" type seminars to identify the factors involved in a health professional's choice of employment and continuation of that employment in the PHS Commissioned Corps, and the identification of sources for potential voluntary auxiliary recruiters in schools of health professions.

The requirement related to factors for choice of employment and retention are addressed in the document titled *REPORT OF FINDINGS OF FOCUS GROUPS WHICH EXAMINED THE ISSUE: WHY HEALTH PROFESSINALS JOIN AND REMAIN IN THE COMMISSIONED CORPS OF THE US PUBLIC HEALTH SERVICE.* In this document, included in this report as Appendix F, is a priority listing of reasons for joining and reasons for remaining.

The requirement related to the source of potential auxiliary recruiters is addressed in the listings provided of former PHS officers in the Schools of Public Health and Schools of Pharmacy and the framework for such a listing at Schools of Dentistry. These documents are included as Appendix G, Appendix H and Appendix I in this report.

6) Analyze and make recommendations concerning the need for modification of current, or development of new recruitment materials.

See response to item number 1 above.

7) Develop and produce reports on recommendations, list of schools involved, school points of contact, and number of school members and students who became familiar with the Commissioned Corps as a career through this effort.

The overall recommendations related to this project are contained in the next section of this report.

The schools involved are noted in item I-2 above.

The school points of contact are noted in Appendix B of this report and additional potential auxiliary recruiters are noted in the listings of former PHS officers and "Friends of the PHS." in Appendix G, and Appendix H of this report.

The number of school members (Faculty and staff) who have become familiar with the Commissioned Corps through this effort at the <u>pilot schools</u> is estimated at 52. The number of students at the <u>pilot schools</u> who have become familiar with the Commissioned Corps as of the concluding date of the contract of March 31, 2003 is estimated at 131.

FINDINGS AND RECOMMENDATIONS

The Findings and Recommendations of the project are presented in four areas as noted below;

1) Findings and Recommendations for Change in the Recruitment and Placement Process

A) DEVELOP A PRODUCTIVE CENTRALIZED COMMISSIONED OFFICER OPERATED RECRUITMENT SYSTEM LINKED TO PLACEMENT AND CAREER DEVELOPMENT

The process of officer recruitment and placement as currently conducted (outside of the work of the Division of Commissioned Personnel {DCP}) is primarily a function of the agencies. This lends itself to **agency level human resources planning rather than department wide human resources planning.** It also leads to insularity where the professional identification of the officer in some agencies is to that agency rather than to the overall mission addressed by the Commissioned Corps. It also results in the inevitable loss of many potentially effective officers.

When commissioned officers are in a central position in the recruitment and placement undertaking, the process is generally very effective. When the reverse is true it suffers.

A system that provides a "seamless" track from recruitment to placement carried out in a more centralized Department wide manner and directed by the Surgeon General, would not only enhance the effectiveness of the utilization of the Commissioned Officers to the benefit of national health problem solution, but could also result in a higher level of satisfaction and thus retention through the use of a more system wide mentoring process.

Seminal to the achievement of such an enhanced system are the following recommendations:

1) Movement of DCP which includes the functions of recruitment, placement, career mentoring and assignment of commissioned officers directly within the Office of the Surgeon General.

2) Maintenance of the recruiting function under the direct control and authority of uniformed personnel from the Director of the Division of Commissioned Personnel down to the active duty recruiters.

3) A resource augmented Division of Commissioned Personnel and in particular its Recruitment and Assignment Branch, that can carry out overall recruitment plans in collaboration with agency and discipline recruitment efforts and also rapidly respond to vacancy needs specified by the individual agencies.

4) An augmented Division of Commissioned Personnel, acting in consort with auxiliary recruiters at the various Universities, that can rapidly process applications and match them with agency needs in a short period of time.

5) Resources for a computer based system operated and updated by the Division of Commissioned Personnel that will provide information on capabilities, education, experience and special skills and certifications that can be used to rapidly respond to the particular needs of the agency human resource personnel as well as to provide information valuable in making rapid deployment of individuals for emergency needs.

6) Resources for an effective public affairs program operated by the Division of Commissioned Personnel, that can provide useful material to opinion makers, the professional community and the general public about the past present and future contributions of the PHS Commissioned Corps to the health of the nation and to the world community.

7) A broader and more formalized system of involvement of the Commissioned Corps system within the Human Resources units of the agencies and their sub units to assure that all professional positions are made not only eligible but promoted for application by commissioned officers.

B) ENLIST INSPIRED, KNOWLEDGEABLE RECRUITERS

Recruitment should be conducted by knowledgeable recruiters, in so far as possible from the same discipline as those being recruited. Regular DCP recruiters and Associate recruiters from the various disciplines can and should be supplemented by auxiliary recruiters drawn from the ranks of former PHS officers who are on the faculties of the schools of the health professions. Some of these auxiliary recruiters could be identified and enlisted into a formal program using the principles of the other uniformed services that provide incentives for "Reserve Officers" for their recruitment efforts.

Recruitment efforts of these active duty and volunteer recruiters should emphasize the merited role of the active duty officer in enhancing national health goals and the respect that comes from being part of an admired professional team. In addition, long term benefits including remuneration, that follows a dedicated career needs to be explained.

Contrary to conventional thinking, a great many young professionals are also attracted by the challenge of differing posts over a career and the opportunity for service as a team member in national emergencies. In this regard, recruiters appearing in uniform underscore many of these values that can be stressed in the recruitment effort.

C) EMPHASIZE PRIDE IN THE CORPS AND THE UNIFORM

Retention determination seems also to follow the elements which serve as incentives for entry into the corps. While not totally consistent for all in the corps, the sense of pride of service to the nation and to the underserved is often felt in the discipline of wearing the PHS uniform. Identification with others who are respected and who wear the same uniform is an attractive incentive for many to join and remain in the corps. Auxiliary recruiters can strengthen this link to national service by inviting active duty officers in uniform to participate in the educational programs at schools of the

health professions. The recruitment efforts of the other uniformed services may be used as a model for recruitment of personnel into the commissioned corps of the PHS.

D) PROVIDE AND PROMOTE THE REALITY OF LEADERSHIP OPPORTUNITY

Equally important to the judgment to join the corps is the incentive to remain in service if professionals understand that they will be able to shape the policy directions that they follow in their work environment. This is particularly true for those serving in direct service billets, research activity, and emergency assignments.

Equity in treatment as regards recognition, promotion, remuneration and opportunity for leadership are also seminal to recruitment and retention of people with highly desirable professional skills. This goes beyond the traditional aspects of gender and racial equity and encompasses the notion of professional growth and opportunity for every age group and in every professional category.

E) EMPHASIZE COSTEP PROGRAMS

The Division of Commissioned Personnel should be given additional resources in order to place a priority effort on the broad use of the junior and senior COSTEP programs to stimulate a flow of officers from the health professions schools. When appointed, all COSTEPs should be required to take the Basic Officer Training Course. As noted above it would be well to utilize recruiters from the same discipline, including former PHS officers serving on university faculties. The careers of these individuals can be presented as role models for those being recruited.

2) Findings and Recommendations regarding appointment of auxiliary recruiters

All of the faculty members contacted at the seven "pilot schools", without exception, enthusiastically agreed to serve as auxiliary recruiters for the PHS Commissioned Corps. In addition other non PHS officers who attended the faculty briefing sessions agreed to also serve as auxiliary recruiters. Those who can be listed as "friends of the PHS" included school Deans and Assistant Deans for student services who can be instrumental in the recruitment effort.

From this sampling taken at schools of medicine, public health, environmental health science, dentistry and pharmacy; it is appropriate to conclude that **almost every former PHS officer on such a faculty of a health professions school would in like fashion agree to serve as an auxiliary recruiter.**

While not part of the original project plan or required by the project contract, the project investigators decided to develop lists of former PHS officers (and in the case of Schools of Pharmacy, "Friends of the PHS") in two of health professions categories. The concept is that such lists would enable the regular recruitment operations of the Service led by the Chief Professional Officers, their Professional Advisory Committees

and the Division of Commissioned Personnel to enlist these individuals into their ongoing, coordinated recruitment and placement effort.

It is therefore recommended that the Division of Commissioned Personnel (DCP) and in particular its recruitment and Assignment Branch in consort with the Chief Professional Officers and their Professional Advisory Committees undertake to (1) utilize former PHS officers and "Friends of the PHS" now serving on the faculties of the schools of the health professions as auxiliary recruiters and that (2) the DCP undertake to maintain and update the listings of former officers and "Friends of the PHS" provided by the project and undertake to develop similar listings for all of the other health professions.

It is also recommended that the Commissioned Corps examine the potential of identifying former officers at schools of the health professions who can be commissioned in the reserve corps of the PHS and can be provided with a stipend for such service as is now done for health and medical officers in the other uniformed services and in particular, the US Navy. When so appointed, all such recruiters should be required to take the Basic Officer Training Course.

3) Findings and Recommendations on recruitment material

A major portion of the project was devoted to an examination of what currently available PHS recruitment material would be useful to former PHS officers now serving on the faculties of schools of the health professions in their work as auxiliary recruiters. That work included providing advice to students about future career options including a potential career as a Public Health Service Officer.

To accomplish that, a series of four recruitment material review panels were held at which time all of the available recruitment material was reviewed and evaluated. The panels included every active duty PHS officer category or discipline at ranks from 02 (Lieutenant Junior Grade) to 06, (Captain). Each panel also included retired officers, primarily those on faculties of schools of the health professions, as well as graduate students.

In addition to commenting on the material, the panels placed each recruitment tool into one of five categories as follows:

One: Excellent for all uses
Two: Excellent for all uses if adaptations or deletions of some visuals are possible and permissible.
Three: Good but needs to be revised
Four: Suitable only for specific groups
Five: Not suitable

All of these evaluations are documented in Appendix D of this report which is titled, ***SUMMARY OF COMMENTARY ON PHS COMMISSIONED OFFICER RECRUITMENT MATERIAL RESULTING FROM PANEL SESSIONS HELD ON MARCH 14 AND APRIL 18, 2002***

4) Findings and Recommendations on "teachable moments" for recruitment

A) Teachable Moments at the Schools of the Health Professions

The subject of the "teachable moments" in which to introduce health professions students to the notion of a career in the Commissioned Corps of the PHS was central to the project activity. In the course of the conduct of the several seminars with faculty from the schools of the health professions (which included schools of Medicine, Pharmacy, Environmental Health Science, Dentistry and Public Health) a variety of ideas, most of which resulted from actual experience with the concept, were put forward.

The following several points summarizes those ideas:

1) Faculty noted that each school of the health professions will be able to identify their own "critical moments" in which to communicate information about the Corps. A uniform finding for all of the schools is that the best communicators to be used in that process are those who are in the **same discipline**; **those who have had or are currently having the experience of service as a commissioned officer; and those who would be regarded by the student as someone who they regard as a role model.** In particular faculty members and fellow students have considerable influence in these interactions.

2) Arranging for the participation of current faculty who are former PHS Officers as well as invited active duty officers (In uniform) as participants (speakers) in ongoing courses, practice and seminar settings to discuss the current professional work of PHS officers contributes to the quality of the educational process while also providing an opening for discussion of career options as a PHS Commissioned Officer.

3) Opportunities present themselves in medical school courses such as THE PRACTICE OF MEDICINE; seminar presentations on WHAT SHOULD INFLUENCE THE SELECTION OF A SPECIALTY; and specialty courses ranging from PEDIACTRIC CARE through RESEARCH METHODS and INFECTIOUS DISEASE EPIDEMIOLOGY. These are forums where current and former PHS officers could be invited (In uniform) to present topical information related to their professional experience. This also provides the opportunity for individual or group discussion on a career in the Service.

4) At Schools of Public Health, It was suggested that there are opportunities to utilize active duty Commissioned Officers as adjunct faculty to teach whole courses, parts of other courses or to participate as mentors for the "extern instruction" of students during their matriculation. In some cases, there is an added value in the use of students who are in the Corps as teaching assistants and advocates. These individuals along with committed faculty can serve as auxiliary recruiters. In connection with this point it was noted that the practice of assigning active duty PHS officers for short term duty at a school of the health professions has proven valuable to both the PHS and to the University and particularly to the students.

5) In Environmental Health Science Schools it was noted that the practice of introducing ongoing and scheduled seminars on EMPLOYMENT OPPORTUNITIES IN THE FIELD OF ENVIRONMENTAL HEALTH SCIENCE and having faculty who have

served in the Corps counseling students are effective ways to stimulate appropriate candidates to consider the PHS as a career early in their matriculation.

6) Faculty from all of the schools noted the value of the availability of up to date PHS recruitment material particularly the interactive CDs which can be used independently by students. They also suggest the establishment of a "named mentor" in the PHS who could assist the aspiring professional in making his or her way through the bureaucratic maze from recruitment to selection and placement as well as for career guidance after placement.

7) Faculty from all of the Schools felt that the CAREER DAY SEMINARS and JOB FAIRS which are routinely attended by the Armed Forces Recruiters are a missed opportunity that the PHS and its faculty recruiters should consider.

8) Faculty members who were members of the Uniformed Services Reserve noted in particular the Navy program of using faculty members who are reserve officers as recruiters, during which time they earned pay as if they were participating in reserve training. They suggested the identification of former PHS officers who could be called to reserve duty (In uniform) with responsibilities for recruitment, mentoring and placement of potential PHS officers.

9) One additional comment made by a number of the participants was the suggestion that a high ranking officer of the PHS, possibly the chief professional officer or the Surgeon General should make it a point to attend meetings of the Health Professions Associations (Association of Medial School Deans; Association of Schools of Public Health, etc.) to personally enlist former PHS officers and other "friends of the PHS" as active participants in this recruitment process.

B) Teachable Moments in Schools of Pharmacy

Faculty colleagues from the area of Pharmacy commented in some detail about opportunities for influencing students about a career in the Commissioned Corps. Their ideas are noted below:

1) Most Pharmacy schools have some kind of seminar course very early in the curriculum where faculty and/or outside speakers expose the students (often for the first time) to information about the variety of practice opportunities in the profession. At this point, most students know only of their personal experiences with community, retail pharmacy. This may be regarded as a teaching opportunity, where students could be initially exposed to the kinds of practice available in the IHS, FDA, CDC, NIH, etc. Such first exposure usually takes a while to incubate.

2) As appropriate during specific professional classes, examples of PHS practice can be used by knowledgeable instructors to illustrate clinical situations where pharmacists are challenged to use their skills to influence patient outcomes. IHS patient counseling, FDA drug advertising regulation and BOP patient education programs are examples of where these activities are done well by PHS pharmacists and are models for the profession. This builds on the initial exposure to such roles described above.

FINAL REPORT
RECRUITMENT AND SELECTION OF USPHS COMMISSIONED OFFICERS IN THE CLINICAL DISCIPLINES

FOUNDATION RECRUITMENT AND SELECTION PROJECT

June, 2003
PHS Commissioned Officers Foundation for the Advancement of Public Health
8201 Corporate Drive Suite 560
Landover, Maryland 20785
With funding support from the
U.S. Department of Health and Human Services

Final Report
Recruitment and Selection Project

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I EXECUTIVE SUMMARY

The purpose of this project was to conduct a study of the recruitment and selection of clinically related categories (Nurse, Physician, Dentist and Pharmacist officers) for the Public Health Service Commissioned Corps.

The stimulus for the project was the fact that many senior Commissioned Officers felt that recruitment and selection process for new officers was fragmented and functioned without sufficient coordination, due in part to the underfunded and understaffed Division of Commissioned Personnel which traditional was the lead group in this activity.

The project was designed to document the current practices related to recruitment and selection of officers in the clinical categories and to identify procedures to improve upon those practices and, in particular, to evaluate similar, but perhaps more effective, practices as carried out by the other uniformed services.

The project was conducted by CAPT (Ret.) Milton Z. Nichaman and the Co-Director was RADM (Ret.) Jerrold M. Michael.

Following a series of interviews with the Chief Professional Officers of the physician, nurse, dentist and pharmacist categories, further interviews were conducted with 47 individuals in selected DHHS and non-DHHS agencies that currently have large numbers of PHS Commissioned Officers on their staffs. All interviews were recorded and summarized and provided the basis for the present report.

The major findings of the study were as follows:

- Validation of the lack of coordination in recruitment, selection and routine mentoring of Commissioned Officers
- Lack of a force management process including components of an active reserve, which can properly guide the recruitment and placement process and of a computerized information system on all officers including those being recruited and those already on duty.
- Lack of a uniform process of developing a career pathway system for all officers which can begin with the initial recruitment process.
- Lack of general knowledge of the Corps and its potential by the DHHS leadership and human resource unit personnel as well as the general public.
- Lack of information given to civil service and appointed employees about the value and potential of conversion of their employment status to that of a PHS Commissioned Officer
- Presence of antipathy toward the Corps

- Lack of useful Corps-specific recruitment material including special programs such as the Commissioned Officer Student Program (COSTEP)

These findings led to a series of recommendations which are summarized below:

- Develop a force management process, including an active reserve component,, similar to that in the other uniformed services, which among other values sets out the short and long term needs for officers
- Develop a recruitment and retention system that is under the leadership of the Surgeon General
- Ensure that all activities related to recruitment, selection and mentoring of Commissioned Officers are coordinated by the Division of Commissioned Personnel or its replacement organization
- Develop and put into place a billet system that serves the needs of the force management process
- Ensure that a PHS Commissioned Officer in included on the staff of each Agency-level Human Resources Unit.
- Ensure that each officer has a defined career pathway, beginning in the initial recruitment and placement process, that it is reviewed and amended periodically
- Conduct recruitment by discipline-specific "age appropriate" officers and with a priority focus on the use of the mechanism of COSTEP
- Provide continuing leadership, public health practice and scientific educational opportunities for officers in order to increase their value to the nation
- Provide adequate monetary and personnel support for a fully functioning DCP, or its replacement organization, under the leadership of the Surgeon General

II INTRODUCTION

On October 1, 2002 the Office of the Surgeon General awarded a contract (Contract #233-02-0079) to the PHS Commissioned Officers Foundation for the Advancement of Public Health to conduct a study of the recruitment and selection of clinically related categories (Nurse, Physician, Dentist and Pharmacist officers) in the Public Health Service (PHS) Commissioned Corps.

The contract was initiated as a follow-up of an earlier contract given to the Foundation to examine the potential of using former PHS Commissioned Officers on

the faculties of schools of the health professions as auxiliary recruiters. The project was designed to document the current practices related to recruitment and selection of officers in clinical categories and to identify procedures to improve upon those practices and, in particular, to evaluate similar, but perhaps more effective, practices as carried out by the other uniformed services

The Contract required the Investigators to present a Work Plan to the Contract officer; carry out interviews with the staff of DCP, the Chief Professional Officers(CPO) and representatives of the Agencies having a large number of Commissioned Corps personnel; determine recruitment and placement outcomes and provide recommendations to improve recruitment and placement of officers.

The Director of the project was CAPT (Ret.) Milton Z. Nichaman and the Co-Director was RADM (Ret.) Jerrold M. Michael. The project was carried between October, 2002 and June 30, 2003

III BACKGROUND

The Commissioned Corps of the US Public Health Service

Recognition of the need for a national public health focus dates back to 1798 when Congress established the Marine Hospital Service to provide medical services to merchant seaman. The need for a specialized cadre of professionals dedicated to public heath was recognized in 1871, when Dr. John Woodworth set up the Commissioned Corps as a new personnel system along military lines, a characteristic that today gives the Corps its unique uniformed service readiness. The PHS Commissioned Corps was formally authorized by Congress on January 4, 1889. Initially restricted to physicians, the Commissioned Corps has evolved into a uniformed service representing all of the major health disciplines

In its formative years, the Corps devoted its resources to health issues of the day, including care of merchant seamen, prevention of communicable diseases, and improvements in sanitation and environmental conditions. As the Corp responsibilities broadened, officers have been instrumental in pioneering research and applications in bacteriology, virology, parasitology, epidemiology and nutritional diseases.

Corps offices played vital roles in both World Wars and the Korean Conflict, during which the President placed the Corps into military status. Many officers also served in the Vietnam War. PHS officers were detailed to the armed forces to provide public health and medical expertise. Recently, hundreds of Corps officers provided emergency services at all three sites resulting from the terrorist acts of September 11th, 2001 as well as during the anthrax crisis. Officers also served in both of the Gulf Wars and are currently serving in trouble spots such as Kosovo, Afghanistan and Iraq.

Current size and dimensions of the Corps

As of June 2003 the Corps had 6033 officers as compared to 5848 in June 2002. The number of applications for Corps admission more than tripled in the past year.

Nurse and Physician officers are the largest groups at 1198 and 1224 respectively. Other relatively large groups are the pharmacists with 846 and the health services officers with 920 officers.

Among current Corps officers 43% were female and 24% were non Caucasian, although 635 (11%) did not report their ethnicity.

The largest numbers of officers, 36%, serve with the Indian Health Service (IHS). Approximately 14% are at the Centers for Disease Control and Prevention (CDC); 11% at the Bureau of Prisons (BOP); 12% at the Food and Drug Administration (FDA) and 8% each at the National Institutes of Health (NIH) and the Health Resources and Services Administration (HRSA) as of June 2003.

The Public Image of the Commissioned Corps

On October 17, 2001, the Health Care News reported that two agencies of the Department of Health and Human Services, the Centers for Disease Control and Prevention and the National Institutes of Health have the best ratings among the ten well-recognized Federal government agencies. The report noted, "The Centers for Disease Control and the National Institutes of Health are more favorably rated by the public than eight other major agencies, including the Securities and Exchange Commission (SEC), Food and Drug Administration, Environmental Protection Agency (EPA), Central Intelligence Agency (CIA), and the Federal Bureau of Investigation (FBI). Among those who say they understand what these Agencies are and what they do, the CDC received a 79% positive rating and a 17% negative rating and, similarly, the NIH had a 77% positive rating and a 21% negative rating."

When it comes to the recognition of the role that the Commissioned Corps plays in these well regarded agencies, the results are not as favorable. Only during the period of time that the Surgeon General was Dr. C. Everett Koop did the public have a reasonable level of understanding of the Commissioned Corps and its leadership role in the health programs of the Federal government. The wearing of the uniform by all officers, particularly when they are interviewed on the visual media, is regarded by many as an important way to provide the public, with a greater understanding of the Corps and its function in advancing the public's health.

IV PROBLEM STATEMENT

The recruitment of commissioned officers is carried out by the Recruitment and Assignment Branch of the Division of Commissioned Officer Personnel (DCP); the Human Resources units of the various Agencies of DHHS and Departments who employ Commissioned Officers outside of DHHS. Recruitment is also carried out by specific programs with large Commissioned Officer components such as the Epidemic Intelligence Service at CDC; the Chief Professional Officers and their Professional Advisory Committees (PAC); volunteer Associate Recruiters; Auxiliary Recruiters at Universities and individual officers with employment authority. Among all of these

groups, the Recruitment and Assignment Branch of DCP has been traditionally vested with the overall responsibility for managing the process of recruitment and placement.

Two and one half years ago the DCP had 115 employees. It now has 95. There are only 26 people in the Recruitment and Assignment Branch of DCP, which carries out a wide variety of functions in addition to recruitment. Only three people are free to do recruiting. As a consequence, it is difficult for that unit to follow through on broad recruitment assignments. In addition, once DCP recruits an individual, placement is under the control of the Agencies. This produces a situation in which an applicant, having gone through the recruitment process and told that she/he is eligible to join the Commissioned Corps, is then informed that she/he must find their own job unless they have already been "pre-selected" by someone in an agency.

Many individuals interview for the project have commented that from a service-wide standpoint there is insufficient priority placed on recruitment and assignment. This is further aggravated by the remote placement of the DCP away from the Surgeon General's office which further impairs the ability of DCP to meet any assumed "target" for overall recruitment.

An overarching problem in the recruitment and retention of officers is that the operation does not now follow a force management process. Such a process is one in which recruitment is driven by long term service needs. The Corps needs to know what its personnel needs are in the next five years, not only for next month, and it needs to know how many in each category are needed and where. It also needs to know if an officer is committed for a long term career.

The Surgeon General should, in consultation with Agency leadership, be able to set the targets for the size of the Corps. As noted below, such a process of force management is practiced in all of the other uniformed services.

V STUDY PROCEDURES

Following a series of interviews with the Chief Professional Officers, individuals at the Agencies with large numbers of Commissioned Corps officers were identified by CAPT Nichaman and RADM Michael as potential interviewees. Based on the recommendations from these initial interviewees, other Agency staff members were contacted and scheduled for interview. In total 52 individuals were interviewed. The names and Agency affiliations of these interviewees are provided in Appendix A.

All interviews were recorded and were then summarized by either CAPT Nichaman or RADM Michael. In order to include individuals from a variety of settings, site visits were made to Indian Health Service programs in Phoenix, Arizona, the Centers for Disease Control and Prevention in Atlanta, Georgia, as well as at the National Institutes of Health ,the Food & Drug Administration, the Division of Commissioned Personnel and the Bureau of Prisons Headquarters in Washington, DC.

In carrying out the interviews the following questions were used as guidelines:

1. What are the positive things about the current system of recruitment of PHS Commissioned Officers given the project focus of recruitment of clinical specialties (Physicians, Dentists, Pharmacists, and Nurses)? What are the negative things?
2. Is there a difference in recruitment practices when you are seeking people from the clinical specialties?
3. Are there principles involved in a successful recruitment program that can be extrapolated for application in other programs?
4. How is retention related to recruitment and recruitment related to retention?

VI CURRENT RECRUITMENT PRACTICES

Overall recruitment and Placement

It is clear from of the comments of many of the interviewees that the Division of Commissioned Personnel is seriously underfunded and understaffed, which makes it virtually impossible for it to function adequately and meet assigned targets. The DCP does not have the resources to develop and carry out timely updates to a personnel data base from which it could, if mandated, carry out a force management process such as is standard practice in the other uniformed services. Interviewees have noted that for many categories recruitment is relatively successful, but when the applicant is cleared for commissioning and must in essence seek his or her own first placement in an Agency, the process is less effective.

Agencies should be able to turn to the DCP to find eligible candidates who meet their specific needs. What is clearly needed is a functioning data system with information on current and potential officers including experience, education and credentials. Such a data system could serve as a mechanism to provide the Surgeon General with the knowledge as to who is available and where for routine rotation as well as for emergency deployment.

The ability to offer positions to applicants to the Corps rests in the Agencies. The link between DCP recruitment and these job opportunities is not always seamless or timely. There is no centralized mechanism to offer applicants a specific job. As a consequence, Agencies conduct much of the recruitment.

It was made clear in a number of the interviews that Agencies would resist a return to recruitment at a centralized level, as they would regard such a system as "interference from the outside." At several Agencies the comment was made that the major problem with an organized recruitment process is that there is no overall centralized recruitment plan with resources to implement it. DCP has the general charge to conduct recruitment, but is given inadequate resources to develop such a plan and manage a centralized recruitment system.

In keeping with their professional mandate, the Chief Professional Officers have taken an active role in the recruitment process and in many cases are responsible for preparing discipline-related recruitment materials. However each Chief Professional Officer and their Professional Advisory Committees (PAC) are "volunteers" in regard to recruitment-related activities because they have regular full time jobs as well. To make their category's recruitment effective they have to "borrow" resources from the Agency in which they reside. There is also the matter of convincing supervisors, particularly those who are not PHS Commissioned Officers, that service on a PAC provides useful experience not only for the individual, and of course the Corps, but also for the program in which they reside and thus to the benefit of the officer's supervisor.

DCP does maintain good relationship with most Agencies and places applicants in the vacancies that they have listed in a newly developed summary vacancy register which is posted on the DCP web site. However, this vacancy register requires that the Agencies provided information regarding their vacancies to the DCP in a timely and complete manner. Some units within an Agency are not always cooperative, and some civil service personnel do not want to deal with or hire PHS Commissioned Officers. As a consequence there are many vacancies that could potentially be filled by PHS Commissioned Officers that are never listed or known by DCP to be available.

Approximately 30% of those people who apply for the Corps get placed. Interviewees have commented that the Corps is loosing good people to other employment systems. People, they note, don't generally apply to just one organization. Most heath professionals apply to multiple organizations and the one that is most responsive is usually the one who ends up with the new employee.

Interviewees also stated that the overall application and placement process needs to be dramatically improved and made more user friendly. Examples were given that showed that PHS Commissioned Officer applications can be "fast tracked" in as little as 15 days if the resources to permit doing that are routinely provided. There are "system enhancers" that can be used to facilitate the recruitment to placement process. These include issuing the call to duty form in advance of all of the paper work being completed when position vacancies are known and when a qualified commissioned officer is ready to accept the duty assignment and by selecting a medical facility tht can do the required physical examination in an expedited manner that does not slow up the process.

Individuals of all disciplines who were interviewed noted the common theme that for PHS Commissioned Officer recruitment and placement to be strong and timely there there must be a strong linkage between the work of the Chief Professional Officer; the Professional Advisory Committee (made up of committed people from each discipline); and the DCP.

Nurse Recruitment

In order to facilitate nurse recruitment, the Chief Nurse Officer has addressed the lack of a broad officer data system for all officers by developing a computer listing of all nurse applicants. This system is maintained by a nurse applicant committee under her direction. The system contains information on all of the education, experience, skills and interests of each applicant.

This committee includes the Chief Nurse from each DHHS Agency and other Department units staffed with PHS Commissioned Officer nurses, as well as the nurse staffing officer at DCP. They meet once a month and track all nurse applicants personally. They monitor where they are in the process, what their strengths are, where applicants want to work and then try to match them with an Agency position. Each applicant is personally contacted by one of the committee members. The information on the applicants comes partly from the nurse staffing officer in DCP and partly from the work of the committee members and other nurse associate recruiters.

With efforts such as those described above, the number of PHS Commissioned Officer nurses in FDA has doubled in the past year. A number of interviewees noted that this kind of process is needed system-wide, but should be under the direction of a revitalized DCP with adequate resources and personnel.

It has also been suggested that if CDC were to place nurses into some of their Public Health Advisor and Public Health Analyst positions, which are charged with public health consultation and advising, both things that nurses do very well given their clinical background, the result would be an increase in the number of effectively placed PHS Commissioned Officers. It would also result in the positioning of a great many more officers in States and local communities who could serve a dual purpose by being available in the event of national or local emergencies. It has also been pointed out that the addition of nurse officers in State and local health Agencies would boost the effectiveness of many public health program at these levels.

It has also been suggested that nurses join the Commissioned Corps because they are interested in careers that include both clinical service and leadership roles. About 45% of the Corps nurses have had prior military experience and they are accustomed to the issue of change and are regarded by many as "ready" for promotion that includes taking on greater responsibility. According to several interviewees they have accommodated to being mobile; a significant departure from the typical attitude of civil service nurses.

Physician recruitment

The issue of physician recruitment was noted by many interviewees to be different in a number of respects from recruitment of other disciplines. The National Health Service Corps (NHSC) has downsized and deemphasized the recruitment of PHS Commissioned Officers where in the past one in three of those selected for that program would remain in careers in the Corps. The loss of the "draft deferment", in

force until the late 60s, also reduced the opportunity for people to experience service in the PHS. Many who did so found it very much to their liking.

When asked for the reason that there is a diminished focus on Commissioning National Health Service Corps assignees, interviewees suggested that it was probably in response to the "political environment" that presumes that private is better than government and that if people go to a National Health Service Corps site that is a shortage area and are employed by the community, or even are civil servants instead of Corps officers, they are more likely to stay there after their obligation has been fulfilled. What is overlooked in that judgment, one interviewee noted, is that Corps officers in positions like those in the NHSC are a unique force that can be called to emergency duty there or elsewhere in the event of a national emergency."

It was also pointed out that the closure of the PHS hospitals in the early 80s also put a crimp on opportunities for clinical service by physicians as an attractive starting career in the PHS. During those earlier times individuals from the Division of Hospitals would flow freely to other units in clinical, but also in research and administrative roles, providing the Service with a useful cadre of experienced physicians. What remains for entry physician positions now is service with the IHS, Epidemic Intelligence Service (EIS), Coast Guard, Immigration and Naturalization Service (INS) and Bureau of Prisons (BOP)

The EIS is the one remaining growth area for physician PHS Commissioned Officers because there is a strong preference that all EIS officers be PHS Commissioned Officers so that they will be fully and rapidly mobile. This program has been training field epidemiologist since 1951. The Epidemic Intelligence Officer program has about 70 to 75 new individuals in their training program each year. In 2002 they had 90 individuals with 65 of them being PHS Commissioned Officers. Others are internationalists and some are designated through a competitive process from DOD units. Most of the EIS officers are physicians.

From the 2001 EIS class, one person went into private practice, about 80% went into public health, (half at CDC) and 20% went to academia as a teacher or for further education. As noted above, in order to join EIS, all physicians are required to be PHS Commissioned Officers, and many of the other categories choose to be an officer because of salary, although CDC does not require them to do so. Some EIS officers are transfers from other Agencies like NIH or FDA and even a few come from IHS.

In terms of filling CDC posts, a large proportion of the PHS Commissioned Officers at CDC are from the EIS program (70 to 80%) and of these, 90 to 95 % are physicians. The pride felt by these former EIS officers devolves almost entirely from identification with CDC and not from the Commissioned Corps

Some interviewees noted that in the last ten years or so the motivation for physicians to join the Corps has been more about compensation and less about a career per se. For that reason many physicians, given the opportunity to make a choice, select Title

38 employment, which is much like Title 42 at NIH for scientists. This option is particularly rewarding in regard to initial pay for physicians who are in the difficult to recruit specialty areas.

A person coming out of medical school can make between $100,000 and $125,000 in an HMO where as the Corps can only offer them around $80,000 which includes some incentives and the prospects of going up to $180,000 in a reasonable period of time. The "real income" is much higher but it is difficult to sell this fact at the time of first employment.

It should be noted that in the Bureau of Prison, a non DHHS Agency, the vast majority of physicians are Civil Service employees because of compensation concerns and also due to the fact that many applicants do not intend to remain in the BOP, or even in government, for a career.

One problem noted in connection with the hiring of physicians in the Corps is that a "culture" exists in some Agencies to avoid recruiting PHS Commissioned Officers for the long term. It is noted by some of those who oppose Commissioned Corps appointees that they can recruit lower paid people and thus cut their immediate costs. The "short term" supervisor is often satisfied with that short term saving.

Pharmacist recruitment

Pharmacists interviewees noted that there were distinct differences among the Agencies as regards the ease of recruitment and placement. In the case of IHS and the INS, the process is often driven by PHS Commissioned Officers in the systems who are in the habit of asking for a specific number of Commissioned Officer pharmacists for open positions. This initiates the recruitment process among PHS pharmacists to deliver the required number of qualified people who can be placed into those open positions. This is also true to some extent in the FDA, particularly in recent times when national security issues resulted in a demand for a number of pharmacists in a variety of FDA programs.

The pharmacists are also clear as to the role of their Chief Professional Officer and the PAC on the issue of recruitment. They conclude that the role of their Chief Professional Officer is to develop recruitment, placement and mentoring policies; develop a pattern of sustainability of the recruitment and placement process; and support "capacity building" for the future. The latter implies working within the system to be sure that the organizational structure supports the overall process.

In reflecting on the focal point for recruitment, pharmacists are particularly enthusiastic about the value of the Associate Recruiters program (active duty officers) combined with the Auxiliary Recruiters (former PHS officers) in making university level recruitment work well. The Associate Recruiters visit the University at least twice a year and the school gets the experience of knowing that the PHS officer pharmacists are dong more than "classical" service. The contact people at the university often ask

for active duty officers to visit and participate in classes that deal with a variety of subjects ranging from regulation, research, and administration to classic pharmacy services in a clinical setting.

Pharmacists, as well as dentists and physicians, are interested in expanding the COSTEP program into a two year stint. Pharmacists, in particular, credit the COSTEP program with attracting large number of their new officers into the Corps. A former Chief Pharmacy Officer was responsible for developing affiliation agreements with 14 colleges of pharmacy for their students to spend their required internship at CDC as a COSTEP student. This activity has been extremely effective in recruiting people who then go on to Commissioned Corps service in a variety of Agencies, not only CDC. The DCP acted as an adjunct in this process, with the local pharmacy officers or colleagues at the school doing most of the actual recruitment. At one time DCP had a pharmacy recruiter on staff who was very helpful in placing former COSTEP students after graduation.

Dentist Recruitment

The leadership of the dental discipline feels that every officer should be recruiting for the Service as a whole and therefore needs to be somewhat knowledgeable regarding the other disciplines and recognizes that in many positions officers from all disciplines are interchangeable, particularly at the leadership level.

Dental vacancies and turnover rates are quite different in the various Agencies. IHS, as noted below, employs several dentists with a major job responsibility for recruitment since that Agency has high vacancy and turnover rates. (a 23% dental vacancy rate and a 30% turnover rate at the time of this assessment). In contrast, the BOP has a 4% vacancy rate in part due to the fact that incentives for dentists are substantial. As a result of repayment of student loans for service in remote stations as well as recruitment bonuses, 85 dental officers in the BOP are now receiving loan repayment stipends.

The dental category effectively uses the recruitment materials made available by the DCP and has also developed additional materials for their specific recruitment efforts (i.e. IHS specific material)

Officers in the dental category feel that to enhance recruitment they need a process wherein every officer has broad career options and where mentoring is provided as a routine matter with all officers being permitted to obtain further education, particularly in public health, in order to serve the Corps more broadly and to sastify overall national needs.

A very interesting dilemma presents itself for the dental officer. They are recruited in the main for a clinical position and most begin their careers with IHS, BOP and the Coast Guard. The leadership of the disciplineas noted above is concerned that the service should be providing continuing and long-term education for these people so

that they can also be subsequently placed in research, administrative or policy positions and thus better serve the Corps and the nation.

The discipline also recognizes that recruitment may take place at different levels. One level is the recruitment of the beginning clinician. Another is the recruitment of an experienced dentist who may also have had training in public health, management or in research methodology. Related to that is the matter of recognizing that not all dentists want to or should stay for a full 20 to 30 year career. Change is recognized as good for the individual and good for the Corps which is invigorated by a change in its makeup. The discipline leadership therefore recognizes that recruitment should consider the person who wants to stay 4 or 5 years as well as 25 years.

The IHS has dental officers specifically assigned to recruit for their Agency. In 2002 they hired 17 PHS Commissioned Officer dentists and 21 civil service dentists. The principal dental recruitment officer at IHS noted that there is a significant financial advantage to a dentist being hired through civil service because they can be hired through Title 38 which sets a new dentist's salary at $85,000 and they can also offer that civil service dentist around $24,000 to repay their dental school loans. This IHS officer noted that if he does not hire civil service people then he does not meet the quota for vacancies in IHS. On the other hand, he does counsel civil service dentists regarding switching to the Commissioned Corps within 5 years of their original hire so that they can get their civil service time credited to the Corps retirement system and help in their final retirement "package."

Recruitment and placement differs for each discipline. The recruitment of Health Services Officers is due in large part to the work of the associate recruiters, active duty officers who take on recruitment as a volunteer extra task. The value of the associate recruiters has been underscored by almost all of the disciplines.

Agency-Related Recruitment Issues

Many interviewees noted that it would be most practical to work within the existing "organizational culture" in order to affect the kind of changes in recruitment and retention that are targeted as important. They noted that culture changes slowly and we should not look for miracles that only occur in fantasies. Thus, while in theory it would be productive to have all positions "owned" by the Surgeon General, it is not likely that such a change will be forthcoming in the near future.

One interviewee noted that there is no way that you can tell an Agency head that you are going to remove the process of selection of their personnel from them and centralize it entirely. That fact makes it literally impossible to put the recruitment process totally back with the Surgeon General and expect it to thrive.

There is a distinct disconnect and clearly not a "seamless" transition between recruitment and placement. As noted previously, recruitment is usually relatively successful but when the applicant is cleared for commissioning and must in essence

seek his or her own first placement in an Agency the process looses inertia. This is at least in part due to several Agency level problems as noted above and also detailed by Agency below.

Immigration and Naturalization Service

The Division of Immigration Health Services at the Immigration and Naturalization Service (INS) does 60% of its own recruitment with DCP providing them with the applicants for the remaining 40%. Of that 40%, about one half are by transfers of commissioned officers from other programs.. With only five technicians at DCP to process new applicants for a Corps of almost 6,000 officers, the unit is hard pressed to keep things moving smartly. In order to get people processed in a more timely fashion, staff officers at INS have to do a lot of the paper work. If they did not do this the sheer volume of the load on DCP makes it difficult to get people on board in a short period of time.

Centers for Disease Control and Prevention

As noted above, CDC does its own recruiting for its very effective EIS program. They generally receive about 300 applications and select between 75 and 90 individuals for the program. CDC is not comfortable with the use of DCP in their recruitment of these mainly physician officers. "If DCP were to do the central recruiting it would be a matter of concern for CDC" said one highly placed officer. They feel that there is no need to change the way people are recruited because "you don't fix something that is not broken." CDC officials indicated that they are clearly not 100% comfortable with the track record of DCP.

Bureau of Prisons

The BOP employs almost all of their dentists and pharmacist as PHS Commissioned Officers but only a small number of their physicians are in that category because they can offer them a Title 38 employment with a higher salary. For a new physician graduate the equivalent of a GS 15 at step 10 is around $120,000 as compared to $45,000 to $55,000 for a starting PHS Commissioned Officer.

The BOP has a very positive record with use of the COSTEP process. For example, with pharmacists, they have been able to retain a large number who formerly served in a COSTEP position. Unfortunately, the BOP central office has chosen to cut funds for the COSTEP program.

National Institutes of Health

At the NIH a system of "tenured track like positions" has been developed for "Research Officers" that manages to provide an incentive type pay for physicians who are not in clinical, but are rather in research posts. This process provides equity for these hard to recruit and retain specialists who are critical to the mission of NIH.

VII MILITARY EXPERIENCE IN RECRUITMENT

The process of centralized recruitment follows a pattern in all of the other uniformed services where at least the first assignment is handled by a centralized system which is backed up by a full skills record and tied to a data system called *resumex services* that makes it possible to access the skills, background and specialties of all active duty officers.

Mentoring also takes place out of a central command where all disciplines and sub-disciplines (i.e. Nurse Anesthesiologist, Infectious disease physician) have a mentor that keeps in touch with the individual and assists in career counseling and mobility.

The recruiting process for health professions officers in the U.S. Navy is controlled through a central recruitment command and carried out exclusively by uniformed Navy personnel. In many cases this is done at recruitment centers but much of it is done at professional meetings and at universities.

Recruitment officers are given quotas for their recruitment targets and are evaluated on the number of recruits entering the Navy and not by numbers of people contacted or seminars attended. If a military recruiter fills billets he or she does well. If not, they get transferred to another job. The quotas are provided on the basis of a force management process where the total numbers of health professionals needed for each discipline is calculated on a long-term basis. The Navy also evaluates and awards scholarships for health professional schools at a central facility with centralized resources. This year (2003) they gave out 300 medial school scholarships

A key point made was related to the use of retired or former Navy Officers at the schools of the health professions as auxiliary recruiters. In those locations the former officer is commissioned as a member of the active Navy reserve and wears the uniform periodically and is paid as a reserve officer (without attending weekend or summer drills). Their obligation is to expose their students to a potential career in the Navy and to be able to steer them to the proper channels. They bring these University reservists from medicine, dentistry, nursing, etc together from time to time and update them on the issue related to recruitment.

The Naval Dental Corps relies on a scholarship program to assist in their recruitment. They have 30 three year, 30 four year and 10 two year scholarships. They also have authority to institute a program similar to the IHS program to pay back matriculation costs on a year to year basis.

Dental recruiters have found that though applicants frequently talk about "flag, uniform and country" often it is the financial support alone that attracts the individual and that comes through after they have been on duty for a while. Their retention is not as good as they need it to be and they are considering instituting a post-entry program of debt repayment to offset academic debt by officers who have been in the Corps for a period of time.

When a dentist comes into the Navy they can take advantage of a one year program that gives them additional clinical experience. In some cases it is the equivalent of what they need to pass a state dental exam. If they take the additional year, they do not have that year credited toward their payback obligation time. The Navy also sends their dentists for extended or specialty training to meet the needs of the service. When they do so, the officer accrues additional years of obligation to the service.

The Navy is considering sending young officers out to the Universities to chat with the students and serve as a recruiter for young graduates. This is similar to the Associate Recruiters Program of the PHS.

Like the other military services, the Navy carries out a "sponsor program" where a new officer and the family are helped to get settled in the community. In addition in many locations they are given an extended orientation in order to help them in the transition to military life.

A former military officer now serving in the PHS provided insights into recruitment and retention issues in the PHS as contrasted to that in the military. He noted that, in contrast to the PHS, in the military there is a consistent infrastructure to support the recruiting function. This structure begins with a clear recruitment target for each discipline that is driven by the needs of the service and is determined by a force management process.

A key factor in the strength of the military (and the PHS) is the development of an active or ready reserve because the service must have a universe of people to draw from to meet unexpected national needs . No uniformed service can maintain everyone who may be needed at any one time on active duty status. It is too costly and wasteful of human resources.

VIII OTHER ISSUES RELATED TO RECRUITMENT AND SELECTION OF PHS OFFICERS

Civil Service and DCP: Two Competing Personnel Systems?

Agency human resource people are almost exclusively Civil Service personnel. Some of these people have negative feelings about the Corps, but in general terms the major problem is that they lack a full knowledge of the Corps and the benefits to their Agency Secondly, even if they are knowledgeable about the Corps, they suffer from the disconnect between the recruitment efforts of the DCP, the CPOs and the PACs and their own Agency level human resource needs.

In some cases Agencies may also hesitate to select a PHS Commissioned Officer based on the misconception that the overall costs of placement of the officer vs. the civil service employee is more expensive. This was noted above in the recruitment of physicians in the BOP. They also have a concern that the officer may one day be transferred out of their control and that if their employees are moved to temporary emergency duty they may be gone for an extended period of time.

In connection with certain disciplines there is a resistance to paying for "accession bonuses" (one time incentives paid to officers such as pharmacists and dentists) when they are not sure that the person will stay in the Agency for a reasonable number of years. Given that the administrative and human resources people are also predominantly civil service personnel, they are interested in having the close allegiance of each and every employee. They look at each new employee as someone who will remain with them for their federal entire careers. They are oriented to "owning the employee".

While there is a need to recognize that most officers should be available for transfer in order to maintain the mobility of the Corps and to permit people to have opportunities for other more challenging and rewarding assignments, it should also be recognized that some officers are so specialized in their current expertise and job that they will remain in one or two positions for their entire careers.

In addition, Agency heads and many of their associates are appointed by the political administration running the government. It is a practical issue to recognize that they have a "short-term view of life" as compared to a long-term view that would predominate in employees such as those in the Corps. Priority effort needs to be exerted with those "appointees" to demonstrate values that coincide with the views of the PHS such as flexibility, mobility and 24/7 duty status.

What could follow from such an understanding is an agreement by the Surgeon General with each Agency head as to how many of the open positions in that Agency should be filled by PHS Commissioned Officers. Also, a number of interviewees said that we should be seeking to develop agreements with other Agencies such as The Department of Agriculture and the Department of Veteran's Affairs.

A number of interviewees noted that it would be prudent to alter the recruitment practice at the Agency level in order to more fully integrate civilian and Corps officer recruitment. The civilian human resources staffers need to be charged to include both civilian and Corps opportunities in their hiring of health professionals. They will need to be made fully competent in the procedures that are involved in hiring under both systems. The recruitment process also needs to highlight to the prospective applicant the fundamental differences between the two personnel systems. All other things being equal, the prospective PHS Commissioned Officer needs to be presented with the range of global opportunities that will be available to him or her as differing from that of a civil servant. While both may change Agencies and positions, change will be inevitable for the officer.

The integration of civil servant and PHS Commissioned Officer recruitment has been initiated with some marked success at FDA. In order for that to happen it required that a high level PHS Commissioned Officer in the Agency serve as an advocate in the strongest possible terms for that kind of change and follow through on a long-term basis to be sure that it is works in practice.

The notion of "integrating" the hiring of both systems has been introduced as a standard practice at the FDA. In the FDA the assignment of a PHS Commissioned Officer at the Agency-level Human Resources unit (introduced by Surgeon General Koop) has remained viable. In that Agency, a PHS Commissioned Officer Representative has also been assigned to almost every major human resources unit (Centers).

The head of the Human Resources office at FDA has done a number of things to enhance the use of PHS Commissioned Officers including (1) conduct of training programs to demonstrate to human resource people in the various Centers and other units the comparative financial and performance value of having officers on their staffs as well as the advantages to the employee of being a Corps officer; (2) maintaining close contact and participation with the head and members of the DCP by assigning PHS Commissioned Officers to the various human resources staffs and (3) the conduct of educational seminars to advise civil service personnel about the process for selecting PHS Commissioned Officers.

It is clear that the institutional attitude of the FDA is that Corps officers are valuable assets and the Corps is much more than a personnel system In the FDA, the senior PHS Commissioned Officer "monitors" the process to assure that equity is the standard in the offering of PHS Commissioned Officer opportunities. This senior officer takes on this role as part of her responsibility as the designated Agency member to the Surgeon General's Professional Advisory Committee. It may be, she noted, that such assignments should take place in every Agency if equity in recruitment is to be achieved.

The Corps as a Career Option and not a Personnel System

It is a well established, if not a documented fact, that in some Agencies of the Department the Commissioned Corps has been used only as an alternative personnel system without exacting the individual's full commitment to the Corps. That and the practice of granting instant Flag Officer positions are demoralizing to committed officers. On the contrary, the practice of promotion to leadership positions by promotion from within is one that strengthens morale and contributes to committed leadership.

It is equally important that top level positions in Agencies be filled by PHS Commissioned Officers. The determinants which make that practice appropriate are found in the positive qualities which derive from having an officer in leadership positions including mobility, flexibility and a long-term outlook for the entire enterprise.

A head of the FDA Human Resources unit noted the following six factors as the guiding principles of marketing the Corps as a career within the Agencies:

1) Ensure that strong Corps Officers who are willing to be involved in the recruitment process are in key leadership positions within the Agency.

2) Educate civil service supervisors as to the advantages of selecting PHS Commissioned Officers and inform them of how to provide incentives for their work.(i.e. awards, recognition, parity in benefits)
3) Educate human resources staffs as to the merit of advertising vacancies for application by PHS Commissioned Officers as well as civil servants and provide the opportunity for civil servants to convert to Corps status.
4) Work closely with the various staff officers in DCP
5) Enhance communications in the broadest sense using all of the tools available including seminars, group teaching, web sites and personal mentoring.

Creating a system where the Surgeon General is fully in command of all Corps officers would make the Corps a clear cut career option rather than merely a personnel system. However, as noted above, the reality is that the heads of Agencies are not likely to want to give up the control of budget, personnel and policy. Interviewees noted that "anyone who even thinks that the head of NIH or CDC report even to the Secretary are ill informed." They serve, it was concluded, at the pleasure of their constituency groups and key member of the Congress. Changing the current process to a billet system controlled by the Surgeon General is going to be very difficult even if needed.

Increasing the number of PHS Commissioned Officers would alter the relative influence of Corps officers. It has been suggested that the 900 or so officers who are in administrative positions might concentrate on hiring PHS Commissioned Officers for vacancies that they control. If that were done by having each of the 900 hire only one new officer per year; in two years it would result in 1800 new officers.

Many interviewees commented on the fact that every recruitment officer, including senior officers, must be able to make the case when asked "Why the Commissioned Corps?" All such people they said should understand that the health of the nation is tied to the security of the nation, including the health security, and thus the defense of the nation. Whether by natural or national impact, all PHS Commissioned Officers are involved in the health of our nation and that is why national preparedness is so critical.

Retention and Mentoring

The comment was frequently made that retention is often determined by future opportunity, recognition of accomplishment and appropriate promotion within the system. When this is well known, recruitment is enhanced. When it is practiced the result is that the best and the brightest remain in the service.

Many feel that career mentoring should rest, as is now the case, with the Chief Professional Officers acting as individuals with their officers and as an aggregate group. In addition there must be personnel in DCP with a specific responsibility for mentoring who can coordinate and augment the efforts of the Chief Professional Officers. Most interviewed felt that all officers of all disciplines should receive

leadership and public health training and experience to assure that senior leadership posts in the Service could be achieved by all officers .

Career changes should be guided by the CPOs acting in conformity with individual career plans, the needs of the Service and with the concurrence of the Agencies involved in such position transfers. Many interviewees noted that if the system takes care of the officer's development they will remain with the Corps.

It is of interest that at CDC, two groups of employees are closely mentored. The mentoring process is followed in two of the programs within the CDC Epidemiology program office, namely the Epidemic Intelligence Officer (EIS) and the Public Health Advisor (PHA) programs. This mentoring is carried out entirely as a function of the operations at CDC and is not done in the same manner in other units or Agencies of the Public Health Service.

When an EIS officer is assigned to a State or locality, an agreement is struck with his or her supervisor and an individual at the CDC Epidemiology Program. They guide the officer in his first assignment and that process carries through for a career related to the functioning of the Epidemiology Program office. There is a well maintained and updated "data book" on each officer who has gone through the program since its inception in 1951. This is a voluntary program of updating that has nearly 100% participation. Such a system of record does not exist for any category of officer in the Corps as such. The same type of process is followed for the first and subsequent assignments of the PHAs.

While many officers note that remuneration was not a factor in their decision to remain in the Corps, there is some evidence in places like NIH and CDC, that officers switch from a Corps position to appointment as a Title 42 employee (Scientist) or a title 38 employee (Physician) where a more attractive salary is most tempting. Title 42 employee positions, as an example, can enjoy salaries set by the Agency at as much as $250,000 without the need to advertise or to require competitive analysis. An Agency that could but does not use Title 42 and 38 opportunities is the FDA

The impact on retention of the offering long-term training to active duty Regular Corps officers was noted by a number of interviewees. Resources for such training were once lodged within the office of the Surgeon General. Such training not only imposed a requirement for the officer to remain in service for a time equivalent to the training period but also pointed up the fact that they were serving the long-term needs of the nation. Currently, training funds are now controlled by the Agencies and they are not generally inclined to provide them to anyone who would be interested in switching Agencies or even changing their job focus through education from clinical to administrative or research positions despite the value to the public health community in general.

Many regard it as important to have at least a two week orientation program, the Basic Officer Training Course (BOTC) combined with CCRF training conducted before the

person enters active duty. In addition to learning how to wear their uniform and basic military courtesies, new officers would be indoctrinated into the "culture" of the PHS Commissioned Corps and to the field of public health. This would help them to feel more conformable about wearing their uniform even if they get less than enthusiastic support from other colleagues and their supervisor. One NIH officer noted that younger officers at NIH do not have an aversion to wearing the uniform.

IX SUMMARY OF FINDINGS

- Validation of the lack of coordination in recruitment, selection and routine mentoring of all categories of Commissioned Officers
- Lack of a force management process including components of an active reserve which can properly guide the recruitment and placement process and of a detailed computerized information system on all officers including those being recruited and those already on duty.
- Lack of a uniform process of developing and monitoring of a career pathway system for all officers which can begin with the initial recruitment process
- Lack of general knowledge of the Corps and its high service potential by the DHHS leadership and human resource unit personnel as well as the general public.
- Lack of information given to civil service and appointed employees about the value and potential of conversion of their employment status to that of a PHS Commissioned Officer
- Presence of antipathy toward the Corps
- Lack of useful Corps-specific recruitment material including special programs such as the Commissioned Officer Extern Program (COSTEP)

X RECOMMENDATIONS

- Develop a force management process, including an active reserve component, similar to that in the other uniformed services which sets out the needs for officers based on the qualifications necessary for each category. These needs should be guided by the national and global health targets of the country. Such a force management system must include a comprehensive data system that records all officers and potential applicants with information that includes skills, experience and specialty certifications. This data system will also assist and support the ongoing and emergency missions of the other agencies outside of DHHS using PHS Commissioned Officers.
- Develop a recruitment and retention system that is under the leadership of the Surgeon General, is geared to a force management process and utilizes a centralized recruitment plan coordinated by DCP or its replacement organization.

- Ensure that the DCP or its replacement organization coordinates and utilizes the Chief Professional Officers and their Professional Advisory Committees, Volunteer Active duty officers serving as Associate Recruiters, and Auxiliary recruiters who are members of the PHS Reserve component and are on the faculties of health professional schools. In order to carry out this mandate, the unit must be provided with sufficient monetary and human resources for the task.
- Develop and put into place a billet system that serves the needs of the force management process and permits the flexibility of assignment that serves the ongoing and emergency needs of the Nation. This will require firm agreements between the Surgeon General and Agency Directors as to the billets to be allocated to commissioned officers and which will involve an assessment of those positions where a commissioned officer might be a preferred incumbent.
- Each Human Resources unit throughout the DHHS agencies and in Departments outside of DHHS who employ Commissioned Officers should include, at the director level, PHS Commissioned Officers to assist in the process of recruiting and placement.
- Ensure that from the point of first recruitment and placement, and throughout their careers, each officer has a defined career pathway which is reviewed and amended periodically. This process shall be monitored by the Chief Professional Officers and DCP, with a view toward ensuring that cross-over opportunities to leadership posts in all agencies are available as appropriate.
- Ensure that the process of recruitment and retention follows the findings of the Recruitment and Retention Project (PHS Foundation, March 2003) which pointed up the need for recruitment to be conducted in concert with discipline-specific "age-appropriate" officers and with a priority focus on the use of the mechanism of COSTEP.
- Examine current positions that are predominantly filled by civil service personnel and determine if it would be appropriate to place commissioned officer in these positions, particularly those that include a major placement in State and local health authorities. Such a process is supportive of emergency service capacity. Examples of such positions that may filled by both commissioned corps and service applicants are the public health advisor and public health analyst positions at CDC.
- Each officer on entrance to the Corps, and throughout their careers should be given the opportunity to be exposed to the history and standards of the Corps. Further, it is incumbent on the Service to provide leadership, emergency response and preparedness training for each officer, along with the opportunity for further graduate education in leadership, public health practice and scientific skill building for those officers who enter the regular corps. This notion is related to the recommendation above regarding career pathways for each officer.

Appendix A

List of Interviewees and Agency Affiliation

Name	Rank	Agency
Richie Taffet	CAPT (Ret)	NIH
Eugene Migliaccio	CAPT	INS/OSG
James Hughes	RADM	CDC
James Dowdy	CAPT	CDC
Austin Hayes	CAPT	CDC
Amanda Dunnick	LCDR	ATSDR
Paul White	Civil Service	CDC
Jan Lognecker	Civil Service	CDC
Steve Thacker	RADM	CDC
William Vanderwagen	RADM	IHS
Mary Couig	RADM	FDA
Dushanka Kleinman	RADM	NIH
Terry Golden	CAPT	DCP
Richard Walling	RADM	OS
John David	LCDR	INS
John Olsen	Civil Service	INS
Mary Louise Ganaway	CAPT	INS
Eric Ewers	Sr. Enlisted	US Navy
Richard Wyatt	RADM	NIH
Marlene Haffner	RADM	FDA
Mary Babcock	Civil Service	FDA
Peter Lynch	CAPT	US Navy
G. Bryan Jones	CAPT	OS
Darrel Pratt	Civil Service	IHS
Scott Murchee	Civil Service	BOP
Timothy Lozon	CAPT	IHS

Name	Rank	Agency
Linda Brown	CAPT	NIH
Jim Sayers	CAPT	OSG
Sarah Krajnik	CAPT	US Army
Rauf Hanna	Civil Service	IHS
John Freidrich	Civil Service	IHS
Betsy Bercovich	Civil Service	IHS
Claire Helminiak	CAPT	IHS
Darren Vicenti	Civil Service	IHS
Alan Croft	CAPT	IHS
Kevin Chadwick	CDR	IHS
Chris Watson	CAPT	IHS
Stephen Tetrev	CAPT	IHS
Ed Stein	CDR	IHS
Kim Smith	Civil Service	IHS
Norm Cavanaugh	CDR	IHS
Diane Montello	Civil Service	IHS
David Yost	Civil Service	IHS
Robert Hallowell	Civil Service	IHS
Kevin Buck	SGT	US Army
Penny Coppola	Civil Service	DCP
Ann Randall	Civil Service	DCP
Angela Williams	LT	BOP
Nathan Tatum	LCDR	ATSDR
Edwin Vasquez	LCDR	DCP
James Schaeffer	LCDR	NIH
Patricio Garcia	LT	INS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Food and Drug Administration
Rockville MD 20857

August 15, 2003

Secretary Tommy Thompson
Secretary, Department of Health and Human Services
200 Independence Avenue
Hubert Humphrey Building
Washington, DC 20201

Dear Mr. Secretary:

On July 3rd you announced a Transformation of the US Public Health Service Commissioned Corps (Corps) with significant changes to support newly established goals, especially for deployment of officers. The Corps is a major resource that benefits the Department and each agency, and exemplifies the "One Department" vision. The Food and Drug Administration, which relies on the significant capabilities of Corps officers, looks forward to assisting you in this important Transformation endeavor. On July 28, 2003 the Division of Commissioned Personnel (DCP) issued draft Commissioned Corps Personnel Manual (CCPM) chapters referring to USPHS Commissioned Corps Permanent Promotions, Temporary Promotions, Deployment, and Details. The comment period of one week was extended to two. I have been meeting with my Senior Corps Officers to discuss the proposed changes described by the draft policies. They in turn have met with FDA Corps members. The comments below reflect their and my concerns. I know that the 28 July proposals are extremely important to the Corps Transformation. I want to emphasize that I and FDA's senior Commissioned Corps officers are very much in support of the Transformation, and I am writing in order to make sure the Transformation is implemented successfully.

The changes proposed within these documents are sweeping. I am concerned that some of the key ideas and implementation strategies that I have discussed at considerable length in recent months with the Surgeon General and the senior leadership in the Corps are not included. As you are aware, there was a Commissioned Corps promotion task force which made recommendations for change in the promotion process. The documents available on 28 July differ in significant ways from the task force recommendations. Consequently, I feel that the latest proposed changes would benefit from further analysis in order to implement effectively.

The FDA Officers have provided many comments and have voiced many concerns which, in order to implement the Transformation effectively at least in FDA, I feel must be reviewed and addressed in some way prior to the issuance of any final document. Of particular concern are the provisions in the policies that apply retroactively. In order for the Transformation to succeed, I believe that the following comments must be reviewed and appropriate action taken:

1) Deployment: Meeting newly proposed PHS Deployment Standards (essentially membership in CCRF) will become a prerequisite for junior officers to be considered for promotion and an overarching consideration for senior officers for promotion. There is no phase-in period for this requirement nor are there any opportunities for a waiver, based on needs of the service/agency.

In your July 3, 2003 announcement of the Transformation of the Corps, you spoke to parity with the military services. My understanding is that 20% of military officers are waived from meeting deployment standards. I am fully committed to the availability of our officers for necessary deployments. However, to impose these standards on the entire Corps immediately and without exception may well end up reducing participation and thus availability of officers for deployment.

This concern could be addressed by allowing a phase-in period for the implementation of needed deployment standards. Infrastructure necessary for supporting deployment is currently not in place and must be in place prior to any implementation of Corps-wide deployment standards. Indeed, our Corps staff have been working with the Surgeon General's office in recent months to try to develop a deployment matrix that would enable many more officers to participate in CCRF with much less disruption for their own lives and for the agency. Also officers must be provided an opportunity to determine if they are able to make the necessary commitment to CCRF. Unlike the military, PHS officers currently are faced with achieving deployment readiness solely through their own initiative while being responsible for their full-time job. Additionally, officers must have strong support from their programs for the time to obtain necessary training and ultimately deploy. The Corps must have in place training programs and policies for training time-off, funds for deployment uniforms/supplies, and other means of support for officer deployment readiness. Although the draft deployment standards do not include physical fitness requirements, they currently exist and should continue. Physical fitness standards should be mission/job-specific and should not be imposed equally across the board for all officers. Also, there will be individuals who, because of family considerations or physical conditions, may not be able to become a CCRF member. They did not join the Corps with deployment as a requirement, although I recognize that with a change in mission, additional responsibilities may be applied. They are, nonetheless, extremely talented and committed officers. To impose such requirement in mid-career will disrupt their participation in the Corps, and thus Corps and agency activities.

While participation in and maintenance of CCRF deployment standards is critical, it must also be understood that these officers were hired by the Agency for a specific Agency mission. I am very concerned that the emphasis on deployments will be a negative incentive to many civilian supervisors in the hiring of Corps officers. Again, I firmly believe that this can be addressed with effective planning, and so a deployment matrix should be developed as soon as possible.

2) Promotions for PHS Recruits from the Armed Forces: The proposed changes in the promotion process - both permanent and temporary - raise important issues with respect to our recruitment of personnel from the armed forces. The FDA has long been fertile ground for recruitment from the Army, Navy, Air Force and the Marines. We have, in the last year, recruited many very talented officers from these sister services. The new promotion guidelines clearly make a PHS

career less attractive to these fine and capable individuals relative to other recruits. There is no apparent reason to impose such measures for promotion. If the proposal as drafted, is effected, we will lose the ability to recruit and maintain the services of many individuals, especially those with bioterrorism and counterbioterrorism expertise. The proposed new definitions state that no more than one year with another service can be counted toward promotion. This is not in concert with the PHS sister services.

3) Exceptional Proficiency Promotions: Occasionally officers fulfill assignments and/or assume levels of responsibility that are significantly different than their professional peers. Often they are in multi-disciplinary billets. For example, an officer in the pharmacist category with exceptional capabilities could be serving in a management billet normally occupied by a senior physician. Under the proposed changes, a promotion board of only pharmacists would review the candidate but may not recognize the significance of the assignment. Further, the draft policy imposes a penalty on the officer who does not succeed in being promoted ahead of his peers under this process, which is likely to have unfair consequences in many circumstances. The current system, which requires a written justification from the agency for this type of accelerated promotion, works well because the candidates are reviewed by multi-disciplinary boards. FDA wishes to keep the current policy, possibly modified to make sure it is used only in exceptional cases.

4) Up or Frozen In Grade Policy for Promotions: The introduction of a new policy that limits the number of times an officer can be considered for temporary promotion has merit, but may have substantial undesirable effects as proposed. As you know, the proposed limit is 3 times plus one other chance for promotion if a program makes a special request.

In particular, implementation should be undertaken with an effective force management infrastructure in place. The policy is aimed at officers with consistently mediocre performance or continuing conduct issues, which makes them consistently non-competitive. However, there are many officers who are performing well who could be harmed unnecessarily by this policy. For example, officers located in remote community health clinics or small field offices are at a disadvantage when competing for promotion because they do not have the same opportunities for distinctions more readily available to officers stationed in larger offices in metropolitan areas. Unlike the military services, the PHS currently has no force manager to "balance" assignments and training among all officers. Officers in small field office/clinic assignments must, based on their own initiative, find and compete for a higher graded billet at a new location, obtain additional training not available in their community, and get a temporary substitute so they can train or deploy. Since these officers now would also face the prospect of being frozen in grade, they will have more incentive to leave the Corps.

Implementing the policy as drafted also penalizes officers who for personal or professional reasons do not wish to make necessary changes in their life that would make them more competitive for promotion. They may be willing to stay a few more years in their current field assignment because it is professionally rewarding or because of a family situation. Often the

agency benefits by having staff continuity at a hard-to-fill site. This choice, appropriately, should result in no promotion. It should not, however, automatically penalize the officer for the rest of the officer's career, when, at a future date the officer does decide to take the steps needed to achieve promotion. Also, some officers must stay in the same location, often hard-to-fill locations, for a set number of years to pay back a scholarship or loan repayment. These officers, who often have to overcome special circumstances in order to get their health training and get into the Corps, should get waivers.

Officers who have been passed over three times currently will get one more opportunity for promotion, but under new promotion precepts for which they will not have enough time to prepare. An officer must provide all supporting documentation to their OPF by Dec 31, which leaves only a few months to address their deficiencies, such as achieve deployment readiness and/or transfer to a higher rated billet. Because of the short period of time, it appears to be unreasonable to implement this criterion for the next promotion cycle. Obtaining the necessary immunizations alone requires as much as 6 months time.

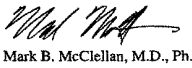
A stricter promotion policy is entirely consistent with many of the goals of the Transformation. However, this should be accompanied by steps that encourage excellence and that recognize the diverse circumstances of Corps personnel over their careers, to ensure that the very best and most dedicated are promoted – not simply those who do not have special circumstances in their career paths.

5) Details: Over the years the PHS has participated in providing full time teaching staff at the Uniformed Services University of the Health Sciences (USUHS). USUHS trains a large number of PHS officers in the MPH program, the Graduate School of Nursing, and in F. Edward Hébert School of Medicine. Many of these talented teachers have become leaders at the University as department chairs. The proposed CCPM discussion of details speaks to a maximum of 5 years. While 5 years is reasonable for most details, for those in academia teaching our future PHS doctors, nurses, and other leaders, a blanket personnel order should be implemented, similar to that in effect for Bureau of Prisons, EPA and The Department of Agriculture.

As FDA Commissioner, I am very proud of the accomplishments of all our Officers. The recruitment of new talent is very important to the FDA. In the last two years we have increased the number of FDA officers by close to 200 new recruits. Ideally, I would like the promotion and deployment standards currently being promulgated by the DCP to have a constructive and healthy effect on recruitment and retention of PHS Commissioned Corps Officers. Based on comments received widely from our PHS staff, I am concerned that, if implemented as proposed Corps and civilian morale as well as Agency and PHS effectiveness could be seriously negatively affected by the imposition of standards such as those proposed. Now more than ever, we need a flexible responsive Corps is needed by our nation to preserve our health and safety. That's why it's so important that we get the Transformation strategy right, and I and my senior Corps officers stand ready to do all we can to make that happen.

Thank you for this opportunity to provide comments on behalf of FDA and our excellent Corps staff. My staff and I look forward to working with you in the Corps Transformation. Further, I look forward to discussing these issues with you along with other OPDIV Heads.

Sincerely,



Mark B. McClellan, M.D., Ph.D.
Commissioner
Food and Drug Administration

cc: C. Beato
W. Turenne