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Issue Brief

# Healthcare and National Security: Territorial Army Medical and Dental Corps Revitalisation

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## Summary

Proactive utilisation of civilian medical talent in a cost-effective manner under the Territorial Army umbrella ensures that the 'sword arms' of all branches of the military, i.e., troops, plus dependants and veterans, are supported by a robust, deep and unbreakable medical shield while also freeing finite financial resources that can be allocated for combat-related needs.

## Introduction

War is fundamentally an onslaught on an entire nation and not just the armed forces. It is incumbent upon all State resources to collectively plan and prepare for any eventualities. Accordingly, this brief examines certain aspects of healthcare and their intersection with national security. It outlines a framework to re-engineer the Territorial Army Medical and Dental Corps (TA AMC and ADC) through a structural Civil–Military Fusion (CMF) model.

Contemporary high-intensity warfare paradigms can compromise traditional medevac lines, and injury profiles can be higher and more rapid in proportion than before. This shift would require extensive capabilities to be deployed directly within the life-saving 'Golden Hour' at the tactical edges. Concurrently, during peacetime and in static formations, many military medical facilities face challenges due to escalating epidemiological shifts. The rapid rise of non-communicable diseases, malignancies and complex metabolic and lifestyle disorders among the population requires highly skilled tertiary super-speciality care across the board in smaller military hospitals as well, which is not possible, leading to extensive referrals causing fiscal loss and compromise in patient care.

Integrating civilian healthcare providers via the TA model solves these challenges. Commissioning civilian specialists under relaxed benchmarks in a fiscally beneficial model will bring premier clinical, academic, and technological edge and assets to the ecosystem and within its own jurisdiction. This model delivers cost-neutral operational surge capacity, guarantees absolute information sovereignty, eliminates commercial billing exploitation, caters to modern-day felt needs of tertiary care in all hospitals, and builds a resilient approach.

Hence, there is a strategic need to revive the Territorial Army AMC and ADC while enabling resource and staffing buffering in static establishments. The essence of CMF, anyway, lies in the convergence of civil and military resources and systems to maximise a nation's ability to express its comprehensive national power in both war and peacetime. Accordingly, this 'civil-military fusion' model provides a cost-neutral and fiscally beneficial surge capacity of specialists and super-specialists, leverages localised terrain expertise, and remediates certain clinical gaps, especially in smaller-than-command hospitals, which form the bulk of military hospitals.

## Strategic Context: The Changing Face of Conflict

Recent conflicts (Russia–Ukraine, Israel–Gaza, US–Iran), with their protracted nature and domestic standoffs (Galwan, Op Sindoor), underscore a 'new normal' in all

aspects of modern warfare, including military medicine and the necessity of civil–military fusion, including in healthcare. Some of these scenarios are military in nature, as detailed further, and some are biological as well.

***Unconventional Injury Profiles***

Open-source published data, such as from Gaza, shows a surge in complex polytrauma and femoral injuries at multiple locations and closer to conflict zones in both military and civilian populations, leading to higher loss of limb/life. Newer high-intensity formations (e.g., Rudra/Bhairav) and the unethical nature of adversaries will invariably lead to more situations requiring immediate proximity to multiple teams of Vascular, Trauma, Orthopaedic, Maxillo-facial, and Anaesthesia specialists across multiple locations simultaneously to reduce mortality.

***DRAM (Drone, Rocket, Artillery, and Mortar) Scenarios***

Overwhelming drone swarms and loitering munitions can paralyse traditional road and air medevac corridors, apart from also being highly cost- and equipment-intensive, such as in air medevac. When aerial and road evacuations are contested, life-and-limb-saving care must be pushed forward.

***Future Weapons and Targeting of Civilian Hospitals***

AFMS in future will be dealing with potential fallouts of newer weapons such as high-energy weapons systems, which are not individual-specific, such as bullets, which could potentially inflict a high number of non-CBRN casualties; in which case, both civilian and military infrastructure in large areas could get quickly destabilised. There have also been many instances of hospitals being targeted in conflicts despite the Geneva Conventions, as their locations are well known. In such scenarios, AFMS will be called upon by the GOI and will thus need many hands rapidly.

***Hybrid and Non-Kinetic Resilience***

COVID-19 and recent cybersecurity breaches (e.g., AIIMS Delhi) demonstrate that medical infrastructure is a primary target. A 'whole-of-nation' approach is needed to ensure resilience against multi-dimensional assaults. The National Health Policy 2017 also advocates for two beds per 1,000 population, distributed to enable access within the Golden Hour, a goal TA can support.

***Border Area Threats***

In the event of exigencies arising from kinetic actions by adversaries that may cause large-scale civilian casualties in border and nearby areas, AFMS may be tasked with addressing them; augmentation by TA AMC & ADC is a good way forward.

***Fiscal Optimisation***

Establishing new infrastructure is cost-prohibitive. Currently, mid-zonal military hospitals and below cannot operate at peak capacity due to a lack of year-round specialists and super-specialists (e.g., a smaller hospital with an ultrasound but no radiologist) or a hospital with a single specialist who is on leave. TA AMC/ADC will enable permanent specialist cover across all streams. This optimises existing assets by redirecting capital expenditure to equipment.

## Operational Benefits of TA AMC/ADC Revival

The revival of TA AMC and ADC offers some of the following advantages.

***Enhanced Combat Support and Proximity Care***

The golden hour is widely recognised as the most crucial window of the first 60–90 minutes, critical to life- or limb-saving, even if only effective conservative management is provided by a trained specialist. Accordingly, TA Specialists and Super Specialists can enable mobilisation for life- and limb-saving surgeries in the immediate vicinity of the Tactical Battle Area (TBA) at multiple locations, bypassing compromised evacuation routes within the Golden Hour, the most crucial stage during which effective care cannot be provided.

In Jammu and Kashmir, for instance, while multiple military hospitals do exist, due to differing authorised scales, not all can meet felt medical needs. Thus, while there may not be a lack of authorised need, practically speaking, felt need exists, impacting proper care daily. To give a further example, mass casualties in Galwan were because of a combination of trauma and hypothermia, which is beyond the functional remit of Regimental Medical Officers (RMOs) or General Duty Medical Officers (GDMOs). Inducting specialists from other areas would take time and require acclimatisation. However, local TA Specialists, e.g., from Leh, can step in earlier.

The North East has terrain and climatic difficulties, as well as significant multi-pronged threats, and even providing adequate cover by Temporary Duties (TD) in time is operationally infeasible, with air evacuation restricted even in peacetime due to weather and terrain constraints. Border states, e.g., Punjab, are a theatre in every kinetic situation. However, the border districts have very few apex tertiary-level medical facilities with super-specialist support capable of handling large volumes, leading to a lack of immediate, fully equipped, and staffed tertiary facilities indispensable for limb-salvage and life-saving interventions, particularly in the contested medevac corridors there. This shall result in a loss of the Golden Hour in combat and peacetime situations. Areas such as Ferozepur are also the Dengue

capital of India, with significant cases of Dengue-related deaths in serving personnel, dependents, and veterans, which at present cannot be fully dealt with due to structural inadequacies.

Hill States, e.g., Uttarakhand, have one of the highest percentages of serving and veteran populations and border China. At present, no Base Hospital provides super-specialist care to its patient clientele, leaving them dependent on referrals. TA officers will bring deep terrain knowledge and access to local civil supply chains (medicines/equipment) that are vital in volatile areas. Not only would they be better aware of crucial resources such as blood components in emergency scenarios, but a large TA pool would also serve as excellent HUMINT assets, including in potentially worrying scenarios involving a recent surge in white-collar extremism in healthcare.

The Line of Control (LoC) remains highly susceptible to heavy shelling, causing severe trauma. Humanitarian medical assistance to civilians is often needed. The TA framework would make it easy to deploy additional specialists and local practitioners seeking enrolment. Likewise, the Line of Actual Control (LAC) is also prone to multiple kinetic exigencies across large stretches.

TA physicians, being part of the military chain, will ensure information and data security, including during transmission. They will be within the system to ensure all hands are on deck in exigencies throughout the year, without any surprises. During Op Sindoor in Punjab, while for complex casualties AIIMS Bathinda could have been used, any information about injuries to service personnel would not only have been more public but also prone to digital manipulation and rumours, and would have been a fertile ground for Psy Ops. Thus, the role of AFMS is crucial in maintaining this critical aspect. However, relying on a purely civilian environment has drawbacks that TA personnel can mitigate, as they will be a part of the system.

While routine recruitment with year-round deployment comes with a certain cost to the company (CTC), TA physicians would be at a much lower cost and allow deficiencies to be plugged rapidly. They would significantly reduce referral and reimbursement costs, as well as the profit component of every referral. The referral cost for every patient sent to a private setup will be greater than the cost of treating the patient in a Millitary Hospital (MH) by a TA Specialist.

While on a routine basis, smaller hospitals are not authorised for all basic specialists, TA, AMC and ADC can allow for their availability in almost every MH and MDC. In the current system of local hiring allowed to individual hospitals, there is a lack of legal coverage in some respects. For example, if a civilian doctor rendering service in an MH is injured, resulting in the loss of a limb or life, this will likely lead to litigation for compensation. TA will remove such legal hassles as well as medico-legal issues

arising from the discharge of their duties. An increased workforce would automatically result in better utilisation of available static resources, e.g., OPD care in cardiology and neurology, dialysis, anterior segment eye surgery, and subspecialty radiology reporting.

***Optimisation of HADR and Peace-Time Care***

TA empanelled specialists can seamlessly backfill roles during HADR, ensuring continuity of care for all. Mid-zonal hospitals rely on a single specialist in authorised streams, such as anaesthesiologists, medical specialists, surgeons, gynaecologists & obstetricians, and ophthalmologists. If that individual is unavailable, especially due to an exigency, critical care is hampered by the unavoidable interdependence between streams. TA specialists provide a 'safety net' to prevent such lapses.

The current shortage of super-specialists in most hospitals forces the serving clientele to rely heavily on referrals to higher centres and veterans on ECHS-empanelled hospitals. This not only incurs massive financial outflows but also fragments the patient–physician relationship. Re-introducing TA specialists would help reduce this, reinforce the internal ecosystem, and ensure that financial resources are used to strengthen internal infrastructure. This also mitigates complaints regarding service provided to the ECHS clientele in empanelled hospitals, as well as civilian hospitals, which also complain about lack of timely reimbursements.

TA AMC/ADC would allow AFMS to tap into scarce super specialists and ensure their availability throughout the year in all military hospitals, without routine issues such as leaves or Temporary Duties (TD) affecting patient care. It would also allow the provision of super-speciality dental care in zonal setups. Such individuals are very few, usually highly trained, and have cost-intensive setups. Though they may be highly motivated to serve, they are unable to do so in routine patterns for various reasons, including borderline medical conditions such as flat foot, myopia, or an inability to sustain a long-term transferable lifestyle. TA would allow AFMS to tap into their expertise on a long-term basis and provide the best medical care to our troops within our safe confines, without logistical or financial hassles.

***Technological Integration (AI and Imaging)***

The civilian sector leads in AI-driven diagnostics and remote imaging. Engaging TA specialists trained in such tech domains will allow the Armed Forces to leverage cutting-edge diagnostic aids for more accurate triage and surgical management, especially in the field. Enhanced use of technology will have immense benefits in AI-powered battlefield care and medical evacuations in both conventional military and disaster relief scenarios. Therefore, year-round collaboration between AFMS and

civilian personnel in this field is necessary, and TA AMC/ADC could be the safest route.

These are highly human-resource-dependent, and TA would enable AFMS to tap into them rapidly, robustly, and year-round. It will be highly beneficial in terms of in-house knowledge enhancement of our super specialists and specialists, as many TA professionals would be more exposed to best practices and advancements in their subjects in both India and abroad, such as in developing and using screening and imaging protocols and would bring this technical expertise at no additional cost to the military hospitals.

A reservist/TA-type commissioning is one of the most novel modes through which fruitful collaborations can be achieved. For example, a renowned physician from AIIMS, or a physician with extensive credentials in Oncology from ICMR through TA, could also provide their expertise to our troops in-house in AH (R&R).

## Addressing Structural Deficiencies

While, as per open sources, there are approximately 140 Military Hospitals and 90 Field Hospitals, most of these are Zonal and below, so they are not authorised Super Specialists despite large Areas of Responsibility (AORs). A complete lack of Super Specialists results in a breach of the 'Golden Hour' timeline due to logistical transfer delays. As per World Health Organization (WHO), Ministry of Health & Family Welfare (MoH & FW) statistics, myocardial infarction (heart attacks) accounts for approximately 30 per cent of all adult deaths, and brain strokes for 10 per cent. Early conservative management by locally based TA Super Specialists can markedly improve outcomes and save lives.

Without adequate specialists, since smaller hospitals are not authorised in certain specialities such as Psychiatry, Dermatology, Orthodontics, etc., existing infrastructure such as operation theatres (OTs), major diagnostic categories (MDCs), and intensive care units (ICUs), as well as beds, remains underleveraged. Under present financial rules, if any equipment, procedure, or specialist is unavailable, the patient is referred to the nearest government hospital, which, in most cases, is a district hospital or a state government medical college hospital. The patient may go to a private healthcare setup and be reimbursed at CGHS (Central Government Health Scheme) rates only if the facility is not available in that particular government setup, with an undertaking from the Medical Superintendent (MS) of the concerned hospital to this effect. While on paper this may sound logical, it is common knowledge that, except for large metros and a few tier-II cities, government setups are

overcrowded and short on many counts, such as ICU/ward beds. Thus, quality of care is not assured.

Given the pattern, TA AMC/ADC personnel could be attached to a zone, allowing deficiencies to be plugged in across multiple setups. For example, A TA AMC specialist based in Delhi could be utilised in the National Capital Region (NCR), which has multiple AFMS Hospitals. Likewise, at Chandimandir/Ambala/Patiala. Similar continuity could also be ensured in hilly terrain. ECHS has been plagued by lacunae and varying client satisfaction despite spending large sums, due to various factors. The surest way to improve the same is by augmenting the in-house specialist pool.

Class A polyclinics have specialists in certain streams but serve only as referral centres, lacking in-house logistics for IPD treatments, resulting in under-utilisation. It is also to be noted that, given the cost incurred on ECHS care, it is ultimately a cost to the exchequer, even if classified under a different head, so possibilities for reducing it must be explored.

Further mention is made of these two specialities due to a strong need to provide enhanced cardiac and neurological care in more military hospitals. While upgrading every MH to the level of super specialists posted is impractical, the TA Pathway will enable AFMS to provide these services for at least conservative management and routine OPD/IPD care, with better survival rates for patients.

Armed Forces in many advanced economies and countries have already explored this pattern as a method of augmentation of routine medical streams, including the US, Israel, NATO, Australia and Canada. There have also been examples of naturalised US Citizens of Indian origin who are likely to hold OCI cards and are empanelled in a TA manner with the US Navy (e.g., Lt Rujwi Kamat, a PIO, is a reservist in the US Navy).

The gaps pointed out cannot be filled by additional SSC recruitment, as that is cost-intensive and will not allow rapid scale-up/scale-down. TA physicians shall be more cost-effective in terms of remuneration for services rendered, including perks. Despite regular PC and SSC commissioning in AMC/ADC, both authorised and felt workforce needs exist that present patterns alone cannot meet. The number of AFMS hospitals is also increasing, and specialist augmentation is likely to be costly, thereby reducing the budget available for purely combat-related needs. On the other hand, many former SSC Specialists/Super Specialists, post-release, may choose to continue providing their services to AFMS via TA AMC/ADC, similar to TA Officers in Combat/Combat Support Streams. These individuals, who are already trained in all aspects of the military, may be among the biggest force multipliers at a fraction of the cost.

The current framework being utilised for Commandants to hire civilian specialists or enter into MoUs with civil setups is highly patchy and subjective, and thus ineffective. Private setups also operate on an obvious profit-making principle, which TA would reduce, saving crores for the exchequer. TA AMC/ADC would, in fact, offer a significant reduction in the logistical costs borne by AFMS, not only for patient transfers but also for AME/PME at various locations due to the non-availability of a specialist during particular periods that a civilian physician cannot supplement.

While many setups may be running on authorised need, with changing times there is a significant change in 'felt need'. The TA framework shall provide services to better address felt needs without requiring cumbersome, delayed changes to the authorised needs on file. Short-term engagement of civilian specialists or MoUs with civil setups is patchy, subjective and ineffective. Private setups also operate on an obvious profit-making principle, which TA would obviously reduce. TA AMC/ADC would, in fact, offer a significant reduction in logistical costs, borne not only for patient transfers but also for AME/PME at various locations due to the non-availability of specialists during particular periods.

## Towards an Enhanced Hybrid Medical Doctrine

The revival of TA AMC/ADC allows India to enhance further a Hybrid Medical Doctrine that blends the speed and mobile modularity of NATO doctrine with the large-scale casualty management and prolonged field care strengths of Russian methodology, evolving it into a more resilient, flexible, and technologically advanced force. Proactive utilisation of civilian medical talent in a cost-effective manner under the TA umbrella ensures that the 'sword arms' of all branches of the military, i.e., our troops, plus our dependants and veterans, are supported by a robust, deep, and unbreakable medical shield while also freeing our finite financial resources to allocate more for combat-related needs.

The revival of the TA AMC and ADC is not merely an operational expansion but a masterstroke in fiscal management and enhanced operational efficacy, with far-reaching positive benefits for the armed forces and the nation. By adopting a 'Pay-as-you-use' or 'Call-up' model while ensuring the safety umbrella of the Army Act, AFMS can access high-value Super-Specialists—whose full-time recruitment or consultations are otherwise prohibitively expensive at a fraction of the cost.

Through appropriate policy frameworks, prominent civilian surgeons and specialists can be encouraged to 'serve the nation' via TA, providing them with the prestige of uniform while the military gains access to their world-class expertise. This would enhance both AFMS and the overall healthcare delivery system in India, as its

healthcare management system is known to be very robust, and exposure to it in any form would be beneficial.

Since TA personnel serve on a part-time basis or during specific call-up periods, there are no long-term pensionary and administrative overheads, allowing for higher budgetary allocation for operational and combat matters. Individuals serving in TA in any manner will, obviously, lead to a larger segment of society contributing more actively to national security and nation-building, and will lead to enhanced discipline and patriotism in society at large.

It is undeniable that addressing national challenges requires a multi-domain strategy, with TA as one of the best-tested models for this purpose. It is also undeniable that TA shall create a large repository of well-trained, nationalistic and disciplined citizens and healthcare providers who shall be available in every national exigency. Incidents such as COVID-19 have also shown that exigencies in healthcare can be extremely sudden and lay bare even the best routine planning models, and that global adversaries can weaponise citizens' health as a tool of modern combat. TA AMC/ADC will thus allow India to plan for standing up to the same. The revitalisation of the TA Medical and Dental Corps is likely to be a strategic imperative in the current geopolitical and technological climate. By integrating the vast reservoir of civilian medical expertise into the disciplined framework of the AFMS, the Indian armed forces can achieve an unprecedented level of resilience. This model addresses the dual challenges of high-intensity modern combat and the burgeoning healthcare demands of the clientele.

## Way forward

Constitution of an empowered committee or a study group with civilian and military stakeholders for further deliberation and fine-tuning of proposal for formal adoption to ensure both civil and military views would be apt as true fusion can only be achieved if done from planning stages and nuances incorporated at the beginning to ensure seamless implementation and ensure maximum service and national benefits so that India's healthcare remains 'Ready, Relevant, and Resilient'. This will enable in-depth brainstorming with relevant stakeholders from civilian and military medical and operational angles, which is important for practical and durable fusion. To begin with, it is suggested that TA AMC/ADC be opened across all Specialist and Super Specialist streams given their higher significance and impact. In so far as ranks at which commissioning is to be considered, all routine issues can be debated and modelled on existing TA as well as concerned branch/Corps parameters.

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