# Health Care Challenges in NATO

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**In time - Integrated – Innovative Health Service Support**

# 70th Anniversary of NATO

**Washington Treaty or North Atlantic Treaty**


**Primary aim of the treaty: To share the risk, responsibilities and benefits of collective defense – a pact of mutual assistance**

# NATO in a Nutshell

- North Atlantic Treaty Organization's (NATO) key attribute is the member countries themselves.
- NATO is a political and military alliance between 29 Member Nations
- A "NATO decision" is the collective decision of all 29 member nations and must be by consensus.
- The 3 essential core tasks:
  - Collective Defence
  - Crisis Management
  - Cooperative Security

# NATO Command Structure

## NATO HEADQUARTERS BRUSSELS

Secretary General
Jens Stoltenberg

NORTH ATLANTIC COUNCIL - NAC

MILITARY COMMITTEE - MC

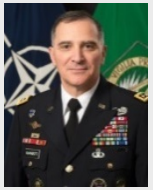
Chairman
Military Committee
Air Chief Marshal
Sir S. Peach

International Staff

International
Military Staff

## STRATEGIC MILITARY COMMANDS

### SHAPE / Allied Command of Operations



Mons / BEL

SACEUR
General Curtis M. Scaparrotti

### Allied Command Transformation

Norfolk / USA

SACT
General A. A. Lanata

# SHAPE MEDAD Functional Tasks

SHAPE/ACO Medical Advisor, as the Senior Medical Officer within NATO is responsible for:

- Guidance and supervision of all medical staffs across ACO, subordinate Commands and on medical matters for NATO operations.
- Planning of Medical support to operations and missions, including deterrence and defence-related measures.
- Liaise with Host Nation (HN), intergovernmental Authorities and increase civil-military interaction,
- Doctrine and Policy Development

# NATO Operations

- **Resolute Support Mission –** Afghanistan
- **Kosovo Force –** Kosovo
- **Operation Sea Guardian –** the Mediterranean
- **NM-I** Iraq
- **NATINAMDS / NATO Support to Turkey**
- **NATO Support to African Union**

# Security Environment

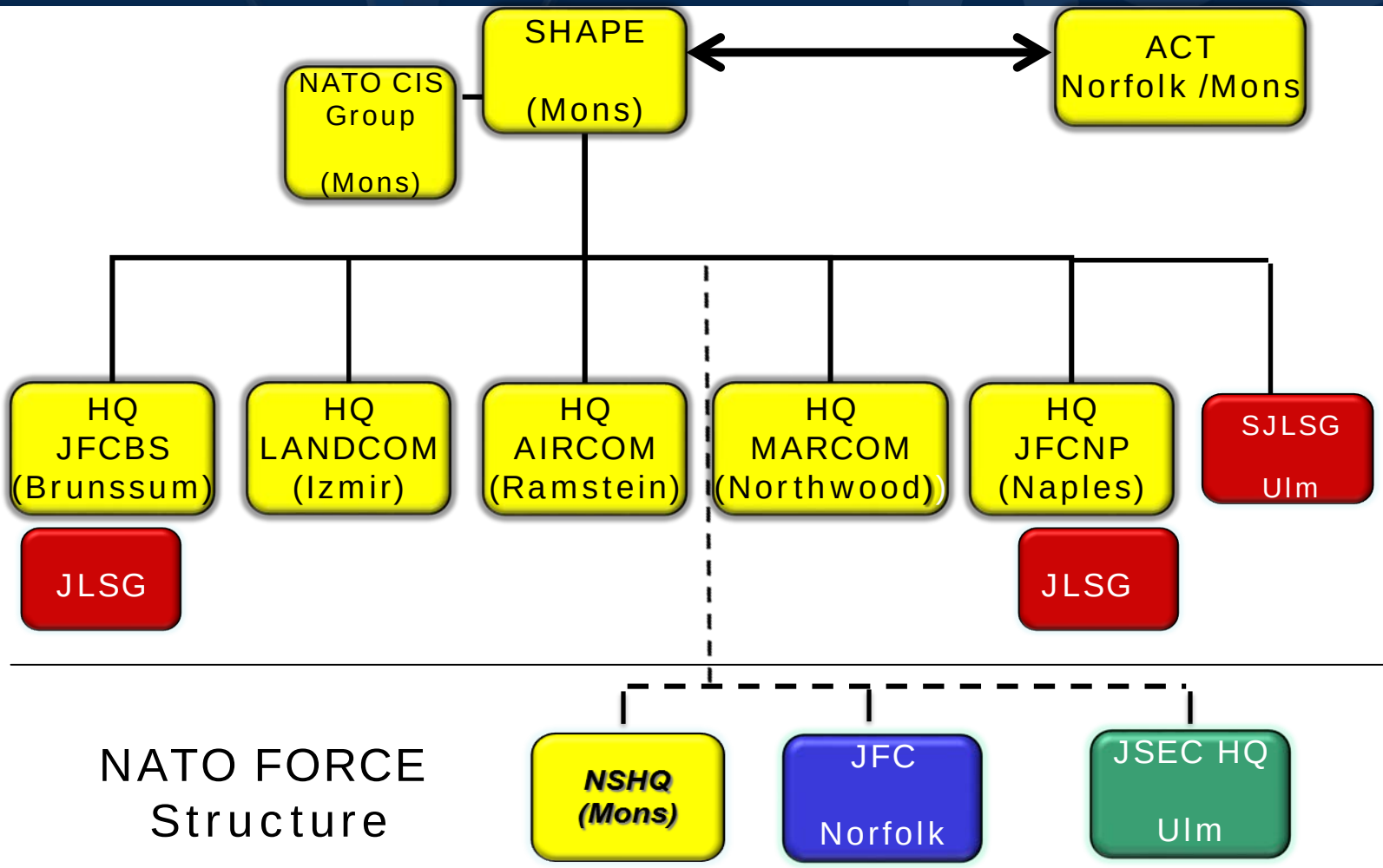
- NATO Sec Gen Stoltenberg: NATO now facing "the biggest security challenges in generations".
- Alliance is confronted with more diverse, complex, fast moving and demanding security environment.
- Faces more challenges and threats from the east and south; from state and non-state actors; from military forces and terrorist; cyber and hybrid attacks.

Secretary General
Jens Stoltenberg

# Wales and Warsaw Summit

- **NATO Response Force (NRF) ≈ 40,000 troops, including a 5,000-strong Spearhead Force (VJTF land) plus maritime and air elements.**
- **4 multinational battlegroups in the Baltic States and Poland (eFP), increased presence in the Black Sea region (tFP), small headquarters to link national and NATO forces (NFIU).**
- **NATO Air Policing for Baltic countries**

# NATO COMMAND STRUCTURE ADAPTION




**Except one HQ - independent medical staff elements in NATO Command Structure (no subordination to J4 branches/divisions). Increase of personnel nearly of 50 %.**

# High Readiness Initiative

NTM vs. RTE

Visibility for SACEUR

Training & Exercise

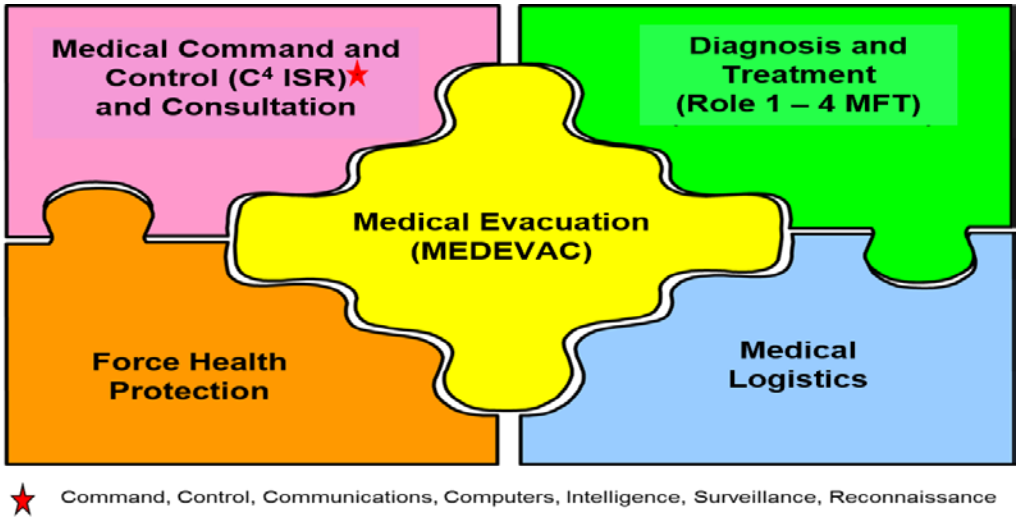

Larger Formations

## Culture of Readiness



# A – NRF

# Health Service Support




- **All elements of the Health Service Support are important enablers for the theatre of operation.**

- **The Healthcare Cycle is an end-to-end process, which includes the full spectrum of capabilities.**

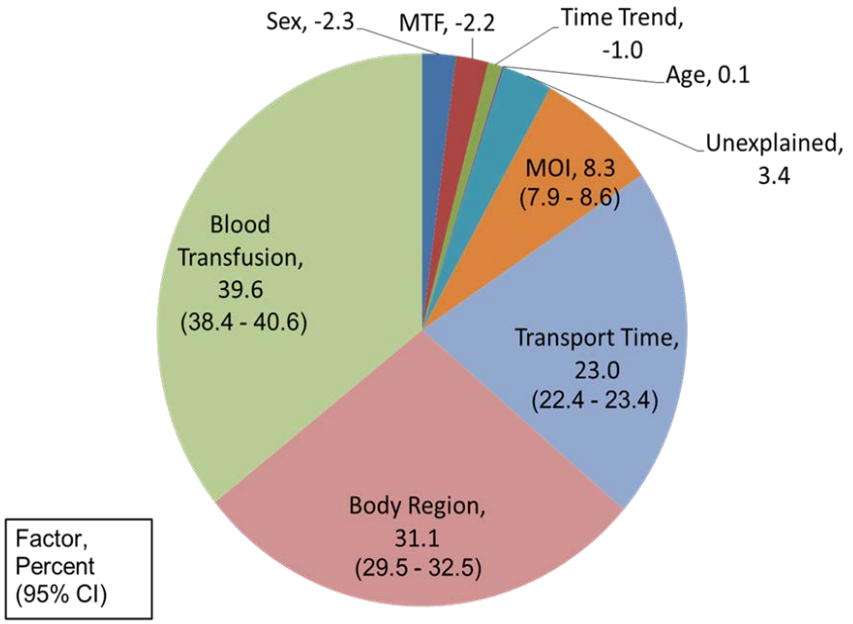
# Golden Hour Policy

**Reduction in KIA mortality is associated with early treatment capabilities, rapid transport, blunt mechanism, select body locations of injury**

**Source: J Trauma Acute Care Surg Volume 84, Number 1, Pg 11-18**

Reexamination of a Battlefield Trauma Golden Hour Policy

Jeffrey T. Howard, PhD, Russ S. Kotwal, MD, Alexis R. Santos-Lazada, PhD, Matthew J. Martin, MD, and Zsolt T. Stockinger, MD, Fort Sam Houston, Texas



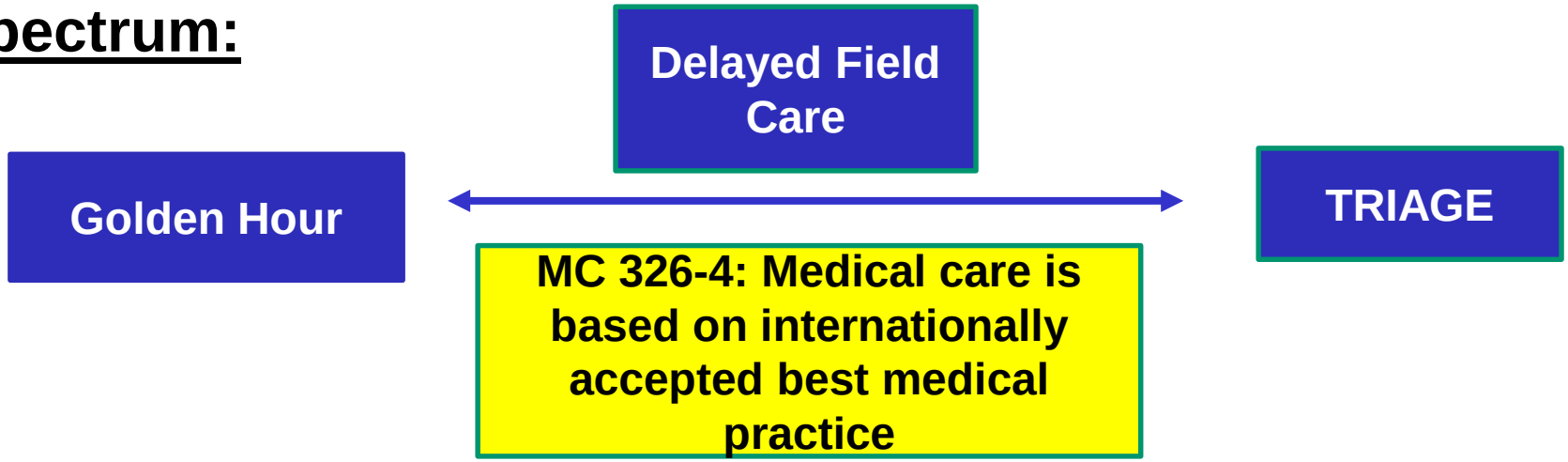

**Percentage of KIA reduction attributable to each factor**

# Medical Support for Collective Defence

## Environment:

- **Joint combined operations with high intensity, high mobility on the tactical and operational level with an increased number of casualties**
- **Hybrid threat mechanisms could be used to destabilize the host nation's civil society.**
- **No Forward Rotary Wing (RW) Medical Evacuation (MEDEVAC) and a reduced RW Tactical MEDEVAC capability in the brigade area due to lack of air superiority and the high intensity combat environment.**
- **Long distance ground MEDEVAC.**
- **NATO Forces' compliance with Humanitarian Conventions for Article V Missions.**

## Spectrum:



# MEDEVAC

| Role 1 MTF Health Care National Responsibility | Provision of Multinational Medical Support (Role2/3 MTF) and health care including Multinational TACMEDEVAC in the JOA of a JFC HQ | STRAT MEDEVAC to Role 4 MTF National Responsibility |
|---|---|---|

**MEDEVAC of patients is a crucial part of the medical treatment provided by the medical support organization.**

**If STRAT MEDEVAC not appropriately managed, increased number of patients overwhelm the capacity of the limited MTFs in the JOA.**

# New Challenges

STRATEVAC out of the JOA in Non Art 5 missions mainly executed by Strategic Aeromedical Evacuation with individual patients on a case by case basis.

For Art 5 operation with higher numbers of patients the concept and processes has to be adapted

Requirement for an integrated sea-air-land MEDEVAC system

SHAPE: COMPREHENSIVE PATIENT FLOW MANAGEMENT CONCEPT FOR ARTICLE 5 MISSIONS



# Clinical Needs

However, in an Article 5 mission and with the anticipated large number of patients, STRAT MEDEVAC assets (air and naval platforms, trains) provided by nations can and should be useable by all patients independent of their nationality but based on the clinical needs and transportation priority. These requirements must be integrated into the OPLAN (STANAGS).

# Request documentation

For patient flow management following documents will be used:

- **“9 Liner”** from POW/Casualty Collecting Point to next treatment facticity
- **Patient Movement Request (PMR)** for an individual patient

And new ones are required!

- **Bulk PMR** for higher number of patients moved to next higher echelon in the Joint Area of Operation
- **Strategic PMR** for every patient, who is stabilized for Strategic Evacuation out of the JOA

# Bulk MEDEVAC

- Movement of 1-10 / 20 / 40 to 60 Patients in one airlift will be necessary

- Requirement: Sufficient assigned, designated or dedicated AE assets (medically configured and equipped platforms or a system of opportunistic tasking of  multi-role mission air platforms)

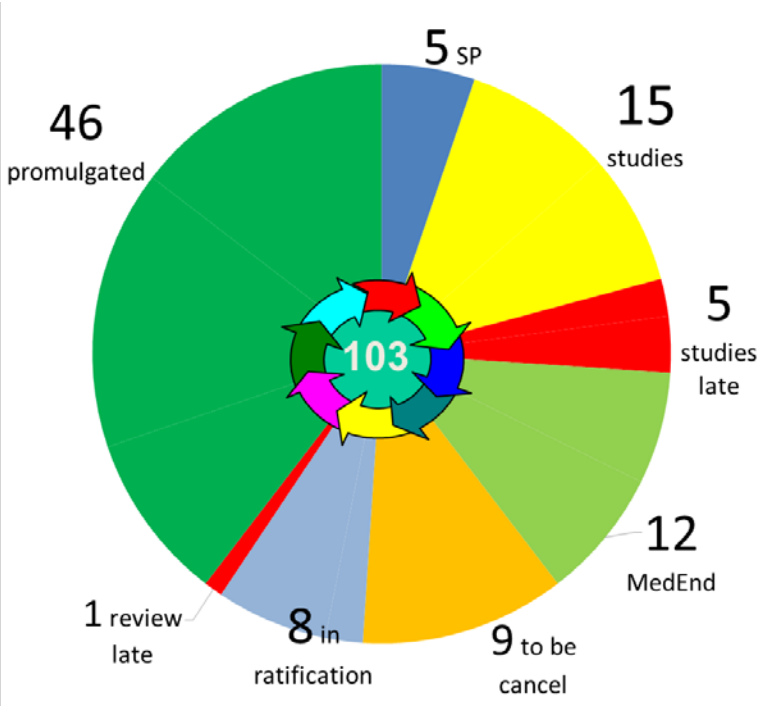
# STANAGS

**Definition of Interoperability:**

The ability to act together coherently, effectively and efficiently to achieve allied tactical, operational and strategic objectives.

**STANAGS**

- MC 326-4: NATO Principles and Policies of Medical Support
- AJP 4.10 Edition B: Allied Joint Doctrine for Medical Support (AJP 4.10 C in final ratification)
- AJMEDP 1 to 9
- AAMEDP: 25



# MEDEVAC

The provision of multinational medical personnel for MEDEVAC is based on:

- AAMedP 1.1 Aeromedical evacuation, 2014
- AAMedP 1.2 Aeromedical training of flight personnel, 2018
- AAMedP 1.20 Recommended Medical Equipment for Aeromedical Evacuation 2018

# Aeromedical Care

Multinational aeromedical care of assigned personnel on flying status and air traffic controller (e.g. NATO Airborne Early Warning & Control Force, E-3A Component)

- AAMedP 1.10 Interchangeability of NATO aircrew medical categories, 2017
- AAMedP 1.13 Minimum requirements for physiological training of aircrew in high G environment, 2017

Nations are responsible for the medical support and healthcare (especially long-term grounding)

Very important scientific work regarding aviation medicine in cooperation with NATO Science and Technology Organization / Human Factors and Medicine Panel

# Global shortage of medical personnel

- Significant reduction in medical capacity and capabilities in NATO nations due to nations' focus on Non-Article 5 Crisis Response Operations.
- Last two decades have seen a decrease of healthcare reserve or surge capacity across Europe due to:
  - National economic drivers to make civilian health systems as lean as possible
  - Decline in the recruitment of healthcare professionals.
- Both military and civilian health services are competing for the same resources

# Medical Resupply

- Hampered by medical supply or vaccination shortages
- Pharmaceutical industry limited production during periods of stability, in favour of a “just-in-time” systems
  - Less likely to be prepared for a disaster relief situation or crisis, deterrence and defence.
- Limited blood products
  - Civilian healthcare facilities and providers are regularly facing capacity problems.
- Storage of medical supply might be required

# Cyber Attacks

- Hybrid warfare threats
  - May significantly hamper a nation's ability to provide health care services and resources.
- Cyber-Attacks is an existing and persistent threat
- Cyber-Attacks on health systems
  - Can destabilize a societies' health care system.
- Recent cyber-attacks on civilian health care systems underline the extent to the cascading effects on medical service provision.

# Health Crisis

Examples of major international health crises:

- 2000: SARS crisis.
- 2009: H1N1 influenza pandemic.
- 2014: Ebola
- 2016: Zika outbreaks.

Key lessons:

- Impossible to predict where the next health crises will come
- We have to be prepared (readiness/responsiveness).

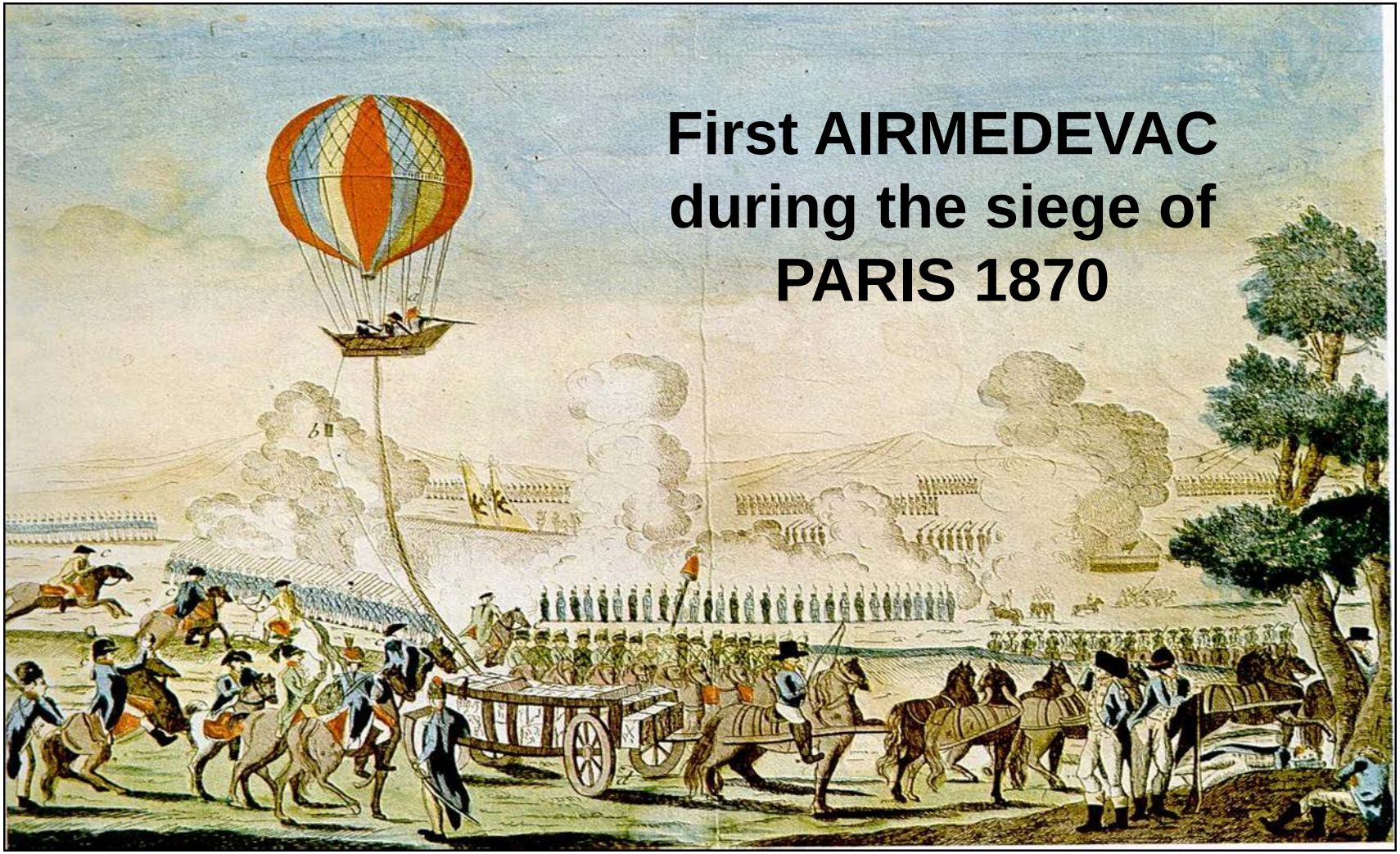
We have to reinforce the efforts to develop MEDEVAC capability and capacity for infectious patients!

# Take Home Message

**“There is only one thing worse than fighting with allies -**

**and that is fighting without them.”**

**Winston Churchill**



# Questions

http://www.philly.com/philly/health/healthcare-exchange/faq/Your_Health_Care_Law_Questions_Answered_with_Robert_I_Field.html