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Health Reports

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PREFACE

Health Reports is a list of health products including reports and testimonies issued by the General Accounting Office (GAO) over the past 2 years. Organized chronologically, the entries provide a title, report number, and issue date for each GAO health product. Reports and testimonies on the same topic may be combined into a single entry.

The first section--Recent GAO Health Products--summarizes reports and testimonies on selected health issues published during the past four months. This section is followed by a list of additional products published during the same period and then a section listing summaries of most frequently requested health reports. The remainder of Health Reports is a list of health products published during the past two years and organized by subject areas as shown in the table of contents. As appropriate, entries have been cross-indexed and are included in more than one subject area. Order forms to be placed on our mailing list for Health Reports and to request GAO products appear at the end of this publication.

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ABBREVIATIONS

ADMS	Alcohol, Drug Abuse and Mental Health Services
ADP	automatic data processing
AIDS	acquired immunodeficiency syndrome
CDC	Centers for Disease Control and Prevention
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
	Services
CRI	CHAMPUS Reform Initiative
DC	District of Columbia
DOD	Department of Defense
DOE	Department of Energy
ERISA	Employee Retirement Income Security Act of 1974
EPA	Environmental Protection Agency
FDA	Food and Drug Administration
FTCA	Federal Tort Claims Act
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HealthPASS	Philadelphia Accessible Services System
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HMO	health maintenance organization
IHS	Indian Health Service
IRS	Internal Revenue Service
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MCCR	Medical Care Cost Recovery
MRI	magnetic resonance imaging
NAIC	National Association of Insurance Commissioners
OSHA	Occupational Safety and Health Administration
PHS	HHS Public Health Service
RBRVS	Medicare Resource-Based Relative Value Scale
SSA	Social Security Administration
USDA	United States Department of Agriculture
VA	Department of Veterans Affairs
WIC	Special Supplemental Food Program for Women, Infants, and Children

RECENT GAO HEALTH PRODUCTS
(July-October 1993)

SUMMARIES OF SELECTED REPORTS

1993 German Health Reforms: Initiatives Tighten Cost Controls
(Testimony, Oct. 13, 1993, GAO/T-HRD-94-2). Report on same topic
(July 7, 1993, GAO/HRD-93-103).

In 1993, Germany instituted reforms to tighten existing cost-control measures. Before 1993, Germany had budget caps for the physician and hospital sectors that were negotiated between the associations representing providers and the sickness funds. These funds provide health insurance to most Germans. The initial thrust of the 1993 reforms was government-imposed mandatory global budgets for three years. These generally limit the growth of expenditures in the physician and hospital sectors to the rate of increase of the revenues of the sickness funds. Global budgets were also instituted for the first time on the pharmaceutical and dental sectors. The government's goal is to stabilize contribution rates and save over \$6 billion the first year. Additional cost-containment measures are in various stages of development and are expected to reduce continued reliance on global budgets. Early indications are that expenditures are being reduced. Some critics, however, assert that the quality of care will be compromised as costs are squeezed.

Veterans Affairs: Service Delays at VA Outpatient Facilities
(Testimony, Oct. 27, 1993, GAO/T-HRD-94-5). Testimony on same topic
(July 21, 1993, GAO/T-HRD-93-29). Report on same topic
(Oct. 15, 1993, GAO/HRD-94-4).

Veterans have experienced lengthy delays when they receive medical care in the more than 200 outpatient facilities operated by the Department of Veterans Affairs (VA). Veterans frequently waited one to three hours before having their nonurgent conditions examined by a physician in VA's screening clinics. Inefficient operating practices are major contributors to veterans' service delays. To be a viable competing provider under health reform as proposed by President Clinton, VA needs to quickly restructure its outpatient delivery system to provide more timely ambulatory services.

Medical Malpractice: Maine's Use of Practice Guidelines to Reduce Costs (Report, Oct. 25, 1993, GAO/HRD-94-8).

To reduce health care costs and improve the standard of medical care, Maine is testing an innovative medical malpractice reform initiative. In 1990, the Maine legislature established the Medical Liability Demonstration Project. This project set in motion a process that incorporates into state law 20 practice guidelines for four specialties: anesthesiology, emergency medicine, obstetrics

and gynecology, and radiology. Maine was able to implement the guidelines into law by (1) gaining broad involvement of those affected, (2) assuring that those developing and choosing the guidelines were accountable to the public, and (3) protecting the physicians who use the guidelines in their practices.

Managed Health Care: Effect on Employers' Costs Difficult to Measure (Report, Oct. 19, 1993, GAO/HRD-94-3).

Although many employers believe that, in principle, managed care plans save money, little empirical evidence exists on the cost savings of managed care. Most studies that compare firms' health care costs for employees under managed care to those under indemnity plans do not adequately control for key factors affecting cost, such as employees' age or health status. Some managed care plans have a potential for cost savings. Restrictions on employee choice of health care provider is viewed as the major constraint on employee acceptance of network-based managed care plans. Increasingly, employers are taking steps to address the need for adequate information on health plans' costs and quality.

VA Health Care: Medical Care Cost Recovery Activities Improperly Funded (Report, Oct. 12, 1993, GAO/HRD-94-2)

Before 1990, VA medical centers used medical care appropriations to finance the recovery of health care costs from certain veterans or third parties. In November 1990, the Congress established a Medical Care Cost Recovery (MCCR) Fund to finance all expenses related to collecting the costs of medical care and services provided by VA. GAO found that for fiscal year 1992, VA medical centers continued to use medical care appropriations to finance some cost recovery activities--apparently unaware that federal law prohibits such use. Without better definitions for cost recovery activities and a reasonable method for allocating personnel costs between different activities, some cost recovery expenses may continue to be improperly charged to the medical care appropriation. Further, the two medical centers GAO visited were using inefficient recovery procedures, which increased their administrative costs. VA has several departmentwide actions under way, which, when completed, will help its medical centers better contain recovery costs.

Medical Malpractice: Estimated Savings and Costs of Federal Insurance at Health Centers (Report, Sept. 24, 1993, GAO/HRD-93-130).

The Federally Supported Health Centers Assistance Act of 1992 authorized the Department of Health and Human Services (HHS) to assume responsibility for medical malpractice claims involving community and migrant health centers under the Federal Tort Claims Act (FTCA) for 3 years. With a fully operating program, centers could save an estimated \$55 million in insurance costs while the

government's costs for claim payments could total an estimated \$27 million for malpractice claims filed and closed between 1993 and 1995. However, because of the possible time lag between when an injury occurs and when a claim is filed and paid, it could take the government 10 or more years to pay for all the compensable injuries that occur at the centers while FTCA coverage is authorized. Over time it could cost the government considerably more money to resolve the centers' malpractice claims under FTCA than it would have cost to resolve the claims if the private sector's insurance coverage had continued, because the government provides a different type of coverage than that which most centers had purchased.

VA Health Care: Labor Management and Quality-of Care Issues at the Salem VA Medical Center (Report, Sept. 23, 1993, GAO/HRD-93-108).

GAO examined aspects of the quality assurance program; nursing and medical care provided; and management initiatives at the Salem, Virginia, VA Medical Center. The review, in part, was prompted by the discovery of the bodies of two patients on the center's grounds. Personnel changes are restoring both staff and public confidence in the management of the facility. The new medical center director has begun to address quality-of-care concerns, labor management issues, and staffing shortages; however, more needs to be done. Longstanding problems have resulted in poor quality of care for some patients.

Defense Health Care: Expansion of the CHAMPUS Reform Initiative Into Washington and Oregon (Report, Sept. 20, 1993, GAO/HRD-93-149).

The Department of Defense (DOD) certified the modified CHAMPUS Reform Initiative (CRI) as the most efficient method of health care delivery to eligible DOD beneficiaries in Washington and Oregon after comparing it with the standard CHAMPUS program. DOD does not, however, know how other health care delivery methods currently in operation or being tested in various parts of the country compare with the modified CRI program or standard CHAMPUS. As a result, we do not believe that DOD's comparison was inclusive enough to determine the most efficient method of providing health care to its beneficiaries in Washington and Oregon.

Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays is Needed for Federal Health Programs (Report, Sept. 17, 1993, GAO/HRD-93-92).

Investigations to date have revealed that federal health programs have been subjected to fraudulent and abusive psychiatric hospital practices, but apparently to a lesser extent than private insurers. Federal programs have many controls in place to guard against unnecessary or poor quality care. However, some control weaknesses exist that render federal programs vulnerable to fraudulent and abusive psychiatric hospital practices, resulting in some

unnecessary hospital admissions, excessive lengths of stay, poor quality care, and unauthorized or duplicate payments.

Medicaid Managed Care: Healthy Moms, Healthy Kids--A New Program for Chicago (Report, Sept. 7, 1993, GAO/HRD-93-121).

To begin addressing the problems faced by pregnant women and children, Illinois is implementing a Medicaid primary care case management program in Chicago called "Healthy Moms, Healthy Kids." Our recent review indicates that plans for this program include management and oversight controls that address prior weaknesses we previously reported in Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (Report, Aug. 27, 1990, GAO/HRD-90-81) and Quality of Care Provided Medicaid Recipients by Chicago-Area HMOs (Testimony, GAO/T-HRD-90-54, Sept. 14, 1990).

Health Care Access: Innovative Programs Using Nonphysicians (Report, Aug. 27, 1993, GAO/HRD-93-128).

This report describes (1) a unique method used by the Indian Health Service (IHS) to deliver emergency and primary care in remote Alaska villages and (2) a Florida county's plans to use aspects of this method to provide health care services in a medically underserved urban setting. The Alaska program trains local residents to provide emergency and primary care services in villages, which are often hundreds of miles away from the nearest physician. The Pinellas County Emergency Medical Services of Florida, whose service area includes medically underserved areas in St. Petersburg, has proposed adapting key aspects of the Alaska program in order to increase access to primary care.

Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (Report, Aug. 25, 1993, GAO/HRD-93-129).

A high percentage of policyholders will likely let their policies lapse before they receive any covered services. Unless there is a provision in the policy, these policyholders would not get a return from the premiums they paid. In this study, sales commissions paid by companies for the first year of the policy averaged about 60 percent of the total value of the first year's premium. As reported previously in Long-Term Care Insurance: Risks to Consumers Should Be Reduced (Report, Dec. 26, 1991, GAO/HRD-92-14), many states have not adopted the National Association of Insurance Commissioners (NAIC) model for reporting lapse rates and commission rates. State adoption of the NAIC provisions would strengthen monitoring of policies by state insurance commissioners and provide greater protection to consumers who buy them.

Medical Malpractice: Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses (Report, Aug. 11, 1993, GAO/HRD-93-126).

Medicare and Medicaid patients are less likely than other patients to file malpractice claims. When they file claims, their awards or settlements are significantly lower than those for patients with other health insurance. From October 1985 through September 1990, Medicare and Medicaid patients received about one-fourth of the \$2.3 billion of hospital malpractice awards, although they represent more than 45 percent of hospital patients. While Medicare patients' percentage of hospital malpractice awards is significantly lower than their portion of hospital discharges, Medicaid patients' percentage is slightly higher than their discharge rate.

Preventive Health Care for Children: Experience From Selected Foreign Countries (Report, Aug. 4, 1993, GAO/HRD-93-62).

Although England, France, Germany, Japan, and the Netherlands provide universal access to health care for all children, they do not rely solely on systems of universal coverage to ensure that all children receive preventive services. Instead, these countries do one or more of the following: (1) notify health authorities of new births, (2) target new parents for home visits, (3) provide booklets for maintaining a child's health record, (4) provide physical exams and immunizations in schools, and (5) facilitate the continuity of care through computerized tracking systems.

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (Report, Aug. 2, 1993, GAO/HRD-93-118). Testimony on same topic (Aug. 2, 1993, GAO/T-HRD-93-28).

Twenty-one of the Medicaid Fraud Control Unit directors told GAO of problems involving drug diversion. Several factors, including data inadequacies and staff shortages, complicate attempts to curb drug diversion schemes. States are taking steps to address these problems, but despite local success stories, drug diversion persists. State agencies do not follow up cases of potential diversion. States and federal agencies also fail to use their authority to impose sanctions and recover program losses. Offenders frequently retain some connection with health care delivery, with the consequent opportunity for future violations.

VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (Report, July 29, 1993, GAO/HRD-93-94).

The complex eligibility and entitlement provisions of the Department of Veterans Affairs (VA) place more restrictions on the availability of services than do other programs. About two-thirds of veterans eligible for VA care can obtain medical services only to the extent that space and resources are available after other

veterans with higher priorities for care are served. Other public and private health care programs essentially guarantee payment for covered services to all eligible participants. Once in the VA system, veterans are generally offered a more extensive array of services, fewer limitations in terms of the duration and number of visits or services covered, and less cost sharing than are available under most public and private health benefit programs.

VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (Report, July 27, 1993, GAO/HRD-93-68).

VA could potentially offset a significant portion of its nursing home and domiciliary care costs if it had the same authority states have to operate estate recovery programs under Medicaid. The potential for recovering nursing home and domiciliary costs may be greater for veterans than for Medicaid recipients because (1) home ownership is significantly higher among elderly VA hospital users than among Medicaid nursing home recipients and (2) veterans living in VA facilities generally contribute much less of their incomes toward the cost of their care than do Medicaid recipients. Oregon's successful Medicaid estate recovery program could serve as a model for a VA program.

Nonprofit Hospitals: For-Profit Ventures Pose Access and Capacity Problems (Report, July 22, 1993, GAO/HRD-93-124).

In 1991, according to American Hospital Association data, about 18 percent of nonprofit hospitals were participating in joint ventures with physicians. The 23 joint ventures we reviewed in depth provided significantly less care to Medicaid and charity patients than their parent hospitals provided. These joint ventures provided evidence that such projects can contribute to excess capacity for medical services in their communities.

Medicare: Separate Payment for Fitting Braces and Artificial Limbs Is Not Needed (Report, July 21, 1993, GAO/HRD-93-98).

Separate fees for professional services are not necessary because Medicare's payment amounts for braces and artificial limbs already include a component for the practitioner's professional services. With the assistance of two industry groups, we identified 42 items paid for under the orthotic and prosthetic fee schedule that do not require professional fabrication or fitting services. We also identified considerable variation in coverage criteria for braces and artificial limbs among Medicare's claims processing contractors. Medicare's December 1992 action to reduce the number of contractors that pay brace and artificial limb claims from 54 to 4 should remedy this problem and result in the use of more consistent criteria.

Medicare Physician Payment: Geographic Adjusters Appropriate But Could Be Improved With New Data (Report, July 20, 1993, GAO/HRD-93-93).

The Health Care Financing Administration (HCFA) actively sought and tested numerous data sources when developing the geographic adjusters and made reasonable data and methodology choices, considering the time constraints under which the adjusters were developed. We found that the Internal Revenue Service (IRS) has data available that could prove beneficial when the adjusters are updated. HCFA did not use IRS data in developing the current practice-cost adjuster because it did not believe that the technical and legal impediments to using these data could be overcome in the available time. Currently, HCFA is working with IRS to assess the feasibility of using IRS data in updating the adjusters.

VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (Report, July 16, 1993, GAO/HRD-93-106).

Veterans' access to outpatient care at VA medical centers varies widely for two reasons: (1) medical centers interpret VA outpatient eligibility criteria differently and (2) medical centers' rationing decisions vary, including whether to ration and what rationing method to use. This variation results in veterans with similar medical conditions or income status receiving outpatient care at some medical centers but not at others.

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (Report, July 14, 1993, GAO/HRD-93-123).

Of 198 veterans surveyed, 168 (85 percent) obtained needed care after VA medical centers turned them away. These veterans received diagnostic evaluations or needed treatment, including medication, for the same conditions for which they had initially sought treatment at the VA centers. The remaining 30 veterans did not obtain further medical care, primarily because they could not afford it.

1993 German Health Reforms: New Cost Control Initiatives (Report, July 7, 1993, GAO/HRD-93-103). Testimony on same topic (Oct. 13, 1993, GAO/T-HRD-94-2).

Sharp increases in the mandated health insurance premium paid by most workers and retirees triggered the 1993 German health care reforms. The government-imposed emergency global budget controls will remain in effect for the next 3 years to give the health care industry time to change the structure of the health care sector. These changes are expected to sufficiently reduce cost pressure so that federally imposed budget limits become unnecessary. The new reforms have initiatives to improve equity and stimulate competition in Germany's multiple third-party payer system. The

reforms are expected to generate net savings of about \$6.3 billion or about 6 percent of total sickness-fund spending in 1992.

FDA Regulation of Dietary Supplements (Letter, July 2, 1993, GAO/HRD-93-28R).

The Food and Drug Administration (FDA) regulates dietary supplement companies on a case-by-case basis as it receives complaints or other information concerning a product's safety or labeling. Preliminary information we obtained from FDA indicates that from fiscal year 1989 to 1992 FDA had taken action against about 290 companies that manufactured or marketed dietary supplements. FDA estimated that, between fiscal years 1988 and 1992, the amount of resources expended to address reported problems or complaints involving dietary supplements ranged from 13 to 57 of the agency's 3,400 full-time-equivalent employees.

ADDITIONAL GAO HEALTH PRODUCTS ISSUED BETWEEN JULY AND OCTOBER 1993

Automating Medical Information (Letter, Oct. 22, 1993, GAO/AIMD-94-47R).

Medicare: Better Guidance Is Needed To Preclude Inappropriate General and Administrative Charges (Report, Oct. 15, 1993, GAO/NSIAD-94-13).

HCFA Payment Rate for Erythropoietin (Letter, Oct. 13, 1993, GAO/HRD-94-1R).

Drug Control: Reauthorization of the Office of National Drug Control Policy (Report, Sept. 29, 1993, GAO/GGD-93-144).

CDC's Mission and Duplication in PHS (Letter, Aug. 30, 1993, GAO/HRD-93-32R).

Medicaid: Alternatives for Improving the Distribution of Funds to States (Report, Aug. 20, 1993, GAO/HRD-93-112FS).

Medical Technology: Quality Assurance Systems and Global Markets (Report, Aug. 18, 1993, GAO/PEMD-93-15).

Medicare Part B: Reliability of Claims Processing Across Four Carriers (Report, Aug. 11, 1993, GAO/PEMD-93-27).

Operation Desert Storm: Army Medical Supply Issues (Report, Aug. 11, 1993, GAO/NSIAD-93-206).

Operation Desert Storm: Improvements Required in the Navy's Wartime Medical Care Program (Report, July 28, 1993, GAO/NSIAD-93-189).

Veterans Affairs: Accessibility of Outpatient Care at VA Medical Centers (Testimony, July 21, 1993, GAO/T-HRD-93-29).

Medicaid Estate Planning (Letter, July 20, 1993, GAO/HRD-93-29R).

Long-Term Care Forum (Discussion Paper, July 13-14, 1993, GAO/HRD-93-1-SP).

Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System (Report, July 9, 1993, GAO/HRD-93-125).

Social Security Disability: SSA Needs to Improve Continuing Disability Review Program (Report, July 8, 1993, GAO/HRD-93-109).

Medical Readiness Training: Limited Participation by Army Medical Personnel (Report, June 30, 1993, GAO/NSIAD-93-205).

MOST FREQUENTLY REQUESTED HEALTH REPORTS

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (Report, Jan. 29, 1993, GAO/HRD-93-44).

Rochester, New York, has succeeded in keeping health care costs lower than costs in other communities without sacrificing its residents' access to care. Rochester residents are more likely to have health insurance than are people living elsewhere in the nation. Rochester's system is distinguished by the interaction of several factors, beginning with a long history of community-based health planning. These planning initiatives have included limiting the expansion of hospital capacity, implementing global budgeting that capped total hospital revenues, and controlling the diffusion of medical technology.

Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (Report, Jan. 4, 1993, GAO/HRD-93-4).

Nationwide emergency department patient caseloads grew dramatically from 1985 through 1990. Growth was concentrated among patients whose medical care is often not reimbursed, such as the uninsured and Medicaid patients in some states. This disproportionate growth may make it more difficult for hospitals to absorb or offset losses due to unreimbursed emergency department patient care costs. Nationwide patterns of caseload growth, payer mix, and timeliness of care conceal substantial variations in emergency department conditions among hospitals.

Prescription Drugs: Companies Typically Charge More in the United States Than in Canada (Report, Sept. 30, 1992, GAO/HRD-92-110).

Manufacturers' prices to wholesalers for identical prescription drugs are typically higher in the United States than in Canada. The price differences are largely attributable to actions taken by Canada's federal and provincial governments to restrain drug prices, not to any differences in manufacturers' costs in the two countries. The implications of adopting Canadian regulations in the United States are in dispute. It is not clear how such regulations would affect manufacturers' ability to develop innovative drug products.

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (Report, Sept. 22, 1992, GAO/HRD-92-125).

Many employers are facing rapidly increasing health insurance premiums and are frustrated by their unsuccessful efforts to contain health care costs. Firms most vulnerable to rising health costs are those whose health insurance plans offer extensive benefits and cover a large number of retirees or dependents; those whose workers are older, less healthy, or earning higher incomes; those with relatively few workers; and those in high health-cost

areas. Individual firms can do little to lower their health care costs because they cannot readily change their size, location, or employee demographics.

Access to Health Care: States Respond to Growing Crisis (Report, June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

States have taken a leadership role in devising strategies to expand access to health insurance and contain the growth of health costs. A difficult hurdle to overcome, however, is the restrictions imposed by the preemption clause of the Employee Retirement Income Security Act of 1974 (ERISA). This clause effectively prevents states from exercising control over all employer-provided insurance. Hawaii is the only state with an exemption, in part because its law requiring employer-provided health insurance took effect before ERISA was enacted. Other states have tried to move toward coverage of all their citizens within ERISA's constraints. Some state initiatives have been more narrowly focused, creating programs to assist specific groups. State budgetary constraints, however, have limited these programs to serving a small fraction of the uninsured population.

Medicare: Excessive Payments Support the Proliferation of Costly Technology (Report, May 27, 1992, GAO/HRD-92-59).

In some localities, Medicare's technical component payments for magnetic resonance imaging (MRI) do not reflect the lower costs per scan now being achieved through faster scanning and higher machine utilization. Current payment levels are based, in part, on the charges allowed by local Medicare contractors in the mid-1980s. The 1991 payment levels in some localities were more than twice as high as in others, reflecting wide geographic disparities in the historical allowed charges. Medicare should base its payments on the costs incurred by high-volume, efficient facilities to reduce Medicare program expenditures and to discourage providers from adding excess capacity to the health care system.

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (Report, May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

Weaknesses within the health insurance system allow unscrupulous health care providers to cheat insurance companies and programs out of billions of dollars annually. Repairing the system's weaknesses presents a dilemma to policymakers: on the one hand, safeguards must be adequate for prevention, detection, and pursuit; on the other, they must not be unduly burdensome or intrusive for policyholders, providers, insurers, and law enforcement officials. GAO has asked the Congress to consider establishing a national health care fraud commission as a way to unite the efforts of

public and private payers and to build consensus among representatives of divergent viewpoints.

Health Care Spending Control: The Experience of France, Germany, and Japan (Report, Nov. 15, 1991, GAO/HRD-92-9). French and German translations available (Nov. 15, 1991, GAO/HRD-92-9ES). Testimony on same topic (Nov. 19, 1991, GAO/T-HRD-92-12).

France, Germany, and Japan achieve near-universal health insurance coverage. This report describes these countries' health insurance and financing methods, their policies intended to restrain health care spending increases, and the effectiveness of these policies. While GAO does not endorse the specific health systems in the reviewed countries, their strengths and weaknesses could be instructive in helping resolve U.S. health care problems.

U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (Report, June 10, 1991, GAO/HRD-91-102). French and German translations available (June 10, 1991, GAO/HRD-91-102). Testimony on same topic (Apr. 17, 1991, GAO/T-HRD-91-16).

This report contains April 17, 1991, testimony presented to the House Committee on Ways and Means on health care costs in the United States as well as on long-term strategies for reform of the U.S. health care system.

Canadian Health Insurance: Lessons for the United States (Report, June 4, 1991, GAO/HRD-91-90). Testimony on same topic (June 4, 1991, GAO/T-HRD-91-35).

If the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans who are uninsured. Enough would be left over to permit a reduction, or possibly even the elimination, of copayments and deductibles. With the authority and responsibility to oversee the system as a whole, as in Canada, the single payer could potentially constrain the growth in long-run health care costs. Canadians have few problems with access to primary care services. The Canadian method of controlling hospital costs has limited the use of expensive, high-technology diagnostic and surgical procedures.

HEALTH FINANCING AND ACCESS

1993 German Health Reforms: Initiatives Tighten Cost Controls (Testimony, Oct. 13, 1993, GAO/T-HRD-94-2). Report on same topic (July 7, 1993, GAO/HRD-93-103).

Health Care Access: Innovative Programs Using Nonphysicians (Report, Aug. 27, 1993, GAO/HRD-93-128).

Nonprofit Hospitals: For-Profit Ventures Pose Access and Capacity Problems (Report, July 22, 1993, GAO/HRD-93-124).

1993 German Health Reforms: New Cost Control Initiatives (Report, July 7, 1993, GAO/HRD-93-103). Testimony on same topic (Oct. 13, 1993, GAO/T-HRD-94-2).

Organ Transplants: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs (Report, Apr. 22, 1993, GAO/HRD-93-56). Testimony on same topic (Apr. 22, 1993, GAO/T-HRD-93-17).

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (Testimony, Mar. 8, 1993, GAO/T-HRD-93-8).

Major Issues Facing a New Congress and a New Administration (Testimony, Jan. 8, 1993, GAO/T-OCG-93-1).

Health Insurance: Legal and Resource Constraints Complicate Efforts to Curb Fraud and Abuse (Testimony, Feb. 4, 1993, GAO/T-HRD-93-3). Report on same topic (May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (Report, Jan. 29, 1993, GAO/HRD-93-44).

Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (Report, Jan. 4, 1993, GAO/HRD-93-4).

Transition Series: Health Care Reform (Report, Dec. 1992, GAO/OCG-93-STR).

Removal of Breast Implants (Letter, Dec. 7, 1992, GAO/HRD-93-5R).

Bone Marrow Transplants: National Program Has Greatly Increased Pool of Potential Donors (Report, Nov. 4, 1992, GAO/HRD-93-11).

Trauma Care Reimbursement: Poor Understanding of Losses and Coverage for Undocumented Aliens (Report, Oct. 15, 1992, GAO/PEMD-93-1).

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (Report, Sept. 22, 1992, GAO/HRD-92-125).

Hospital Costs: Adoption of Technologies Drives Cost Growth
(Report, Sept. 9, 1992, GAO/HRD-92-120).

State Health Care Reform: Federal Requirements Influence State Reforms (Testimony, Sept. 9, 1992, GAO/T-HRD-92-55). Report on same topic (June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

Health Insurance: More Resources Needed to Combat Fraud and Abuse
(Testimony, July 28, 1992, GAO/T-HRD-92-49).

Access to Health Care: States Respond to Growing Crisis (Report, June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

Federally Funded Health Services: Information on Seven Programs Serving Low-Income Women and Children (Report, May 28, 1992, GAO/HRD-92-73FS).

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