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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

The Congress Should Mandate Formation Of A Military-VA-Civilian Contingency Hospital System

The Department of Defense (DOD) is developing a civilian-military contingency hopital system for treating returning battlefield casualties because it has insufficient resources of its own. However, several issues and unanswered questions regarding DOD's implementation plans need immediate attention.

The most important issue, in GAO's opinion, is the extent of support the Veterans Administration (VA) will provide DOD. DOD plans considered limited VA assistance. VA cannot fully support DOD without modifications to VA's current legislative authority and responsibilities. Therefore, GAO recommends that the Congress enact needed legislation.

GAO also recommends the development of plans using available Federal and civilian medical resources to treat battefield casualties. Such plans should include coordination of civilian resources with both DOD and VA facilities.

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

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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the need for developing a contingency hospital system consisting of Department of Defense, Veterans Administration, and civilian medical resources. The report's primary emphasis is our belief that the Veterans Administration's role should be greater than currently planned by the Department.

We performed this review at the request of Representative Robin Beard.

We are sending copies of the report to the Secretary of Defense; the Administrator of Veterans Affairs; the Director, Office of Management and Budget; the Director of the Federal Emergency Management Agency; and other interested parties.

Milton J. Socolar

Acting Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

THE CONGRESS SHOULD MANDATE FORMATION OF A MILITARY-VA-CIVILIAN CONTINGENCY HOSPITAL SYSTEM

D I G E S T

The extent of support the Veterans Administration (VA) will provide the Department of Defense (DOD) in treating returning battlefield casualties is the most important issue in developing a civilian-military contingency hospital system for medical treatment of wartime casualties.

DOD PLANNING TO USE CIVILIAN HOSPITALS IN WARTIME

DOD has looked primarily to civilian medical resources to meet anticipated shortfalls should the United States become involved in war. Only recently has specific consideration been given to VA's medical capability. DOD officials said that civilian resources would still be needed to treat battlefield casualties, even if DOD and VA resources were fully used for that purpose.

DOD planned to begin implementing a civilian-military contingency hospital system in October 1979. GAO recommended that implementation be suspended because of several unresolved or unexplored issues. (See app. I.) DOD did not agree with GAO's recommendation, and felt the system should proceed. Unresolved issues would be addressed during implementation. (See p. 4 and app. II.)

DOD recently revised several aspects of its original system. Major changes appear to be (1) elimination of a new, possibly duplicative administrative structure as originally proposed and (2) reliance on the military services for patient administration responsibilities.

GAO agrees with these revisions. However, more issues and uncertainties concerning

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the extent of VA participation, and civilian bed and staff availability remain to be resolved. (See pp. 9, 12, and 15.)

UNCERTAINTIES REMAIN CONCERNING DOD'S PLANS TO USE NONMILITARY HOSPITALS

DOD's original plan focused on identifying excess beds, which GAO believed would be a limited indicator of bed capacity usable on short notice. (See p. 10.) DOD's plans also assumed that medical staff would be available, but lacked specific information about how physician and support staff would be obtained. (See p. 14.)

DOD's revised plans are still unclear about how civilian beds and staff would be made available. The military services will have discretion over determining how to secure civilian resources. GAO believes available beds and staff should be identified assuming (1) patients are discharged early whenever possible and (2) nonemergency admissions are restricted during the war surge period. (See p. 15.)

OTHER ISSUES TO BE RESOLVED BEFORE USING CIVILIAN HOSPITALS

DOD needs to further address, with the military services and other organizations, issues concerning regulation of patient transfers (see p. 19) and ground transportation (see p. 20). Issues also remain regarding civilian physician and hospital reimbursement and liability (see p. 24) and coordination with the Federal Emergency Management Agency, the Department of Health and Human Services, 1/ and other agencies having wartime

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1/On May 4, 1980, a separate Department of Education commenced operating. Before that date, activities discussed in this report were the responsibility of the Department of Health, Education, and Welfare.

planning responsibilities. (See p. 25.) GAO believes that failure to resolve these issues could limit implementation of the planned system.

VA AS A POTENTIAL WARTIME MEDICAL RESOURCE

DOD and VA have recently been discussing possible wartime coordination of medical resources, but some questions about VA's participation remain. DOD plans for VA to care for battlefield casualties not expected to return to duty--that is, service-connected veterans. However, VA's mission is to care for such veterans; therefore, such a plan involves no real change from VA's current primary responsibilities. (See p. 13.)

GAO believes that VA should be much more involved in planning and caring for battlefield casualties than it would be in caring only for those who will not return to duty. Just how much VA can participate is questionable. DOD has not told VA what its needs are, nor has VA told DOD what its capabilities are. In fact, the Administrator of Veterans Affairs recently told DOD that VA would not be able to directly support casualty treatment in the United States, unless it was given that mission in other than a declared national emergency. (See pp. 12 to 15.)

In GAO's opinion, the Nation should prepare for a possible conflict by planning to appropriately use Federal medical resources before calling on civilian resources. Moreover, GAO believes that a strong peacetime medical resources sharing program, such as that which it recommended in its June 1978 report, could provide a more effective relationship between VA and DOD that could prove invaluable in war. (See pp. 15 and 16.)

RECOMMENDATIONS TO THE CONGRESS

GAO recommends that the Congress enact legislation which provides that both DOD and VA

fully participate in Federal medical planning for and care of returning wartime casualties. Such legislation should:

--Give VA the mission of providing direct medical support to DOD for treating battlefield casualties.

--Place battlefield casualties above veterans with non-service-connected, nonemergency conditions in VA's priority for care.

--Remove numerous obstacles to interagency sharing, as GAO previously recommended, so that VA and DOD may establish a strong peacetime medical resources sharing program to serve as an effective foundation for a military-VA-civilian contingency hospital system. (See p. 31.)

RECOMMENDATIONS TO DOD AND VA

GAO recommends that the Secretary of Defense and the Administrator of Veterans Affairs jointly:

--Develop and establish the framework for a military-VA-civilian contingency hospital system.

--Analyze DOD's and VA's medical care resources to determine the Federal patient treatment capability on a time-phased basis.

--Identify Federal and civilian capability that could be provided assuming that (1) patients are discharged early whenever possible and (2) nonemergency admissions are restricted during the war surge period. (See pp. 31 and 32.)

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

The Secretary should:

--Compare the medical care requirements calculated under various wartime scenarios

with available Federal medical resources to determine how much and what type of civilian medical care capability would be needed to augment Federal capability.

--Determine the optimal number and placement of U.S. aeromedical staging facilities with emphasis on locations near concentrations of military and VA medical resources.

--In concert with other agencies having contingency planning responsibilities, assume overall coordinating responsibility for plans jointly developed by DOD and VA using Federal medical resources and necessary civilian medical capability under the military-VA-civilian contingency hospital system. (See p. 32.)

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

The Administrator should:

--Provide estimates to DOD concerning VA's potential facility and staffing capabilities to treat returning battlefield casualties regardless of whether those casualties would be expected to return to duty. These estimates should be developed through the joint DOD-VA planning effort to establish a military-VA-civilian contingency hospital system.

--Ascertain the extent to which VA's affiliated hospitals would be able to assist VA in treating battlefield casualties. (See pp. 32 and 33.)

AGENCY COMMENTS AND GAO'S EVALUATION

DOD, VA, and the Federal Emergency Management Agency indicated their concerns about how the full implementation of the recommendations would affect their current plans and operations. GAO believes the comments provide further evidence that congressional guidance

is needed to establish an effective military-VA-civilian contingency hospital system.

DOD stated that actions necessary to carry out the recommendations to the Secretary of Defense had already been initiated. It noted that active dialogue with VA is now in progress for wartime planning.

Notwithstanding the dialogue, GAO believes that DOD is proceeding to implement only a slightly modified version of its original plan. GAO does not agree with this approach. (See pp. 33 to 35.)

VA stated its concern regarding possible misinterpretations of several recommendations. GAO recognized these concerns and clarified the recommendations. (See pp. 35 to 36.)

The Federal Emergency Management Agency was concerned that it and the Department of Health and Human Services had not been sufficiently included in DOD's planning and development of the contingency system. (See pp. 36 and 37.)

Contents

ABBREVIATIONS

AHA	American Hospital Association
ASF	aeromedical staging facility
ASMRO	Armed Services Medical Regulating Office
CMCHS	Civilian-Military Contingency Hospital System
DOD	Department of Defense
EMS	Emergency Medical Services
FEMA	Federal Emergency Management Agency
GAO	General Accounting Office
HHS	Department of Health and Human Services
JMRO	Joint Medical Regulating Office
MAC	Military Airlift Command
MMLO	Military Medical Liaison Office
PHS	Public Health Service
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

In response to a May 1, 1979, request from Congressman Robin Beard, we reviewed the Department of Defense (DOD) plans to use nonmilitary hospitals to treat battlefield casualties in the event of war or conflict. During this effort, we identified several important issues relating to those plans which need immediate attention. Accordingly, as agreed with the Congressman's office, although we did not perform a detailed, comprehensive review of these issues, this report discusses the issues so that they may be considered during proposed congressional hearings and DOD's continuing preparedness planning process.

DOD's health care system is comprised primarily of the direct care systems of the Army, Navy, and Air Force. 1/ These systems are to provide medical care to support the U.S. military forces. For example, the Army Surgeon General stated during 1978 congressional hearings that the Army Medical Department's objectives include:

--Maintaining physically and mentally fit soldiers and trained health staff to support Army combat, contingency, and mobilization plans.

--Providing care and treatment capabilities for combat casualties in a theater of operations and in the United States.

The size of DOD's direct care medical operations worldwide is shown in the following table.

Military service	Number of Hospitals U.S.	Hospitals Other	Clinics U.S.	Clinics Other
Army	36	12	75	54
Navy	23	8	136	34
Air Force	65	16	20	20
Total	124	36	231	108

1/In addition to DOD's direct medical care system, dependents of active duty members, retirees and their dependents, and dependents of deceased members may obtain medical care in the civilian sector under the Civilian Health and Medical Program of the Uniformed Services.

The medical facilities in the direct care system range from small clinics with limited medical capabilities to large medical centers with extensive medical specialty capabilities and medical teaching programs. In fiscal year 1978, DOD's total normal bed capacity 1/ was about 35,000. However, fewer than 20,000 beds were actually set up, staffed, and equipped, and an average of fewer than 16,000 were actually occupied.

To assure patient access to medical care, DOD operates a worldwide aeromedical evacuation organization. The Air Force's Military Airlift Command (MAC) operates various types of aircraft for aeromedical evacuation missions from overseas to the United States and throughout this country. During peacetime, the Air Force uses the same system that would be expanded and used during wartime.

The Veterans Administration (VA) hospital system is much larger than DOD's. In November 1979, VA operated 172 hospitals containing over 85,000 beds.

DOD WARTIME MEDICAL PLANNING TO USE CIVILIAN HOSPITALS

DOD has historically relied extensively on its own medical resources to care for sick and wounded personnel evacuated from overseas conflicts. Past conflicts generated a need for large quantities and various types and levels of medical services to care for military personnel. However, in the past, sufficient time was available to build up medical support units and other medical care system elements to provide treatment to returning casualties.

Current wartime planning scenarios discuss U.S. involvement in short but intense conventional warfare. Under such scenarios, adequate time may not be available for a gradual and orderly buildup of medical care capability in the theater of operations or in the United States. In a short, intense conflict, many casualties would be incurred quickly. This situation would require that much of the military's total active duty medical personnel resources be committed in the theater of operations to handle early life-saving, patient

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1/Normal bed capacity refers to the space available in existing hospitals where beds could be set up. However, DOD does not have the beds, staff, or equipment needed to make the space usable for patient treatment.

stabilization, and definitive care requirements. The resources remaining in the United States would be quickly strained until they could be augmented by reserve personnel, draftees, and others.

DOD officials told us that current war planning scenarios result in casualty estimates so large that non-Federal civilian medical resources would be needed even if both DOD and VA capabilities were fully used to treat battlefield casualties. Studies have shown that most casualties would have to be treated in non-DOD facilities.

Health program planning guidance directs DOD to look to civilian staff and nondefense facilities for capability to meet anticipated wartime requirements. The guidance recognizes that there would be military medical personnel shortages resulting from a major conflict, and that the ability to quickly augment military facilities with reserve personnel or draftees would be limited. To date, most of DOD's planning efforts have concentrated on civilian resources. Only recently has any specific consideration been given to other Federal capability, such as that provided by VA.

DOD and other planning efforts regarding the use of civilian medical resources include:

--A 1978 DOD study concerning DOD's wartime reliance on civilian sector health care resources.

--A 1979 report by Maximus, Inc., a private contractor, entitled "Study of the Problems Associated with Reliance on Civilian Medical Manpower and Non-DOD Facilities During Periods of National Emergency, Mobilization, and War."

--Two Contingency Support Plans (OPLANS 9550) prepared at two Air Force hospitals. They are not Air Force policy and represent plans only for the facilities where they were developed.

The Maximus report, completed in March 1979, addressed the potential for using civilian hospitals to augment DOD medical resources in a major conflict. It is the most comprehensive effort that DOD has supported or undertaken in this area. The report recommended that DOD establish a Civilian-Military Contingency Hospital System (CMCHS) to coordinate DOD's use of wartime medical resources. CMCHS included setting up the following organizations to facilitate obtaining medical care from the civilian sector:

--A DOD-level office--the Office of Civilian-Military Contingency Hospital System--to organize, implement, and oversee a system of DOD-linked civilian hospitals.

--A series of Military Medical Liaison Offices (MMLOs) to interface with participating local civilian hospitals. The MMLOs would be located in major metropolitan areas where adequate civilian medical capability had been identified. The Maximus report identified 41 such areas.

Maximus also recommended that CMCHS be implemented by establishing formal contracts and agreements with civilian hospitals in the 41 areas. Under the Maximus concept, DOD would obtain access to about 40,000 beds for wartime purposes.

On the basis of the Maximus report, the Assistant Secretary of Defense for Health Affairs circulated a draft directive establishing CMCHS to the military services for comment. We understood that DOD originally planned to begin CMCHS implementation in October 1979.

On October 25, 1979, we recommended that implementation of CMCHS be suspended. (See app. I.) In our opinion, many fundamental issues for developing a contingency medical system with the civilian sector were either unresolved or unexplored. Included were issues concerning (1) whether excess civilian beds and medical staff were in fact available and (2) a lack of adequate coordination with the Selective Service System, the Federal Emergency Management Agency (FEMA), and the Department of Health and Human Services (HHS). 1/ These organizations have responsibilities for preparedness programs involving the Nation's medical resources during wartime. Also, DOD appeared to be proceeding to implement CMCHS without an accurate picture of what total Federal medical capability could be obtained.

DOD did not agree with our recommendation that implementation of CMCHS be suspended. In a December 10, 1979, response to our report, DOD stated that CMCHS should proceed and that the unresolved issues would be addressed during the system's implementation. (See app. II.)

1/On May 4, 1980, a separate Department of Education commenced operating. Before that date, activities discussed in this report were the responsibility of the Department of Health, Education, and Welfare.

In January 1980, DOD circulated another CMCHS draft program directive to the services for comment. DOD's new draft directive is a continuation of its CMCHS planning efforts. DOD has revised some of the original concepts proposed by Maximus and included in the earlier draft directive. For example, DOD officials told us that proposed administrative structures such as the MMLOs have been dropped. Administrative functions will now be performed by the military services through DOD hospitals, rather than by the MMLOs.

Implementation of CMCHS is now beginning. The new CMCHS Director joined DOD in early March 1980, and the Deputy Director arrived in late April.

Under CMCHS as now being implemented, civilian hospitals in the United States will be linked by formal agreement to the DOD health care system. DOD has no current estimate of the number of beds that will ultimately be involved in the program. VA hospitals, while not a formal part of the CMCHS administrative structure, will also help DOD treat returning wartime casualties, according to DOD officials.

Another Maximus report concerning VA capabilities was issued on December 31, 1979. This report recommended that DOD and VA continue their efforts to develop and maintain a working contingency system which would enhance wartime preparedness. The report recommended, in part, that DOD intensify its planning efforts with VA to:

--Develop specific contingency plans.

--Draft and sponsor legislative language to permit VA hospitals to give higher priority to care of active duty patients during wartime.

Although the above recommendations, if implemented, would enhance VA's role in any proposed contingency hospital system, uncertainties regarding the extent of VA participation and civilian bed and staff availability remain to be resolved.

SCOPE OF REVIEW

We made our review at the headquarters offices and selected health care facilities of DOD and VA and at several civilian health organizations. Our general objective was to evaluate DOD's and the military services' plans and efforts to involve the civilian sector and other Federal capability in providing medical care to war casualties.

Although we visited many locations and spoke with numerous Federal and civilian officials, we did not perform a detailed review or evaluation of the issues discussed in this report. We concentrated on assessing whether DOD had sufficiently explored these issues, either itself or through contractor studies, to be able to implement an effective system for using nonmilitary resources in wartime. We limited our fieldwork in order to give the Congress timely information on the unresolved issues which may be discussed during hearings proposed by the Chairmen of the Subcommittees on Military Personnel and Military Compensation of the House Armed Services Committee on DOD's wartime medical posture.

To identify military medical plans and procedures, we met with officials of DOD's Office of Assistant Secretary of Defense for Health Affairs; Office of Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics; Offices of the Surgeons General of the Army, Navy, and Air Force; and Armed Services Medical Regulating Office (ASMRO). Our work with these officials was conducted at their headquarters in the Washington, D.C., area. We also visited the Army's Health Services Command in San Antonio, Texas.

We met with VA's Chief Medical Director to discuss support for DOD during wartime. We also visited representatives of the American Hospital Association (AHA); Maximus, Inc.; FEMA; and HHS.

At the field level, we discussed with Federal and civilian hospital managers their capabilities to support wartime efforts. We visited MAC headquarters at Scott Air Force Base, Illinois, to discuss aeromedical evacuation plans and procedures. We visited 3 of 10 Air Force bases which have aeromedical staging facilities (ASFs) designed to receive returning war casualties. We also met with representatives of civilian emergency medical services units to discuss their patient transportation capabilities, and health systems agency 1/ officials to discuss excess bed capability.

The following Federal facilities and civilian organizations were included in our review:

1/Health systems agencies are the primary health planning organizations for specified geographic areas of the country. They are responsible for obtaining information on medical care resources in the local areas.

Washington, D.C., area

Malcolm Grow USAF Medical Center, Andrews Air Force Base

Scott Air Force Base, Illinois

USAF Medical Center, Scott

San Antonio, Texas, area

Brooke Army Medical Center
Wilford Hall USAF Medical Center
Audie L. Murphy Memorial Veterans Administration Hospital
Bexar County Emergency Medical Service
Camino Real Health Systems Agency

Los Angeles, California, area

USAF Clinic, Norton Air Force Base
Air Force Regional Hospital, March Air Force Base
Naval Regional Medical Center, Long Beach
Veterans Administration Hospital, Long Beach
Veterans Administration Hospital, Loma Linda
Inland Counties Emergency Medical Authority
Inland Counties Health Systems Agency

San Diego, California, area

Naval Regional Medical Center, San Diego

CHAPTER 2

UNCERTAINTIES REMAIN CONCERNING DOD'S PLANS TO USE NONMILITARY HOSPITALS TO MEET WARTIME NEEDS

DOD's major studies and efforts completed to date leave several unanswered questions concerning its ability to work directly with civilian hospitals to secure wartime medical care capability. Also, more needs to be done to get the Federal sector--primarily DOD and VA 1/--working together as a team, planning to maximize use of Federal medical capabilities in time of war or conflict.

We identified several problems and uncertainties with DOD's original plan to use civilian medical capabilities. DOD's civilian sector efforts focused on identifying excess beds, which we believe may be a limited indicator of bed capacity that would actually be usable on short notice. DOD plans also assumed that medical staff would be available, but lacked specific information about how physician and support staff would be obtained.

DOD's revised plans are unclear about how civilian beds and staff would be identified and under what arrangements they would be made available. Moreover, although DOD and VA have begun to discuss coordinating resource use during wartime, questions remain about the extent of VA's involvement in this effort. Our work suggests that an excellent opportunity exists to develop an effective and available contingency medical system within the Federal community by giving VA responsibility for assisting DOD in developing plans for and providing care to wartime casualties. The civilian sector could then be relied on for any additional capability deemed necessary.

1/A Public Health Service (PHS) official told us that several meetings were held among PHS, DOD, and Maximus officials to discuss the possible use of PHS resources in wartime. The officials agreed that, because of limited resources, DOD should not rely on PHS for wartime medical assistance.

BED CAPABILITY

Although DOD has sponsored two efforts to assess the availability of civilian medical care, it still does not have an accurate picture of the number and types of beds it could obtain either throughout the United States or in specific geographic areas. The reason is that both efforts focused on estimates or reports of excess civilian hospital beds without verification of actual bed availability. Also, only recently has the availability of other Federal medical capabilities been addressed.

DOD's civilian sector survey provided inadequate data

In 1978, DOD directed the military services to conduct a survey around each military medical facility to identify civilian medical resources which could be relied on during mobilization. According to military service reports to the Assistant Secretary of Defense for Health Affairs, the consolidated survey results were inadequate for use in planning wartime operations. We reviewed the surveys conducted at three military medical installations and found that they used substantially different methodologies.

In San Antonio, for example, Brooke Army Medical Center and the Air Force's Wilford Hall Medical Center reported that 14 civilian hospitals in San Antonio could care for 1,200 casualties on a short-term or no-notice basis. The civilian capability was based on reported excess bed statistics for non-Federal hospitals compiled by a local government agency.

The Naval Regional Medical Center, Long Beach, also reported local capabilities in terms of excess hospital beds. Long Beach calculated the number of beds within 20 miles of the hospital, using statistics in the AHA Guide to Health Care Institutions. Fifteen percent of the hospital beds identified were then reported as available for use during mobilization.

We found that the Naval Regional Medical Center, San Diego, sent letters to area hospitals, asking how many patients above normal patient loads might be admitted on short notice during mobilization. Responses from 27 hospitals identified 630 medical/surgical, 104 psychiatric, and 77 other beds as available within 48 hours after notification of mobilization.

The San Diego survey results indicate that some of the 1978 survey data were reasonably good, but the services' reports to DOD noted that the overall data were severely limited. In addition, the Navy recommended that a more extensive and methodical study of civilian resource availability be done.

DOD's original plan to use civilian beds

Maximus, Inc., issued its report on civilian medical resource use in wartime on March 15, 1979. However, the Maximus data, like the 1978 DOD study, had some serious limitations.

Excess hospital beds were the basis on which Maximus assessed civilian capability to support military medical readiness. The Maximus report discussed the type, size, and distribution of hospitals in the United States and offered a number of alternatives for defining the number of beds that might be available to DOD.

Ultimately, Maximus estimated the number of beds available in 41 selected metropolitan areas using essentially the same approach as that used by the Long Beach Naval Hospital. That is, Maximus calculated available excess beds by taking 15 percent of selected civilian hospital beds in the area reported as having been set up and staffed. However, only six hospitals located in 2 of the 41 metropolitan areas were visited. Therefore, little was known about whether those beds were actually available or whether there would be equipment and staff to operate them.

Excess hospital beds, as calculated by Maximus, may be a limited indicator of actual capability because the "excess" beds may not be adequately staffed. According to HSA officials, excess beds are a meaningful measure of the civilian sector's capability to respond to an immediate need for medical care if the beds are actually set up and staffed. However, because many hospitals have reduced nursing staffs to core groups, which are supplemented by temporary nurses, beds reported as set up and staffed may not be available on a full-time basis.

Administrators at two San Antonio civilian hospitals also told us that some beds are classified as set up and staffed when in fact they are not staffed. At one hospital, the administrator stated that unstaffed beds could be made

available only when staff could be provided from the hospital's school of nursing. At another hospital, we were told that the core nursing staff could handle all the beds reported as set up and staffed, but only for less than 1 week. Additional staff would be needed for longer periods.

In addition, the original CMCHS concept was to use only a small portion of a civilian hospital's facilities and medical staff, and assumed that normal civilian health care delivery would not be affected. Maximus made this assumption in its study, even though large numbers of casualties were expected, and all military and other Federal health facilities were expected to be severely taxed.

In our opinion, this assumption was unrealistic and limited the potential effectiveness of a civilian-military linked medical system. It was unrealistic because an intense war that would generate great numbers of casualties could not help but disrupt the normal functions of many of the Nation's activities. It would limit the effectiveness of a civilian-military system because casualties would have to be scattered throughout a large number of civilian hospitals. Transportation and administrative burdens would increase with each hospital added to the system, making control over patients more difficult.

Some DOD hospitals have attempted to determine how they would deal with the influx of casualties from a war or conflict. For example, Malcolm Grow and Scott Air Force hospitals expect to accommodate incoming casualties by divesting patients who could be transferred to other smaller military, VA, or civilian hospitals. For patients requiring transfers to other hospitals, such facilities are identified in each hospital's Contingency Support Plan, OPLAN 9550. Malcolm Grow and Scott officials surveyed nearby hospitals to determine their ability to receive various categories of wartime patients. Both hospitals also developed plans to expand and reconfigure their facilities to meet their medical missions during the wartime surge period. The hospitals' plans were based on the assumption that DOD funds and staffing would be provided to support such expansions.

DOD's revised plans remain unclear

DOD issued a revised draft directive concerning the CMCHS program on January 7, 1980. The directive defines CMCHS as civilian hospitals linked by formal agreements to the DOD health care system through a Federal hospital in the same geographic area. Linkages will be accomplished either through the use of contracts or letters of agreement.

DOD's revised plan does not include guidance on how civilian hospital resources should be obtained (e.g., through excess beds or some other arrangement). DOD officials told us that the specifics would be up to officials in the military services, who may or may not use concepts discussed in the Maximus study.

While many aspects of CMCHS remain unclear, DOD officials told us that the need for CMCHS clearly exists. They said that DOD planning scenarios estimate large numbers of casualties being returned to the United States. The casualty estimates are constantly being revised based on latest intelligence and other data. DOD officials said that, based on current estimates, however, both the DOD and VA systems would become saturated and that some civilian medical resources would be needed to treat battlefield casualties. Studies have shown that most casualties would have to be treated in non-DOD facilities.

VA'S MEDICAL CAPABILITY NOT FULLY DEVELOPED AS A POTENTIAL WARTIME MEDICAL RESOURCE

As discussed on page 2, as of November 1979, VA operated 172 hospitals containing over 85,000 beds. VA also has affiliation agreements with many civilian medical schools and hospitals which it could, conceivably, use to enhance its ability to provide care to battlefield casualties.

Although DOD and VA have begun to coordinate on possible wartime relationships, questions remain about the extent of VA's involvement and legislative and/or procedural changes needed to increase that involvement.

In connection with the Maximus contract to assess VA capability, DOD requested information on possible VA assistance during wartime. In a September 4, 1979, letter to VA, the Acting Assistant Secretary of Defense for Health Affairs asked for VA capability available to DOD in terms of hospital location, numbers of beds, types of active duty patients that can be accommodated, and time phasing of bed availability.

VA did not provide the data DOD requested. However, in an October 19 letter to DOD, the Administrator of Veterans Affairs stated that more contingency planning is necessary, and assigned the Chief Medical Director and his staff to work with DOD representatives to that end.

The Administrator also raised questions about the support VA could actually provide DOD under existing legislative authorities. For example, he stated that, although authority exists for some interagency sharing of resources between VA and DOD, VA's basic statutory mission ensures treatment availability to VA beneficiaries, with preference to those having service-connected disabilities. He also stated that, in light of this statutory constraint, VA foresees some difficulty in meeting all of the contingency needs being considered by DOD. The Administrator concluded that some legislative modifications will be necessary, if it is decided that VA's mission should be expanded to include contingency support to DOD during wartime conditions, other than a declared national emergency.

DOD officials told us that VA hospitals would be considered for use in treating returning battlefield casualties before civilian hospitals. VA would be expected to provide care to casualties who would not be returned to duty. These casualties would become VA's responsibility since they would have service-connected conditions and would fall into VA's highest priority treatment category. The officials were also interested in sending patients to VA who would return to duty. They were unsure, however, whether VA statutes or regulations would prevent this arrangement.

While treatment of battlefield casualties discharged from the service has historically been VA's responsibility, neither DOD nor VA has any estimate of how many of these casualties would be flowing from DOD to VA under existing scenarios. DOD has just recently begun to develop such estimates. Until these estimates are developed, no one will know what capability, if any, VA might have to treat battlefield casualties who are expected to return to duty.

VA's Chief Medical Director told us that many of the country's major population centers have large concentrations of both DOD and VA medical capability that could be used to treat battlefield casualties. He indicated, however, that VA's existing authorizing legislation limits the assistance VA can provide to DOD in a contingency. Modifications in VA's legislation would be necessary to give casualties expected to return to duty a sufficiently high priority for VA to treat substantial numbers of such casualties in its facilities. These modifications would include placing battlefield casualties above veterans with non-service-connected, nonemergency conditions, in VA's priorities for care.

VA hospital directors we interviewed said they could make a substantial number of beds available for wartime casualties by (1) transferring and discharging patients when appropriate and (2) limiting admissions to life-threatening emergencies during the war surge period. The directors believe that using the VA hospital system would be a logical way to extend the military's capability to treat wartime casualties. However, they said that it would be necessary to change VA's priorities for providing medical care during wartime in order to follow this approach. In their opinion, a policy to change eligibility priorities to place battlefield casualties above veterans with non-service-connected conditions would be required before VA could assist DOD in the above manner.

The VA hospital directors also said they could determine how many patients could be treated within existing capabilities if VA knew how many patients would arrive within a defined time period, what types of injuries they would have, and where to expect them. In addition, the capability to handle casualties could be expanded by (1) discharging patients at the earliest possible time, (2) waiving space per patient requirements, (3) reducing research and teaching programs, (4) eliminating or reducing special treatment programs and specialties, (5) delaying admissions for non-emergency conditions, and (6) increasing staffing by using existing affiliation agreements with medical school hospitals and by transferring staff from other VA hospitals. The directors emphasized again, however, that eligibility priorities would need to be changed before this assistance could be provided.

Observations

Although DOD plans to use VA in treating battlefield casualties, VA assistance may be limited due to statutory restrictions on its ability to accept active duty military patients. We believe that DOD and VA, with the legislative modifications discussed by VA officials, can provide the basis for an efficient and effective contingency hospital system.

There are currently no estimates of the numbers of casualties not expected to return to active duty. As a result, the potential capability of VA to treat that category as well as those expected to return to active duty is unknown. However, it seems logical that VA be given the authority to treat any casualties which the VA system might

be able to treat. DOD and VA should have the flexibility to allow the use of Federal medical capabilities to their best advantage.

DOD's original CMCHS plan calculated excess beds as a measure of civilian bed availability to support wartime needs. We believe this is a limited indicator of bed availability that would be usable on short notice. Federal and civilian hospitals should be asked to identify capability that could be provided assuming patients are discharged early and nonemergency admissions are restricted during the war surge period. These actions would free beds and staff, which could then be available to treat battlefield casualties.

In our report, "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" (HRD-78-54, June 14, 1978), we stated that the military and VA medical systems need to work more closely together and share their medical resources. We recommended that the Congress enact legislation to encourage increased interagency sharing of Federal medical resources and remove numerous obstacles we identified as inhibiting such sharing. Such legislation has recently been introduced but not yet acted upon. We believe that an active Federal medical resource sharing program could provide the foundation for building effective working relationships between VA and DOD during peacetime that could be invaluable in war.

POTENTIAL AVAILABILITY OF STAFF IN NONMILITARY MEDICAL FACILITIES

DOD's original study, conducted by Maximus, included little information about the potential availability of medical staff in civilian hospitals that might ultimately participate in CMCHS. Rather, it concluded that acquiring the necessary medical staff would be the responsibility of the participating hospitals.

Likewise, DOD's revised plans for using civilian hospitals do not address the issue of staff availability during wartime. In addition, as with bed capability, the feasibility of obtaining VA medical and support staff has not been fully explored. However, as mentioned, DOD and VA are working toward a wartime contingency arrangement.

The issue of civilian hospital staff availability

The original CMCHS, as proposed by Maximus, was tested in 1978 as part of "Nifty Nugget," a military exercise of U.S. mobilization capability for a limited war. Physician participation was not directly measured in this exercise. Rather, participating hospital administrators--from eight hospitals in two metropolitan areas--were asked to advise physicians of the test and its importance. From the test results, Maximus reported that physicians would be available, if for no other reasons than their Hippocratic oath and their patriotism.

Maximus discussed reserve callup and the physician draft only in general terms and in the context of the "Nifty Nugget" exercise. Most hospital administrators believed that, even if reserves were called up and the physician draft reinstituted, they could call in physicians from surrounding and outlying areas. Thus, Maximus' initial assessment was that sufficient civilian physician staff would be available during the early surge of CMCHS activation and that physicians would be cooperative.

In its conclusions, the Maximus report identified a number of tasks for the civilian medical community that would participate in CMCHS and raised a number of unresolved issues. Specifically, the report stated that:

--Civilian hospital administrators should be tasked to obtain physicians for patients admitted under CMCHS. At a minimum, the hospitals should maintain a list of physicians as part of their emergency preparedness plans. A hospital without a list of physicians available for emergency duty should not be permitted to participate in the system.

--Hospital administrators should, as a part of their plans for CMCHS, develop procedures for coping with nonavailability of physicians and other critical staff.

--The roles and relationships of active duty, reserve forces, and CMCHS physicians should be examined to determine where the physicians or unit could have the greatest value. Choices would have to be made among drafting physicians, deferring physicians at CMCHS hospitals, or delaying CMCHS physicians' induction for some specified period of time, say 180 days, to allow them to serve CMCHS during the initial stages of a conflict.

During our discussions with DOD and VA physicians and hospital administrators, we obtained their views about Maximus' idea that civilian physicians would be likely to cooperate under a program such as CMCHS. They believed that current civilian physician-hospital relationships could pose a problem for such a program. In this regard, they said that, unlike structured systems, such as DOD and VA, civilian hospital administrators do not have an effective mechanism for influencing doctors to practice at any one hospital. For example, in large communities most physicians have admitting privileges and practice medicine at more than one hospital. The physicians would be free to leave a hospital if they believed the conditions associated with admitting privileges were not suitable. This situation would, in their opinion, diminish the ability of an administrator of a hospital participating in CMCHS to effectively deal with physician availability during wartime.

DOD officials told us that under the revised CMCHS program the issue of staff availability is still the responsibility of civilian hospital administrators.

VA's hospital system could potentially provide additional wartime staffing

VA administrative and clerical employees could be made available to assist DOD with casualties, according to VA officials. The administrative and clerical employees who normally handle VA patient paperwork could handle that associated with battlefield casualties. We were told that the job requirements for VA medical administrative and clerical positions are probably very similar to those of the military services. Also, the military and VA use standardized medical record forms, laboratory slips, and clinical history sheets. If treating military casualties increases workload, the administrative staff could be augmented either from areas within the hospital or from other sources, such as nearby VA facilities or through new hires.

VA officials also told us that physicians, nurses, and technicians could be detailed from one VA hospital to another if additional staffing was needed to care for casualties. For example, if casualties were being treated at Loma Linda (about 4 miles from the Norton Air Force Base ASF), staff from other VA hospitals could be detailed there under existing legislative authority.

However, VA officials stated that certain problems could arise. For example, physicians might leave VA if they were

detailed, and housing and transportation might be needed if the location was not close to the employees' home.

On the other hand, VA's Chief Medical Director told us that DOD's use of VA's medical resources for contingency purposes could allow DOD to have immediate access to civilian medical resources. This would include both beds and staff at VA-affiliated medical schools and hospitals. The extent of availability of such support, however, is unknown at this time.

Observations

Obtaining the necessary medical staff to provide care to wartime casualties is an area where much has been assumed and little specific information has been developed. In the original CMCHS study, Maximus placed the responsibility for obtaining the necessary staff on civilian hospitals, as a condition of participation in CMCHS. Evidently, no further plans have been developed under the revised CMCHS program.

DOD does not yet know the full extent of support VA will be able to provide. Our work suggests there are opportunities to use VA medical personnel because they are available, in place and, if necessary, could be moved to provide medical care to wartime casualties if that were made a part of VA's mission or responsibility.

In our recent report to the Congress, "Military Medicine Is in Trouble: Complete Reassessment Needed" (HRD-79-107, Aug. 16, 1979), we stated that, since the draft ended in 1973, the military's direct medical care system has faced a gap between the number of military physicians it needs to provide medical care and the number it actually has. This has seriously impaired the system's ability to efficiently and effectively meet peacetime medical care demands.

It is likely that a short, intense conflict would severely strain an already taxed DOD medical system. VA has the potential to assist DOD by providing a dependable means of treating returning battlefield casualties. The extent of this potential will remain unknown until DOD develops estimates of its requirements for VA's assistance in treating casualties (both those who will not return to active duty and those who will) and VA develops estimates of its capabilities to treat such casualties.

CHAPTER 3

OTHER ISSUES NEEDING RAPID RESOLUTION AS DOD PLANS FOR USE OF CIVILIAN HOSPITALS

DOD needs to resolve several issues--in addition to those relating to civilian bed and staff availability--as it begins to implement a system to use civilian hospitals to treat battlefield casualties. DOD needs to further address issues relating to regulation of patient transfers and transportation with the military services and other organizations. In addition, other unresolved issues regarding (1) civilian physician and hospital reimbursement and liability and (2) coordination with other agencies having wartime planning responsibilities could potentially limit or block effective implementation of a system such as CMCHS.

REGULATING PATIENT TRANSFERS FROM OVERSEAS TO THE UNITED STATES

Military systems exist for regulating patient transfers from overseas to U.S. medical care facilities in both peacetime and wartime. The original CMCHS plan established new organizations and procedures for regulating patient transfers, which left issues unresolved and may have conflicted with current military plans. The revised CMCHS allocates many patient transfer functions to existing military organizations, a plan with which we agree. However, some questions about patient transfer and ground transportation capabilities remain.

The existing patient transfer system

DOD's air evacuation system for moving patients from overseas to U.S. military hospitals is controlled by the ASMRO and MAC. ASMRO determines bed availability, and MAC supplies aircraft to transport the patients.

ASMRO, a joint agency of the Army, Navy, and Air Force, was established to regulate patient transfers to military hospitals in both peacetime and wartime. ASMRO receives reports of beds available in U.S. military hospitals. Peacetime bed reporting is based on about 60 medical categories. In wartime, these beds would be reported by three categories--medical, surgical, and psychiatric.

ASMRO's counterpart overseas is the Joint Medical Regulating Office (JMRO). In wartime, JMRO is responsible for categorizing patient bed requirements into the three categories mentioned above. The wartime plan is for JMRO to tell ASMRO how many and what types of beds are needed. ASMRO would tell JMRO where they are available, and JMRO would tell overseas military hospitals where they could send their patients. The overseas hospitals would decide which patients go to U.S. hospitals with available beds.

The overseas hospitals would also arrange for MAC aeromedical evacuation transportation from overseas to the United States. Patients would then be air evacuated to 1 of 10 ASFs in the United States. Each ASF has capability for holding patients until they are transferred elsewhere for definitive care.

Under DOD's revised CMCHS plans, priority destinations for returning casualties will be (1) the established ASFs, (2) other military airports, and (3) civilian airports. A DOD official stated that there are some disadvantages with using civilian airports. For example, no repair facilities would be available for the MAC aircraft, and civilian airports have no patient holding areas like those at ASFs.

DOD officials also told us that there are not enough ASFs, and more would be needed to accommodate the returning casualties. They also felt that some existing ASFs are in the wrong places. A MAC study is underway to analyze the locations and capabilities of ASFs in the United States.

PATIENT TRANSFERS FROM AIRFIELDS TO HOSPITALS

The original CMCHS included plans to rely on civilian Emergency Medical Services (EMS) units to transport patients from airfields to destination hospitals. However, Maximus recognized that these units have differing capabilities and cannot be relied on without an analysis of those capabilities.

DOD hospitals and ASFs now rely on military transportation organizations, but there are questions about whether these organizations are capable of supporting wartime needs. These questions remain under the revised CMCHS program, but are currently under study.

Civilian transportation capabilities appear questionable

If DOD intends to rely on civilian transportation organizations to help move military patients from airfields to hospitals under the revised CMCHS, some lessons can be learned by examining the original CMCHS concept. The Maximus report acknowledged that the extent to which well-organized EMS units exist throughout the country could not readily be determined. Maximus recommended that DOD determine whether EMS units are organized, available, and capable of transporting arriving military patients before enlisting hospitals in CMCHS. Maximus is proceeding with a separate study to analyze EMS capabilities DOD may need to successfully implement CMCHS.

EMS systems are organized to provide emergency health care services for designated geographic areas. Basic systems are to include areawide coverage by radio-equipped ambulances staffed with technicians capable of providing emergency medical care.

Three EMS units we visited had varying capabilities. In San Antonio, the one EMS unit did not have sufficient capability to support CMCHS operations. The unit had 24 one-litter ambulances stationed at 15 locations throughout the city. According to a unit official, EMS could not, by itself, transport a planeload of litter casualties to local hospitals, without support from area military installations.

In the San Bernardino-Riverside area, California, around the Norton ASF, a regional EMS unit coordinates a four-county operation of 41 separate ambulance companies having a total of 91 ambulances. According to unit officials, transportation for military casualties could be provided. However, a joint military-EMS contingency plan would have to be established, DOD physicians would be needed to evaluate and process patients at the airfield, casualty estimates would be needed to determine whether existing resources are adequate, and the system would have to be tested.

The Los Angeles County EMS unit operates 47 ambulances which could be augmented by about 140 others from civilian organizations in an emergency. Unit officials believe that as many as 100 ambulances could be mobilized, at one time, to move military casualties from airfields to hospitals. According to unit officials, DOD's use of the EMS transportation network would require that an agreement be negotiated

with the county board of supervisors, a reimbursement mechanism be established, and a decision be made about operational control--military or civilian--at the airfield.

We agree with the Maximus report that EMS capabilities must be carefully evaluated on an area-by-area basis. It appears that much planning and coordination with civilian officials would be needed before EMS units could be used for transporting casualties.

Military ground transportation to move patients

If DOD plans to use military ground transportation to move patients under the revised CMCHS, an assessment of military capabilities in this area needs to be made.

DOD hospitals and ASFs rely on military transportation capabilities to move patients from airfields to hospitals. Current wartime plans assume that destination military hospitals will provide ground transportation from airfields to hospitals. We visited three military hospitals and found that ground transportation is available, although there are questions about whether capabilities are adequate for wartime needs.

In San Antonio, Brooke Army and Wilford Hall Air Force medical centers operate ambulance buses (ambuses) to provide transportation from airfields to hospitals. Wilford Hall, which also has an ASF, operates two ambuses to transport patients between the flightline at Kelly Air Force Base and the ASF. Hospital officials told us that the purchase of three additional ambuses is planned, because the hospital is authorized five vehicles.

According to ASF officials, Wilford Hall's ambuses will not be used to transport patients to local area hospitals. Instead, destination hospitals, other than Wilford Hall, must provide transportation for patients assigned to them. Brooke Army Medical Center operates two ambuses for this purpose. We do not know what resources exist at other military hospitals served by Wilford Hall's ASF.

We also visited Scott Air Force hospital, where officials told us that a major problem exists in how to transport patients to civilian hospitals. Scott has six old and deteriorating ambuses that could not be relied on, but replacements

are expected, so the situation should improve. However, the officials stated that additional resources would be needed during wartime and the civilian EMS unit would not be able to provide much assistance.

In addition, the commander of the clinic at Norton said that transportation is a bottleneck in ASF operations. Norton has three old ambuses and will probably get two more. Even with five ambuses, the commander felt that transportation to local hospitals would be inadequate. He also said that no contacts had been made with civlian EMS units for assistance, and that more planning was needed in the tranportation area.

Current wartime plans assume that destination military hospitals within 100 miles of an ASF will provide ground transportation to move incoming casualties to the hospital. During a 1979 military exercise, questions arose about the capabilities of some military medical facilities to perform this function.

As a result, in April 1979, MAC requested its ASFs to survey all military and VA facilities within 100 miles of each ASF, to determine their transportation capabilities and to identify any deficiencies. MAC did not, however, supply each ASF with information concerning the estimated number of casualties arriving at the facility. As of February 1, 1980, the ASFs had supplied the information MAC requested, but the data had not been compared with casualty estimates.

Observations

We believe that existing military transportation capabilities should be used, to the extent possible, for transporting casualties to destination hospitals whether they are military, other Federal, or civilian facilities. This would enable the military to rely on its own known available resources and reduce dependence on EMS units of differing capabilities around the country. Requirements would include adequate numbers of military ambuses and other military emergency medical vehicles located at or quickly available to ASFs.

The patient transportation area is being studied by two groups. Maximus is studying civilian EMS resources, and MAC is studying military transportation. A DOD official told us that the studies would be coordinated to arrive at a decision on the proper mix of civilian and military transportation resources needed.

PATIENT ADMINISTRATION

The original CMCHS would have established a new, possibly duplicative, administrative structure to accomplish various functions that the existing military hospital system now performs in peacetime. The revised CMCHS has assigned administrative responsibility for patients in civilian hospitals to the linked DOD facility, rather than to the separate organizations envisioned under the original CMCHS plans.

Observations

We believe that DOD has taken the proper course of action. The revised plans build on existing administrative capabilities rather than establishing a duplicative system.

REIMBURSEMENT AND LIABILITY

According to AHA, reimbursement and liability may be the two most sensitive issues DOD will have to deal with in attempting to obtain medical care for casualties from civilian physicians and hospitals. The Maximus report noted that, in meeting with AHA staff to discuss the CMCHS concept, the consensus was that "there were grave problems facing it [the CMCHS concept] in a number of key areas, including payment mechanisms and malpractice suits."

According to the Maximus report, AHA believed that civilian hospitals, physicians, and others should be granted immunity from liability. Maximus concluded that it did not appear that CMCHS hospitals and personnel could be protected from malpractice suits by existing statutes. The Maximus report offered the following alternatives:

--Amend existing legislation to permit the Government to grant hospitals and physicians participating in CMCHS immunity from liability.

--Require CMCHS hospitals to provide adequate malpractice insurance coverage for their employees. The cost of such insurance could then be billed to the Government as part of the hospital charges.

The Maximus report left the issue open. It said that several participants in the "Nifty Nugget" exercise believed that malpractice would not be a significant issue in a wartime environment.

Regarding the issue of payment to civilian hospitals and physicians, the Maximus report recommended that DOD obtain care on a fee-for-service basis. According to the report, other reimbursement methods, such as those used by Medicare and Medicaid, would only hinder hospital and physician cooperation. DOD has a precedent for paying charges for civilian care of active duty patients, as Maximus pointed out. Military hospitals have established funds, such as those for supplemental care, which pay for military patients' care from civilian providers.

A DOD official told us that wartime reimbursement and liability situations would be extensions of its current peacetime practices for obtaining supplemental care for active duty members. He stated that hospitals and physicians have no problem with DOD's peacetime supplemental care practices, and he expects that no problem would be raised during wartime.

Observations

Unanswered questions remain regarding these issues, which were identified as major concerns by AHA. Failure to address and consistently resolve these issues could result in limited civilian hospital cooperation in DOD planning to care for wartime casualties.

While we do not endorse a particular reimbursement or liability system, we believe the plans should be as simple as possible so that civilian medical efforts can be directed toward patient treatment rather than paperwork.

COORDINATION WITH OTHER AGENCIES

A situation similar to that involving reimbursement and liability questions exists regarding coordination with other agencies. Both the original and revised CMCHS plans have unresolved issues concerning other agencies' wartime medical responsibilities.

Unresolved issues with the Federal agencies

FEMA has responsibilities for establishing and predicting the levels of need for certain resources during emergencies, and prioritizing conflicting needs if there is a shortage.

Federal agencies submit plans for resource claims to FEMA, which acts as overseer and arbiter for the President.

In the original CMCHS plan, Maximus did not believe that DOD had to submit the CMCHS plan to FEMA for approval. The reason, according to the Maximus report, was that CMCHS was not intended to hinder the delivery of civilian health care, and would not be subject to FEMA's resource allocation process.

In our opinion, any conflict large enough to generate the number of casualties that would necessitate activating a CMCHS would greatly affect civilian health care as well as other elements of society. Therefore, we believe if CMCHS had to be activated it is likely there would be considerable demand for health personnel and resources, and that FEMA and HHS would probably become involved in a resource allocation process.

HHS officials told us that the Department would have a key role in developing and implementing such a contingency system. The officials said that it is contrary to the Department's responsibilities for DOD and civil sector hospitals or DOD and VA to preallocate health resources without the Department's advised consent.

The Maximus report recognized another potential problem regarding the Selective Service System and the draft and suggested that deferments could be given to CMCHS participants. The report said, "It should be noted that the CMCHS plan could substantially impact on the pool of physicians available for mobilization." The report suggested that the Selective Service System become involved in CMCHS planning so that it would be aware of revised Armed Forces estimates for staff in general, and physicians in particular.

A DOD official told us that Selective Service System representatives have stated that short-term draft deferments would not be a problem for certain staff participating in CMCHS. However, a Selective Service System official, while acknowledging previous discussions with DOD regarding possible induction deferments or postponements, told us that either would require special authorization and would not be automatic.

Observations

The CMCHS concept seems to have been structured so that it could be implemented without involving or requiring the approval of other Federal agencies having wartime responsibilities. While this might simplify the system's implementation, it could also render it ineffective if other agencies with wartime responsibilities were to reduce the supply of physicians at the hospitals DOD was using. Therefore, we believe that any system for using civilian hospitals during wartime should be planned and developed recognizing the responsibilities and authority of other Federal agencies in a wartime setting.

In our opinion, recognizing the responsibilities and authority of other agencies highlights the value of looking for assistance within the Federal sector, since this is the area where the Government has greatest control over resources.

CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS AND OUR EVALUATION

CONCLUSIONS

A plan to use nonmilitary resources for medical treatment of returning wartime casualties is needed. However, several issues and unanswered questions regarding DOD's CMCHS implementation plans need attention.

The most important issue, in our opinion, is the extent of support VA can provide DOD in treating battlefield casualties. DOD's most recent plans have included VA's providing care for those casualties not expected to return to active duty. However, no estimates have been made of the expected number of such casualties. Moreover, VA has not given DOD estimates of its capabilities to treat such casualties under its current legislative responsibilities or its potential capabilities to treat casualties expected to return to duty.

VA cannot fully support DOD in treating casualties expected to return to duty without legislative modification to its current responsibilities. In our opinion, the Congress should include in VA's responsibilities an additional mission--to directly support DOD in treating battlefield casualties, including those expected to return to duty. With the addition of this mission, DOD and VA should develop systematic plans using available Federal medical resources to treat battlefield casualties, with civilian capability linked to both DOD and VA facilities. An excellent entry into civilian medical resources could be through VA's affiliated medical schools and hospitals.

In the Maximus study, which represented the foundation for DOD's original CMCHS plan, potential civilian sector medical capability was based on excess bed estimates in selected metropolitan areas of the country. Such estimates represented, in our opinion, limited indicators of medical care capability, since they did not identify beds which were actually available and staffed for use.

Also, Maximus assumed that the implementation of CMCHS would not adversely affect civilian medical care, including

medical staff availability in hospitals participating in the system. Maximus suggested that DOD task participating civilian hospitals to assure that enough medical staff will be available to treat casualties. We believe the assumption regarding the impact of a system such as CMCHS on civilian sector medical staffing was unrealistic because it overlooked the potential demands which an intense military conflict could put on the Nation's medical resources.

DOD has recently revised its CMCHS plan. We see no evidence, however, that the revised plan addresses the unresolved issues of bed and staff availability any differently from the original plan proposed by Maximus. In fact, the military services will apparently have considerable flexibility in making their individual plans to secure civilian beds and staff, including using concepts recommended by Maximus.

We would not encourage DOD's identifying only excess beds for possible use in its contingency hospital system. Recognizing that an intense war would adversely affect health care delivery in this country, DOD should identify nonmilitary capability assuming that (1) patients are discharged early whenever possible and (2) nonemergency admissions are restricted during the war surge period. These actions would free beds and staff, which could then be available for treating battlefield casualties.

Other issues also need to be resolved as DOD begins to implement its revised CMCHS. Specifically, the optimal numbers and placement of ASFs in the United States need to be determined. First priority for ASFs should be near concentrations of military and VA medical capability with sufficient civilian resources available if needed. DOD also needs to determine the adequacy of ground transportation resources to transport patients from airports to destination hospitals.

In addition, other unresolved issues have the potential to limit implementation of a system such as CMCHS. These issues include (1) physician and hospital reimbursement and liability and (2) potential conflicting demands other Federal agencies may make on the same civilian medical resources in wartime.

VA as a potential
wartime medical resource

Throughout this report, we have emphasized the need for DOD to look to VA as a potential source of medical assistance

in time of war or conflict. DOD and VA have recently been discussing possible wartime coordination of resources, but some questions remain about VA's participation.

DOD currently plans for VA to care for casualties not expected to return to duty. However, VA's mission is to care for such veterans; therefore, such a plan involves no real change from VA's current primary responsibilities.

We believe VA should be much more involved in planning and caring for all returning battlefield casualties rather than only those not returning to duty.

Since VA is a Federal medical care system, one might presume that part of its mission is to directly support the treatment of battlefield casualties. This is apparently not the case. In fact, the Administrator of Veterans Affairs recently told DOD that VA would not be able to directly support DOD in treating wartime casualties in the United States, unless it is given that mission in other than a declared national emergency.

The Congress should add this mission to VA's current responsibilities, so that DOD and VA can take advantage of the time now available in peacetime to develop plans using available Federal medical resources to care for battlefield casualties. The alternative of waiting until a national emergency before fully involving VA could, in our opinion, result in

--unnecessary confusion during mobilization regarding where returning casualties should be sent for medical care,

--underuse of VA's medical capabilities during war or conflict,

--inability of DOD to know what the total Federal wartime medical capability is to identify the shortage which needs to be made up by the civilian sector, and

--unnecessary effort and expense by DOD to identify and contract for civilian medical resources.

In our opinion, the Nation should prepare for a possible conflict by planning to appropriately use Federal medical resources before calling on civilian resources. Major DOD and

VA hospitals could provide acute care to returning casualties. Smaller DOD and VA hospitals could provide convalescent care, enabling larger hospitals to receive more acute care casualties as patients are transferred to convalescent facilities. Civilian hospitals could handle patients divested from the Federal systems and provide additional capability for casualties as needed.

We believe that a contingency hospital system which makes use of VA's medical resources for all categories of returning casualties would be an efficient and effective use of Federal medical capability. Moreover, we believe that a strong peacetime medical resource sharing program, such as we recommended in June 1978, could provide a sound foundation for establishing effective working relationships between VA and DOD, which could be invaluable in the event of war. (See p. 15.)

RECOMMENDATIONS TO THE CONGRESS

We recommend that the Congress enact legislation which provides that both DOD and VA fully participate in Federal medical planning for and care of returning wartime casualties. Such legislation should:

--Give VA the mission of providing direct medical support to DOD for treating all categories of battlefield casualties.

--Place battlefield casualties above veterans with non-service-connected, nonemergency conditions in VA's priority for care.

--Remove numerous obstacles to interagency sharing, as we previously recommended, so that VA and DOD may establish a strong peacetime medical resources sharing program to serve as an effective foundation for a military-VA-civilian contingency hospital system.

RECOMMENDATIONS TO DOD AND VA

We recommend that the Secretary of Defense and the Administrator of Veterans Affairs jointly:

--Develop and establish the framework for a military-VA-civilian contingency hospital system. As part of this development, establish a mechanism for obtaining civilian medical care capability that (1) recognizes the responsibilities and authority of FEMA, HHS, and other

Federal agencies during war or conflict and (2) adequately considers other unresolved issues, such as physician reimbursement and liability, and ground transportation availability.

--Analyze DOD's and VA's medical care resources to determine the Federal patient treatment capability on a time-phased basis. This analysis should be made first near existing DOD aeromedical staging facilities, but should also include other locations where there are large concentrations of DOD and VA medical resources.

--Identify Federal and civilian capability that could be provided assuming that (1) patients are discharged early whenever possible and (2) nonemergency admissions are restricted during the war surge period.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

We recommend that the Secretary:

--Compare the medical care requirements calculated under various wartime scenarios with available Federal medical resources to determine how much and what type of civilian medical care capability would be needed to augment Federal capability.

--Determine the optimal number and placement of U.S. aeromedical staging facilities, with emphasis on locations near concentrations of military and VA medical resources.

--In concert with other agencies having contingency planning responsibilities, assume overall coordinating responsibility for plans jointly developed by DOD and VA using Federal medical resources and necessary civilian medical capability under the military-VA-civilian contingency hospital system.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator:

--Provide estimates to DOD concerning its potential capabilities, in terms of both facilities and staffing,

to treat returning battlefield casualties regardless of whether those casualties would be expected to return to duty. Such estimates should be based on the assumptions that patients would be discharged early whenever possible and nonemergency admissions would be restricted during the war surge period. These estimates should be developed through the joint DOD-VA planning effort to establish a military-VA-civilian contingency hospital system.

--Ascertain the extent to which VA's affiliated hospitals would be able to assist VA in treating battlefield casualties.

AGENCY COMMENTS AND OUR EVALUATION

We received written comments on our draft report from DOD, VA, and FEMA. HHS officials responsible for the Department's emergency coordination activities and Selective Service System officials also provided us with comments on the draft report.

DOD comments

The Assistant Secretary of Defense (Health Affairs), in a letter dated May 14, 1980 (see app. III), stated that DOD generally agreed with our recommendations and that actions necessary to implement those to the Secretary of Defense have already been initiated. DOD stated that it has long looked to VA for wartime support and that an active dialogue is now in progress to effect the necessary wartime planning between the two organizations. The Assistant Secretary stated that DOD has only recently begun to look to the civil sector for contingency augmentation beyond combined DOD and VA capabilities.

DOD did not comment on the specific recommendations we made for joint implementation by the Secretary of Defense and the Administrator of Veterans Affairs other than noting that an active dialogue between the agencies is taking place. Notwithstanding such a dialogue, there are strong indications that DOD plans to proceed to implement an only slightly modified version of its original CMCHS plan. For example, recently published remarks by the Special Assistant to the Assistant Secretary responsible for initial development of CMCHS indicate that DOD still intends to secure excess beds in scattered civilian hospitals, and to assume that delivery

of civilian medical care would not be interrupted. Neither the Assistant Secretary in his comments, nor the Special Assistant in his remarks, mentioned the inclusion of VA as a full partner in the planning process for caring for wartime casualties.

We believe that DOD's plans to secure small numbers of excess civilian beds and the assumption that civilian care would remain essentially uninterrupted are unrealistic in planning for a contingency hospital system. We continue to believe that a system such as CMCHS should be a military-VA-civilian contingency hospital system. DOD and VA should, together, develop systematic plans for using Federal medical resources to treat battlefield casualties, with civilian capability linked to both DOD and VA facilities.

DOD also stated that it is incorrect for us to assert that it has looked primarily to civilian medical resources to meet anticipated shortfalls should the United States become involved in war. DOD noted that it and VA executed a memorandum of understanding in 1965 under which VA beds would be made available to DOD in time of national emergency not involving an attack on the United States.

We are aware of the memorandum. However, in its report concerning VA's capabilities, Maximus stated the views of VA staff members that "The 1965 agreement was limited in scope and purpose, and may no longer be valid or useful." The report also summarized efforts to develop the emergency planning which was anticipated by the 1965 agreement. Maximus summarized the ultimate development of emergency planning as follows:

> "In any event, by early 1966 joint development discussions were abandoned. In early 1969, an unsuccessful effort was made to reserve a block of VA beds for DOD use. Since that time, neither VA nor DOD has updated any list of capabilities or anticipated needs under this agreement. And no firm commitment was ever made on the exact size or nature of capabilities to be requested or provided."

In view of the above, we believe the 1965 memorandum of understanding has not contributed substantially to joint DOD and VA medical contingency planning.

DOD also stated that, during the 1978 Nifty Nugget exercise, VA made a number of beds available to treat DOD casualties. However, Maximus in its original CMCHS report stated that:

> "The initial plans for CMCHS play in Nifty Nugget had not included either Public Health Service or Veterans Administration facilities. However, in late August, emergency preparedness officials who were the VA players in the exercise found out about the exercise of CMCHS and, after being briefed on the system expressed a desire to be included in the play. Thus, arrangements were made to incorporate them into the exercise flow." (Emphasis added.)

As shown above, VA officials asked to be included in the exercise only after they found out about it by chance rather than because of any DOD coordinating action. The Maximus report on VA stated that "Subsequently DOD sponsored this study to explore ways of formalizing a working contingency relationship with VA." Thus, only after VA asked to participate in the CMCHS part of the Nifty Nugget exercise did DOD sponsor an exploratory study of VA's capabilities.

VA comments

By letter dated May 13, 1980 (see app. IV), the Administrator of Veterans Affairs stated that VA agreed with the need for legislative changes to remove statutory obstacles to VA's meeting DOD's contingency needs. However, he also expressed concern about several specific aspects of our recommendations.

First, the Administrator said he was concerned that legislation such as we are recommending should not be misconstrued to require an explicit change in VA's fundamental mission. Rather, VA believes there is a need for sufficient flexibility to permit VA to serve a contingency support role, unhindered by current restrictions in law and regulation.

We support VA's position and do not intend that VA's basic mission be diminished. Rather, we believe that mission should be expanded to include responsibility for providing direct support to DOD in treating battlefield casualties, including those expected to return to duty.

Second, VA expressed concern that several of the recommendations may be construed as suggesting that VA become the spokesman for part of DOD's contingency planning. VA recommended that DOD be charged with coordinating responsibility for contacting and developing emergency contingency plans with civilian hospitals. VA also stated that other agencies, such as FEMA, HHS, and the Selective Service System, should be involved in determining the extent of support the civilian health care community is willing and prepared to provide.

We agree with VA's suggestions and have added a recommendation to the Secretary of Defense to address this matter. We believe, however, that VA could be extremely valuable in initiating and fostering relationships between its affiliated hospitals and DOD. VA should determine the extent to which affiliated hospitals could assist VA in treating battlefield casualties as stated in our recommendation to the Administrator.

Third, VA stated its belief that it would be premature to provide DOD with capability estimates as we recommended. VA stated that estimates of the number of beds that might be available should be determined through a joint DOD-VA planning effort. We agree and have modified our recommendation to the Administrator.

Finally, VA expressed concern about the authority for providing VA administrative and clerical staff to bolster DOD's wartime staffing needs. VA stated that there may be some difficulty in planning on staff availability particularly without legislation which would subordinate veteran health care priorities to caring for battlefield casualties.

Our recommendation to the Congress regarding the placement of battlefield casualties in VA's priority for care was developed to provide authority for such staffing actions by VA.

FEMA comments

By letter dated May 2, 1980 (see app. V), FEMA's Associate Director for Plans and Preparedness generally agreed with our conclusions and recommendations, but was concerned that FEMA and HHS had been excluded from the planning and policymaking process involved in CMCHS. FEMA pointed to several major responsibilities assigned to both FEMA and HHS by the President regarding wartime medical resource allocations.

In performing this study, we were concerned about how these and other agencies would influence medical resource use during wartime and DOD's apparent lack of coordination with them as it planned and developed CMCHS. Our October 1979 report to DOD (see app. I) addressed this and other unresolved issues and recommended that DOD suspend actions to establish CMCHS until they were resolved. However, DOD has proceeded with the CMCHS development apparently without coordination with these agencies.

APPENDIX I

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

HUMAN RESOURCES
DIVISION

B-133044

OCTOBER 25, 1979

The Honorable Harold Brown
The Secretary of Defense

Dear Mr. Secretary:

Subject: Implementation of a Civilian-Military Contingency Hospital System Should be Suspended (HRD-80-21)

During the past several months, we have been reviewing DOD's plans to use nonmilitary hospitals to provide medical care to wartime casualties. While we have not finished our review, we have a number of concerns about these plans that we want to bring to your attention before a specific plan is implemented.

On March 15, 1979, Maximus, Inc., issued a final report to the Office of Assistant Secretary of Defense (Health Affairs) entitled "Study of the Problems Associated with Reliance on Civilian Medical Manpower and Non-DOD Facilities During Periods of National Emergency, Mobilization and War." We understand that this study represents the foundation for the Civilian-Military Contingency Hospital System (CMCHS) to be implemented beginning this month under the Assistant Secretary's direction.

Based on our work to date, we have identified several basic problems in the Maximus report which DOD has not resolved and which, therefore, tend to weaken its validity as a foundation for CMCHS. Some of our concerns are:

1. The report identified excess acute care beds in 41 U.S. metropolitan areas. The excess capacity was determined by taking 15 percent of the total bed capacity of certain hospitals, as shown in the 1976 issue of the American Hospital Association's hospital guide. However, only six hospitals located in 2 of the 41 metropolitan areas were visited.

(101017)

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Therefore, little is known about whether those beds are actually available or whether there is equipment and staff to operate them. Similarly, the impact that rapid population growth in certain areas has had on excess capacity has not been analyzed.

2. Even if the excess acute care beds identified in the Maximus report were available and staffed, no analysis has been made of the impact of divesting non-active-duty patients from military hospitals to civilian hospitals during mobilization. Our preliminary analysis showed that, in several major metropolitan areas, the divesting process would use much of the excess bed capacity believed available for the implementation of the system. Because of this consideration, DOD may not be able to fully rely on the areas identified by Maximus to have the capability to treat casualties.

3. The CMCHS as recommended by Maximus will concentrate on obtaining acute care beds, but not convalescent beds. However, some military officials we talked to believe that many convalescent beds will also be needed.

4. The Maximus study did not determine whether civilian hospitals in general would participate in CMCHS. A Maximus official told us that hospitals' willingness to participate in the system will be tested as part of the system's implementation. Although Maximus coordinated its study with the American Hospital Association, the Association had reservations about many aspects of the CMCHS concept. Also, according to a Maximus official, there has been no coordination with the American Medical Association, the American College of Surgeons, or the American Association of Medical Colleges. We believe these groups--because of their influence on the physicians needed to staff the beds in civilian hospitals--would play a major role in determining the ultimate success or failure of the CMCHS concept's implementation.

5. The Maximus report left various issues unresolved concerning how the Selective Service System, the Federal Emergency Management Agency, and the Department of Health, Education, and Welfare would influence the use of civilian medical resources during wartime. These agencies have responsibilities which would affect the same resources that CMCHS, if implemented, would rely on during wartime.

6. CMCHS as described by Maximus would be a new organization with responsibility for carrying out various functions that may duplicate those of existing military organizations. The military services raised this objection when the CMCHS draft implementation directive was circulated for comment.

7. The Maximus study was limited to assessing civil sector capability for DOD's use during wartime. Through another contract with DOD, Maximus is assessing what wartime capability the Veterans Administration could provide to DOD. In our opinion, DOD ought to determine the full extent of available Federal resources before beginning to contract for private sector capability.

We are summarizing in another document the results of our work to date concerning the above issues and others relating to DOD's use of nonmilitary medical facilities to care for wartime casualties. As you know, the Chairmen of the Subcommittees on Military Personnel and Military Compensation of the House Armed Services Committee, in a July 17, 1979, letter, stated their intention to hold hearings on the development and implications of a DOD draft report on the wartime medical posture. We understand that the issues raised during our work will also be discussed during those hearings, which are expected to be held in the near future.

RECOMMENDATION

Because many basic questions have not yet been resolved concerning the use of nonmilitary hospitals to provide medical care to wartime casualties, we believe it is premature to establish a new organization to interface with civilian hospitals and begin contracting for medical care capability. Accordingly, we recommend that you suspend actions to establish CMCHS at least until the Subcommittee Chairmen have held their planned hearings.

- - - -

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees

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B-133044

on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Chairmen of the four above-mentioned Committees and the House and Senate Committees on Armed Services and to the Director, Office of Management and Budget. We are also sending copies to the Chairmen of the Military Personnel and Military Compensation Subcommittees and to Congressman Robin Beard, who requested our review.

We appreciate the cooperation and assistance provided by DOD personnel during our ongoing review. We will be glad to discuss any questions with you or your representatives.

Sincerely yours,

Gregory J. Ahart
Director

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

10 DEC 1979

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

Dear Mr. Ahart:

This is in reply to your letter of October 25, 1979, to the Secretary of Defense regarding "Implementation of a Civilian-Military Contingency Hospital System Should Be Suspended (HRD-80-21)" (OSD Case #5309).

Significant shortfalls exist in military medical preparedness for war. Several studies have been conducted to quantify and to validate these shortfalls, as well as to examine various options to overcome them.

The Maximus study referred to in your letter was an initial investigation of the feasibility of using civilian hospitals as one source of the needed capabilities. The study identified what appears to be a workable, extremely low-cost method of ensuring rapid expansion of hospital bed capacity in the continental United States (CONUS) for support of military contingencies. The issues raised in your letter have been examined and each is addressed in the enclosure. We do not agree with your assertion that it is premature to begin establishing civilian linkages or your recommendation that DoD suspend actions to establish CMCHS. Our position is that:

o Basic questions will not be resolved concerning the use of non-military hospitals until civilian linkages are established.

o It is clear that DoD does not have adequate bed capability to care for casualties arising from a major short-warning contingency.

o It is also clear that other Federal hospitals will be unable to fill the total deficit;

o Therefore some other source of CONUS bed capability is required;

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o We have concluded that civilian hospitals offer the only viable solution;

o The lack of alternatives and the issues you raise further emphasize the urgent need for prompt efforts to provide effective links to civilian health capability.

It is estimated that contracting activities can begin in approximately six months. In the interim, we will be pleased to discuss our progress with members of your staff.

Sincerely,

Vernon McKenzie
Principal Deputy Assistant Secretary

Enclosure

COMMENT ON SPECIFIC ISSUES

1. Absolute knowledge of bed availability lacking:

Because of seasonal variations, cost containment activities, and special hospital situations, the data about bed availability always lags behind the reality of the dynamic U.S. health system. However, the CMCHS concept intends that each individual civilian hospital make its own decision about the extent of it participation, if any. Until actual linkage mechanisms (contracts) are tested, we will not have certain knowledge of bed availability or willingness to participate. The definitive nature and small cost of such contracts makes them an attractive alternative to continuing expensive studies which further delay implementation.

2. Impact of divesting non-active duty patients from military hospitals:

CMCHS commitments are intended to cover active duty military patients only. Military hospitals are also required to plan for moving hospitalized eligible non-active duty beneficiaries into local civilian hospitals in order to free staff for transfer overseas or for receipt of military patients. Special coordination during implementation of CMCHS should prevent duplication or overload of civilian hospital commitments.

3. Active vs. convalescent beds:

The initial need in a contingency will be for acute care beds. CMCHS is intended to provide these beds. The need for and possible alternative sources of convalescent beds are presently being addressed.

4. Hospital willingness to participate:

While absolute certainty is lacking, all of our evidence on this subject suggests that, in general, hospitals will be pleased to assist in the care of war casualties. A significant aspect of the CMCHS implementation plan calls for continuing coordination with the American Hospital Association, the American Medical Association and other appropriate health groups.

5. Medical manpower and resource issues unresolved:

The Maximus report documented these issues, which were raised during Exercise NIFTY NUGGET. Resolution actions are part of the CMCHS implementation plan.

(Enclosure)

6. Organizational duplication:

The plan being developed will require an initial concentration of policy and management oversight during program implementation efforts. Once established, however, the system will be managed and operated by the military departments with no organizational duplication.

7. Determine full availability of Federal beds before contracting: Assessment of VA and PHS bed availability is nearing completion. However, there are significant problems associated with military use of these Federal beds. Even the most optimistic availability of these assets would not obviate the need for the civilian bed levels proposed for CMCHS.

APPENDIX III

ASSISTANT SECRETARY OF DEFENSE

WASHINGTON D C 20301

HEALTH AFFAIRS

14 MAY 1980

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

Dear Mr. Ahart:

This is in reply to your letter of April 3, 1980 to the Secretary of Defense regarding your draft report entitled, "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System" (GAO Code 101017) (OSD Case #5411).

We are in general agreement with the recommendations contained in your draft report and have already initiated the actions necessary to implement the recommendations to the Secretary of Defense. We are pleased that you concur with the changes that have taken place in the CMCHS concept as it has evolved from the point of departure recommended by the contractor. The constructive efforts of the Services and OSD staff elements during the coordination process of the first draft DoD Directive were most helpful in refining the concept to its present state.

We are also pleased that you agree with the courses of action we have outlined to address the remaining unresolved issues we identified to you. We anticipate rapid resolution of these issues, when the CMCHS director and deputy director can dedicate their full-time to these efforts.

It is, however, incorrect to assert that DoD has looked primarily to civilian medical resources to meet anticipated shortfalls should the U.S. become involved in war. DoD and the VA executed a memorandum of understanding in 1965 under which VA beds would be made available to DoD in time of national emergency not involving attack on the United States. During Nifty Nugget 78, the VA made a sizable number of beds available to treat DoD casualties. As your report states, active dialogue is now in progress to effect the necessary wartime planning between the two organizations. It is much more accurate to state that DoD has long looked to the VA for wartime support and has only recently begun to look to the civil sector for contingency augmentation beyond the combined DoD and VA capabilities.

Sincerely,

for John H. Moxley III, M.D.

APPENDIX IV

Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420

Veterans
Administration

MAY 13 1980

Mr. Gregory J. Ahart
Director, Human Resources Division
U. S. General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

Thank you for the opportunity to review your April 3, 1980 draft report, "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System," which states the Department of Defense (DoD) is developing a Civilian-Military Contingency Hospital System for medical treatment of battlefield casualties. The General Accounting Office (GAO) report states that while such a system is necessary because DoD has insufficient resources to treat anticipated casualties, several issues and unanswered questions regarding DoD's implementation plans need immediate attention. In GAO's opinion, the most important issue is the extent of support the Veterans Administration (VA) will provide DoD in treating casualties. DoD's most recent plans have considered limited assistance; however, GAO found that VA cannot fully support DoD without legislative modifications to its current responsibilities and recommends that the Congress enact needed legislation.

We agree that the question of the extent to which VA can support DoD in treating returning battlefield casualties is a most important issue in wartime contingency planning. As this Agency has advised DoD health planners, there are statutory obstacles to VA's meeting all of the Department's contingency needs. We concur with the need for legislative change. Earlier discussions about the incompatibility between the VA's mission and a significant role in supporting DoD in treating battlefield casualties who are expected to return to duty, should not be misconstrued to require an explicit change in the fundamental VA mission set forth at 38 U.S.C. section 201. The basic statutory mission of this agency (in section 201) and its Department of Medicine and Surgery (in section 4101) need not be altered. Rather, there is a need, recognized by this agency and GAO, for sufficient flexibility to permit VA to serve a support role, unhindered by current restrictions in law and regulation.

The report recommends that the Secretary of Defense and I jointly:

--develop and establish the framework for a military-VA-civilian contingency hospital system. As part of this development, establish a mechanism for obtaining civilian medical care capability if needed, that (1) recognizes the responsibilities and authority of other Federal agencies during war or conflict, and (2) adequately considers other unresolved

APPENDIX IV

issues such as physician reimbursement and liability, and ground transportation availability;

--identify Federal and civilian capability that could be provided assuming that (1) patients are discharged early whenever possible and (2) non-emergency admissions are restricted during the war surge period;

The GAO also recommends that I:

--ascertain the extent to which VA's affiliated hospitals would be able to assist VA in treating battlefield casualties.

We believe these might be construed to direct that the VA become the spokesman for DoD in contacting and developing emergency contingency plans with civilian hospitals in VA communities, and specifically, those with whom we are affiliated. While we fully support and will cooperate with DoD's efforts to determine the civilian health care capability to meet military needs in time of national emergency, we recommend that DoD be charged with this coordinating responsibility. The Department of Health and Human Services, the Selective Service System, and the Federal Emergency Management Agency, as cited on page 5 of the report, should also be involved in determining the extent of support the civilian health care community is willing and prepared to commit. These agencies would then be cognizant of the resources they will be required to provide VA in support of any agreements which evolve.

The report also recommends that I:

--provide estimates to DoD concerning its potential capabilities, in terms of both facilities and staffing, to treat returning battlefield casualties regardless of whether those casualties would be expected to return to duty or not. Such estimates should be based on the assumptions that patients would be discharged early whenever possible and non-emergency admissions would be restricted during the war surge period.

We believe any indication of the number of beds that might be available is premature at this time. This should be done through a joint DoD/VA planning effort.

Page 23 of the report carries the statement that VA administrative and clerical employees could be made available to assist DoD with casualties as one means of bolstering that Department's wartime staffing needs. The only authority we can identify for such an initiative lies in section 686 of title 31, U.S.C. That provision authorizes "cross servicing agreements," including the purchase of services by one department or agency from another, and presupposes the availability of the personnel.

APPENDIX IV

While the "provider" agency has the discretion of determining if the staff is available, there would appear to be some difficulty in planning on that availability. This difficulty is compounded by the absence of legislation which would permit the veteran health care mission to be subordinated to meeting DoD's health care needs.

The recommendations in this GAO report are not inconsistent with the VA's interests and past efforts, and, as the report acknowledges, DoD and VA officials have been working toward wartime contingency arrangements.

Indicative of this fact, for example, our General Counsel and his Department of Defense counterpart have communicated recently regarding the specific legislative barriers to be hurdled if satisfactory contingency planning is to be realized.

Sincerely,

MAX CLELAND
Administrator

FEDERAL EMERGENCY MANAGEMENT AGENCY
Washington. D.C. 20472

MAY 2 1980

Mr. Henry Eschwege
Director
Community and Economic Development Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Eschwege:

Thank you for the opportunity to review and comment on the draft report, "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System".

We agree, in general, with the conclusions and recommendations of the draft. However, we are deeply concerned about the exclusion of the Federal Emergency Management Agency (FEMA) and the Department of Health and Human Services (HHS) in the planning and policy-making processes involved. While the draft report alludes to FEMA's role on pp 34-35, the Digest and Conclusions and Recommendations lack any reference to this subject. Similarly, we noted no citations or discussions of the HHS (formerly HEW) responsibilities and interests in this matter.

In view of the important responsibilities of FEMA and HHS, as set forth in Executive Orders 12148 and 11490 respectively, and other authorities, it is unclear why they have been omitted in past and current Civilian-Military Contingency Hospital System (CMCHS) and related planning activity.

The crucial issue which the report fails to address adequately is the need for central control, coordination, and management of the planning for and the actual use of the Nation's essential resources likely to be required in emergencies (e.g., hospital beds). FEMA was created to perform this important function for the President. HHS has the assigned responsibility, under FEMA's guidance, to develop plans and programs for mobilization of the Nation's health resources (including hospital beds).

In our view, the Secretary of Health and Human Services, along with the Administrator of Veterans Affairs, should work jointly with the Secretary of Defense and others, as necessary, to develop and establish the framework for a Military-Civilian Contingency Hospital System. FEMA should participate as the coordinator and function in its adjudication role in the event unresolved issues develop.

We believe this arrangement would be more effective in solving DOD's hospitalization and evacuation problems, while concurrently ensuring that such matters as the following will be factored into the planning equation:

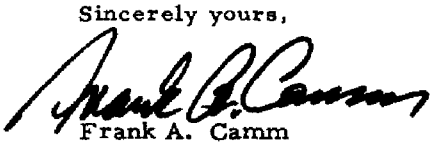
o consideration that the war scenario may progress to an attack on the CONUS, thus broadening the battlefield; in which case standby plans for mobilization and utilization of health resources may conflict with the CMCHS concept.

o a Presidential priority assigned to Crisis Relocation Planning, especially with respect to hospitals, may be incompatible with CMCHS planning.

o standby health workforce mobilization policies and plans will be supportive of overall preparedness objectives.

Finally, we endorse strongly the concept of sharing and partnership within the Federal Executive Branch in the development of our overall preparedness posture and are prepared to contribute to the solution of DOD's problems in keeping with our responsibilities and resources.

Sincerely yours,



Frank A. Camm
Associate Director for
Plans and Preparedness

(101017)

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