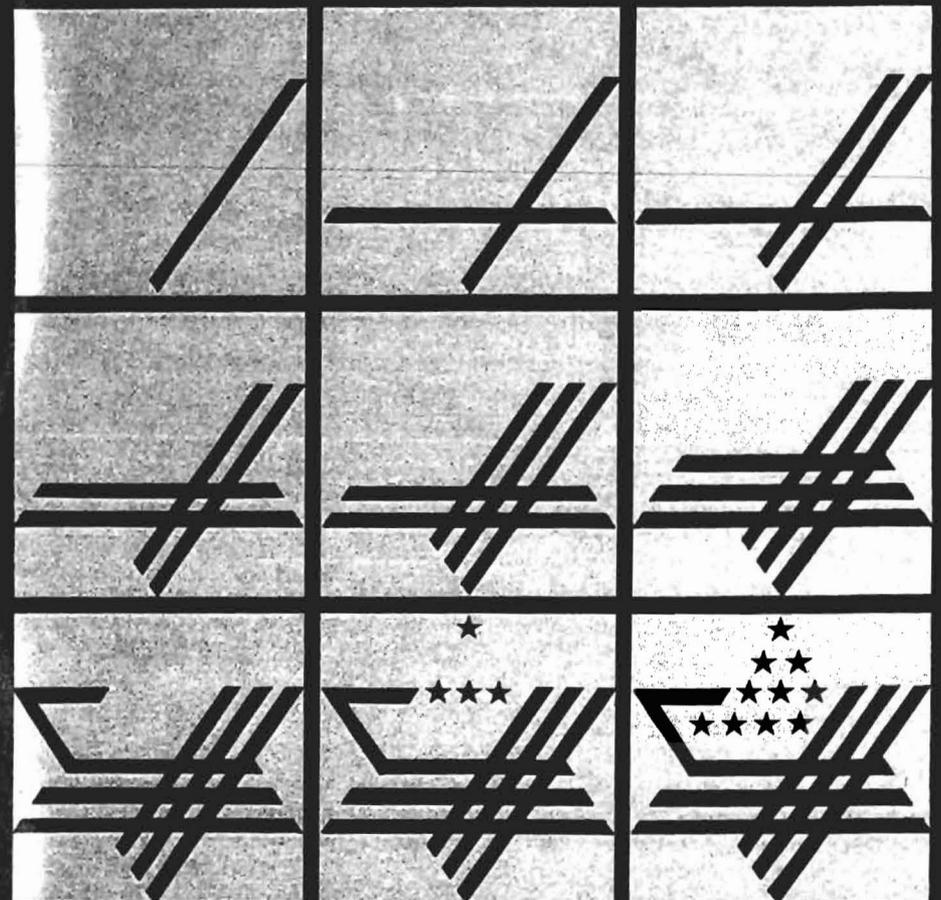


A Publication of:
AMERICAN ISRAEL PUBLIC AFFAIRS COMMITTEE
444 NORTH CAPITOL STREET, N.W.
WASHINGTON, D.C. 20001
(202) 638-2256

Israeli Medical Support for the U.S. Armed Forces

Stephen P. Glick





Israeli Medical Support for the U.S. Armed Forces

Stephen P. Glick

AIPAC Papers On U.S.-Israel Relations

This paper continues research initiated by Guilford Glazer

PREFACE

Publication of this study, after many months of research, happens to coincide with a major discussion between President Reagan and Prime Minister Shamir on enhancing U.S.-Israel strategic and defense cooperation. The agenda of this summit includes the issue of medical cooperation, which became a matter of national attention after the brutal bombing of the U.S. Marine barracks in Beirut on October 23.

But this study was not initiated in response to this tragedy, nor is it concerned primarily with Lebanon. Rather, it looks at the medical support requirements of the U.S. armed forces in the wider context of Middle Eastern crises in which the U.S. might find it necessary to act. The author, Stephen P. Glick, is a military analyst and regular contributor on defense issues for various periodicals.

The study continues a series on the potential for enhanced cooperation between the two countries, past publications of which include *The Strategic Value of Israel*, *Israel and the U.S. Air Force*, and *Israel and the U.S. Navy*. The overall purpose of this thematic series is to enhance public understanding of the ways in which the security of the United States, Israel and the non-communist world would be increased by strategic cooperation between the United States and its most enduring, reliable, and effective Middle East ally. We are encouraged by the fact that, after a period of neglect, this issue is beginning to receive attention in the higher councils of our government.

Thomas A. Dine
Executive Director
November 28, 1983

The AIPAC Papers on U.S.-Israel Relations

Editor: Steven J. Rosen
Managing Editor: Fay Randall

- No. 1 The Strategic Value of Israel
- No. 2 Israel and the U.S. Air Force
- No. 3 The Campaign to Discredit Israel
- No. 4 Israel and the U.S. Navy
- No. 5 Israeli Medical Support For the U.S. Armed Forces

Subscriptions price for ten issues:
\$25 for members
\$30 for nonmembers

Not available on a single issue basis

Inquire for bulk purchase rates

© Copyright 1983 by the American Israel Public Affairs Committee.

Second Printing

Cover design by Jill Indyk

EXECUTIVE SUMMARY

American military planners encounter serious difficulties in trying to arrange adequate medical care for American servicemen in foreseeable wartime situations, particularly in the Middle East and the Persian Gulf. The medical requirements for a large-scale conflict in the region could exceed the provision of over 17,000 beds. Currently, the United States armed forces are capable of providing only about half that number, under optimum conditions. The resulting shortfall could cause many otherwise unnecessary deaths among American casualties.

A shortage of deployable medical facilities is not the only problem afflicting American military medical planners when considering a Middle East scenario. There are desperate shortages of skilled medical and support personnel, which would need to be addressed if deployed hospitals were to be operational. In addition, the American military is short of aeromedical evacuation capacity needed to move casualties within and out of the theater.

To deal with these problems, the armed services have begun a number of programs. However, it will be at least the end of the decade before enough of the deployable facilities and evacuation aircraft will be ready. The services do not expect to make up the staffing shortages without resort to a possibly infeasible draft of health care professionals.

Until and unless all of the desired programs are completed, and perhaps even then, America's military planners must seek other solutions. One such solution might be to use the medical facilities that exist in Europe. However, those facilities are several thousand miles away, requiring large amounts of aeromedical evacuation capacity and involving long delays until the casualties receive proper treatment. Also, these European facilities might not be available due to military or political factors. Another solution might be to have the Arab states of the Persian Gulf make the necessary peacetime arrangements to place portions of their hospital systems at the disposal of the American armed forces during war. Unfortunately, most of these nations possess systems that are inadequate for their own needs, let alone for handling large numbers of American casualties. And none of these states has been willing to make the necessary peacetime preparations for such an arrangement.

However, there is one nation in the Middle East that not only possesses a large, modern medical system, but has explicitly offered such assistance to the United States. Israel could, through a combination of its own existing hospitals and prepositioned American 'folding hospitals', provide about 4,000 beds—tripling the ready medical capacity of American forces in the Middle East. Furthermore, the geographic position of Israel would allow such facilities to support American forces in the Eastern Mediterranean and supplement the American medical system in Europe.

The major objection to such an arrangement with Israel is the assertion that it would antagonize Arab nations with which the United States wishes to be on friendly terms. This argument fails to note that the United States has been able to improve its relations with Arab nations while growing closer to Israel. In the case of Israeli medical support for American forces, it is clear that such a humanitarian move cannot be interpreted as hostile to the Arab world. In fact, by enhancing America's ability to defend the region against outside aggression, such an arrangement would serve the interests of the moderate Arab states.

By exploiting medical facilities in Israel, the United States can demonstrate the strength of its resolve to defend its interests in the Middle East. This demonstration in turn will deter potential aggressors, thus lessening the chances of a conflict. Most importantly, these arrangements with Israel would help to ensure that, should a conflict occur, everything possible will be done to protect the lives of American soldiers.

TABLE OF CONTENTS

Preface	iii
Executive Summary	v
Israeli Medical Support for the U.S. Armed Forces	1
Introduction	1
The Problem	2
Effects of the Shortfall	4
Programmed Solutions	4
Alternate Solutions	6
The Israeli Option	8
Arab Objections	11
Conclusion	12
Appendix A The Hospital Bed Shortage	13
Appendix B Sizes of Some Hospital Systems	14
Footnotes	15

Israeli Medical Support for the U.S. Armed Forces

Introduction

American military planners have encountered serious difficulties in trying to arrange adequate medical care for American servicemen in future wartime scenarios. Major shortages exist in physical facilities (hospitals), personnel, and aeromedical evacuation capabilities. To quote the Assistant Secretary of Defense (Health Affairs), "The harsh reality is that if the United States entered combat today, whether in the Far East, in Southwest Asia, or in Europe, we could not care for our casualties."¹

The United States military would find it particularly difficult to provide reasonable levels of medical care for forces deployed in the Middle East/Persian Gulf, because we do not have large-scale bases in the area. It is openly recognized that a medical support problem exists, though the exact dimensions of the shortage have never been made public. It is possible, however, to estimate the size of the medical facilities that would be required and available to support a large-scale deployment of forces to the Persian Gulf from Congressional testimony and other sources (see Appendix A). These indicate that the United States may now be able to provide only about half of the medical facilities needed in-theater to care for its sick and wounded during a conflict in this region.

The nearest out-of-theater facilities, attached to our NATO forces in Europe, are a considerable distance from the Persian Gulf. In addition, the medical resources in Europe may not be available to the Middle East command (now known as Central Command, which is chiefly a planning staff) either because of urgent need in the NATO theater or because of possible political circumstances.

Another choice might be to obtain support from one or more of the Arab states surrounding the Persian Gulf (the anticipated center of operations for the region). However, these nations, including those already cooperating in other arrangements with the United States, have not provided this type of support on a substantial scale. Even if these nations should decide to assist with medical support, the size and character of their medical systems would render their contribution of limited use.

A major alternative now being explored is to employ the medical support offered by Israel and to preposition U.S. equipment in Israel. In a crisis, Israel's hospital system is large enough to cover much of the anticipated shortage of hospital facilities. The quality of Israeli medical care is on a par with that of the United States. Moreover, the expertise of Israel's medical professionals in the field of battlefield medicine as well as in the diseases of the Middle East is unequalled. Furthermore, Israel's location makes its facilities available for contingencies involving American forces in the eastern Mediterranean and Europe as well as the Middle East.

The Problem

In order to properly understand the importance of Israeli medical care for American forces, it is necessary first to examine what medical resources the United States military can provide for its troops in the Middle East. Currently, according to the Pentagon, the United States armed forces “. . . do not have even enough deployable hospitals of any kind to provide even the emergency surgical treatment required to prepare the predicted numbers of patients for evacuation.”²

A large-scale American deployment to the Middle East could involve as many as 300,000 troops, including six combat divisions, fourteen wings of tactical aircraft, three carrier battle groups, and supporting forces.³ While the anticipated hospital needs of a force that size have not been released, it is likely that at least 17,000 hospital beds would be needed for a major conflict in the Persian Gulf (see Appendix A for a discussion of how this figure was calculated). A smaller force would probably require fewer beds, as would be the case during the early stages when a larger force was being transported to the region. Despite this, it is reasonable to project a need for 17,000 beds, since military planners must count on being able to provide a reasonable level of support for a 300,000 man force.

The armed services can provide at most half of the rapidly deployable medical facilities that would be needed to sustain a speedy, large-scale Central Command force buildup—8,000 beds out of the anticipated requirement of 17,000 or more beds.

To achieve this figure alone would require all of the Navy's amphibious assault helicopter carriers (LPHs) and amphibious assault ships (LHAs) (carrying a total of 3,600 beds), the Marine Rapidly Deployable Medical Facility stored on a cargo vessel off the island of Diego Garcia in the Indian Ocean (1,000 beds), its Army predecessor now stored in California (1,000 beds), all of the Air Force's Air Transportable Hospitals (576 beds), and another 1,800 beds prepositioned in Europe and the United States.

Actually it is unlikely that all 8,000 hospital beds could be deployed to the Middle East. Many of the shipboard hospitals will be unavailable, since about one-third of all ships of each type will be undergoing maintenance and overhaul at any one time in the United States. In any case, it is uncertain that the U.S. Navy would be able to gather together all these ships in time of crisis. Nor could the Air Force send all its Air Transportable Hospitals to Central Command, since to do so would leave the remaining air wings bereft of mobile hospital facilities. Many of the deployable hospitals in Europe and the United States have been in storage for a long time and are considered to be both unready and unsuitable for rapid deployment to the Middle East. Many of them require that the sites at which they are to be set up be provided with pre-existing shelters and the complete range of utility services. These conditions are present in Europe where it was originally envisioned that many of these hospitals would be used. Such pre-existing amenities simply do not exist in the Middle East. Thus it will be necessary to construct shelters and provide support services for those hospitals which are not wholly self-contained. This will increase the time needed to make these hospitals fully operational. Even the fully deployable hospitals (those possessing their own shelters, water purifiers, power sources, etc.) might still require weeks to become fully operational after arrival at their sites.⁴

In Vietnam, for example, the establishment of medical systems was leisurely and largely unopposed. Nevertheless, it often took much longer than expected to get new hospitals into use because of the many problems associated with the new environment.⁵ The circumstances accompanying a Central Command deployment in the Middle East would be considerably more urgent than in Vietnam. The consequent dangers, confusion and problems of adaptations would therefore make both the deployment and achievement of full operational status even slower.

The U.S. military also anticipates difficulties in transporting the hospitals to the theater. The larger hospitals, such as the Army's general hospital, could require 100 C-141 and 30 C-5A sorties. At this time the American armed services have only 254 C-141s and 73 C-5As. Airlift in such quantities might be unavailable because of the other heavy demands on America's limited transport capabilities at the time. The combination of these and other factors could reduce the number of available beds by 2,000 or more.⁶ This would leave a shortfall of over 10,000 beds.

Even if the hospitals were available, the U.S. military faces a serious shortage of medical and medical support personnel. The shortages are greatest in certain critical skill areas, such as surgeons. At this time all active, reserve, and national guard personnel and units together, are only able to provide 32 per cent of the surgeons needed during wartime.⁷ According to the Assistant Secretary of Defense (Health Affairs), “An inadequate surgical capability is a ‘war-stopper . . .’”⁸ The shortage of nurses is estimated at over 30,000 and

the overall medical personnel shortage is close to 200,000.⁹ These estimates envisage American involvement in a major war in Central Europe as well as in the Middle East. However, they indicate that the shortages of medical personnel are so great that they would seriously hamper a deployment in the Middle East while maintaining necessary levels of medical support elsewhere.

Effects of the Shortfall

The consequences of this shortfall of medical facilities could be devastating. If a conflict should occur, the shortage of properly functioning hospitals could mean many more deaths among American casualties than would otherwise be the case. According to one estimate, one of every four soldiers wounded in combat could die as a result of the shortage of medical care.¹⁰ Losses on this scale could reduce morale of American soldiers, lowering their combat effectiveness. This shortage of adequate medical care could even increase the likelihood of a conflict by reducing the credibility of our deterrent. In a statement calling for additional procurement of deployable medical facilities, then-Commandant of the Marine Corps General Barrow stated, "I am confident that hospital ships and fleet hospitals in their own way can do as much to foster deterrence as do other higher visibility weapons systems."¹¹

The scarcity of deployable hospitals will also aggravate the already acute shortage of aeromedical evacuation transport. The comparatively limited facilities of the forward deployable hospitals will force the evacuation, to fully equipped hospitals outside the theater, of most patients needing serious care. When large numbers of casualties are involved, even more aeromedical transport aircraft will be needed. Currently, the U.S. has only about 35 dedicated aeromedical evacuation aircraft.¹² Other transport aircraft can be used for this role, and in fact this was done in October 1983, when wounded Marines were flown from Beirut. However, the U.S. has a serious shortage of strategic and tactical airlift and using those planes for aeromedical transport would divert them from other important missions.

Programmed Solutions

The U.S. armed forces have adopted a number of programs to solve these problems. Providing adequate quantities of in-theater hospitals has received the most attention, reflected in a multi-service, multi-year acquisition program. The Navy has begun to acquire hospital ships (2,000 beds in two ships), and Fleet Hospitals (with 2,500 beds). The Air Force is procuring several Rapid Deployment Force hospitals (250 beds apiece), as well as

additional aeromedical staging facilities to support longer distance aeromedical evacuations. The Army has initiated procurement of 500 and 1,000 bed Mobile Army Surgical, Combat Zone, and Communications Zone Hospitals.

However, the procurement of these facilities will not solve the military medical problem. All these planned facilities will not be ready until almost the end of this decade, if then. That completion date assumes that the programs continue to be funded according to schedule and that no major problems arise. These hospital systems are also expensive. The cost of procuring these hospitals is about \$49,000 per bed.¹³ Some of the planned hospital facilities will be even more costly. For example, the hospital ships have a predicted acquisition/modification cost of \$580 million (\$290,000/bed).¹⁴ There are also disagreements over specific acquisitions. For example, purchase of the hospital ships has been delayed for well over a year by debates over the type to be procured.¹⁵ Finally, there is a constant and inevitable competition between the concrete, definable peacetime demands upon the military medical system and the uncertain, debatable, and costly wartime requirements that hopefully will never be needed.¹⁶ Yet another difficulty is the competition for scarce medical resources from other theaters.

Another important problem is where the deployable hospitals will be prepositioned. Optimally, the hospitals would be stored near anticipated battle areas, but not so close to the frontlines as to risk their capture during an enemy advance. Unfortunately, none of the 'first-line' nations in Southwest Asia, which the United States has approached to assist in the preparations for Central Command, seems willing to preposition medical facilities on its territory. This means that hospitals will have to be stored outside the theater and that it will take days or even weeks to transport to the area of need. Only if combat forces are given a lower priority than hospitals could these medical facilities arrive earlier.

To relieve the shortage of aeromedical evacuation, the American military is depending upon a mix of solutions. It appears that the greatest increase in aeromedical transport will come from the wartime conversion of other transport aircraft. The military is also planning to procure additional dedicated aeromedical evacuation aircraft. Military planners, however, seem to be counting on increased in-theater hospital capacity to hold down the demand for aeromedical evacuation.

To provide adequate numbers of hospital personnel, three solutions have been adopted. The first, already well underway, has been an intense recruitment campaign to raise medical strength to authorized levels of qualified individuals, particularly for the reserves. Second, non-medical personnel are being retrained to fill needed slots. Third, preparations are being made for a draft of trained health care personnel, including women. Although this draft has been in the planning stages for some time, it has not yet been presented to

the Congress. It is unclear whether this draft would ever be enacted into law, or if it could survive anticipated legal challenges.¹⁷

Alternate Solutions

Until all of the planned military medical programs are completed, and perhaps even then, American military planners will have to seek additional solutions in order to provide adequate medical care for American servicemen in case of a conflict in the Middle East. One possible solution is to employ already existing American and European medical facilities in NATO to compensate in part for shortages in-theater. The use of such facilities, however, would depend upon their actually being available. For any of several reasons, that might not be the case. First, should a conflict spread to Europe, the facilities there would be fully utilized. Even if it only appeared that the conflict might spread to Europe, it would certainly be preferable to keep most of the hospitals there free for a NATO contingency. Moreover, in some circumstances, America's NATO allies might be reluctant to allow use of facilities in their countries for fear of adverse reactions in the Middle East or Eastern Europe.

Even if these problems did not arise, the military medical facilities in Europe are roughly three thousand miles from the most likely areas of conflict in the Middle East (around the Persian Gulf). Flying casualties to Europe would increase the strain on the already limited aeromedical evacuation capacity. It could also mean a long, exhausting evacuation trip (lasting seven or more hours) that could further increase the mortality rate of the wounded evacuees. Finally, at that distance, aeromedical evacuation aircraft are at the limit of their range. This will require them to refuel enroute at a friendly airbase. This would further increase the evacuation time. It would also require the cooperation of one or more conveniently situated nations. This cooperation can no longer be taken for granted. For example, in September 1983, Greece and Turkey, American NATO allies, refused to allow American aircraft supporting the American deployment in Lebanon to land in their countries.¹⁸ Put simply, the use of medical facilities in Europe does not provide an adequate solution.

Optimally, the United States should try to arrange for the nations of the Middle East to reserve portions of their medical systems for the use of Central Command. In fact, American forces are directed to use local facilities whenever possible by the current U.S. Defense Guidance, the policy document of the Department of Defense. It states "Host nation support is to be used to the maximum practical extent."¹⁹

However, few nations in the region possess adequate medical facilities for the United States armed forces. Most of them have fairly small medical

systems (see Appendix B), and many of their hospitals are antiquated. In any case, most of the systems can barely care for the needs of their own populations. Even Saudi Arabia, which has invested great sums of money in health care since 1973, possesses less than 7,000 hospital beds, only .72 per 1,000 people.

Although Iran and Iraq each have hospital systems with over 15,000 beds (.52 and 1.23 beds respectively per 1,000 people), their systems were already fully occupied tending to the needs of their populations even before the war between them broke out. Since then, their hospitals have been pushed to the limit of their capabilities. Moreover, Iraq is a formal ally of the Soviet Union and Iran has declared the United States to be one of its foremost enemies.

Egypt, which possesses by far the largest health care system in the Arab world (over 24,000 hospital beds) has to care for a population of over 38 million people with only .64 beds per 1,000 people. Although Egypt's medical system is considered to be one of the best in the Arab world, only two of its hospitals are regarded as adequate even for American tourists.²⁰

In any case, none of the nations in Central Command's region of responsibility in the Middle East (which excludes Israel, Lebanon, Syria, and Turkey) have been willing to make the necessary peacetime preparations to provide wartime medical support. Many of the nations within the region are actively hostile to the United States (such as Afghanistan, Iran, and South Yemen), while others have not been willing to support the existence and purpose of Central Command (such as Saudi Arabia, Kuwait, and the United Arab Emirates).

Other nations, (Egypt, Sudan, Oman, Somalia, and Kenya) are assisting the United States in preparing for Central Command's possible deployment by providing certain types of conditional assistance in exchange for American aid. However, they have not made the necessary arrangements to provide medical assistance to the United States. Such arrangements cannot easily be established in the midst of a conflict. To be effective, they must be negotiated in detail during peacetime. These arrangements affect the standard operating procedures of the services and require a firm commitment from the host country to assist the United States in time of war. This type of commitment has not been forthcoming from any of the nations currently assisting Central Command.

The unpopularity of ties to the United States plagues Central Command's operational planning. In many cases, governments of the area friendly to the United States lack a popular base and are unstable. Often, a friendly regime's very association with the United States undermines its domestic support. Should such governments be overthrown, they are all too likely to be replaced by anti-American regimes. During a crisis requiring American intervention, even regimes wishing to remain close to the United States might be forced to repudiate promised assistance in order to remain in power. Thus, even if the

medical facilities were adequate and were actually offered, the reliability of such arrangements would be doubtful.

The Israeli Option

Israel is the one country of the Middle East which has repeatedly expressed a willingness to assist the United States by providing medical support to American armed forces. It formally agreed to such an undertaking in the 1981 Memorandum of Understanding on strategic cooperation (which, unfortunately, was later suspended by the United States). Israel has offered to perform such services several times since, most recently after the terrorist bombing of the Marine barracks in Beirut in October 1983. The concept of such cooperation is supported by a wide spectrum of political leaders and by the Israeli public, so practical arrangements could be built on a solid political foundation (unlike many Arab countries, where there is strong opposition to defense cooperation with the United States).

Israel is also the only country in the Middle East capable of providing medical support on a substantial scale. It has 18,000 beds in 106 hospitals²¹—more than all the ‘friendly’ Persian Gulf Arab states combined. Relative to population, Israel has roughly six times the capabilities of the Arab countries (4.72 beds per 1,000 people versus .64 in Egypt and .72 in Saudi Arabia, for example).²² Its medical system is, of necessity, designed for wartime expansion. This capability was demonstrated in October 1973, when up to 9,000 hospital beds were readied for military use within eight hours of mobilization. Possibly Israel can mobilize an even larger number today.²³

Of course, it cannot be assumed that all of the theoretically available beds could be provided to the American armed forces. A complete mobilization could be achieved only by imposing a considerable strain on the facilities, the civilian population of Israel, and particularly on the medical personnel involved. Nor could the possibility that Israel might be attacked while providing such support be excluded. Israel would have to reserve a portion of its medical capacity for its own use.

Despite these difficulties, it should be possible to provide and preposition medical facilities in Israel that would approximately triple the medical resources currently available to Central Command in the region. This could be accomplished through a series of measures using existing Israeli facilities, supplemented by American resources, resulting in a considerable capability in place in a relatively short period of time. First, the Israeli hospital system has, on the average, 1,000 vacant beds²⁴ which could be made available immediately. Second, Israel might agree to provide a fraction (e.g. 25%) of its sustained mobilization capability, for an additional 1,500 beds. Third, to

reduce reliance on some of the austere measures Israel uses to expand wartime capacity for its own casualties (such as the placement of temporary beds in large rooms), currently vacant hospital buildings, such as the former Tel-Hashomer facility, could be outfitted with perhaps 500 beds as facilities exclusively for American use. Fourth, the United States could preposition in Israel a “folding” deployable hospital with 1,000 beds, like that currently stored at Diego Garcia. The combination of such near-term, cost-effective solutions would provide Central Command with 4,000 extra beds in the region, going a long way to correct the shortfall of current capabilities.

Beyond its size, Israel’s medical system is also modern. Over 80 per cent of the system has been constructed in the last 35 years.²⁵ Hospital care is on a par with that provided in the United States (not the case in other Middle Eastern states). Most of the health care personnel speak English. In addition, many of the physicians have trained, studied, or practiced in the United States, and are familiar with the latest procedures and treatments in their respective fields. Also, because of Israel’s unfortunate war experiences, virtually all Israeli health personnel are familiar with the problems and procedures encountered in modern military medicine. This experience represents an invaluable asset. Israeli hospitals possess special units to treat virtually every type of wound to be found on the modern battlefield.

The Israeli medical system would be particularly useful in treating troops stricken with disease. Israeli doctors are familiar with almost every disease to be found in the Middle East. This familiarity stems from the need to deal with the wide variety of illnesses brought to Israel by two generations of immigrants from Middle Eastern countries. Experience in past wars has shown that a majority of American troops admitted to hospitals were suffering from exposure to indigenous diseases. In fact, during some years of the Korean War about two-thirds of the hospital admissions were for disease. In Vietnam the disease admissions never dropped below 60% of the total. Since Israeli doctors are likely to be more familiar with the local diseases than their American counterparts, the sick soldiers would get superior treatment in Israel. Also, since the troops stricken by disease would most likely be capable of returning to their units in a comparatively short time, it would be better to keep them within the theater. If they are evacuated out of the theater it would be far more difficult to return them to their units. It was for this reason that the U.S. expanded its hospital facilities for disease victims during the Vietnam war. By removing them from front-line hospitals to Israel, more of those facilities would be available for combat casualties needing more urgent and timely care.

The Israeli health care system also has sophisticated rehabilitation facilities for the severely wounded. Though the American military will probably prefer to fly such casualties back to the United States, cooperation between the two

countries would enable both of them to improve their rehabilitation procedures and facilities.

Israel's geographical position also enables her facilities to directly support American forces operating in the Eastern Mediterranean, or to treat casualties from a conflict in Europe. Since Israel is only about five to six hours flight time from Central Europe, as opposed to the 11 hour flight from Central Europe to the eastern United States, its hospitals could be a useful supplement to the American hospitals in Europe. This would be most valuable when caring for casualties who could be returned to duty after a few weeks of treatment. In addition, the shorter distance to hospitals in Israel would dramatically reduce the demand for aeromedical evacuation aircraft.

Israel is also well-placed to serve as a prepositioning site for hospitals intended for use in forward areas, either in Europe or in the Middle East. Israel is only about two hours flight time from the Persian Gulf, as compared to seven hours from Diego Garcia to the Persian Gulf. The security that Israel's military prowess brings to its territory can protect prepositioned equipment from guerrilla or terrorist attacks. In other countries in the region, a comparable level of security might require the peacetime stationing of American combat units, a possibility that is anathema to all of America's other supporters in the region. This same security can guarantee the safety of American soldiers convalescing in Israeli hospitals during wartime against attacks from guerrilla forces or terrorists. As a result the United States would not have to use scarce combat units to protect hospitals from those who might not respect the sanctity of those hospitals.

The greatest advantage to the United States of using the Israeli health care system for Central Command is that it is already in place and fully operational. It would not be necessary to wait weeks for hospitals to arrive and be established. The whole system could be ready to operate in a matter of hours. Nor would it require the diversion from other tasks of precious mobility assets. The problems to be expected when systems are taken out of storage and sent into the field would be minimized. Because the medicines would be part of a constantly rotated stock, needing only augmentation, there would be no worry about shelf life. The shortage of personnel that could severely hamper American military medicine would be less of a problem if Israel's medical system were used, since there would be less need to worry about staffing hospitals.

For the United States to take full advantage of Israeli medical facilities, arrangements must be worked out in peacetime. Adoption of standard operating procedures that will make possible such medical cooperation must be done before a crisis takes place. It is not possible to rely on *ad hoc* agreements made at the last moment. This is the lesson to be drawn from the failure of the United States to use Israeli medical facilities after the terrorist bombing of the

Marine headquarters in Beirut. Unless American medical personnel are familiar with Israeli facilities, and have developed procedures to take advantage of Israeli medicine, the United States military cannot expect that American doctors will send wounded and sick troops to unknown facilities with unfamiliar capabilities.

But, it will not be possible to get maximum benefit from available Israeli facilities without some effort on the part of the United States. For the American military to take advantage of Israel's mobilization hospital capacity, even in part, the United States would have to ensure that proper equipment and adequate quarters would be available for incoming casualties. In addition, the United States should anticipate that American medical personnel would work side by side with Israelis to staff these facilities. Further, the United States should make Israel responsible for setting up any prepositioned hospitals stored in that country. Since such hospitals could be erected at their storage sites, or very near, they could be equipped with amenities not available to more austere equipped stored hospitals elsewhere. Such hospitals stored in Israel would still be deployable to other theaters should the need arise.

Arab Objections

The major objection to an arrangement allowing the United States military to use Israeli medical facilities is the belief that such an accord might antagonize the Arab nations friendly to the United States. This objection fails to acknowledge, however, that while the United States has grown closer to Israel since 1967, and especially so since 1973, it has at the same time managed to build much closer relationships with Arab nations like Egypt, Oman, Somalia, and Sudan. In fact, in some cases the Israeli-American tie has played an important part in making closer relations with certain Arab countries possible. It was Israel's decision to relinquish the Sinai Peninsula to Egypt, with its airfields, strategic depth, and valuable oil fields, that enabled America to cement ties with Egypt. It was an Israeli threat to attack Syria that enabled the United States to halt the Syrian invasion of Jordan in 1970, thus preventing Jordan from falling into the hands of anti-American forces.

An arrangement to use Israeli medical support could not possibly be interpreted as a threat to any Arab country. Its clear humanitarian intent and its multi-theater positioning remove it from the realm of Arab-Israeli issues. In fact, such an agreement will help the United States defend the Arab world without having to increase its profile there, a phenomenon that should be welcomed by many Arab supporters of America. Ironically, Arabs from countries hostile to Israel sometimes choose to be treated in Israeli hospitals, so Arab objections to such arrangements between Israel and the United States can be given less weight.

Conclusion

Central Command will certainly be able to deploy its forces in the Middle East even if Israeli medical facilities are not utilized. Nor is it likely that an American victory in battle will depend on having such an arrangement. But at the same time, a failure to use Israel's hospitals will certainly ensure that in the event of a conflict in the region, American lives will be lost which otherwise could have been saved. Also, international perceptions of real American intentions and capabilities will be affected. By exploiting Israel's medical facilities, America helps make it clear that it is serious about defending the Middle East. This will make potential aggressors less likely to test American resolve. In this sense, arranging to use Israeli medical facilities has benefits far beyond caring for the American soldiers sent to the region. But should deterrence fail, at least America's soldiers, their families, and their countrymen will know that their government is taking all possible steps to ensure that they will return home alive and well.

Appendix A

The Hospital Bed Shortage

According to testimony presented to Congress by John Beary III, M.D., Acting Assistant Secretary of Defense (Health Affairs) (in Hearings Before a Subcommittee of the Committee on Appropriations, United States House of Representatives, *Department of Defense Appropriations for 1983*, part 9, pp. 434-435), the Navy (including the Marines) and the Air Force were to procure deployable hospitals totaling 2,000 beds (the Air Force was to procure 500 beds, the Navy and Marines the rest) during Fiscal Year 1983 for the primary use of Central Command in the Middle East. The Army was also procuring a certain number of beds for the same purposes, but the figure was not given. The total procurement of beds for Central Command for that Fiscal Year (1,500 Navy/Marine beds, 500 Air Force beds, and an unknown number of Army beds) amounted to 11.8 percent of the number believed required. Assuming that the Army bought no beds for use in the Middle East, using this data a need for 17,000 beds is established to support in-theater operations in the Middle East. If the Army's hospital purchases for Central Command had been 1,000 beds, the anticipated total hospital bed need would be over 25,000 beds.

A requirement of 17,000 beds is consistent with experience of hospital admissions in previous conflicts. Expected daily hospital admissions rates can be calculated using United States Army data given in its staff officers planning manual, FM 101-10-1 (Department of the Army, 1977; Chapter 5). According to this source (pp. 5-24 to 5-28, Table 5-28g), hospitalization rates for defensive operations in hot plains are 11.24 men per 1,000 for infantry, 9.88 men per 1,000 for mechanized units, and 4.70 men per 1,000 for non-divisional forces. It is expected that a 300,000 man Central Command force would include 91,000 men in infantry divisions (three Army divisions with 15,000 men apiece and two Marine divisions with 23,000 men apiece), 15,000 men in one Army mechanized division, and 194,000 men in non-divisional units of the Army or with the Navy or Air Force contingents. Using these figures, hospital admissions should total about 2,100 per day.

These calculations are based on admissions rates for a conflict fought thirty years ago, the Korean War. This was the last war involving large numbers of American soldiers fighting conventionally against a non-guerrilla enemy. Recent experience suggests, however, that increases in firepower, resulting in part from the appearance of new weapons, will cause greater numbers of casualties on today's battlefield than on those of the past.

Should the United States send a force smaller than 300,000 to the Middle East, the size of the hospital facilities needed to treat the casualties might be fewer than the 17,000 estimated above. According to one press account, even a smaller force might still require a fairly large number of hospital beds to treat the sick and wounded. According to this story ("RDF predicted to Have High Casualty Rate," *The Washington Post*, August 7, 1981, p. C-15), a 100,000 man deployment might need 10,000 beds in-theater and a 130,000 man force might need more than 15,000 beds.

Appendix B

Sizes of Some Hospital Systems

Country	# Hospital Beds	# Hospital Beds per 1,000 people
Bahrain	572	2.16
Egypt	24,429	.64
Iran	16,705	.52
Iraq	15,159	1.23
Israel	18,804	4.72
Jordan	2,446	1.22
Kenya	17,896	1.29
Kuwait	1,873	1.66
North Yemen	2,799	.05
Oman	805	.99
Qatar	661	7.69
Saudi Arabia	6,888	.72
Somalia	5,163	1.76
South Yemen	1,858	1.06
Sudan	8,381	.49
Syria	4,798	.61
UAE	682	2.84
United States	1,365,626	6.30

Source: Adapted from *World Health Organization Statistic 1980*, Hospital Establishments, and *Statistical Abstract of Israel 1981*.

The information given in this table should be treated with caution.

FOOTNOTES

1. Testimony of John H. Moxley III, M.D., Assistant Secretary of Defense (Health Affairs), Hearings Before a Subcommittee of the Committee on Appropriations, United States House of Representatives, *Department of Defense Appropriations for 1982*, part 4, p. 596.
2. *Ibid.*
3. Figures from Defense Marketing Service, *Rapid Deployment Force*, 1980, extracts from the Joint Chiefs of Staff *RDJTF Capability Study*, January 1981, assorted volumes of testimony before Congress, and articles in a variety of periodicals.
4. Hearings Before a Subcommittee of the Committee on Appropriations, United States House of Representatives, *Department of Defense Appropriations for 1983*, part 9, pp. 613-616.
5. Major-General Spurgeon Neel, *Medical Support 1965-1970*, Department of the Army, 1973.
6. This assumes four out of twelve LPHs and LPAs out of service (for a loss of $4 \times 300 = 1,200$ beds) and presumed undeployability of one of the 500 bed hospitals either in Europe or the United States due to one unforeseen event or another (missing sections, etc.) and the availability of only half of the Air Force's Air Transportable Hospitals (a loss of 288 beds). The total loss would be just under 2,000 beds.
7. Calculated from the testimony of John Beary III, M.D., in Hearings Before a Subcommittee of the Committee on Appropriations, United States House of Representatives, *Department of Defense Appropriations for 1983*, part 9, p. 437.
8. *Ibid.*
9. United States General Accounting Office, *Will There Be Enough Trained Medical Personnel In Case Of War?*, June 24, 1981, p. 55.
10. Captain Michael B. Parini, "Air Force Medicine on the Move," *Air Force Magazine*, October 1983, p. 67.
11. Letter from General Barrow to Senator Denton as quoted by John Beary III, M.D., Acting Assistant Secretary of Defense (Health Affairs), in testimony in Hearings Before a Subcommittee of the Committee on Appropriations, United States House of Representatives, *Department of Defense Appropriations for 1983*, part 9, p. 439.
12. Calculated from Mark Hewish, Bill Sweetman, Joseph C. Wheeler, and Bill Gunston, *Air Forces of the World*, Simon and Schuster, 1979, pp. 25-41, and Bill Gunston, editor, *The Encyclopedia of World Air Power*, Crescent Press, 1981, p. 243.
13. This is for the Navy's fully deployable Fleet Hospitals. Hearings Before a Subcommittee of the Committee on Appropriations, United States House of Representatives, *Department of Defense Appropriations for 1983*, part 9, pp. 539-540.
14. *Ibid.*, p. 573.
15. The debate centered on whether or not the World War II era hospital ship *Sanctuary* could be modernized, and if not, whether the liner *United States* or some other ship(s) should be converted to the role. It was eventually decided to acquire and modify two cargo ships.
16. Although the declared primary mission of the military medical system is to prepare for and perform the care of wartime casualties (see Hearings Before a Subcommittee of the Committee on Appropriations, United States House of Representatives, *Department of Defense Appropriations for 1982*, part 4, p. 595), an examination of budget expenditures shows that

the peacetime care of military personnel, their dependents, and the retired military community commands the lion's share of the resources (*ibid.*, pp. 589-594). For example, 69 per cent of those cared for by the Air Force's medical system are dependents and retired personnel (Captain Michael D. Parini, "Air Force Medicine on the Move," *Air Force Magazine*, October 1983, p. 67). This is not necessarily wrong, as the United States has been essentially at peace throughout the greater part of its existence and hopes to remain so in the future. If peace is maintained, and the deterrent value of medical preparations is ignored, then expenditures on preparations for war might be perceived as having been wasteful. Such a perception, while plausible, is incorrect.

17. Henry David Rosen, "Pentagon seeking to Register Health Care Women for Draft," *The Washington Post*, September 1, 1983, p. A2.
18. *U.S. News and World Report*, October 2, 1983; *Jerusalem Post*, September 28, 1983, p. 1; Reuters news reports of September 20 and September 27, 1983.
19. The 1984-1988 Defense Guidance, as quoted in testimony Before a Subcommittee of the Committee on Appropriations, United States House of Representatives, *Department of Defense Appropriations for 1983*, part 6, p. 50.
20. For instance, see David Lamb, "Egypt Lifts Veil on U.S. Maneuvers," *Los Angeles Times*, August 10, 1983, p. A7.
21. Figures calculated from the *Statistical Abstract of Israel 1981*, p. 675.
22. *World Health Organization Statistic 1980*, pp. 61-63, 123.
23. These calculations were made using the figures given in Lechaim Naggan, "Medical planning for disaster in Israel," *Injury: the British Journal of Accident Surgery*, vol. 7, no. 4, p. 281 together with the figure for hospital beds given in the *Statistical Abstract of Israel 1981*, p. 675. According to Naggan, "8 hours after the alert and 4 hours after the war started, most hospitals had increased their regular bed capacity by 40-60 per cent, and 60-80 per cent of these beds were vacant, ready to admit battle casualties." For the purposes of this study, it is assumed that it will only be possible to expand capacity by 40 percent, and that only 60 percent of the total capacity will be vacant. This means that the total number of general hospital beds will be expanded from about 11,000 to about 15,400, and that roughly 9,240 of these beds would be vacant within hours of a crisis. The actual number of beds made available probably would be much higher given the conservative nature of these calculations.
24. *Statistical Abstract of Israel 1982*, p. 686.
25. Calculated from the *Statistical Abstract of Israel 1981*, p. 675.

The AIPAC Papers on U.S.-Israel Relations

No. 1 The Strategic Value of Israel

No. 2 Israel and the U.S. Air Force

No. 3 The Campaign to Discredit Israel

No. 4 Israel and the U.S. Navy

No. 5 Israeli Medical Support for the U.S. Armed Forces

Future titles

How Does Aid to Israel Serve the U.S. National Interest?

Secure Borders Between Israel and Jordan

U.S. Government Procurement from Israeli Suppliers

The AIPAC College Guide: A Survey of Political Activism

To: **AIPAC Monograph Series**

American Israel Public Affairs Committee

500 North Capitol St., N.W.

Washington, D.C. 20001

I am enclosing: \$25 (AIPAC members only)

\$30 (Nonmembers)

(or credit card number below)

Subscription covers 10 issues.

Please begin my subscription with # _____

(or current issue)

Name: _____

Address: _____

Credit Card Visa # _____ Expiration Date _____

Mastercard # _____ Expiration Date _____

Signature _____

A Publication of:

AMERICAN ISRAEL PUBLIC AFFAIRS COMMITTEE

500 NORTH CAPITOL STREET, N.W.

WASHINGTON, D.C. 20001

(202) 638-2256