GAO

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Access to Medical Care at Overseas Military Hospitals

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Statement of
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Before the
Subcommittee on Military Personnel
and Compensation
Committee on Armed Services
House of Representatives

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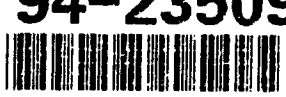

SUMMARY

GAO examined the process the military services use to staff overseas medical facilities and the adequacy of access to care at 6 overseas military hospitals and in 9 specialty care areas. It interviewed about 200 medical providers, including more than 90 department heads, and obtained documentation on waiting times for routine and emergency care and laboratory results. GAO's testimony focuses on access to medical care problems at the overseas military medical facilities it visited, the primary causes for these problems, and options the military services should consider in addressing the problems.

Access to care was a major concern at all the facilities GAO visited, although the conditions it identified varied by medical specialty, by location, and even by time of year. As might be expected, access to care in some medical specialties was satisfactory and waiting times for appointments were short. However, access problems were especially evident in specialties that provide care primarily to dependents, such as obstetrics, gynecology, family practice, and pediatrics. Specialties, including orthopedics and psychiatry, had access difficulties that affected both active duty personnel and dependents. The problems manifest themselves in long waiting times for routine appointments and surgeries, lengthy delays in obtaining laboratory results, and situations in which important services have been reduced or are simply unavailable.

The most significant cause of access problems is staffing; there are simply too few physicians, nurses, physicians' assistants, and medical technicians, as well as administrative and clerical help. Other factors contributing to beneficiaries' access-to-care difficulties include a lack of diagnostic and other equipment; facility constraints; and the significant amounts of time medical staff have to spend on nonmedical duties which reduce the time available to care for patients.

GAO believes the access conditions it found are symptomatic of systemic problems which must be addressed if access to military medical care overseas is to be substantially improved. The dramatic unfolding of events overseas appears to present a unique opportunity to focus on these medical care issues as troops are withdrawn. GAO believes that consideration should be given to retaining the number of overseas medical providers and support staff at a proportionately higher level than other categories of personnel. In overseas areas not likely to have significant troop withdrawals, the alternatives involve difficult choices such as according even higher priority to the staffing and equipping of these overseas medical facilities.

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Madam Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the results of our work on access to medical care at overseas military medical facilities. My testimony will focus on the types of access problems we found at overseas locations, the primary causes of these problems, and options the military services should consider in addressing the problems. Access to care is an extremely important issue to active duty personnel and their dependents stationed overseas. They expect quality medical care similar to that provided in the United States. However, medical care options in overseas locations are more limited than those in the United States.

As you are aware, the challenges confronting military medicine are numerous. One such challenge is the requirement that the military medical corps be ready to provide wartime medical care to active duty personnel while providing peacetime health care to these people, their dependents, military retirees, and their dependents and survivors. DOD also has the difficult challenge of having to allocate what it considers to be insufficient medical resources among its hospitals and clinics both in the United States and overseas.

Today's hearing is timely in light of recent developments concerning anticipated troop withdrawals from overseas locations, especially in Europe. A unique opportunity now exists to address concerns that this Subcommittee and others have expressed about

staffing problems at overseas medical treatment facilities. We believe that the information we have obtained regarding access-to-care problems illustrates the need to consider withdrawing proportionately fewer medical personnel than other personnel specialties. Such an action could alleviate many of the medical care access problems we and others have identified. In areas where troops may not be withdrawn in large numbers, potential solutions to the access-to-care problems will require hard choices among several "not so good" alternatives.

Before elaborating on these matters, I would like to make a few observations about overseas military medicine in general and describe briefly the scope and methodology of our work.

Our work has shown that the overseas medical corps is doing a lot of good work; they are highly committed to providing quality service, work long hours, and care for many people day in and day out. In an environment where the demand for health care outstrips the supply, work pressures continually mount. The managers of the system, including the Surgeons General, are keenly aware of this and are looking for solutions.

SCOPE AND METHODOLOGY

At your request, Madam Chairman, we examined the process the services use to staff overseas medical facilities and the adequacy

of access to care at such facilities. We visited six overseas hospitals--two in each service--and several clinics. The hospitals we visited were Landstuhl and Bad Cannstatt Army hospitals in West Germany; Air Force hospitals at Clark Air Force Base in the Philippines and Wiesbaden, West Germany; and Navy hospitals in Naples, Italy, and Okinawa, Japan. Our efforts at these facilities focused on access-to-care conditions for nine specialty care areas.

We interviewed about 200 medical providers, including more than 90 department heads at the six hospitals, and obtained documentation about their operations, including waiting times for routine and emergency care and laboratory results. We also obtained, from 23 other overseas hospitals, a description of the medical services they have reduced or are no longer able to provide. Additionally, we interviewed most of the services' medical specialty consultants who have responsibility for advising the Surgeons General on the distribution of physicians worldwide.

CONDITIONS IN OVERSEAS MEDICAL FACILITIES

Access to care was a major concern at all the facilities we visited, although the conditions we identified varied by medical specialty, by location, and even by time of the year. As might be expected, access to care in some medical specialties was satisfactory and waiting times for appointments were short. However, access problems were especially evident in specialties

that provide care primarily to dependents, such as obstetrics, gynecology, family practice, and pediatrics. Specialties, including orthopedics and psychiatry, had access difficulties that affected both active duty personnel and dependents.

The problems manifest themselves in long waiting times for routine appointments and surgeries, lengthy delays in obtaining laboratory results, and situations in which important services have been reduced or are simply unavailable. Further, because of restricted access to primary care, many patients with routine medical needs create overflow situations in emergency rooms, reducing emergency room efficiency and effectiveness. In addition, many patients must travel long distances by air or ground transportation to obtain needed care.

The full extent of access problems cannot be accurately measured because appointment waiting lists are not always maintained and appointments are not made for more than 3 weeks in advance at some locations. Headquarters and overseas medical officials believe that there may be many eligible people who need medical care but never gain access to the system and decide to forego care entirely.

OTHER STUDIES ON ACCESS PROBLEMS

Several study groups have reached conclusions similar to ours. For example, the Army Science Board, an independent advisory group to the Secretary of the Army and the Army Chief of Staff, reported in May 1989 that medical care for soldiers, families, and eligible civilians in the Army in Europe is "sadly lacking" and that patients often have to wait several months for appointments. The Board also pointed out that clinics and hospitals are often understaffed, causing medical professionals to be overworked and patients to loose confidence in the quality of care and feel that the benefits promised to them are being eroded. Moreover, the 1988 report of the Navy Medical Blue Ribbon Panel concluded that Navy medicine has increasingly been unable to provide care in its U.S. and overseas facilities because of systemwide physician, nursing, technical support, and administrative and clerical staffing shortages.

CAUSES OF ACCESS PROBLEMS

Many causes contribute to the access problems. The most significant, of course, is staffing; there are simply too few physicians, nurses, physicians' assistants, and medical technicians, as well as administrative and clerical help, to meet the health care demands of those eligible for care in overseas military medical facilities.

At last year's hearing on military staffing before this Subcommittee, service medical officials indicated that they give high priority to staffing overseas hospitals and that these hospitals are staffed at or near their authorized staffing levels. However, authorized staffing levels and the extent to which they are filled do not reflect the adequacy of staffing at overseas military hospitals. This is because authorized staffing levels are driven by factors other than the demand for health care services--factors such as budgetary constraints, previous levels of authorizations, and a reluctance to authorize positions when personnel are not available to fill them.

Other factors contributing to beneficiaries' access-to-care difficulties include a lack of diagnostic and other equipment; facility constraints; and the significant amounts of time medical staff have to spend on nonmedical duties, which reduce the time available to care for patients. In addition, the geographic separation of patients from needed specialty care--up to hundreds of miles--is another factor that complicates the access-to-care issue. We were also told that individuals arrive overseas with routine medical and dental conditions that could have been attended to before they left the United States.

Perhaps the best way to illustrate problems encountered by military beneficiaries in accessing overseas medical facilities is through examples. I have included several such examples in the

attachment to my statement. I want to emphasize that we believe the access difficulties illustrated in the attachment are symptomatic of systemic problems that must be addressed if access to military medical care overseas is to be substantially improved.

CONCLUSIONS

Madam Chairman, access to medical care at overseas medical treatment facilities is inadequate for many dependents and, in some cases, active duty members. Action needs to be taken to address this problem. The dramatic unfolding of events overseas appears to present a unique opportunity to focus on these medical care issues as troops are withdrawn.

We believe that consideration should be given to retaining the number of overseas medical providers and support staff at a proportionately higher level than other categories of personnel. At the same time existing equipment shortages should be alleviated so that necessary and timely medical treatment can be provided to the remaining overseas beneficiaries.

In overseas areas not likely to have significant troop withdrawals, the alternatives involve more difficult choices, such as according even higher priority to the staffing and equipping of these overseas medical facilities as well as reducing the number of authorized dependents overseas.

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Madam Chairman, this concludes my prepared statement. My colleagues and I will be glad to answer any questions you and members of the Subcommittee may have.

ATTACHMENT ATTACHMENT

EXAMPLES OF ACCESS-TO-CARE PROBLEMS IN MILITARY MEDICAL FACILITIES OVERSEAS

We found many access-to-care problems at the locations we visited that, in our view, need to be addressed by the military services if they are to provide adequate medical support to the thousands of military members and dependents overseas. The following illustrations--developed through discussions with and documentation provided by overseas medical officials--are not intended to represent all the conditions we identified at the locations we visited, but we believe they are representative of the conditions we found during our review.

-- The number of intensive care beds at Landstuhl Army Hospital was reduced from 23 to 11 in June 1989 because of nursing shortages. This necessitated shortening the stays of patients in intensive care to accommodate new patients and also reducing the number of operating rooms, thereby causing nonelective surgeries to be delayed and elective ones to be cancelled. The reduced intensive care capability remained until 2 months ago.

-- During much of 1989, only four of nine well-baby visits (recommended by the American Academy of Pediatrics for children up to 2 years of age) were provided by the pediatric department at Okinawa Naval Hospital because of

a shortage of pediatricians. As of November 1989, the department was providing five of the recommended visits.

Only one of the nine recommended well-baby visits was performed at Wiesbaden Air Force Hospital from early 1988 to the fall of 1989. A department physician said that this condition placed the children at significant risk. However, one additional pediatrician was assigned to the hospital in late-1989, and well-baby checks are currently being performed at recommended intervals for infants through 18 months.

-- At Landstuhl Army Hospital, the head of obstetrics and gynecology said that because of staffing shortages and the inexperience of physician staff, complicated deliveries and most deliveries for women who are normally served in outlying clinic areas are referred to West German medical providers and no elective surgeries are performed. None of the department's physicians are board certified, and all the physicians are within their first or second year of residency. The department head considers staff inexperience to be a risk management issue.

-- At Bad Cannstatt Army Hospital, each obstetrician was delivering about 25 babies a month, exceeding the department's standard of 15 per month. The department head said if he did not receive two additional physicians to handle the workload, he would consider reducing services to patients, including referring more patients to West German providers.

-- The Okinawa Naval Hospital has fewer obstetricians than authorized and needed. The obstetrics staff at the hospital delivers about 90 to 110 babies per month, or about 18 to 24 deliveries per physician. They each work about 100 hours per week. The obstetrics department head stated that during 1989, the number of obstetricians on the staff ranged from three to six and it was authorized six. This included six through June, three in July, four in August and five since October. He said the hospital's workload justifies seven to eight.

-- Okinawa's obstetrics workload and staffing shortages also resulted in the obstetrics department not being able to conduct all the recommended prenatal examinations and limiting patient consultations with physicians to about 7-1/2 minutes--about one-half the length of time normally taken.

-- The anesthesiology department at Okinawa was unable to provide epidural blocks for labor and delivery patients, except in extreme cases. The hospital had only three anesthesiologists, and their heavy surgical workload did not allow them time to handle the labor and delivery cases, especially since patients administered epidurals require close monitoring.

-- The head of the Bad Cannstatt Army Hospital obstetrics and gynecology department said that about 400 women were waiting for follow-up gynecology visits as of September 1989, of which 180 were for abnormal pap smear results. Some of the patients had been waiting up to 3 months for appointments when the department sent letters advising them that the hospital was unable to schedule their appointments because of a long-standing shortage of physicians. The letter recommended that, as an option, they seek care from West German medical providers. The department head said that he did not know what happened to these patients after the letter was sent. A physician at a nearby Army clinic followed up on 62 of these cases and found that 3 of the patients had cervical cancer.

-- The Air Force's Kadena Clinic at Okinawa routinely sent pap smear tests to Travis Air Force Base in California for

analysis. Kadena clinic officials said that Travis historically returned Kadena's pap smear test reports in about 6 weeks--which they considered a reasonable amount of time. Beginning about March 1989, however, turnaround times for the test results began averaging 3 months, with the results of some March tests still unreturned as of November. As of January 1990, the problem had worsened to a 4-month average turnaround time. A clinic official said that patients with abnormal pap smear results may have to wait up to 1 year from the time of their initial tests to the time they are seen by a specialist.

-- The pathology department at Clark Air Force Hospital had been experiencing delays in obtaining pap smear test results dating back to early 1989 when results were taking five months to be returned from Travis Air Force Base. The department initiated action that resulted in them being notified of abnormal test results in four weeks. The department head said that as of February 1990, abnormal results were received in four weeks and normal results in two to three months.

-- Access to otolaryngology care is a problem, especially in Europe. An otolaryngologist at Wiesbaden Air Force Hospital stated that the hospital was unable to provide

this specialty care beginning in July 1989 for several months because of staffing shortages. Before that, the typical waiting time at Wiesbaden Air Force Hospital had been 6 months.

-- In August 1989, Landstuhl Army Hospital sent a letter to 430 patients advising them that their otolaryngology appointments could not be scheduled and that they should seek care elsewhere or keep waiting. Dependents were able to be seen again in late-September 1989; however, the list of patients to whom the letter was sent was destroyed and hospital officials did not know if those patients received care. Also, in December 1989, there was an estimated -year backlog for routine surgeries such as tonsillectomies and a 2-month backlog for the insertion of tubes in children's ears.

-- Psychiatric care was a problem at the Okinawa Naval Hospital. The greatest needs for services were child psychiatry, long-term psychiatric care, and family counseling. Long-term psychiatric care was unavailable, and family counseling and child psychiatry services were minimal. The child psychiatrist said there was also a lack of support groups for families on the island. As a result, the hospital's psychiatric workload was

substantially higher than if support services were available.

The psychiatric department may not be able to pass accreditation reviews because of the lack of a clinical psychologist at the facility. Although it was authorized two clinical psychologist positions, the fact that no clinical psychologist was available inhibited it from adequately operating its inpatient psychiatric ward and from performing much-needed psychological diagnostic testing.

The child psychiatrist stated that staffing problems date back to at least 1987. Staffing needs were documented in monthly quality assurance minutes throughout most of 1989.

-- Bad Cannstatt Army Hospital had no capability to treat children with serious psychiatric conditions. These patients were referred to the Landstuhl Army Hospital (about 3 hours away by automobile); referred to German psychiatrists (although German hospitals will not accept children with psychiatric problems as inpatients); or evacuated to the United States.

ATTACHMENT

-- At Okinawa Naval Hospital, the Family Practice Department had 5 full-time physicians and 1 part-time physician although it was authorized 16 physicians (5 of its physicians were on loan to the Emergency Medicine Department). The department also had only two of its eight authorized physician assistants. The head of the department said the needs of many patients requiring primary care are not met. Further, he said that since his staff could not see all patients who needed their services, many of them sought care from the hospital's emergency room.

One of the three Okinawa clinics that offer family practice services estimated that they turned away about 125 patients per month in 1989. A second clinic measured unmet need during October 1989 and found that 212 patients could not be seen and had to be referred elsewhere. Even though continuity of care is central to the concept of family practice, the department head said continuous care could not be provided.

-- The head of the emergency medicine department in Okinawa said the emergency room currently experiences "bedlock," a combination of bedlam and gridlock that results when there are not enough beds to accommodate the patients waiting in

the emergency room. However, this official said that about 85 percent of the department's workload is a result of inadequate access to primary care on the island. He said the department commonly serves as a substitute for family practice clinics that cannot treat the routine workload because of staff shortages.

The American College of Emergency Physicians, in a position statement developed by its task force on military emergency medicine, stated that an emergency department that consistently is forced to manage the overflow from nonemergency facilities has its primary mission seriously compromised.

Also, the department head, in a memorandum to the hospital's commanding officer, wrote that the department was operating with one nurse at the busiest times of the day--far less than what the workload requires. He commented that this inadequate nurse staffing situation causes serious quality assurance issues to go unattended.

-- At Wiesbaden Air Force Hospital, many patients with nonemergent conditions who cannot get appointments in other clinics present themselves in the emergency room, where they wait up to 8 hours before being seen.

-- Equipment and facility problems were in evidence at all locations. Patients at the Naples Naval Hospital have undergone diagnostic surgeries because the hospital lacked a state-of-the-art ultrasound machine to scan small body parts. Also, as of January 1990 a mammogram machine had been in storage for months at Naples because of a lack of space to install the unit. The obstetrics staff at Landstuhl Army Hospital did not have an ultrasound machine in the department. It shared one with the radiology department but could not use it as frequently as it needed it. However, in late-1989 the obstetrics department leased an ultrasound machine.

-- At Naples, inpatient capacity is 26 beds. (It was 100 until several years ago, when an earthquake forced the closure of 74 beds.) A shortage of beds has resulted in more patients having to be flown to West Germany for hospitalization or released early from the Naples hospital. Several types of cases (such as psychiatric, surgical, and pediatric) are cared for on the same wards.

APPENDIX II

Table II.1: DOD-Wide Savings From Defense Management Report Initiatives by Appropriation Account (dollars in millions)

Appropriation account	FY 1991	FY 1992-95	Total
Operations and maintenance	$ 890.0	$ 9,361.5	$10,251.5
Military personnel	151.5	3,496.7	3,648.2
Procurement	109.9	4,490.1	4,600.0
Other procurement	77.7	1,588.3	1,666.0
Research, development, test, and evaluation	83.2	845.5	928.7
Military construction	.2	.8	1.0
Other			
Stock fund	986.0	12,019.3	13,005.3
Industrial fund	55.0	1,016.9	1,071.9
Contingency fund	300.0	5,150.0	5,450.0
Central fund	(254.0)	(1,222.0)	(1,476.0)
Foreign military sales	.1	2.0	2.1
Corporate information management	(80.0)	0.0	(80.0)
Total	$2,319.6[a]	$36,749.1[a]	$39,068.7[a]

[a]Totals may vary slightly from DOD estimates due to rounding.

APPENDIX III

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