



FUNDAMENTALS OF AIR FORCE HEALTH SERVICE SUPPORT

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Air Force medical forces provide [combat support](#) (CS) functional capability. They provide the force health protection capability of CS. Likewise, medical forces are by design not self-sustaining; they depend upon CS capabilities for security and infrastructure support. They are an integral part of forces employed to open, establish, and operate airbases.

Employment as Part of a Combat Support Force Module

During the planning stage leading up to an operation, force module elements are linked together in planning systems so they may be rapidly identified and tasked to deploy. Medical force capabilities are integrated into each air expeditionary task force module with specific capability types and quantities based on the population at risk in the force module and the typical force health protection threats found at most airbases. Medical forces in CS force modules are those required to provide direct support to an expeditionary unit conducting operations from one airbase. For additional information on force modules, see AFDP 4-0, [Combat Support](#).

When opening an airbase, medical teams assess the potential health impact of a beddown location, base configuration, and provide advice on mitigating health hazards. These teams also provide initial medical support to the fielded forces from the initial commencement date. Based on existing theater and local medical capabilities, they provide input into additional medical capabilities required to support the projected population at risk. Continual health surveillance and assessment of operational, disease, and environmental exposures and risks are part of total exposure health. This continual surveillance and assessment is essential for optimal health outcomes and operational performance.

Upon establishing the airbase, medical personnel and materiel assets continue to flow into the operational area and contingency locations to expand medical support capabilities. Medical forces remain focused on threats and countermeasures to sustain and optimize warfighter performance. Medical forces establish a theater health care system using the following assets:

- ✦ Theater Patient Movement is tied into the theater aeromedical evacuation (AE) system. This includes forward resuscitative care (FRC) assets like Role-2 Light-Maneuver surgical capabilities, such as ground surgical teams (GSTs) and special operations surgical teams (SOSTs). Initial AE and patient movement item assets to evacuate casualties.
- ✦ FRC provided as close to the point of injury as possible based on current operational requirements to attain stabilization, achieve the most efficient use of life-and-limb saving medical treatment, and provide essential care so the patient can tolerate evacuation.
- ✦ A theater contingency and disaster casualty management plan to integrate theater, host nation, and coalition medical services; expeditionary medicine platforms; and the AE network.

During expeditionary operations, Air Force medical capabilities are planned based on the Air Force population at risk and access to available AE using organic or contract aircraft. In a joint deployment, additional resources may be required to care for joint personnel. Air Force medical personnel also work closely with line of the Air Force personnel to monitor operational threats and provide risk management data for maximum operational effectiveness. The theater health care system is tied together with a robust network of local, host nation, joint, and coalition medical force capabilities linked by air, ground, and maritime evacuation platforms.

When redeployment commences, medical force resources should be used in the same manner as when deploying. Larger assets should be redeployed first with smaller elements providing ongoing care.

Employment Tailoring

Medical force employment tailoring includes population at risk support, rapid incremental employment, CS force module employment, hub and spoke employment, or flexible tasking of an in-place force. Each has benefits as well as risks to be weighed for the operation at hand. In practice, when considered at the theater level, medical forces use these employment methods to optimize a theater medical system characterized by speed, responsiveness, flexibility, and agility. The goal is to strike a balance in devising a medical operations plan that exploits the capabilities yet limits the risks that come with a light and lean system of capabilities. The plan should be designed to maximize the commander's capability to stabilize, treat, stage, and evacuate casualties and patients from points of injury to [definitive care](#) on a worldwide scale.

Rapid Incremental Employment

Air Force medical forces possess the ability to insert forces into forward areas with a team tailored to the specific operational mission. Tailored forces may include preventive medicine, primary care, trauma surgery, intensive care, and connectivity to the medical evacuation and AE system. Within this dynamic window of rapid deployment, combat and support forces compete for limited airlift into new airfields based on priority. This priority is not always an “all or nothing” decision for the deployment of combat support forces. Rather, the decision may be a balanced response to increase combat support capability as the airfield opens and begins operations, or as requirements change. During the period of medical vulnerability, en route critical care capabilities (e.g., critical care air transport team, etc.) are able to expedite evacuation while continuing active resuscitation and treatment of casualties from initial forward resuscitative care teams. When deploying, medical forces strive to ensure health protection capability arrives as early as the warfighters and minimizes the demand on limited airlift resources.

During the periods of opening and closing airbases, Air Force forces are at a high risk of injury or illness due to non-combat vulnerabilities such as poor food, water, or sanitation and industrial or occupational accidents. The use of tailored medical forces allows a tiered approach to flowing medical capabilities in or out to match changing medical support requirements, mission or threat scenarios, availability of airlift, or the population at risk. Flowing in only essential medical capability on the first available aircraft provides the necessary force health protection yet maximizes the limited airlift available for competing priorities. Additional medical capability flows in to meet requirements as operations dictate and airlift becomes available. When Air Force forces redeploy, medical force capabilities decrease incrementally as the population at risk decreases and the threat allows.
