The Evolution of Dependent Medical Care in the U.S. Army

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ABSTRACT There is great focus within the military medical community regarding the ever growing cost of medical care overall and dependent care specifically. A great deal of discussion relates to the delivery of care through a growing military–civilian partnership, where an increased amount of health care will be referred to an ever growing network of civilian providers. The U.S. military establishment now stands at an important crossroad leading into the future of dependent care. However, the special concerns, which arise from the responsibility of caring for military dependents, are not a solely recent phenomenon. Ever since the establishment of a permanent standing U.S. Army in the late 1700s, there have been families in need of medical treatment. Although changes occurred continuously, the development and evolution of policies regulating the delivery of medical care to dependants can be divided into three periods. The first is the longest and ranges from the establishment of the Army until the year 1900. The second period spans from 1900 to the post-Korean War year of 1956. The third and final period is from 1956 to 1975. Special changes and advances in each of these periods have served to shape the face of dependent care in today’s Army Medical Department.

INTRODUCTION Currently, there is much turmoil and concern within the military medical community regarding the ever growing cost of medical care overall with a particular focus on providing medical care to dependents. A great deal of discussion relates to the delivery of care through a growing military–civilian partnership, where an increased amount of health care will be referred to an ever growing network of civilian providers. The U.S. military establishment now stands at an important crossroad leading into the future of dependent care. However, the special concerns, which arise from the responsibility of caring for military dependents, are not a solely recent phenomenon. Ever since the establishment of a permanent standing U.S. Army in the late 1700s, there have been families in need of medical treatment. Although changes occurred continuously, the development and evolution of policies regulating the delivery of medical care to dependants can be divided into three periods. The first is the longest and ranges from the establishment of the Army until the year 1900. The second period spans from 1900 to the post-Korean War year of 1956. The third and final period is from 1956 to 1975. Special changes and advances in each of these periods have served to shape the face of dependent care in today’s Army Medical Department.

1783–1900

Although it is not always wise to assume, it is reasonable to believe that the early Army physicians followed the spirit of the Hippocratic Oath to heal the sick and attend to all persons who had access to their medical care. Those having access in the U.S. Army were the soldiers, officers, and their families. Treating the ill in this manner, while blessed by Hippocrates, may not have been fully sanctioned or funded by the U.S. Government. Records detailing to whom treatment is entitled do not extend back to the very earliest years of the permanent standing Army. However, they do go back quite far.

The earliest guideline establishing parameters of delivery of medical care in the Army is dated March 2, 1799. Section 5 of Statutes at Large states:

“That is shall be the duty of the physician-general, with two or more hospital surgeons, to frame a system of directions relative to the description of patients to be admitted into the hospital.”

This early guideline gives great latitude to the physicians in charge of the hospital. However, the regulation further states that the directions framed by the physicians are:

“Subject in the first instance to the approbation and revision of the commander in chief, the commander of the separate Army, or in separate district as the case may be, and eventually to the approbation and control of the President of the United States: Provided always, that the said directions, having received the sanction of the commander in chief or the commander of the separate Army, shall be operative, and remain in full force, unless altered or annulled by the President of the United States.”

Therefore, in this policy statement of 1799, two very important precedents are set. First, dependants can receive medical care from Army physicians, if the board of physicians decides to make it the policy of their particular facility. Second, the ultimate decisions governing medical policy will always be subject to approval or change by some higher authority. This early statute has had long lasting effects in the realm of medical care delivered by Army physicians. It provides no policy guidance, however, regarding another aspect of dependent care, which has a major impact on current medical care issues. The aspect to which I refer is the incorporation of civilian physicians into the Army medical care system.

The employment of civilian physicians to provide treatment to military personnel was in practice very early. The earliest
regulation governing the employment of military physicians was written in 1808 and given the title, “Regulations Relative to Employment of Physicians.” It stated that:

“In the future no surgeon, surgeon’s mate, or physician, not holding an appointment in the Army of the United States, is to be employed on public account, by any officer or other person whatever to act in the capacity of surgeon or physician for any man, or men attached to the Army, unless by special agreement first entered into, in which the compensation for medical service to be performed, shall be stipulated in writing either by day or by month.”

The fact that the regulation states: “In the future,” indicates that civilian medical treatment was used by Army personnel before 1808. The utilization of nonmilitary physicians makes sense when viewed in the light of westward expansion and the limited number of Army physicians.

The size of the Army ebbed and flowed, as did the authorized size of the medical department. Army detachments were intermittently deployed westward for exploration, thus taking them away from the Army medical facilities. It became practice to hire a nonmilitary physician to accompany patrols westward to provide care for the expedition. Although this practice made sense, it was not authorized until the writing of the above regulation. Although the “Regulation Relative to Employment of Physicians” makes no reference to military families, it is still very important in the respect that the use of civilian physicians is being recognized, authorized, and regulated.

As the territory of the United States expanded westward, so did the Army. In 1818, The Office of the Surgeon General of the Army was established. Permanent posts were built on the ever-expanding frontier and with these permanent assignments came the Army family. Some of the first edicts issued from the new Surgeon General’s office pertained to the distribution of medical services to these outposts.

In 1821, a regulation from the Surgeon General’s Office stated, “Citizens, employed as surgeons, will be allowed the following rates of compensation: for attending a post, garrison, or detachment of one hundred and upwards, including soldier’s wives.” The fact that soldier’s wives are included in the number is truly significant because it indicates that the Army is taking responsibility for the care of military dependents. Following this 1821 regulation, most subsequent regulations included families in the number of those entitled to medical care.

As time went on, regulations were expanded and more detail was given regarding the manner in which civilian physicians were to be paid for their services. In 1827, one such regulation was issued from the Adjutant General’s Office. It stated:

“All bills of private physicians for attendance on officers and their families will be paid by the officers themselves who will be refunded on their presenting the account in the form required by the 1264th paragraph of General Regulations for the Army.”

The above regulation, like the many during this time, dealt with the issue of payment for services rendered by a civilian physician. Before this regulation, families were lumped together with all others assigned to a post or garrison. The 1827 regulation, however, touches on the facet of reimbursement by the Army to individual officers for medical treatment given, solely to them and their families. Although the above regulation was written in 1827, reimbursements took place long before official sanction.

The earliest record of reimbursement occurred on July 9, 1823 to an officer in Mobile, Alabama. The record of payment indicated that a sum of $15.00 had been paid for attendance on the officer and his family from January 4, 1823 to May 2, 1823. Although the incidence of reimbursement taking place before official sanction is important, it is not significant. What is significant is the fact that reimbursements and regulations regarding reimbursements for medical care took place, and these early actions by the Army led to further modification and elaboration in the area of dependent care.

The regulations outlining the procedures to follow when hiring non-Army physicians were refined in 1831 when it was required that the contract with a physician must be in writing, and a duplicate of that contract must be, “Immediately transmitted to the surgeon general.” More detail was also demanded when reimbursement was desired. Private physicians had to submit certificates outlining the propriety of their charges, officers had to submit certificates stating that they had witnessed all treatment given, and reimbursement would only be made after all paperwork had been properly submitted. Regulation changes during the early 1800s were, for the most part, simply attempts to fine-tune the guidelines of medical care given by non-Army physicians, and the authorization for care given to Army families was conspicuous in these early regulations. However, the regulations began to subtly change.

In 1834, the Medical Department issued expanded regulations, broadening the umbrella of medical care. The regulation required surgeons, “to attend all officers, noncommissioned officers, musicians, privates … and the private servants to which each officer is entitled by law.” The most unusual aspect of this regulation is that the only reference to families occurs at the end of the regulation when authorization is given to issue medicines to the families of the personnel stated in the above guideline. No further significant change occurred in the regulations until 1856 when a modification in the guidelines for payment of private physicians was written. Along with a change in payment rates was a statement that authorized servants and laundresses to be included in those allowed to receive medical care. No reference to families was made. Perhaps, families were omitted in this regulation because entitlement of families to treatment had become such common practice that it did not need to be written. However, later regulations indicate another possible reason.
During the years of the Civil War, the Army Medical Department had more pressing concerns than care of dependents. After the Civil War, an interesting development in Army regulations took place. In 1874, the Inspector-General wrote in reference to soldiers:

“The recruiting-regulations, paragraph 930 Revised Army Regulations, say: ‘No man having a wife or a child shall be enlisted in time of peace without special authority obtained from the Adjutant-General’s Office through the superintendent.””

The Inspector-General’s report paints a very unflattering picture of the condition of some Army posts as being “over-run with the wives of enlisted men.” Although the Inspector-General’s report did not directly refer to medical care, it brought to light that wives and children of soldiers were considered by some to be an ever growing problem in need of a solution.

A part of the solution developed in 1884 when the 48th Congress of the United States placed in its Appropriations Bill that, “The Medical Officer of the Army and Contract Surgeon shall, wherever practicable, attend the families of officers and soldiers free of charge.” This brief statement became the cornerstone and legal justification for the medical care of dependents.

1900–1956

At the turn of the century, in one of the first reports to state actual numbers, there were approximately 13,856 civilian attaches of the Army. The 13,856 included families of the Army personnel and families of servants and employees. Along with the annual gathering of numbers of dependents came the annual reports pertaining to the types of treatments these dependents received. The advent of these reports serves to indicate that the care of families is beginning to be monitored more closely by the Army establishment.

The time spanning from 1900 to 1956 can best be termed as a period of growth. Although very little developed pertaining to the written dictates of dependent care, the same cannot be said regarding medical education programs within the Army. During these 56 years, it becomes evident that much of the evolution of care, training, and specialties within the Army coincides with the special medical treatment families require. Of particular impetus during the early part of the 1900s is the rise of civilian–military residency programs.

During the early 1900s, the U.S. Army Medical Department and the American people were occupied with the events surrounding World War I. Large-scale mobilization took place, and many health care professionals donned a uniform. However, following the war, demobilization occurred creating a shortage of trained medical personnel. The Army, to attract highly qualified individuals to meet the military medical needs, started the Army Nursing School in 1918 and the Army Internship program in 1920. The purpose of the residency program was to attract high-quality medical graduates to fill the expanding needs of the Army. The Army also began to offer residency training in many fields including pediatrics, and obstetrics, and gynecology. The Army program flourished, with 200 to 230 interns admitted per year. In 1937, the program was discontinued as a result of the depression when adequate numbers of physicians joined the military because of the fact that income in the military was higher than in the civilian sector. Depressed era conditions also served to be a major catalyst for expansion of military dependent care.

America began mobilizing for war in 1940, and with the buildup came an increased number of dependents. In fact, the number of women and children requiring medical care began to overwhelm the military medical system. As a result, the Children’s Bureau, an agency that had been established under the Social Security Act of 1935, began providing medical care for dependents of the lower four enlisted grades. Military families received medical care through the Children’s Bureau until 1949, when the number of dependents of soldiers shrank to a manageable number.

Immediately following the war, the Army Medical Department expanded services. One such expansion was the establishment of a social work department. Initially established to help soldiers after war, the social work department soon directed attention toward the military family. Counseling programs focused on handling family, marriage and adolescent problems began and continue to this day. The postwar years also saw the return and expansion of the Army Residency Program. Then the Korean War struck, focus shifted and military medicine again experienced problems in delivering care to dependents.

Finally, in 1956, as a direct result of the events which occurred during World War II and the Korean War, Congress established the Dependent’s Medical Care Act, better known as Medicare. This law was necessary because the Army steadily grew, with number of dependents entitled to medical care totaling 2,772,800 by the end of fiscal year 1956.

1956–1975

The span of time from 1956 to 1975 must be considered the period of turmoil. The main purpose of Medicare was to allow military dependents access to medical care through civilian institutions. Following implementation, it did not take long for Congress to become concerned with the soaring costs incurred under the Medicare Act. Rewriting of the law soon followed.

The first alteration in the Medicare Act came in 1958. In an attempt to cut costs, Congress placed restrictions on the types of medical care dependents received from military institutions. The two major changes included limiting dependents right to choose between a military or a civilian institution, and drastically narrowing the scope of care dependents received in the civilian sector. Some cuts were in treatment of emotional disorders, neonatal visits, outpatient treatment for bodily injuries, many X-rays and other lab tests, and planned surgical care. The second change, in 1960, restored coverage for most
of the types of care deleted in 1958 but kept the restrictions on freedom of choice to ensure maximum usage of military facilities.\textsuperscript{21} Medicare was viewed as a major morale, recruitment, and retention factor by soldiers. In fact, 60\% of soldiers in 1961 placed the availability of dependent care as a main reason for continuing a military career.\textsuperscript{22} In the 10 years the Medicare system remained in place, the number of active duty dependents increased from 2,772,800 in 1956 to 3,960,000 in 1966.\textsuperscript{23} Increased expenditures accompanied the steady growth. The cost of the system caused Congress, in 1963, to establish a study by MANPOWER to develop more efficient methods of providing care to the growing number of dependents.\textsuperscript{24} Due in part to the study, in 1966, a major change in dependent care legislation took place.

On September 30, 1966, President Johnson signed Public Law 89-614, which was a major augmentation to military medical benefits. Law 89-614 established a new department to administer dependent care called the Civilian Health and Medical Program of the Uniformed Services, better known as CHAMPUS. The new law removed many restrictions on care of mental disorders and returned to dependents the right to choose between military and civilian care. In addition, medical treatments available to dependents expanded. Family planning services, wheel chairs, hospital beds, artificial limbs, and prosthetic eyes were all made available for the first time to military dependents.\textsuperscript{25} These amendments of 1966 were a powerful move to better the benefits of military dependents. However, it was not long before CHAMPUS came under major scrutiny because of the soaring costs of medical care.

By 1974, the number of dependents eligible to receive medical care under CHAMPUS had increased to over six million. This resulted in a phenomenal increase in expenditure from 75 million dollars in 1966 to 507.7 million dollars in 1974. As a result, the Senate began to closely scrutinize CHAMPUS and made changes in the medical benefits available to dependents. The cuts of 1974 included limitations in psychiatric care, treatment of learning disabilities, orthodontic services, dental treatments, and some forms of outpatient care.\textsuperscript{26} Although many changes and limitations took place in medical care of dependents, the period from 1956 to 1975 included some solid expansions of dependent specific care.

The Army Medical Department established the first military Adolescent Clinic in 1958.\textsuperscript{27} In 1971, the Surgeon General required that an Adolescent Medicine Service be established at all Army teaching hospitals.\textsuperscript{28} Also a nursing midwife program was started to add another facet to maternal care. The final major and perhaps most important medical advancement in the arena of dependent care occurred in 1972 with the establishment of the Army’s Family Practice Residency Program.\textsuperscript{29} The family practice program began at Fort Benning with nine residents in training. Since that time, the program has grown and the family practice option is one of the most popular and requested forms of treatment by Army dependents and is the cornerstone of military primary care.

**SUMMARY**

Dependent medical care in the Army is not a new development. The Army has provided medical care for dependents since the very early days of a permanent standing force. Since that time, many significant developments have evolved. Westward expansion and limited medical resources resulted in the incorporation of civilian doctors in the military medical community. Expanding forces and new demands resulted in many diverse Army residency training opportunities. The problems encountered during World War II and Korea shocked the military and the government. As a result, the first actual laws were passed to ensure that military dependents would always receive the medical care that they need. These laws (Medicare and CHAMPUS) became a double-edged sword. Their inception has resulted in unprecedented medical demands and costs, which are of major concern to the government and the military community. However, since the establishment of Medicare and CHAMPUS, medical care expansions have resulted in a wide range of excellent medical care available to Army families. The evolution and development of dependent care in the Army has had a profound influence on the military medical community and, to a large extent, has shaped Army training and treatment functions. What about the future of dependent care? The answer to this question is anything but simple, and since this is a history review, it is a question that will remain untouched. Suffice it to say, the medical care of dependents is so interwoven in the history and tradition of the Army that it is undoubtedly here to stay.

**REFERENCES**

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