

SINGLE MANAGEMENT OF THE MILITARY
MEDICAL SUPPLY AGENCY

24 January 1958

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INDUSTRIAL COLLEGE OF THE ARMED FORCES

Washington, D. C.

Rear Admiral William L. Knickerbocker, USN, Executive Director of the Military Medical Supply Agency, was born in Marshall, Michigan, 13 March 1904. He was graduated from the Naval Academy and commissioned ensign on 2 June 1927. His first assignment was on USS OMAHA, after which he served in various assignments, ashore and afloat. Following a course of instruction at the Army-Navy Staff College, he was assigned to the staff of Vice Admiral D. E. Barbey, Commander, 7th Amphibious Force, 7th Fleet, where he participated in the occupation of Korea and North China and the surrender of the Japanese Armies at Tientsin and Tsingtao. In November 1944 he assumed the duties of Supply Officer, Naval Shipyard, Pearl Harbor, returning to the mainland in 1947 to attend the Naval War College. After a tour of duty in the Bureau of Ordnance, he was ordered to the Plans Group of the Armed Forces Special Weapons Project in January 1951 and six months later reported to the staff of Major General P. W. Clarkson, USA, Commander of Joint Task Force 132, as Assistant Chief of Staff for Logistics. This Joint Task Force conducted OPERATION IVY at the AEC Pacific Proving Grounds at Eniwetok Atoll in the fall of 1952 and for his services in that operation he was awarded the Legion of Merit by the Secretary of the Army. He continued in the same capacity with the Joint Task Force SEVEN which conducted OPERATION CASTLE at Eniwetok and Bikini Atolls in the spring of 1954. On 1 July 1954 he reported as Pacific Fleet Supply Officer at Pearl Harbor whence after his promotion to flag rank he was ordered to Brooklyn where he assumed command of the Naval Supply Activities, New York, on 23 December 1954. On 12 April 1956, the Secretary of Defense approved the nomination of Admiral Knickerbocker as Executive Director of the Military Medical Supply Agency which was activated on 1 July 1957. This is his first appearance at the Industrial College.

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COLONEL LACKAS: Colonel Nyquist, Students, and Faculty: If you will recall, some time ago we had Mr. Brodsky speak on the supply system for common-use items. Following that we conducted a seminar at which we had representatives of the Executive Directors of the Military Subsistence Agency and the Military Clothing and Textile Agency. We had hoped at that time to have the speaker for this morning participate in that seminar, but, due to a prior commitment, he was unable to be with us.

However, his agency, the Military Medical Supply Agency, is an agency of such importance and of such a unique character that we felt that we should have a discussion of it. So we urged our speaker for this morning to come down to us and to discuss his agency for us. We are very grateful to him for not only coming himself but for bringing with him members of his staff.

We shall have, following his talk, a break, and following the break, what might be comparable to a seminar, at which you may direct questions to the various members of the panel.

Admiral Knickerbocker, we welcome you to the Industrial College of the Armed Forces, to the Class of 1958, and we are most grateful to you for coming down here to talk to us.

ADMIRAL KNICKERBOCKER: Colonel Lackas, Gentlemen of the Industrial College, and Guests: This is my first offense down here, but I am very very happy to be aboard. I certainly regret that I was unable to participate in your 12 December seminar, but I am very pleased, however, to join in this morning's program on the subject of the single manager plan as it applies to medical material. I certainly hope that we will be able to discuss all of the elements within the scope of your December seminar and that afterwards we will be able to answer most of the questions that you may throw at us.

Gentlemen, the Military Medical Supply Agency was activated on the first of January just a year ago, in accordance with an activation schedule approved by the Department of Defense and under a charter

issued on 4 May 1956 by the Secretary of Defense. The detailed planning by a small planning staff, including representatives of the three Surgeons General, provided for the selection of personnel, the establishment of training programs and organizational staffing patterns, and the preparation and coordination of the required internal and external operating procedures. The timely scheduling and accomplishment of these functions, and particularly the very splendid cooperation which we received from all three services, contributed to an effective and a very smooth activation of the new agency. This activation was accomplished without interruption in the overall medical supply support of our Armed Forces.

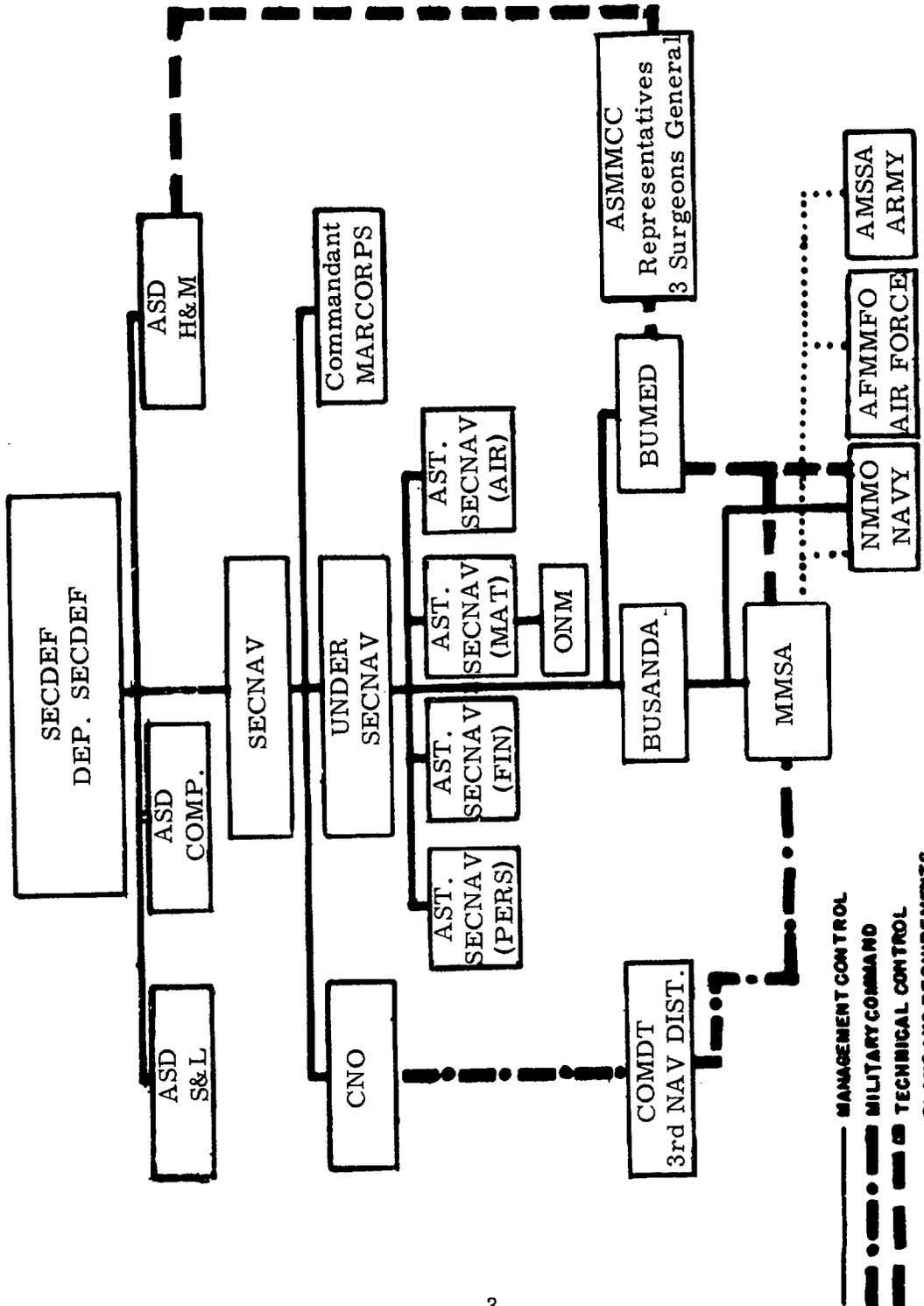
Chart 1, page 3. --It might be well to point out here at the outset just where our agency fits into the organizational pattern of the Department of Defense. This chart indicates those offices which are considered to have the greatest interest, the greatest responsibility, in exercising direction and control over the single manager medical supply function.

The Department of Defense Assistant Secretaries who have primary interest are those for Health and Medical, Comptroller, and Supply and Logistics. Of course the Secretary of the Navy is the single manager for medical material. Directly beneath the Under Secretary of the Navy are shown the four Assistant Secretaries. The two having the greatest interest in our operations are those for Material and Financial Management.

MMSA, is under the management control of the Bureau of Supplies and Accounts and the technical control of the Bureau of Medicine and Surgery. I think you can make out the legend for these various lines. Military and coordination control stems from the CNO over on the left, down through the Commandant of the Third Naval District. The three blocks down here at the lower right indicate the three service medical material offices with which we coordinate our medical supply plans and requirements. I will mention them again later.

I'd like particularly to invite your attention to this block up here, ASMMCC, an alphabetical organization. That means the Armed Services Medical Material Coordination Committee. This very important group consists of one representative of each of the three Surgeons General, plus a dental representative, when required. All told, they and their permanent staff comprise about 28 people. The committee meets frequently, and also meets with us once a month, to settle differences on new items which are coming into the system and to recommend the removal of obsolescent or obsolete items.

CHART 1
 SINGLE MANAGER ORGANIZATION
 FOR MILITARY MEDICAL SUPPLY AGENCY



————— MANAGEMENT CONTROL
 - - - - - MILITARY COMMAND
 - - - - - TECHNICAL CONTROL
 PLANS AND REQUIREMENTS
 COORDINATION

The committee meets and also discusses any other problems affecting the technical qualifications of any or all items within the responsibilities of our agency. The committee advises the Chief of the Bureau of Medicine and Surgery in the implementation of all technical control functions within the scope of the single manager assignment for medical material.

To date all technical problems have been resolved at the committee level. However, any matters which cannot be resolved by the committee are submitted to our technical bureau, the Bureau of Medicine and Surgery, for coordination with the other two Surgeons General. In the event agreement cannot be reached at that level, the matter is referred to the Assistant Secretary of Defense for Health and Medical. To my knowledge that hasn't occurred to date.

Chart 2, page 5. --The Secretary of the Navy made the original decision that MMSA would be headed by a Navy Supply Corps flag officer as executive director. Our charter, however, provides for staffing the agency with military personnel from all three services. It also specifies that "key military staff positions subordinate to the Executive Director shall be subject to rotation on a periodic basis among the military services as agreed to by the Single Manager and the Secretaries of the other military departments." We have sincerely tried to carry out the intent of that directive consistent with good organizational and business management practices, taking into consideration the specialties and the backgrounds of the officers assigned to this agency by the three services. I would like to say that the best qualified officer gets the job regardless of the color of his--I was going to say "necktie," but I will say--"shirt," or his particular branch of service.

Chart 3, page 6. --Our charter also provides for an administrative committee, and you are probably familiar with that from previous presentations. This committee assists the executive director in identifying and overcoming problems concerning the operation of his assignment. This committee was Mr. Wilson's personal idea and, as far as we are concerned, it has worked out very satisfactorily. We have found the committee members very helpful and, what's more, very friendly.

By definition, this committee is neither a policy board nor an executive directorate, but rather a group of specialists who meet to recommend solutions to special problems that we may have encountered and to promote the effectiveness with which our agency meets the needs of the military services.

CHART 2

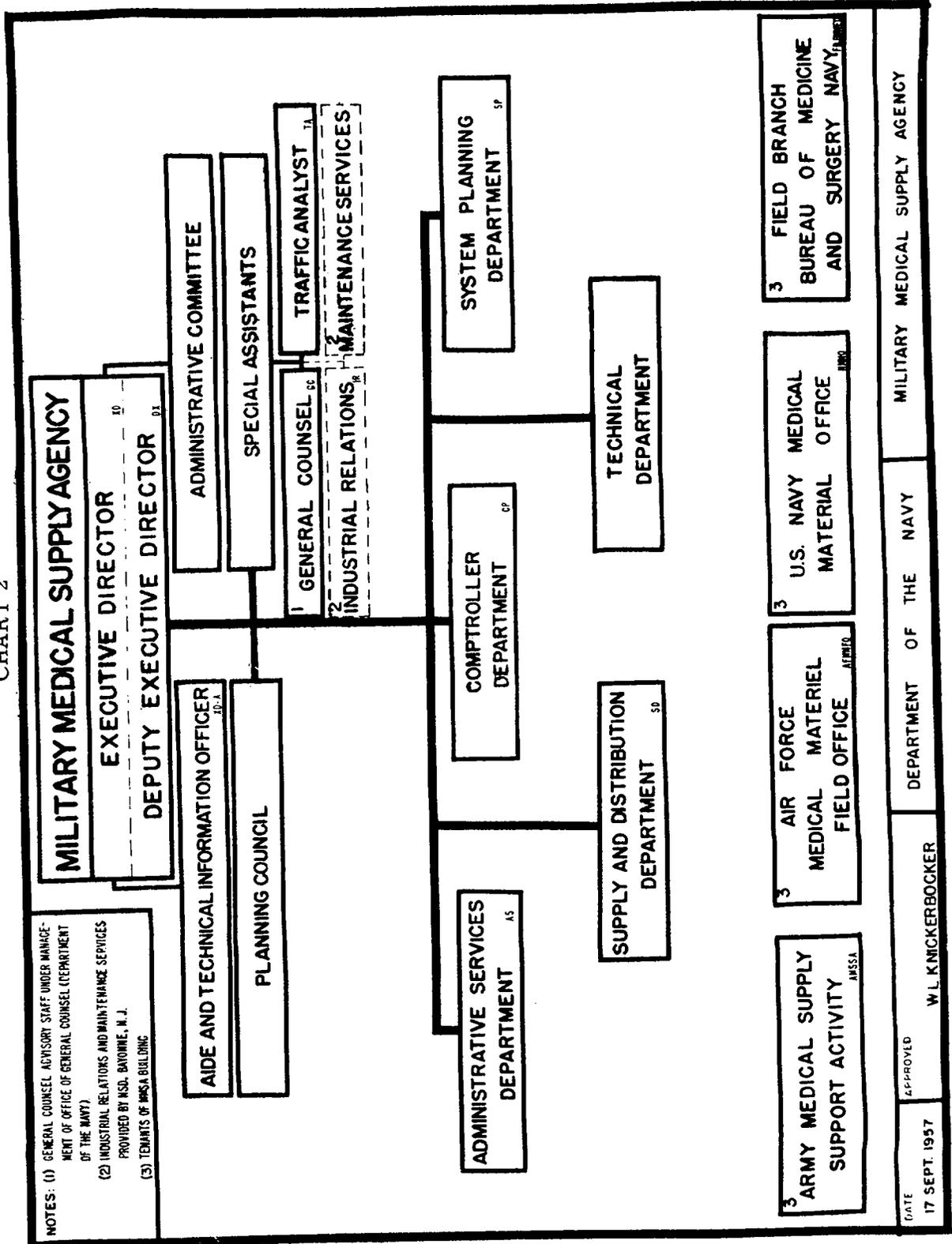


CHART 3
ADMINISTRATIVE COMMITTEE

PURPOSE

ASSIST EXECUTIVE DIRECTOR

PROMOTE EFFECTIVENESS AND ECONOMY DEFINITION

NOT A POLICY BOARD NOR AN EXECUTIVE DIRECTORATE,
BUT A GROUP OF SPECIALISTS WHO

RECOMMEND SOLUTIONS TO PARTICULAR PROBLEMS

MEMBERSHIP

EXECUTIVE DIRECTOR, CHAIRMAN

REPRESENTATIVES--

ARMY, NAVY, MARINE CORPS, AND AIR FORCE

ASSISTANT SECRETARIES OF DEFENSE,
COMPTROLLER, HEALTH AND MEDICAL, SUPPLY
AND LOGISTICS OR THEIR REPRESENTATIVES

TECHNICAL OR PROFESSIONAL AUGMENTATION AS NEEDED

7

tee comprises the executive director
representative each from the Army, Navy, and
Assistant Secretaries of Defense -- and
Supply and Logistics. We meet at least once a
month and have held 21 meetings to date, 7 of them here in Washington.

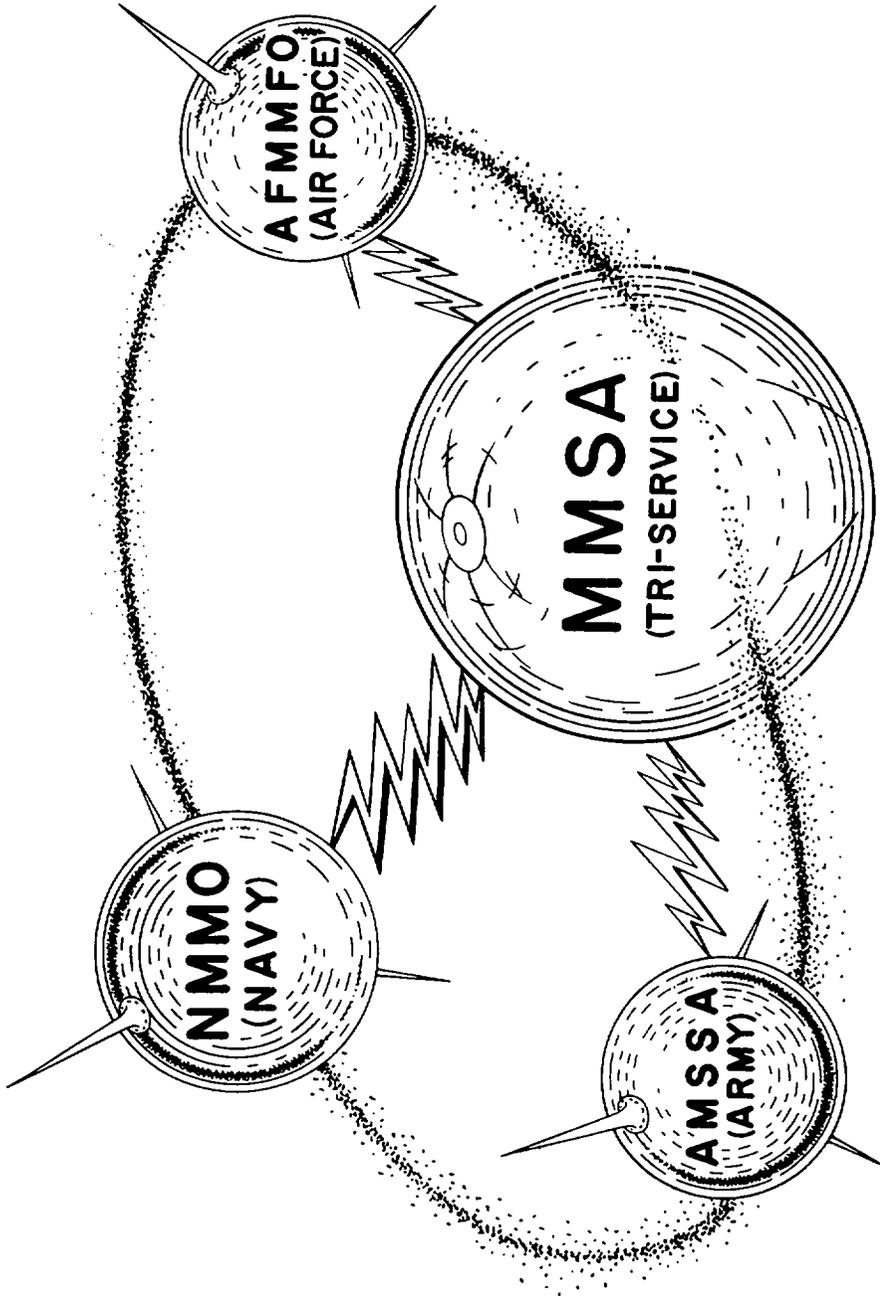
Down at the bottom of the organization chart we have indicated our
four tenant activities. Those are the ones I mentioned previously. The
three on the left represent the three service medical supply support offices. The
which direct their respective retail medical supply support offices. The
the field. MMSA works hand in glove with these activities. They are all
located on one floor of our building. We speak the same common language
of logistics, we freely exchange information, we coordinate our operations in
requirements, and, to the best of my knowledge, we hold no secrets from
one another. We play our cards right on top of the table. In addition, we
utilize the same common services within the building, including the ma-
chine room and industrial relations services; we belong to the same ward-
room mess, and we participate in many of the same social activities. For
instance, we hold our semiannual calling parties or receptions together. For
We feel that this is a most important advantage enjoyed by no other ward-
manager activity, and one which, in our opinion, has provided a tremendous
contribution to the smooth operation of our medical system. Differences
are ironed out on the spot by people who know one another and solutions
to problems are reached in a matter of hours, as a general rule, and may-
be days, instead of possibly weeks of hours, as a general rule, and may-
I think you all know what I mean. I would like to say, gentlemen, that we
are truly unified up at 84 Sands Street in Brooklyn.

Chart 4, page 8. -- The extent of this unification is indicated by this
cartoon. This is in keeping with the times, you might say. Colonel Butler,
who runs the Army field office up there in Brooklyn, had this prepared for
use at one of his presentations.

Now we come to the medical distribution system which I am sure you
will be interested in.

We start out with the 19 Army, Navy, and Air Force depots which
were providing medical material support to the services before the
Single Manager Plan came into existence. The succeeding charts will
show how the various systems overlapped one another.

CHART 4



MEDMATER

First, the Army operated out of its major depots at Schenectady; Louisville; and Sharpe, California. Sharpe is located near Stockton, about 50 miles back of Oakland. The other Army depots shown here are their Reserve Storage Points at Belle Mead, New Jersey; Memphis; and Atlanta.

Superimposed upon that we have the Navy, which operated out of Newport; Bayonne, New Jersey; Norfolk; the Marine Corps Supply Center down at Albany, Georgia; San Diego; Oakland; and Seattle. Other Navy depots shown on there are Mechanicsburg, Pennsylvania, which was used as a distribution point for slow-moving items, and Reserve Stock Points located at Spokane; and Clearfield, Utah.

Lastly, we have the Air Force, whose activities were supported out of its depots at Gadsden, Alabama, and San Antonio; that is, of course, in addition to the Army depots which also stored Air Force stocks and supported Air Force activities. The Air Force depot at Topeka was used primarily as a kit assembly point.

You will agree, I think, that the overlapping here is quite evident.

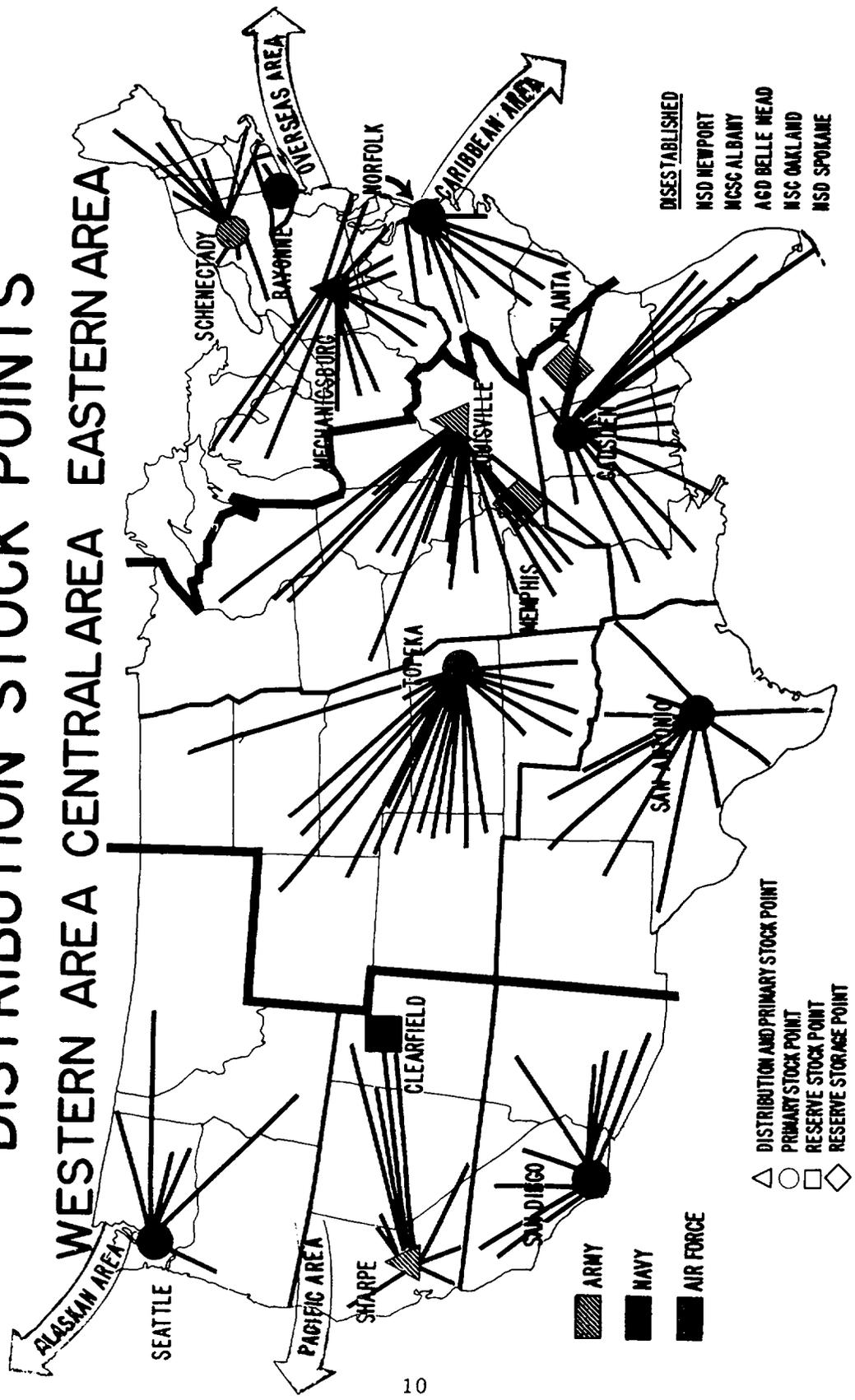
Chart 5, page 10. --This chart indicates our present Single Manager Distribution System.

MMSA adopted the Navy and the Air Force principle of positioning fast-moving items at certain designated depots. Primary Stock Points (the round dots) are designed to carry about 1,450 fast-moving items for issue to all the services activities, Army, Navy, and Air Force, in their assigned segments. I don't know whether those segments show up as well as they might on the west coast. I will describe them later. We have determined that these 1,450 items will satisfy about 90 percent of the demands to be expected from customers. The Distribution Stock Points (the triangles) carry a full range of medical items for issue to all activities in their areas--western, central, and eastern--and they also back up the Primary Stock Points in their respective areas. The Reserve Stock Points (the squares) carry bulk quantities of items which ordinarily are not required for peacetime operation.

On this chart we have five Army depots, six Navy depots, and three Air Force depots.

CHART 5

SINGLE MANAGER DISTRIBUTION STOCK POINTS



Briefly, our distribution system operates this way. Take the southern segment in the western area. An activity out in Arizona, for instance, will go into San Diego for its fast-moving items, and up to Sharpe for everything, since Sharpe carries a full range of items and also acts as a Primary for that segment. An activity in Montana will go into Seattle for its fast-moving items and down to Sharpe for its slow-moving items.

We operate in the same general manner in the other two areas.

Before the activation of MMSA under the Single Manager Plan, storage and issue of medical material were accomplished by the 19 service depots previously mentioned.

Chart 5 indicates that we currently have 14 medical supply stock points consisting of 12 stock reporting depots and 2 reserve storage points. While Clearfield is a reserve stock point, it is also a stock reporting point, and the two reserve storage points are Memphis and Atlanta. Since the activation of MMSA, we have disestablished five depots--at least we have disestablished the medical-supply support functions of those activities. Those are the NSD, Newport; Marine Corps Supply Center at Albany, Georgia; Army General Depot at Belle Mead, which I think GSA is taking over; NSD, Spokane, which I believe is in the same category; and the Naval Supply Center, Oakland.

Accountability for the medical material at Atlanta and Memphis has been transferred up to the Medical Depot at Louisville. That, incidentally, is the only strictly medical depot that we have in our system. They handle no other material. It is contemplated that the wholesale medical stocks at Atlanta and Memphis will eventually be moved to other wholesale stock points. However, because of the shipping costs involved, the Office of Assistant Secretary of Defense, Supply and Logistics, has approved their continuation as Reserve Storage Points in our system, at least until further study of the situation can be made during fiscal year 1959. Meanwhile, there will be no material delivered to either Atlanta or Memphis, and we will do our best to deplete their stocks through issue to the maximum extent possible.

Plans are being developed for the disestablishment of the Primary Stock Points at Topeka, Kansas, and Gadsden, Alabama, because the Air Force has scheduled these depots to be phased out--as it stands at the present moment--by 1 October 1958.

We are presently evaluating the capabilities of Louisville to assume the functions of those two depots, also the desirability of designating

another activity, or other activities, not presently a part of the wholesale distribution system, to assume the primary-stock-point functions which these depots are now performing. In any event, we feel that our system is flexible enough to adjust to this situation or to any similar situation should it arise.

To summarize: It can be seen that, of the 19 medical-supply stock points originally in operation, MMSA has effected the disestablishment of 5 depots, with a planned disestablishment of 2 more Primary Stock Points this year, without loss in supply efficiency.

Chart 6, page 14. --This chart shows the planned Single Manager Distribution System should Louisville take over the segments served by Topeka and Gadsden.

Now a word about the dispersion of wholesale stocks. In relationship to total inventory, the Distribution Stock Points have a combined inventory percentage value of 57 percent; Reserve Stock Points 23 percent; and Primary Stock Points 20 percent. With respect to area dispersal, the Western segment of our distribution system maintains 31 percent of the total inventory value, in one Distribution, one Reserve, and two Primary Stock Points. The Central segment maintains 37 percent of the total inventory value in one Distribution, two Reserve, and three Primary Stock Points. The Eastern segment maintains 32 percent of the total inventory value in one Distribution and three Primary Stock Points. It is balanced out very nicely, we think.

Now, as to the effectiveness of our system: On the basis of information supplied to MMSA by the three retail requirements offices, Army, Navy, and Air Force, the retail activities are receiving supply service which is as good as or better than that which they received when supply support was performed by their own service depots. That is also included in the report of Team No. 2 in the Logistics Study Project. The system's effectiveness has really exceeded our fondest expectations. At the present time we have only seven items in short supply, and they are due in within the next month. Our depots are averaging better than 93 percent effectiveness in satisfying demands from all the military operating forces.

Chart 7, page 15. --Gentlemen, I don't know to what extent you are interested in procurement. I have two or three charts which I will show you, however. As indicated on this Procurement Allocation chart, approximately \$39.8 million of medical material was procured during the period indicated--1 January-30 September 1957. About 86 percent of

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medical material was procured for the armed services and 12 percent for FCDA. Then we had other procurement of 2 percent which was for the Foreign Aid Program and the Public Health Service.

Chart 8, page 16. --This chart shows you the material procured. Drugs, chemicals, and biologicals constituted 51 percent of our procurement; X-ray items constituted 15 percent; medical and surgical instruments 9 percent; and surgical dressings 7 percent. The other procurement of 18 percent represents the purchase of such things as hospital furniture and equipment; veterinary, ophthalmic, dental, and laboratory supplies and equipment. You will note from that that we are primarily in the drug, chemical, and biological business.

I might say in passing that big business received 72 percent on the basis of dollar purchases, and small business received 28 percent. That compares very favorably with the Navy overall average.

Chart 9, page 17. --Now, on the Awards Made, this is a very simple chart. There were 1,686 awards made for under \$10,000; 483 between \$10,000 and \$100,000; and only 68 for over \$100,000.

You might be interested in our administrative lead time. It amounts to 37.9 elapsed days--that is our normal administrative lead time. Our maximum lead time amounts to 64.8 lapsed days.

Chart 10, page 18, --Next something on the Stock Fund. Navy wholesale inventories of medical and dental material, including the DOD stockpile of blood plasma and related items, were transferred to MMSA on 1 January 1957. This capitalization of stocks amounted to \$125 million--represented by that 36.2 percent. Of the \$125 million, \$34 million represents DOD stockpile of blood plasma and related items. Army and Air Force depot inventories in the amount of about \$190 million were transferred to our agency as of 1 April 1957. Thus, the total initial capitalization of our stocks amounted to approximately \$315 million. In addition to stock fund receipts, the agency received procurement authority in fiscal year 1957 in the amount of \$30 million, and of this amount, only some \$97,000 remained uncommitted as of 29 June 1957. We still have the account open. We are coming out pretty well on that. The dollar value of our inventories as of 30 September 1957 amounted to approximately \$316 million.

Subsequent to the capitalization, our agency was able to reduce specific mobilization deficiencies by approximately \$8 million. That was the result of merging the assets of all three military departments into one pot, so to speak. In addition, this consolidation of stock makes possible a better evaluation of the overall DOD readiness position and the application of stocks in terms of priority of requirements. That we feel is one of the big advantages which can be ascribed to the Single Manager Plan.

CHART 6 PLANNED SINGLE MANAGER DISTRIBUTION STOCK POINTS

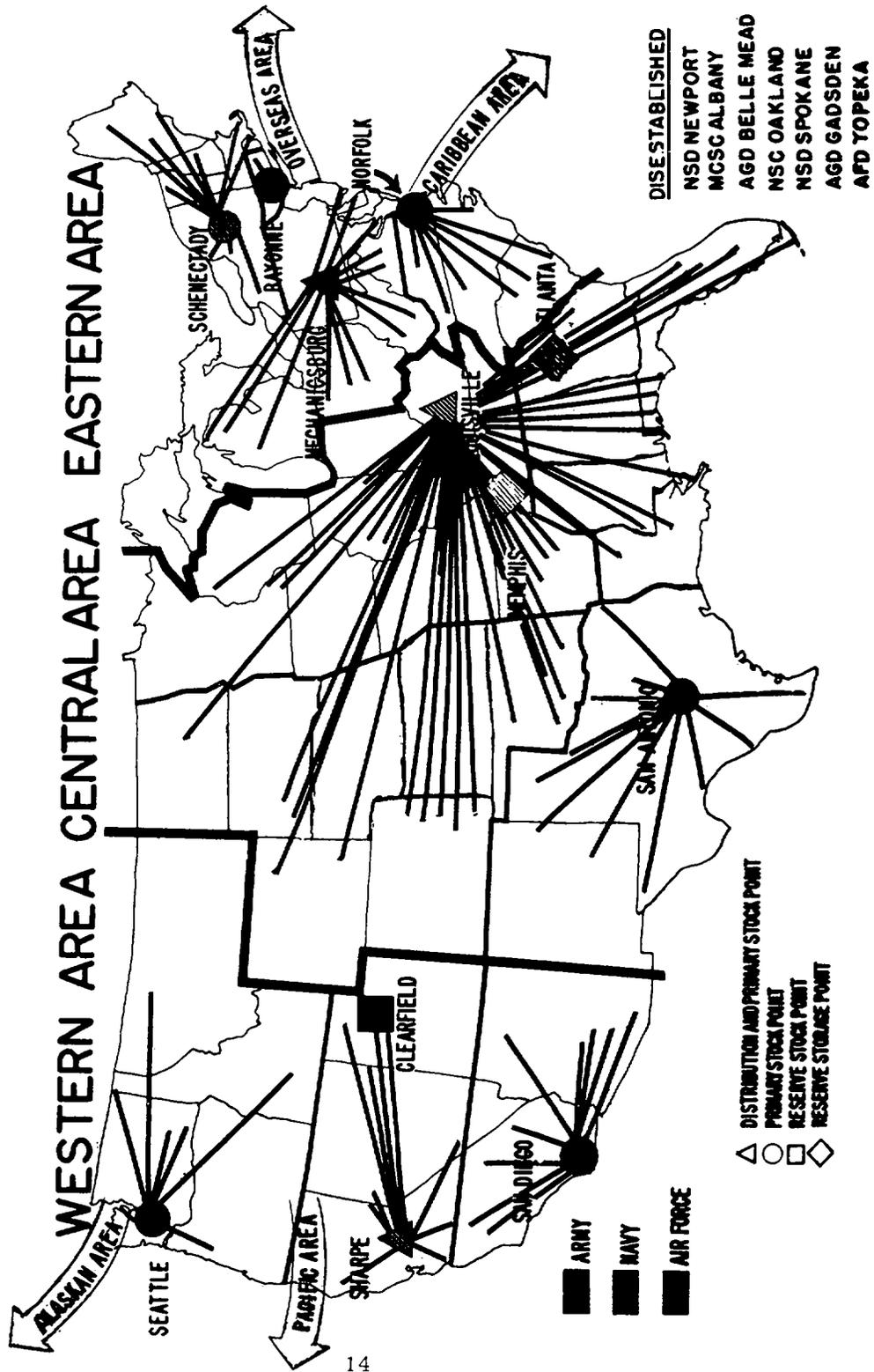
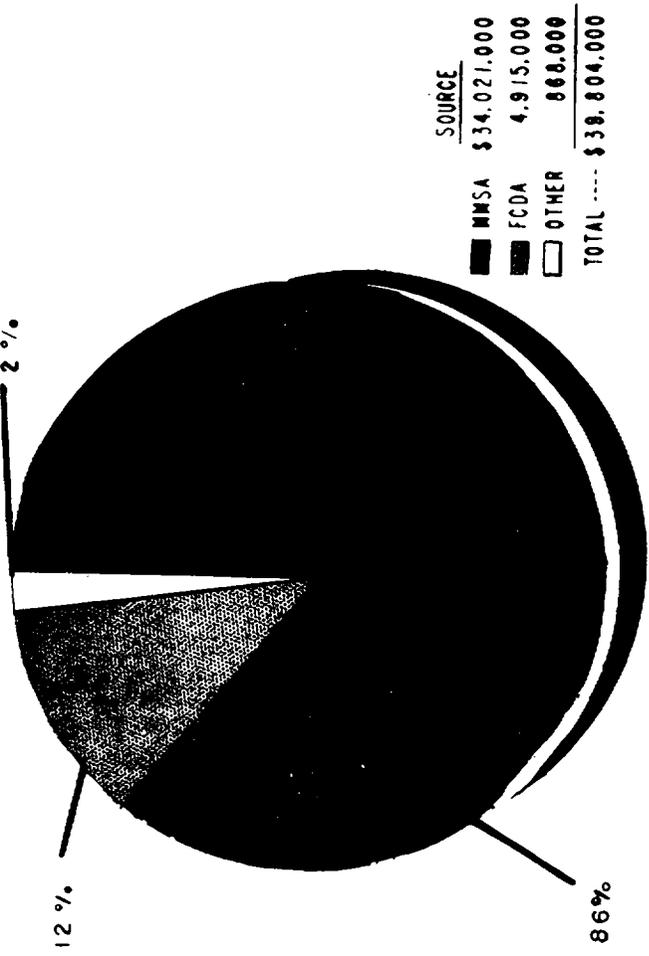


CHART 7

PROCUREMENT ALLOCATION



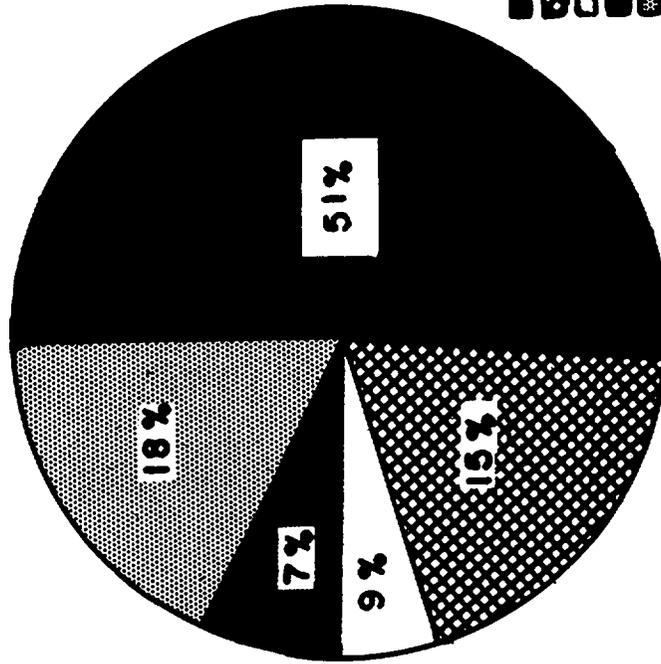
1 JANUARY-----30 SEPTEMBER 1957

CHART 8

MATERIAL PROCURED

TOTAL NUMBER
2007

TOTAL DOLLAR VALUE
\$39,804,000



- DRUGS, BIOLOGICALS, ETC.
- ▨ X-RAY EQUIPMENT, ETC.
- ▩ MEDICAL AND SURGICAL INSTRUMENTS
- ▧ SURICAL DRESSINGS
- ▦ OTHER PROCUREMENT

1 JANUARY-----SEPTEMBER 1957

CHART 9
AWARDS MADE
(NUMBER)

**UNDER
\$ 10,000**

1686

**\$10,000
TO
\$100,000**

483

**OVER
\$100,000**

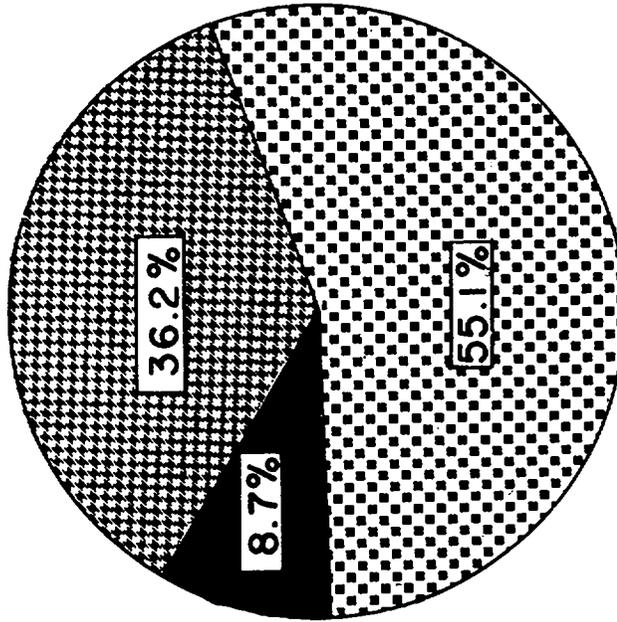
68

PERIOD 1 JAN. 31 DEC. 1957

TOTAL AWARDS - 2

CHART 10

INITIAL STOCK FUND ASSETS RECEIVED FROM:



- * INCLUDED \$34 MILLION DOD STOCKPILE BLOOD PLASMA AND RELATED ITEMS.
- NAVY STOCK FUND \$ 125,129,341 *
- ARMY AND AIR FORCE STOCK FUND 190,172,513
- PROCUREMENT AUTHORITY 30,000,000

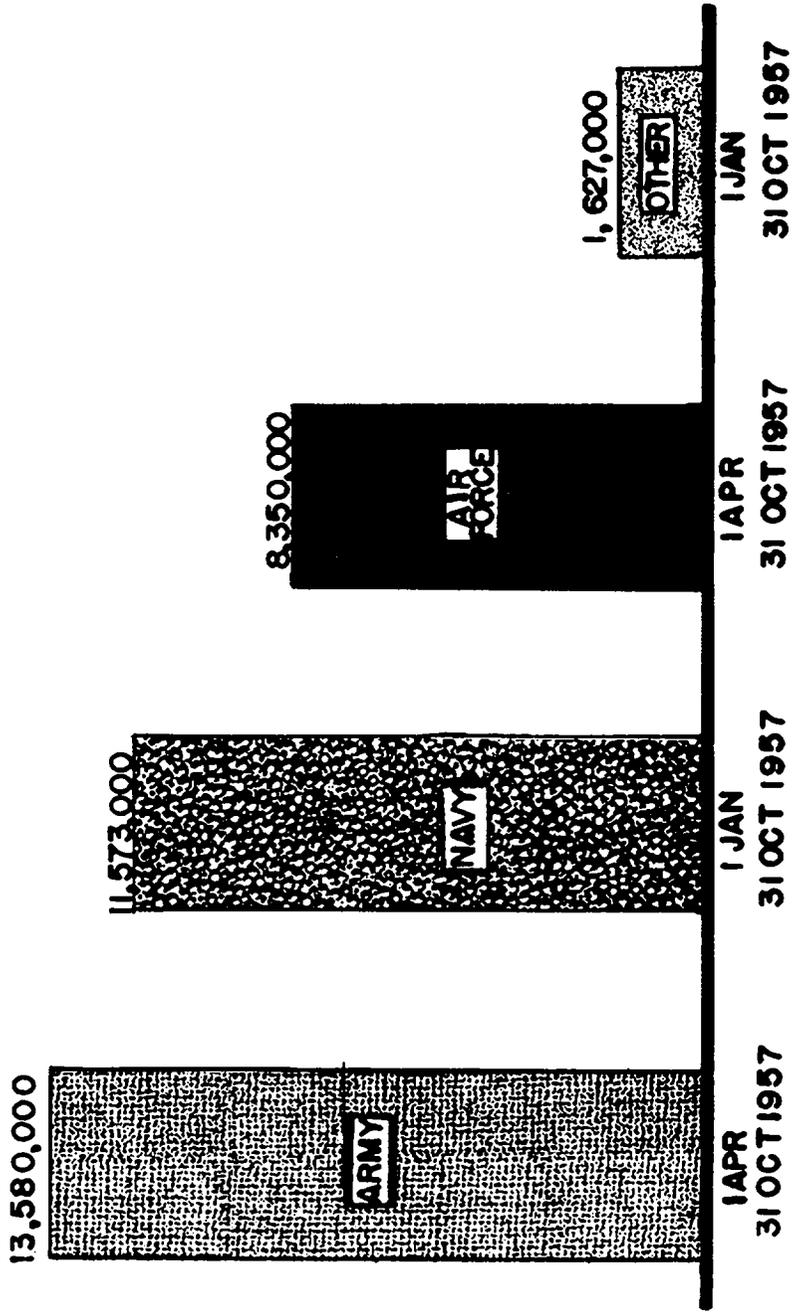
Chart 11, page 20. --Now, Sales. Sales to the Army of \$13.6 million and to the Air Force of \$8.4 million are for a period of seven months-- April through October 1957, since they did not come into our system until April. Navy sales of \$11.6 million are reflected for a period of 10 months--January through October 1957. It is expected that major sales will be made to our Army customers of approximately \$22 million per year, with Navy and Air Force sales being about \$15 million each per year, and the Military Assistance Program will be some \$10 million. Sales to other Government activities, such as the Treasury Department, Public Health Service, and Department of Agriculture, amounted to \$1.6 million for the period January through October 1957.

Chart 12, page 21. --Maintenance and Operation. Our M&O budget is maintained at the minimum amount consistent to meet our operational requirements. Maximum utilization is made of common services that are available at other Navy activities in the New York area. For instance, the Naval Supply Depot at Bayonne, and its Brooklyn Annex, which used to be the Naval Supply Activities, New York, provide: Administration of civilian payrolls, cost and allotment accounting, industrial relations, and public works construction and maintenance services; and we pay for them. In this manner, savings in manpower and dollars--which are quite important at this time--can be realized against the cost of establishing these necessary services in our own organization or in our own building. As you can see from this chart, 74 cents of our operating dollar is consumed in personnel services, 9 cents in contractual services, 6 cents for industrial mobilization contracts, 9 cents for building maintenance, and 2 cents for supplies and equipment. We also have active management improvement programs in work methods, mechanization, procedural, and organizational areas. These have been instituted and directed toward a reduction in personnel cost in future budgets.

Chart 13, page 22. --This is a chart that usually gets me into trouble if I mention it, and, if I don't mention it, someone else does. Prior to activation of the Military Medical Supply Agency, there were 129 military personnel and 751 civilians for a total of 880 personnel performing functions which were eventually transferred to our agency. The initial personnel complement required upon the activation of MMSA was 68 military and 593 civilians, plus 63 civilians performing functions that were transferred to other Navy activities. That made a total of 724. This was 156 fewer people to start out with than were previously required. Joint effort had existed in the purchasing, industrial mobilization, and cataloging functions only, up until that time. Duplication of effort by the three services existed in stock and financial-control functions, machine records--we had IBM and Remington-Rand installations in the same building--and some of the administrative services functions. Consolidation of these functions is largely responsible for the initial savings realized in manpower.

CHART 11

SALES MADE DURING PERIOD SHOWN



TOTAL SALES: 35,130,000

CHART 12

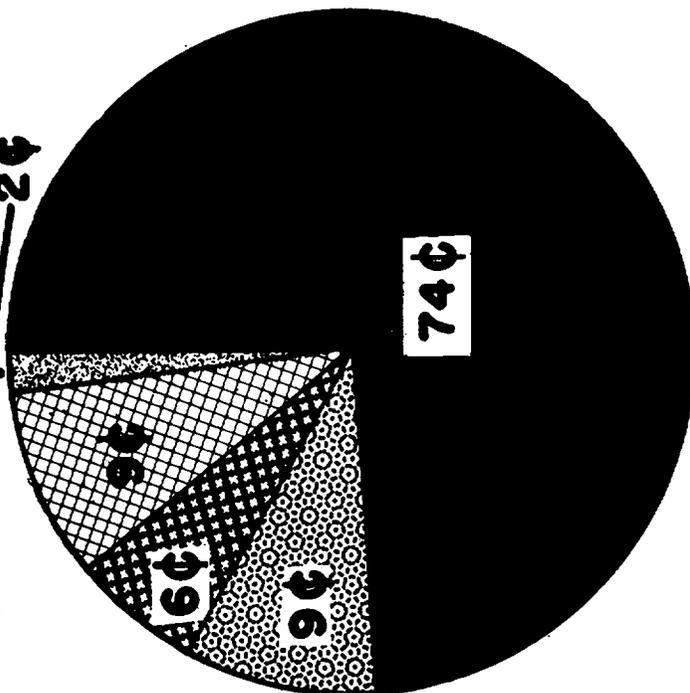
HOW THE AGENCY OPERATING DOLLAR

IS USED

TOTAL BUDGET
\$ 3,076,747

PERIOD
1 JAN - 30 NOV 1957

2¢

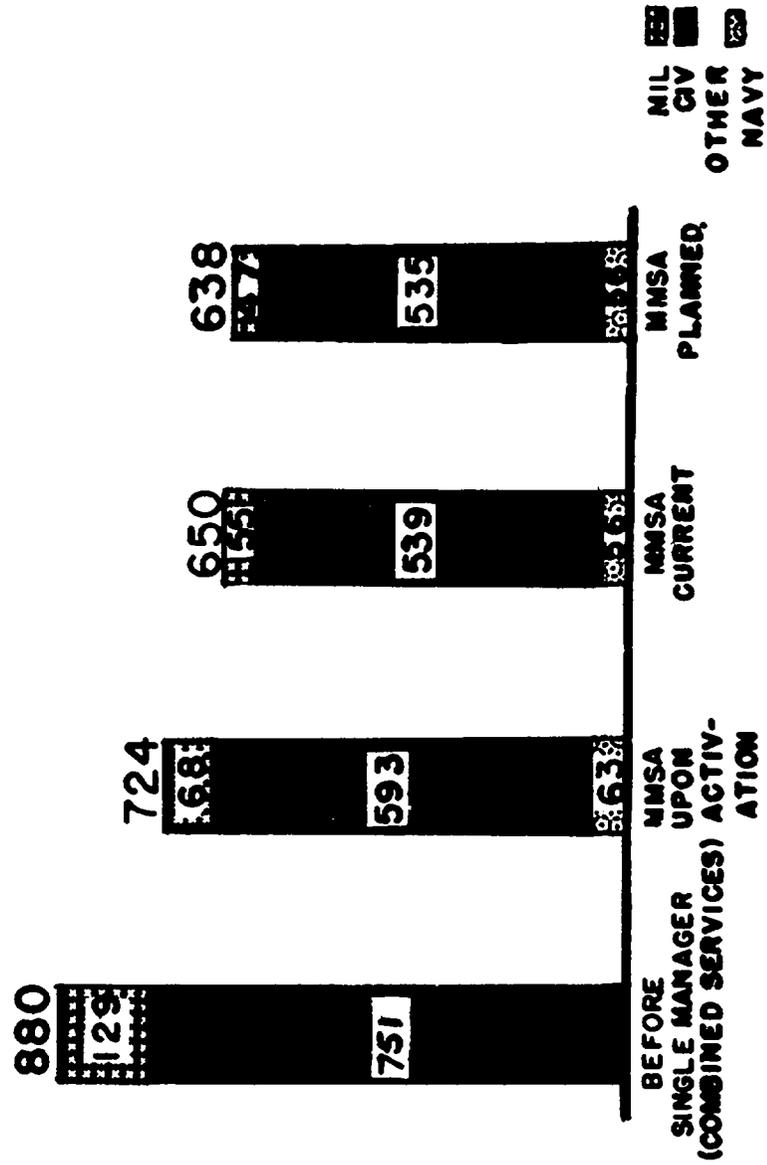


- CIVILIAN PAYROLL
- CONTRACTUAL SERVICES
- INDUSTRIAL MOBILIZATION CONTRACTS
- BUILDING MAINTENANCE
- SUPPLIES AND EQUIPMENT

SOURCE : MMISA BUDGET FOR PERIOD 1 JAN - 30 NOV 1957

CHART 13

AGENCY MANPOWER TRENDS (COMPLEMENT)



14 SEPTEMBER 1956 | JANUARY 1957 | JANUARY 1958 30 JUNE 1958

Since the activation of MMSA, further operational improvements have been made through functional and organizational changes. This has resulted in reducing our personnel complement to 55 military and 539 civilians, for a new complement of 594, plus 56 people at other Navy activities.

So, as reflected by this chart, a total savings of 230 personnel has been accomplished as of 1 January 1958. Of these 230 personnel, 156 were civilian, and 74 were military. As a result of these reductions, an estimated annual savings of \$887,000 has been realized, based on actual personnel records, grades, pay, and so forth.

Our personnel planning contemplates a further reduction of 12 personnel by 30 June 1958.

I would like to mention employee morale, which received our first and continuing attention. However, once our organization was activated, it became quite clear that any fears that we might have had about lowered employee morale were unfounded. A lot of people were a little leery. They had been working under Army administration a long time, and we were these beasties who came in in blue uniforms. They didn't entirely trust us at first and for perfectly understandable reasons.

Although some 800 personnel were affected by the transition to the Single Manager Plan, only one grievance was received, and that was denied by the Civil Service Commission, and right up the line. Of the approximately 125 personnel who were issued separation notices--with letters to Congressmen in advance, I might say--jobs were secured for all except two, either in other Government activities or in industry; and those two elected to retire.

As I told Colonel Lackas a little earlier, our congressional correspondence, which is a very good barometer, has been strictly routine.

Chart 14, page 26.--Now we will go to some Major Programs. We are engaged in many important programs. I think the three here will probably have the greatest overall interest for this particular presentation.

Cataloging: Our agency has been assigned the responsibility for cataloging all standard medical material within the DOD Cataloging Program. Manuscripts of our new catalog are proceeding on schedule. Approval of the military services on our planned cataloging criteria and procedures for identification of items, format, composition of the catalog, and the assignment of items has been received.

CHART 14

MAJOR PROGRAMS

- CATALOGING
- STRATIFICATION
- MATERIAL STANDARDIZATION

I might mention that we have under our cognizance 9,257 items in 135 different FSC classes.

Stratification: This is a very broad subject. We may mention it later, possibly, but, right now, a brief word: Based on the line item requirements submitted by the military services, we did effect the stratification of our inventory to determine our single manager's readiness position to support the military services during mobilization.

We anticipate commencing our second stratification of inventories during March 1958. This will be under new guidelines, and I think you are undoubtedly familiar with them, the recent guidelines promulgated by the Secretary of Defense. Our first stratification was accomplished under the old guidelines.

A complete discussion of the item and dollar volume deficiencies and stratification guidelines cannot be conducted during this presentation; but we will be pleased to try to answer any questions you might have during the question and answer period.

I think material standardization is of interest to you, and we have a chart on that.

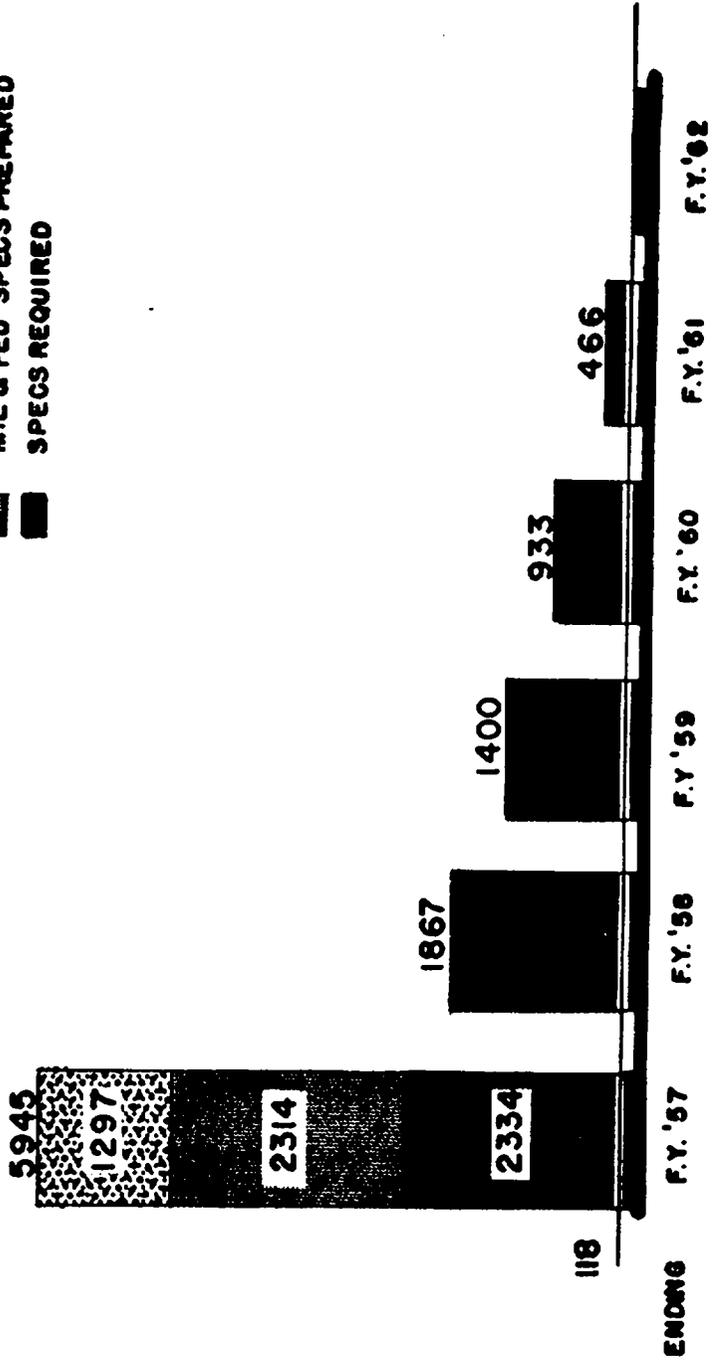
Chart 15, page 26. --Detailed plans for the implementation of the DOD Standardization Program have been coordinated with interested activities within the Department of Defense and the civilian agencies. Considerable progress has been made in the clarification of policy and in the formulation of procedures. In the area of our agency's responsibility for standardization, there are 5,945 items contained in FSC group 6500--that's Medical, Dental, and Veterinary equipment and supplies--and FSC class 8125 (Bottles and Jars).

This chart indicates our specification planned workload and the progress expected through fiscal year 1962. Of the 5,945 items subject to standardization, 1,297 do not require specifications, because they already have certain standards that they meet--U. S. Pharmacopoeia, and that sort of thing--2,314 are already covered by Federal or military specs, leaving 2,334 items for which new specs are required. To this must be added a workload of 1,166 item specifications which require revision. The thin horizontal line indicates our normal recurring workload consisting of approximately 118 new and revised specs every year.

CHART 15

DOD STANDARDIZATION PROGRAM SPECIFICATION REQUIREMENTS (ITEMS)

 SPECS NOT REQUIRED
 MIL & FED SPECS PREPARED
 SPECS REQUIRED



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So you can see here that we expect to process a net gain of approximately 470 item specs during each of the next five years. Items not covered by specifications are normally procured through the use of MMSA purchase descriptions.

Chart 16, page 28. --Other Programs. Some of these programs I have listed here may be of interest to you.

First, Industry Preparedness Measures. We are engaged in pilot production--that is where you saw, I think, that 9 percent of our M&O money goes into industry preparedness contracts--of new developed items--conservation of critical and strategic materials, plastics, and closures, and seals. In other words, we are trying to develop plastics which will stand the high temperatures of sterilization and that sort of thing, for surgeons' wash basins and a variety of other implements that require sterilization.

Second, Training. In addition to comprehensive training programs for our own people, we have trained six classes of inspectors from the Navy Material Inspection Service. They provide our inspection. We do not have any inspectors of our own. We have also conducted several training seminars for our field depot personnel. We are also developing a one-year course of instruction in Medical Logistics for the Medical Service Corps Officers of all three services.

Third, Maintenance and Repair. This is a very important program which provides for the continuous review of maintenance and repair needs, including rehabilitation of the single manager stocks in our wholesale system. It provides an ancillary service to our customers and develops repair parts lists as needed.

Fourth, In-Store Quality Control. I might say this is even more important since we still have some World War II stocks and Korean stocks that have to be looked at. Under this continuous program, we provide in-store surveillance and inspection over all single manager stocks. It is also designed to detect deterioration in store, to provide corrective measures, and to recommend disposition of unsatisfactory stocks. Constant emphasis will be placed on this particular program in order that we may insure that the material issued to our medical and dental customers will be in all respects suitable for issue. I am sure that you are all as interested in that as we are.

CHART 16

OTHER PROGRAMS

INDUSTRY PREPAREDNESS MEASURES

TRAINING

MAINTENANCE AND REPAIR

IN-STORE QUALITY CONTROL

Chart 17, page 30.--We have some Major Problem Areas. I just happened to borrow a Play Boy magazine coming down on the plane yesterday, and I noticed a story in there about a psychiatrists' convention which I think is appropriate in connection with the problem areas.

It seems that one of the delegates noticed one of his colleagues pawing a very charming female delegate during one of the cocktail parties that they had during the convention. When he couldn't stand it any longer he went up to this young lady and he said, "Is this man annoying you?" She said, "Why should I be bothered? It's his problem!"

We have some problems, too, but not quite the same kind. These problems I do think are up your alley. For instance, the first one is the Mobilization Reserve Criteria. With respect to the ownership of mobilization reserve assets, a specific criterion is required to determine those mobilization reserve assets which should be owned by and prepositioned at the service level, versus those which should be retained in the Single Manager Wholesale System. In addition, we also require specific guidance as to:

- (1) The application of wholesale assets to the specific mobilization reserve requirements of the individual services.
- (2) The application of wholesale stocks in excess of peacetime needs to the specific and/or general mobilization requirements of the services.
- (3) The priority of issue of general mobilization reserve stocks during wartime. Who gets what, how soon, and in what amount?

Under Mobilization, Operation Alert 1957 disclosed three major mobilization problems:

Rationing of Available Material: There is a very distinct lack of guidance for the rationing of available material between FCDA and the military; and also among the military services.

Rationing of Procurement Capability: Upon mobilization it is assumed that the single manager will continue procurement for the Federal Civil Defense Administration as part of its mission. They used to be our biggest customer, but they didn't get much money this last year. This could very well create a problem as to priority of contracts. In this particular area we are going to require DOD and ODM guidelines to solve the problem.

CHART 17

MAJOR PROBLEM AREAS

MOBILIZATION RESERVE CRITERIA

MOBILIZATION

RATIONING OF AVAILABLE MATERIAL

RATIONING OF PROCUREMENT CAPABILITY

RESTORATION OF INDUSTRIAL PRODUCTIVE CAPACITY

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Restoration of Industrial Productive Capacity: This problem requires close and continuous coordination and study between DOD, ODM, and the single manager. While the national stockpiling of raw materials is essential, and we recognize that, all this material becomes meaningless if the capability of processing the raw material into finished products is not available. Stock levels of survival-type items should be increased at retail and wholesale stock points as soon as possible after M-day.

Operation Alert revealed that the bulk of the medical industry was subjected to extensive destruction, and only a small portion of the country's needs for emergency supplies was available.

Gentlemen, in closing, let me say that we are very well pleased with the progress the Military Medical Supply Agency has made up to this time. Based on our first year of operation, we feel that the Single Manager Plan for medical material has worked out, by and large, very successfully. It is also my impression that this optimistic feeling is generally shared by those offices primarily concerned with the implementation of the plan.

As indicated earlier in this presentation, the consolidation of inventory functions has resulted in quite significant manpower savings. Refinements in our distribution system have reduced the number of medical supply depots and, to a large extent, have eliminated the crosshauling of material. This was one of the principal criticisms of the three-service system. The consolidation of assets has assisted MMSA in maintaining a high degree of supply effectiveness, at the same time providing for greater utilization of our wholesale stocks. I do not mean to imply that we have reached Utopia. We recognize that no plan is perfect, and we still have some "bugs" in our system. But we have progressed to the point where we can recognize our major problems and do something about resolving them.

I would like to emphasize again that certain factors have contributed significantly to the success of the single manager concept, at least as it applies to medical material, and that is what we are interested in today.

Procurement, specifications, cataloging, and standardization have for many years been under joint control. We have a relatively small number of items to manage--only about 9,300. What is more important, 85 percent of these items are common to all services. In addition, we operate in close coordination with the three service requirements offices, which I have mentioned from time to time, because I think it is very

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important. They are located in the same building with us and our working relationship with these activities has been exceptional. Our agency has received the full support of the Surgeons General of the three services. Without that we couldn't have gotten to first base. We have also received the full support of our management and technical bureaus. We enjoy a close association with the administrative and medical-dental professional offices of the Department of Defense. We maintain close and continuing contacts with the depots in our system out in the field and, through seminars and frequent field trips, we have been able to gain a better understanding of our mutual problems. We also watch the system at work and evaluate individual depot operations.

While the single manager assignment is a responsibility of the Secretary of the Navy, our planning and operations to date have represented a truly unified effort. All three services have actively participated from the very outset, and the spirit of cooperation at all levels has been outstanding; more so, perhaps, because we do have a common aim, and that is "to make the plan work." To this end we are convinced that it does work and, even more important, that it is working effectively and efficiently.

Chart 18, page 33. --I just happen to have one more chart which may be appropriate to this presentation. This cartoon indicates some of the hurdles we had to negotiate in implementing our activation plan. This has been used in previous presentations when we were getting the show on the road. Incidentally, I made a mistake at my first Administrative Committee meeting. I wanted to get off on a friendly basis with everyone so I remarked that we were having considerable success in "getting our medicine show on the road." The four doctors on my Administrative Committee looked right straight ahead and didn't crack a smile. Afterwards, I said, "Well, either I am not very funny or you don't have a very good sense of humor. I don't know which." We all understand one another now!

I might point out that the hole in the shoe has no political significance.

We successfully cleared the last hurdle when our new distribution system went into effect on 1 July 1957. We are, however, under no illusions that all our troubles are over and that we can sit back and relax. With that in mind our illustrator added a little something to the chart-- just so we wouldn't forget. Those in front will see that the principal obstacle, the coil of barbed wire, has dollar signs representing the barbs. There is also no finish line in sight.

I hasten to add, however, that there is one thing that we do keep in sight at all times.



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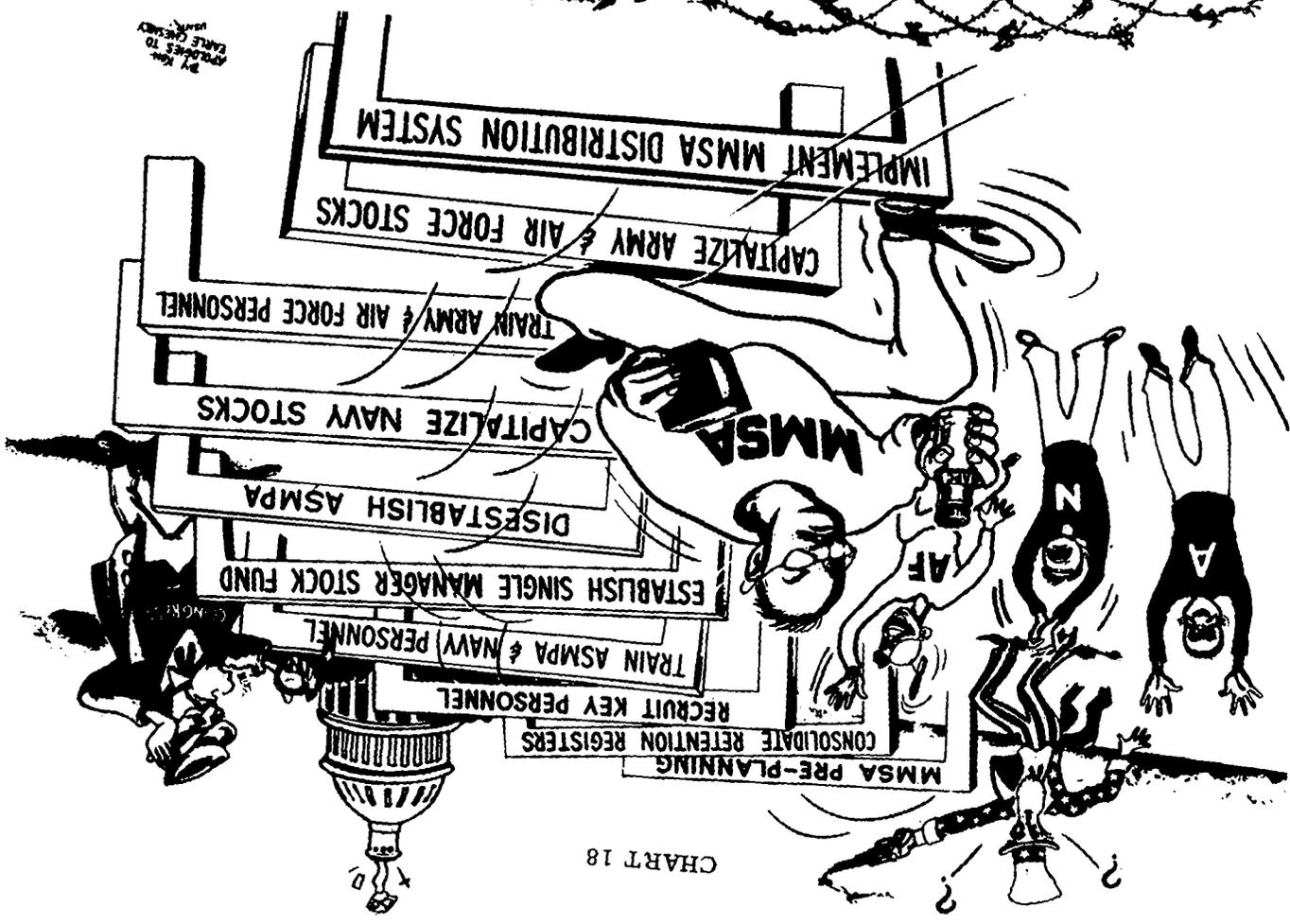


CHART 18

Chart 19, page 35.--Our Primary Mission--To Effectively Support The Overall Military Effort Of Our Country.

Thank you, gentlemen, very very much.

COLONEL LACKAS: Admiral Knickerbocker will first introduce the members of his staff.

ADMIRAL KNICKERBOCKER: Gentlemen, my Deputy is a graduate of this school, and he said, "Those guys down there get pretty rough. You had better be prepared to answer all sorts of loaded questions and that sort of thing."

I brought along a couple of experts today in case you get into any detailed questions. I think among the three of us, we can answer most of them.

Here is Commander Anderson, who heads up our System Planning Department. Commander Anderson was the executive officer of the Navy Medical and Dental Supply Office in Brooklyn for two years, so he has a very fine medical background. He and I were the first two people ordered to this agency, and I regret that I am going to lose him in the near future. He is going to Hawaii to help get things straightened out at Pearl Harbor.

Next is Commander Voegeli who heads up the Financial Control Division.

We expected to have Lieutenant Colonel Butler of the Army accompany us today. He unfortunately has the flu. I also regret to hear that General Mundy and Admiral Clark are both ill today.

We'll do our best to answer any kind of questions you want to throw at us. If we can't answer them, we'll tell you so.

QUESTION: Admiral, back in November FCDA held a training session for executive reserves in which they considered various matters involved after a nuclear attack. One of the sections of their report pertains to survivor items. Under this section they have a series of assumptions. One of the assumptions states very emphatically, that survivor items, including medical supplies, excess to military requirements for operations, will, in accordance with an agreement between DOD, FCDA, and ODM, be transferred to FCDA.

CHART 19

OUR PRIMARY MISSION — TO EFFECTIVELY SUPPORT

THE OVERALL MILITARY EFFORT

OF OUR COUNTRY

My question is, Who determines the excess of minimum requirements for military operations, and what percentage of your inventory do you now consider available, as of today, for transfer under those conditions?

ADMIRAL KNICKERBOCKER: Commander Anderson can best answer this, because he was the one who personally conducted our Stratification Program.

COMMANDER ANDERSON: Yes, sir. We expect to declare excess \$10 million worth of stock this year. Your second question is, "Who determines whether it will be excess?"

STUDENT: I am particularly interested in the items listed by FCDA as survivor items.

COMMANDER ANDERSON: We know of no such listing of items. There is a committee coming up with selected items. We know about that. I can't tell you offhand what percentage of stocks we have which we can supply against that.

QUESTION: Have you had an opportunity as yet to compare the requirements estimates that you have gotten over the past year from the various military services with the actual sales that have materialized? If you have, how good have their forecasts been?

ADMIRAL KNICKERBOCKER: You know the three services do not submit peacetime requirements to us. They submit only mobilization requirements. From the standpoint of budgeting, one thing we do look at in our budgeting for the stock fund is the consumer budgets of the respective services. At no time should our budget ever come out so that it will be of greater value than the total value of the consumer budgets of the three services. As a matter of fact, it is usually considerably less.

STUDENT: Do you figure these requirements on a peacetime basis?

ADMIRAL KNICKERBOCKER: We determine requirements on a peacetime basis, yes.

QUESTION: Sir, I have two questions. The first one is directed to you, Admiral, and the second to Commander Anderson. The first

question is this: Since the Veterans' Administration has about as many hospitals as do the Army, Navy, and Air Force combined, would it not be feasible and desirable from the taxpayer standpoint to cut them in on the single manager service and furnish them supplies out of your depots?

The second question, to Commander Anderson, is this: You indicated by the chart that you have a System Management Division. Do you have authority to design the system utilized below the depot level for the requisitioning and accounting for supplies? It would seem to me from my observations that there is considerable difference in the systems utilized by the Army, the Navy, and the Air Force, and there ought to be some additional opportunities for accomplishment there.

ADMIRAL KNICKERBOCKER: In answer to the first question, as I recall, we worked up a proposed agreement under which our procurement facilities would be made available to the Veterans' Administration if they wanted to participate in that kind of program.

I believe GSA makes purchases now for the Veterans' Administration. I personally feel that we could probably support Veterans' Administration hospitals out of our distribution system, but it would take a considerable amount of planning and indoctrination. I don't see anything particularly standing in the way, if the agreement could be worked out.

We feel that we have a very efficient procurement organization. We also feel that we have an efficient distribution system. That distribution system, of course, was approved by the Department of Defense, with one minor exception and that was the substitution of Sharpe as a distribution point for Oakland.

Do you want to add something on this VA matter, Commander Anderson?

COMMANDER ANDERSON: No, sir. We have started along that line. We have just worked out a purchase agreement with the Public Health Service. I think it will probably eventually come, because we expect other Government departments to find that, if they work through us, they can get the materials cheaper.

With regard to the second question, we have no authority over the retailers as to what kind of accounting procedures they use.

Our policy has been to try to affect the depots as little as possible, except to tell them what will be given to them, to tell them what we want from them, and let them work out their own procedures. You must recognize that with all the single managers in being everyone is coming up with his own way of doing things.

ADMIRAL KNICKERBOCKER: That came out before the single manager plan ever went into effect. That was one of the arguments used against the single manager plan. It is something that still has not been resolved.

QUESTION: My question is concerned with this problem of allocating short supplies in the event of mobilization. This, as everybody knows is a very serious problem for all single managers and is vital to military operations. Would you tell us what is being done now to get this problem resolved, and what the prospects are of getting an answer in the next year or so, and what you would do if the balloon went up tomorrow?

ADMIRAL KNICKERBOCKER: I see some Department of Defense people sitting up in the balcony. Maybe we ought to throw that at them. This problem has been pointed out to DOD and I understand they do have a committee working on it now. Just when we will get some kind of decision, your guess is as good as mine. It's a very, very difficult problem. That's the reason I included it in my presentation.

COMMANDER ANDERSON: I can add a little something as pertains to medical. In medical we have reserved for each service specific reserve stock at the depot level. In other words, every depot is protecting a certain quantity of stock for the Air Force, the Army, and the Navy, and each of the three services knows that.

We don't like that, because we don't think it is too practical. In this last Operation Alert we found that, although we had it reserved, someone else went in and took it. The depot commander had no authority to stop them. We are reserving material to meet specific requirements. In the general mobilization requirement area we are not. There is no priority system of issue right now.

ADMIRAL KNICKERBOCKER: I might mention that this particular problem came up quite early in the game. I think it was just before or just after the Army and Air Force stocks were merged, right back in April. It came up in connection with polio vaccine. We had a pretty good stock of Navy polio vaccine, but the Army and the Air Force stocks were practically

down to zero. It came down to the point of what we would do, how we would ration the stocks that we had.

We referred this problem to the Surgeons General and they got together and came up with a certain set of criteria as to the issue of stocks and areas and ages of personnel within the areas, and that sort of thing. We weathered that storm pretty well. But, right at the moment, even in peacetime, this priority of issue of stocks, rationing, if you want to call it that, has to be handled practically on an individual situation basis. Right now, if it comes up, we give it to this Armed Services Medical Material Coordination Committee. They have representatives of all three Surgeons General there, and they come up with rationing criteria for us.

QUESTION: I would like to pursue the Colonel's line of questioning a little further. We have heard from GSA representatives on what a fine job they have done. Indeed we have heard from an Air Force representative on what a fine job GSA has done for the Air Force on small tools and the like. I am sure there are other hospitals besides the Army, Navy, and Air Force, and Veterans' Administration, Government hospitals. Why don't we move one step further and throw all this to GSA and let them buy for all of us?

ADMIRAL KNICKERBOCKER: Commander Voegeli just said, "Well, let's hang our hat on prices. The prices we have been able to get are better than the prices GSA has been able to get." I don't know the answer to that particular problem. Perhaps Commander Voegeli has a further comment.

COMMANDER VOEGELI: I think the problem rests with DOD. The public law which established GSA also provides an escape clause for the Department of Defense. I don't have it verbatim, but as I recall, it provides that the Secretary of Defense may exempt any item from GSA control which, in his opinion for the security of the Nation, is better handled in the Department of Defense Supply System.

QUESTION: This won't be quite such a loaded question. The other day I had a doctor call on one of the members of my family and he prescribed some drug. I said, "That looks to me like a new one." He said, "Oh, yes, it is. It came out just last week. As a matter of fact, two new drugs came out last week. It's a big job just keeping up with the new drugs." Would you trace for us the procedure by which this thing gets into the system, a new drug? Is it prepared by the U.S. Pharmacopoeia Act? How does it come into the medical system so that it is available to a doctor at the far end of the line?

ADMIRAL KNICKERBOCKER: Actually it does take a little while for a new drug to get into our system. As a matter of fact, the tranquilizers, which are a good example--I took one before I came here--I don't think are standardized yet. They are procured on open purchase. The retail requirements officers control the allotments for local purchase out at the field level. The professional people out there have a certain amount of latitude, that is, within the funds available, to go out and purchase the new drugs, new preparations, and that sort of thing, that they feel are appropriate and necessary for the health of the personnel.

Sooner or later, if these work out, if they need them in large enough quantities, they will start requisitioning them. As the demand builds up for a particular item, then our technical people, working toward coordination with stock control will say, "Perhaps that item should be standardized." Then the problem is given to the Armed Services Medical Material Coordination Committee for consideration. If they decide that the item is fit for issue to the armed services, they will come back and tell us to standardize it. Or they may tell us to standardize an item that we haven't given them, or they will recommend that it be standardized. We never standardize anything that they haven't recommended. That doesn't necessarily mean that we will standardize every item that they have recommended to us.

Commander Anderson, do you want to say something on that?

COMMANDER ANDERSON: Our agency is not considered professionally competent. As to whether new drugs should be used in the respective services, the Coordination Committee is the key point on this. When the respective services get recommendations from members in the field or from their own research people, these items go before the Coordination Committee and they determine whether or not to standardize the items.

At the time of the consideration, we supply to the Coordination Committee the amount of stocks we have on hand, which would be replaced by the new item. They try, in standardizing a new item, to make sure that we are not caught with stocks that we have to dispose of.

But, as the Admiral said, the Coordination Committee is the key point, because they represent the professional side of the business which we are in.

ADMIRAL KNICKERBOCKER: I would like to point out that we don't have a single professional man in our organization. However, we feel that

we are highly competent technically. Seventy-five percent of our officers are Medical Service Corps officers and the other 25 percent are supply officers. We depend on our technical bureau and the Surgeon General of the Navy in coordination with the Surgeons General of the other two services, to provide us with professional advice that we need.

I might say at the outset that we had quite a discussion in one of our first Administrative Committee meetings about this Medical Material Coordination Committee. Some of the DOD representatives thought that that committee ought to be responsive to me directly, and I am not so sure that my own people didn't feel that it should. I felt that, even though these people might represent their Surgeons General, and be professionally qualified, that that would set me up, a layman, a supply officer, as a rubber stamp for any kind of decision that this committee would make. So I personally like this committee just exactly where it is, right under the control of the three Surgeons General. They are responsible for the health of all our military forces.

COMMANDER VOEGELI: I just want to comment that standardization does not slow down the application or the stocking of a new vaccine. For example, take the Asian flu. When an item is approved for application and use in the three services, such as the flu vaccine, they immediately submit requirements to us. We go out and buy that as a local item. As soon as it is standardized, then its local designation drops off, and it is a standard item.

As a matter of fact, sometimes you will find, if you peruse it closely, that we have a lot of items that, soon after they become standardized, a new item comes along to replace. We hardly ever have them standardized.

Standardization does not slow down utilizing the technological advances in the field of medicine.

ADMIRAL KNICKERBOCKER: My Medical Service Corps people tell me--to go back to this subject of tranquilizers, for instance--that you read a lot of articles now and then in magazines saying that maybe some of those things have bad side effects, and those may not show up immediately. For that reason, the armed services do not want to standardize those particular items until they know that they are in all respects fit for consumption and for use in the armed services

COLONEL LACKAS: Admiral Knickerbocker, Commander Anderson, Commander Voegeli, we are very happy that it worked out the way it did.

I am certain I can speak for your audience in saying that this was a most informative morning. We thank you very much for coming down from your agency to explain this most interesting operation to us. On behalf of the College, I thank you.

(12 June 1958--4,100)O/rmc:mjs:ekh