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Report to Sen. Daniel K. Inouye; by Elmer B. Staats, Comptroller General.

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In Hawaii, three Federal agencies -- the Department of Defense (DOD) through its military services, the Veterans Administration (VA), and the Public Health Service -- provide health care to a beneficiary population of about 230,000 people. Because of location and size, a unique opportunity exists in Hawaii to assure that Federal health care is delivered more economically without sacrificing the quality of care. Findings/Conclusions: The DOD Mid-Pacific Review Committee has not systematically assessed the use of medical and dental facilities in Hawaii, but an interservice assessment of the beneficiary population residing around the various military clinics showed that a more equitable distribution of workload is possible at considerable savings to the Government. The DOD Mid-Pacific Review Committee needs specific guidance concerning how to assess the need for increasing or decreasing health care services in particular areas of the State and whether to include the resources of other Federal and non-Federal agencies in such assessments. The Committee does not have a clear mechanism to resolve differences of opinion and program emphasis among the services, and it has not received feedback from DOD headquarters when it has presented interservice opporation proposals for specific health care areas. Of major consequence is the opportunity afforded the Government by the planned renovation and construction project involving Tripler Army Medical Center on Oahu. Recommendations: The Secretary of Defense should: make sure that the DOD Health Council provides the direction, guidance, and feedback needed by the Mid-Pacific Review Committee and directs that Committee to seek VA and Public Health Service representation; establish interagency agreements with VA and the Department of Health, Education, and Welfare to

provide dental care in military facilities when this would be advantageous; and make sure that the Army keeps other Federal health care providers and State officials informed of its planning for the Tripler renovation and gives full consideration to their concerns. (RRS)

REPORT BY THE

Comptroller General

OF THE UNITED STATES

Better Coordination Could Improve The Provision Of Federal Health Care in Hawaii

Three Federal agencies--the Department of Defense; Veterans Administration; and Department of Health, Education, and Welfare's Public Health Service--provide health care to about 230,000 Federal beneficiaries in Hawaii. Although Federal health care generally is readily accessible to those eligible for such care, better use could be made of Federal health care facilities in the State.

The planned major renovation and construction project at Tripler Army Medical Center offers a unique opportunity for the Government to design a facility that will more closely meet the health care needs of all Federal beneficiaries in Hawaii.

HRD-78-99
MAY 22, 1978

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-133142

The Honorable Daniel K. Inouye
United States Senate

Dear Senator Inouye:

This report is in response to your February 21, 1977, request that we determine the extent to which Federal health care is available and accessible to citizens of Hawaii who are eligible for care in Federal health facilities. Information on the status of Department of Defense plans for the renovation of the Tripler Army Medical Center on the island of Oahu is also included.

Our review showed a need for better coordination among the military services and other Federal agencies in Hawaii to insure that better use is made of existing Federal health care facilities in the State. In addition, we believe that the Army, in its planning for the Tripler renovation, needs to (1) keep other Federal health care providers and State officials fully informed and (2) give full consideration to their concerns so that, when completed, Tripler will be more capable of serving as the State's only Federal hospital and as a useful partner in the State's health care community.

As a result of our review, the Administrator of Veterans Affairs, in December 1977, requested the Secretary of Defense to include in the plans for the renovation of Tripler, the capacity to make available 20 psychiatric beds for Veterans Administration patients on a daily basis. The Department of Defense responded that those requirements will be presented to the Congress in the military construction proposal for Tripler.

As arranged with your office, we are sending copies of this report to the Secretary of Defense; the Secretary of Health, Education, and Welfare; and the Administrator of Veterans Affairs. Copies will be made available to other interested parties upon request.

Sincerely yours,

Comptroller General
of the United States

REPORT BY THE
COMPTROLLER GENERAL
OF THE UNITED STATES

BETTER COORDINATION COULD IMPROVE THE PROVISION OF FEDERAL HEALTH CARE IN HAWAII

D I G E S T

In Hawaii, three Federal agencies are responsible for providing health care to a beneficiary population which amounted to about 230,000 persons in fiscal year 1977. That care, which is provided by the Department of Defense (DOD) through its military services, the Veterans Administration (VA), and the Public Health Service is, for the most part, readily available and accessible to eligible citizens of that State. Because of its location and size, a unique opportunity exists in Hawaii to assure that Federal health care is delivered more economically without sacrifice in the quality of care provided. This can be done by

--making better use of Federal facilities there and

--making sure that the renovation and construction project at Tripler Army Medical Center is designed to meet more closely health care needs of the military, VA, and other Federal beneficiaries.

The DOD Mid-Pacific Review Committee--operating in Hawaii under the Armed Forces Regional Health Services System--has not systematically assessed the uses of medical and dental facilities in Hawaii. An interservice assessment of the beneficiary population residing around the various military clinics shows that a more equitable distribution of workload is possible at considerable savings to the Government. (See pp. 10 to 18.) For example, increased use of Navy dental capabilities in Hawaii could allow for reductions in the dental activities of Tripler Army Medical Center (with potential

savings of up to $215,000 annually) and the Public Health Service (with potential savings of up to $81,000 annually). In addition, relocation of underused Navy dental equipment could reduce new equipment purchase costs by about $67,000. Alternatively, most (if not all) of VA's dental workload, contracted out for about $500,000 per year, could be performed by the military services with their existing dental capabilities.

Implementation of these alternatives would require interagency agreements between DOD and the other two agencies to permit beneficiaries of VA and Public Health Service dental programs to be treated in DOD facilities. (See pp. 12 to 18.)

The DOD Mid-Pacific Review Committee needs specific guidance concerning

--how to assess the need for increasing or decreasing health care services in particular areas of the State and

--whether to include the resources of other Federal and/or non-Federal agencies and organizations in such assessments. (See pp. 10 and 11.)

The Committee does not have a clear mechanism to resolve differences of opinion and program emphasis among the military services; nor has it received feedback from DOD headquarters when it has presented local proposals for interservice cooperation in specific health care areas. (See pp. 8 to 10.)

Of major long-term consequence is the opportunity afforded the Government by the planned Tripler renovation and construction project to design a facility that will more closely meet the changing health care needs of military, VA, and Public Health Service beneficiary populations. This project is estimated to cost about $120 million. Requests for the project's funding will be included in the Army's 5-year construction program beginning in fiscal year 1980.

Veterans are hospitalized at Tripler because Hawaii is without a VA hospital. However, DOD's method for allocating beds for VA use is based on prior usage and, at the time of GAO's review, no effort had been made to allocate these beds among specific treatment areas.

VA's largest and fastest growing need for inpatient services lies in the psychiatric area. Lack of psychiatric bed space at Tripler has led to increased use of private facilities. Nevertheless, plans for the renovation of Tripler call for a slight reduction in psychiatric beds.

If this is still true when the plans for the new hospital are completed, VA's needs for psychiatric beds as well as the military's need for such beds for non-active-duty beneficiaries, may continue to be unmet. (See pp. 21 to 24.)

As a result of GAO's review, VA requested in December 1977 that DOD incorporate VA's needs, particularly for 20 psychiatric beds, in future planning for the Tripler facility. In response to this request, DOD stated that VA's medical service requirements will be presented to the Congress in the military construction proposal for Tripler. (See p. 24.)

Hemodialysis (for which Tripler has only limited capability) and open heart surgery (which is not performed at Tripler) are two other areas of concern to VA in its relationship with Tripler. While informal efforts are underway to determine if open heart surgery should be performed at Tripler, hemodialysis is one area in which VA and civilian health community concerns should be considered in the Army's renovation plans for Tripler. (See pp. 25 and 26.)

Hawaii State Health Planning and Development Agency officials had not been kept informed of plans for Tripler's renovation and, until May 18, 1977, were not invited to comment on

the project. Future reliance on civilian hospitals by Federal health providers in Hawaii will depend on Tripler's ultimate size and, more particularly, on how inpatient beds are allocated among the medical services. DOD should make a determined effort to keep State officials informed and to take their concerns into consideration in the renovation design at Tripler. (See pp. 27 to 30.)

RECOMMENDATIONS AND AGENCY COMMENTS

The Secretary of Defense should:

--Make sure that the recently established DOD Health Council (1) provides the direction, guidance, and feedback needed by the Mid-Pacific Review Committee to function as an effective coordinating body and (2) directs that Committee to seek VA and Public Health Service representation.

--Establish interagency agreements with VA and HEW to provide dental care in military facilities in Hawaii when this would be advantageous to the Government and the individuals involved.

--Make sure that the Army keeps other Federal health care providers and State officials fully informed of its planning for the Tripler renovation and give full consideration to their concerns so that Tripler will be more capable of serving as the only Federal hospital in the State and as a useful partner in the State's health care community. (See p. 33.)

DOD and VA agreed with GAO's recommendations. (See apps. VI and VII.)

HEW also agreed with GAO's recommendation to DOD that the Mid-Pacific Review Committee seek Public Health Service participation in the Committee's activities and that the Army give full consideration to the comments of other Federal agencies regarding the plans for renovating Tripler.

However, HEW disagreed with GAO's conclusion that the Navy could handle all of the Public Health Service's dental patients, thereby allowing for the closing of its dental clinic. HEW said GAO's conclusion would be disruptive, and perhaps uneconomical, because Health Service beneficiaries would receive attention for their medical needs at the Health Service clinic but would be required to go to naval facilities for dental care. (See pp. 33 and 34.)

A Public Health Service official stated that the Health Service's Honolulu clinic is able to schedule and process needed dental services in an expeditious manner, particularly when American seamen must return to ships preparing for departure. According to the official, referral of American seamen dental cases to DOD dental facilities would seriously impair the Health Service's ability to respond promptly to shipping industry requirements.

GAO believes that obtaining dental services at the Navy's facilities would not present an undue hardship to Public Health Service beneficiaries affected by the closure of the Health Service's dental clinic and that such action would result in a cost savings to the Government. However, in pursuing this alternative, the Health Service should insure that DOD's dental facilities will be able to promptly satisfy the dental needs of American seamen who must return, sometimes on short notice, to their ships. (See p. 34.)

Contents

ABBREVIATIONS

CINCPAC	Commander in Chief of the Pacific
DOD	Department of Defense
HEW	Department of Health, Education, and Welfare
MMRCO	Military Medical Region's Coordinating Office
OMB	Office of Management and Budget
PHS	Public Health Service
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

In response to a February 21, 1977, request from Senator Daniel K. Inouye (see app. I), we made a study of the availability and accessibility of health care to the citizens of Hawaii eligible for care in Federal facilities. As part of our study, we reviewed Department of Defense (DOD) plans for a major construction and renovation project at Tripler Army Medical Center. We focused special attention on the extent to which the new Tripler facility will contribute to meeting the specific health care needs of military and other Federal beneficiaries.

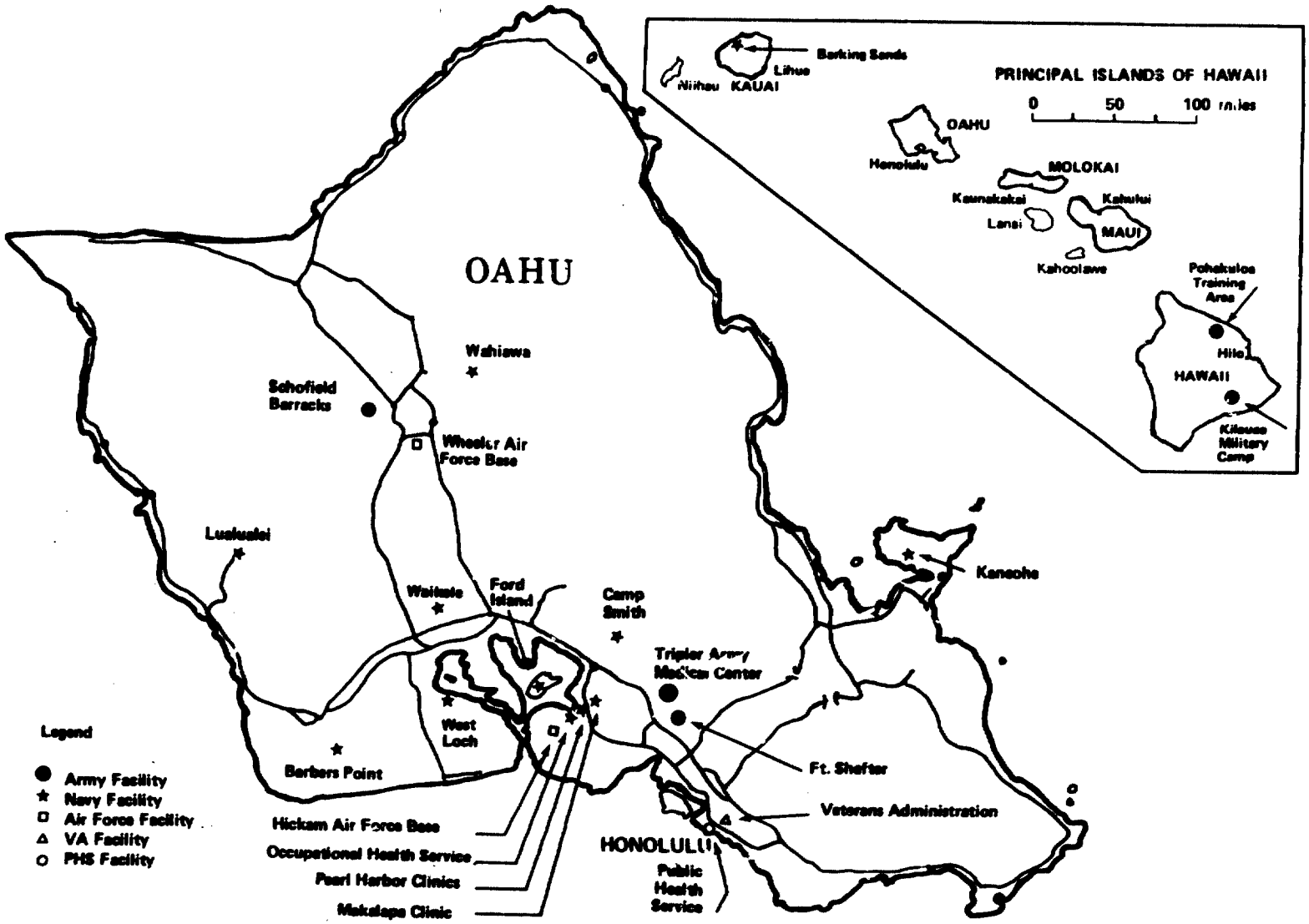
FEDERAL RESPONSIBILITIES FOR HEALTH CARE DELIVERY IN HAWAII

In Hawaii, three Federal agencies--DOD through its three military services, i.e., the Army, Navy, and Air Force; the Veterans Administration (VA); and the Department of Health, Education, and Welfare's (HEW's) Public Health Service (PHS)--are responsible for providing health care to a beneficiary population, which amounted to about 230,000 persons in fiscal year 1977. The facilities through which these agencies provide care vary widely from small clinics staffed by medical assistants and visiting physicians to Tripler Army Medical Center, which (1) serves as the major hospital for patients in the Hawaiian Islands and elsewhere in the Pacific area and (2) is the only Federal inpatient facility in the State. One of Tripler's missions is to serve as the predominant inpatient facility for VA beneficiaries. Tripler also serves as the principal backup for hospitalization and diagnostic and consultative services for PHS beneficiaries on a reimbursable basis.

Federal health facilities in Hawaii are concentrated on the State's most populous island, Oahu. (See map, p. 2.) Of the 19 facilities on the island--exclusive of units which are part of mobile field forces--17 are operated by the military services and 2 are operated by civilian agencies. 1/ A list of these Federal facilities and their respective fiscal year 1976 workloads follows on page 3.

1/In addition, the Federal Aviation Administration operates a small clinic staffed by one physician to administer a medical certification program.

FEDERAL HEALTH FACILITIES IN HAWAII



Federal Health Care Facilities on Oahu

	Facility	Fiscal year 1976 workload	
Inpatient services:			
Army	Tripler Army Medical Center	471 average daily inpatient beds occupied	
		Outpatient visits	
		Medical	Dental
Outpatient services (clinics):			
Army	Tripler Army Medical Center	637,655	19,256
	Schofield Barracks	139,065	64,849
	Ft. Shafter	---	8,434
Total		776,720	92,539
Navy	Pearl Harbor	a/161,573	75,338
	Ford Island		14,103
	Barbers Point	69,203	17,708
	Kunia		c/1,031
	Wahiawa		4,941
	Lualualei	b/20,201	2,031
	Waikele		599
	West Loch		778
	Kaneohe	145,198	34,948
	Occupational health	35,251	-
	Aiea-Halawa	-	5,150
	Camp Smith	---	3,852
Total		431,426	160,479
Air Force	Hickam Air Force Base	127,061	45,890
	Wheeler Air Force Base	20,665	4,312
Total		147,726	50,202
VA, Honolulu		27,231	---
PHS, Honolulu		26,601	5,515
TOTAL		1,409,704	308,735

a/Includes Inactive Ships Maintenance Clinic at Pearl Harbor, which was closed in June 1976.

b/Represents the combined workload for the five facilities. The Kunia branch medical clinic closed in January 1977.

c/The Kunia branch dental clinic closed in June 1976.

As can be seen from the table, most of the Federal health care's workload is concentrated in relatively few facilities.

The estimated cost for operating these facilities was $63.9 million in fiscal year 1976. The cost to the three military services amounted to about $57.5 million, while the VA and PHS costs were about $5.6 million and $0.8 million, respectively. A detailed breakdown of the types of costs incurred by each agency is shown in appendix II.

NEW VA CLINIC AND OTHER PLANNED FACILITIES

VA moved its clinic into a new facility in December 1977. The new clinic provides a full range of outpatient services, including a dental service, a physical therapy service, and several patient education activities.

VA's budget for the operation of its clinic during fiscal year 1977 was originally approved at a level of about $5.4 million; however, because of its move to the new facility, VA spent an additional $444,561 for more staffing and equipment required as part of the relocation and expansion of direct-care services.

As part of its expansion, VA established student training programs under an affiliation agreement with the University of Hawaii Medical School in the fields of psychiatry, psychology, family practice, and internal medicine. The psychiatry program started in July 1977, with two residents and one paid faculty member.

The Army has in the planning stages, two major projects for upgrading medical facilities. The larger of these involves a major renovation and construction project at the Tripler Hospital site. Tripler has not undergone a major alteration since its completion in 1948 even though (1) it was designed to serve a primarily male inpatient population and (2) medical community emphasis has shifted from inpatient care to outpatient care.

Various proposals for major alteration of the facility have been submitted to DOD since 1963. A more detailed discussion of the proposals made and the current plans for construction and renovation of the Tripler facility is included in appendix III.

The second project involves the medical and dental clinic at Schofield Barracks, which supports an active-duty population of about 15,000 (primarily the 25th Infantry Division) and about 15,400 dependents. The physical facilities were originally constructed during 1928-29. Clinics are now located in seven separate buildings originally designed as hospital wards. The project proposal notes that adequate utilities are lacking and termite damage is extensive.

Because of these deficiencies, renovation of the present structures is considered uneconomical and Tripler officials have proposed the construction of a replacement medical and dental family practice clinic at Schofield Barracks.

A project justification was submitted through Army channels in April 1977 to fund the dental clinic in fiscal year 1980 and the medical clinic in fiscal year 1982. The estimate for construction cost was about $7.5 million for a total of 60,000 square feet for both portions.

SCOPE OF REVIEW

During our review, we visited the major Federal health facilities in Hawaii, discussed health care with officials at those facilities, and analyzed data provided by them concerning the operations of these facilities. We also held discussions with Commander in Chief of the Pacific (CINCPAC) officials and Hawaii State Health Planning and Development Agency officials, and analyzed data which they provided us. In addition, we reviewed the minutes of the Mid-Pacific Review Committee meetings as well as its reports sent to DOD headquarters.

We also contacted DOD headquarters officials; officials in the Offices of the Surgeons General of the Army, Navy, and Air Force; and VA and PHS officials, to determine their activities in connection with the operations of their health care facilities in Hawaii. We were particularly interested in the activities of the Army Health Facility Planning Agency and other DOD offices as they relate to the planning of the proposed renovation and construction project at Tripler and the sizing of Tripler's inpatient facilities.

CHAPTER 2

BETTER INTERSERVICE AND INTERAGENCY COORDINATION COULD IMPROVE THE USE OF HEALTH CARE FACILITIES

We found that health care provided by the military services, VA, and PHS in Hawaii is generally available and easily accessible to the citizens of the State eligible for such care. However, due to budgetary and/or staffing constraints, individual Federal health facilities in Hawaii sometimes must limit medical services to certain categories of beneficiaries or eliminate a specific service to all beneficiaries. In such situations, arrangements are made for needed care to be provided at other Federal facilities or at non-Federal public or private hospitals under reimbursement arrangements worked out by the agency primarily responsible for providing the care.

The most recent data available during our review showed that the Government is responsible for providing health care to 230,000 persons in Hawaii. A detailed breakdown of the various categories of Federal beneficiaries is included in appendix IV.

Precise estimates of the target populations to be served by the individual facilities of each military service and Federal agency are difficult to arrive at because

--military beneficiaries are eligible for care at any military health facility;

--some military beneficiaries obtain care at VA and PHS facilities;

--some VA and PHS beneficiaries receive care in military facilities; and

--all Federal beneficiaries are eligible for care, at least on a referral basis, at Tripler because it is the only Federal hospital in Hawaii.

Because of the multiple eligibility of many of the persons and because of the small geographical area, there are numerous opportunities for increased coordination among the Federal health care providers in the State.

Some interservice and interagency coordination already exist in the State primarily because of Tripler's role as the only Federal inpatient facility and the lack of a full range of health care capabilities at the various Federal clinics. 1/ However, our review showed that:

--Even though formal organizations have been in place for some time to promote interservice cooperation in the health area, the efforts of these groups, for several reasons, have been largely ineffective.

--Opportunities exist to make better use of the Federal health care resources in Hawaii. By taking advantage of these opportunities, the services and agencies could more evenly spread their workloads and/or reduce medical care costs without sacrifices in the quantity or quality of care provided.

ROLE OF THE TRI-SERVICE REGIONAL REVIEW COMMITTEE IN PROMOTING INTERSERVICE COOPERATION

In October 1973, DOD initiated the Armed Forces Regional Health Services System in the continental United States. DOD said the system was a means of collectively organizing and managing a system of peacetime health care designed to (1) reduce duplication of resources and (2) achieve economy. Implementation of the system was extended to the Pacific area in January 1975 when the Mid-Pacific Review Committee was organized. This Committee includes the senior staff medical officer of each military service in Hawaii, and the chairmanship rotates quarterly among these members. The Committee reports its activities through the surgeon assigned to the staff of CINCPAC, to DOD's Military Medical Region's Coordinating Office (MMRCO) 2/ in Washington, D.C.

1/Tripler Hospital acts as a center for inpatient and specialty outpatient care; and for laboratory, medical supply, optical, and consultant services for other military and Federal outpatient facilities.

2/In addition to MMRCO, DOD, in December 1976, established a Health Council made up of the Assistant Secretary for Health Affairs, the three Surgeons General, and others. One of the Health Council's responsibilities is to monitor the activities and programs of all triservice or joint military medical activities, including the regionalization program.

According to Army, Navy, and Air Force medical officials in Hawaii, the main contribution of the regionalization program has been the promotion of mutual trust and respect among the services, which facilitates the solving of interservice problems as they arise. Among the specific accomplishments cited by the Committee itself are the promotion of

--a common prescription refill policy;

--some cross-training of personnel;

--temporary coverage of medical personnel shortages of one service by other services;

--a coordinated child abuse program;

--a coordinated approach to blood donation;

--cooperation with civilian authorities on airport disaster planning; and

--exchange of information on treatment policies, procedures, and records.

Lack of DOD action has hindered interservice cooperation

Before the Mid-Pacific Review Committee was formed in January 1975, interservice coordination was carried on through quarterly meetings of the heads of medical facilities and through a group known as the Hawaii Sub-zone Group. The latter group was established under CINCPAC to promote interservice and interdepartmental support among military and other Federal agencies in Hawaii.

Two reviews were initiated by the Sub-zone Group. The first of these concerned consolidation of medical and dental supply operations in Hawaii and was initiated in October 1971. The completion of this study has been repeatedly delayed because of changes in the individual services' medical supply organizations. Now that Tripler has converted to a new supply system, it is expected that the Committee will take over this study.

In February 1973, the Sub-zone Group initiated a study of possible consolidation of military maintenance activities for medical/dental equipment. The results of this study, made by Tripler management personnel, indicated that (1)

consolidation of medical and dental equipment maintenance functions would be feasible and (2) Tripler, as the largest provider and user of such services, would be the most effective administrator of such a program. The study recommended that a neutral DOD party make a followup study before implementing such a consolidation.

In February 1975, the Air Force and Navy expressed concern that a consolidated program would detract from their own capabilities. They suggested that any further study should be conducted by the newly formed Committee. It was not until April 1976, however, that the Committee took over responsibility for the study.

The Committee, in April 1976, sent a letter to CINCPAC recommending that it (the Committee) undertake further study of the matter but not before MMRCO had a chance to evaluate the proposal. The CINCPAC surgeon's office rejected the Committee's suggestion and to date, no action has been taken on this matter.

An additional problem which appears to have impeded the activities of the Committee, as well as those of other such committees in the Pacific area, is the lack of direction received from MMRCO at DOD headquarters.

DOD's instructions for implementing its regionalization program state that triservice regional review committees should, among other activities, identify management improvements and procedures for health service within their designated regions. The instructions also state that:

> "Changes that would impact on command jurisdication will be referred to commanders concerned as well as MMRCO for evaluation and appropriate action."

In October 1976, directors from the five military medical regions in the Pacific area met to assess progress under the regionalization program. This meeting produced a number of recommendations which were forwarded to MMRCO in early November. The directors recommended the establishment of

--uniform regulations on physical examinations given by one service on a patient of another service and

--uniform standards of treatment among the services for drug and alcohol abuse patients.

It was thought that adoption of triservice regulations and standards could result in greater efficiency by reducing the number of air evacuations of patients to military treatment facilities of their own service.

The directors also observed that:

> "A marked communication deficiency exists between the Tri-Service Regional Committees and the Military Medical Regions Coordinating Office. There has been no feedback from the MMRCO even though recommendations for changes have been made."

The directors then recommended that:

> "* * * the MMRCO respond to recommendations made in reports and letters, and
>
> * * * * *
>
> "* * * the MMRCO consider distribution of a brief report of innovations, accomplishments, or similar activities made in any region which may be appropriate for consideration in other regions."

As of March 1978, no response had been received on these or other recommendations made by the directors.

Following the directors' meeting in October 1976 through April 1977, the Committee made two proposals through CINCPAC to MMRCO--one (in January 1977) dealing with the consolidation of optical fabrication activities in Hawaii and the other (in April 1977) dealing with the need for a triservice regulation regarding maternity leave for pregnant active-duty members. On each occasion, the Committee believed there were sufficient interservice implications regarding these matters and that they should be studied at the DOD level. As of March 1978, no response had been received from the headquarters committee concerning either matter.

SYSTEMATIC ASSESSMENTS OF CURRENT NEEDS FOR FEDERAL MEDICAL AND DENTAL SERVICES HAVE NOT BEEN MADE

Under DOD's regionalization instructions, responsibilities for military facilities programing and utilization have been specifically retained at departmental levels of each of the

services and DOD. However, individual triservice regionalization committees are directed to provide continuing assessments of the need for increased or decreased services, facilities, or other resources. We were informed that no specific guidance has been provided to the Committee on how to make such assessments nor on whether to include the resources of other Federal and/or non-Federal agencies and organizations in such assessments. The Committee has not assessed the workloads or populations served by each military or other Federal facility to determine if there is a potential for more optimal patterns of facilities use.

Our review showed that, although opportunities exist for more efficient and effective use of the Federal health facilities in Hawaii, little effort has been directed toward taking advantage of these opportunities. The uses of existing medical and dental facilities on the island are illustrative of these opportunities.

Use of Federal medical facilities

On March 31, 1976, the Navy opened a new clinic at the Barbers Point Naval Air Station which was designed to accommodate a military beneficiary population of about 15,000 persons. The medical portion of the clinic has room for 15 full-time physicians, but as of March 1978, only 9 were assigned. According to fiscal year 1977 data provided to us by the Navy's Bureau of Medicine and Surgery, the Barbers Point facility serves a beneficiary population of about 6,700, less than half of whom are active-duty military members.

By contrast, the Army's clinic at Schofield Barracks--located about 16 miles from Barbers Point--provides medical outpatient services to about 30,000 persons, about half of whom are active-duty members. As previously mentioned, the clinic is located in seven separate buildings originally constructed in the late 1920s and badly in need of repair. We were informed that, as of March 1978, Tripler had assigned 12 physicians to the Schofield Barracks clinic. According to Tripler officials, the Schofield clinic is understaffed and overcrowded.

We were unable to obtain reliable data on the size of the military population which resides near the Barbers Point clinic because the data used by military clinics to estimate the populations to be served is based on the active-duty populations assigned to each military base. As such, these

estimates do not reflect the total military--or other federally eligible--beneficiaries who could be served at any one clinic. We analyzed Navy housing data and other data from Army, Air Force, and Coast Guard officials and estimated that about 3,300 active-duty military members and 8,500 military dependents live within the Barbers Point clinic area. Navy officials told us that the Barbers Point clinic, as of late 1976, held active medical records for 3,363 active-duty personnel, 11,670 dependents, and 679 eligible civilians.

We found that the Committee did not attempt to ascertain the eligible populations around the various military clinics. Such an assessment might have shown that the Barbers Point clinic could take on some of the current Schofield workload without undue burden on the Navy clinics or on the persons (particularly dependents) being served. We also found that the Committee had not promoted increased use of underused facilities in lieu of overcrowded ones by encouraging members of one military service and their dependents to seek outpatient treatment at another service's facility.

Federal dental capability in Hawaii

There are 16 military dental clinics, excluding mobile units, on Oahu--11 Navy, 3 Army, and 2 Air Force. In addition, PHS operates a dental clinic for its beneficiaries. VA contracted with private dentists for the care of its beneficiaries at a cost of about $500,000 in fiscal year 1976. The fiscal year 1976 workloads of each military clinic and of the two civilian agencies are shown in the table on page 13. As can be seen from the table, each military service's workload is composed predominantly of members of their respective services.

Brief descriptions of each service's and the two agencies' dental capabilities follow.

Navy

In August 1976, the Navy had 53 dentists at the 10 clinics under its regional command and expected that its dental staffing would be reduced to 43 by June 1, 1977. Two of the Navy clinics (Pearl Harbor and Barbers Point) have been opened within the last 5 years and are equipped with relatively new and up-to-date equipment.

Dental Visits by Clinic and Personnel Category for Each Service, Fiscal Year 1976

	Army	Navy and Marine	Air Force	Dependents	All other	Total	Percent
Army:							
Tripler	7,749	1,227	153	5,499	4,628	19,256	
Schofield	55,122	39	10	9,284	394	64,849	
Ft. Shafter	6,300	-	-	2,007	127	8,434	
Total	69,171	1,266	163	16,790	5,149	92,539	30
Navy:							
Pearl Harbor	-	66,782	-	3,845	4,711	75,338	
Barbers Point	601	13,732	68	2,638	669	17,708	
Camp Smith	-	3,401	1	450	-	3,852	
Ford Island	-	14,103	-	-	-	14,103	
West Loch	-	672	-	35	71	778	
Waikele	-	599	-	-	-	599	
Wahiawa	-	4,577	-	206	156	4,941	
Makalapa	-	5,150	-	-	-	5,150	
Lualualie	-	1,949	-	39	43	2,031	
Kunia Point (note a)	-	1,031	-	-	-	1,031	
Kaneohe	79	32,989	7	1,527	346	34,948	
Total	680	144,985	76	8,740	5,998	160,479	52
Air Force:							
Hickam	454	22	31,093	10,661	3,660	45,890	
Wheeler	10	11	2,884	1,150	257	4,312	
Total	464	33	33,977	11,811	3,917	50,202	16
Total military	70,315	146,284	34,216	37,341	15,064	303,220	98
Public Health Service	-	b/121	-	1,043	4,351	5,515	2
TOTAL	70,315	146,405	34,216	38,384	19,415	308,735	100

a/Kunia Branch Dental Clinic closed in June 1976.

b/All DOD personnel--breakout not available.

Note: VA not included because it maintains dental data on a patient and not a visit basis. In fiscal year 1976, VA obligated about $500,000 for 1,159 completed cases.

The Barbers Point dental clinic, with a total of 27 dental chairs, was designed to accommodate more people than it actually serves. In fiscal year 1976, this clinic served less than three patients per chair per day. It appears that at least 50 percent of these chairs and associated equipment is not needed. Nevertheless, the Navy planned to purchase seven new chairs in fiscal year 1977 for distribution to its various clinics and has projected a need for three additional chairs in fiscal year 1979.

The Commander of the Naval Regional Dental Center told us that the Navy could absorb a 10- to 15-percent increase in workload at its various clinics with little or no increase in the June 1977 personnel level.

Army

The Army operates dental clinics at Tripler, Fort Shafter, and Scholfield Barracks. As of March 1978, 29 dentists were assigned to the Tripler command, which has in turn assigned 3 dentists to the 6-chair clinic at Fort Shafter and 17 to the 39-chair clinic at Schofield Barracks. The Chief of Dentistry at Tripler, which has 9 dentists in an 18-chair clinic, told us that some dental capability, including oral surgery, is needed at Tripler to meet the dental needs of inpatients and the hospital staff. However, the routine, non-hospital-related dental services now done at Tripler apparently could be spread to other facilities, allowing Tripler to assign additional dentists to the overcrowded Schofield Barracks clinic. The Army purchased 11 dental chairs to replace older equipment in fiscal year 1977 and has plans to purchase 23 chairs in fiscal year 1978 and 11 chairs in fiscal year 1979.

Air Force

The Air Force operates two dental facilities in Hawaii--one, a 19-chair clinic at Hickam Air Force Base and the other, a 3-chair clinic at Wheeler Air Force Base (which is located about 2 miles from Schofield Barracks). Both clinics are operated by 16 dentists assigned to the Hickam clinic. The Wheeler clinic is staffed by dental assistants 5 days a week and by a visiting dentist from Hickam, 3 days a week. The commander of the Hickam dental clinic told us that previous attempts to close the Wheeler clinic had, thus far, been unsuccessful. We were informed that the Air Force spent about $4,400 in fiscal year 1977 for a replacement chair at the Wheeler clinic.

PHS

PHS operates a 3-dentist, 6-chair clinic as part of its overall clinic operations. The PHS dental workload of about 5,500 visits per year consists of services provided to civilian American seamen, Coast Guard members and their dependents, and emloyees of several Federal agencies.

VA

VA planned to have an in-house dental capability in April 1978. Historically, VA spent about $500,000 a year to provide dental services--through private dentists--to certain of its beneficiaries, most of whom were veterans eligible to receive dental care within 1 year of their discharge from active-duty military service. In its new clinic, VA has employed one dentist whose main task is to prepare and/or approve dental treatment plans. Although the new dentist will perform some work himself, VA will continue to rely primarily on private dentists for most of its workload.

Possible alternatives to enhance use of existing Federal dental capability

Our discussions with dental officials of the three military services and the two civilian agencies and our analyses of the workloads of each of the dental clinics in Hawaii, as well as the plans for expansion of the Federal dental capabilities, indicated several alternatives to the present uses of dental facilities. These alternatives could result in (1) a more equitable spread of workloads among the clinics and (2) possible savings to the Government. Each would require greater interservice cooperation than now exists in the dental area and, in some cases, would require interagency cooperation (which has not been attempted). The possible alternatives we developed in our review are discussed below.

--Navy dental capability could be more fully used, which would allow for reductions in Army and PHS dental clinics. Based on the Navy's estimate that it could absorb a 10- to 15-percent increase in workload at present staffing levels, the Navy could absorb most, if not all, of the non-hospital-related dental workload at Tripler. The Army, under such an arrangement, could achieve personnel cost savings of up to $215,000 annually or, alternatively, could assign additional dentists to its Schofield Barracks clinic to allow them to pick up workload from nearby Wheeler Air Force Base. Should the Army not want to reduce

its operations at Tripler, it could close its Fort Shafter dental clinic and refer that workload to the Navy. This option could result in annual personnel cost savings of up to $128,000.

--The Navy could also absorb all of PHS' dental workload. Savings to the Government would amount to at least $81,000 annually if PHS would reimburse the Navy for dental services provided to other than military beneficiaries. Although PHS beneficiaries and their dependents may be provided medical services at DOD facilities, American seamen are not eligible for care in such facilities, except as may be specifically authorized and paid for by PHS. Because American seamen are not legally entitled to receive medical care in DOD facilities, the Secretary of Health, Education, and Welfare would be required to enter into an interagency agreement with the Secretary of Defense under the authority of the Economy Act (31 U.S.C. 686) 1/ to permit all PHS dental patients to be treated at DOD dental facilities in Hawaii.

In discussing this alternative, a PHS official emphasized that the dental services provided in the PHS facility are primarily for American seamen and active-duty personnel. This enables the small Honolulu clinic to schedule and process needed dental services in an expeditious manner, particularly when American seamen must return to ships which are ready for departure. (The clinic is located at the waterfront in close proximity to docking facilities.) The official stated that he believes the referral of American seamens' dental cases to DOD dental facilities, which are located inland, would seriously impair PHS' ability to respond promptly, as it does now, to shipping industry requirements.

He expressed concern that the health care of PHS beneficiaries not be compromised solely on the basis of least cost without consideration of:

1/Under this act, Federal agencies may procure supplies and services, including health care services, from other Federal agencies in order to allow agencies' resources to be fully used and avoid unnecessary duplication of activities.

(1) the individual patient's total health needs; (2) patient access to services and patient convenience; and (3) whether the patient can, in fact, use the services that are available. He stated that if PHS patients are not eligible for care in other agencies' facilities, or if their interests are submerged due to low priorities in a crowded and theoretically "efficient" combined system, then PHS would fail in its fundamental mandate to provide good quality health care to those eligible beneficiaries.

--The small dental clinic at Wheeler Air Force Base could be closed and patients referred to nearby Schofield Barracks if additional Army dentists could be assigned to handle the small increase in workload. Air Force staff could be reassigned to the Hickam clinic.

--Relocation of underutilized dental equipment from the Navy's Barbers Point dental clinic to other military facilities could reduce equipment purchases of at least $67,000.

--A portion of the dental workload contracted out by VA could be absorbed by the Navy or, if the other clinics are maintained at current levels, by a combination of the military dental capabilities. VA's beneficiaries are not authorized treatment at military dental facilities--other than hospital-related treatment and speciality outpatient treatment at Tripler. If this obstacle could be overcome by an interagency agreement between DOD and VA under the authority of the Economy Act most, if not all, of the VA workload for which VA is paying $500,000 a year could be performed by the military services using their dental capability.

Role of the Mid-Pacific Review Committee in Federal dental activities

DOD's instructions for implementing its regionalization program specifically charged individual triservice regionalization committees with the task of making continuing assessments of the need for increased or decreased services, facilities, or resources. The minutes and correspondence of the Committee since its establishment show no evidence that (1)

it has addressed the question of overall Federal dental (or medical) treatment capabilities in Hawaii or (2) possible ways to make more effective and economical use of these capabilities. Nor could we find evidence that PHS and VA have participated in the Committee's medical or dental activities.

The Federal dental situation in Hawaii offers the Committee a unique opportunity to make its first systematic assessment of ways to achieve optimum use of Federal health care in the State. Such an assessment--if it is carried out by the Committee--should take into account the needs of VA and PHS which do not presently participate in the military's regionalization activities.

CHAPTER 3

PLANNED CONSTRUCTION OF FEDERAL HEALTH FACILITIES OFFERS OPPORTUNITIES FOR INCREASED FEDERAL COORDINATION

The planned improvement of the Tripler Army Medical Center is the major forthcoming Federal medical facility construction and renovation project in Hawaii. Planning for the project, to date, has been carried out primarily through the joint efforts of Tripler officials and the Army Health Facility Planning Agency at the Army's Headquarters in Washington, D.C. We noted that the Committee's involvement has been minimal.

Perhaps of greater potential consequence is the fact that VA's involvement in the planning process for the facility has been minimal, even though the Tripler facility is also intended to serve VA. VA officials in Hawaii have expressed some specific concern about Tripler's ability to accommodate VA beneficiaries referred for specific types of treatment. In December 1977, the Administrator of Veterans Affairs requested that the Secretary of Defense, in future plans for the Tripler facility, incorporate needed capability to meet VA requirements.

VA'S RELATIONSHIP TO TRIPLER

Hawaii is one of two States without a VA hospital. Eligible veterans are hospitalized at Tripler under a reciprocal agreement between VA and DOD. Under this agreement, VA's bed needs at Tripler are determined annually by headquarters officials. They inform the Army of these needs and budget for them so that VA can reimburse the Army. At the time of our review, determination of each year's need for beds was based on the prior year's use of beds by VA beneficiaries at Tripler. As shown in the following table, the allocation of Tripler beds for VA use has declined over the last several years.

Number of Beds Allocated for VA Inpatients at Tripler Army Medical Center

Fiscal year	Number
1969	70
1970	65
1971	65
1972	65
1973	65
1974	50
1975	49
1976	45

Under current procedures, once VA determines its needs for Tripler beds, the hospital includes that number in planning its total bed capacity. No effort is made to allocate this number of beds to specific treatment areas--e.g., psychiatric beds. Instead, VA beneficiaries--like military dependents, military retirees and their dependents, and dependents of deceased military members--are treated on a first-come-first-served basis after Tripler's active-duty patients are cared for.

VA also refers patients to public and private hospitals in Hawaii and pays these hospitals for the services provided to its beneficiaries. The following table shows VA's use of Tripler and other hospitals for its medical and surgical inpatient needs and psychiatric inpatient needs.

VA Inpatients' Medical-Surgical and Psychiatric Average Daily Census

Fiscal year	Beds allocated for VA at Tripler	Medical and Surgical			Psychiatric				
		Tripler	Public hospitals	Private hospitals	Tripler	Public hospitals (note a)	Private hospitals (note b)	Total (note c)	Average VA use of Tripler
1973	65	42	5	2	3	25	1	79	45
1974	50	41	3	2	2	40	1	91	43
1975	49	36	4	4	4	44	2	95	40
1976	45	39	3	4	2	49	6	104	41
1976T (note d)	45	37	3	4	1	35	18	97	38
1977 (note e)	45	28	3	2	2	42	20	97	30

a/Primarily chronic psychiatric care.

b/Primarily acute psychiatric care.

c/Totals may not add due to rounding.

d/Transition quarter (July-Sept. 1976).

e/Average for first 5 months of fiscal year 1977.

As can be seen, VA's use of Tripler has declined during the last 4 years, while its use of public and private civilian hospitals has increased, particularly in the psychiatric area.

The VA clinic director told us that (1) a separate VA hospital in Hawaii would be impractical based on the VA inpatient workload and (2) such a facility could not support the medical specialties now available at Tripler and other public and private hospitals. He stated that VA had three principal areas of concern over Tripler's current and projected ability to meet VA's needs--in the psychiatric, cardiac surgery, and hemodialysis treatment areas.

Psychiatry

VA's largest need for inpatient services lies in the psychiatric area, both for long-term psychiatric patients and for patients needing short-term or acute treatment. Since Tripler does not generally provide treatment for chronic psychiatric patients, 1/ VA usually refers its chronic patients to the Hawaii State Hospital. According to the VA clinic director, funding and staff shortages at the State hospital have inhibited aggressive treatment programs.

Acute psychiatric care is the fastest growing portion of VA's inpatient workload in Hawaii. This expansion is apparently due to a number of factors:

--Increasing numbers of Vietnam era veterans requiring such care.

--VA outpatient programs that are designed in part to search out such veterans.

--The increased availability of such care at a private medical center in Honolulu.

A 1974 study by the VA staff in Hawaii regarding the mental health needs of veterans noted that the number of Vietnam era veterans seeking mental health care was increasing and that this group posed particular problems in counseling, mental hygiene, and alcohol and drug abuse. The report cited the expansion of a private medical center from 32 to 51 psychiatric beds concurrent with the development of

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1/Tripler's emphasis is on acute psychiatric care, and active-duty members with chronic conditions are usually referred to hospitals closer to their home of record.

an acute inpatient treatment program. The report also noted that Tripler was taking care of a variety of patients in its psychiatric ward, including drug and alcohol cases.

The report said:

"They (Tripler) try to offer 5 or 6 beds for VA patients, but they are frequently occupied to capacity and unable to comply with our requests."

In an effort to address VA's needs for acute psychiatric inpatient beds, the Honolulu VA clinic director in July 1976 proposed that Tripler establish a 10- to 20-bed, acute care psychiatric ward for exclusive use by veterans. Under the proposal:

--VA would provide financing and a full-time psychiatrist.

--Tripler would provide the physical facilities, laboratory, and other basic support.

--The decisions concerning who would provide psychiatric nurses and other ancillary personnel would be negotiable.

--The program would be conducted under an agreement among VA, Tripler, and the University of Hawaii Medical School.

The proposal, when presented to Tripler, was described as tentative with initial support from the VA District Office in San Francisco but not yet presented for approval to VA officials in Washington. VA stated that (1) the purpose of making the proposal was to obtain Tripler's general agreement with VA's idea and (2) details of the program could be worked out later.

On September 30, 1976, the Tripler commander notified the Honolulu VA Director that the Army's Health Services Command had turned down the proposal on the basis that:

"* * * uncertainties associated with command control and management functions could possibly generate significant problems for the two organizations. In addition, the severe shortage of psychiatric nursing personnel experienced by the Army Surgeon General quite obviously has a profound impact on this decision."

On November 8, 1976, in a second letter to the Honolulu VA Director, the Tripler commander stated that Tripler could offer no solution to VA's problem but suggested that a proposal similar to the one made to Tripler might be made to other public or private institutions.

The VA clinic director informed us that there was no shortage of psychiatric nurses in the private sector and VA would have been willing to hire the necessary nurses. He acknowledged the probability of command control and management problems cited in Tripler's response; however, he felt such problems were faced by any two institutions working together and could be worked out.

VA subsequently started referring all acute psychiatric patients to a private medical center in Honolulu. VA officials noted that the difficulty in gaining admission to Tripler led to the direct referral of patients to the private center without first checking on the availability of bed space at Tripler. Patients are admitted to the center for 2 weeks and then discharged or referred to other institutions. The basic room and board charge at the center is $172 per patient day, not including physician charges and other costs.

VA has started a physician residency training program in psychiatry, in affiliation with the University of Hawaii and plans similar programs in medicine and psychology. The purpose of the programs is to enhance the level of care afforded to VA patients.

The VA clinic has a Day Treatment Center and a Mental Health Clinic as a part of an overall Mental Health and Behavorial Sciences Program. Patients at the Day Treatment Center receive intensive psychiatric care while still residing within the community. One of the objectives of this program is to reduce the number of psychiatric hospital admissions. However, budgetary constraints during fiscal year 1977 forced VA to limit the number of patient visits, including visits to the Mental Health Clinic and the Day Treatment Center.

At the time of our review, the availability of further acute care psychiatric beds at Tripler and the private medical center appeared limited. The 1976 occupancy rate at Tripler exceeded 90 percent and was about 81 percent at the private center. Each institution has 50 beds devoted to psychiatric care. In the same year, the Hawaii State Hospital recorded an occupancy rate of 103 percent.

The chief of psychiatric services at Tripler informed us in April 1977 that a large active-duty workload was forcing Tripler to continue to limit non-active-duty admissions. He saw little reason to expect any marked change in workload. He characterized the quantitative level of staffing as barely able to support a 50-bed facility which includes beds for care of drug and alcohol detoxification patients, as well as acute psychiatric patients. He noted that there are currently no inpatient areas adjacent to the hospital's psychiatric wards which could be used to establish a separate ward for the exclusive use of veterans.

Plans for the renovation of Tripler called for a total of 48 beds for psychiatric care--2 less than present capacity. Also, it appeared that no separate beds would be operated for alcohol and drug detoxification patients. If the plans for the new hospital, when finalized, continue to call for 48 or less acute psychiatric beds, VA's needs for such beds--as well as those for military beneficiaries other than active-duty members--will continue to be unmet.

We discussed this issue of unmet needs for VA acute psychiatric patients with both the Army Health Facility Planning Agency and the VA Department of Medicine and Surgery's policy and planning staff. The Army Health Facility Planning Agency pointed out that VA's official request was for 45 inpatient beds in fiscal year 1977 and no specific types of beds, i.e., psychiatric, medical, or surgical were requested. The Army's plans for the new Tripler facility included 45 beds requested by VA.

As a result of our review, the Administrator of Veterans Affairs in December 1977, requested that the Secretary of Defense incorporate VA's needs--particularly for 20 psychiatric beds--in future planning for the Tripler facility. DOD responded that VA's needs will be presented to the Congress in the military construction proposal for Tripler.

At the time of our review, VA's request for beds at Tripler was based on historic use. As noted in the chart on page 20, the decreasing use is apparently due to a decrease in need by veterans for the types of care Tripler can provide. In fact, although VA has increased workload in the acute psychiatric area (which it is sending to private hospitals), its fiscal year 1978 request for beds at Tripler is decreasing to a 43-bed average daily patient census.

Hemodialysis

A second area of VA concern relates to its continuing need to contract with private hospitals for hemodialysis treatments for its beneficiaries.

In fiscal year 1976, costs for hemodialysis treatments of 18 patients amounted to about $310,000--$200,000 for outpatient treatments and $110,000 for related inpatient care. VA reimbursed a private hospital for most of these cases; however, two patients have been regularly referred to Tripler for outpatient dialysis treatment.

The charge to VA for one outpatient hemodialysis treatment in the primary private facility in Hawaii was $65 in fiscal year 1976, but costs for associated medical care raised this to an average of about $113 per treatment. The charge to VA for one treatment at Tripler is $20--DOD's standard interagency outpatient charge. Tripler officials do not believe that this charge covers the cost of a hemodialysis treatment. They estimate that each such treatment costs about $55.

Our review of the continuing hemodialysis workload at Tripler 1/ and VA's needs for dialysis treatments for its beneficiaries indicated that, to fulfill these needs, Tripler would have to increase its hemodialysis capability about threefold. If Tripler were to expand its capability in this area to provide care for VA's beneficiaries, VA could save about $40,000 annually even if it reimbursed Tripler for the full cost ($55) of hemodialysis treatments. However, such an arrangement may not result in overall savings to the Government when the costs of expanding Tripler's capability are taken into consideration. More important, VA's patients are treated at a renal institute in a private Honolulu hospital that is supported, in part, by Federal payments under social security legislation. The effects--in terms of the institute's federally reimbursable hemodialysis treatment costs--of a reduction of workload at the institute are not known.

1/Tripler performs uncomplicated chronic dialysis on new patients for 90 days until such patients are eligible for social security coverage at a private facility. Approximately 80 percent of hemodialysis costs are covered under the Social Security Act after an initial 90-day period. Tripler officials estimate 20 patients were referred to private hospitals in 1976.

Hawaii State Health Planning and Development Agency officials told us, however, that it is their desire to see Tripler participate in a regional renal dialysis program with the objective of insuring access to a treatment for sufferers of renal disorders; in fact, it is their hope that Tripler's participation in a regional program would encourage Tripler to use civilian facilities to the extent possible rather than expanding its own hemodialysis capability.

Hemodialysis appears to be one area which should be evaluated carefully--to insure that VA's needs are adequately met and the civilian health community's concerns are considered--in completing the plans for renovating the Tripler facility.

Open heart surgery

Currently, Tripler is not performing open heart surgery. The cost of such surgery in Hawaiian private hospitals is estimated by VA and Tripler officials at about $10,000 for each case. Tripler and VA, therefore, refer these patients to mainland military and VA hospitals unless it is an emergency or travel is considered medically unsound. According to the VA clinic director, VA refers as many as two patients per month to mainland VA hospitals for open heart surgery. Tripler officials estimate that six patients were referred to local hospitals and seven to mainland hospitals for this surgery in 1976.

No formal study has been made to determine if open heart surgery capability should be established at Tripler to meet its own and VA's needs. However, the Chief of Medicine at Tripler has initiated his own study to determine if the number of such patients would meet or exceed the minimum number required to establish this capability. (According to its Chief of Medicine, Tripler would need to perform at least 100 open heart surgical procedures a year to justify the addition of this capability at Tripler.) As a result of an agreement between Tripler's Chief of Medicine and the VA clinic director, VA has also, for the first time, started to maintain data on the number of VA patients needing open heart surgery.

Should the minimum requirements be met or exceeded, this information would be reported to Tripler command levels to decide if a more formal study should be conducted.

FEDERAL COORDINATION OF FACILITIES PLANNING WITH CIVILIAN HEALTH GROUPS NEEDS IMPROVEMENT

Officials of the Hawaii State Health Planning and Development Agency told us of their need to have a closer relationship with Tripler in order to better meet their obligations under the National Health Planning and Resources Development Act of 1974 (Public Law 93-641). State health planners believe they need more information on the military's health care capabilities to more fully understand the impact of any changes in these capabilities and facilities on the civilian community. A State advisory council recently formed under this act in Hawaii does not have military representation. However, the military can be invited to participate in the activities of various State subcommittees dealing with facilities planning and other areas when they are formed.

Tripler has extensive professional and educational ties to the civilian health community. It also cooperates closely with State officials on disaster planning, emergency treatment, blood banks, and other public health matters. However, in regard to facilities planning, the relationship has not been a very close one. An official informed us that Tripler might be willing to participate in State facilities planning activities as a nonvoting participant.

Passage of the National Health Planning and Resources Development Act of 1974 has resulted in the revision of the Office of Management and Budget (OMB) Circular A-95 which requires, among other things, all Federal planning agencies (including DOD planning agencies) to coordinate their activities with State and area agencies authorized to perform comprehensive health planning. DOD's regulations and procedures are being revised to reflect the requirements of OMB's circular. These revised regulations may also require that State planning bodies be permitted to review and comment on major DOD health facility construction projects. These comments will then be included in requests to DOD for project approval.

DOD regulations require that project proposals contain a brief summary of nearby community medical facilities and the relationship of the proposed projects to specialized medical services provided by the community. The regulations also require that every project proposal be supported by an area medical study which is defined as:

"* * * a compilation and analysis of Federal and civilian community medical capabilities, projected requirements and plans for future medical capabilities within the local area of a proposed military medical facility."

In accordance with these regulations, DOD initiated an area-wide medical survey in November 1973 in connection with the Tripler proposal. This survey included visits to the State by DOD and OMB personnel. DOD contacted State, VA, and other health officials and collected data on medical capabilities and needs. However, neither Tripler nor Army headquarters officials have been able to locate a copy of any report which may have resulted from this survey.

We reviewed the report which DOD's consultant prepared on its comprehensive, economic, and functional analysis for the Tripler project and subsequent planning documents. The only reference to DOD's coordination with civilian hospitals we could find in these documents was a listing of civilian hospitals within a 45-minute driving distance of Tripler and their respective bed capacities. We could find no substantive analysis of community medical facilities or of any potential impact of the Tripler project on community medical resources.

In response to our question, Hawaii State Health Planning and Development Agency officials told us they had not been apprised of the progress of the plans for the Tripler project and, until May 18, 1977, they had not been invited to comment on any of the various proposals for the project. On that date, Tripler Hospital notified the Hawaii State Health Planning and Development Agency by letter that the Army Surgeon General had (1) directed that Hawaii Health Planning and Development Agency officials be invited to comment on the proposed Tripler project and (2) provided the State agency with a point of contact in Hawaii for further information on the project. An official of the State agency told us that the agency planned to seek more information on the project before it prepared comments for DOD.

The Army Health Facilities Planning Agency has prepared a bed capacity proposal for the renovated Tripler facility, using as its primary planning tool a hospital sizing model we developed in a review of DOD's sizing of the proposed

San Diego Naval Hospital. 1/ DOD's original proposal for the new Tripler facility, before application of the sizing model, contained an estimated acute care capacity of 540 beds. Using the planning model, the Army Health Facilities Planning Agency suggested 480 acute care beds. However, an additional requirement for 55 light care beds brought the total to 535 beds. Estimates showed that the beds would be allocated as follows.

Obstetric	60
Acute psychiatric	48
All other acute (note a)	372
Light care	55
Total	535

a/Includes general medical/surgical, medical intensive care, surgical intensive care, cardiac care, and pediatric beds. The final number of beds for each category has not yet been determined. The Army expects that VA's December 1977 request for additional psychiatric beds will be honored by DOD without increasing the overall size of the renovated facility.

At present, the joint-venture architect and engineering firm is completing the design of the proposed facility.

The degree to which Tripler will have to rely in the future on civilian hospitals to provide care to Federal beneficiaries requiring certain medical services will be dependent on

--the ultimate size of the renovated Tripler facility;

--how the inpatient beds at the new facility are allocated among the medical services; and

--the ability of DOD, or perhaps VA, to provide additional staff for those services.

Our analysis of data supplied to us by Hawaii State Health Planning and Development Agency officials indicated that the civilian hospitals on the Island of Oahu could absorb

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1/See our report "Policy Changes and More Realistic Planning Can Reduce Size of New San Diego Naval Hospital," MWD-76-117, Apr. 7, 1976. DOD now requires that the model described in this report be used in sizing all proposed hospital construction projects.

some of Tripler's workload if necessary; however, their ability to do this, like Tripler's, varies among medical treatment categories with psychiatric beds in the shortest supply.

Because of the potential that Tripler may--as it does now in some cases--have to refer patients to civilian hospitals through DOD's Civilian Health and Medical Program of the Uniformed Services, DOD should make a concerted effort to keep State health planning officials continually informed of the plans for Tripler as they progress. DOD should consider the concerns of these officials as they continue with plans and designs for the new Tripler facility.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Health care by the military services, VA, and PHS in Hawaii is generally available and easily accessible to eligible citizens of the State. This assessment does not mean that the health facilities of the individual services and agencies are not, at times, constrained by budgetary, staffing, and other problems. These problems sometimes limit their ability to provide direct care to all those eligible beneficiaries who present themselves for such care. In such situations, arrangements are made for needed care to be provided at other Federal facilities or at non-Federal public or private hospitals under reimbursement arrangements worked out by the agency primarily responsible for providing the care.

Because of the size of the State and the periodic budgetary and other problems experienced by individual agencies delivering health care, it would be in the interest of those agencies to foster a much closer working relationship among themselves. There are opportunities--particularly in the dental area--for the services and agencies to make better use of existing Federal facilities. Also, and perhaps of greater long-term consequence, the planned construction and renovation project at Tripler Army Medical Center offers the opportunity for the Government to design a facility which will more closely meet the changing health care needs of the military, VA, and PHS beneficiary populations.

To take advantage of the opportunities to streamline the Federal health care delivery in the State, more cooperation is needed (1) among the military services themselves, (2) between the services and the other two Federal agencies delivering health care in the State, and (3) between the Federal health care community and the State Health Planning and Development Agency. Specific conclusions concerning each of these relationships follow.

Relationships among the military services

We believe that, to be effective as a local forum for increased interservice cooperation, the Mid-Pacific Review Committee needs specific guidance, directives, and continuing feedback from the DOD Health Council. Also, it needs a mechanism to resolve differences of opinions and program

emphasis of the individual services. The Committee should conduct continuing assessments of the capabilities of the individual services' health facilities and of the populations which are, or could be, served by these facilities in an effort to foster optimal facility use patterns. The military dental situation in the State offers a good opportunity for such an assessment.

Relationship of the military to VA and PHS

VA and PHS should be invited to participate in the Committee's activities; the health care needs of these agencies' beneficiaries (e.g., in the dental area) should be considered when the Committee assesses the use patterns of Federal health care facilities. Interagency agreements should be established between DOD and VA, and DOD and PHS to permit beneficiaries of VA and PHS dental programs in Hawaii to be treated in DOD facilities.

In addition, VA's and PHS' needs for specific medical capabilities--for example, VA's needs in the psychiatric area--should be fully considered by DOD as it plans and designs the renovation of Tripler since that facility will continue to operate as the only Federal inpatient hospital in the State.

Relationship of the Federal health community to the Hawaii Health Planning and Development Agency

This agency, which is responsible for the planning of public and private health delivery facilities in the State has stated its desire to have a closer working relationship with the Federal health community and, in particular, with the Army as it plans the renovation of the Tripler Army Medical Center. The Army has requested the agency's comments on the proposal for Tripler and has provided the agency a point of contact for receiving more information on the proposed project. We believe that DOD should followup on this initiative to insure that the agency is kept apprised of the plans, so that it can adequately carry out its planning responsibilities. DOD should likewise apprise the agency of the progress of the plans for the new Army outpatient facility at Schofield Barracks.

RECOMMENDATIONS

We recommend that the Secretary of Defense:

--Insure that the DOD Health Council (1) provide the Mid-Pacific Review Committee the direction, guidance, and feedback needed for the Committee to function as an effective coordinating body for military health care activities in Hawaii and (2) direct the Committee to seek the representation of VA and PHS as participating members.

--Establish, in cooperation with the Administrator of Veterans Affairs and the Secretary of Health, Education, and Welfare, interagency agreements to permit VA's and PHS' dental patients, not otherwise eligible for care in DOD facilities, to be treated routinely in all military dental facilities in Hawaii when such treatment would be advantageous to the Government and the individuals involved.

--Insure that the Army, in its plans for renovating the Tripler facility, (1) keeps other Federal health care providers and Hawaii State Health Planning and Development Agency officials fully apprised of the progress of the plans for that facility and (2) gives full consideration to the comments and concerns of those agencies regarding the project so that when completed, Tripler will be more capable of serving as the only Federal hospital in the State and as a useful partner in the State's health care community.

AGENCY COMMENTS AND OUR EVALUATION

DOD and VA generally agreed with each of the recommendations contained in this report. The Administrator of Veterans Affairs expressed strong interest in better coordination among Federal medical providers in Hawaii. Also, in a December 1977 letter to the Secretary of Defense, the Administrator of Veterans Affairs requested that DOD incorporate VA's needs, particularly for 20 psychiatric beds, in future planning for the Tripler facility.

In January 1978, DOD said it is committed to the ideal of a coordinated Federal approach to planning and delivering health services. DOD has worked with other Federal providers to establish a Federal Health Resources Sharing Committee and has proposed a DOD Directive which emphasizes coordination on health matters with other governmental and civilian agencies. (See pp. 46 to 48.) In addition, if VA presents

its medical service requirements to DOD, those requirements will be presented to the Congress in the military construction proposal for Tripler. DOD's and VA's specific comments are included as appendix VI and VII, respectively.

In commenting on our report by letter dated February 17, 1978 (see app. VIII), the Inspector General of HEW agreed with our recommendation to DOD that (1) the Committee seek PHS participation in the Committee's activities and (2) the Army give full consideration to the comments of other Federal agencies regarding the plans for renovating Tripler. However, the Inspector General disagreed with our conclusion that the Navy could handle all of PHS' dental patients, thereby allowing for the closing of the PHS dental clinic. The Inspector General stated that while this action might result in a reduced expenditure, it would also mean that PHS beneficiaries would not have access to dental services on a priority basis. Access is especially important to American seamen since the scheduling of treatment for them is controlled by departure dates of their ships. In addition, under existing legislation, dependents of PHS beneficiaries are not authorized to receive routine dental services in DOD facilities. Therefore, HEW believes that it would be disruptive, and perhaps uneconomical, for PHS beneficiaries to receive attention for their other medical needs at the PHS clinic but require them to go to the Navy facility for dental work, even if a reimbursable arrangement could be developed.

We do not fully agree with HEW's position. Although approximately 50 percent of the dental workload at the Honolulu PHS clinic is comprised of American seamen, we believe that obtaining dental service at the Navy's facilities would not present an undue hardship to the individuals affected. We believe that through an interagency agreement, PHS beneficiaries could obtain dental services at Navy dental facilities at less cost to the Government. However, in pursuing this alternative, PHS should insure that DOD's dental facilities will be able to promptly satisfy the dental needs of American seamen who must return--sometimes on short notice--to their ships which may be ready for departure.

APPENDIX I

DANIEL K. INOUYE
HAWAII

United States Senate

WASHINGTON, D.C. 20510

February 21, 1977

Mr. Elmer B. Staats
Comptroller General of the
United States
General Accounting Office
Washington, D.C. 20548

Dear Mr. Staats:

As a result of discussions between members of your Human Resources Division staff and my staff, I am aware that your Office has been performing some survey work at the Tripler Army Medical Center as well as at other health care facilities on the island of Oahu in Hawaii. I would appreciate it if your Office would provide me with a report which discusses the extent to which Federal health care is available and accessible to those citizens of the Islands who are eligible for care in Federal health facilities. I have received a number of letters from constituents--particularly veterans--who do not believe that the health care services, to which they are entitled, are being satisfactorily provided.

Funds were included in the Department of Defense's fiscal year 1977 appropriations for the planning of a major renovation and modernization program at the Tripler facility. As a member of the Military Construction Subcommittee of the Senate Appropriations Committee, I am particularly concerned that DOD's planning for the modernized Tripler facility adequately takes into consideration how the renovated facility, along with the efficient use of the other health facilities on Oahu, will meet the health needs of the Government's constituent population. As you know, the matter of sizing of Federal health facilities as part of DOD's construction planning process has been a matter of particular concern to the subcommittee and its counterpart in the House of Representatives. I would appreciate your Office, as part of its ongoing work in Hawaii, providing me with information on the status of DOD's planning for the proposed renovation of Tripler.

APPENDIX I

Mr. Elmer B. Staats
February 21, 1977

I am looking forward to receiving a report on the results of your review efforts in Hawaii and my staff will be available to discuss any matters of mutual interest as your review continues.

Aloha,

DANIEL K. INOUYE
United States Senator

APPENDIX II

MILITARY HEALTH FACILITIES IN HAWAII

ESTIMATED COSTS FOR FISCAL YEAR 1976

Service	Personnel and benefits	Operation and maintenance	Construction	Medical equipment	Total
	(thousands)				
Army	$20,608.0	a/$26,052.0	$183.0	$891.0	$47,734.0
Navy Medical	3,389.8	b/2,375.7	21.6	31.8	5,818.9
Navy Dental	2,273.4	b/454.0	-	12.0	2,739.4
Air Force	414.9	806.3	-	-	1,221.2
Total	$26,686.1	$29,688.0	$204.6	$934.8	$57,513.5

a/Includes installation support.

b/Includes reimbursements.

VETERANS ADMINISTRATION REGIONAL MEDICAL CLINIC IN HONOLULU, HAWAII, ESTIMATED COSTS FOR FISCAL YEAR 1976

	(thousands)
Contract hospitalization	a/$3,235.2
Operating funds	436.6
Salaries	994.5
Equipment	28.5
Maintenance and repair	2.2
Community nursing home care	92.3
Fee medical services	120.3
Fee dental services	499.9
Hemodialysis	200.0
Travel	4.2
Total	$5,613.7

a/Over $2.3 million was obligated for reimbursement to the Department of the Army for care received by veterans at Tripler Army Medical Center.

APPENDIX II

U.S. PUBLIC HEALTH SERVICE OUTPATIENT CLINIC IN HONOLULU, HAWAII, ESTIMATED COSTS FOR FISCAL YEAR 1976

Personal services and benefits	$646,941
Supplies	61,657
Equipment	10,037
Maintenance and repair	13,000
Miscellaneous	78,739
Total	$810,374

APPENDIX III

HISTORY OF DEPARTMENT OF DEFENSE PLANNING FOR THE CONSTRUCTION AND RENOVATION PROJECT AT TRIPLER ARMY MEDICAL CENTER

Tripler was designed to serve a primarily male inpatient population, but it has had no major alteration since its completion in 1948. Proposals for the modernization of Tripler were made as early as 1963 when it was noted that changes in emphasis from inpatient to outpatient care and advances in medical care had impaired the efficiency of the hospital's configuration. This proposal did not result in any major construction at the hospital.

Another modernization proposal for the hospital, submitted by Tripler officials in November 1969, called for converting certain inpatient wards and administrative offices into an outpatient clinic. Again, it was noted that piecemeal conversion of inpatient space into outpatient clinical areas had resulted in an inefficient and confusing configuration. The project was estimated to cost about $6 million. This and an earlier $5.3 million proposal for air-conditioning were resubmitted in October 1970. Both projects were approved by DOD on November 6, 1970, for inclusion in the 5-year construction program starting in fiscal year 1974.

In 1972 Tripler officials submitted a proposal for a new pathology laboratory which was approved by DOD in November of that year. Funding for the project was scheduled for fiscal year 1976.

In August 1973, DOD instructed Tripler to combine the air-conditioning and modernization projects. A combined proposal was then resubmitted in December 1973 for a total of $48.6 million to be funded in fiscal year 1977. The project, as submitted, was designed to provide a completely new hospital layout, which would separate inpatients from outpatients and would provide for

--an efficient flow of outpatient activity,

--a modern cardiac catheterization laboratory,

--a modernized labor/delivery area and newborn nursery,

--a neurological intensive care unit,

APPENDIX III

--air-conditioning, and

--other improvements.

In January 1974, DOD sent a team to survey health care facilities in Honolulu, Hawaii. A memorandum based on the survey was prepared by the Office of the Assistant Secretary of Defense for Health Affairs on March 13, 1974. The memorandum noted that Tripler was no longer functionally organized to economically deliver quality care and directed the Army to contract for a comprehensive functional and economical analysis contrasting a potential modernization of the existing facility with the construction of a total replacement.

A contract for this analysis was awarded to a consulting firm in June 1974. The firm's study, which was completed in January 1975, showed that it would cost $141 million (in 1975 dollars) to build a new facility in contrast to an estimated $84 million to renovate the existing facility.

DOD did not act on the study's recommendations until April 14, 1976, when it directed the Department of the Army to proceed with developing the project scope. On April 19, 1976, the Army Surgeon General prepared a project proposal for a combined renovation and construction project with an estimated cost of $131.5 million. Funding for the project was to be requested in DOD's fiscal year 1979 budget.

Almost concurrently, however, Tripler officials submitted a separate proposal to the Army's Health Services Command for the fiscal year 1978 military construction program. Tripler officials felt that the most critical deficiencies--those relating to health and safety and those cited as problems by the Joint Committee on Accreditation of Hospitals--needed to be corrected immediately. They also believed that the total renovation and construction project would be deferred until sometime in the 1980s. The officials proposed that a new wing be constructed at a cost of about $20 million to house the hospital's radiology, pathology, and surgical activities which are now in very confined spaces and, in the cases of pathology and radiology, scattered throughout the hospital. Tripler's proposal was based on the findings in the consulting firm's January 1975 study.

In June 1976, the Army Surgeon General notified Tripler officials that the Army Health Facilities Planning Agency would be responsible for coordinating the development of design for the total project and that it would be necessary

APPENDIX III

to develop detailed space requirements and justifications to gain DOD's approval prior to submission of the project to the Congress for funding.

Detailed space requirements were to be developed under a "utilization and requirements" study, which was conducted by the Army Health Facilities Planning Agency in June and July 1976. A new proposal was developed in August 1976 for a combined construction and renovation project, with an estimated cost of $115.7 million, to begin in fiscal year 1979. The project was to be constructed in phases. The first phase was to incorporate Tripler's April 1976 proposal on the construction of a new hospital wing and was estimated to cost $27,391,000. Three additional phases for renovation of existing Tripler structures were estimated to cost about $30 million each.

In October 1976, a consortium of architect-engineers was hired by the Army to design the proposed project. Total costs for the design work--which will be accomplished in two stages--are presently estimated at $5.1 million. The first stage will encompass the conceptual design and an environmental impact statement and will cost $1.35 million. Conceptual design work will establish the functional relationship between departments, physical layout, and proper staging of construction, to keep the hospital functioning. The second design stage will encompass contract plans, specifications, design analysis, and cost estimates leading up to final design and solicitation of competitive bids for construction. This stage will be performed under a separate contract for $3.75 million and can be implemented by the Government, at its option, upon acceptance of the first stage. Submission of completed work under the first stage was scheduled for October 1977.

In January 1977, the Army prepared--for the use of the design consortium--an estimate of $132 million for the planned project at Tripler. Since that time the estimate has fluctuated upward to as much as $141.5 million and downward to $120 million--the current estimate. The Army plans to request funding of the project in its 5-year construction program beginning in fiscal year 1980. Although the final size and cost estimates for the Tripler project will not be firmed up until completion of the design phase, it is now expected that the hospital will have an operating capacity of about 480 acute-care and 55 light-care beds. According to Tripler officials, the current renovation and construction plans for Tripler provide

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--the capability for increases in the quantity and quality of inpatient and outpatient care to be offered,

--reduced reliance on civilian facilities,

--the ability to meet accreditation and Occupational Safety and Health Administration requirements,

--allowances for medical technological advancements, and

--other improvements.

APPENDIX IV

FEDERAL MEDICAL BENEFICIARY POPULATION IN HAWAII, FISCAL YEAR 1977

Active-duty military	58,748
Active-duty Coast Guard (note a)	949
Dependents of active-duty military	63,761
Dependents of active-duty Coast Guard (note a)	1,270
Retired	7,267
Dependents of deceased and retired	13,807
Veterans (note b)	86,733
Total	232,535

a/Active-duty Coast Guard personnel and their dependents and PHS Commissioned Corps officers and their dependents are eligible PHS beneficiaries. American seamen and Office of Workers Compensation Program beneficiaries are also entitled to receive medical care at the PHS clinic. However, PHS officials in Hawaii were unable to estimate the number of American seamen or Office of Workers Compensation Program beneficiaries eligible for care in the Honolulu PHS clinic.

b/VA estimates that there were 94,000 VA beneficiaries in Hawaii as of June 30, 1976. The above represents the number of veterans less the number of military retirees.

VA ESTIMATE OF HAWAII VETERAN POPULATION BY ISLAND, JUNE 30, 1976

Island	Number	Percent
Oahu	78,500	83.5
Hawaii	7,480	8.0
Maui (note a)	3,880	4.1
Kauai (note a)	3,370	3.6
Molokai (note a)	510	0.5
Lanai (note a)	230	0.3
Niihau (note a)	30	-
Total	94,000	100.0

a/Based on VA methodology of distributing veteran population within the counties of Kauai and Maui in relation to the distribution of overall civilian population on each island, including dependents of military personnel but not including servicemen.

Note: We were told admissions to neighbor island hospitals and to hospitals throughout Oahu may be authorized in instances of emergency. Transfer to Tripler Army Medical Center is required if the patient's condition permits. A patient's stay in neighbor island hospitals is authorized when the patient's condition does not permit travel or if extensive hospitalization is not required. In most instances, VA will cover transportation costs.

Routine outpatient care for eligible veterans residing on neighbor islands is authorized from fee-basis providers of services--predominantly private physicians.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

25 [illegible] 1977

Mr. Gregory J. Ahart
Director, Human Resources Division
General Accounting Office
441 G Street N.W.
Washington, D.C. 20548

Dear Mr. Ahart:

This is in reply to your letter of October 21, 1977 to the Secretary of Defense requesting comments on a draft report entitled "Better Inter-service and Inter-agency Coordination Could Improve the Provision of Federal Health Care in Hawaii," (OSD Case #4744) (GAO Code 10189).

The audit concluded that, for the most part, health care is readily available and accessible to eligible Federal beneficiaries in Hawaii. However, it further concluded that the care could be delivered more economically, without sacrificing quality, by making better use of existing Federal facilities in the state and by assuring that the planned renovation and construction project at Tripler Army Medical Center (TAMC) will be designed to more closely meet the health care needs of the military, Veterans Administration (VA) and other Federal beneficiaries. The Department of Defense (DoD) supports the concepts of inter-service and inter-agency coordinated planning and delivery of health care. In this regard, the following specific comments are provided:

DoD's commitment to the ideal of a coordinated Federal approach to planning and delivering health services is manifested in our work with other Federal providers to establish a Federal Health Resources Sharing Committee (FHRSC).

A working group is in the process of developing a charter that will state the range of issue areas intended to be addressed by the FHRSC. The charter will eventually be submitted to the Assistant Secretary for Health, Department of Health, Education and Welfare, the Chief Medical Director, Veterans Administration, and the Surgeons General of the Army, Navy and Air Force for approval. The current proposed charter for the FHRSC states the committee's purpose as follows:

- to identify and promote opportunities for joint planning and use of health care resources in the Federal Government and

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- to provide a forum for representatives from Federal agencies to interact in the cooperative exploration of joint planning and sharing opportunities in the delivery of medical services and the use of medical resources.

The report recommends that the Army, in its planning for TAMC keep other Federal health care providers and state officials fully informed and give full consideration to their concerns so that, when completed, TAMC will be more fully capable of serving as a useful partner in the state's health care community. DoD concurs with the need for such an approach. The isolation and containment of Hawaii necessitates a special sensitivity to the need for a cooperative approach to planning and delivery of health care.

If the VA presents its medical service requirements to DoD, those requirements will be presented to Congress in the military construction proposal for TAMC. However, in addition to facility requirements, equipment and manpower must also be given consideration. Arrangements might be made for the provision of these resources, particularly manpower, through inter-agency agreements between DoD and the VA and PHS.

DoD concurs with the need to keep state officials fully informed of plans for TAMC. Army officials have provided information to various state agencies and officers; however, if necessary, more such contact can be made. A proposed DoD Directive, "The Armed Forces Regional Health Services System," places emphasis on such coordination by charging the Regional Review Committees in each Military Medical Region to "...maintain liaison and coordinate planning and delivery of health services with other governmental and civilian agencies."

The draft report concluded that dental workload is inequitably distributed among DoD dental clinics in Hawaii and that excess capacity exists. The report recommends the establishment of an inter-agency agreement between DoD and VA to enable the VA to purchase dental care at DoD clinics at a cost less than that currently paid to civilian sources. The aforementioned proposed DoD Directive urges the participation of PHS and VA in meetings of the Regional Review Committee representatives when matters of interest to them are under discussion. This provision provides a mechanism for the PHS and VA to obtain consideration of dental services. It would seem appropriate that the matter be referred by the DoD Health Council to the Mid-Pacific Regional Review Committee for its deliberation and recommendation. If sufficient capacity to render such services is found to exist, an inter-agency agreement can be established. Likewise, the assessment of dental care for DoD beneficiaries and the effectiveness of the distribution of DoD dental capabilities in Hawaii is appropriately an issue for consideration

APPENDIX VI

by the Regional Review Committee. There is some question as to whether excess capacity or maldistribution of services does exist as concluded in the report. Nevertheless, as specified in the proposed DoD Directive, further analysis and recommendations for tri-service coordination are a responsibility of the Regional Review Committee.

DoD concurs with the audit recommendation that the DoD Health Council provide the direction, guidance, and feedback needed by the Mid-Pacific Regional Review Committee to function as an effective coordinating body. The new DoD Directive, if approved, will clarify responsibilities, establishing the Council as the central entity within DoD to provide the necessary coordination, and oversight of the Armed Forces Regional Health Services System. Upon such designation, the Military Medical Regions Coordinating Office (MMRCO) would be abolished.

In addition to the responsibilities already mentioned, the proposed Directive also specifies that Regional Review Committees will perform such functions as:

- Continuing assessment of health sources capability and operation,

- Identifying and recommending changes in regional health care delivery capability or procedures that will improve the effectiveness of services provided to authorized beneficiaries, and

- Developing and submitting annual plans for the coordinated delivery of health services within the region.

Each Regional Review Committee is also directed to establish certain standing subcommittees including a Demand Assessment and Health Requirements Subcommittee.

It is believed that the above described actions will be responsive to recommendations made in the draft report.

Thank you for the opportunity to provide these comments.

Sincerely,

Vernon McKenzie
Principal Deputy Assistant Secretary

APPENDIX VII

VETERANS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D.C. 20420

JANUARY 25 1978

Mr. Gregory J. Ahart
Director, Human Resources Division
U. S. General Accounting Office
441 G Street, N.W.
Washington, DC 20548

Dear Mr. Ahart:

We have reviewed the October 21, 1977 draft report, "Better Interservice and Interagency Coordination Could Improve the Provision of Federal Health Care in Hawaii," and are in general agreement with the recommendations it contains.

The Veterans Administration (VA) and the Department of Defense (DOD) have held several discussions in order to arrive at a mutual agreement concerning the VA's needs for health care for eligible veterans residing in Hawaii. My December 28 1977 letter to Secretary Brown formalized these discussions and requested that DOD incorporate the VA's needs, particularly for 20 psychiatric beds, in future planning for the Tripler Army Medical Center facility. We would be pleased to continue these communication and liaison activities with DOD through the Mid-Pacific Review Committee and would be willing to provide representation on the committee.

We are also agreeable to the recommendation that the Department of Defense establish, in cooperation with the Administrator of Veterans Affairs, an interagency agreement to permit VA's dental patients in the State of Hawaii to be treated routinely in all military dental facilities in the State when such treatment would be advantageous to the Government and to the individuals involved.

The VA is currently authorized to provide dental care to veterans in Hawaii. A large portion of this dental care is provided by private dentists at VA expense. Underscoring the fact that this expenditure has been of concern to this agency is the VA's statement in response to Recommendation #25, "Limited Dental Services," appearing on page 149 of the Veterans' Administration Response to National Academy of Sciences' Report entitled "Health Care for American Veterans," (House Committee Print No. 68, 95th Congress, 1st Session), which states in part: "A significant portion of VA dental resources are now applied to the care of recently discharged veterans who may receive upon application, within one year of discharge, full dental care. The VA believes this entitlement

APPENDIX VII

Mr. Gregory J. Ahart
Director, Human Resources Division

could be re-examined as a part of a narrower delineation of the VA's responsibility for dental care."

We appreciate having the opportunity to review and comment on this report.

Sincerely,

MAX CLELAND
Administrator

P.S. I have personally visited Hawaii and expressed strong interest in better coordination.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

FEB 17 1978

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Better Interservice and Interagency Coordination Could Improve the Provision of Federal Health Care in Hawaii." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

Comments of the Department of Health, Education, and Welfare on the Comptroller General's Draft Report Entitled "Better Interservice and Interagency Coordination Could Improve the Provision of Federal Health Care in Hawaii

General Comments

Although there are no recommendations directed to this Department, the report has been carefully reviewed since the recommendations to the Secretary of Defense could impact on programs of the Public Health Service (PHS).

While the PHS operations in Hawaii are small in relation to those of the Department of Defense (DOD) and the Veterans Administration (VA), we are concerned that the responsibilities of PHS to certain categories of its beneficiaries have not been adequately considered. For example, there is no indication that the needs and special requirements of American seamen and beneficiaries of the Office of Workmen's Compensation Program have been considered.

Further, we disagree with the conclusion on page 24 that the Navy could handle the PHS dental patients, thereby allowing for the closing of the PHS' dental clinic. While this might result in a reduced expenditure, it would also mean that PHS beneficiaries would not have access to dental services on a priority basis. This is especially important to American seamen since the scheduling of treatment for them is controlled by departure dates of their ships. In addition, under existing legislation, dependents of PHS beneficiaries are not authorized to receive routine dental services in DOD facilities. Therefore, we believe that it would be disruptive, and perhaps uneconomical, for PHS beneficiaries to receive attention for their other medical needs at the PHS clinic but require them to go to the Navy facility for dental work, even if a reimbursable arrangement could be developed.

Finally, we endorse the recommendations to DOD that the Mid-Pacific Review Committee seek PHS participation in their activities and that the Army give full consideration to the comments and concerns of other Federal agencies regarding the plans for Tripler Army Medical Center.

GAO note: Page references in this appendix refer to the draft report and do not necessarily agree with the page numbers in the final report.

APPENDIX IX

PRINCIPAL OFFICIALS RESPONSIBLE FOR ADMINISTERING ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
DEPARTMENT OF DEFENSE		
SECRETARY OF DEFENSE:		
Harold Brown	Jan. 1977	Present
Donald H. Rumsfeld	Nov. 1975	Jan. 1977
ASSISTANT SECRETARY (Health Affairs):		
Vernon McKenzie (acting)	Jan. 1978	Present
Robert N. Smith, M.D.	Sept. 1976	Jan. 1978
Vernon McKenzie (acting)	Mar. 1976	Sept. 1976
James R. Cowan, M.D.	Feb. 1974	Mar. 1976
DEPARTMENT OF THE ARMY		
SECRETARY OF THE ARMY:		
Clifford L. Alexander, Jr.	Feb. 1977	Present
Martin R. Hoffman	Aug. 1975	Jan. 1977
THE SURGEON GENERAL:		
Lt. Gen. Charles C. Pixley	Oct. 1977	Present
Lt. Gen. Richard R. Taylor	Oct. 1973	Oct. 1977
DEPARTMENT OF THE AIR FORCE		
SECRETARY OF THE AIR FORCE:		
John C. Stetson	Apr. 1977	Present
Thomas C. Reed	Jan. 1976	Apr. 1977
James W. Plummer (acting)	Nov. 1975	Jan. 1976
THE SURGEON GENERAL:		
Lt. Gen. G. E. Schafer	Aug. 1975	Present

APPENDIX IX

	Tenure of office	
	From	To
DEPARTMENT OF THE NAVY		
SECRETARY OF THE NAVY:		
W. Graham Claytor, Jr.	Feb. 1977	Present
J. William Middendorf II	June 1974	Feb. 1977
J. William Middendorf II (acting)	Apr. 1974	June 1974
THE SURGEON GENERAL:		
Vice Admiral Willard P. Arentzen	Aug. 1976	Present
Vice Admiral Donald L. Custis	Mar. 1973	July 1976
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE		
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Joseph A. Califano, Jr.	Jan. 1977	Present
David Mathews	Aug. 1975	Jan. 1977
ASSISTANT SECRETARY FOR HEALTH:		
Julius B. Richmond, M.D.	July 1977	Present
James Dickson, M.D. (acting)	Jan. 1977	July 1977
Theodore Cooper, M.D.	May 1975	Jan. 1977
Theodore Cooper, M.D. (acting)	Feb. 1975	Apr. 1975
VETERANS ADMINISTRATION		
ADMINISTRATOR OF VETERANS AFFAIRS:		
Max Cleland	Mar. 1977	Present
Richard L. Roudebush	Oct. 1974	Mar. 1977
Richard L. Roudebush (acting)	Sept. 1974	Oct. 1974
CHIEF MEDICAL DIRECTOR:		
John D. Chase, M.D.	Apr. 1974	Present

(10189)