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DEFENSE HEALTH CARE

Resources, Patient Access, and Challenges in Europe and the Pacific

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Contents

Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
MTF	military treatment facility
O&M	operations and maintenance

GAO
Accountability * Integrity * Reliability

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The Honorable Steve Buyer
Chairman
The Honorable Neil Abercrombie
Ranking Minority Member
Subcommittee on Military Personnel
Committee on Armed Services
House of Representatives

The Department of Defense (DOD) maintains a significant military medical presence in Europe and the Pacific. As in the United States, the primary mission of DOD's overseas health care activities is to maintain the health of military personnel and support U.S. forces during military operations. Also, when space and resources are available, military treatment facilities (MTF) provide health care to dependents of active duty members, retirees and their dependents, and survivors of service members. When an MTF cannot provide needed health care services, DOD may refer beneficiaries to local host nation providers or transport patients to military facilities elsewhere.

In 1990, we testified that beneficiaries in both Europe and the Pacific were having considerable problems obtaining health care at MTFs.[1] These problems were exacerbated during the post-Cold War downsizing of the U.S. military presence overseas, which included MTF closures. In 1995, we reported that access problems were continuing at the remaining MTFs in Germany and Italy, particularly problems with access to specialty care.[2] At that time, DOD committed itself to improving access and in 1997 implemented TRICARE, its managed care program, which better integrates host nation care into the military health care system.

In September 1999, you asked that we review DOD's health care system in Europe and the Pacific to determine whether problems persist. Specifically, you asked the following: What DOD health care resources are available in Europe and the Pacific and what is their cost, how does DOD integrate host

[1] *Access to Medical Care at Overseas Military Hospitals* (GAO/T-HRD-90-20, Mar. 29, 1990).

[2] *Defense Health Care: Problems With Medical Care Overseas Are Being Addressed* (GAO/HEHS-95-156, July 12, 1995).

nation care into its military health care system, how does DOD ensure the quality of such care, do beneficiaries have adequate access to medical care, and do obstacles still exist to obtaining health care?

To answer these questions, we interviewed and obtained relevant documents from officials of the TRICARE Management Activity, which has overall responsibility for managing DOD's military health care system; the TRICARE Europe and Pacific Lead Agent[3] offices; each military service; and the Department of State. We visited the following MTFs in the TRICARE Europe and TRICARE Pacific Regions: In Germany, the Landstuhl Regional Medical Center, the Ramstein Air Base clinic, and the Army Health Clinic in Wiesbaden; in the United Kingdom, the Navy's London clinic and the Air Force's hospital at Lakenheath; in Italy, the Navy's hospital in Naples and the Army Health Clinic in Vicenza; in Turkey, the Incirlik Air Base hospital; in Japan, the Navy's hospital in Yokosuka and the Yokota Air Base hospital; and in Korea, the Army's 121st General Hospital in Seoul and the Osan Air Base hospital. At these locations, we interviewed and obtained relevant documents from hospital and clinic commanders, senior medical staff, patient liaisons, and health benefits advisors. We also visited three remote locations—Ankara, Turkey; Bangkok, Thailand; and Singapore—that have no local MTFs but significant numbers of beneficiaries. We conducted interviews with about 100 beneficiaries and beneficiary representatives.

Also, we reviewed DOD's criteria for selecting local providers and hospitals for use by beneficiaries and observed operations at Homberg University Klinik and Wiesbaden Stadt Klinik, Germany; Addenbrookes Hospital and Clementine Churchill Hospital, United Kingdom; San Bortolo Hospital, Italy; Seyhan Hospital, Turkey; and Bumrungrad Hospital and BNH Hospital, Thailand. We also interviewed officials from International SOS, the contractor responsible for coordinating beneficiary care in much of the western Pacific. We conducted our work between November 1999 and August 2000 in accordance with generally accepted government auditing standards.

[3]Lead Agents are senior military medical officials responsible for planning and coordinating peacetime health care operations within their respective regions. The Europe Lead Agent is responsible for U.S. military personnel stationed in continental Europe, Great Britain, Iceland, the Middle East, and Africa. The Pacific Lead Agent's responsibilities include U.S. military personnel stationed in Guam, Korea, Japan, and other nations throughout Asia and the western Pacific.

Results in Brief

DOD maintains in Europe and the Pacific an extensive system of 18 hospitals and 69 clinics providing primary and specialty care to about 500,000 beneficiaries in over 100 countries. DOD spends about $1.1 billion annually to staff, operate, and maintain these overseas MTFs. Most beneficiaries live near MTFs and receive their care from military physicians, although host nation providers and facilities are also used to augment MTF resources. In Europe, MTFs have developed formal networks of English-speaking host nation providers to serve as referral specialists. In the Pacific, MTFs have traditionally used less local care and have not developed formal provider networks. Pacific MTFs, more so than those in Europe, rely on transporting patients between MTFs for specialty care. Beneficiaries living in remote areas hundreds of miles from MTFs, particularly in the Pacific, provide DOD a major care challenge. For such beneficiaries, DOD relies on various care sources, including Department of State health clinics and local health care, as well as on transporting patients to distant MTFs. Also, to improve services in the Pacific remote areas, DOD recently hired a contractor to arrange for and manage the care of beneficiaries living there. DOD and the remote beneficiaries have given high ratings to this contractor's services.

To ensure host nation provider quality, DOD relies primarily on each country's licensing and credentialing requirements, as well as on limited inspections and monitoring by U.S. military physicians. Differences in language, culture, and health care practices between the United States and the Europe and Pacific Regions at times can cause frustrations and inconveniences for beneficiaries using host nation care. Patient liaisons play a key role in helping beneficiaries deal with these barriers, serving as intermediaries between the MTFs and the host nation. Using MTF and local providers, DOD has generally been able to ensure timely access to both primary and specialty care for overseas beneficiaries. However, MTF-provided specialty care is not always available within the 4-week TRICARE access standard, and local specialty providers are not available in all areas.

The medical systems in Europe and the Pacific face continuing challenges. DOD believes that the aircraft serving the aeromedical evacuation system, critical for ensuring access to specialty care in each region, may need to be replaced, at considerable cost. Also, DOD officials told us that the services' medical screening process for active duty family members does not always identify individuals with significant health problems. Moreover, DOD civilians assigned overseas are often not screened at all. As a result, individuals with complex, recurring medical needs are sometimes assigned

overseas where local MTFs cannot provide the needed care and local care is unavailable or unreliable. Beneficiaries also expressed concerns about the portability of their TRICARE benefits from region to region, particularly citing difficulties they face in obtaining health care when temporarily visiting the United States.

DOD is now seeking to expand local care options in some overseas locations and has begun reviewing alternatives for its aeromedical evacuation needs. DOD officials also told us that they plan to review concerns about overseas screening and benefit portability. We are recommending that DOD complete these actions to improve overseas health care for its beneficiaries. DOD agrees with our findings and recommendations.

Background

Most DOD health care beneficiaries in Europe and the Pacific are active duty personnel and their family members, and they are usually stationed near a military hospital or clinic. MTFs also provide care on a space-available basis[4] to thousands of military retirees and their family members living abroad. U.S. government civilian and DOD contractor employees, along with their dependents, can register in the Defense Eligibility and Enrollment System and receive space-available care at rates established by DOD. Table 1 shows the estimated number and type of beneficiaries in Europe and the Pacific in fiscal year 1999.

[4]Under the terms of the Dependents' Medical Care Act, enacted in 1956, DOD has the authority to provide retirees of any age health care in its medical facilities as long as space and resources are available. This is referred to as "space-available" care.

Table 1: Estimated Number of Beneficiaries by Category in Europe and the Pacific, FY 1999

Beneficiary category	Europe	Pacific	Total
Active duty personnel	110,000	96,534	**206,534**
Active duty family members	143,500	59,317	**202,817**
Retirees and family members	24,427	18,406	**42,833**
U.S. civilian employees, DOD contractors, and dependents	27,415	12,500	**39,915**
Total	**305,342**	**186,757**	**492,099**

Source: TRICARE Europe and TRICARE Pacific Lead Agents.

DOD's managed care program, TRICARE, offers two benefit options—Prime and Standard—for active duty personnel and their families living overseas in military communities that have MTFs. Under TRICARE Prime, beneficiaries receive cost-free MTF care supplemented, as needed, by a civilian host nation provider network. Prime enrollees are assigned to a local MTF physician who, serving as primary care manager, oversees their care and authorizes referrals for specialty care. Prime beneficiaries are not billed for specialty care obtained from network physicians. Rather, DOD pays for all such services. TRICARE Prime is mandatory for active duty personnel assigned to the TRICARE Europe and TRICARE Pacific Regions, and optional for their accompanying family members. According to the Lead Agents, about 90 percent of eligible beneficiaries enroll in TRICARE Prime.

Family members choosing not to enroll in TRICARE Prime are automatically placed in TRICARE Standard, an option that allows beneficiaries to seek covered care from any MTF or host nation provider. Standard beneficiaries, however, receive a lower priority for MTF appointments than Prime beneficiaries do, their host nation care is subject to cost-sharing and deductibles, and they must often pay for host nation services in full and wait for reimbursement. Family members who are citizens of the host country and routinely receive their care through the host nation health care system often use TRICARE Standard.

Overseas military retirees under age 65 and their family members may not enroll in TRICARE Prime but are eligible for TRICARE Standard and cost-free MTF care on a space-available basis. Retirees over age 65 may also obtain cost-free, space-available MTF care, but they are not eligible for TRICARE Standard and thus are responsible for any host nation care costs they incur.[5] U.S. civilian employees, DOD contractors, and family members of both may obtain space-available MTF care. These patients, or their insurance plans, must pay DOD's established rates for these services.

Approximately 23,000 active duty personnel and family members are now classified as living in remote areas. DOD defines remote areas as being "over 30 minutes traveling time from an MTF." Remote sites in Europe and the Pacific vary greatly in distance from MTFs, availability and quality of medical services, and beneficiary populations. For example, several hundred military personnel are based in Australia and Singapore, where there are no MTFs but where local health care standards are comparable to those of the United States. In contrast, small numbers of personnel are stationed in third-world countries where the nearest MTF may be hundreds or thousands of miles away and the local health care system cannot adequately provide all needed services.

All remotely located active duty personnel and their family members may enroll in a modified TRICARE Prime program that entitles them to cost-free host nation care. Active duty family members in remote locations who choose not to enroll in this program participate in TRICARE Standard, with its cost-sharing and deductibles. Military commanders may authorize the transport of beneficiaries, when care needs exceed local capability, to MTFs or other acceptable medical facilities elsewhere.

DOD Uses Significant Resources in Europe and the Pacific

DOD spends about $1.1 billion annually to provide health care to beneficiaries in Europe and the Pacific. In fiscal year 1999, DOD spent about $463 million to operate and maintain hospitals and clinics in these areas and to transport beneficiaries between facilities for care. In addition, DOD spent about $609 million to compensate military personnel who staff the MTFs. Also, over the past 5 years, DOD has committed about $62

[5]In the United States, military retirees over age 65 are also ineligible for TRICARE Prime, but if they are eligible for Medicare, they may use their Medicare benefits to pay for nonmilitary provider care. However, Medicare is not available overseas.

million in military construction funds for projects overseas, and another $249 million for future projects.

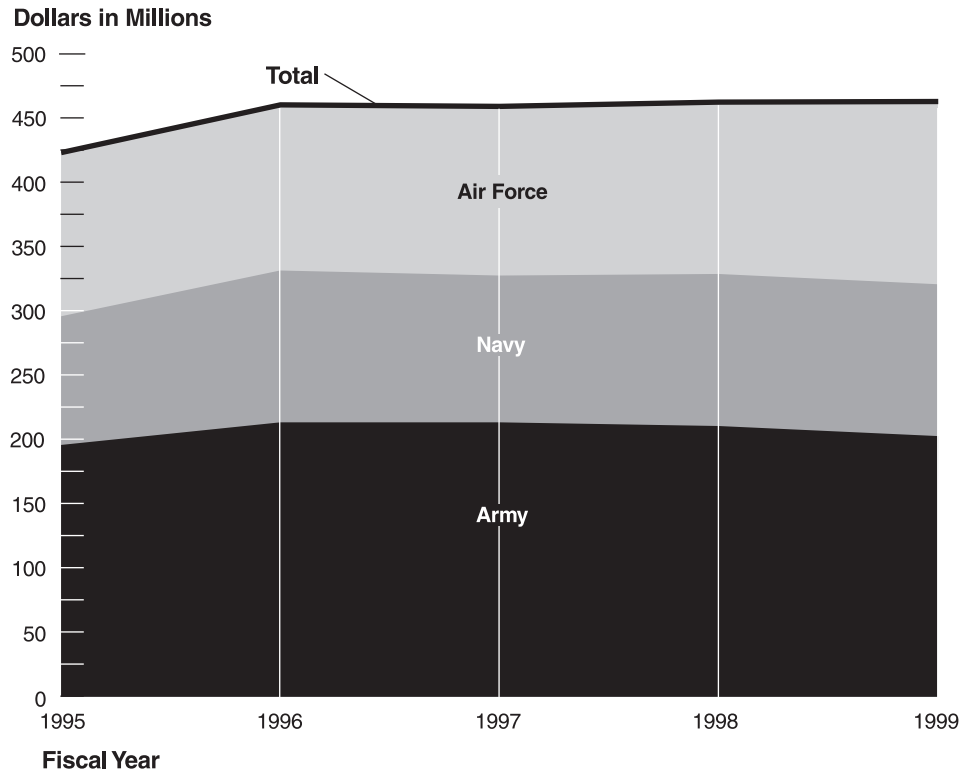
Facilities and Funding

DOD operates 18 hospitals and 69 clinics in Europe and the Pacific. Most of these MTFs are located in Germany, Italy, the United Kingdom, Japan, and Korea—the countries with the largest U.S. military presence. The Landstuhl Regional Medical Center in Germany provides many specialty and subspecialty services not available at other MTFs in the TRICARE Europe Region. In addition, DOD maintains 10 community hospitals and 41 clinics in Europe and 7 hospitals and 28 clinics in the Pacific. Most beneficiaries live near MTFs and receive their care from military physicians.

Clinics are staffed to provide primary care and limited specialty care services to the local military population. Hospitals offer primary care and a greater variety of specialty care services and usually serve as referral centers for a large geographic area. Military hospitals overseas typically maintain a small inpatient capability—often fewer than 50 beds—but are expandable to accommodate many additional patients in wartime.

Much of the overseas care system's funding is provided through the Defense Health Program budget, which provides operations and maintenance (O&M) funding for each service to operate MTFs both in the United States and overseas. Funding for Europe and Pacific MTFs has remained virtually constant over the past several years (see fig. 1).

Figure 1: O&M Funding for MTFs in Europe and the Pacific, FY 1995-99



Source: Army, Navy, and Air Force Surgeons General.

Salaries for civilian employees are included in the MTF O&M budgets. Salaries and benefits for military personnel are paid from separate budget accounts. According to the military services, a total of 11,700 military personnel were authorized for MTF operations in fiscal year 1999, with an estimated cost of salaries and benefits of $609 million.

Military Construction Funding

In addition to the O&M funds, each service receives military construction funds to pay for new facilities and additions to existing facilities overseas. During the early 1990s, funding for overseas construction projects was halted; since 1995, limited funding has again become available: about $62 million (of a total DOD medical construction authorization of $1.3 billion) has been earmarked for specific medical projects in Europe and the Pacific, and an additional $249 million has been proposed for projects to be initiated during the next 7 years.

Aeromedical Evacuation Funding

Both Europe and the Pacific rely on the aeromedical evacuation system to move patients to obtain care not locally available and to provide emergency transportation for critical patients. Although the system's primary mission is to move combat zone casualties to fixed or field hospitals as needed, the routine peacetime movement of patients is used, to some extent, to train personnel for readiness purposes.

The Air Force has stationed one squadron of C-9 evacuation aircraft at Yokota Air Base in Japan and another squadron at Ramstein Air Base in Germany. These aircraft fly regular routes between military communities throughout Europe, the Middle East, and the western Pacific. In many cases, patients are flown from locations served by a clinic to receive specialty care at one of the region's military hospitals. In fiscal year 1999, the two overseas C-9 squadrons received about $12 million in O&M funds. An additional $22 million was required to pay the military personnel carrying out the aeromedical evacuation activities in Germany and Japan.

DOD Has Formalized Local Care Use

DOD has traditionally relied on some local health care to supplement MTF care overseas, and with TRICARE's introduction has expanded and formalized host nation provider use. MTFs in Europe have established formal host nation provider networks that serve TRICARE Prime beneficiaries and bill DOD's claims processor, not the beneficiaries. In contrast, TRICARE Pacific, because of cultural differences, concerns about local provider quality, and other factors, uses less local care, and MTFs there have not developed provider networks.

For remote beneficiaries, TRICARE Europe often relies on the Department of State to provide care through embassy or consulate clinics or to recommend local physicians. TRICARE Pacific relies on State Department resources to some extent but also uses a contractor to arrange health care for many remote beneficiaries. Air evacuation is used routinely to move patients between MTFs for specialty care, and in medical emergencies evacuation aircraft can be dispatched to assist beneficiaries almost anywhere in the world.

Europe Host Nation Network Supplements MTF Care

For years, DOD has used local providers in Europe to augment MTF care. In many areas, long-term relationships have developed among local military communities, MTFs, and local physicians and hospitals. The local providers have offered mainly specialty, emergency, and inpatient care to

active duty family members under DOD's old Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program.[6] According to Lead Agent officials, local providers have helped ensure that patients can be treated near their homes, have cut down on waiting times for specialty care, and have allowed patients with access to only a military outpatient clinic to receive inpatient services without being transported to another MTF.

In 1995, MTFs began entering into written agreements, or memorandums of understanding, with public and private health care providers and thus developed a formal provider network to supplement MTF care. Individual physicians or entire hospitals can be included under the agreements, which generally define the conditions for providing services to DOD beneficiaries. Network providers agree not to request payment from U.S. beneficiaries at the time of the visit and instead to submit their bills directly to DOD for payment. The memorandums of understanding require that network physicians be licensed to practice medicine in their host country and that providers or their staff be able to communicate in English and maintain medical records for inclusion in patients' permanent files.

During fiscal year 1999, TRICARE Europe had approximately 750 agreements with providers and facilities. Most network providers are located in Germany, the United Kingdom, and Italy, with smaller networks serving the smaller military populations of The Netherlands, Turkey, Spain, Portugal, and other locations throughout the region. Host nation physicians provide a significant portion of both inpatient and outpatient care received by TRICARE Europe beneficiaries. In 1998, for example, host nation providers conducted over 200,000 outpatient visits with U.S. beneficiaries (about 10 percent of the region's total medical visits), and host nation facilities treated 12,300 inpatients (about 43 percent of all inpatient stays for the year). According to the TRICARE Europe Lead Agent, about $41.7 million was paid to host nation providers in fiscal year 1999.

Europe Lead Agent officials and military physicians told us they were generally satisfied with the host nation physicians' care. Nevertheless, DOD officials noted that differences in language and health care practices in

[6]CHAMPUS was an insurance-like program administered by DOD that paid for a portion of the care military families and retirees under age 65 received from private sector health care providers. The benefits available under CHAMPUS were essentially the same as under TRICARE Standard.

some European countries occasionally caused frustrations and inconveniences for beneficiaries. Examples follow.

- The memorandums of understanding require that providers communicate with beneficiaries in English. However, in Turkey and Italy, and to a lesser extent in Germany, nurses and administrative staff do not speak English, and the fluency of the doctors varies. This language barrier can make it difficult for patients to discuss their medical problems with host nation personnel. Also, patients expressed concerns about translation—especially that medical terms might not be translated accurately.
- Conservative hospital admissions practices and long stays are issues in some countries we visited. For example, the way Italians practice medicine is characterized by more inpatient admissions, longer hospital stays, and greater use of prescribed rest for injuries and illness. According to an MTF physician, many of the local Italian hospitals' inpatients would not have been admitted to an MTF as inpatients. He told us, for example, that patients who visit the local hospital on weekends or after MTF hours with various aches and pains are often admitted for observation rather than sent home with a prescription. Once in the hospital, patients tend to stay longer than in the U.S. system. Also, routine diagnostic work at the local Italian hospital can be completed only Monday through Friday, so patients are often kept over the weekend for procedures such as ultrasound or other diagnostic tests that would be done on an outpatient basis in the United States. We were told that as a result, MTF staff occasionally go to the local hospital to discharge DOD patients who would otherwise be kept longer by Italian physicians.
- In Europe, physicians are not used to patients who ask questions about their diagnoses or treatment plans. In the United States, the opposite is often true: U.S. patients tend to be more involved in their treatment and often ask questions about treatment strategies, procedures, and expected outcomes. As a result, American military patients can become frustrated at times with the more reserved attitude of host nation physicians.

Patient liaisons play a key role in helping beneficiaries deal with these language and cultural barriers, serving as intermediaries between the MTF and the host nation medical community. Liaisons assist beneficiaries by providing information about host nation care, making host nation appointments, and serving as translators. In some cases, liaisons also accompany patients to appointments and handle health care claims and

billing. At the MTFs we visited, the most effective liaisons spoke the local language, had completed some health-related training, and were familiar with the local and the DOD medical systems. For example, at the MTF in Vicenza, a U.S. doctor who spoke Italian and had been trained at an Italian medical school served as the primary liaison with the medical community. In some locations, liaisons had no health-related training and were not always comfortable discussing complex medical situations with patients.

Host nation providers we interviewed generally were pleased to be included in the networks, and many had made special efforts to accommodate DOD beneficiaries. For example, a network dermatologist in Italy set aside certain hours during the week for DOD patient appointments to ensure that access would not be a problem. Also, an Italian hospital in Vicenza now routinely provides U.S. patients epidural anesthesia during childbirth, which is not the usual practice in Italy. After delivery, U.S. patients are allowed to stay in the same room with their babies, another adjustment made by the hospital.

In the United Kingdom, local providers have entered into agreements with DOD to allow beneficiaries to bypass the often-lengthy waits for specialty care in the British health care system. Also, a local network hospital in Turkey provides DOD patients special, larger private rooms that have Western-style accommodations, such as refrigerators and cable television. At a German hospital used frequently by U.S. beneficiaries, an English-speaking liaison meets regularly with patients to assist them as needed. Host nation doctors in the European network told us they like treating U.S. patients and are willing to treat more of them. However, some providers told us they would prefer more feedback from MTF staff and patients about their clinical treatment of, and interaction with, U.S. patients. Lead Agent officials told us they plan to seek ways to increase communication between host nation physicians and MTF staff to help ensure the local provider networks' continued success.

According to Lead Agent officials, the local provider network is continuing to evolve. In some areas, MTFs had recruited more local physicians than were needed, and some physicians who were little used by beneficiaries have been dropped from the network. In other areas, MTF commanders are seeking additional local providers to augment MTF specialty care. For example, at Incirlik, Turkey, the MTF is exploring the possibility of using additional specialists at the local hospital to improve access for its beneficiaries.

Beneficiaries we met with who had used local care were generally satisfied with the care they received. Some told us, however, they would choose to wait for an MTF appointment or travel to an alternative MTF because they were generally less comfortable with host nation care. In fiscal year 1999, the aeromedical evacuation system in Europe moved about 12,000 patients to MTFs for specialty care. Patients were typically flown to the nearest MTF offering the needed specialty. Those patients needing more extensive services than are available at MTFs in Europe are usually transported to U.S. MTFs via scheduled C-141 flights from Ramstein Air Base, Germany.

Pacific MTFs Use Host Nation Care Less Frequently

MTFs in the Pacific—particularly Japan and Korea, where most MTFs and beneficiaries are located—have no formal networks and use much less host nation health care than in Europe. Pacific Lead Agent officials told us that differences in host nation medical practices have minimized patient referrals to local national providers. Examples of obstacles to local care use include the following:

- MTF officials told us that because no consistent standards exist for hospital accreditation in the Pacific, officials cannot readily obtain independent reviews of host nation facilities. And, although Japanese hospitals were thought to provide good care in many medical areas, MTF physicians told us they had concerns about the long hospital stays, routine inpatient admission of noncritical cases, and outdated medical practices that often preclude aggressive early intervention. Regarding Korea, MTF officials told us that while quality of care has improved over the years, few facilities exist there that can offer care that meets U.S. standards.
- In both Japan and Korea, only a limited number of physicians speak English well enough to communicate without difficulty with American patients. Even when physicians can speak English, the nurses and other support staff usually cannot. Beneficiaries also told us that Japanese doctors normally do not explain diagnoses or treatment options and expect not to be questioned. Also, Japanese and Korean nursing care is significantly different than in the United States: patients' families normally provide sheets, towels, and toiletries and stay with and otherwise assist patients during hospitalizations. Also, beneficiaries expressed concerns about the comfort of local facilities and the native foods served there.
- Unlike in Europe, written agreements used to formalize health care policies are not culturally accepted in Japan and Korea. While MTFs often have verbal agreements for certain services—usually for

emergency situations or specialized diagnostics—local facilities have been reluctant to formalize such agreements in written documents.

- Host nation providers and facilities in Japan and Korea typically require payment prior to care or before the patient leaves the treatment area. According to Lead Agent officials, the Japanese particularly do not tolerate claims delays. In some areas, goodwill with local providers has eroded as patients have left the host nation without paying what they owe local providers. Some civilian facilities have banned DOD beneficiaries from access unless cash is received in advance.

Thus, in the Pacific, DOD uses minimal host nation care and largely depends on MTFs and the aeromedical evacuation system to move patients between facilities for specialty care. In fiscal year 1999, for example, the aeromedical evacuation system transported about 5,400 patients in the Pacific Region. About 3,600 traveled to other MTFs for treatment, while another 1,800 were returned via C-141 flights to Hawaii or other U.S. locations for care. Host nation facilities were used primarily for emergency cases in which patients could not be moved without risk and for diagnostic tests not available at the MTF. The Pacific Lead Agent reported that only $3.7 million (about $20 per beneficiary) was paid to host nation providers in fiscal year 1999, compared with $41.7 million (about $150 per beneficiary) in Europe.

Nevertheless, MTFs in Korea have recently begun increasing their efforts to identify qualified local providers and establish working relations with them. Military physicians from the Army's 18th Medical Command in Seoul have inspected local hospitals in an attempt to determine which of their services are adequate and appropriate for DOD beneficiaries. The Medical Command has developed an agreement that outlines U.S. expectations—English-speaking staff, 24-hour translation services, private rooms, and full-time nursing care—and makes clear DOD's intent to promptly pay for services for active duty personnel. However, Korean hospitals have not yet agreed to change their billing practices and continue to bill family members directly. Thus, local care users have to make payments up front and await DOD reimbursement.[7]

[7]According to DOD officials, MTFs in the Pacific have developed informal arrangements with some local providers to ensure that MTFs, and not beneficiaries, are billed for medical services.

MTFs in Korea have also acted to encourage beneficiaries to use local facilities for services not available at the MTF. For example, the Army's 121st General Hospital now provides a shuttle to take patients, accompanied by a translator when needed, from the MTF to host nation facilities. Similarly, Osan Air Base now ensures that a patient liaison is available to greet beneficiaries arriving at local hospitals and assist with health care claims. According to the hospital's commander, the greater use of local resources will (1) improve access to specialty care for patients and (2) reduce the burdens created for patients and military units when beneficiaries require extended absences to obtain treatment at other MTFs.

Remote Locations Rely on Varied Health Care Support

Beneficiaries living at remote sites hundreds of miles from MTFs provide a significant challenge for DOD's overseas health system. DOD has an obligation to ensure that such beneficiaries have adequate access to quality health care. To do so, DOD uses Department of State health resources, local health care, and contractor-provided services. DOD also transports patients to distant MTFs. Under a modified TRICARE Prime program, DOD pays for medical services that remote beneficiaries receive from host nation providers.

State Department Assists Remote Beneficiaries in Europe, Africa, and the Middle East

According to the Europe Lead Agent, there are about 20,000 remote beneficiaries in Europe, Africa, and the Middle East who do not have ready access to an MTF for care. Many of these beneficiaries rely primarily on the State Department to provide or help arrange their medical care. The Lead Agent advises remote area beneficiaries to contact the nearest U.S. embassy or consulate for a list of local providers who meet U.S. medical standards and have a history of providing quality care. In some cases, DOD beneficiaries are stationed at or near embassies or consulates that operate small primary care clinics staffed by U.S. medical personnel. DOD units in these locations can pay a per-capita fee to provide their personnel access to the clinic.

For specialty care in remote areas, State Department staff usually refer beneficiaries to an informal network of host nation practitioners who have favorable reputations. The State Department does not have contractual agreements with local providers and does not specifically seek to engage providers who will forgo advance payment for health care. Instead, patients that State refers for local care are responsible for their own payment arrangements and may need to pay for host nation care when they receive it. Then beneficiaries can file a claim for reimbursement from TRICARE.

In Ankara, Turkey, for example, the 210 assigned DOD beneficiaries can receive care from the U.S. Embassy clinic staffed by a U.S. nurse practitioner and two locally hired bilingual nurses. A State Department regional medical officer, a physician based in Vienna, makes 3-day visits to the clinic about every 4 to 5 months. Most beneficiaries are not willing to seek primary care from local Turkish providers, and several told us they appreciate having U.S. medical personnel available for them. The nurse practitioner has made office visits to the local specialty care providers she uses for referrals. She has determined that these providers can speak acceptable English and most have some U.S. training. The nurse practitioner acts as gatekeeper and case manager to the extent possible for patients referred to Turkish doctors. She gives patients a form to use to provide feedback on local care, and patients are reporting positive results from the visits she has referred thus far. In most cases, one of the clinic's nurses accompanies patients to appointments primarily for translation purposes.

In January 2000, TRICARE Europe officials met with State Department medical personnel to obtain a better understanding of State operations, share information, and find areas in which to work together to enhance effectiveness. For example, they discussed procedures for increased cooperation regarding physician referrals in Europe. According to the Europe Lead Agent Office, the State Department's processes for evaluating referral physicians are similar though not identical to those used by MTFs for the provider network.

Contractor and State Department Assist Beneficiaries in Remote Pacific

As in Europe, much of the Pacific Region's remote area beneficiary care traditionally has been provided by or arranged through the State Department. However, problems such as the frequent unavailability of regional medical officers due to their travel to cover other areas, and the up-front payment local providers require of beneficiaries, led the Pacific Region to hire a contractor to supplement State's role.

In 1998, DOD contracted with International SOS[8] to provide a managed health care option for active duty personnel and their family members stationed in the Pacific Region's remote areas where MTF care is not available. For each remote site, SOS developed networks of licensed

[8]International SOS provides emergency assistance, medical services, and management of the delivery of health care to corporate travelers and multinational organizations outside their home country.

English-speaking physicians for primary and specialty care. Each network physician must agree not to charge DOD patients at the time of service; rather, SOS guarantees providers their payment and gets reimbursed by DOD for covered services. Beneficiaries may schedule their own primary care appointments with network physicians. For specialty care, however, beneficiaries must obtain an SOS authorization and use an SOS specialist. SOS also staffs 24-hour toll-free call centers to assist beneficiaries in arranging health care and with any emergencies that may arise.

DOD beneficiaries we interviewed expressed high overall satisfaction with SOS' health care operations, adding that SOS and its contractor network were highly responsive to their health care needs. For example, in Singapore, SOS arranged to have a local doctor practice at a small clinic located near the military's primary housing area, and specialty care is available in Singapore within 24 hours. Also, Singapore network providers speak English, most specialists are trained in Western countries, and patient care is similar to that in the United States.

In Bangkok, DOD officials told us that many public hospitals are crowded and not up to U.S. standards, but that beneficiaries are very pleased with the SOS network private hospitals' quality. At these facilities, many physicians and nurses are U.S.-trained, English-speaking, and accommodating to U.S. patients' needs. Nursing care is generally good, and medical education standards are high. Beneficiaries told us that when they first arrived in Bangkok, they were reluctant to use local care; however, after using local providers, they had confidence in the local care available through the network. Also, beneficiaries told us they had no problems obtaining primary care appointments and no language difficulties with network doctors. They told us that their visits went smoothly and that the paperwork was handled properly.

Although SOS regional call centers have the primary role of coordination, the Bangkok and Singapore DOD remote unit staff also help beneficiaries access care. For example, in Singapore, DOD has an active duty medic to help coordinate local care. In Bangkok, the Pacific Lead Agent hired local health benefits advisors, including a local nurse with a long history of working with the U.S. military and a sound grasp of the local care options, the military health care system, and beneficiary concerns. Some of these staff have duties that replicate SOS contract responsibilities—for example, the medic is also on call 24 hours a day. Nonetheless, beneficiaries clearly

appreciated the health care assistance and coordination options available to them while stationed in these foreign countries.

The SOS contract has complicated DOD's health care relationship with the Department of State. Currently, the SOS contract covers all DOD beneficiaries stationed in the Pacific areas without MTF access. In places where military personnel are stationed at or near U.S. embassies, individual military units can decide whether to continue using State Department health clinics or to rely on SOS network physicians for their care. In Singapore, for example, all DOD units have withdrawn from the State Department system, and the SOS network provides all local care. In Bangkok, one DOD unit has withdrawn from the State-sponsored health program,[9] but other DOD beneficiaries may still use the embassy clinic.

Remote Beneficiaries Can Travel to MTFs

In addition to host nation and State Department care, DOD beneficiaries in remote areas can sometimes arrange travel to MTFs elsewhere for care. Consistent with each service's guidance, military commanders may authorize patient transport to MTFs when beneficiaries need care that is beyond local capabilities. For routine care, military beneficiaries often arrange medical appointments to coincide with planned leave or official travel to MTF locations. In some areas, beneficiaries can travel via military aircraft that stop at their remote duty station. In other cases, travel via commercial carriers is authorized. In life-threatening medical emergencies, DOD can dispatch a medical evacuation aircraft to move a patient from a remote site to an MTF.

DOD and State Rely on Local Standards and Patient Feedback to Ensure Quality of Care

The TRICARE Europe and Pacific regions cover large geographic areas, and countries and local areas differ in their provider and facility quality standards. To determine network physician and facility qualifications, DOD generally relies on local certification and licensing practices, which vary from country to country. DOD's monitoring of local patient care varies, and the level of scrutiny is often based on overall confidence in the host nation's medical system. For remote locations, DOD relies primarily on the State Department and SOS to ensure that beneficiaries are referred to competent providers.

[9]Because the operating costs of the consulate and embassy health clinics are shared among participating agencies, the decision by DOD units to withdraw increases the amount paid by the State Department and other U.S. government agencies operating out of the U.S. mission.

MTFs Provide Limited Oversight of Local Health Care

In Europe, both the Lead Agent and MTF commanders are responsible for ensuring that doctors brought into the provider network can deliver acceptable care. Before allowing local providers into the network, the MTF commander verifies that the providers are licensed to practice in the country and requests other documentation on their specialty training. Providers joining the network must provide to the MTF commander copies of their educational degree(s); medical credentials, including licenses, registration, and other certification; work history for the last 10 years; and any history of adverse action taken against them regarding clinical privileges or any other disciplinary action.

According to the TRICARE Europe Lead Agent, in many areas of Europe, medical care systems are comparable to the U.S. medical system. In the United Kingdom, for example, medical facilities are accredited, and specialists receive rigorous training prior to being licensed for independent medical practice. Germany has similar training and licensing requirements for specialists, and in northern Italy, the health care quality and technology available are comparable to those in the United States. Many local physicians have received specialty training in the United States or participated in exchange programs and are familiar with U.S. care standards. Thus, DOD makes frequent use of local care in these areas.

According to DOD and State Department officials, however, the medical systems in some parts of Europe, the Middle East, and Africa often lack processes for ensuring care that meets U.S. quality standards. In these areas, medical facilities sometimes lack competent clinical nursing staff and do not always have effective quality control procedures to assure U.S. medical personnel that the health care meets U.S. standards. In some cases, physicians are not licensed, and continuing education is not required; therefore, assessing physician qualifications is particularly difficult. In addition, according to MTF physicians, local hospitals do not always use the most stringent sterilization and quality control techniques. As a result, DOD uses local care in these areas much less often.

Once local providers and facilities enter the TRICARE Europe network, the extent of MTF monitoring of their care delivery generally reflects the MTF commanders' confidence in the local quality of care. For example, in the United Kingdom, Germany, and northern Italy, much of the care provided to U.S. beneficiaries is not closely monitored. In most cases, MTF staff review local providers' reports of treatment results to ensure the care is appropriate. In other areas, where managers are more wary of the local

care, MTF staff make more frequent visits to hospitalized patients and more closely scrutinize the care provided.

MTFs in Europe are also required to obtain beneficiary feedback on local care. According to Europe Lead Agent officials, providers who do not meet DOD expectations and receive poor patient appraisals are reevaluated and, if necessary, dropped from the network. These officials told us that while MTFs do not receive much feedback, what they do receive is generally favorable. Europe Lead Agent officials told us they have dropped two network providers since 1997 because of beneficiary feedback that identified inadequate treatment.

In the Pacific, where MTFs have no formal host nation provider networks, MTF commanders and their staffs have sought to develop and cultivate relationships with local providers and facilities and have done so over time by making occasional site visits to facilities. MTF officials are more confident of Japanese providers and facilities than they are of Korean health care. In the relatively few cases when local facilities are used, MTF staff monitor the care by maintaining liaison with the attending physician, visiting inpatients, and reviewing treatment results. Mindful of the normally longer hospital stays in these countries, MTF staff act to remove inpatients from local hospitals and transfer them to MTFs as soon as is medically possible.

Various Sources Ensure Quality of Local Health Care in Remote Areas

In remote locations, the Department of State provides guidance to embassy and consulate medical units on how to assess providers and facilities, but implementation of this guidance is not consistent. According to State Department health officials, each post is responsible for assessing its country's health care resources and identifying competent local providers to provide care. These officials told us that each embassy or consulate health unit should request a provider's medical license and credentials and maintain patient feedback on each provider. For hospitals, State staff should also perform a facility evaluation that addresses the facility's location, capacity, services offered, hours of operation, and equipment, as well as the credentials of its nurses. Providers and health care facilities are to be reviewed every 2 years, but State Department officials told us that this is not necessarily done at each location. State is currently developing an electronic database of provider and country profiles that should help ensure more consistent data for each of its overseas locations.

For DOD beneficiaries in remote Pacific areas, SOS assesses the quality of its primary and specialty care provider network by reviewing providers' credentials and conducting facility inspections. The SOS contract requires that the medical practice quality for network physicians and facilities meet or exceed reasonable care standards as determined by the local licensing and oversight authorities. Network physicians must also meet the credentialing requirements set forth in the contract; for example, they must have graduated from an approved medical school, have completed a residency program, and be licensed to practice medicine in the host country. The contract encourages SOS to recruit physicians who follow medical standards similar to those of the United States or other developed countries.

The contract also requires SOS to continuously monitor the provider network. Monitoring activities must include verification of the availability of network providers and their adherence to contract requirements, as well as investigation and resolution of specific provider and beneficiary complaints or concerns. SOS also reviews and approves all specialty care referrals to ensure that recommended treatments are both medically sound and reimbursable under TRICARE.

TRICARE Overseas Has Improved Beneficiary Access to Care

With the implementation of TRICARE overseas and the increased use of host nation care to augment MTF care, beneficiaries have better access to medical care. At the MTFs we visited, patients and hospital administrators told us that most appointments meet the TRICARE access standards governing waiting times for scheduled appointments. The most recent appointment data show that most primary care clinics at the facilities we visited have appointments available to be booked. MTF specialty care appointments are not always available within the TRICARE access standard, but MTF staff told us that referrals made to local providers, especially for active duty family members in Europe, help eliminate appointment delays.

DOD Meets Access Standards for Most Primary Care Appointments

Access to medical care has improved since we reported on overseas health care in 1990[10] and 1995.[11] In our previous work, we found that beneficiaries, especially non-active-duty patients, often faced long waiting times and significant air or ground travel for routine appointments and surgeries. To help ensure timely access to care, DOD established appointment timeliness standards for TRICARE Prime enrollees similar to the standards used in private sector managed care programs. The standards were made applicable to the overseas regions in 1997 with TRICARE's implementation and can be met by using either MTF or local civilian care. The primary care standards are a wait of no longer than 1 day for urgent care, 1 week for routine care, and 4 weeks for a wellness visit. The standard for specialty care referrals is 4 weeks.

At the MTFs we visited in Europe and the Pacific, MTF staff and TRICARE Prime beneficiaries told us that most primary care appointments took place within the TRICARE access standards. The available appointment data for the MTFs we visited confirmed that most primary care clinics had same-day appointments available for patients who needed urgent care. Even when all same-day appointments are filled, MTF doctors told us, urgent care patients are treated, regardless of whether this requires working extended duty hours. For routine care and wellness visits, the data confirmed that most clinics had appointments available within the 1-week and 4-week standards. In a few of the busier primary care clinics, however, the data showed that routine and wellness appointments were not available within the access standards.

MTF staff and beneficiaries also told us that most of the time specialty care appointments took place within the 4-week access standard, usually in the MTF specialty clinic. However, for some MTF specialty clinics, the most recent data showed few appointments available for new patients during the next 4-week period. In addition, some specialty clinics occasionally place restrictions on access for some beneficiary groups. For example, for capacity reasons, the otolaryngology, orthopedic, and podiatry clinics at the Landstuhl Regional Medical Center at times treat only active duty patients, so family members and others are referred to host nation providers. Also, appointments at Landstuhl's orthopedic clinic have been booked as much as 48 days in advance, and the waiting lists have grown

[10]GAO/T-HRD-90-20, Mar. 29, 1990.

[11]GAO/HEHS-95-156, July 12, 1995.

lengthy. Pacific Lead Agent officials also reported occasional problems with long waits for specialty care in Pacific MTFs, especially in high-demand areas such as orthopedics.

In Europe, efforts to establish a host nation provider network have improved overall access to specialty care for beneficiaries. According to TRICARE policy, when MTF specialty clinics cannot offer patients appointments within the 4-week access standard, beneficiaries should be offered a referral to the host nation network. Beneficiaries in Europe told us they generally had adequate access to local providers in those cases when MTF specialty care was not available. Nonetheless, some patients prefer to wait for an MTF appointment instead of using the host nation network, thus waiving their right to an appointment within the access standards.

In the remote areas we visited, beneficiaries told us that primary care doctors were readily available for appointments. In the Pacific, we were told that SOS quickly reviewed and approved referrals to specialists so that these appointments could also be completed within the DOD access standards.

Overseas Health Care Faces Challenges

DOD's overseas medical system faces continued challenges as DOD seeks to maintain access to care for beneficiaries. The aeromedical evacuation system is critical for ensuring access to specialty care in each region, and the system's aircraft need to be replaced, at considerable cost. Also, DOD officials told us that the services' medical screening process for family members of active duty personnel assigned overseas does not always identify individuals with significant health problems and that DOD civilians often are not screened at all. As a result, individuals with complex, recurring medical needs are being assigned overseas where local MTFs cannot provide the needed care. In addition, overseas beneficiaries complained to us about accessing health care benefits when traveling in the United States.

Aging Aeromedical Aircraft

According to a recent Air Force study, the fleet of dedicated C-9s currently being used for aeromedical evacuation within the regions needs to be replaced. According to the study, the C-9s' future is being called into question for numerous reasons:

- the aging C-9s are experiencing corrosion problems, particularly the C-9 squadron in the Pacific, and have an uncertain remaining service life;
- the C-9s do not comply with U.S. and international aircraft noise restrictions; and
- the C-9s do not meet all Global Air Traffic Management requirements for improved communications, guidance, and surveillance systems.

Also, the C-9s have a limited flying range that is especially problematic in the Pacific, where distances are considerable and there are few alternate airfields on overwater routes. According to the Air Force study, C-9s do not have sufficient range to meet all regional patient movement requirements without refueling, and frequent fuel stops can be detrimental to patients. Seasonal winds also play a large role in planning routes for patient movement.

Further complicating the situation, the C-141 fleet—which currently moves most patients between the overseas regions and U.S. MTFs—is undergoing retirement, which is scheduled for completion in fiscal year 2006. Breakdowns by aging C-141s cause frequent delays on flights to and from the overseas regions. For example, Air Force officials told us that during fiscal year 1999, 25 percent of C-141 missions returning from Europe were delayed 24 hours or more because of breakdowns.

In response to these challenges, the Air Force undertook an analysis to determine which aircraft are best suited to perform aeromedical evacuation for the next 30 years. After considering eight potential solutions, the analysis team focused on two preferred alternatives: (1) modifying existing military transport aircraft to be used for peacetime evacuation missions or (2) purchasing a dedicated fleet of 737-700 aircraft, which have sufficient range to complete all evacuation missions currently performed by C-9s and C-141s. The analysis team noted that patient movement could suffer if modified aircraft are used, because these aircraft might also be needed to move cargo and refuel other aircraft. Therefore, the team recommended that the Air Force purchase a fleet of 737-700 aircraft, a procurement that would require several billion dollars.

The Air Force has yet to reach a final decision, and the Lead Agents have been involved in the assessment of proposed changes to patient movement in Europe and the Pacific. The Lead Agents recognize that greater use of commercial aircraft or local health care might be required to ensure that beneficiaries receive timely care.

Concerns Exist About Overseas Medical Screening

According to MTF commanders in Europe and the Pacific, the process for screening family members of personnel assigned overseas does not always identify individuals with extensive medical requirements. The presence of such patients overseas can potentially strain MTF resources, increase health care costs, and reduce readiness and morale.

Each military service has its own screening mechanism to ensure that family members accompanying active duty troops overseas do not have medical problems that exceed the capacity of local health care providers. However, DOD officials told us this medical screening is often inadequate and sometimes does not take place at all. Officials note that family members occasionally arrive with serious physical and psychological problems, requiring continuous follow-up from MTF specialists. In some cases in which the required care exceeds MTF capabilities, dependents might need extensive and potentially expensive local treatment, care that must be coordinated and reviewed by MTF staff. In other cases, patients might be returned to the United States for care, resulting in additional expense; strain on military families; and, in some cases, the need for active duty members to take extensive leave to manage family medical problems. According to DOD officials, readiness suffers when active duty troops are absent from duty or distracted by the problems of coordinating care for family members.

In addition, DOD officials told us that currently no requirement exists for medical screening of DOD civilian employees, contractors, or their families prior to being selected for an overseas position. According to medical personnel in Europe and the Pacific, civilian employees and family members have arrived with serious medical conditions—including chronic heart disease, spinal bifida, congenital heart deformities, and psychiatric disorders—that exceeded community health resources. Furthermore, for these beneficiaries, MTF care is on a space-available basis, and the TRICARE Management Activity notes that “many civilians have unrealistic expectations of on-base medical support.” These patients might require extensive and often costly local care or returning to the United States for treatment. Civilian employees often perform critical functions overseas, and coordinating medical care for themselves or their family members could result in financial hardship, extended leave, and other strains that could compromise their effectiveness.

DOD officials agree that overseas medical screening needs to be improved, noting that while the number of individual cases is small, these cases can create significant problems for MTFs. Officials said that a DOD committee

will review current policies regarding overseas screening for active duty family members and civilian employees in an effort to improve the process.

Beneficiaries Are Concerned About TRICARE When They Travel

Accessing health care while away from their home base has reportedly been a problem for some beneficiaries. In fact, beneficiaries we spoke with recurrently complained that they have had difficulty accessing MTF care when traveling back in the United States. Beneficiaries told us that U.S.-based MTFs have sometimes denied them access to care, referred them to civilian providers, or demanded authorization from a primary care manager at the overseas duty station.

According to TRICARE Management Activity officials, DOD beneficiaries are encouraged to obtain most of their care at their duty station's MTF. However, TRICARE program guidance states that overseas beneficiaries enrolled in TRICARE Prime should not be denied care when visiting MTFs in the United States. Overseas Prime enrollees have the same access priority at U.S. MTFs as stateside enrollees, and preauthorization from their primary care manager is not required. TRICARE Management Activity officials acknowledged that overseas beneficiaries do not always receive uniform access to MTF care when traveling in the United States. They added that DOD is planning to develop a new policy letter reinforcing access standards for all enrollees and emphasizing the commitment to provide services to overseas personnel traveling outside their home region.

Conclusions

The military health care system in Europe and the Pacific has undergone considerable downsizing during the past decade and continues to face operational challenges. Yet the system appears to have largely overcome the extensive access to care and other problems we reported in 1990 and 1995 and generally to be satisfactorily caring for beneficiaries. Nevertheless, routine and specialty care at some MTFs is still sometimes unavailable within the TRICARE access standards, resulting in care delays for some beneficiaries.

Host nation care options help MTFs meet TRICARE access standards for specialty care and allow beneficiaries to be treated nearer their duty stations and their families, reducing the stress and extra costs that can be associated with the transport of patients between MTFs. Bilingual patient liaisons play an important role in increasing local care acceptance by breaking down cultural and language barriers between local doctors and DOD patients, reassuring patients being treated locally, and otherwise

serving as a reliable link between the military health care system and local providers. Efforts to expand local care options, such as those under way in Turkey and Korea, can help improve access to specialty care and should be extended to other locations where possible.

DOD is currently reviewing aeromedical utilization and options but has not yet identified the best long-term approach for transporting overseas patients needing care not available locally. Also, DOD's current screening process does not always prevent DOD civilians, contractors, or family members of active duty personnel with complex or chronic medical requirements from being sent overseas, and some overseas beneficiaries have had difficulty obtaining health care services when traveling outside their region.

Recommendations

We recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to

- complete the analysis of aeromedical utilization and implement the best long-term approach identified for transporting overseas patients needing care not available locally;
- improve medical screening policies to help ensure that beneficiaries overseas do not have medical problems exceeding the capacity of MTFs or local health care providers;
- complete the development of policies reinforcing standards to ensure health care access for overseas beneficiaries when they travel outside their TRICARE regions; and
- continue working to expand, where possible, the use of host nation providers and provide feedback to such providers on the quality of care.

Agency Comments and Our Evaluation

We obtained comments on this report from DOD. DOD agreed with our findings and recommendations, acknowledging that while improvements have been made since our last review of overseas health care, issues requiring attention remain. DOD said, for example, that it is continuing to evaluate alternatives to the C-9 airframe to improve, streamline, and cost-effectively meet the needs of patients needing medical evacuation. Also, DOD indicated that the medical screening matter is under review and that a solution will require extensive coordination among the services and with the medical and personnel communities. DOD also stated that a new policy letter to help ensure health care access for overseas beneficiaries when

they travel across TRICARE regions is being drafted and will be issued shortly. Finally, DOD said it would work with the overseas Lead Agents to expand the use of host nation providers where possible and to implement a formal feedback mechanism for such providers.

DOD outlined its plans to address our recommendations in its comments, which appear in the appendix. DOD also provided several technical comments, which we incorporated into the report as appropriate.

We are sending copies of this report to the Honorable William S. Cohen, Secretary of Defense; appropriate congressional committees; and other interested parties. We will also make copies available to others upon request.

If you or your staff have any questions about this report, please contact me at (202) 512-7101 or Daniel M. Brier at (202) 512-6803. Jon Chasson and Linda S. Lootens also made key contributions to this report.

Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

Comments From the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

AUG 15 2000

HEALTH AFFAIRS

Mr. Stephen P. Backhus
Director, Veterans' Affairs and Military Health Care Issues
Health Education, and Human Services Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Backhus:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "Defense Health Care: Resources, Patient Access, and Challenges in Europe and the Pacific" dated August 11, 2000 (GAO Code 101632/OSD Case 2062).

DoD concurs with the GAO draft report and recommendations. Your review highlighted some exciting and positive examples of how our medical facilities and Lead Agents continue to significantly improve the TRICARE Overseas Program. While great strides have been made since your last review of overseas health care, there are remaining issues that require attention, and the Department is already taking aggressive action to address them. We are currently addressing these issues in coordination with the Services and Overseas Lead Agents. In addition, we have raised them directly to the Medical-Personnel Executive Steering Committee, a group comprised of the Service Personnel Chiefs, the Service Surgeons General, Office of the Under Secretary of Defense Personnel & Readiness (Force Management Policy) and TRICARE Management Activity.

We remain steadfast in our commitment to ensuring that our service members, their families, and others who support the overseas mission, are provided quality, accessible health care regardless of their location. The DoD appreciates the continuing interest and feedback provided by the General Accounting Office for these important quality of life issues. Our responses to your recommendations are enclosed. We will keep you apprised of our progress.

A few minor technical corrections to the report were separately provided to the GAO staff. Thank you for the opportunity to comment on the draft report.

Sincerely,

J. Jarrett Clinton, MD, MPH
Acting Assistant Secretary

Enclosure:
As Stated

GAO DRAFT REPORT DATED AUGUST 9, 2000
(GAO CODE 101632) OSD CASE 2062

"DEFENSE HEALTH CARE:
RESOURCES, PATIENT ACCESS, AND CHALLENGES IN EUROPE
AND THE PACIFIC"

DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATIONS

Now on p. 29.

RECOMMENDATION 1: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to complete the analysis of aeromedical utilization and implement the best long-term approach identified for transporting overseas patients needing care not available locally. (p. 22/GAO Draft Report)

DOD RESPONSE: Concur. In the past few months, representatives from the Air Force Surgeon General Office, Air Mobility Command, and the Pacific and European theaters, have engaged in an analysis of the Aeromedical Evacuation (AE) system to determine long term requirements, particularly in the OCONUS and strategic arena. We are evaluating alternatives to the C-9 airframe, to include exploring re-engineering initiatives for C-9 and "other than C-9" patient movement, strategic AE and Air Staging Facilities to improve, streamline and cost effectively meet the needs of our patients who are unable to receive care locally, especially in OCONUS.

Now on p. 29.

RECOMMENDATION 2: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to improve medical screening policies for overseas assignees to help ensure that such assignees do not have medical problems exceeding the capacity of local MTFs and health care providers. (p. 22/GAO Draft Report)

DOD RESPONSE: Concur with the finding. This issue (for both family members and DoD civilians) has been referred to a combined Medical/Personnel high level forum. Since responsibility for the program is shared with the personnel community, it is beyond the authority level of the ASD(HA). Hence, it will require extensive coordination between the Services, the Medical and Personnel communities. In the interim, the Navy has issued a new instruction that provides extensive and detailed guidance to the field on conducting screening for overseas, remote duty and operational assignments and enrolling in the Exceptional Family Member Program.

Now on p. 29.

RECOMMENDATION 3: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to complete the development of policies reinforcing access standards to ensure health care access for overseas beneficiaries when they travel across TRICARE regions. (p. 23/GAO Draft Report)

DOD RESPONSE: Concur. A new policy letter that emphasizes adherence to existing policy is being drafted and will be issued shortly.

Now on p. 29.

RECOMMENDATION 4: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to continue working to expand, where possible, the use of host nation providers, and to give feedback to such providers on care quality. (p. 23/ GAO Draft Report)

DOD RESPONSE: Concur. While the technical quality of the services provided overseas and the competence, training and credentials of the healthcare providers are essential elements in expansion of the TRICARE overseas networks, the overarching and paramount determination of quality is via the perception of quality from the perspective of the beneficiary. In view of the above, the feedback to the host nation providers should also include input from patients, particularly in regard to meeting the health care expectations of our beneficiaries such as patient-provider communication, a voice in health care decisions, and obtaining information about their health and treatment. We will work with the overseas Lead Agents on implementing a formal feedback mechanism to host nation providers and to expand the use of host nation providers where possible.

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