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Questionable Use Of The Domestic Aeromedical Evacuation System

Department of Defense

UNITED STATES
GENERAL ACCOUNTING OFFICE

MWD-75-45

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APRIL 21, 1975

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

MANPOWER AND WELFARE
DIVISION

B-161475

The Honorable
The Secretary of Defense

Dear Mr. Secretary:

This report describes questionable uses of DOD's domestic aeromedical evacuation system and suggests ways to reduce the costs and enhance the effectiveness of the system.

Our recommendations are included on page 16 of the report. DOD generally agreed with the recommendations and informed us of the actions taken to reduce questionable uses of the system. We emphasize, however, that DOD should periodically assess the effectiveness with which the Armed Services Medical Regulating Office carries out its expanded responsibilities and the degree to which the services are cooperating with that Office to improve regulation of patient movements.

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report today to the Chairmen, House and Senate Committees on Appropriations, Government Operations, and Armed Services, and to the Director, Office of Management and Budget.

Sincerely yours,

Gregory J. Ahart
Director

Contents

ABBREVIATIONS

ASMRO	Armed Services Medical Regulating Office
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CONUS	continental United States
DOD	Department of Defense
GAO	General Accounting Office
MAC	Military Airlift Command
375 AAWg	375th Aeromedical Airlift Wing

GENERAL ACCOUNTING OFFICE
REPORT TO THE
SECRETARY OF DEFENSE

QUESTIONABLE USE OF THE DOMESTIC AEROMEDICAL EVACUATION SYSTEM
Department of Defense

D I G E S T

WHY THE REVIEW WAS MADE

After World War II, DOD established a policy that all patients would be evacuated by airlift whenever practicable.

The aeromedical evacuation system offers continuous evacuation service throughout the world. In fiscal year 1973, DOD spent about $29 million to move about 49,000 patients in its worldwide system.

In this report GAO discusses how the domestic segment of the system has operated and opportunities to improve it.

FINDINGS AND CONCLUSIONS

Operation of the system

The system is available to Armed Forces personnel (active duty and retired) and their dependents, certain employees or beneficiaries of other Federal agencies, and others approved by the Air Force. (See p. 1.)

GAO focused on the domestic segment of the system since:

--64 percent of the aeromedical evacuation costs ($18.5 million) and 88 percent of the patients moved (43,000) were in this segment.

--Alternate sources of care and transportation are more readily available within the continental United States than overseas.

The domestic system has two primary functions--movement of patients and medical regulating.

The Air Force is responsible for actual patient transportation in the domestic system and carries this out with 12 C-9A aircraft, about 60 pilots, about 45 flight nurses, and 60 medical technicians.

The Air Force also is primarily responsible for operating aeromedical staging facilities. (See pp. 2 to 4.)

The primary purpose of medical regulating is to determine appropriate hospitals for the necessary care of patients. Only a patient's physician may determine that needed treatment is unavailable at the facility where the patient is located and determine the movement priority to be assigned to the patient.

These determinations are

subject to approval by the chief of the medical department at the facility where the patient is hospitalized. (See p. 4.)

Medical-regulating activities of the individual services or the Armed Services Medical Regulating Office currently determine where patients are to be moved within the continental United States.

The Regulating Office, a triservice agency, is responsible for regulating or monitoring the transfer of patients to medical treatment facilities capable of providing the necessary medical care.

The services generally perform their own regulating activities for patients transferred on an intraservice, intraregional basis. Before October 1973 each service had designated its own medical service regions.

Effective October 1, 1973, DOD established the Armed Forces Regional Health Services System (regionalization) to collectively organize and manage a health care delivery system on a triservice basis.

Within the continental United States, DOD has designated 13 medical regions on the basis of military population and location of specialty treatment facilities. The Regulating Office's patient-regulating responsibilities are expected to expand under regionalization. (See pp. 4 to 5.)

Questionable uses of the system

About 97 percent of the 43,000 patients transferred in the domestic system in fiscal year 1973 were classified by the Air Force Military Airlift Command as "routine," 2 percent were classified as "priority," and only 1 percent was classified as "urgent."

To determine how and by whom the system was being used, GAO sent questionnaires to attending physicians of patients transferred in the system and hospitalized on specified days in early 1974 at six major military medical facilities.

The questionnaire was used to determine the reasons for each patient's transfer, his requirements for in-flight medical treatment or supervision, and whether his condition precluded his being transported by alternate means. GAO received responses on 214 patients--170 active duty members and 44 retirees and military dependents. (See pp. 5 and 6.)

On the basis of the responses and other information, it appears that the need for the system as it currently operates is questionable.

Of the 214 patients, 171, or

80 percent, could have received needed care at or near their originating military facilities or at military facilities closer than those to which they were transferred.

GAO found that:

--44 patients who could have received care in local civilian hospitals under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) were transferred in the system.

  Dependents of active duty members, retirees and their dependents, and dependents of deceased military members may receive medical care either in the military medical system or by entering a civilian medical facility under CHAMPUS. (See pp. 1 and 7.)

--37 active duty patients were transferred from military medical facilities which, according to the Regulating Office's records, had the needed medical specialties available at the time required. (See p. 8.)

--90 active duty patients were transferred to other than the closest military medical facility capable of providing the required care. (See p. 9.)

The questionnaire responses also showed that transportation by means other than the aeromedical evacuation system appeared appropriate for about half the 214 patients. (See p. 11.)

The system and, in particular, the problems of transferring patients excessive distances ("overflights") were discussed in DOD's May 1974 testimony before two congressional subcommittees.

Several subcommitee members expressed concern regarding overflights which appeared to have resulted from the individual services' attempts to provide medical services to their own members.

GAO also noted that interservice transfers have been minimal--apparently because of the health care policies of the individual services to care for their own members.

In this regard, some transfers of patients have been initiated on a physician-to-physician basis; that is, by a physician at an originating military facility arranging directly with a specific physician at another military facility for the hospitalization and treatment of a patient. (See p. 8.)

DOD officials said that inefficient use of the system would be greatly reduced by the issuance of a new DOD patient-regulating directive under which the Regulating

Office would centrally control all military inpatient movements from overseas to and within the continental United States. It was not intended, however, that the Regulating Office's patient-regulating authority would preclude continuance of traditional military medical practices, such as physician-to-physician referrals. (See p. 12.)

Safe and speedy transportation of sick or injured military personnel is essential. However, DOD's continued operation of the domestic aeromedical evacuation system as it now exists is questionable in view of many of the system's current uses and DOD's efforts to streamline its medical care delivery system through the regionalization program.

DOD should reassess the entire domestic aeromedical evacuation system to determine whether a modified system could more effectively and efficiently meet the system's objectives.

Emergencies--both medical and humanitarian--will continue to require evacuation by airlift on specially equipped and staffed aircraft. However, DOD could modify the present system and still effectively provide for these situations. (See p. 15.)

RECOMMENDATIONS

GAO recommends that the Secretary of DOD:

--Insure that the Armed Services Medical Regulating Office, as part of its expanded patient-regulating responsibilities (1) promote greatly increased use of interservice patient transfers and (2) limit long-distance transfers initiated by physician-to-physician referrals to necessary instances.

--Initiate a departmental reassessment of the domestic aeromedical evacuation system with a view toward modifying it to coincide with the objectives of the recently established regionalization program. (See p. 16.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

DOD generally agreed with GAO's recommendations and stated that its revised procedures should improve the system. One change--expansion of the regulating responsibilities assigned to the Armed Services Medical Regulating Office--was fully implemented on January 27, 1975.

In addition, DOD has begun an evaluation of the requirements and capabilities of the entire aeromedical evacuation system--domestic and overseas--during mobilization and contingency operations. (See pp. 16 to 17.)

CHAPTER 1

INTRODUCTION

Aeromedical evacuation is the airlift of patients under medical supervision to, between, and from medical treatment facilities. Since World War II, the Department of Defense (DOD) has extensively used aeromedical evacuation to provide safe and speedy air transportation to the sick and injured. In 1947 DOD established a policy that all patients would be evacuated by airlift whenever practicable.

In July 1972 DOD promulgated a regulation containing its current policies and procedures for transporting patients. The regulation provides that a patient is eligible for aeromedical evacuation when (1) his or her needs are recognized by a physician, (2) treatment is unavailable locally, and (3) transportation is required to obtain prescribed medical care. Aeromedical airlift is available to U.S. Armed Forces personnel (active duty and retired) and their dependents;1/ beneficiaries of the U.S. Public Health Service and the Veterans Administration; employees of the U.S. Government who are stationed overseas; and civilians, when approved by the Air Force Director of Transportation, in emergencies involving immediate threat to life or limb.

The DOD regulation also establishes the following movement priorities:

--Routine--patients who should be airlifted on regularly scheduled flights within 72 hours after being reported as needing aeromedical transportation.

--Priority--patients who require prompt medical care and who must be airlifted within 24 hours and delivered with the least possible delay.

1/Military retirees and their dependents and dependents of deceased military members may receive medical care either in the military medical system or by entering a civilian medical facility under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Dependents of active duty military members may also receive care under CHAMPUS. Generally these dependents must obtain a certificate stating that needed care is unavailable in a local military facility. CHAMPUS medical service costs are shared by the Government and the beneficiary.

--Urgent--patients who must be airlifted immediately to save life or limb or to prevent complications of a serious illness.

PRIMARY FUNCTIONS OF THE AEROMEDICAL EVACUATION SYSTEM

The system has two primary functions--actual patient movement and medical regulating. These functions are described briefly below.

Patient movement

Patient movement covers two principal activities--actually transporting patients and operating aeromedical staging facilities. The transportation activity is assigned to the Air Force. Four major Air Force commands have specific aeromedical evacuation missions, each of which operates independently:

--The Military Airlift Command (MAC), Scott Air Force Base, Illinois, is responsible for all patient movements within the continental United States (CONUS), airlifts of patients transferred from overseas to CONUS, and airlifts within overseas areas as requested by the overseas commanders.

--The U.S. Air Forces in Europe is responsible for patient movements within the European theater.

--The Pacific Air Force is responsible for patient movements within the Pacific theater.

--The Tactical Air Command, a tactical unit located at Pope Air Force Base, North Carolina, does not normally participate in patient flights but, rather, trains with Army units in support of contingency plans involving the U.S. Air Forces in Europe and the U.S. Readiness Command.

Both the Air Force and the Army are responsible for operating aeromedical staging facilities, which are medical units that provide reception, administration, processing, food, and medical services for patients entering, en route in, or leaving the system.

In fiscal year 1973, DOD spent about $29 million to move about 49,000 patients in its worldwide aeromedical evacuation system. For evaluation purposes, the system may be divided into domestic and overseas segments. Our evaluation focused on the domestic (within CONUS) segment

because (1) 64 percent of the aeromedical evacuation costs and 88 percent of the patients moved were in this segment and, more importantly, (2) alternate sources of care and means of transportation are more readily available within CONUS than overseas. The scope of our evaluation is discussed more fully in chapter 4.

Domestic aeromedical evacuation

The domestic aeromedical airlift system was created in 1948. The original unit was stationed at Brooks Field, Texas, and was responsible for all domestic medical airlifts. Through the years, growing medical airlift needs dictated expansion of the system. In 1964 the system's headquarters was moved to Scott Air Force Base.

The 375th Aeromedical Airlift Wing (375 AAWg) of MAC, located at Scott Air Force Base, is currently responsible for domestic aeromedical airlifts, which include near offshore flights to Laborador, Cuba, Bermuda, and Puerto Rico. The 375 AAWg provides flight crews (from a group of about 60 pilots) to operate the aircraft and medical crews (from a group of about 45 flight nurses and 60 medical technicians) to provide medical care in flight and during in-transit ground operations.

The 375 AAWg has 12 C-9A aircraft assigned to the aeromedical evacuation mission. The C-9A, called the "Nightingale," is a military version of the commercial DC-9 aircraft and was purchased from the McDonnell-Douglas Aircraft Corporation at a cost of about $3.8 million. The aircraft is characterized as a flying hospital ward capable of carrying a maximum of 43 patients and having several possible configurations of litter and seat spaces.

During fiscal year 1973, about 43,000 patients were airlifted in the domestic aeromedical evacuation system at a cost of about $18.5 million. Because aeromedical evacuation is an Air Force mission, military departments using the system are not charged. However, other Government agencies are billed for services and/or transportation provided. About 95 percent of the 43,000 patients transported in the system during fiscal year 1973 were either (1) active duty military members; (2) military retirees; or (3) dependents of active duty, retired, or deceased military members. Transportation was provided for the remaining 5 percent of the patients on a reimbursable basis.

The 375 AAWg performs aeromedical airlift missions throughout the country. The individual itineraries (en route stops) that constitute each scheduled mission are made up daily on the

basis of actual patient airlift requirements. Military and civilian airfields are used to serve about 650 Government-operated medical facilities.

Several missions depart daily from Scott Air Force Base, follow predetermined routes to pick up or deliver patients, and arrive at final destinations of one of six aeromedical staging facilities at Andrews Air Force Base, Maryland; Maxwell Air Force Base, Alabama; Kelly Air Force Base, Texas; Buckley Air National Guard Base, Colorado; Travis Air Force Base, California; and Scott Air Force Base. Missions also return to Scott Air Force Base--either on the same day or the following day--from one of the other staging facilities, again using a predetermined route for patient pickup and delivery.

Medical regulating

The primary function of medical regulating is to determine the appropriate hospital for the necessary care and treatment of each patient; it does not include actually moving the patient.

If a patient's physician determines that needed medical treatment is unavailable at the military medical facility where the patient is located, the patient is eligible for aeromedical evacuation to another military facility where the prescribed treatment may be obtained. The physician also determines the movement priority assigned to the patient. These determinations are subject to approval by the chief of the medical department at the facility where the individual is a patient.

Determinations as to where patients are to be moved within CONUS are made either by the individual services or the Armed Services Medical Regulating Office (ASMRO)--a joint agency of the Army, Navy, and Air Force established by DOD charter. ASMRO is responsible for regulating or monitoring the transfer of patients to medical treatment facilities capable of providing the necessary medical care. This responsibility includes providing for efficient and economical use of military treatment facilities, particularly in terms of patient welfare and the best use of available beds.

Generally, the services perform their own regulating activities for transferring patients on an intraservice, intraregional basis. The services must submit a monthly information report to ASMRO on their patient transfer activities during the preceding month.

ASMRO's responsibilities for patient regulating recently expanded under the Armed Forces Regional Health Services System (regionalization), which DOD initiated in October 1973. Before that time, each service had designated its own medical service regions. Regionalization is a means of collectively organizing and managing a system of health care delivery in specified geographic areas to increase productivity and achieve economy without unnecessary duplication of resources. Under regionalization, CONUS is divided into 13 medical regions on the basis of military population and location of specialty treatment facilities. Each region has a triservice regional review committee to monitor health service programs.

The expansion of ASMRO's patient-regulating responsibilities under regionalization became operative on January 27, 1975, after DOD's approval of a revised ASMRO charter on November 26, 1974, and the services' issuance of an implementing instruction about 60 days thereafter.

ASMRO now centrally controls or monitors all patient movements within CONUS. The individual services' regulating offices have been replaced by a coordinator in each military medical facility, who contacts ASMRO on an "as needed" basis to report on patient transfer needs and bed availability.

CHAPTER 2

PROBLEMS INVOLVED IN USING THE DOMESTIC AEROMEDICAL EVACUATION SYSTEM

The domestic system transported about 43,000 patients during fiscal year 1973 at a cost of about $18.5 million. About 27,000 of these were active duty military members and about 13,000 were military retirees or dependents of active duty, retired, or deceased military members. The remaining patients were employees or beneficiaries of other Federal agencies or others authorized to use the system.

During fiscal year 1973, about 97 percent of the patients transferred in the domestic system were classified under the patient movement priority system as "routine," 2 percent were classified as "priority," and only 1 percent was classified as "urgent." Similarly, of the approximately 2,600 domestic aeromedical evacuation missions carried out by MAC, 91 percent were classified as "routine" in that they carried only routine patient transfers. According to MAC's classification, the remaining 9 percent were "urgent" or "priority."

To determine how and by whom the domestic system was being used, we sent questionnaires to the attending physicians of patients transferred in the system and hospitalized on specified days in early 1974 at six major military medical facilities--three on the east coast and three on the west coast. The questionnaire was developed to determine the reasons for each patient's transfer, his requirements for in-flight medical treatment or supervision, and whether his condition precluded his being transferred by alternate means. (See app. II.) We sent questionnaires to physicians at destination hospitals to enable them to base their responses on their review of the patients' medical records which accompanied the patients to the hospitals and, if necessary, on discussions with the patients themselves. Responses were received on 214 patients for whom we requested data--170 active duty members and 44 retirees and military dependents.

On the basis of the questionnaire responses and other information, it appears that the need for the system as it currently operates is questionable in that 171, or 80 percent, of the 214 patients could have received needed care at or near their originating military facilities or at military facilities closer than those to which they were transferred. In this regard:

--44 patients eligible for CHAMPUS who could have received needed care in local civilian hospitals near the originating military facilities were transferred in the system.

--37 active duty patients were transferred from military medical facilities which, according to ASMRO's records, had the needed medical specialties at the time required.

--90 active duty patients were transferred to other than the closest appropriate military medical facility to receive needed care.

The questionnaire responses also showed that transportation by means other than the aeromedical evacuation system appeared to be appropriate for about half the 214 patients transferred.

TRANSPORTATION OF PATIENTS ELIGIBLE FOR CHAMPUS

Air Force statistics showed that, during fiscal year 1973, about 13,000, or 30 percent, of the 43,000 patients transported in the domestic aeromedical evacuation system were military retirees or dependents of active duty, retired, or deceased military members. These patients were eligible for medical care in military hospitals at little or no cost, subject to the availability of facilities and the capabilities of the hospitals' medical and dental staffs. However, these patients were also eligible for care at local civilian medical facilities under CHAMPUS if those facilities had the medical capabilities for proper treatment. CHAMPUS medical service costs are shared by the Government and the beneficiary.

Forty-four of the 214 patients for whom we received data were patients who, although transferred from one military hospital to another by aeromedical evacuation, were eligible for CHAMPUS. To get an indication of the extent to which aeromedical evacuation of these 44 patients was necessary, we contacted administrators or their representatives in civilian hospitals in the localities of the military hospitals from which the patients were transferred and asked if the civilian facilities had the capabilities to treat the patients when they entered the destination military hospitals. The results showed that all 44 patients could have obtained the necessary care at the required time in a civilian medical facility near the military medical facility from which they were transferred.

Since all the patients eligible for CHAMPUS included in our review could have received needed care at civilian hospitals near the originating military facilities, it seems reasonable

that many, if not all, patients eligible for CHAMPUS could receive similar care in lieu of being transferred by military aeromedical evacuation.

TRANSPORTATION OF PATIENTS WHEN MEDICAL SPECIALTIES WERE AVAILABLE AT ORIGINATING MILITARY MEDICAL FACILITIES

We compared the particular medical specialty requirements for the 170 active duty patients with ASMRO's data regarding specialty and bed availability at the hospital from which each patient was transferred. According to ASMRO's information, which is updated on an "as needed" basis using information from military hospitals, 37 of the 170 active duty patients were transferred from military medical facilities which had the required specialties when needed.

At the time of these transfers, ASMRO shared patient-regulating responsibilities with the individual services and, therefore, participated in the regulation of 30 of the 37 patients. ASMRO could give us no records concerning the transfers of 10 of the 30 patients. The remaining 20 transfers were generally regulated in accordance with the medical practices of the individual services to care for their own members. In this regard, 10 of the 20 patients were transferred on a physician-to-physician basis; that is, by a physician at an originating military facility arranging directly with a specific physician at another military facility for hospitalizing and treating a patient. ASMRO merely approved each referral.

Among the reasons for the transfers of these 37 patients cited by the physicians answering our questionnaire were:

--Patients' personal requests for transfers.

--Patients' needs for medical evaluations of their fitness for continued military duty.

Most of the patients who needed medical evaluations were transferred to a facility of their own service from that of another service to obtain the evaluations. We found no DOD or individual service regulation which requires that medical evaluations be made exclusively by a member's own service. However, we were informed that this has been a longstanding practice because (1) each service has its own physical standards and (2) such evaluations are facilitated from an administrative standpoint when each service makes its own evaluations.

There appears to be little reason to transfer patients from facilities which can provide the needed specialty care. It further seems that the accessibility of the domestic aeromedical evacuation system contributed to the transfers of many, if not all, of these patients. Closer control by the services or by ASMRO might have precluded such transfers.

TRANSPORTATION OF PATIENTS TO OTHER THAN THE CLOSEST APPROPRIATE MILITARY MEDICAL FACILITY

Because 37 active duty patients needed medical specialties available at their originating military hospitals, we compared the questionnaire responses on the remaining 133 active duty patients with ASMRO's specialty availability records to see if these patients could have received required treatment at medical facilities closer to their originating hospitals. We noted that 90, or about 68 percent, of the 133 patients could have received needed treatment at closer military medical facilities.

Further analysis of the 90 cases showed that, in many instances, the excessive distances involved in the transfers were significant, as indicated in the following table.

Excessive distances involved in transfers (note a)	Destination Military Medical Facilities						
	Bethesda	Oakland	Walter Reed	Letterman	Andrews	Travis	Total
	(Number of transfers)						
Less than 100 miles	1	1	4	2	1	2	11
100 to 199 miles	6	-	8	-	2	2	18
200 to 299 miles	7	-	1	-	-	1	9
300 to 399 miles	6	-	7	1	1	7	22
400 to 499 miles	3	1	10	-	-	1	15
500 to 1000 miles	2	-	3	1	-	1	7
Over 1000 miles	-	4	-	2	1	1	8
Total	25	6	33	6	5	15	90

a/The excessive distances were calculated by deducting the transfer distance to a closer appropriate military medical facility from the actual transfer distance.

To insure that, in all the preceding cases, the patients could have received appropriate care at closer military facilities, we verified specialty and bed availability on a case-by-case basis with ASMRO.

As shown in the following table, most of the transfers which involved excessive distances also involved movement of the patients from one hospital to another within the same service.

	Transfers To			
Patients	Army hospitals	Navy hospitals	Air Force hospitals	Total
Army	39	-	-	39
Navy	-	29	-	29
Air Force	-	2	20	22
Total	39	31	20	90

Further analysis of this aspect of the patient transfers showed that:

--Of the 39 Army patients transferred to Army hospitals, 8 could have received the required care in closer Army facilities, 17 in closer Air Force facilities, and 14 in closer Navy facilities.

--Of the 29 Navy patients transferred to Navy hospitals, 13 could have received the required care in closer Navy facilities, 8 in closer Army facilities, and 8 in closer Air Force facilities.

--Of the 20 Air Force patients transferred to Air Force hospitals, 4 could have received the required care in closer Air Force facilities, 10 in closer Army facilities, and 6 in closer Navy facilities.

ASMRO shared patient-regulating responsibilities with the individual services and participated in regulating half the 90 patients who could have gone to closer facilities for appropriate care. ASMRO had no records on 15 of the 45 transfers it regulated. An additional 20 transfers regulated by ASMRO were due to requests by the originating hospitals for the assignment of specific destination hospitals or were arranged on a physician-to-physician basis. ASMRO merely approved both of these types of transfers rather than assigning destination hospitals on its own. ASMRO regulated the remaining 10 patients in general accordance with the medical practices of the individual services to care for their own members.

The problems of transferring patients excessive distances in the aeromedical evacuation system have been of concern to two subcommittees of the House Committee on Appropriations. As a result of an April 1974 report by the Committee's Surveys and Investigations staff, several subcommittee members expressed concern regarding "overflights" in the aeromedical evacuation system--particularly those which appear to have resulted from the parochialism of the individual services. They also questioned DOD officials about their plans to reduce the number of such overflights.

The May 1974 testimony of DOD officials showed that DOD had become increasingly concerned over reports of overflights and the scope of the problem insofar as inefficient use of resources might be involved. DOD stated also, however, that its regionalization program would directly address the question of patient regulating by the September 1, 1974, expansion of ASMRO's patient-regulating responsibilities to include centralized control--on a triservice basis--of all patient movements both within CONUS and from overseas to CONUS. The full expansion of ASMRO's patient-regulating responsibilities became operative on January 27, 1975.

POTENTIAL USE OF ALTERNATE MEANS OF TRANSPORTATION

The physicians of the 214 patients we surveyed responded that (1) 47 percent of the patients were physically able to have traveled by alternate means and (2) an additional 11 percent required neither in-flight medical care nor supervision.

Patients en route do not necessarily reach their destination facility the same day they leave the originating facility. Often patients spend one or more nights in one of the six established CONUS aeromedical staging facilities awaiting further aeromedical airlift.

In July 1973 we interviewed five patients being transferred in the domestic system at the Andrews Air Force Base aeromedical staging facility. They had spent from one to five nights in various staging facilities en route to their destination hospitals. Each thought his condition was such that he could have taken either another scheduled military flight or a commercial carrier to his destination hospital and arrived there quicker than by the aeromedical evacuation system. The following table summarizes the transfers of the five patients and shows that, even though some of the trips were short, the patients spent at least one night in one of the system's aeromedical staging facilities.

Staging Facilities

Origination	Destination	Location	Nights spent	Required in-flight medical care?
Naval Hospital Newport, R.I.	Naval Hospital Philadelphia, Pa.	Andrews Air Force Base	1	Yes--prescription medication
Naval Hospital Chelsea, Mass.	Naval Hospital Philadelphia, Pa.	Andrews Air Force Base	1	No
Fitzsimons General Hospital Denver, Colo.	Veterans Administration Hospital Richmond, Va.	Andrews Air Force Base	5	No
Naval Hospital Great Lakes, Ill.	Naval Hospital Newport, R.I.	Scott Air Force Base	1	No
		Andrews Air Force Base	2	
Naval Hospital Great Lakes, Ill.	Boston, Mass.	Scott Air Force Base	1	No
		Andrews Air Force Base	2	

It appears that many of the patients being transferred in the aeromedical evacuation system could be appropriately transferred by alternate means--such as other regularly scheduled military flights or commercial carriers--and often more promptly.

CENTRALIZATION OF PATIENT-REGULATING RESPONSIBILITY UNDER DOD'S REGIONALIZATION PROGRAM

As previously stated, DOD officials, in testimony before subcommittees of the House Appropriations Committee, said that the problems of inefficient use of aeromedical evacuation system resources--particularly overflights--would be greatly reduced when a new DOD patient-regulating directive was issued.1/ Under this directive, ASMRO was to control all inpatient regulating, both from overseas to CONUS and within CONUS for all categories of beneficiaries. DOD stated that:

1/As indicated on p. 5, the DOD directive became operative on January 27, 1975.

"* * * patients will be regulated--unless otherwise directed--to the nearest uniformed services medical treatment facility which is capable of providing the required care. Members being evacuated from overseas and those not expected to return to duty will be regulated to uniformed services medical treatment facilities nearest their home which are capable of providing the required care. We recognize that exceptions occur which deal with humanitarian aspects of long-term hospitalization or cases of significant clinical interest which may warrant transfer to a teaching hospital. Other service regulations provide guidance for the selection of sources of care when required care is not available in the local military facility. * * * While the control of inpatient movements will be provided by ASMRO, the management of outpatient referrals is at the discretion of the local medical facility commander utilizing guidance based upon professional considerations and travel economy. Options available to the local commander--in order of precedence--include other uniformed services facilities, facilities of other Federal agencies, and then, civilian sources of care."

In its September 1973 plan for establishing the regionalization program, DOD:

--Commented on the expanded patient-regulating responsibilities of ASMRO under the program and stated that transfers of urgent or priority patients would continue to be arranged directly between hospitals, with prompt after-the-fact notification to ASMRO.

--Stated that central regulating authority would not preclude physician-to-physician referrals when warranted, replace local transfer agreements that had evolved between medical facilities, or inhibit direct support of advanced graduate medical education and clinical research programs.

--Said that, in such cases, prompt after-the-fact notification to ASMRO would be required so that the current bed availability at the receiving hospitals could be known.

Under the January 1975 instruction implementing ASMRO's expanded patient-regulating responsibilities, justifications of physician-to-physician referrals are to be provided to ASMRO before the actual transfers.

Since 1955 DOD has had a regulation providing for interservice transfers of active duty patients. In practice, however, interservice transfers in the aeromedical evacuation system have been minimal--apparently because DOD's policy on such transfers has been largely overridden by the health care policies of the individual Surgeons General.

Unless DOD, as part of its recent expansion of the patient-regulating program, insures that increased interservice patient transfers are promoted and that ASMRO closely monitors physician-to-physician referrals, problems such as these may continue in the domestic aeromedical evacuation system.

CHAPTER 3

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Safe and speedy transportation of sick or injured military personnel is essential. However, DOD's continued operation of the domestic aeromedical evacuation system as it now exists appears questionable in view of DOD's concentrated efforts to streamline its medical care delivery system through the regionalization program.

It appears the domestic aeromedical evacuation system is used as we noted because the system is continually accessible to military hospitals throughout the country and because there is little incentive for individual hospitals to limit their use of it to justifiable instances. The uses noted--particularly when they are considered collectively--raise a question as to whether the system is being used primarily for convenience or for legitimate requirements for long-distance patient transfers.

DOD should reassess the entire system to see if a modified system directed at eliminating those uses which appear to be for convenience could effectively and more efficiently meet the system's objectives. Such a reassessment should consider such factors as:

--The recent DOD efforts to achieve an effective regionalized approach to health care delivery.

--The expansion of ASMRO's patient-regulating responsibilities with an increase in scope and stringency of centralized control over patient regulating.

--The potential use of alternate means of transportation, such as other regularly scheduled military flights; commercial carriers; or, in some cases, ground transportation for those patients who must be transferred but who require little, if any, in-transit medical attention.

Emergencies--both medical and humanitarian--will continue to require evacuation by airlift. However, DOD could effectively provide for these situations without the continued operation of the present domestic aeromedical evacuation system. The modifications of the system--if accomplished in concert with factors such as those discussed above--could result in major cost savings to DOD without a corresponding decline in the effectiveness with which health care is delivered to the military's constituency.

RECOMMENDATIONS TO THE SECRETARY OF DOD

We recommend that you insure that ASMRO, with the recent expansion of its patient-regulating responsibilities (1) promote increased use of interservice patient transfers and (2) limit long-distance transfers initiated by physician-to-physician referrals to those instances which are necessary in view of medical or humanitarian considerations. We further recommend that you initiate a departmental reassessment of the domestic aeromedical evacuation system with a view toward modifying it to coincide with the objectives of the recently established regionalization program.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on our report (see app. I), DOD generally agreed with our conclusions and recommendations and stated that the expansion of ASMRO's patient-regulating responsibilities--which became fully operative on January 27, 1975--should correct the discrepancies noted in the report.

DOD anticipates that the expansion of ASMRO's responsibilities will insure adequate support of patient flow within DOD's regionalization program and increase cross-service use of limited resources. Also, according to DOD, all patient movements--including physician-to-physician referrals--will be closely monitored by a newly initiated monthly reporting system that will give the management the visibility necessary to insure compliance with required procedures. We believe the actions taken by DOD, if effectively implemented by ASMRO and the services and monitored by DOD, will result in fewer questionable uses of the domestic aeromedical evacuation system.

DOD also said it believes that, because of congressional concern over the rapidly rising costs of CHAMPUS at a time when military facilities are being underutilized, the availability of nearby civilian facilities, while it should be a consideration, cannot be the overriding determinant in considering whether or not to use the aeromedical evacuation system as part of its care for CHAMPUS-eligible beneficiaries. We believe that, in those cases where it is determined that a CHAMPUS-eligible patient must be treated at a military facility, careful consideration should be given to whether the patient could be transported by means other than aeromedical evacuation.

Further, a DOD Health Personnel Task Force has begun a study to evaluate the system's requirements and capability for aeromedical evacuation during mobilization and contingency operations. We believe that, in addition, DOD should periodically

assess the effectiveness with which ASMRO carries out its expanded responsibilities and the degree to which the services are cooperating with ASMRO to improve regulation of patient movements. Minimizing questionable uses of the system should enhance the effectiveness and reduce the cost of operating the system during peacetime and form a sound basis for its expansion in the event that mobilization and contingency operations occur.

CHAPTER 4

SCOPE OF REVIEW

Our review of the domestic aeromedical evacuation system included an examination of pertinent congressional hearings as well as DOD and military departments' directives, regulations, and manuals which explain airlift operations and contain pertinent policies and procedures. We obtained statistics and documents on patient loads, categories of patients moved, and cost of the system. We also accompanied patients on four aeromedical evacuation missions to observe in-flight operations and patient loads.

We sent questionnaires (see app. II) to the attending physicians of 369 patients transported within CONUS via the aeromedical evacuation system and hospitalized on specified days in January and February 1974 at 6 major military medical treatment facilities. The sample was not designed to be statistically valid but included three facilities on the west coast and three on the east coast. We received responses concerning 214 patients--170 active duty members and 44 military dependents and retirees. Appendix III lists the number of questionnaires distributed to and returned from each facility.

We discussed specific matters relating to the use of the aeromedical evacuation system with officials of DOD, the individual services, and ASMRO.

APPENDIX I

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AND
ENVIRONMENT

21 FEB 1975

Mr. Gregory J. Ahart
Director
Manpower and Welfare Division
General Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

On behalf of the Secretary of Defense, we have considered the findings, conclusions and recommendations contained in the GAO Draft Report, "Questionable Use of the Domestic Aeromedical Evacuation System." (OSD Case #3955)

The domestic aeromedical evacuation system provided by the Air Force serves as an integral part of total patient care within the Department of Defense. A curtailment of the system might result in cost savings but not without detrimental effects upon the health care provided military beneficiaries. Some abuses of the type cited in the draft GAO report have occurred, however, and the system has been modified to insure adequate support of patient flow within the tri-service regional program and to realize increased cross-service utilization of limited resources.

Recently revised procedures should correct the system discrepancies noted in the Report. Expansion of regulating responsibilities assigned to the Armed Services Medical Regulating Office (ASMRO) under a revised Charter (DoD Directive 5154.6) were implemented fully on January 27, 1975. These responsibilities include the requirement to regulate patients to the nearest facility possessing the appropriate specialty capability. This will further complement the effective and efficient use of regionalized health care delivery. Further, it is designed to eliminate overflight movements where valid medical, administrative and humanitarian reasons do not exist. All patient movements, including physician-to-physician referrals, will be monitored closely by a newly initiated monthly reporting system that will provide the management visibility required to insure compliance with required procedures.

Program costs of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which have been escalating at a rapid rate for a number of years, have been a source of major concern to the House Committee on Appropriations. This Committee believes the CHAMPUS is being overutilized at a time when underutilization of military facilities is taking place. It is their opinion that savings may be realized if

APPENDIX I

DoD medical beneficiaries are provided maximum amounts of health services from military facilities before being authorized use of the CHAMPUS. We believe it is necessary to make every effort to comply with the Committee's desires in this regard even though it will have an impact on utilization of the aeromedical evacuation system. Thus, the availability of nearby civilian facilities in the case of CHAMPUS eligibles, while it should be a consideration, cannot be the overriding determinant.

Results of the changes now being made should be observed for a reasonable period to determine whether the desired effects are being achieved before further alterations are made. Concurrent with this observation, however, a DoD Health Personnel Task Force has embarked upon an aeromedical evacuation study. Each of the five subsystems (forward, tactical, intratheater, strategic, and domestic) will be studied and modeled. The overall objective is to evaluate the requirements and capability for aeromedical evacuation during mobilization and contingency operations - the single most important criterion in evaluating the utility of the domestic aeromedical evacuation system.

We appreciate the helpful comments provided during the course of the study and in this Report.

Sincerely,

Vernon McKenzie
Principal Deputy Assistant Secretary

APPENDIX II

PHYSICIAN QUESTIONNAIRE

Patient's Name _____

Diagnosis _____

1. What medical specialty is required for treating the patient?

2. What will be the disposition category of the patient (active duty member)?
   (a) discharged for duty _____
   (b) discharged through action by Physical Evaluation Board and Medical Evaluation Board _____
   (c) other (please specify) _____

3. Why was the patient transferred from his original hospital?
   (a) cannot determine from information provided by the originating hospital _____
   (b) medical specialty not available _____
   (c) medical specialty available, but capability temporarily lacking _____
   (d) patient's request _____
   (e) other (please explain) _____

4. Why was the patient transferred to your particular facility?
   (a) cannot determine from information provided by the originating hospital _____
   (b) closest medical specialty available _____
   (c) close to patient's home _____
   (d) patient's personal preference _____
   (e) other (please explain) _____

5. Did the patient require in-flight medical care?

   Yes _____ No _____ Don't Know _____

6. Did the patient require in-flight medical supervision or observation?
   Yes _____ No _____ Don't Know _____

7. Based on your review of the patient, in your opinion, could he have traveled by other than the aerovac system?

   Yes _____ No _____

DISTRIBUTION AND RECEIPT OF QUESTIONNAIRES

Medical facility	Questionnaires sent	Questionnaires received	Percent responding
Letterman Army Medical Center, San Francisco, Calif.	18	13	72
Naval Regional Medical Center, Oakland, Calif.	25	21	84
U.S. Air Force Medical Center, Travis Air Force Base, Calif.	28	26	93
Walter Reed Army Medical Center, Washington, D.C.	205	78	38
National Naval Medical Center, Bethesda, Md.	72	55	76
U.S. Air Force Medical Center, Andrews Air Force Base, Md.	21	21	100
Total	369	214	58

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