United States General Accounting Office

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Report to the Honorable Ike Skelton
House of Representatives

July 1995

DEFENSE HEALTH CARE

Problems With Medical Care Overseas Are Being Addressed

GAO/HEHS-95-156

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-259399

July 12, 1995

The Honorable Ike Skelton
House of Representatives

Dear Mr. Skelton:

The American military presence in Europe has declined dramatically since 1989. The active duty population has been reduced by 57 percent—from about 322,000 to 138,000. At the same time, the military health services system (MHSS) has also been substantially cut back. During this period of downsizing, many beneficiaries have expressed concern about their reduced access to health care from military medical facilities overseas and dissatisfaction with care they received from host nation providers. They have charged that the Department of Defense (DOD) is not doing enough to ensure access to appropriate health care during the drawdown.

Citing these concerns, you asked that we review beneficiary access to military health care in Europe. Specifically, you asked that we provide information on (1) the availability of health care in military facilities, (2) any obstacles to providing that care, (3) the experiences of beneficiaries that have used host nation providers as an alternative to military health care, and (4) whether DOD is addressing service delivery problems and beneficiary concerns.

To develop this information, we visited 15 military communities in Germany and northern Italy. Many of the beneficiary complaints about medical and dental care that were made to DOD and Members of Congress originated in these communities. While there, we conducted numerous interviews with military health care providers, officials in host nation facilities, and beneficiaries.

We also held discussions with and reviewed available documents provided by the military medical leadership in Europe, officials in the Offices of the Surgeons General, and top officials in the Office of the Assistant Secretary of Defense (Health Affairs). Appendix I contains a more detailed discussion of our scope and methodology.

Results in Brief

Since the downsizing began in 1989, beneficiaries have generally found it more difficult to obtain health services at military facilities. Beneficiaries have access to primary care, but for some, particularly non-active duty

beneficiaries, access to specialty care varies and is often inconvenient. Military medical personnel must overcome many obstacles to provide the care that is offered. These personnel are hampered by staff shortages, long waits for laboratory test results, and equipment failures.

The reduced military health care system has resulted in DOD's placing a greater reliance on the German and Italian medical systems for providing treatment to beneficiaries. Beneficiaries, however, must contend with language barriers, cultural differences, unfamiliar doctors, quality of care concerns including differences in treatment, and a general lack of information about how to obtain host nation care. Additionally, active duty family members using host nation providers were, until October 1, 1994, required to pay deductibles and copayments for their care.

To address these problems and concerns, DOD has taken or is planning to take a number of actions. For example, DOD is developing an interservice health care plan for all beneficiaries in Europe that seeks to maximize the use of military medical facilities supplemented by a network of German and Italian health care providers. DOD has also hired liaison personnel to help beneficiaries obtain health care from German and Italian providers. DOD now pays the deductibles and copayments of families of active duty members who obtain after-hours emergency services or routine care at host nation facilities. DOD also plans to contract for (1) services to monitor the care that beneficiaries receive from host nation providers, (2) an education program that explains beneficiary health care options in Europe, and (3) the translation of host nation medical records. Although each of these actions is positive, some have been slow to materialize. DOD's goal is to have all of these measures in place by October 1995.

Background

The MHSS consists of military medical facilities and private sector health care providers. The primary mission of the MHSS is to maintain the health of military personnel and to support the services during time of war. In addition, the MHSS provides health care to dependents of active duty members, retirees and their dependents, and survivors of service members. Active duty members receive their care almost entirely from military medical facilities. When space and resources are available, other beneficiaries may obtain their care from military medical facilities as well. Overseas, U.S. civilian government employees are also eligible to receive care in military medical facilities on a space-available basis.

The collapse of the Warsaw Pact and the end of the Cold War have significantly changed the American military landscape in Europe. Because of the easing of East-West tensions, the United States has chosen to substantially reduce its military forces in Europe. Between July 1990 and April 1993, DOD initiated three major plans to reduce its military forces in Europe, each with successively lower personnel levels. The first plan, developed in July 1990, would have reduced military positions in Europe to 225,000; the second to 150,000; and the latest plan calls for about 100,000 Army, Air Force, and Navy personnel in Europe by the end of fiscal year 1996.

The U.S. military medical system in Europe has also been reduced and reorganized. The number of military hospitals and clinics in Europe is being cut from 23 hospitals and 89 clinics in 1989 to 9 hospitals and 48 clinics in 1995. In Germany, for example, the Air Force is reducing its hospitals from three to one and its clinics from six to five. Army hospitals and clinics in Germany are being reduced from 9 to 3 and 55 to 25, respectively. In northern Italy, the Air Force has one clinic and the Army has one hospital and one clinic, the same as in 1989. The Army, however, plans to convert the hospital to a clinic in October 1995 because (1) very low utilization makes it difficult to maintain a high-quality hospital and (2) quality medical care is available from host nation providers. Appendix II lists those Air Force and Army medical facilities operating as of April 21, 1995.

The number of dental clinics is also being significantly cut back. Prior to the downsizing, the Army had 94 dental clinics in Europe. The Army has completed its reduction and now has 35 dental clinics. The Air Force is reducing its dental clinics from 31 to 11.

Beneficiaries Have Access to Primary Care but Specialty and Dental Care Are Limited

Beneficiaries have access to primary care at military facilities, including outlying clinics. Most of the outlying clinics are closed in the evenings and on weekends, however, necessitating that after-hours primary care and emergency services be obtained from German and Italian providers. In general, U.S. military specialty care is available to active duty personnel and is most accessible to beneficiaries living near U.S. military hospitals. Dental care is more readily available to active duty personnel than other beneficiaries.

Most Beneficiaries Can Obtain Primary Care at Military Facilities

Military providers told us that primary care clinics are able to serve most beneficiaries. Since 1989, the ratio of primary care providers (general medical officers, family practice physicians, physician's assistants, and nurse clinicians) to beneficiaries has improved—from 1:1,222 to 1:868—and plans call for further improvement to 1:661 by November 1995. Generally, clinics are open Monday through Friday, and some have extended hours—one evening during the week or morning hours on the weekend. Two Army clinics in Germany are open 24 hours, 7 days a week. Beneficiaries in all categories expressed general satisfaction with their access to primary care in military facilities. They did, however, express frustration over difficulties in making appointments by telephone and delays in obtaining routine physical exams and well-woman exams. They also stated concerns about delays in obtaining test results.

Although the overall ratio of primary care providers is improving, staff at many of the outlying clinics we visited mentioned that they need more physicians trained in family practice and pediatrics. Some of the clinics had no family practice, pediatric, or other primary care specialty physician except the clinic commander who also had administrative and supervisory responsibilities. Army clinics rely heavily on general medical officers to provide primary care. Army officials stated that they do not have enough family practice or other specialty-trained primary care physicians to assign to clinics.

Access to Specialty Care in Military Facilities Varies and Can Be Inconvenient

DOD was unable to provide us with data to compute how the ratios of specialists to beneficiaries have changed since 1989 or to measure how long it takes to get an appointment with a specialist. However, the military medical leadership, military physicians, and beneficiaries all commented that there has been a significant reduction in the amount and location of U.S. military specialty care available in Europe since the downsizing began. As a result, access to specialty care varies by specialty and among categories of beneficiaries.

Some specialty areas have substantially fewer physicians than before the downsizing began. For example, the number of Army obstetricians/gynecologists has been reduced from 42 to 17; urologists from 6 to 2; otolaryngologists (ear, nose, and throat) from 8 to 4; general surgeons from 32 to 11; and orthopedic surgeons from 26 to 11. Only one specialty (nephrology), however, is no longer available in Europe.

Active duty members are generally able to obtain the specialty care they need, although in some instances they must wait a month or longer. Service members needing inpatient psychiatric services are sometimes sent back to the United States for such care because of limited inpatient mental health resources in Europe. Non-active duty beneficiaries have less, and in some cases no, access to specialty care, particularly otolaryngology, orthopedics, and mental health—also because of limited resources. Beneficiaries and military medical officials commented that many people who need these services must either wait a substantial period of time to get the care from military facilities in Europe or return to the United States for it.

Access to specialty care is also less convenient because of the reduction in U.S. military hospitals. In 1989 the Army had nine hospitals in Germany. Now U.S. military specialty care is provided almost entirely in the three remaining Army hospitals in Germany: Landstuhl, Wuerzburg, and Heidelberg. Beneficiaries in Augsburg, for example, must travel about 130 miles one way to obtain the specialty care that is available at the U.S. Army hospital in Wuerzburg or about 170 miles one way to Landstuhl to obtain specialty care that is not available in Wuerzburg. Beneficiaries in many communities throughout Germany find themselves in similar circumstances.

Obtaining specialty care is also inconvenient for beneficiaries when repeat hospital visits are required. For example, most outlying clinics do not have physical therapists or mental health professionals on staff. Consequently, patients must travel to one of the military hospitals to obtain these recurring services. Each visit frequently requires patients to spend a full day traveling and receiving services.

To help beneficiaries living in remote areas, specialists assigned to the three Army hospitals periodically visit clinics to provide care, but these visits are infrequent. Also, military communities provide shuttle bus service to the nearest U.S. military hospital. In most communities, the shuttle bus makes one trip daily between the military community and the hospital, leaving early in the morning and returning in the late afternoon of the same day. In some communities, however, the service is limited to only a few days each week. Regardless, making long trips for follow-up appointments created hardships on family members and active duty service members with family and work responsibilities. Also, we were told that soldiers' full-day absences from their assigned duties can adversely affect their units' wartime readiness.

In northern Italy, the Army plans to convert its hospital in Vicenza to an outpatient clinic in October 1995. The clinic will maintain an after-hours acute care capacity to treat minor injuries and illnesses. Emergency and specialty care, now available at the Vicenza Army hospital, will be provided by the city hospital in Vicenza, by other Italian facilities, or by military facilities in Germany or the United States. (For some time now, life-threatening emergencies have been sent to Vicenza's city hospital.) For other military communities in northern Italy, such as Aviano and Livorno, specialty care will continue to be provided by host nation facilities, as it has since 1989.

Relatively few military retirees and their dependents age 65 and older live overseas. Those that do are especially concerned about their access to specialty health care because Medicare coverage does not extend to beneficiaries living overseas. DOD estimates that fewer than 1,400 such beneficiaries reside in Europe. These beneficiaries, who have chosen to reside overseas, have been largely dependent on the military health care system to provide their medical care and, as a result, many have never purchased supplemental health insurance through U.S. or host nation health companies. Obtaining private insurance may not be an option for some elderly retirees and family members because it is costly.

Dental Care Is Limited

Access to dental care is limited for many beneficiaries living in Europe. Active duty personnel have better access to dental care than do their family members, who are generally able to obtain only emergency dental care, annual examinations, and cleanings. Many beneficiaries, except for active duty, have limited or no access to specialty dental care. The dental staff in some clinics dedicate most of their orthodontic care to patients whose treatment programs were initiated in the United States. New cases are seldom started. In Vicenza and Livorno, all beneficiaries have access to dental services.

Many beneficiaries and U.S. military dentists do not consider host nation dental care a viable option. It is expensive, and beneficiaries do not like the differences in the practice patterns of host nation dentists.

The MHSS in Europe Faces Numerous Obstacles

Numerous obstacles confront the MHSS in Europe. Some existed prior to the downsizing, including medical staffing shortages, long waits for laboratory results, and equipment problems. Many U.S. military physicians

stated that these obstacles hinder their ability to provide quality medical care.

MHSS Faces Personnel Shortages and Other Staffing Problems

Many clinic and hospital officials we met with stated that they have too few military and civilian personnel. Their facilities are staffed at less than 100 percent of authorized military levels in such positions as nurses, medics, X-ray technicians, and pharmacy technicians. In addition, medical staff frequently complained about shortages in civilian personnel, including receptionists, custodians, and patient liaisons. Medical staff are working long hours attempting to meet the demand for care.

Two other factors have had a serious impact on the military's ability to meet the health care needs of all beneficiaries in Europe. First, medical and dental units have been under additional strain to meet the demand for care during the downsizing. The military had intended to keep medical resources in Europe at levels proportionally higher than nonmedical units so that access to health care would be improved during the downsizing. To the contrary, many of the health and dental clinics we visited were staffed at their so called "endstate" levels, while nonmedical units had not yet reached their final levels. Army officials were unable to provide documents showing how a coordinated withdrawal of medical and nonmedical personnel was planned to ensure improved access to health care. However, they did provide data indicating that the ratios of total medical personnel to beneficiaries have changed little since 1989—from 1:31 to 1:38. Over time, as more units withdraw from Europe, this tension should ease somewhat.

Second, until recently, Army medical units have not received replacements when their medical personnel are temporarily reassigned to other units. Between October 1993 and December 1994 the Army in Europe sent 715 men and women from medical units to other areas of the world without providing replacement personnel for the affected medical units. These actions often resulted in immediate personnel shortages for the medical units in Europe and further hindered the delivery of health care to beneficiaries there. The Army has implemented a policy which calls for replacing medical personnel (not necessarily on a one-for-one basis) who are temporarily assigned to other units for more than 14 days. Since March 1995, the Army has provided temporary replacements to medical units in Europe.

Equipment Problems and Untimely Laboratory Test Results

Medical staff experience daily problems with equipment failures and delays in obtaining laboratory test results. Generally, these problems are attributed to old and unreliable equipment. Staff repeatedly told us that X-ray, X-ray processor, and culture machines are frequently broken. They also mentioned that problems exist with the ambulance fleet, defibrillators, CT scanners, and pulse oximeters because they are old, outdated, or in short supply.

Medical staff also experience problems in obtaining laboratory test results. Although data were unavailable on the specific or average times needed to get laboratory results, staff said that all test results require more time than they should to get back. Results of glucose, potassium, cholesterol, liver and thyroid function, and tissue exams are typically delayed, as are X rays. Health care providers at one clinic estimated that it took between 2 and 4 weeks to obtain the results for such tests. They cited delays as long as 2 months for Pap test results. DOD is currently implementing a medical information system that will allow providers to obtain test results via computer rather than mail. The new computer system, officials believe, should enable military providers to get laboratory results in a more timely manner.

Beneficiaries Are Frustrated When Obtaining Host Nation Care

Beneficiaries under age 65 who either are unable or do not want to receive care from military medical facilities have the option of obtaining care from host nation providers.[1] Although the beneficiaries we spoke with were generally satisfied with the outcome of the host nation health care they received, they expressed a great deal of frustration over their specific experiences in obtaining that care. They also expressed a strong preference to receive their health care from military facilities. Beneficiaries and military medical officials agree, however, that as less and less care is available from military medical facilities in Europe, beneficiaries will have to rely more on host nation providers.

Beneficiaries are frustrated with host nation medical care for a variety of reasons. Some host nation providers, for example, require payment or a large deposit in advance of treating U.S. military beneficiaries. These upfront payments, we were told, amount to as much as the equivalent of about $6,000. Also, U.S. military officials provide beneficiaries little information or help in choosing German or Italian providers. Essentially,

[1]The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), allows non-active duty beneficiaries to obtain health care from private sector medical care providers. The most current data available indicate that, in fiscal year 1993, CHAMPUS costs in Germany and Italy were about $30 million.

beneficiaries are given a list of English-speaking doctors and encouraged to ask other beneficiaries about their experiences with these doctors before selecting one. In addition, beneficiaries feel abandoned by military medical physicians when they use host nation providers. In general, military physicians are not required to actively monitor U.S. patients' care in host nation facilities. Although they may be aware of their patients' progress, the lack of direct contact gives beneficiaries the impression that they have been "dumped" on host nation providers and that the military is not concerned about their care. The Aviano community is an exception. Several patient assistance services have been in place for some time there. For example, the Air Force contracts with bilingual Italian physicians to help beneficiaries understand their diagnosis and treatment.

Beneficiaries also mentioned that they need help obtaining services from host nation facilities, especially during evenings and weekends. They are concerned about such matters as knowing where to go, having someone available to translate their medical emergency, and getting assistance with paperwork. In addition, beneficiaries using host nation providers were required to pay deductibles and copayments for their care. When admitted, beneficiaries explained that they must contend with language barriers, cultural differences, and quality of care concerns such as differences in treatment. Military physicians told us that some differences in treatment do exist among the U.S., German, and Italian systems. Although the cultural and treatment differences are unsettling to U.S. patients, the military medical staff, for the most part, are confident about the quality of health care delivered in Germany and northern Italy.

Once care is completed and patients are released from host nation providers, many patients are left with their medical information in a foreign language. This problem is most prevalent in Germany where, currently, treatment records are written in German, and often the only information translated is that done by bilingual physicians working for the U.S. military. In several communities, military physicians estimated that less than 10 percent of medical records are ever translated. Consequently, patients may not have an adequate record of their medical conditions and treatments.

DOD Actions to Address Beneficiaries' Concerns

DOD and beneficiaries recognize that there must be a greater reliance on host nation care: Rebuilding U.S. military medical facilities overseas is not an option. Therefore, DOD has taken and is planning a number of steps to alleviate beneficiary concerns and improve access to host nation care.

Although some of DOD's actions have been slow in coming, most are expected to be in place by October 1995. In our view, these actions are positive steps toward alleviating the concerns voiced by beneficiaries. However, the extent to which beneficiaries will be satisfied remains to be seen.

To address beneficiaries' overall concern, DOD is developing an interservice health care plan for all beneficiaries in Europe that seeks to maximize the use of military medical facilities. This effort is being headed by a tri-service executive steering committee made up of senior medical officials in Europe and assisted by a military treatment facility commander's council—a group representing military hospital and clinic commanders in Europe. Instead of focusing on tangible outcomes, most efforts to date have focused on planning, coordinating, and determining how the military services can effectively work together to better serve their beneficiaries. These formative sessions represent a significant step because, in the past, the services have essentially operated independently rather than working in a collaborative way.

Beginning in the summer of 1994, DOD also initiated efforts to establish a preferred provider network in Europe, Africa, and the Middle East. Once completed, this network will enable beneficiaries to choose among various host nation providers who (1) are interested in serving them, (2) are willing to accept payment under CHAMPUS, and (3) will not require advance payments from beneficiaries. At the outset approximately 20,000 host nation providers were identified as having billed CHAMPUS for services. DOD contacted these providers and asked if they were willing to treat U.S. beneficiaries, outlining the conditions. DOD is also working to ensure the quality of network participants by verifying their qualifications. As of February 1995, over 4,000 of these providers had indicated an interest in joining a CHAMPUS-preferred provider network. In April 1995, the Army established a toll-free telephone number for beneficiaries to obtain after-hours referrals to host nation facilities. The service is currently available at Army hospitals in Heidelberg and Wuerzburg and is planned for Landstuhl as well.

To assist beneficiaries who are using host nation providers, DOD established a patient liaison coordinator program. As of June 5, 1995, 59 patient liaisons were assigned to Europe. These liaisons (1) coordinate consultations with host nation facilities and follow-up care, (2) help make appointments at host nation facilities, (3) educate beneficiaries on host nation medical services, (4) interpret information between host nation

providers and beneficiaries, (5) assist with paperwork associated with hospitalization at host nation facilities, and (6) visit patients in hospitals.

Beneficiaries generally agree that the patient liaisons reduce the anxiety involved in using host nation facilities. However, most communities have only one or two patient liaisons and whose services are generally available only on weekdays until 4 p.m. The patient liaison program is intended to be supplemented with a volunteer system to provide coverage after business hours. However, none of the communities we visited had yet established a volunteer system that provided evening and weekend coverage. Consequently, beneficiaries using host nation facilities after normal business hours often obtained that care without assistance. In response, DOD has agreed to increase the availability of liaisons to provide 24-hour coverage.

Effective October 1, 1994, DOD expanded an existing CHAMPUS initiative to improve access to host nation facilities for active duty family members. DOD estimates this initiative will cost approximately $2.8 million annually. The expanded CHAMPUS initiative waives cost sharing for active duty family members who obtain outpatient and inpatient care at host nation facilities. Beneficiaries are pleased and indicated that the elimination of copayments and deductibles has enhanced their willingness to seek care at host nation facilities.

DOD is also planning to use host nation physicians to act as liaisons and assist military doctors in monitoring beneficiaries admitted to host nation facilities for care. The direct involvement of a physician representing the military may ease beneficiaries' feelings of being "dumped" when they are referred to host nation facilities.

To better inform beneficiaries and thereby reduce their anxieties about health care—military and host nation—available in their communities in Europe, DOD is creating an education program. DOD is also planning to have host nation medical records translated into English. This should help ensure that in the future patients will have an adequate record of previous medical conditions and treatments.

To improve beneficiaries' access to dental care, DOD is taking a number of steps. First, DOD is striving to efficiently use its existing dental capabilities, including sharing resources among the three services. Second, DOD is increasing the number of dentists, orthodontists, pedodontists, and other dental support personnel assigned in Europe. The Air Force plans to

assign an additional 23 general dentists, 2 orthodontists, 2 pedodontists, and 54 dental assistants to Europe during fiscal year 1995. As of May 26, 1995, all but four dentists had arrived overseas. The Army has contracted with civilians to fill 22 general dentist, 5 orthodontist, and 10 dental hygienist positions. Third, at remote locations or areas with small populations where military dental services may not be available, DOD plans to arrange for dental care through host nation providers. Fourth, family members will be allowed to remain enrolled in the Dependents Dental Plan while the service member is assigned overseas.[2] This will permit family members to obtain dental care in the United States, for example, during stateside visits.

Finally, over the past year, DOD has made an effort to educate beneficiaries on the forthcoming changes in Vicenza and to develop a plan to ensure the availability of quality medical care. For example, it has (1) prepared a new detailed handbook to inform patients about host nation obstetrical services; (2) developed a questionnaire to obtain beneficiary feedback about host nation medical care; (3) held meetings with beneficiaries to educate them on the changes; (4) hired a host nation physician to perform oversight and liaison services among the host nation facility, the patient, and the military medical providers; and (5) made arrangements for translators to assist when Italian ambulance service is needed. Several other significant steps are described in detail in a plan DOD prepared and sent to the Congress in March 1995.[3]

In February 1995, an Italian newspaper reported that the hospital in Vicenza—the primary host nation referral facility—was alleged to have engaged in poor health care practices. These practices included improper disposal of contaminated waste in the emergency room, operating rooms, and the pathologic anatomy and metabolic disease sections. Expired or spoiled medicines were also reportedly discovered throughout the hospital. Army medical officials in Vicenza followed up with hospital administrators and were assured that U.S. beneficiaries did not receive expired medicines or have resultant bad medical outcomes. Army officials believe the situation is resolved and that beneficiaries are not at any risk. They believe the hospital provides superb care overall. This incident does, however, provide sufficient reason for military medical providers to

[2]The Dependents Dental Plan covers spouses and children of active-duty members of the uniformed services. It is not for active duty members or retired members. To be eligible for the Dependents Dental Plan, dependents must reside in the United States, Guam, the U.S. Virgin Islands, or Puerto Rico.

[3]Report to Congress in Response to Section 733, Defense Authorization Act for FY95, Delay in Closure of Army Hospital, Vicenza, Department of Defense (Washington, D.C.: 1995).

remain actively involved in their patients' care when they are referred to host nation facilities. Army officials recognize this need and have pledged to actively monitor all patient care in host nation facilities.

Conclusions

Military health and dental care professionals are working long hours attempting to meet beneficiary demands that are greater than military facilities are staffed to provide. Even though some of the strain placed on medical and dental resources may decrease slightly as the beneficiary population in Europe continues to shrink, the military medical facilities in Europe will not have the capacity to handle all care to eligible beneficiaries. Nor does it appear practical to staff and maintain enough military medical facilities to meet the peace-time health care needs of all eligible beneficiaries. Troops are widely dispersed and, in some places, too few in number to provide the workload necessary to justify a full service medical facility and enable medical staff to maintain their skills. Therefore, beneficiaries' use of host nation medical care will continue and may increase.

Given these circumstances, the U.S. military medical leadership needs to continue to take an active role in attending to and managing the health care needs of beneficiaries—particularly those who must rely on host nation care. An active military role not only will ensure that beneficiaries receive appropriate care but should also improve the perceptions that beneficiaries have about host nation health care.

DOD has been slow to address the problems confronting military beneficiaries. In our view, though, the steps that have been taken are directed toward alleviating the major concerns of most beneficiaries. Because of these actions, we are not making any recommendations.

Agency Comments

In a letter dated June 20, 1995, the Assistant Secretary of Defense (Health Affairs) generally concurred with this report. (See app. III.) The letter acknowledged that we accurately described the problems and the corrective actions under way and planned. In addition, DOD officials provided updated information on some of the actions they are taking, and this has been added to the report.

We are sending copies of this report to the Chairman and Ranking Minority Member, Senate Committee on Armed Services; the Chairman

and Ranking Minority Member, Subcommittee on Military Personnel, House Committee on National Security; the Secretary of Defense; and other interested parties.

This work was performed under the direction of Stephen Backhus, Assistant Director. Other major contributors were Timothy Hall and Barry DeWeese. Please contact me on (202) 512-7101 if you have any questions about this report.

Sincerely yours,

David P. Baine
Director, Federal Health
Care Delivery Issues

Contents

Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
MHSS	military health services system

Scope and Methodology

To assess how DOD is meeting the needs of beneficiaries overseas as the number of military personnel and facilities are reduced, we visited the following 15 military communities: Augsburg, Darmstadt, Frankfurt, Grafenwoehr, Hanau, Heidelberg, Kaiserslautern, Katterbach, Nuremberg, Spangdahlem, Stuttgart, Wiesbaden, and Wuerzburg, Germany; and Aviano and Vicenza, Italy. During these visits we met with numerous military health officials, including the commanders of the of the five remaining U.S. military hospitals in Germany and northern Italy (four Army and one Air Force). In addition, we interviewed 29 physicians representing obstetrics/gynecology, family practice, pediatrics, orthopedics, allergy/immunology, psychiatry, ambulatory patient care, internal medicine, radiology, otolaryngologists, and general surgery. We also met with 11 Army and Air Force commanders and staff of outlying health clinics.

Because beneficiaries indicated concerns over a lack of access to U.S. dental facilities overseas, we interviewed six Army dental commanders, including three Army dental clinic commanders assigned to outlying military communities.

We conducted "round-table" panel discussions to obtain input from beneficiaries as to changes in the availability of health care. We convened 20 panels with a total of 102 beneficiaries in the military communities we visited in Europe. Most of the beneficiaries were active duty members and their dependents. The beneficiaries were not randomly selected but were identified by representatives of the National Military Family Association, Army Community Services, and Air Force Family Support Centers. These meetings with (1) military medical and dental staff and (2) beneficiaries provided the basis for much of the information contained in this report.

Both before and after our visit to Europe, we met with officials of the Office of the Assistant Secretary of Defense (Health Affairs) and Offices of the Surgeons General to discuss the status of their actions and plans to meet the health care needs of beneficiaries overseas. In addition, we met with representatives of the National Military Family Association—an advocacy group for military families—to discuss their concerns about military and host nation health care in Europe.

We reviewed documents obtained from military medical officials in the Office of the Assistant Secretary of Defense (Health Affairs), Offices of the Surgeons General, and various medical activities in Europe. These documents included legislation, policy memorandums, medical drawdown

information, data on beneficiary access to care, data on military medical staffing in Europe, analyses of beneficiary complaints, and beneficiary handbooks about military and host nation medical care.

We did our work between March 1994 and March 1995 in accordance with generally accepted government auditing standards.

U.S. Military Medical Facilities in Germany and Northern Italy

The following is a list of all U.S. Air Force and U.S. Army medical facilities operating in Germany and northern Italy as of April 21, 1995. Air Force facilities are noted with an asterisk.

Hospitals

Bitburg, GM*
Heidelberg, GM
Landstuhl, GM
Wuerzburg, GM
Vicenza, IT

Clinics

Geilenkirchen, GM*
Ramstein, GM*
Rhein Main, GM*
Sembach, GM*
Spangdahlem, GM*
Aviano, IT*
Augsburg, GM
Babenhausen, GM
Bad Aibling, GM
Bad Kreuznach, GM
Bamberg, GM
Baumholder, GM
Buedingen, GM
Butzbach, GM
Darmstadt, GM
Dexheim, GM
Friedberg, GM
Giebelstadt, GM
Grafenwoehr, GM
Hanau, GM
Hohenfels, GM
Illesheim, GM
Kaiserslautern, GM
Karlsruhe, GM
Katterbach, GM
Kitzingen, GM
Mannheim, GM
Nuremberg, GM
Sandhofen, GM
Schweinfurt, GM

Stuttgart, GM
Vilseck, GM
Wiesbaden, GM
Livorno, IT

Comments From the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

JUN 20 1995

Mr. David P. Baine
Director, Federal Health Care Delivery Issues
Health, Education and Human Services Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Baine:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "Defense Health Care: Beneficiary Concerns with Medical Care Overseas Now Being Addressed by DoD," dated May 24, 1995, (GAO Code 101451/OSD Case 9948). The DoD generally concurs with the report.

The Department recognizes that some of our beneficiaries encountered difficulties in accessing the military health care system in Europe during the drawdown. Given the magnitude of change involved in the drawdown in Europe, a great deal of progress has already been made both in providing, or facilitating, health care delivery and in establishing a TRICARE management team to continue program implementation. Unquestionably, this has taken longer to accomplish than some beneficiaries, and the Department, would have preferred.

The focus of the DoD continues to be on improved access to primary care, both medical and dental, and facilitating use of host nation health care, when necessary, as the cornerstones of the TRICARE Europe program. The problems that developed during the drawdown have largely been solved; the actions already taken and plans now underway appropriately address the remaining issues.

A few minor technical corrections to the report were separately provided to the GAO staff. The DoD appreciates the opportunity to comment on the GAO draft report.

Sincerely,

Edward D. Martin /for
Stephen C. Joseph, M.D., M.P.H.

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