SYNCHRONIZING U.S. GOVERNMENT EFFORTS TOWARD COLLABORATIVE HEALTH CARE POLICYMAKING IN IRAQ

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PREFACE

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ABSTRACT

A primary requirement in achieving strategic aims in Iraq is the reestablishment of a functional health care system. Currently, there is no agreed solution among the stakeholder agencies regarding strategic health policy in support of this objective. Health care is a component of basic human needs and should be accessible, affordable, and effective. Following combat operations and phasing into stabilization operations, basic health care infrastructure and systems have often been either disrupted or degraded altogether. To address this situation, the U.S. Government requires a coordinated interagency approach to formulate a strategic health care plan. Incorporating all relevant players into this endeavor will promote sound organizational design, unity of effort, and a culture favorable to synchronization. This paper contains specific recommendations and advocates a renewed effort toward addressing them. The primary constructs under review are U.S. Government organization, leadership, and culture as they relate to a strategic health care policy. This approach will reduce redundant efforts, conserve resources, and augment the legitimacy of the new Government of Iraq while supporting U.S. national strategic aims.

SYNCHRONIZING U.S. GOVERNMENT EFFORTS TOWARD COLLABORATIVE HEALTH CARE POLICYMAKING IN IRAQ

> [S]trategy is defined as the systematic, integrated, and orchestrated use of various means to achieve goals.
>
> —Brad E. O'Neal[1]

A primary catalyst in achieving our strategic ends in Iraq is through the formulation of a consolidated and cooperative strategic health care policy to enable the successful operation of the Iraqi health care system. An often-cited criticism of U.S. policy, however, is that, after the end of major hostilities and transition into stabilization operations, we fall short in post-conflict planning and execution.[2] Rationales for this repeated predicament abound; nevertheless, the failure to adapt and leverage our current systems along a seamless continuum impedes the achievement of functional outcomes.[3] A key tenet on the list of stabilization requirements in a theater of operations is reestablishing a system which tends to the basic human need of health care.[4] An operational health care system can then quickly become a major strategic facilitator in establishing a legitimate, self-securing, and sustainable Iraq.[5] As Lieutenant General David Barno, U.S. Army Ret., Commander, Combined Forces Command-Afghanistan (CFC-A) in 2005, has stated, "Health care is one of the most critical components to ensuring a reduction in insurgency while likewise having an immense long-term positive impact."[6]

Relieving populations from undue suffering caused by a disrupted or degraded health care system ameliorates negative perceptions and promotes the legitimacy of government.[7] The final element of promoting a functional health policy is the eventual transition of responsibility for these systems from U.S. agencies to host nation authorities. Effective transition requires a synchronized approach among all agencies involved.[8]

Establishing a sound health care policy for Iraq requires a collaborative effort on a scale not yet exercised in the history of the conflict. The challenges we face in planning, implementing, and sustaining a viable health care policy in Iraq are ominously multifaceted at best. These challenges are compounded by an overall strategy for health care that fails to fully appreciate the favorable effect a full synchronization of effort would have on achieving a desirable end state.[9] The desired end state is the complete and sustainable management and operation of the Iraqi health care system—by the Iraqis.[10] With a host of differing opinions from international members, as well as divergent views among our own departments and agencies charged with reviving the preexisting health care system in Iraq, the challenge of conducting seamless civil-military operations while deconflicting priorities and strategies is daunting.[11]

The following analysis highlights some of the impediments followed by recommendations for achieving a more coordinated, functional, and thereby synchronous strategic health care policy. Initially, we shall review the history and present state of the problem. Secondly, discussion turns to organization, leadership, and culture as the core constructs of a synchronized health care policy. Finally, there are proposals for new or amended civil-military health care design, training, leadership and cultural change mechanisms. Such steps will enable the U.S. Government (USG) to address health policy operations in stabilization and transitional phase contexts currently and in the future.[12]

LITERATURE REVIEW

The development of a more streamlined and effective planning model of health care operations, regardless of context, begins with aligning the strategic health care plan with the goals of the overall national strategic and joint campaign plans.[13] The current joint campaign plan, for example, emphasizes the critical goals of the national strategic plan, goals which include political, security, economic, and diplomatic components.[14] The diplomatic component is designed to build confidence in the Government of Iraq (GOI), a goal that a synchronized health care policy can significantly further. Health care is a basic precondition for tackling the most difficult challenges faced in the stabilization phases of contingency operations. The phases of stability operations in general terms are initial response, transformation, and fostering sustainability.[15] While many phase requirements can be identified and developed prior to entry into theater, more often than not, the rapid progression of hostilities and projection of fighting forces in predeployment phases may not free up the significant staff resources necessary to formulate a comprehensive strategic plan initially.[16]

Typically the tenets of stabilization operations currently in use in a theater are based on previous, often erroneous, conclusions of a former campaign.[17] To counteract this effect, the relevant players should establish and/or update plans so as to adapt organizational structure to the situation on the ground, select lead agents based on the applicable situation, and sort out specific context-dependent strategic health care tenets to pursue.[18] The membership should include, at a minimum, the key representative agencies in theater that can readily affect operations of local health systems. Historically, these teams have been incomplete: several pronounced examples will illustrate the results of such shortfalls and suggest organizational, leadership, and cultural changes.

History.

History speaks eloquently to our issue. Through past examples, whether specific to health care, or ancillary to it, such as water, sanitation, and infrastructure reconstitution, the past offers indispensable lessons for developing a new synchronous policy.[19] The past becomes increasingly relevant since future departmental and interagency functions will need to be aligned and implemented with the same level of flexibility as asymmetric warfare presently mandates.[20] Health operations in today's operational environment include vulnerabilities, uncertainties, complexities, and ambiguity (VUCA) in the application of organizing, planning, and training requirements.[21] These VUCA elements require great flexibility in application from all players involved.[22] The one constant for the foreseeable future is the requirement that the USG be prepared for operations that closely mirror "national assistance" type stabilization endeavors, and approach them with a cooperative interagency focus.[23]

The history behind interagency cooperation is a mixed bag of personalities, conditions on the ground, and the capabilities of the host nation involved.[24] Although not all challenges are exactly alike from context to context, collectively they tend to touch most of the important bases. They show, for example, the frequent inability of agencies to work seamlessly along differing lines of authority. This inability may be tolerable in environments where interdepartmental differences do not require immediate remedy, but it can be debilitating on the battlefields and mortar-pocked suburbs of nations where we are currently engaged in contingency operations.[25]

Knowledge of the varying levels of civil-military cooperation in previous conflicts provides a foundation for future effective health care policy and planning. One example from the 1989 Panama campaign (Operation JUST CAUSE) reveals failed coordination in reestablishing a stable and functional government after the deposing of General Manuel Noriega.[26] The overall lack of

synchronization led to immense challenges on the ground as agencies across the spectrum failed to implement their plans in tandem with other partners, resulting in disjointed and ineffective outcomes.[27] In contrast, Operation UPHOLD DEMOCRACY in Haiti in 1994 demonstrated a significant improvement. The inclusion of an interagency plan catered to the need for more synchronized civil-military planning (in the form of the Haitian Interagency Working Group).[28] Metrics were devised to measure the success of stabilization operations at the conclusion of hostilities.[29] Although there were still some deficiencies in coordination, the creation of this group, the first in a modern operational scenario, brought about significant improvement.[30] This new organization was developed based on after-action reviews of organization, leadership, and processes emerging from the experience in Panama.[31] These lessons, along with those of other operations, resulted in several updates to policy, culminating with the implementation of Presidential Decision Directive (PDD-56) in 1997, *Managing Complex Contingency Operations.* This document established mandates for the meshing and functioning of interagency processes.[32]

Although historically military planners have given short shrift to stabilization operations, such planners are uniquely skilled in certain areas, particularly in health care and civil engineering. These fields enjoy experienced administrators and managers who practice their skill in peacetime as well as during times of conflict.[33] The military arm of the nation's power will continue to be heavily involved with civil-military cooperation and planning, and should routinely incorporate previous lessons into organizational designs, doctrine, leadership training, and cultural adaptations on a continuing basis.[34]

Interagency cooperation continues to evolve: in 2005 the Bush administration superseded PPD-56 in favor of the new National Security Presidential Directive (NSPD) 44.[35] This directive does outline responsibilities of the agencies involved; however it does not provide for the required structure, matching doctrine, and especially the resources to allow flexibility in application.[36] Currently the USG is addressing some of these shortfalls as part of proposals for a deployable agency structure.[37]

As for the Army, it has specifically highlighted five primary tenets—establish civil security, establish civil controls, restore essential services, support governance, and support economic and infrastructure development—governing stability operations decided upon by the USG. These tenets are reflected in current Army and Department of Defense (DoD) doctrine.[38] These doctrinal statements, however, treat health care only glancingly, failing to detail strategy, planning, or guidance for civilian agencies in collaborating under any specific authority.[39] Even with the movement toward a deployable organizational design at the national and Army levels, the health care community has a responsibility to address shortfalls in the interim.[40] As a DoD component that executes peacetime and wartime missions simultaneously, the military medical community has certain resources capable of supporting nation-building, stabilization, humanitarian assistance, and peacekeeping operations, most specifically as they relate to the restoration of essential services.[41] In contexts such as Iraq and Afghanistan, the medical communities have an implied obligation to conduct the necessary planning, training, and leveraging of joint assets in manpower and experience.[42]

Interagency and interdepartmental challenges, coupled with the lack of an organizational structure to support coordinated activities, present obstacles to synchronized planning.[43] A prime example specific to health care policy coordination surfaced at the Al Rashid Hotel in Baghdad in the spring of 2007 during a meeting about the transportation of medications from a warehouse by Iraqi Security Forces (ISF). The meeting included leadership from the Department of Health and Human Services (DHHS) representing the Department of State (State or DoS) and the Health Attachés Office, Multinational Security and Training Command-Iraq (MNSTC-I) Health Affairs, the Iraqi Ministry of Health (MOH), the Iraqi Ministry of Defense (MOD), and select members of the Multinational Forces-Iraq Surgeons office (MNF-I Surg).[44] Differing agendas and lack of

a unified position prevailed among the USG representatives present. Such differences between disparate institutions is not uncommon and often understandable, but the failure to present a united front in formal negotiations with the host nation displays a degree of dysfunctionality that organizational change alone will not fully address.[45] The problem requires a review of leadership training, planning, and resourcing as well as doctrinal and cultural changes in application at the theater and higher levels to bridge the gap.[46]

These challenges facing agencies and departments in the current context are similar to those experienced during the Vietnam era. During that time, attempts to pacify populations and win the peace included the Medical Civil Action Program (MEDCAP) in which medical personnel would enter villages and administer immunizations and basic health care to the populace.[47] Similar to present-day Iraq, these were "feel good" experiences for the Soldiers involved, but they were not tied into an overall strategy and did not account for the effect on those communities that did not receive this benefit. As one previous medical researcher states, ". . . MEDCAPs accomplished little except to possibly improve the American image."[48] Another Vietnam analyst is more specific:

> Commanders did not have the resources to develop health care systems, solve sanitation dilemmas, dig wells, and change lifestyles that had evolved over the centuries. Such activities required a comprehensive strategy and assistance plan beginning with overhauling the health care delivery system of the host nation. . . . [49]

Even with the introduction of the Civil Operations and Revolutionary Development Support (CORDS) group, designed to address the interagency challenges and synchronize the approach, the medical element was poorly examined for its true effect.[50] This was reflected in Brian Jenkins' observation on medical operations in 1970: "Increases in the amount of our own military efforts are measured, and this is called progress."[51] Measurements of medical "progress" lacked the capability of judging true medical capacity building and thus could not enable any sustainable features of the Vietnamese health system.[52]

Based on such historical and current examples, the USG must continue to seek improvement. Ongoing analyses should highlight models, training, and cultural change to align joint and interagency processes. These organizational processes in turn would promote a unified strategic medical vision in support of overall national policy aims. With so much as prologue, let us review the relevant organizations, leadership, and culture.

Organizational Structure.

The current structures of the agencies under review are the results of decades of ill-directed change, growth, and evolution. Thus the challenge of breaking down barriers to change within and between these agencies can be substantial. Changing the organizational structure of many of these entities demands an executive level focus and a joint vision for all parties. Stove-piped systems, i.e., separate, largely independent lines of command for subordinate elements of a larger organization, coupled with parochial organizational characteristics and values, require robust, narrowly targeted changes and directions to enforce change.

The first element to address is the present overall structural layout, specifically as it pertains to health care systems. For example, the relevant players in this system in the Iraqi theater of operations include, at a minimum, the DoS, DoD, DHHS, United States Agency for International Development (USAID), Nongovernmental Organizations (NGOs), International Organizations (IOs), MNF-I Surgeon, Multinational Corps-Iraq Surgeons (MNC-I Surg), MNSTC-I, MOH, and complementary agencies, plus the Medical Brigade Headquarters (MED BDE HQ) that manages

the U.S. military medical assets in theater. This list is not exhaustive, as there are also a Central Command Surgeon (CENTCOM Surg) and several consultant agencies available through "reach back" systems stateside who are indirect stakeholders. Nonetheless, it is the on-the-ground representatives who form the core working group in theater. Once their organizational roles and missions are clearly articulated and they are emplaced in an organiztional framework that matches design, planning, and training goals, the representatives (whether military official, diplomat, Foreign Service officer, or civil servant) can better integrate into the team and function successfully.

For stabilization missions, one proposal for a new State organization calls for the creation of a Civilian Reserve Corps to address the need for a coherent and fully resourced organization to plan stabilization phases in contingency operations.[53] From the health care perspective, DoD medical resources and expertise would be a valuable adjunct to any such entity. Stabilization environments that have experienced disruption to health care systems require subject matter experts in policy, strategy, and medical infrastructure to adequately address the process for rebuilding. Although the DoD is familiar with executing civil-military operations, each context requires a flexible and adaptive approach. In the case of Iraq, the Provincial Reconstruction Team (PRT) is an example of one such design attempt to incorporate several different professional elements across the spectrum of stabilization operations at tactical and operational levels.[54]

PRTs were initially introduced in Afghanistan as Joint Reconstruction Teams (JRTs), where they achieved some successes in interagency cooperation.[55] The PRTs promoted improvements to reconstruction and restoration of essential services based on availability of personnel. The teams were designed to include experts from relevant agencies in several key areas such as economics, governance, and infrastructure development. However, PRTs often suffered from poorly developed mission statements, lack of unity of command, unclear roles, and, in many cases, limited representation outside the DoD.[56] In 2005 the PRT concept was implemented in Iraq, yet continued to be afflicted by several of the previous shortcomings. The primary defect regarding health policy promotion was the absence of health care personnel in the early PRT organizational designs. However, in conjunction with the "surge" in Iraq in 2007, a new concept of Embedded Provincial Reconstruction Teams (ePRT) was introduced as the next phase in promoting stabilization efforts.[57] These teams now included medical personnel, but with one major shortfall—the vast majority of medical personnel assigned to these teams had little experience in health policy, health planning, or management of health care systems within international or interagency systems. [58]

Organizational Training.

As one might expect, disadvantages from lack of appropriate training, experience, and political acumen can hamper initial efforts in syncing health policy with overall strategic health care plans. Although we could not immediately make up for lack of experience, some training opportunities quickly emerged. These included training and medical orientation for PRTs and ePRTs in country through a weekly meeting run by the Health Attaché Office. This training, however, was ad hoc, not provided for by doctrine, standing operating procedure, or any established strategic health care policy. We may note in passing that critical orientation topics included describing the strategic health plan for Iraq as outlined by the MOH, including indoctrination on the cultural sensitivity of the Iraqi population regarding gender specific medical concerns, and public and private health care options, just to name a few. However, to adequately address the strategic health policy needs of the Iraqi MOH or the USG,[59] we require an upfront synchronized health care strategy created through updates to current doctrine and improved organizational and cultural relationships among the USG structures.[60]

Investing in orientation and training of PRTs and ePRTs promotes our strategic health care tenets locally by providing some basic skills training and management consultation to the local authorities; they could then rapidly become a catalyst for health policy application.[61] The ePRTs could act as the eyes and ears of local health operations in the 18 provinces which make up Iraq and could therefore provide updates and provincial level medical intelligence to enable any adjustments to strategic level planning variables through the Health Attaché Office.[62] This would promote a singular common operational picture (COP) to supplement a strategic vision for all agencies to work from. A vital component of a strategic vision includes assessing the current training available in health care administration in order to design programs that increase knowledge of health policy and strategy. Training programs must incorporate scenarios and other tools capable of improving leadership competencies as well as relationships.[63] One such program, the U.S. Army Baylor University Graduate Program in Health and Business Administration, provides training for Health care administrators in the Army, Navy, Air Force, Coast Guard, and Veterans Administration.[64] Within the last few years, this program has opened slots for Civil Service personnel and expanded the focus to include business administration.[65] The separate services and agencies provide funds to underwrite staff participation in the program. Training, which includes some residency phases, provides to students, regardless of background, experience in health care challenges in a variety of contexts.

If the training components and assets, along with several other key health policy promotion tenets, are set forth prominently in doctrine and policy, the medical elements on the ground will more easily integrate into the overall strategic policy design. These assets would complement metrics and asset distribution requirements. Metrics used to gauge effectiveness of health policy operations at all levels would then follow the same strategic vision.[66]

As the renowned business consultant and organizational analyst John Naisbett declares, "Strategic planning is worthless—unless there is first a strategic vision."[67] The organizational components necessary for collaborating and coordinating on a strategic medical vision and plan in Iraq include, at a minimum, the MNF-I Surgeons Office, the MNC-I Surgeons Office, the MNSTC-I Surgeon, and the Medical BDE HQ—all from the DoD—plus the Health Attaché Office (DHHS), State, USAID, and NGOs from the civilian sector. These interagency players have distinctly different missions and strategies, but aim for the same goal—an operable health care system.[68] While executive order NSPD 44 makes State the overall responsible agent for stabilization operations, the military medical community may contribute substantively to the goal, as it has certain resources and competencies already built into its structures to augment health systems planning, logistics, and construction.[69] Filling civilian agency billets is not the overall intent; collaboration toward a common goal is. The Army Action Plan for Stability Operations promotes the sharing of assets on a consultant basis to achieve mutual national policy goals.[70]

Organizational Resources.

Developing new approaches to organizational design and incorporating flexibility in application requires a review of roles. In certain operations, the DoD may need to assume roles that inherently fall to another agency in order to support an overall USG health care strategic policy. A subtext of virtually all the relevant literature is the significant shortages in personnel, training, and experience of civilian agencies such as State, DHHS, and USAID.[71] Shortages are also pervasive in the health care arena. For example, for more than 8 months in 2007, there was only a single staff member from DHHS in the Office of the Health Attaché in the U.S. Embassy in Iraq. Unfilled billets included the health attaché, deputy health attaché (a new requirement), facilities and engineering officer, and an assistant. For nearly 3 months of this time, the only billet filled was the liaison officer position from the MNF-I Surgeons Office. Such a situation has been

more near the norm than the exception, and for the foreseeable future any change to structure that requires an additional manning commitment is likely to experience this same fill deficiency.

In response to these manning shortfalls, based on present inventories and skill sets, the services all have varying degrees of capacity to fill the positions. Many Air Force, Navy, and Army assets have training in or currently hold positions as planners for health policy applications and strategic development.[72] If the USG would adopt greater flexibility in manning such positions (i.e., through doctrinal or organizational change), it would enable a "whole-of-government" approach and achieve solidarity in application of strategic health care intent.[73] Lieutenant General Barno succinctly characterized ideal interagency working relationships and unity of effort: "Same goals, different uniforms."[74]

When we are faced with a dearth of manpower and experienced personnel on the ground, temporarily filling civilian positions with military personnel can confer some distinct advantages for the USG. Resourcing certain billets in that manner allows personnel from the DoD with experience and training in health care operations to give voice to other perspectives. We are not speaking here of diplomatic roles as such. Those are best executed by DHHS and State representatives, who are more versed in the diplomatic arena. But such roles as Acting Chief of Facilities Construction and Planning for the Iraq Reconstruction and Management Office (IRMO), now reestablished by another Presidential Executive Order as the Iraq Transition Assistance Office (ITAO), the deputy health attaché (who can also serve as the chief of health policy for the DoD through the MNF-I Surgeons Office), and the chief logistician for health care planning can easily be filled by DoD personnel.[75] These elements can then blend skills developed stateside into common planning and training scenarios with DHHS elements, thereby achieving goal alignment and facilitating strategic decisionmaking.[76]

Decisionmaking in a multinational, multicultural, and joint environment is highly complex, requiring special organizational mechanisms to ensure compliance. Poor decisionmaking can result in agencies establishing misaligned goals, wasting resources, and consuming excessive time.[77] Blindly insisting that the civilian health care mission in these contexts "belongs" solely to State (through DHHS) weakens the USG ability to achieve strategic aims.[78]

Planning and Implementation.

In addition to finding resource solutions, it is also necessary to coordinate plans and strategies for implementation. Historically, planning a policy for post-conflict operations has been deficient, and execution has accordingly been poor.[79] Planning has been deficient owing to a combination of disparate organizational structures, leadership, and culture, all as exacerbated by time shortages and a resourceful enemy. The planning of the various agencies has been approached from several angles. Civilian agencies typically do not focus on the implementation of broad plans as much as on diplomacy and the creation of discrete objectives to achieve discrete ends. One example of their focus on objectives is the development of the Essential Task Matrix from the Office of the Coordinator for Reconstruction and Stabilization for State.[80] the DoD typically focuses on Joint Planning guidance along with the principles published in the new Stability Operations Field Manual.[81] Since civilian agencies do not arrive in theater with the same resources and capabilities as the DoD, it has assumed resource-dependent stabilization tasks on an ad hoc basis, resulting in poor execution (at least initially).[82] Emphasizing a need to rectify this shortcoming, Dr. Conrad Crane, a leading researcher on insurgency operations captures the resulting dilemma: "The inadequacies of civilian organizations insure that the Army will not be able to avoid such missions in the future."[83] So how do we avoid less than optimum execution? The complexities involved in answering this question and implementing solutions demand effective leadership.

Leadership.

As with any other organization, the structure of civil-military operations is often perceived through the prism of prior experience on the part of stakeholders. Lieutenant General Barno states this idea more strongly: organizational leaders are "often prisoners of their own experiences."[84] The leadership of the host nation affected is often just as entrenched. Therefore, all our efforts should be bent on assuring that both sets of leaders are incorporated in a whole-of-government approach in future policy applications.[85]

Leadership is the key to promoting unity of effort. Meetings involving governmental agency representatives at the central ministry level in Iraq, for example, require the presence of the health attaché (State representative) as well as an MNF-I representative (augmented by other USG assets based on the topic of the discussion). This arrangement provides a united front from the USG perspective. The leadership involved in negotiations over strategic intent must understand the plurality of paths available in health care policy. The leadership must appreciate other agency approaches and leadership competencies, and then exploit those differences to strategic advantage.[86] We often fail to take such intricate details and characteristics into account, thereby degrading unity of effort. In failing to promote a united front, implementation suffered in Iraq, with USG agencies often leaving the table thinking they understood each other's position, only to return to their offices and execute completely different plans.[87]

Also in Iraq, the Ministry of Health leadership failed to maintain seamless or collaborative relationships with the other ministries and was often at odds with separate party affiliations. The challenges inherent in this leadership culture impede forward progression. MOH leadership requires capacity development through consultation and a common focus by all USG players to increase their ability to sustain the Iraqi health system in the future. MOH officials therefore need to be included in relevant training on health care management and other critical facets that enable them to sustain their health care system. This objective of ministerial capacity development is a key component of strategic health care policy implementation. Additionally, the MOH in Iraq operated under different methods of health care application. Such subtleties are relevant if we expect the Iraqi health care community to absorb and sustain the training and planning provided.[88]

The leadership endeavor also has cultural implications. Breaking down the barriers to success by gaining a better understanding of the cultural differences in strategic health care planning is essential (e.g., Iraqis define the term "health care" differently than do their Western counterparts).[89] As a result, some aspects of Western-based systems need to be excluded in planning for Iraqi health policy. For example, certain managed care imperatives, insurance systems, and geriatric care facilities are aspects that are either vastly different or absent altogether in the Iraqi system. Even the conduct of negotiations with the Iraqis and the relevant parties needs to take careful cognizance of Iraqi social norms. To appropriately educate our medical practitioners and policymakers through orientations, therefore, we cannot use our Western lens to evaluate their practices; we have to use their lens. Lastly, not only do we need to take leadership and cultural elements into consideration in synchronized health policy planning, we also need to look inwardly to identify the organizational culture shifts necessary to promote a common strategic medical vision within the USG.

Organizational Culture.

Any organization, whether military or civilian, national or international, volunteer or paid, possesses a set of values, goals, and understanding representative of the organizational culture.[90] Leadership and culture are highly correlated, allowing for good initial predictions about an organization's ability to work in tandem with other agencies.[91] Stereotypes and prejudices are often grounded in historical examples of failed cooperative efforts between agencies and departments. Leadership has the responsibility to shift members away from cultural stereotyping and toward the establishment of solid foundations for future cooperation.[92] Clearly there are always mutual shortfalls in understanding and reconciling cultural differences between disparate organizations. Addressing these challenges is necessary for improved performance and a unified vision.[93]

The oft-cited under-resourcing and disfunctional design of civilian organizations vis-à-vis post-conflict operations requires certain resource and training solutions.[94] the DoD possesses the resources to ameliorate the situation in some cases, but may not be appropriate for others. Since no agency can be ideal for every contingency, we are forced to compromise by seeking out that agency offering the "best fit" which often turns out to be the DoD.[95] Thus the military winds up conducting the vast majority of contingency operations, including everything from disaster relief and hurricane response to nation-building and stabilization operations.[96] "Best fit" speaks to the need to marry the mission to the agency best able (through resources, training, and experience) to perform particular roles.[97] Best fit also applies to different phases of operations, which may necessitate mixing of agency resources or switching the agency assigned the lead role. Lack of a best fit is often exacerbated by conditions on the ground, leader personalities, cultural stigmatism, resource constraints, and sometimes simple absence of a functional relationship between the lead agency and the others. Perhaps the single greatest challenge is to achieve mutual understanding among organizations and to effectively capitalize on their cultural differences.

The Iraq health care environment requires particular attention to the cultural dimension. Our previous paternalistic promotion of Western medicine, as well as ignorance of preexisting governmental structures and cultural components of Middle Eastern systems of management, stymied initial efforts at health policy planning.[98] Many who arrive in Iraq, to include myself, have preconceived notions of health care delivery and other biases that do not fit the Iraqi model. Particularly in health care, perhaps the simplest instructions should read, "Please check your Western ideals and views at the door."[99]

The essential cognitive requirement here is not limited simply to understanding the institutions that relate to health care in our domestic environment, but also appreciating subtle and overt differences in health care on the international stage. Iraq has a socialized health care system during the day and a privatized system afterwards.[100] To fund this socialized system, there is currently no tax system to replace Iraq's former reliance on oil revenues and private users.[101] Physicians and staff often have different roles in this environment as well as a different location as to where health care is provided (most health care is provided in Primary Health Clinics [PHC] instead of inpatient facilities). Health care delivery in this context is very different from typical experiences of U.S. Health care facilities. We would therefore be wise to induce the host nation medical authority to enter into discussions with us on the intricacies of their system and how best to address their shortfalls, thereby enabling their successful reconstitution.[102] The cultural elements of our systems must meld with those of the host nation as a basis for recommendations on future organizational, training, planning, and cultural adaptations.

RECOMMENDATIONS

From our examination of the literature and expert opinion, specific courses of action emerge in the form of organizational, leadership, and cultural strategies for best enabling future synchronization of health care policy. In this process, creative and critical thinking are vital imperatives, allowing for revisions and paradigm shifts in application as necessitated by different milieus.[103] The specific recommendations deal with creating new organizational structures (or changes to old ones), addressing the challenges of disparate leadership and personalities, and coming to terms with the cultural elements which affect both organization and leadership.

New Organizational Design.

An appropriate organizational structure is essential to executing collaborative health policy operations. Currently, State through the DHHS designates billets for attending to health care policy issues. When these billets go unfilled or are filled by personnel lacking experience in formulating international health care policy, for example, we risk failure or even collapse of our health care policy execution. To address such potential personnel shortfalls, this paper proposes a flexible program of professional training and identification of experience as a basis for forming capable teams to apply synchronized health care policy.

Leadership roles of this team can be visualized by phases (see Figure 1).[104] The initial conflict stage, where security is not yet fully established, requires the operational management and leadership of the DoD system.[105] Once the phase transitions to the stabilization element of health care operations, the ownership of the process begins to transition to the DHHS element in theater, with the DoD assuming a supporting role (security dependent).[106] The next phase is transitional, with the stabilization phase maturing and the DHHS assuming complete responsibility, including resourcing. This allows time to field the DHHS resources necessary to complete the mission. The final phase is the sustainment of a health care system. The host nation medical authority assumes full control, with the DHHS taking on a consultant role (if any).

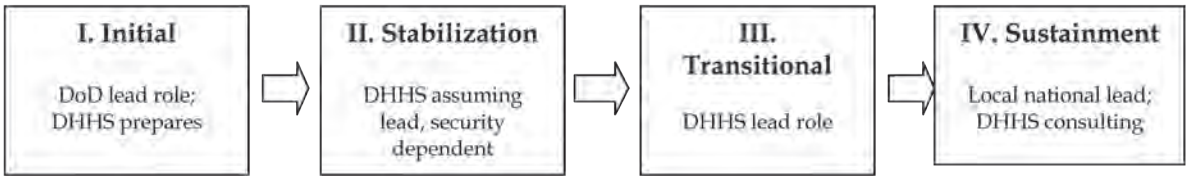

Figure 1. Phases of Medical Stabilization Support Operations (Proposed).[107]

The four-phase organizational concept described above is sound, but its implementation could be greatly improved if members of both agencies, DHHS and DoD, were combined into a single framework to create a new organizational "design" (see Figure 2).[108] This design is a physical manifestation of the idea of promoting organizational change and collaboration of efforts. Although currently not a part of any manning document available in a DoD table of organization and equipment, the separate service medical departments possess skill sets, assets, and other capabilities to perform health planning missions. These elements would form the core elements of a flexible medical model within the State structure allowing for a new approach to strategic health care planning in contingency operations.[109] Regardless of the composition of the model, the strategic aim is the same—to establish a new, more streamlined, effective, and efficient system for contingency operations and health care policy decisionmaking.

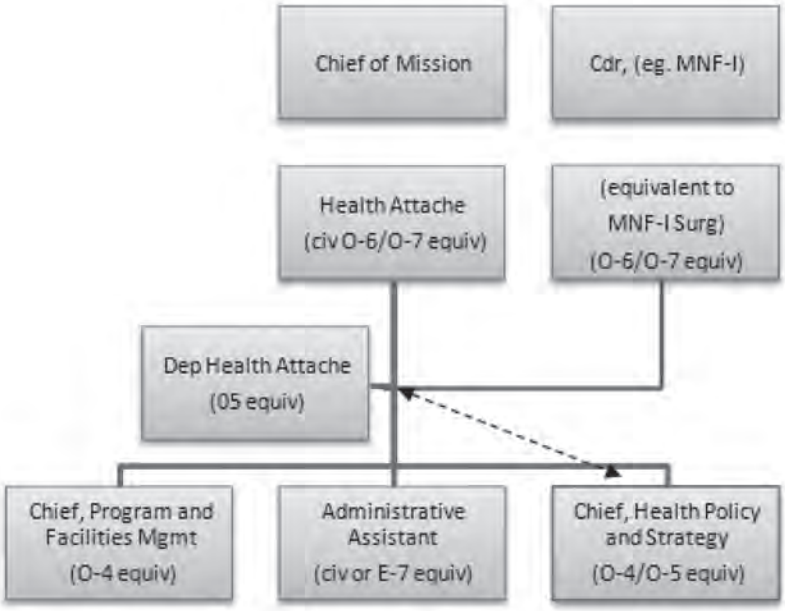

Figure 2. Flexible Medical Model (Proposed).

Selection of the model membership must be made according to established criteria and vetting among peers to choose the most experienced and capable representatives. This process would then be supplemented by training programs which all elements of the medical leadership (civilian and military) would be required to complete.[110] In this proposal, the lead in emergent health care issues and Phase I requirements is the MNF-I Surgeon (or equivalent). In Phases II-IV, the health attaché (from DHHS) assumes the lead on local civilian health policy initiatives. As the most vulnerable phase, Phase II (Stabilization) requires close collaboration between the health attaché and the MNF-I Surgeon (or equivalent) and their staffs, depending on the security situation. To assist the health attaché in Phases II and III and beyond, the DHHS requires a deputy versed in health policy operations and capabilities achieved through advanced civil training. At the operational and strategic levels, the military health care administrator is the most likely agent as he is often immersed in civilian agency health care theory and application during peacetime.[111] This individual can then perform the role of health policy and strategy chief or of the deputy health attaché or both, depending on the complexity of the current phase (see the dashed lines of authority in the proposed model).

As shown, these DoD assets, if utilized appropriately, have the potential for pronounced and immediate improvements in strategic-level attention to the health care battlefield.[112] Additionally, this new design provides for flexible augmentation of the module with other assets as the tactical/operational situation dictates. In the case of Iraq, for example, a military health facilities expert should be made available to consult with State and DoD leadership on the Iraqi health care reconstruction and rehabilitation program. There should also be an administrative assistant element, in consideration of the large amount of planning, briefings, and coordination required.[113] These roles, initially filled by the DoD, would eventually be filled by the DHHS as it matures to take full authority and leadership over the civilian health care policy mission. The ultimate evolution of this model would have an even more flexible design allowing for augmentation and/or reduction as appropriate.[114] This small investment up front would eliminate redundant efforts, promote a united effort, and expedite transition to host nation

responsibility.[115] A new consolidated training program would define how this module would function, who would lead by phase, and how to plan collectively.

Organizational Training Program.

One way to leverage strengths of disparate institutions is through collaborative practical application in training scenarios. Training scenarios could incorporate case studies, table top exercises, and planning sessions, which are all critical tools for gaining an understanding of cultural differences and an appreciation for the strengths of different organizations.[116] For example, the DHHS functions more as a policy agent negotiating through diplomacy and political acumen with local national health care administrators and leadership. The DoD, on the other hand, maintains resources with specific health care competencies designed to implement goals established at the national level. Part of organizational training should also include other partners such as USAID, NGOs, and IOs. Utilizing the strengths of all systems allows optimization of robust health care expertise. Promoting, practicing, and developing action plans through these applications create a type of knowledge management. This knowledge management generates off-the-shelf solutions (action plans) for potential scenarios in contingency environments. Creation of these plans should become a significant component of any new leadership training program.[117] Although some training programs exist currently, none are doctrinally mandated to combine all the relevant health care personnel in a united effort.[118]

Organizational Planning.

Included in the organizational construct is the element of set action plans, as detailed in the proposed training program. Such plans allow for practiced off-the-shelf remedies for operational problems, based on a long list of context-dependent variables to include security, threats, opportunities, weaknesses, and strengths.[119] Currently, the Joint Campaign Plan describes the components of the desired end state, encompassing in general terms the elements of essential services reconstitution and the part they play in the overall effort, i.e., the desired effects. The medical planning subcomponent of this larger plan is primarily the work of the DoD elements on the ground with consultation from CENTCOM, as well as parties stateside.[120] This scheme works well for initial post-conflict missions, which may include emergency health care, humanitarian relief, and immediate logistical support. As the DHHS does not have adequate resources or the deployment capability to match the DoD medical community, the DHHS and the DoD leadership should plan, prior to the conflict, for different phase leaderships and future partnerships to support the overall national strategy (see Figures 1 and 2). The manpower and fiscal officials of civilian institutions need to plan for equitably balanced fiscal responsibility and the civilian institutions' ability to assume required missions in collaboration with the DoD.[121] Whatever the source, the doctrinal inclusion of all players will foment cultural adaptation and lead to collaborative planning exercises accentuating the respective strengths of all the players.[122]

The planning element includes the topics presented in a relevant leader training course as well as anticipation of the assets most likely to be present in theater. For example, exercises can be conducted at a myriad of sites around the United States and even in theater where State, USAID, DoD, and other relevant players work together through scenarios.[123] A common application of scenario-based training used in military contexts is called Training Exercise Without Troops (TEWT).[124] Some potential TEWT topics include managing a medical resupply mission, coordinating security for medical infrastructure, medical training with host nation personnel, and planning asset distribution with multinational partners to include NGOs and IGOs as well

as the host nation medical leadership.[125] More complex scenarios may also involve global issues such as emergency response planning for a pandemic.

As part of the model application process, the medical mission on the ground requires a foundation in prior research and prioritization of planning.[126] Strategic health care planning can then incorporate the latest data for cogent decisionmaking. Currently a multiagency working group is defining the medical-related essential tasks required in a theater and designating which USG agency is most appropriate to address the need.[127] These essential tasks should be addressed in training exercises. In spite of design, training, and planning recommendations, without a combined strategic medical vision on the part of leadership, synchronized planning will remain only a tantalizing possibility.[128]

Leadership.

Leadership is the linchpin of any successful organizational change.[129] The leadership construct defined here is key to identifying the strengths of all relevant parties, applying logical methodology to problem solving on the national level, and working effectively with multinational partners, host nations, and USG counterparts. To support a unified strategic medical vision, leadership competencies are required to mold organizations and shift parochial or entrenched thinking into more effective and efficient systems.[130] Some of the strategic leadership competencies include negotiating, communicating (cross-cultural savvy), interpersonal maturity, complex decisionmaking (where not all parties fall under the same line of command), and "futuring" (exploring other possible scenarios).[131]

At this crucial stage of USG organizational and cultural adaptation, the addition of transformational leadership skills to current basic leadership competencies is essential.[132] These promote strategic leadership thinking, to include special transformation techniques.[133] For transformation, leadership will need to use these specific embedded tools to change, adapt, or adjust organizational culture and sell the concept to constituents.[134] Some of the embedded tools include communication of a unified vision; promotion of dual agency thinking; allocation of appropriate resources; selection of personnel to fill key billets; ensuring that such personnel are retained; incorporating external interests into strategic planning; seeking mid-level leaders to continue to promote the vision (champions); and setting up joint training and planning exercises.[135] Following the use of embedding concepts, reinforcing techniques are needed to sustain changes and adaptations.[136]

Reinforcing elements include several different possibilities yet to be explored in full-spectrum medical operations. Reinforcing elements aimed at aligning efforts include promoting an interagency (medical oriented) philosophy with a collaborative leadership vision; creating organizational design to match new missions (and resources); building structures that support personnel promotion and selection of champions; establishing training programs; and publishing new doctrinal principles. Considering the VUCA environment where leaders operate currently, both the DHHS and the DoD must focus on incorporating such cultural adaptations and proactive mechanisms, including resourcing and executive-level vision.[137]

Assessment of current leadership competency in both health care communities requires close scrutiny.[138] This will ensure that the most developed and capable leadership, with the desired skill sets, assumes the lead in strategic roles in complex environments. Careful selection is crucial considering that leaders will need to utilize collaborative strategic communications to send the correct message to the host nation, deter insurgent activity, and support the legitimization of the government in keeping with national policy goals.[139]

Leadership competencies, transformative leadership through embedding and reinforcing principles, and careful leadership selection further the ideal of mutual assistance and collabor-

ation along all facets of medical stabilization support operations.[140] Appropriate training modules and programs would ensure assimilation of this cultural change into the organization.[141] In the case of health care, the ramifications for failing to promote these elements and competencies could result in confusing and inefficient doctrine which fails to shift organizational culture along the necessary path.

Organizational Culture Change.

The medical community, a significant component of stabilization operations, requires an organizational shift toward greater collaboration and synchronization among visions, doctrine, design, training, leading, and, most especially, culture. One of the basic conclusions of the present research into designing a more synthesized health care policy for Iraq is the need to change the present culture. This cultural conflict, as detailed in the literature review earlier, has been a persistent problem since the outset of stability operations.[142] The cultural conflict is relevant not only to the civilian elements but likewise to the military contingent, which uses different skills, planning guidelines, and operational principles.[143]

Promoting vision through strategic leadership principles and corporate buy-in from all the players is required for lasting cultural change.[144] One significant component of leadership involves identifying the needs of senior, middle, and junior management—specifically, training and development in flexible adaptation to changing conditions, including culture itself. Leadership and support of change through cultural adaptation are instrumental in creating a new organizational environment that integrates the values, heritage, and voice of the members.[145] The reciprocally related components of doctrinal change, organizational design, and training programs also help determine the necessary elements to support culture change.

Doctrine, if appropriately vetted by leadership for mutual concurrence between the agencies, can assist in realigning perceptions, decisionmaking, and overall cultural adaptation of organizations. As the Office for Construction, Stabilization, and Reconstruction (S/CRS) is the State representative for coordination of efforts on stabilization operations, and the DHHS is the State representative for health policy, the National Security Council (NSC) could then direct the DHHS to serve as the lead executive authority.[146] The DHHS could then task the Office of the Secretary of Defense for Health Affairs (OSD/HA) to create a unified medical doctrine incorporating components from both agencies (State/DoD). With this method, collaboration would be solidified through doctrinal guidance synchronizing the effort. Currently, the absence of any unifying doctrinal guidance creates certain significant gaps in operational collaboration.[147] This is reflected in Iraq. Absence of synchronous approaches, unity of effort, and overarching doctrine have led to frequent duplication of efforts and thus greater expense at the national level.[148] This is not to deny that advances have been made.[149] Previous advances, however, were typically not coordinated with other agency elements and did not follow a common medical strategic plan.[150] To function effectively, the players involved require doctrinal guidelines beyond the current language provided in joint campaign plans or equivalent S/CRS task lists.[151] These guidelines must be supported and propagated by a leadership that can address the subtle subculture differences of all players.

Cultural understanding aimed at aligning goals and driven by leadership, doctrine, and training, will permit greater power in leveraging whole-of-government medical assets.[152] While each of the agencies falls under different lines of authority and approaches issues from a different perspective (through organizational values and other cultural perceptions), such differences can also serve as strengths in the right context. DHHS and DoD cultural-specific elements provide them with capabilities that complement one another well. Specifically, the DHHS has access to political venues, understanding of domestic public health sector planning, and diplomatic

training.[153] DoD in turn maintains medical resources available early on in contingency operations, as well as a cadre of trained medical experts.[154] These assets would take considerable time and effort to grow within the other organizations and should be embraced as enablers to facilitate health care operations. Such a combined DoD/DHHS approach is in a better position to execute the strategic health care policy necessary to reconstitute broken health care systems.

STRATEGIC HEALTH CARE POLICY TENETS

The primary elements of a functional health system are well-documented in RAND publications, international health journals, Morbidity and Mortality Weekly Updates, and certain Essential Task Mission listings (ETM) from DoD, as well as State's S/CRS and other sources.[155] The specific health care policy tenets for stabilization operations in Iraq will require further refinement since they should take into consideration theater-specific variables. Although defining each of the basic health policy tenets for stabilization operations is beyond the intent of this research, the tenets are briefly sketched to enable follow-on analysis for new system designs in organization, leadership, training, planning, and culture.

Also relevant are the parallel systems that need to be operational in order to promote overall health of populations, for example, potable water and adequate sanitation systems.[156] Functional water and sewage systems help avoid the onset of pandemics or the extensive spread of other communicable diseases. For large disease outbreaks, nations require a planned and rehearsed pandemic response system.

Other vital strategic health policy and planning considerations include displaced persons support, detainee health care policy, contractor health care, basic medical and pharmaceutical supply systems management, Emergency Management Systems (EMS), health care infrastructure, health education and promotion, and funding mechanisms to enable sustainment of systems.[157] Additionally, fiscal support of any health care system includes a review of insurance mechanisms, salaries, and affordability for the general population.[158] Health system structure involves rating the facilities of a particular system, determining construction needs, and gauging medical facility accessibility and functionality. To operate this system, it is necessary to explore the available pool of health system human resources. This necessity also relates to training, retaining, and recruiting of health care staff. A key element of health systems' functionality is the availability of schooled health care administrators. Training personnel in the principles of health care administration is a vital component of any strategic health policy plan. These specific health care tenets make up the building blocks of health policy for any nation.[159]

CONCLUSIONS

Health care operations, a primary enabler of stabilization operations, require greater focus by leaders in the future.[160] Synchronizing a strategic health policy among the military and participating agencies requires new models, leadership training, and cultural adaptation. Preparing now, even if through historical case studies and scenario-driven practice, will initiate cultural transformation and engender greater cooperation among organizations involved.[161] In international contexts, the sole authority representing the President of the United States is the ambassador. The DoS is the authority for managing stabilization operations in international settings. The DoS designated the DHHS as its agent for managing the health care mission abroad. Although the DHHS has been designated as the lead agent to address the health care capability of a host country, it often lacks resources and experience to handle all the unique challenges.[162] To meet the nation's strategic health care requirements in policy and planning, the ambassador and combatant commander rely on the expertise and judgment of those strategic leaders who share

the mission. These leaders, whether lodged within the embassy organization or with the military authority, must analyze situations, conceive courses of action, and implement solutions together to achieve desired ends.[163]

One suggestion offered in this paper is to build a model that redefines the current system as to design, leadership, and culture. Possession of a unified vision and a complementary organizational design guided by leadership competencies is essential to a coordinated effort.[164] Of course, unity of effort is often construed differently in various organizational cultures. The proposed model, as applied through four operational phases, seeks unity of effort by staffing the Health Attaché Office with both military and civilian membership (see Figures 1 and 2).[165]

Adjusting to a renewed focus on stabilization operations (contingency operations of the future) presents significant challenges to leaders in the medical community. These challenges will prove to be critical elements to consider in planning for strategic goals in the future.[166] Using techniques such as embedding and reinforcing mechanisms to complement leadership, doctrine, training, and planning models, we can reassess the external environment along a continuum of possibilities. Incorporating partners from both military and civilian institutions into the cultural change model is imperative if we are to achieve lasting organizational change and buy-in from all the relevant players.[167] Strategic medical leadership is the key to promoting a vision of effective interagency collaboration and coordination.

As stated by Conrad Crane, "[T]he Army's involvement in stabilization phase operations has been particularly demanding and has pushed the services to perform numerous unwanted nation-building tasks."[168] Stabilization operations have largely become the norm; hence the owners of USG medical assets have an obligation to design, plan, and train together to support national goals. This obligation has recently been set forth in general terms in *Field Manual 3-07, Stabilization Operations,* but detailed implementation on the ground will require granular analysis.[169] There has recently been a move within the Peace Keeping and Stabilization Operations Institute (PKSOI) at Carlisle, Pennsylvania, to bring on board a DHHS representative who has served in a health care delivery role in Iraq. Incorporating this representative in its staff will abet DHHS's future efforts and provide valuable insight into the DHHS processes abroad.[170] It is clear that a more streamlined and functional health policy model for strategic operations is essential to effective and efficient applications. This insight aligns with Army recommendations for 21st century counterinsurgency operations, i.e., to institutionalize new methods for a unified interagency approach, redefine leader training and development, and refine plans and doctrine to complement efforts in counterinsurgency efforts.[171]

Although the Iraqi leadership in the health care sector may not require the United States to manage their system, they do require some specific resources and training to bolster their efforts. This capacity-building approach promotes greater long-term sustainability, more effective policies, and assists in the nation-building process.[172] U.S. agencies in Iraq, as well as those supporting from stateside and other international venues, can accomplish their mission through a more refined roadmap encompassing structure, leadership, culture, and a comprehensive strategic health care plan.[173] Harmonizing the relationships via the changes to the critical elements recommended herein will enhance current civil-military operations within the health care arena.[174]

As to remodeling health policy planning, we should utilize the flexible model design proposed here, as well as pursuing training and other cultural adaptations. The flexible nature of this model should allow for use in other theaters of operation such as Afghanistan, or even in the relatively recent African Command (AFRICOM).[175] As members representing the same government, we should utilize and harmonize all the elements of national power to better achieve our desired end state. Failure to do so may cause divergence from campaign objectives, thereby jeopardizing achievement of national goals. Regardless of the theater, synchronizing effort in international health care policy will continue to be one of the most powerful tools available to the USG in the execution of national strategic objectives in stabilization operations.

ENDNOTES

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3. Seth G. Jones *et al.*, *Securing Health: Lessons from Nation-Building Missions*, Santa Monica, CA: RAND: Center for Domestic and International Health Security, 2006, pp. 238-245; see also RAND Corporation, "Study Finds Nation-Building Efforts in Iraq and Afghanistan Hampered by Failures to Address Health Problems," available from *www.rand.org/news/press/2006/04/19/index.html*.

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36. National Security Presidential Directive 44, Management of Interagency Efforts, December 7, 2005; see also Douglas C. Lovelace, Jr., "Foreword" in Greg Kaufmann, ed., *Stability Operations and State-Building: Continuities and Contingencies*, Carlisle, PA: Strategic Studies Institute, U.S. Army War College, October 2008, p. v.

37. Lieutenant Colonel Lisa Forsyth of the Stabilization Office, Pentagon, interview by author, Washington, DC, October 3, 2008; referenced planning meetings on the essential medical tasks that must be completed in order to address stabilization operational tenets (draft document) and the new agency proposed. Also included discussions of working groups with DHHS and the Office for Construction, Stabilization, and Reconstruction (S/CSR) to work through present challenges; see also Metz, *Learning from Iraq*, pp. 74-75; part of the approach to reorganization of the military role in stabilization type operations is to create a joint "Stabilization and Construction Command" which would be positioned in the DoD and complemented by Special Forces assets. The optimal method is to stand up a special interagency corps with a mission outline mirroring that of stabilization oriented command.

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39. U.S. Department of the Army, *Stability Operations*, chap. 3.

40. Redmond, "AAR—Medical Support to Stability Operations," July 10, 2008.

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42. *Ibid*., p. 6.

43. Steven R. Miles, *Reconstruction under Adversity: Rebuilding Iraq – Lessons for the Future*, Carlisle, PA: U.S. Army War College, March 30, 2007, pp. 4-6.

44. Metz, *Learning from Iraq*, p. 48; MNSTC-I was created to assist the Iraqis as an enabler of their security forces development; see also Spring 2007, Health Attaché meeting in Baghdad Iraq: Meeting held to discuss transportation requirements for operations in Iraq where leadership (USG) failed to reach consensus. Lacking accountability at this level through a single organization to dictate policy, the operations became fragmented and disparate resulting in redundant efforts and wasted resources; see also Thomas Donnelly and Frederick W. Kagan, *Ground Truth: The Future of U.S. Land Power*, Washington DC: American Enterprise Institute (AEI) Press, 2008, pp. 2-42.

45. Michael J. Metrinko, *The American Military Advisor: Dealing with Senior Foreign Officials in the Islamic World*, Carlisle, PA: Strategic Studies Institute, U.S. Army War College, August 2008, pp. 37, 63, 66; in a context where the military or civilian agency is to interact with international organizations, agencies, NGOs, etc., we should be cognizant of divergent agendas and take care to promote a united approach among the disparate groups.

46. Vicki J. Rast, *Interagency Fratricide: Policy Failures in the Persian Gulf and Bosnia*, Maxwell AFB, AL: Air University Press, 2004; discusses the interagency gap between the diplomats and military in the execution of a sustainable peace and some previous failures.

47. Robert J. Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, Lubbock: Texas Tech University Press, 2004, p. 115.

48. *Ibid*., p. 127.

49. *Ibid*.

50. James H. Embrey, *Reorienting Pacification: The Accelerated Pacification Campaign of 1968*, Lexington University of Kentucky, 1997, pp. 24-25; see also Ross M. Coffey, *Improving Interagency Integration at the Operational Level: CORDS – A Model for the Advanced Civilian Team*, Fort Leavenworth, KS: School of Advanced Military Studies, U.S. Army Command and General Staff College, 2006; CORDS was established to promote unity of effort and a revolutionary conceptualization of cooperation.

51. Brian M. Jenkins, "The Unchangeable War," RM-6278-ARPA, Santa Monica, CA: Rand Corporation Paper, November 1970, p. 1.

52. Wilensky, *Military Medicine*, pp. 42-47.

53. Steven Metz and Raymond Millen, "Intervention, Stabilization, and Transformation Operations: The Role of Landpower in the New Strategic Environment," *Parameters*, Vol. 35, No. 1, Spring 2005, pp. 49-50; see also Hans Binnendijk and Stuart E. Johnson, *Transforming for Stabilization and Reconstruction Operations*, Washington, DC: National Defense University Center for Technology and National Security Policy, 2004, pp. 53-69; see also L. Farrel, "Stability, Reconstruction Skills Key to Long Lasting Security," *National Defense,* January 2008.

54. Seth Cropsey, "An Odd Prescription: Old Medicine Won't Solve Pentagon Woes," *Armed Forces Journal*, Vol. 145, No. 11, June 2008: p. 27; see also John Koivisto, *Increasing Effectiveness of Interagency*

Provincial Reconstruction Teams, Strategic Research Project, Carlisle, PA: U.S. Army War College, March 30, 2007, p. 11; see also Steven Mains, *PRT Playbook: Tactics, Techniques, and Procedures*, No. 07-34, Fort Leavenworth, KS: Center for Army Lessons Learned, September, 2007; see also U.S. Department of the Army, *Stability Operations*, pp. F-1 - F-6.

55. Carlos Hernandorena, "U.S. Provincial Reconstruction Teams in Afghanistan, 2003-2006: Obstacles to Interagency Cooperation," in *Interagency and Counterinsurgency Warfare: Stability, Security, Transition, and Reconstruction Roles*, Joseph R. Cerami and Jay W. Boggs, eds., Carlisle, PA: Stategic Studies Institute, U.S.Army War College, 2007, p. 121; see also Office of the Special Inspector General for Iraq Reconstruction, "Status of the Provincial Reconstruction Team Program Expansion in Iraq," SIGIR-07-014, July 25, 2007, pp. ii-iii.

56. Koivisto, *Increasing Effectiveness of Interagency*, p. 8.

57. Office of the Special Inspector General for Iraq Reconstruction, "Status of the Provincial Reconstruction Team," pp. 6-7.

58. Mains, *PRT Playbook*, p. 66.

59. "Iraqi Health Care's Revival and What It Can Teach U.S. Hospitals," *Hospitals and Health Networks*, Vol. 82, No. 9, September 2008, p. 14; implies a need to understand the desires of the Ministry of Health (MOH) more readily.

60. Gary Felicetti, "The Limits of Training in Iraqi Force Development," *Parameters*, Winter 2006-07, p. 81; discusses the issue of institutionalized training resistance which has come about in literature surrounding our National Strategy for Victory in Iraq. If training imperatives are emplaced in our community for "nation-building," for example, we may avoid some of the previous pitfalls experienced with training forces in Iraq.

61. Jane Ward *et al.*, "A Global Engagement Enhancer: The International Health Specialist," *Air & Space Power Journal,* Fall 2002; training similar to that of the Air Force medical components in international settings is an option.

62. Raymond Millen, *Managing Provincial Reconstruction Activities*, Carlisle, PA: Strategic Studies Institute, U.S. Army War College, December 2007, p. 237.

63. Carafano, "Learning from the Past," p. 171; leadership competencies for these roles should include familiarity with diverse but related disciplines, crisis action planning experience, and understanding of other forces affecting operations.

64. U.S. Army-Baylor University Graduate Program in Health and Business Administration, available from *www.baylor.edu/graduate/mha/index.php?id=44639*.

65. *Ibid*.

66. Metz, *Learning from Iraq*, p. 61; the relevance of doctrine that followed the 2005 National Defense Strategy and Secretary Rumsfeld's reinforcement of stability operations as a core competency was an effort to integrate all activities across the department for organization, resources, education, training, and doctrine; see also U.S. Department of Defense, *National Defense Strategy,* Washington, DC: U.S. Department of Defense, June 2008, pp. 17-18.

67. John Naisbett: International Best-Selling Author of Megatrends and Megatrends 2000, available from *www.naisbitt.com/home.php*; see also John Naisbett Biography, available from *www.naisbitt.com/biography_print.htm*; see also Thinkexist.com quotations, available from *thinkexist.com/common/print.asp?id=363708&quote=strategic-planning-is-worthle . . . .*

68. Steven Metz, *Rethinking Insurgency*, Carlisle, PA: Strategic Studies Institute, U.S. Army War College, June 2007, pp. 41-42.

69. Bradford A. Lee, *Winning the War but Losing the Peace? The United States and the Strategic Issues of War Termination*, n.p., 2003, p. 259; see also U.S. Department of the Army, "Army Action Plan for Stability Operations," August 2007, pp. 5-6; Redmond, "AAR—Medical Support to Stability Operations," July 10, 2008.

70. U.S. Department of the Army, "Army Action Plan for Stability Operations," August 2007, pp. 5-6; Redmond, "AAR—Medical Support to Stability Operations," July 10, 2008.

71. Crane, *Landpower and Crisis,* p. 37; see also Brian Friel, "The Powell Leadership Doctrine." *Government Executive*, June 1, 2001, p. 257; resource abundance and State are not synonymous. See also U.S. Congress, House of Representatives, Committee on Armed Services, Panel on Roles and Missions, Initial Perspectives, January 2008, *USAWC Foundations of Military Power, Selected Readings*, pp. 2-3; U.S. Department of Defense, *Health Capabilities in Stability Operations*, p. 8; Bensahel, *International Perspectives on Interagency Reform*, p. 7.

72. Mangelsdorff, "The Army-Baylor Program."

73. Redmond, "AAR —Medical Support to Stability Operations," July 10, 2008.

74. Barno, interview by author, September 12, 2008.

75. Redmond, "AAR—Medical Support to Stability Operations," July 10, 2008.

76. Leonard Wong and Don M. Snider, "Strategic Leadership of the Army Profession," Don M. Snider and Lloyd J. Matthews, eds., *The Future of the Army Profession*, 2d Ed., Boston, MA: McGraw Hill Custom Publishing, 2005, pp. 604-607.

77. Isaiah Wilson, "Thinking Beyond War: Civil-Military Operational Planning in Northern Iraq" (paper prepared for delivery at the Annual Meeting of the American Political Science Association, Chicago, IL, September 2-5, 2004), p. 15.

78. Metz, *Learning from Iraq*, p. 80; see also U.S. Joint Chiefs of Staff, *Joint Publication (JP) 3-08, Interagency, Intergovernmental Organization and Nongovernmental Organization Coordination During Joint Operations*, Vol. I, Washington, DC: U.S. Government Printing Office, March 17, 2006.

79. Crane, *Landpower and Crisis,* pp. 24, 34, 45; see also Carafano, "Learning from the Past," p. 167.

80. Redmond, "AAR—Medical Support to Stability Operations," July 10, 2008; see also National Defense University, *Interagency Management of Complex Crisis Operations Handbook*, Washington DC: National Defense University, January 2003.

81. U.S. Department of Defense, *Joint Operation Planning*, pp. II-6 to II-12; see also U.S. Department of the Army, *Stability Operations*; U.S. Department of Defense, *Joint Publication 4-02, Health Service Support*, Washington, DC: U.S. Department of Defense, October 31, 2006.

82. Crane, *Landpower and Crisis,* p. 24.

83. *Ibid*., p. 56.

84. Barno, interview by author, September 12, 2008.

85. David W. Major, *Regional Initiatives: Eliminating the Causes of Terrorism*, Strategic Research Project, Carlisle, PA: U.S. Army War College, March 15, 2008, p. 4.

86. Dr. S. Stevenson and Dr. Marybeth Ulrich, "Civil-Military Relations Panel," briefing slides with scripted commentary, Carlisle, PA, U.S. Army War College, November 13, 2008.

87. Spring 2007, Baghdad, Iraq Meeting took place where the MOD, MOH, MNSTC-I, and Health Attaché elements negotiated a training program for clinical staff at one of our military medical facilities for a specific number of applicants; although all agreed, participation was nonexistent in the first attempt. The Iraqis assumed we were to meet several more times and agree several more times until implementation occurred; different cultural norms came into play.

88. For background on Ministry of Health (MOH) efforts to analyze its health care system and capacity development needs, see Mohammed J Hawail, *Guideline for Concise Outlook for Health Approaches in Iraq: In Response to the Sixtieth Word [sic] Health Assembly Meeting*, Baghdad, Iraq, May 2007; see also U.S. Department of Defense, *Health Capabilities in Stability Operations*; see also Thomas S. Bundt, *Health Care Policy Operations – A Formulary for Effective Transition in Iraq*, Policy Paper for Health Attaché Operations, June 2007.

89. Bundt, *Health Care Policy Operations*, pp. 4-5.

90. Tyrrell, *What To Know Before*, p. 131.

91. Chris Cline, "The Influence of Stability Operations on the Army Profession and Public Management," in Joseph R. Cerami and Jay W. Boggs, eds., *The Interagency and Counterinsurgency Warfare: Stability, Security, Transition, and Reconstruction Roles*, Carlisle, PA: Strategic Studies Institutes, U.S. Army War College, December 2007, pp. 465-509.

92. Colin S. Gray, *Modern Strategy,* New York: Oxford University Press Inc., 1999, p. 60; see also Crane, *Landpower and Crisis,* p. 24.

93. H.R. McMaster, "Graduated Pressure: President Johnson and the Joint Chiefs," *Joint Force Quarterly,* Vol. 34 Spring 2003, p. 86; differences in agency culture, values, and processes resulted in a flawed strategy. See also George R. Mastroianni and Wilbur J. Scott, "The Politics of Blame and Civilian-Military Relations," *Military Review*, Vol. 88, Issue 4, July/August 2008, p. 54; U.S. Department of Defense, *Military Support to Stabilization, Security, Transition, and Reconstruction Operations Joint Operating Concept*, Norfolk, VA: Joint Forces Command, December 2006, p. D-5.

94. Crane, *Landpower and Crisis,* p. 24.

95. Metz, *Learning from Iraq*, p. 80; in reference to designing a flexible medical module for the future, for example, there is truly "no one size fits all" as the Iraqi theater demonstrates.

96. U.S. Congress, Committee on Armed Services, January 2008, pp. 2-2 - 2-3.

97. Crane, *Landpower and Crisis,* p. 28, regarding "best fit" for the Army in contingency operations; see also "Stochastic Analysis," U.S. Army Program Analysis and Evaluation Directorate, *America's Army . . . into the 21st Century*, Washington, DC: HQDA, 1997, p. 5; U.S. Department of Defense, *National Defense Strategy,* Washington, DC: U.S. Department of Defense, June 2008, pp. 17-18; U.S. Department of the Army, *Stability Operations in an Era of Persistent Conflict*, Washington DC: U.S. Department of the Army, June 1, 2008, p. 7.

98. U.S. Department of Defense, *Health Capabilities in Stability Operations*, p. 5.

99. Stephen J. Gerras, "Thinking Critically about Critical Thinking: A Fundamental Guide for Strategic Leaders," December 2007, pp. 49-77, in U.S. Army War College, *Department of Command, Leadership, and Management, Selected Readings*, AY 2009, Strategic Thinking [DCLM Issue]; references leaving rank at the door and, relatedly, leaving egos and prior perceptions at the door to avoid bias and misreading intent.

100. Jones *et al*., *Securing Health: Lessons,* pp. 221-273.

101. U.S. Department of Defense, *Health Capabilities in Stability Operations*.

102. *Ibid*.

103. Meinhart, "Leadership and Strategic Thinking," pp. 40-48; emphasizes the use of strategic thinking for leadership to integrate all the possible perspectives and challenges of complex systems, which requires greater fidelity and processing of information and outcomes; see also Gerras, "Thinking Critically about Critical Thinking," pp. 49-77.

104. See Figure 1: Phases of Medical Stabilization Support Operations in the present paper.

105. Flavin, "Planning for Conflict Termination," p. 107.

106. Christopher E. Housenick, "Winning Battles but Losing Wars: Three Ways Successes in Combat Promote Failures in Peace," *Military Review,* September-October, 2008, pp. 95-96.

107. U.S. Department of the Army, *Stability Operations*, pp. 2-13; the general phases of stabilization operations are initial response, transformation, and fostering sustainment; however, our proposed model is an intentional modification to align specifically with health policy applications in a stabilization type scenario.

108. Flavin, "Planning for Conflict Termination," p. 46; Flavin states, ". . . typically culture is rooted in history, [is] held collectively, and is of sufficient complexity to resist many attempts at direct manipulation." This tenet is critical to understanding the barriers that exist to sustaining and implementing an effective organizational culture as well as trying to change it. See Figure 1: Phased Stability Operations for Medical Lead Agent; and Figure 2: Proposed Medical Module Model (Flexible Application), both in the present paper.

109. Currently the requirement for a Health Attaché is not a permanent billet in Embassy operations and therefore not organic to the State or DHHS. This has implied flexibility inherent to a more (whole- of-government) system to provide assets tasked specifically to a set mission. For example, if specific health policy subject matter expertise is not available in DHHS (not as robust as joint medical manpower assets), this identifies the need to establish a module complemented by manpower from all agencies and departments to leverage our full medical potential. See also U.S. Congress, Committee on Armed Services, January 2008, pp. 1-13 to 1-16; the relevance of seeking to align structure and assets parallels the need highlighted by the Committee on Armed Services to note the gaps and reduce the duplication of effort across the different departments within the DoD. We should seek to review those elements that are regarded as the core competencies of that organization and align resources accordingly. See also Metz, *Learning from Iraq*, p. 66; it is essential to design operations tailored around the strengths (core competencies) of its membership.

110. Mangelsdorff, "The Army-Baylor Program,"; slots in the U.S. Army-Baylor program are made available to other services and the Veterans Administration, which then transfer funds from their departments to finance their students.

111. B. J. Weiler, "Corps of Engineers Assisting in Building Health Clinics in Iraq," American Forces Press Service New Articles, available from *www.defenselink.mil/news/newarticle.aspx?id=16714*; Mangelsdorff, "The Army-Baylor Program."

112. Mangelsdorff, "The Army-Baylor Program."

113. Putting together briefings for the Minister of Health and providing a consultative element to their tasks will enable them to defend their needs to the Iraqi Government and thereby continue to gain resources and appropriate attention from the government toward the health care sector. One personal example of this was a power point slide show provided to Minister Dr. Ali Alshamari depicting a new retention and allowance plan for those possessing certain skills sets in an effort to curb their emigration (significant exodus of health care staff from Iraq). As a result of the briefing, Dr. Ali was then provided with this slide package; the Ministry of Finance in concert with the Deputy Prime Minister initially granted him the necessary funding to retreive these personnel; the effort advertised in Iraq, as well as in Jordan, to convince others to return.

114. See Figure 1 in the present paper.

115. Dallas W. Homas, *Strategic Medical Leadership in the Global War on Terrorism*, Strategy Research Project, Carlisle, PA: U.S. Army War College, March 15, 2008, p. 2; see also Millen, *Managing Provincial Reconstruction Activities*, pp. 238-244.

116. Donald F. Kettl and James W. Fesler, *The Politics of the Administrative Process,* Washington, DC: CQ Press, 2005, pp. 111-143.

117. Duane R. Ireland and Michael A. Hitt, "Achieving and Maintaining Strategic Competitiveness in the 21st Century: The Role of Strategic Leadership," *Academy of Management Executive*, Vol. 19, No. 4, November 2005, p. 48.

118. U.S. Department of the Army, "Army Action Plan for Stability Operations," August 2007, pp. 5-6; Redmond, "AAR—Medical Support to Stability Operations," July 10, 2008. These references define current efforts to promote cooperative planning efforts.

119. Peter M. Ginter, Linda M. Swayne, and W. Jack Duncan, *Strategic Management of Health Care Organizations*, 3d Ed., Malden, MA: Blackwell, 1998, pp. 175, 562-576, 506-523; see also Thomas L. Wheeler and J. David Hunger, *Strategic Management and Business Policy*, Upper Saddle River, NJ: Prentice Hall, 2002, pp. 1-23; U.S. Department of the Army, *Stability Operations*.

120. U.S. Department of the Army, "Full Spectrum Operations", *Field Manual 3-0*, *Stability Operations*, Washington DC: U.S. Department of the Army, February 27, 2008, Chap. 9; see also Metz, *Learning from Iraq*, p. 83; U.S. Department of the Army, *Field Manual (FM)* 100-23, *Peace Operations,* Washington DC: U.S. Department of the Army, December, 1994; U.S. Joint Chiefs of Staff, *Interagency, Intergovernmental Organization and Nongovernmental Organization*, p. II-16.

121. For assuming a mission not typically under the auspices of that agency or department, a commensurate funding line needs to be created to recognize and adequately support the supporting agency/department.

122. Ireland and Hitt, "Achieving and Maintaining Strategic Competitiveness," p. 47; organizational controls can be powerful tools to place boundaries on interests, while simultaneously granting flexibility in application allowing for the leveraging of other entities (agency resources in this case) to address a specific problem.

123. Andrew S. Natsios, "The Nine Principles of Reconstruction and Development," *Parameters*, Vol. 35, No. 3, Autumn 2005, p. 4. USAID began to see weaknesses in its training programs and has been refocusing efforts to work in tandem with other agencies.

124. Flavin, "Planning for Conflict Termination," p. 107.

125. Metz, *Learning from Iraq*, p. 1, NGOs at one time in the planning process were expected to provide resources and personnel to reestablish society and essential services following conflict; this plan likewise was left wanting; see also U.S. Department of Defense, *Health Capabilities in Stability Operations*, pp. 7-8.

126. Ginter *et al*., *Strategic Management of Health Care Organizations*, pp. 506-523.

127. Forsyth, interview by author, October 3, 2008; discussions regarding DHHS personnel's participation in new interagency working groups. See also Conrad C. Crane and W. Andrew Terrill, *Reconstructing Iraq: Insights, Challenges, and Missions for Military Forces in a Post-Conflict Scenario*, Carlisle, PA: Strategic Studies Institute, U.S. Army War College, February 2003, pp. 63-73.

128. Warner W. Burke, "Organization Change: Epidemics, Integration, and Future Needs," in *Organization Change: Theory and Practice*, Thousand Oaks, CA: Sage Publications, Inc., 2002, p. 68. See also Stephen J. Gerras, Leonard Wong, and Charles D. Allen, "Organizational Culture: Applying a Hybrid Model to the U.S. Army," Carlisle, PA: U.S. Army War College, June 2008, p. 245; one of the first components of a "reinforcing mechanism" for embedded elements to support organizational change is organizational design and structure.

129. Wong and Snider, "Strategic Leadership of the Army Profession," p. 602.

130. Ireland and Hitt, "Achieving and Maintaining Strategic Competitiveness," p. 39; see also Burke, "Organization Change," p. 68; references challenges of being locked into a present culture. Depicts carrying out organizational tasks and missions that may be in direct conflict with the methodologies of other organizations with like missions; Wong and Snider, "Strategic Leadership of the Army Profession," pp. 607-621; Thomas S. Szayna, Derek Eaton, and Amy Richardson, *Preparing the Army for Stability Operations: Doctrinal and Interagency Issues*, Santa Monica, CA: RAND Corporation, 2007, p. 115; emphasizes influencing the direction of interagency collaboration and the need for a unified strategic vision; Darrell L. Jenkins, *Phase Four: Applying History's Successful Nation-Building Lessons in Iraq*, Strategic Research Project, Carlisle, PA: U.S. Army War College, March 30, 2007, p. 2.

131. Ireland and Hitt, "Achieving and Maintaining Strategic Competitiveness," p. 38; see also "The Future Belongs to Those Who . . . a Guide for Thinking About the Future," Institute for Alternative Futures, available from *www.altfutures.com/docs/FuturesTechniques.pdf*; see also Wong and Snider, "Strategic Leadership of the Army Profession," pp. 611-619.

132. Peter W. Chiarelli and Stephen M. Smith, "Learning from our Modern Wars: The Imperatives of Preparing for a Dangerous Future," *Military Review*, Vol. 87, No. 5, September-October 2007, p. 439; transformational leadership will enable the Army in the next evolution of modern conflict and will help in understanding a very dangerous future through a different lens. See also Ireland and Hitt, "Achieving and Maintaining Strategic," p. 46; leadership is key to reshaping the organizational culture of entities, and many components work in tandem to enable this effort.

133. Gerras *et al*., "Organizational Culture," pp. 226-255; see also U.S. Department of the Army, *Army Leadership*, FM 6-22, Washington DC: U.S. Department of the Army, October 2006, p. 25.

134. Burke, "Organization Change," p. 59; see also Stephen A. Shambach, ed., *Strategic Leadership Primer,* 2nd Ed., Carlisle, PA: U.S. Army War College, 2004; to complement these new skills, strategic level leadership needs to understand the intricacies of all the elements of national power such as diplomacy, information, military, and economic (DIME) to be truly effective.

135. Shambach, *Strategic Leadership Primer*, pp. iii, 21-23, 30, 34; communication skills are one of the most important competencies that strategic leaders employ to change culture and adapt organizations to new environmental realities. They require vision, future focus, and an understanding of institutional values, history, and experiences of the organization to best embed changes and complement them with

reinforcing mechanisms. See Kettl and Fesler, "The Politics of the Administrative Process," pp. 114, 120; strategic planning involves the concept of idea generation, an essential parallel to leadership vision. This article suggests that strategic planning on the political levels is not likely to be successful; however, for the purposes of agencies and departments, planning removes boundaries and creates a strong tie to vision and mission support as well as serving a vital component to guide rational decisionmaking.

136. Burke, "Organization Change," p. 53.

137. Shambach, *Strategic Leadership Primer*, p. iii; a key feature to the "VUCA" environment as experienced by present-day leadership is the speed at which changes take place and the mandate to be able to react within a very constrained timeline in order to adequately address challenges.

138. U.S. Department of the Army, *Army Leadership*, p. 27, These core leadership competencies are the baseline elements of all leader attributes in complex organizations. These include leading, developing, and achieving specific aims. These are the baseline variables that form the leadership construct complemented by character, presence, and intellectual capacity.

139. Chiarelli and Smith, "Learning from our Modern Wars," pp. 445-447; see also Metz, *Learning from Iraq*, p. 27. By showing a greater American presence, you can actually work to alienate the population. In the promotion of strategic communication by renewed emphasis on these strategic leadership tenets we can understand a methodology where the Iraqis are represented as providing for their citizens, advertise this element, and thereby increase the legitimacy of their government. U.S. Department of Defense, *Joint Operation Planning*, pp. II-2 to II-3.

140. Burke, "Organization Change," p. 291.

141. Gerras *et al*., "Organizational Culture," p. 242.

142. Crane, *Landpower and Crisis,* p. 56.

143. Metz, *Learning from Iraq*, p. 66; see also U.S. Department of the Army, *Full Spectrum Operations*, Appendix A.

144. Ireland and Hitt, "Achieving and Maintaining Strategic," p. 38; see also Dennis C. Jett, "Challenges in Support and Stability Operations: Why Each One Is Different," in Cerami and Boggs, eds., *The Interagency and Counterinsurgency Warfare: Stability, Security, Transition, and Reconstruction Roles*, Carlisle, PA: Strategic Studies Institute, 2007, p. 15.

145. Michael L. Gibler, *Shotgun Wedding: Interagency Transformation for the 21st Century Security Environment*, Strategic Research Project, Carlisle, PA: U.S. Army War College, March 15, 2008, p. 21.

146. Alan G. Whittaker, Frederick C. Smith, and Elizabeth McKune, "The National Security Policy Process: The National Security Council and Interagency System,"in Gabriel Marcella, ed., *Affairs of State: The Interagency and National Security*, Carlisle, PA: Strategic Studies Institute, U.S. Army War College, December 2008, pp. 97-170.

147. Susan E. Koger-Hill, "Team Leadership," in *Leadership: Theory and Practice* 3rd Ed., Peter G. Northouse, Thousand Oaks, CA: Sage Publications, Inc., 2004, p. 297; see also Forsyth, interview by author, October 3, 2008; reference planning meetings on the essential tasks that must be completed in order to address stabilization operations tenets (draft document); Metz, *Learning from Iraq*, p. 47; Szayna *et al*., *Preparing the Army*, pp. 132-226; and the Post Conflict Essential Tasks Matrix (ETM).

148. Flavin, "Planning for Conflict Termination," p. 102; see also Office of the Special Inspector General for Iraq Reconstruction, "Status of Ministerial Capacity Development in Iraq," SIGIR-06-045, Jan 30, 2007, pp. 18-20; U.S. Department of Defense, *Health Capabilities in Stability Operations*, p. 6.

149. Advances in promotion of health care systems in Iraq are short-term and individualized efforts (e.g., providing clinics in rural communities, establishing MEDCAP exercises to promote capabilities, and addressing individual population concerns); however, when these are not part of the overall strategy (i.e., nested within the Ministry of Health [MOH] strategic map), then the host nation is not part of the plan nor is able to sustain systems once the USG withdraws from this support role. We require long-term and sustainable solutions.

150. Office of the Special Inspector General for Iraq Reconstruction, "Key Recurring Management Issues Identified in Audits of Iraq Reconstruction Efforts," SIGIR-08-020, July 27, 2008, pp. ii-v; see also Gene Bonventre, *Health Issues in Stability Operations*, Position Paper, September 21, 2005.

151. Metz, *Learning from Iraq*, p. 24; we should not repeat the failure to plan for phase IV operations in Iraq by not promoting a collaborative planning effort. See also Redmond, "AAR—Medical Support to Stability Operations," July 10, 2008.

152. Ireland and Hitt, "Achieving and Maintaining Strategic," p. 39.

153. Metz, *Learning from Iraq*, p. 66; see also Robert K. Mendenhall, *Pre-War Planning for a Post-War Iraq*, Strategic Research Project, Carlisle, PA: U.S. Army War College, February 18, 2005, p. 12.

154. Redmond, "AAR—Medical Support to Stability Operations," July 10, 2008.

155. Jones *et al*., *Securing Health: Lessons,* pp. 221-273; see also Forsyth, interview by author, October 3, 2008; U.S. Department of the Army, "Army Action Plan for Stability Operations," August 2007, pp. 5-6; Redmond, "AAR—Medical Support to Stability Operations," July 10, 2008.

156. Jones *et al*., *Securing Health: Lessons,* pp. 230-234; see also Wheeler and Hunger, *Strategic Management and Business Policy*, pp. 1-23.

157. Tyrrell, *What To Know Before*, p. 137; failure to address the health of a population effectively can have deleterious effects.

158. Jones *et al*., *Securing Health: Lessons,* pp. 224-225.

159. Ginter *et al*., *Strategic Management of Health Care Organizations*, pp. 175, 562-576, 506-523.

160. "The Future Belongs to Those Who . . . a Guide for Thinking About the Future," Institute for Alternative Futures, available from *www.altfutures.com/docs/FuturesTechniques.pdf*. It is critical for organizations and, in this case, primarily health care supporting institutions, to evolve due to the changes in the environment and cues of uncertainty and other VUCA elements mentioned. "Thinking about the future . . . does in fact increase the probability of success in the future."

161. Flavin, "Planning for Conflict Termination," p. 107; Ross Coffey, "Revisiting CORDS: The Need for Unity of Effort to Secure Victory in Iraq," *Military Review*, March-April 2006, pp. 24-34, emphasizes the need to use our lessons learned to avoid repeating mistakes in future contexts.

162. Friel, "The Powell Leadership Doctrine," p. 257, provides an example indicating that resource abundance and the DoS are not synonymous; see also U.S. Congress, Committee on Armed Services, January 2008, pp. 2-3; U.S. Department of Defense, *Health Capabilities in Stability Operations*, p. 8; Bensahel, *International Perspectives on Interagency Reform*, p. 7.

163. Coffey, "Revisiting CORDS," pp. 24-34.

164. Mendenhall, *Pre-War Planning*, p. 11; see also Special Inspector General Iraq Reconstruction, Iraq Reconstruction: Lessons in Program and Project Management, available from *www.sigir.mil/reports/pdf/Lessons_Learned_March21.pdf*, p. 16; Carafano, "Learning from the Past," p. 173. The lack of a coordinated effort is typically a result of failing to plan as well as failing to exercise plans together prior to conflict.

165. See Figures 1 and 2 in the present Paper; see also Carafano, "Learning from the Past," p. 176; ensuring unity of effort provides for single overall command authority for each phase.

166. Chiarelli and Smith, "Learning from our Modern Wars," pp. 437-450; authors go into great detail on how to address future full-spectrum operations, providing significant stabilization tenets for discussion and discussing changing roles for the military and encouraging the development of cultural mindsets that support this transformation.

167. Richard L. Daft and Karl E. Weick, "Toward a Model of Organizations as Interpretation Systems," *The Academy of Management Review*, Vol. 9, No. 2, 1984, p. 187; organizational change is often widely believed to be caused solely by the external environment; the organization will suddenly move to address the exogenous issue(s). However, this can occur only if the members of an organization actually interpret the specific signals in the same way that higher management does. This also depends on what specific type of organizational change model they may subscribe to. See also Friel, "The Powell Leadership Doctrine," p. 260; a key catch-phrase introduced by "the Powell Leadership Doctrine" is "encouraging change, empowering people, and fighting for resources."

168. Crane, *Landpower and Crisis,* p. 24.

169. U.S. Department of the Army, *Stability Operations*.

170. Colonel Rick Megahan, Chief, Governance Division, PKSOI, interview by author, Carlisle, PA, October 30, 2008.

171. Metz and Millen, *Insurgency and Counterinsurgency*, pp. 35-36; see also U.S. Congress, Committee on Armed Services, January 2008, pp. 2-2 - 2-3; also Office of the Special Inspector General for Iraq Reconstruction, "Key Recurring Management Issues," pp. ii-v; Special Inspector General Iraq Reconstruction Lessons, p. 16; report stated that the ad hoc nature of organizations and operations consumed excess time and resources and lacked appropriate staff, procedures, and systems to effectively direct the effort. See also Flavin, "Planning for Conflict Termination," p. 106; Petraeus, MNF-I Commander's COIN Guidance, pp. 2-4.

172. Natsios, "The Nine Principles," p. 8; see also L. Mori, D. Meddings, and D. Bettcher, "Health, Human Security and the Peace-Building Process," in *Conflict and Human Security: A Search for New Approaches of Peace-Building*, *English Research Report Series* No. 19, p. 176.

173. Metz, *Rethinking Insurgency*, p. 57; recommendations for improved outcomes in insurgent contexts depends on the ability to develop greater interagency efforts in strategy, doctrine, training, and leader development.

174. Flavin, "Planning for Conflict Termination," pp. 105-106; see also Jeffrey B. Clark, *Lesson Relearned: The Urgent Need to Replace Post-Conflict Improvisation with Policy*, Strategy Research Project, Carlisle, PA: U.S. Army War College, March 18, 2005, pp. iii, 2.

175. Farrel, "Stability Reconstruction Skills."

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