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REPORT BY THE U.S.

# General Accounting Office

## Ways To Reduce The Cost Of Medical Referral Programs In Micronesia And American Samoa

Lacking adequate medical services locally, Pacific Basin governments refer seriously ill patients to Guam, Hawaii, and the U.S. mainland for treatment. These referrals are made at no cost or at nominal cost to patients. Rising referral costs leading to large unpaid debts by the governments threaten continuation of services by the health care providers. Unpaid debts are increasing even though the U.S. government pays three quarters of the health care budgets of these governments.

GAO identified ways to help improve local medical capabilities and to reduce referral costs. Actions needed to implement GAO suggestions rest largely with the local governments. The federal government should stand ready to help resolve problems and to assist the local governments.



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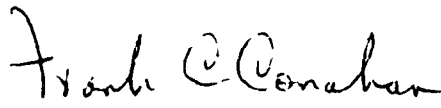
The Honorable John F. Seiberling, Chairman  
The Honorable Don Young, Ranking Minority  
Member, Subcommittee on Public Lands and  
National Parks  
Committee on Interior and Insular Affairs

The Honorable Antonio B. Won Pat, Chairman  
The Honorable Robert Lagomarsino, Ranking  
Minority Member, Subcommittee on  
Insular Affairs  
Committee on Interior and Insular Affairs  
House of Representatives

As requested by your letter of March 9, 1983, we have examined medical capabilities and medical referral problems in Micronesia and American Samoa.

This report discusses problems associated with medical capabilities and medical referrals and identifies ways to improve capabilities and reduce referral costs.

Copies of this report are being provided to the Departments of Interior, Defense, State, and Health and Human Services and to other interested parties.

  
Frank C. Conahan  
Director



D I G E S T

The cost of medical referral services in U.S. Pacific territories--American Samoa, the Commonwealth of Northern Mariana Islands, and the Micronesian states of Palau, the Marshall Islands, and the Federated States of Micronesia--has significantly increased over the years. Many of the territories have incurred substantial amounts of unpaid medical bills which may jeopardize continuation of these services. GAO has identified ways the Pacific Basin governments can reduce both the cost of the medical referral programs and the number of patients referred.

At the request of the Chairmen, Subcommittee on Public Lands and National Parks and Subcommittee on Insular Affairs, House Committee on Interior and Insular Affairs, GAO reviewed the (1) financing of the medical referral programs, (2) health care problems which impact on medical referrals, and (3) management and policies of the medical referral programs.

OUTSTANDING DEBTS MAY RESULT  
IN LOSS OF REFERRAL SERVICES

During the last 3 years, the Pacific Basin governments have incurred costs of about \$15 million to refer patients for treatment in hospitals in Guam, Hawaii, and the U.S. mainland. At the start of fiscal year 1984, the Pacific Basin governments owed \$6.2 million for medical referral services. Unless the problem of unpaid bills is resolved, some U.S. and private hospitals threaten to suspend medical services to patients referred by these governments.

The Pacific Basin governments are not sufficiently budgeting their own funds and funds received from the Department of the Interior to cover medical program costs. During fiscal years 1981-83 actual costs exceeded the amounts budgeted by \$6.0 million, contributing to large deficits and delays in paying medical bills. These bills are owed to medical referral hospitals, air carriers, and other providers of medical referral services.

The largest amount is owed to Tripler Army Medical Center in Hawaii which receives the majority of

referrals and has had a continuing problem with collecting medical referral bills. The Army claims that Tripler was owed approximately \$4.4 million at the beginning of fiscal year 1984. It projects that referral bills will increase to \$8.0 million by the end of the year. Tripler has turned to Interior for payment. Since Tripler's authorization to treat medical referrals was issued by the Secretary of Defense at Interior's request, Interior has accepted the responsibility of working with the Pacific Basin governments to resolve the problem. At the time of the GAO review, Interior and Defense had not resolved this problem, and much of the debt remains unpaid.

GAO believes as a matter of policy that the Pacific Basin governments should be held accountable for medical referral services provided. The federal government should help these governments to develop more cost-effective ways to reduce referral costs and to more adequately budget for referral expenditures. Interior should initiate prompt action to resolve debt problems with the Army. (See ch. 2.)

#### MEDICAL REFERRAL PROGRAM COSTS CAN BE REDUCED

GAO found that medical referral costs can be reduced by

- limiting the amount of subsidized medical referral care provided by the Pacific Basin governments to the referral patients,
- strengthening the referral management process, and
- improving local medical capabilities.

Patients pay little or nothing for their medical referral treatments. Only the Republic of Palau has had any success in making its program more self-sufficient by requiring patients to contribute toward their expenses and transportation costs. The other governments provide free or very low-cost referral services and have no policies requiring some patient contribution. Little has been done to establish realistic fees and effective billing and collection practices. Patients billed for referral costs often refused to pay on the basis that referral services have traditionally been free and should continue to be so.

GAO believes the Pacific Basin governments should reexamine their policies of providing heavily subsidized medical referrals and consider establishing

and enforcing ability-to-pay standards, enforcing eligibility requirements, and improving billing and collection practices. (See ch. 3.)

#### IMPROVING ON-ISLAND MEDICAL CAPABILITIES

Although a detailed assessment of on-island medical capabilities and quality of health was not made, GAO identified areas in which improvements in capabilities could reduce medical referrals. The majority of patients referred require specialized medical care which cannot be provided locally on a cost-effective basis. However, GAO found that, except in American Samoa, improvements in the level of locally provided medical care, personnel, training, equipment, maintenance of existing equipment, and better management of supplies could eliminate as much as 25 percent of the referrals, or as much as \$1 million in fiscal year 1983. Pacific Basin governments can improve the diagnostic capabilities of local staff which could further reduce costs. These governments should initiate efforts to strengthen local capabilities by pursuing the improvements suggested above. (See ch. 4.)

#### MANAGEMENT OF REFERRAL PROGRAMS CAN BE IMPROVED

The medical referral programs are loosely managed and lack controls to prevent unnecessary and costly referral of patients for off-island treatment. All the territories have established medical referral committees to improve the referral management progress but, in practice, these committees seldom function as they should. The approval process needs strengthening to make sure that government-authorized referrals could not have been treated locally. After a decision is made to refer a patient, greater attention is needed in preparing specific treatment authorizations and selecting the most cost-effective referral center.

The Pacific Basin governments can also reduce referral costs by more closely monitoring patient progress at the referral hospitals. Failure to do so leads to excessive hospital stays and additional costs. Beginning in 1982, American Samoa has employed a Hawaii-based physician, on a part-time basis, to monitor referral patients. In fiscal year 1983, an estimated \$85,000 was saved through the actions of this physician. A Marshall Islands physician also visited patients at one referral hospital and concluded that over half of them were well enough to be

discharged or returned to the Republic of the Marshall Islands for treatment. As a result they were sent home.

GAO believes that the local governments should (1) strengthen the role and authority of the local medical referral committees, and (2) consider greater use of part-time physicians to monitor patient progress at referral centers. Both actions could reduce referral costs. (See ch. 5.)

#### AGENCY COMMENTS

The Departments of Interior, Health and Human Services, and Defense and the governments of American Samoa and Northern Mariana Islands agreed in general with GAO's findings and conclusions. (See apps. I through IV.)

Defense raised two issues involving (1) Interior's liability for medical debts incurred by Pacific Basin governments and (2) continuation of services once the trusteeship is ended. Neither of these issues had been resolved at the time of GAO's review.

The Republic of Palau and the Republic of the Marshall Islands did not provide comments on the report.

Prior to issuance of this final report, the Federated States of Micronesia provided comments which are included in appendix V. GAO did not incorporate them into the final report.



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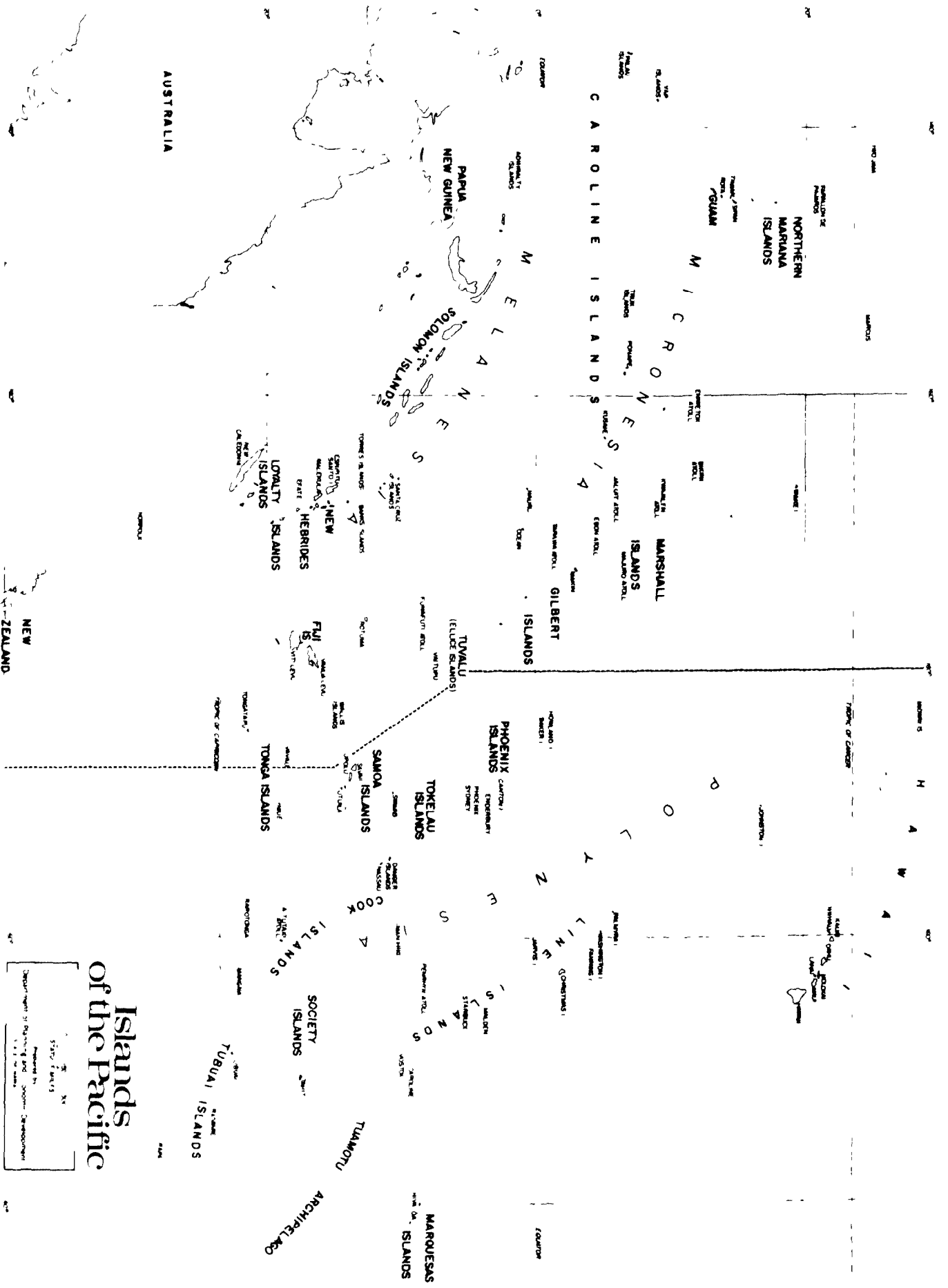
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ABBREVIATIONS

FSM	Federated States of Micronesia
GAO	General Accounting Office
HHS	Department of Health and Human Services
NHSC	National Health Service Corps
NMI	Northern Mariana Islands





# Islands of the Pacific

Prepared by  
 U.S. Navy  
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## CHAPTER 1

### INTRODUCTION

The United States has made significant contributions to the development of health care systems within its Pacific Basin jurisdictions--the Trust Territory of the Pacific Islands and American Samoa. Health care facilities have been constructed and a variety of federal grants and programs have been made available to improve the level of locally provided health care. The result has been a marked improvement in health care.

The Trust Territory of the Pacific Islands, known as Micronesia, consists of the emerging nations of the Republic of Palau, Republic of the Marshall Islands, Federated States of Micronesia (FSM), and the Commonwealth of the Northern Mariana Islands (NMI). Together with the U.S. territory of American Samoa, these Pacific Basin insular areas are widely dispersed throughout the Western Pacific Ocean. These areas include more than 2,000 islands, of which about 200 are inhabited. Total population in 1980 was approximately 175,000.

### U.S. RESPONSIBILITY FOR HEALTH CARE

Since 1947, the Trust Territory of the Pacific Islands has been administered by the United States through a U.N. Trusteeship Agreement under which the United States accepted the responsibility of protecting the health of the inhabitants of Micronesia. Each of these Micronesian entities remains legally a component of the Trust Territory until the Trusteeship Agreement is terminated.

U.S. involvement in American Samoa began much earlier than in the Trust Territory. In 1904, American Samoa became an unincorporated territory of the United States. The role and responsibilities of the United States in American Samoa are described in the Treaty Agreement of 1900 between the United States, Great Britain, and Germany. The treaty obligates the United States to promote the health development of American Samoa.

The responsibility for health development and administration of the Trust Territory and American Samoa was initially delegated to the Secretary of the Navy. In 1951, this responsibility was transferred to the Secretary of the Interior, who delegated executive and legislative authority in 1964 to the High Commissioner, Trust Territory of the Pacific Islands. The High Commissioner is currently the chief U.S. representative in the Trust Territory.

The U.S. government's health and health-related programs have been the principal support for the Pacific Basin jurisdictions' health systems. The assistance has varied from direct services provided by the U.S. Navy during the 1940s to the current approach of providing monetary grants in aid, direct

contracts, U.S. supplied and supported health services, infrastructure improvements, and, most recently, block grants.

Under U.S. administration, health care facilities ranging from dispensaries to modern hospitals have been constructed; health professionals ranging from health assistants to physicians have been hired along with numerous paraprofessionals; and many health service programs, such as health manpower development, immunization, crippled children's service, and health planning, have been initiated.

#### LOCAL RESPONSIBILITY FOR HEALTH CARE

The health care delivery systems in the Pacific Basin are owned and operated by the respective governments. In fact, each Pacific Basin government has assumed the responsibility for deciding where funds should be spent to provide health services and for managing health programs, including medical referrals.

These islands are isolated, and consequently they face unusual transportation, communication, supply procurement, manpower recruitment, and construction and maintenance problems. These problems combined with a small population and dependency on outside funding has made it economically infeasible to provide expensive, highly specialized medical services locally. Lacking such services, the Pacific Basin governments refer seriously ill patients to Guam, Hawaii, and the U.S. mainland for treatment. Even though these governments are moving toward greater self-sufficiency in health care delivery, the need to refer patients off-island is expected to continue into the foreseeable future.

#### MEDICAL REFERRAL CENTERS

The Department of the Interior has arranged for citizens of the Trust Territory of the Pacific Islands and American Samoa to be provided with health care on a referral basis to hospitals in Guam, Hawaii, and the U.S. mainland. The largest medical referral center is Tripler Army Medical Center in Hawaii. The Department of the Army provides care to Pacific Basin residents on a reimbursable basis at interagency rates, under the authority of the Economy Act (31 U.S.C. 1535).

The Pacific Basin governments have arrangements to use the Letterman Army Medical Center in San Francisco and the U.S. Navy Regional Medical Center in Guam. For treatment not available at U.S. military hospitals, several private health care institutions in Guam and Hawaii also accept referral patients.

#### THE COMPACT OF FREE ASSOCIATION

The peoples and governments of Palau, the Marshall Islands, and the FSM have indicated a strong desire to terminate the Trusteeship; they consider themselves ready for the responsibilities of further self-government. To accomplish this objective, political status negotiations were initiated in the early 1970s.

In these negotiations, the Micronesian representatives sought a freely associated political status which would be acceptable in the international community and would balance U.S. security and defense requirements with the Micronesian's desire for sovereignty and self-government. The negotiators have developed a document, known as the Compact of Free Association, which will govern the relationship between the U.S. and the Micronesian political entities. The Micronesian governments have signed the Compact, but before it becomes effective it must be approved by the U.S. Congress and the United Nations.

Through the Compact and its subsidiary agreements, the Micronesian governments will receive approximately \$2.2 billion over a 15-year period, with no less than 40 percent of the money designated for economic development. The balance will be used to maintain public works infrastructure and to operate government programs designed to improve the health, education, and welfare of the islanders. Under the Compact, the Micronesian states will be completely responsible for all health care services on the islands.

#### OBJECTIVES, SCOPE, AND METHODOLOGY

At the request of the Chairmen, Subcommittee on Public Lands and National Parks and Subcommittee on Insular Affairs, House Committee on Interior and Insular Affairs, we reviewed medical referrals from the Trust Territory of the Pacific Islands, NMI, and American Samoa. Guam was not included in the scope of our review. Our primary objectives were to (1) determine the costs associated with the medical referral programs and the ability of each government to pay these costs, (2) assess the need to re-examine existing medical referral policies in the light of rising program costs, (3) identify ways to improve on-island medical capabilities which impact on medical referrals, and (4) evaluate the management of the off-island medical referral program administered by each government. We did not perform a detailed assessment of health care needs, existing indigenous medical capabilities, or quality of health care provided at each location. Such an assessment is being made by the Public Health Service and is scheduled to be completed in the fall of 1984.

We limited our review to referrals which were funded from the Department of Interior operating grants and locally provided funds. We did not review referrals made through the Maternal and Child Health programs, the Crippled Children's Health and Vocational Rehabilitation Service program, or Department of Energy's program for victims of nuclear testing in the Republic of the Marshall Islands.

Our review was conducted during May to December 1983 at the Trust Territory of the Pacific Islands Government, Saipan; the Governments of NMI, Republic of the Marshall Islands, Republic of Palau, FSM (the National Government and Ponape State), and American Samoa; and the Office of Territorial and International

affairs, Department of the Interior; Office of Micronesian Status Negotiations; Public Health Service, Department of Health and Human Services (HHS); and Office of the Surgeon General, Department of the Army, Washington, D.C. In Hawaii our review was conducted at the Tripler Army Medical Center and other referral hospitals, such as Queens, Saint Francis, and Straub Clinic, and at all Pacific Basin government liaison offices. We also did work at the Kwajalein Missile Range hospital, Guam Navy Regional Medical Center, and Guam Memorial Hospital, which also serve as referral centers. In San Francisco, California, we met with Region IX Public Health Service officials, who administer health-related federal grants and programs for the Pacific Basin governments. We also met with the Pacific Basin Initiatives Group, a federal task force established in April 1983 to develop a comprehensive health strategy in the Pacific Basin, and a contractor assisting in the development of this strategy.

We reviewed and analyzed previous studies and task force reports prepared by U.S. congressional committees, the Trust Territory Government, the various Pacific Basin governments, and other public and private institutions. We also reviewed comprehensive health plans developed by each government through HHS under Public Law 93-641, as amended. In addition, we reviewed historical documents and current files at each location we visited to obtain a clear understanding of the bases, policies, costs, and problems associated with medical referrals.

This review was not intended to be a financial audit of the accuracy of the medical referral costs incurred by the Pacific Basin governments. Our analysis of cost data and the number of referrals involved compiling existing data at the individual governments and at the medical referral centers. Since a complete set of records was not obtainable from either source, we combined information from both sources to arrive at our figures. We did not attempt to verify costs and the number of referrals or to reconcile discrepancies which may have existed between these two sources, so many of the figures in this report are estimates based on the data available at the time of our review.

Our review was conducted in accordance with generally accepted government audit standards. We obtained the views and comments of the Departments of Interior, Defense, and HHS as well as the governments of American Samoa and NMI on a draft of this report. Defense comments were provided orally; the others provided written comments, included in appendices I through IV. All comments were taken into account in preparation of this final report.



## CHAPTER 2

### OUTSTANDING MEDICAL REFERRAL BILLS

#### ARE A CONTINUING PROBLEM

At the start of fiscal year 1984, the Pacific Basin governments owed an estimated \$6.2 million for medical referral services provided during fiscal years 1979 through 1983. Of this amount, the Army reported that \$4.4 million is for medical care provided by the Tripler Army Medical Center in Hawaii. Attempts by the Army to collect outstanding bills from some of the Pacific Basin governments have proven unsuccessful. Unless some provisions are made to pay these bills, the amount owed Tripler alone is expected to reach \$8.0 million by the end of fiscal year 1984. To resolve the continuing problem of nonpayment of bills, the Pacific Basin governments must budget adequately for medical referrals.

#### REFERRALS ABSORB MILLIONS IN FEDERAL FUNDING

The United States provides a major portion of the total health care funding for the Pacific Basin governments. Funds available for the local health budgets are derived primarily through annual block grants from the Department of the Interior. In fiscal year 1983, for example, \$15.8 million, or 78 percent, of the total \$20.4 million health operating budgets in the Pacific Basin came from Interior's block grants; the remaining \$4.6 million came from locally provided revenues.

#### BUDGETING FOR REFERRALS IS INADEQUATE

Medical referrals represent a substantial portion of the health costs within the Pacific Basin. In fiscal year 1983, costs incurred for medical referrals averaged 28 percent of the health services budgets, as indicated in table 1.

As shown, except for NMI, the Pacific Basin governments incurred costs of about \$2.2 million more than they budgeted for medical referrals.

Based upon our analysis of medical referral costs during fiscal years 1981 through 1983, costs have exceeded local budgets by over \$6 million, as shown in table 2.

Table 1

Medical Referral Budgets and Costs  
As Percent of Total Health Care Operating Budgets  
 Fiscal year 1983

	<u>Health services budget</u>	<u>Medical referral budget</u>	<u>Percent of health budget</u>	<u>Medical referral costs<sup>a</sup></u>	<u>Percent of costs versus health services budget</u>
Marshall Is.	\$ 2,747,600	\$ 394,900	14	\$1,565,087	57
FSM (Ponape)	2,121,000	425,000	20	671,849	32
Palau	1,505,000	150,000	10	366,701	24
NMI	6,069,400	1,610,000	27	1,438,023	24
American Samoa	<u>8,011,500</u>	<u>980,000</u>	12	<u>1,694,914</u>	21
Total	<u>\$20,454,500</u>	<u>\$3,559,900</u>	17	<u>\$5,736,574</u>	28

<sup>a</sup>Data for fiscal year 1983 is incomplete; actual referral costs will be higher.

Table 2

Budget and Costs for  
Medical Referral Programs  
 Fiscal years 1981-83

	<u>Budget</u>	<u>Costs</u>	<u>Amount over budget</u>
Marshall Is.	\$1,607,000	\$ 4,193,000	\$2,586,000
FSM (Ponape)	931,000	1,829,000	898,000
Palau	518,000	1,205,000	687,000
NMI	3,919,000	3,995,000	76,000
American Samoa	<u>2,406,000</u>	<u>4,405,000</u>	<u>2,000,000</u>
Total	<u>\$9,380,000</u>	<u>\$15,627,000</u>	<u>\$6,247,000</u>

LOW BUDGETS CONTRIBUTE  
TO NONPAYMENT OF BILLS

As medical referral costs exceed the amounts budgeted, most Pacific Basin governments, faced with large deficits, have delayed paying their medical referral bills. These governments owed hospitals, other related medical providers, such as physicians, laboratories, physical therapy facilities, and air carriers, an estimated \$6.2 million for medical referral services rendered during fiscal years 1979 through 1983. As the amount of unpaid bills continues to escalate, some private medical referral centers are considering suspending medical services to these governments.

Subsequent to our fieldwork, the governments of American Samoa and NMI said they have settled their outstanding debts with the Army. As of May 31, 1984, Tripler reported that both American Samoa and the NMI had paid most of their outstanding amounts owed.

Tripler Army Medical Center

Since the early 1970s, Tripler has provided medical services to Pacific Basin residents as part of an interagency agreement with the Department of the Interior. At Interior's request, the Department of the Army agreed to have Tripler provide medical care with the Pacific Basin governments paying the cost.

Attempts by Tripler to receive payment on medical referral bills have generally been unsuccessful. In the past 3 years, Tripler sent 54 collection letters to the Pacific Basin governments but received only 3 responses. Unpaid medical referral bills continue to grow. The Office of the Surgeon General, Department of the Army, kept the Department of the Interior apprised of the problem, but, according to Army officials, no resolution seems forthcoming.

Contending that Interior is responsible for these debts, the Surgeon General directed Tripler to cease direct billing to the Pacific Basin governments as of October 1, 1983, and recommended that all transactions concerning these governments be handled on an interagency basis between the Department of Defense and the Department of the Interior. The Economy Act (31, U.S.C. 1535), which provides for reimbursement for services rendered by one agency at the request of another was cited as support for this action. The issue of debt resolution between Defense and Interior had not been settled as of June 1984.

Micronesian governments blame referral  
debts on inadequate federal funding

According to Micronesian officials, unrealistic medical referral budgets and the resulting unpaid bills are caused by inadequate funding. Local officials believe that the United

States is responsible for health care under the Trusteeship Agreement and that if they cannot afford to pay their debts, the United States should. American Samoan and NMI officials, on the other hand, said their referral debts are largely a local fiscal management problem. Neither blames the federal government for their debt problem, and both claim to have settled their outstanding debts.

Interior response: local governments are responsible for their debts

Interior officials acknowledge that the United States, under terms of the Trusteeship, is responsible for the health and well-being of the island inhabitants. However, they also believe that the Pacific Basin governments must be held accountable for the medical referral bills incurred because they establish the amount of funds to be allocated for medical referrals, the criteria and policy for referrals, and manage the referral programs. Interior contends that the territories are receiving adequate funding for health care. The problem of unpaid referral bills is largely related to inadequate budgeting, inadequate cost control, and inefficiencies and abuses in the current systems. As a result, Interior is opposed to any "bail-outs" to cover medical referral debts.

Interior agrees that under its agreement with the Tripler Army Medical Center, it is legally responsible for Tripler's medical referral debts. Interior officials indicated they would work closely with the territories to help them pay the amounts owed Tripler and others. If necessary, Interior officials said grant appropriations to Pacific Basin governments will be withheld to pay off debts if the governments do not establish repayment agreements.

CONCLUSION

Most of the Pacific Basin governments do not budget sufficiently for medical referrals, which has led to large deficits and unpaid bills. We were told that outstanding debts have become so great that some hospitals are considering suspending services to patients referred by these governments.

We believe as a matter of policy and financial accountability the emerging states of Micronesia should assume greater responsibility for their medical referral services. The local governments, although heavily dependent on federal funding, are in virtual control of their local affairs, including preparing health service budgets, allocating funds, and managing the health programs to meet local needs. However, we also believe Interior should initiate prompt action to resolve debt problems with Defense.

The following chapters offer several suggestions for improving the management of medical referral programs and reducing costs.

## AGENCY COMMENTS

The Departments of the Interior, Defense, and HHS provided specific comments which have been incorporated into the report. All agreed with our major findings and conclusions, and all agreed that medical referral debts are a concern in the Pacific and that steps must be taken to remedy the situation. HHS identified several issues and areas which were beyond the scope of our work.

Comments from the governments of American Samoa and NMI are also included in the body of the report. Both indicated they have taken actions to resolve their debt problems. The Republics of the Marshalls and Palau did not comment on our report.

In its oral comments Defense reiterated its contention that Interior is liable for debts incurred by the Pacific Basin governments and therefore should settle the debts directly and then establish repayment programs with each of the concerned governments.

Defense also raised an issue about continuation of medical services once the Trusteeship Agreement is ended. Defense said the Economy Act is the only basis upon which medical services can be provided by the Army to the Pacific Basin governments. Without enactment of enabling legislation authorizing continued care by Defense facilities, Defense will have no alternative but to terminate all health care concurrent with the end of the Trusteeship. Defense officials expressed concern that continuation of medical services to Micronesia will cease with the Compact of Free Association unless authorization is provided by Congress.

## CHAPTER 3

### PACIFIC BASIN GOVERNMENTS SHOULD RE-EXAMINE

#### MEDICAL REFERRAL SUBSIDY POLICIES

The Pacific Basin governments provide free or low-cost health care for their citizens through their medical referral programs, including medical, transportation, and related costs. The cost of providing these services has significantly increased over the past few years, resulting in a financial drain on the governments' resources. These governments should re-examine their policies of providing heavily subsidized medical referral care.

#### REFERRAL COSTS HAVE INCREASED

Over the past 3 fiscal years, the Pacific Basin governments have incurred costs of about \$15.6 million to refer 1,690 patients to Guam, Hawaii, and the U.S. mainland for medical care, as shown in table 3.

Table 3

	<u>Medical Referral Costs</u>			
	<u>1981</u>	<u>1982</u>	<u>1983<sup>a</sup></u>	<u>Total</u>
Marshall Is.	\$ 756,729	\$1,871,331	\$1,565,087	\$ 4,193,147
FSM (Ponape)	475,601	681,882	671,849	1,829,332
Palau	401,229	436,819	366,701	1,204,749
NMI	1,090,368	1,466,135	1,438,023	3,994,526
American Samoa	<u>979,922</u>	<u>1,730,204</u>	<u>1,694,914</u>	<u>4,405,041</u>
Total	<u>\$3,703,850</u>	<u>\$6,186,371</u>	<u>\$5,736,574</u>	<u>\$15,626,795</u>

<sup>a</sup>1983 figures will be higher, as total costs were not available at the time of our review.

Current costs are significantly higher than they were in the past; in fiscal year 1974, for example, medical referral costs for the Trust Territory and NMI governments totaled \$587,000, compared with about \$4 million for 1983. This increase is especially evident in the per-patient costs for recent years. In fiscal year 1981 the average referral cost was \$6,626, but in fiscal year 1983 it increased to \$10,441. The increase over the years has been due to escalating medical, transportation, and other costs, even though the number of patients referred has remained fairly constant over the past 3 years, as shown in table 4.

Table 4

Number of Patients Referred

	<u>1981</u>	<u>1982</u>	<u>1983<sup>a</sup></u>	<u>Total</u>
Marshall Is.	86	116	88	290
FSM (Ponape)	41	53	50	144
Palau	47	29	40	116
NMI	261	246	225	732
American Samoa	<u>124</u>	<u>136</u>	<u>148</u>	<u>408</u>
Total	<u>559</u>	<u>580</u>	<u>551</u>	<u>1,690</u>

<sup>a</sup>1983 figures are incomplete.

Medical costs

Our analysis shows that over the past 3 fiscal years the medical costs component constituted the largest portion of the medical referral program costs. In fiscal years 1981 through 1983, the Pacific Basin governments spent \$11.9 million for medical services, or 76 percent of the total \$15.6 million medical referral costs.

Hospital costs, which include hospital charges and medical care, have also increased over the years. The U.S. military hospitals, which charge a flat daily rate for hospital charges and medical care, have experienced substantial rate increases. Until fiscal year 1974, patients referred to U.S. military hospitals received a preferential inpatient rate of \$66 per day. By fiscal year 1983 this rate was \$369 per day.

Similar increases have been incurred in private institutions. For example, American Samoa reported that in fiscal year 1971 it was paying \$75 a day for a bed in a private referral hospital but that it now pays an average of \$205 a day plus medical care.

Transportation costs

Since 1978, commercial airline transportation rates have tripled for non-stretcher patients and doubled for stretcher patients, as indicated in table 5.

Table 5

Transportation Charges to Honolulu

<u>From</u>	<u>Non-stretcher patient</u>		<u>Stretcher patient</u>	
	<u>1978</u>	<u>1983</u>	<u>1978</u>	<u>1983</u>
Palau	\$365	\$996	\$2,250	\$4,980
FSM (Ponape)	270	916	1,620	3,664
Marshall Is.	255	894	1,530	3,576
NMI	258	798	1,775	3,990
American Samoa	198	594	1,350	2,970

During fiscal years 1981 through 1983, transportation of referrals accounted for about 5 percent of the total medical referral costs of Pacific Basin governments.

Other related costs

Medical referral costs include not only patient costs but also transportation and subsistence for patient escorts. During the last 3 fiscal years, 772 family and medical escorts cost the Pacific Basin governments \$774,468. Escort costs have increased each year and have more than doubled since fiscal year 1981.

These governments also spent \$1.3 million during fiscal years 1981 through 1983 for such related medical referral services as providing patient care coordinators at each of the government's liaison offices in Guam and Hawaii, ambulance services, mortuary services, and special equipment needs for patients.

PATIENT CONTRIBUTIONS CAN  
REDUCE REFERRAL COSTS

None of the Pacific Basin governments except Palau have attempted to meaningfully reduce their medical referral costs by requiring patient contributions. The State of Ponape of the FSM, the Republic of the Marshall Islands, the NMI, and American Samoa have done little to encourage patients to contribute toward their medical referral expenses.

Trust Territory policy

The Trust Territory Government medical referral policy, formulated in 1968, allowed all Trust Territory citizens who could not have their health care needs met locally to be sent to more sophisticated health care centers at the expense of the Trust Territory Government. In amendments to the 1968 policy, the Trust Territory Government was also responsible for providing all hospital and travel costs of the patient and a subsistence



allotment when necessary. Patients who met the criteria were eligible to have a family member accompany them, also at the Trust Territory Government expense.

This policy remained in effect until 1978, when the High Commissioner, acknowledging the skyrocketing costs of the medical referral program, established a requirement that referral patients pay a rate similar to a fee schedule developed by the Trust Territory Government for patient services at local hospitals. An attempt to make referral patients and their families more responsible for a portion of their referral expenses resulted in a policy revision requiring patients to pay the costs of transportation to and from the referral location. Except for Palau, none of the Pacific Basin governments continued this policy. Current patient contribution policies are summarized below.

#### Patient Contribution Policies

Palau	Patient and escort pay all transportation costs. Patient pays 50 percent of medical expenses.
NMI	No formal policy
Marshall Is.	No formal policy
FSM	No formal policy
American Samoa	No contribution required

#### Palau pursuing greater program self-sufficiency

The medical referral program has been widely discussed in Palau, particularly its high cost relative to the number of people benefiting from the program. During fiscal years 1979 through 1981, 74 referral cases cost the government over \$650,000. In 1981, policy changes were made requiring referral patients to pay all transportation costs in advance and to sign a promissory agreement to reimburse the government 50 percent of all related medical expenses.

The Director of Palau's Bureau of Health Services said this cost-sharing arrangement has saved the government money through decreased transportation costs. For example, for fiscal years 1981-83 the government spent only \$9,230 to transport referrals, less than one percent of total referral costs. In contrast, Ponape, with no patient contribution policy for transportation, spent \$144,125, or 8 percent of total costs during the same period.

Palau has been less successful in getting patients to contribute 50 percent to their medical costs. Local citizens cite their basic right to free medical care as stipulated in the Palau

Constitution. According to Palau's Attorney General's Office, the government is reluctant to assert its powers of fee collection until the constitutionality of medical fees are challenged in court and some legal precedent is established.

NMI should develop  
ability-to-pay criteria

In 1980 the NMI proposed a medical referral policy requiring financially able patients to pay 10 percent of their referral costs. This policy, however, has not been implemented because the government has not developed any ability-to-pay criteria.

The NMI government should also consider adopting the policy of charging patients and their escorts transportation costs, as Palau does. Based on our analysis, collecting 10 percent of medical costs and transportation costs would have accrued cost savings of about \$219,000 to the government in fiscal year 1983.

Little has been done about  
referral fees in the  
Marshalls and Ponape

Except for low user fees, the governments of the Marshall Islands and the State of Ponape have not established any policies requiring patients to contribute to their medical referral costs. Referral patients are not required to pay for their transportation or a portion of their actual medical costs. Instead, fee schedules originally adopted in 1971 by the Trust Territory Government are the only patient contributions required for medical referral services. For the most part, however, this policy is seldom enforced; even if it was fully enforced, the user fees are so low in comparison with the actual cost of providing referral services that the governments' subsidy of referral programs would not be reduced appreciably. In the Marshall Islands, for example, referral patients are billed a standard daily fee of \$4, even though the fiscal year 1983 rate at U.S. military hospitals, which is generally regarded as being lower than private hospitals, was \$369 per day. According to local government officials, the issue of increasing fees is politically unpopular and will most likely result in increased difficulties in collecting bills.

We were unable to determine current amounts collected because there is no formal billing system which records the amount owed for services rendered. Local government officials told us that collections have been extremely low in Ponape and virtually non-existent in the Marshall Islands. They said that most patients that are asked to pay usually refuse on the basis that they cannot afford it. In some instances, patients known to have well-paying jobs also refuse to pay. These officials believe this can be attributed to the fact that Micronesian citizens are accustomed to free medical referral services.

## American Samoa should re-examine financing of referrals

The Revised Code of American Samoa specifies that medical care is to be provided free to residents of American Samoa, and therefore, patients requiring off-island medical care are referred free-of-charge, including all transportation, medical, and escort cost, when authorized. The government, however, does not provide a subsistence allowance for the patients or escorts.

Officials of the American Samoa government said they are currently evaluating alternatives for financing their medical referral program but that charging patients for referral services is not one of the alternatives as it is a highly sensitive issue that is politically unpopular at this time. As an alternative to changing current policy, they are considering such options as a national health insurance plan and special taxes as a way of financing the medical referral program and other government-provided health services. We did not assess the viability of these options.

The Revised Code prohibits charging for medical care for eligible residents. Health officials have interpreted this to mean that they cannot charge for medical referral services unless the patient does not qualify for free medical care because the individual is not a bonafide citizen. This interpretation, however, is seldom applied. During fiscal years 1981 through 1983, we found that 21 percent of the American Samoa government's referrals were not qualified for free care because they were not American Samoan citizens. This cost the government at least \$253,000 and probably much more. We suggest that the government at least require persons who are not eligible for free care to pay for their medical costs. It should also consider changing the Code to charge all referrals and family escorts for transportation, since this cost is not for the medical care itself.

## CONCLUSIONS

The medical referral programs of the Pacific Basin governments have received considerable attention in the past few years because of their high costs relative to the beneficiaries of the program. The high costs are due to several factors. The geographic location of the Pacific Basin islands makes off-island referrals expensive due to transportation costs alone. This combined with rising medical costs has resulted in a substantial drain on the governments' health services budgets. One alternative to lowering the government's level of subsidy is to require patients to pay a portion of their medical referral costs. Charging for medical referral services, however, is a highly sensitive issue that can be expected to receive much public opposition.

Past attempts to generate local revenues by passing on a portion of the costs to users have proven partially successful.

The Republic of Palau, for example, succeeded in having patients and escorts pay for their transportation costs to and from the referral location. Although Palau has also adopted a policy of requiring patients to pay 50 percent of their medical costs, patients often refuse to reimburse the government on the grounds that free medical care is a constitutional right. We believe the Republic of Palau should resolve the constitutionality of this policy.

The other Pacific Basin governments have no or very limited policies of requiring patients to contribute to their referral expenses. Little has been done to develop realistic fees and to set billing and collecting practices for these services. Patients have traditionally received free services even if they are financially able to pay for services.

The formidable task of overcoming these obstacles will have to be addressed by the Pacific Basin governments in order to control or reduce the level of medical referral expenditures. We believe each government should take stronger actions to evaluate the feasibility of requiring some patient contributions to medical referrals, similar to policies adopted by Palau. This can be done by enforcing eligibility requirements, establishing and enforcing ability-to-pay standards, and improving billing and collection practices.

#### AGENCY COMMENTS

Both American Samoa and the Northern Mariana Islands said that increasing patient cost-sharing was a local policy decision and should remain so. The Marshalls and Palau did not comment.

## CHAPTER 4

### IMPROVING ON-ISLAND MEDICAL CAPABILITIES

#### COULD LOWER REFERRAL COSTS

The majority of medical referrals are for specialized care which is not feasible to provide locally. Nevertheless, some referral patients could have been treated locally if the local governments had provided for additional physician training, purchased some new and relatively inexpensive equipment, maintained existing equipment, and ensured a reliable flow of medical supplies. Except for American Samoa, the number of referrals could potentially have been reduced more than 25 percent in fiscal year 1983; using the average per-patient referral cost for each government, costs could have been reduced as much as \$1 million.

The local governments also face some longer term problems related to medical capability which can affect medical referrals. A major problem is the projected shortage of physicians which, unless remedied, threatens to lessen local medical capabilities and increase the number of medical referrals.

#### MAJORITY OF REFERRALS REQUIRE SPECIALIZED CARE

U.S. and Pacific Basin health officials forecast an essential need for continuing to refer patients requiring specialized health care, since small populations and limited financial resources make it infeasible to provide these services in a cost-effective way. According to Pacific Basin health officials, specialized medical care is that level of care which cannot be developed locally because the small size of the population would not adequately use the services of specialized physicians or justify purchasing sophisticated medical equipment. Specific examples of conditions which require off-island referral are open heart surgery, neurosurgery, cancer, and kidney diseases. At the locations we visited, specialized medical care comprised 396, or 78 percent, of the total 510 medical referrals in fiscal year 1983.

#### Development of local capacity to provide specialized care not feasible

The American Samoa Plan for Health 1982-1986 states that the standard population base necessary to economically support radiation therapy services for cancer patients must be no less than 150,000 persons, with a minimum of 450 cancer patients yearly. American Samoa, with an estimated population of 32,000 in 1980 and only 24 cancer-related referrals in fiscal year 1983, decided that development of radiation therapy services was not warranted.

According to the 1983 NMI Health Plan, 200 or more cases are required annually to justify the services of an open heart surgeon. In fiscal year 1983, however, the NMI referred only 9 patients requiring specialty heart services.

None of the Pacific Basin hospitals are able to provide highly specialized medical care. This is true even for the 5 year old Ponape Hospital, which was designed as a regional referral center for Micronesia but was never operated as a referral center. The other local governments preferred U.S. referral centers and felt the Ponape hospital did not have the specialized capability to handle referrals. The complexity of developing highly specialized care was noted by the Chief, Division of Health Services, Ponape State, who told us that improvements in the following areas were needed if Ponape was to provide all specialized services.

- Facilities
- Appropriate diagnostic and treatment equipment
- Medical supplies
- 12 different types of medical specialists
- Qualified support personnel, such as nurses and technicians
- Reliable support services, such as water, electricity, and maintenance.

Visiting teams of specialists  
could reduce referral costs

At the request of the Pacific Basin governments, Tripler Army Medical Center and other health providers send traveling teams of medical specialists to Micronesia and the Pacific territories. These teams have successfully treated patients that would normally have been referred. Local health officials said these visits are cost effective and should occur more frequently. A Tripler official agreed with these views, stated that such visits would reduce the number of specialty referrals, and expressed a strong interest in continuing them.

The requesting government is supposed to pay full expenses for these teams, but budgetary constraints have limited the number of requests for these services. According to a Tripler official, Tripler has no line item budgeted for these visits and without funding assistance it may have to limit these services. Defense comments on this report stated that visiting medical consultant teams are a service provided by Tripler at the request of Interior. They are not part of an authorized Army or Tripler mission, so they cannot be provided on a regularly scheduled or recurring basis.

We believe the local governments should examine the cost effectiveness of inviting off-island specialists to treat potential referral patients. If these visits prove to be cost effective, the governments should strongly consider providing additional funding for the visits.

### Foreign hospitals as referral alternatives

As the Micronesian governments move toward greater political autonomy and self-government, the prospect of establishing a medical referral program to other countries becomes a more viable option. Several Trust Territory and individual Micronesian government delegations have been sent to Far East countries to explore establishing a medical referral program. The hospitals and health care facilities of Japan, the Philippines, and Taiwan were surveyed. Whether the cost of hospitalization in these Far East countries will be found to be less expensive than the care presently provided at U.S. military hospitals remains a question. Most of these delegations found that the necessary medical services, including the specialized fields of medical care, were available, but certain inhibiting factors were the

- cost of establishing and maintaining a liaison office in the country;
- transportation and communication requirements;
- cultural and linguistic problems; and
- concern for the quality control of care.

These problems certainly need to be considered and more analysis made before any decisions are made to establish a medical referral program in a foreign country.

### Use of Kwajalein Missile Range Hospital

The Kwajalein Missile Range Hospital, funded by the Department of Defense, provides referral services for adjacent Marshall Island communities, although serious cases require off-island referral to Hawaii. Most Marshall referral patients live on Ebeye Island, which has a high population density and inadequate medical care capabilities. The number of such patients admitted and treated at Kwajalein hospital more than doubled from July 1980 through June 1983. The current 1983 rate of 93 inpatient and 357 outpatient referrals is anticipated to substantially increase over the coming years.

Recent proposals have been made by Kwajalein and Ebeye hospital staff to better use their personnel and facilities in serving the entire community. No agreements have been reached, and both Kwajalein and Ebeye are planning major new hospital facilities. Kwajalein's military commander and Marshall Island health

officials agree that developing parallel medical facilities on Ebeye and Kwajalein would be an expensive duplication of effort. Ebeye and Kwajalein health planners should coordinate their development of new hospitals, since Kwajalein will likely continue as a referral facility for most of Ebeye's referral needs.

IMPROVED MEDICAL CAPABILITY COULD  
REDUCE NONSPECIALIZED REFERRALS

Nonspecialized medical referrals, according to Pacific Basin Health officials, comprise those patients who require a level of medical care that can be developed and economically justified on-island, given the populations. At our request, physicians and medical referral committee members from each of the Pacific Basin governments we visited reviewed their fiscal year 1983 medical referrals and specifically identified those patients who, in their opinion, could have been treated on-island by increasing medical capabilities through training physicians, purchasing medical equipment, and obtaining needed medical supplies. They concluded that improvements in these three areas could reduce referrals, as indicated in table 6.

Table 6

Estimated Reductions in Referrals  
by Improving Manpower, Equipment, and Supplies  
1983

	<u>Total referrals</u>	<u>Referral reduction</u>	<u>Percent reduction</u>
Marshall Is.	92	26	28
FSM, (Ponape)	51	11	22
Palau	40	11	28
NMI	221	60	27
American Samoa	<u>106</u>	<u>1</u>	<u>1</u>
Total	<u>510</u>	<u>109</u>	<u>21</u>

The capability at the American Samoan hospital reflects the relationship between health care capabilities and referrals needing nonspecialized care. An American Samoa health official attributed the low referral rate for nonspecialized treatment in 1983 to the capabilities of this hospital. This percent rate contrasts with the Majuro, Ponape, Palau, and Saipan hospitals, where referrals for nonspecialized care averaged 27 percent of the referrals in fiscal year 1983.

While actual savings were unavailable, if the fiscal year 1983 average per-patient medical referral costs for each of these



government, were applied to the possible reduction in referrals, about as much as \$1 million could have been saved by treating these patients locally. Referrals could be realistically reduced through training in new medical techniques, purchasing relatively inexpensive equipment, maintaining existing equipment, and ensuring the flow of needed medical supplies.

### Physician training

Local health officials told us that additional physician training could lead to reduced medical referrals. For example, Ponape and NMI health officials said 11 percent of their fiscal year 1983 referrals, or approximately \$166,000 in costs, would not have been necessary if their physicians had additional training in such areas as orthopedics, trauma care, and urology. Marshall Islands health officials were unable to identify specific cases which could have been treated on-island had physician training been available, but they generally agreed that physician training would reduce referrals in the future. Local health officials said such cost-effective training has been limited due to budgetary constraints.

### Medical equipment and better maintenance

Basic, well-functioning medical equipment is especially critical in the Pacific Basin jurisdictions because of the lack of alternative sources of medical care, the high cost of referring patients when equipment is not available, and the length of downtime involved with equipment repair or replacement.

Purchases of basic medical equipment would substantially increase the capability of the local hospitals and reduce non-specialized referrals. Based on the analysis made by physicians at the locations we visited, 68 of the 510 fiscal year 1983 referrals would not have been necessary had additional medical equipment been available. For example, health officials in the Marshall Islands said the purchase of two pieces of equipment costing approximately \$11,000 would have resulted in at least six referrals being treated on-island, at an estimated saving of \$106,710. A Palau health official said the purchase of equipment basic to most U.S. hospitals, such as a blood-testing machine and a bronchoscope, would have saved eight referrals. Equipment necessary to reduce referrals at the other locations we visited included x-ray machines, hematology analyzers, and chemistry analyzers.

According to various Micronesian health officials, their governments do not release or allocate adequate funds for equipment purchases. In the Marshall Islands, for example, the fiscal year 1983 health services budget provided \$310,000 for equipment and supplies, but a physician at the Majuro hospital said only \$10,000 was actually released for new equipment and supplies.

Preventive maintenance of medical equipment is not generally practiced, as none of the hospitals we visited budgeted for such maintenance. We were told that qualified repair technicians are generally not available. A 1983 House Committee on Interior and Insular Affairs assessment of health services in the Trust Territory of the Pacific Islands found medical equipment in universally poor condition. A 1983 audit of the Ponape hospital by a private consulting firm noted that there was no concerted effort to bring inoperative equipment back into service and that broken equipment remained out of service for excessive lengths of time. Health officials at other hospitals we visited also pointed out several examples of equipment in various states of disrepair, some of which had been out of order for over a year. They all agreed that basic maintenance of existing equipment could reduce the need for off-island referrals.

### Medical supply problems

The lack of adequate medical supplies is critical at hospitals in the Pacific Basin. Even with sufficiently trained physicians and proper equipment, the effectiveness of the healthcare system will continually be hampered without adequate medical supplies. According to the Trust Territory of the Pacific Islands' Territorial Comprehensive Health Plan 1980-1985, continuity and quality of patient care is undermined daily by medical supply systems that do not work. The plan states that supply shortages are the rule rather than the exception.

Supply problems have necessitated referring patients to Guam and Hawaii. In 1982, the Chief of Medical Staff at the Majuro hospital estimated that half of the medicines needed for treating patients locally were out of stock. He said that 5 of 92 referrals in fiscal year 1983 were the direct result of this problem. In Ponape, 7 dialysis patients were referred to Guam because the airline could not deliver the necessary supplies in time. Saipan referred 2 patients in fiscal year 1983 because the necessary medicines were not in stock.

Supply problems result from such things as ineffective inventory procedures, budgetary constraints, and transportation difficulties. Often supplies are not ordered on a timely basis; the authorization process for supply purchases requires several departmental approvals, a bureaucratically cumbersome procedure which can take months. In addition, some drug companies have refused to service purchase orders from Ponape and Palau because of slow or nonpayment. Health officials also noted that the only available airline servicing many of the Micronesian islands has been slow in delivering medical supplies because of limited flights and cargo space.

### Diagnostic capabilities

Improving physician training, purchasing additional equipment, maintaining existing equipment, and developing a reliable

medical supply system all contribute to increased diagnostic capabilities. Improving diagnostic capabilities could reduce medical referral costs by identifying illnesses that could be treated locally. A 1981 University of Hawaii study disclosed that approximately 60 percent of all patients referred by a hospital in Saipan between 1977 and 1979 had no definitive diagnoses. According to referral center officials in Hawaii and Guam, many patients referred lack specific treatment authorization due to limited diagnostic information. Lack of a specific treatment authorization contributes to additional off-island costs, since the referral centers must perform these tasks. In effect, the local government loses an effective means of cost control due to limited diagnostic capabilities.

#### Fear of malpractice

Throughout the Pacific Basin, hospital staffs said that the growing fear of malpractice litigation and the unavailability of malpractice insurance are increasing the number of unnecessary referrals. They said that several successful malpractice cases have been based upon allegations that the local medical facilities were inadequate and the patients should have received more sophisticated off-island treatment.

According to the NMI Director of Public Health, approximately 40 percent or 90 out of the 225 referrals for fiscal year 1983 were influenced by physicians' concerns over malpractice litigation. At the other locations we visited, health officials were unable to identify how many patients were referred as a result of malpractice concerns but generally agreed that it is a factor in recommending referrals. The FSM Chief of Health Services expects an increasing number of malpractice threats as patients become more aware of limited local capabilities.

An FSM government health official said that the problem with malpractice influencing referral decisions is that no insurance company wants to insure medical officers because of the poor medical facilities in the Pacific Basin. A Saipan hospital official said this fact, combined with an increasing number of Micronesian lawyers who are anxious to litigate malpractice suits, provokes referrals that could possibly be treated locally. According to the Ponape health administrator, these suits especially influence referral decisions of American doctors who are not accustomed to the limited local medical capabilities and who would rather refer a patient if any doubt exists concerning the diagnosis or ability to treat the patient locally.

If local medical capabilities improve, the problem of malpractice may be partially alleviated.

#### MICRONESIA FACES PHYSICIAN SHORTAGES

Physicians currently working in Micronesia consist of locally hired expatriate medical doctors, doctors of the U.S.

Public Health Service's National Health Service Corps (NHSC) and local medical officers who were trained in Fiji and Guam immediately after World War II. According to a 1979 Trust Territory Health Manpower Plan and the 1983 House Committee on Interior and Insular Affairs report on health care in the Trust Territory, a shortage of health manpower exists at nearly every level of Micronesia's health care system. This shortage will become increasingly critical as the NHSC program phases out and as local medical officers reach retirement age. Unless adequate steps are taken to deal with this shortage, local medical capability will likely decline, contributing to a rise in costly referrals.

Shortage expected  
to worsen

NHSC physicians are practicing in Majuro, Ponape, Truk, Kosrae, and Saipan, where they constitute 10 percent, 33 percent, 40 percent, 33 percent, and 25 percent of the physician staffs, respectively. The Public Health Service considers these locations as physician shortage areas, making them eligible for placement of NHSC physicians. Placement in these remote areas for 2 years allows the physicians to partially repay scholarships and loans provided by the federal government. In 1983 Congress terminated funding for the NHSC scholarship program. Thus, NHSC physicians will not be available in 3 to 4 years.

Unless replacements are found, the loss of the NHSC physicians will result in reduced health care capabilities. In many instances, the NHSC doctors provide a level of expertise that local medical officers do not possess. For example, many NHSC physicians are trained in obstetrics/gynecology. According to the Trust Territory Comprehensive Health Plan 1980-1985, 25 percent of all hospitalizations are for obstetrics/gynecology, yet few Micronesian physicians are trained in this area. According to some Micronesian health officials, the reduced capability will result in an increased reliance on medical referrals to provide the medical care the public has come to expect.

A second problem facing the Pacific Basin governments is the impending retirement of medical officers, who are considered the backbone of the health delivery systems in the Pacific Basin. Many are now over 50 years old and are expected to retire within the next 10 years. Since medical officers currently comprise over half of the 63 physicians currently practicing at the locations we visited, the prospects for a severe shortage are high.

There is little indication that sufficient Micronesian physicians will be available in the near future to alleviate the shortage. Few Pacific Basin students are entering the health field, because the educational systems in the region do not adequately prepare them for the rigors of U.S. medical schools. Those that do successfully complete a medical program, however, usually opt for stateside careers. In addition, the Guam and

Fiji medical officer programs no longer exist. Health care officials express concern over the impending loss of their medical officers, yet no effective program currently exists to provide future medical officers.

#### Problems with proposed medical officer training program

The University of Hawaii has proposed the development of a medical officers training program in Ponape to compensate for the increasing shortage of physicians in Micronesia. However, funding, facilities, and equipment pose serious obstacles to the start-up of this program. The proposal envisions a 10-year program graduating approximately 90 medical officers. Students for the program will be drawn from the Federated States of Micronesia, Palau, and the Marshall Islands. Graduates would receive a medical officer's degree, permitting them to practice only in the region.

There are currently no funds to make the Ponape State Hospital a training facility for medical officers. The Ponape government supports the concept of the program, but only on the condition that outside funding is available. Neither Ponape, the FSM, nor the other Micronesian governments are willing to provide money for the program. In addition, Ponape health officials believe that the facilities at the current hospital are insufficient to support the proposed training program. Training space for students, for example, does not exist, and residential space for students is in short supply. In addition, a local health official stated that the hospital's patient load is too small to support a training facility and that many of the problems with staffing, equipment, and supplies previously discussed must be dealt with before the program can be effective.

We discussed these problems with a University of Hawaii official who believes the proposal is the best alternative for coping with the increasing physician shortage. The official told us that unless these issues are resolved, Micronesia may have to rely on recruiting expatriate physicians to meet its needs or on more off-island referrals.

#### Difficulties in hiring U.S. physicians

The Pacific Basin governments have difficulties in hiring and retaining U.S. physicians because of the low salaries and poor working and living conditions. In 1982, for example, it took the Marshall Islands government 8 months to recruit a permanent U.S. physician. The American Samoan government has attempted to hire U.S. doctors on long term (2-year) contracts in order to assure some measure of continuity and stability in hospital staffing. This goal has been difficult to achieve, and by necessity, the vacant positions have been filled with short-term (1 to 6 months) volunteers.

## Recruiting foreign physicians may alleviate the problem

Recruiting non-western physicians from developing countries like the Philippines could help reduce the physician shortage while providing a measure of stability and continuity that U.S. expatriate physicians are not providing. Physicians from developing countries appear eager to work in the region. In 1982, for example, Marshall Islands health officials made a trip to the Philippines and recruited five physicians. According to local health officials, salaries are lower for physicians from the Philippines and other developing countries and the turnover rate is not as high as with U.S. physicians.

## SPECIFIC MEDICAL CAPABILITIES MUST BE IDENTIFIED AND DEVELOPED

In response to the Senate Appropriations Committee's health strategy for the Pacific Basin governments, the Public Health Service assembled a Pacific Basin Initiatives task force in April 1983. The task force will assess health care needs and existing capabilities in order to devise a strategy with legislative recommendations to improve the health of the Pacific Basin population within the limited resources available to each government. The Public Health Service contracted with the University of Hawaii to collect and analyze data and submit results in September 1984. According to Public Health Service and University of Hawaii officials, identifying medical capabilities needed to reduce medical referrals will be part of this assessment.

## CONCLUSIONS

Since it may not be economically feasible to provide expensive specialized care locally, at least in the foreseeable future, medical referrals are expected to continue. Nevertheless, the local governments can reduce referral expenditures for nonspecialized medical care by providing more training for local physicians, purchasing relatively inexpensive equipment, maintaining existing equipment, and providing adequate medical supplies. Regular visits by traveling teams of specialists may also help keep these referrals down. By initiating these actions, the local governments can enhance local medical capabilities and reduce referral costs.

## AGENCY COMMENTS

Interior, HHS, and the governments of American Samoa and NMI generally concurred with our conclusions. Interior indicated it has instituted some short-term remedies for some of the problems, including funding liaison doctors in Honolulu for the FSM and Marshall Islands and supporting a nonprofit organization which is providing medical training.

HHS commented that improving the physical plants of indigenous hospitals and their equipment and supply systems and increasing the availability of trained health professionals will reduce the need for referrals and the attendant high costs.

## CHAPTER 5

### IMPROVED MANAGEMENT OF MEDICAL

#### REFERRAL PROGRAMS COULD REDUCE COSTS

Medical referral programs in the Pacific Basin jurisdictions have been loosely managed and lack the necessary controls to determine whether patients could have been treated locally rather than off-island. Our review of local management practices indicates that local governments can reduce referral costs by strengthening (1) the role and authority of medical referral committees in approving off-island referrals and (2) the monitoring of patients' stays at referral hospitals.

Some of the local governments have taken actions to improve controls over medical referrals and thereby lessen costs. We believe more can be done.

#### IMPROVEMENTS NEEDED IN APPROVAL PROCESS

Each of the Pacific governments has established medical referral committees to assess, screen, and recommend cases for off-island medical attention. The committees have not been fully successful in regulating the approval process for referring patients. Apparent abuses of the approval process, although small in number, do occur, primarily because of local political pressure. These problems will likely continue unless referral committees are empowered to establish and implement a referral process providing for the efficient and cost-effective treatment of patients, free from nonmedical influences.

#### Committee authority needs strengthening

The medical referral committee usually consists of hospital physicians, the hospital administrator, and often the director of health services. It is designed to provide an open forum for discussing whether a patient can be adequately treated on-island or whether the patient's medical needs exceed local medical capabilities. The committee, however, does not have final authority in making off-island medical referrals.

Our analysis of medical referral files shows that some patients are being referred without committee review. According to local health officials, medical referrals sometimes are made by the patient's attending physician without presenting the merits of the case to the committee. Thus, the decision to refer a patient is sometimes based on the decision of one individual without consultation with other physicians who may have the ability to treat the patient on-island.

It is difficult to keep political and public pressures out of the medical referral process. The medical referral committee



members, medical staff, and other government officials recognize that family, kinship, and political relationships in the Pacific island cultures are extremely interwoven, thereby leading to public pressure on government officials to influence referral decisions. Local health officials stated that in some cases individuals are referred off-island against the recommendation of the referral committee and even though the local facility has the capability to treat them.

The number of socially and politically influenced referrals are currently small, amounting to two to five of the annual referrals in each of the locations we visited. Nevertheless, these referrals represent about 3 percent or approximately \$149,000 of the governments' fiscal year 1983 referral costs. Each of the local governments should strengthen the role and authority of the medical referral committees to guard against unnecessary and costly referrals. The governments cannot afford abuses to the approval process. Except under unusual circumstances, only the committee should decide who requires off-island treatment.

#### REDUCING COSTS AFTER PATIENT REFERRAL IS APPROVED SHOULD BE EMPHASIZED

When patients are selected for off-island treatment, the governments should choose the most cost-effective referral hospital, screen escorts for those patients needing assistance, and monitor patient progress. These administrative procedures, which are designed to hold down medical referral costs, are not always carried out.

#### Most cost-effective referral hospital should be selected

The Trust Territory Government, and later the governments of Micronesia and the Pacific Territories, have historically made arrangements with hospitals and medical centers for quality care at the nearest location. However, the local governments do not give enough attention to selecting the most cost-effective referral center.

Because of the high cost of private hospitals, most referral patients have been sent to U.S. military facilities, which establish charges based on a daily rate regardless of the type of services performed. Private medical providers in Guam and Hawaii said that the U.S. military hospital flat daily rate is reasonable, given the costs for similar services in their facilities. An FSM official said that private providers believe that military hospital charges are below their estimated costs when the case is severe and requires complicated and expensive procedures, such as in open heart surgery. Yet, in some cases, more expensive private hospitals have been used. For example, in fiscal year 1982, a Marshall Island woman with a heart problem was admitted to a private hospital in Hawaii and eventually incurred medical costs of over \$320,000. She was hospitalized for 98 days, which if

charged at the fiscal year 1982 military hospital rate of \$348 a day, would have cost about \$34,000. According to a Marshallese health official, the difference between these amounts could have been saved had the patient been referred to the Letterman Army Medical Center in San Francisco which specializes in heart illnesses.

#### Cost effectiveness of family escorts needs to be assessed

The medical referral policies of the Micronesian and NMI governments allow family escorts to accompany all patients under 18 years of age and adults who cannot adequately care for themselves. American Samoa has no written policy on escorts, although it has informally adopted criteria similar to the other governments. The family escort's duties are to complete and sign necessary patient forms, act as interpreter, run errands with regard to patient's needs, and provide moral support.

Our analysis of family escorts since fiscal year 1981 indicates a rising trend in proportion to the total number of referral patients. In fiscal year 1981, family escorts totaled 26 percent of the total number of referrals; this increased to 41 percent in fiscal year 1983. Family and medical escorts cost the Pacific Basin governments \$775,000 during this period.

During the past few years, the Pacific Basin governments have permanently stationed patient care coordinators at their liaison offices in Guam and Hawaii to provide services similar to those used to justify family escorts. Despite the use of patient care coordinators, the number of escorts has not lessened.

Liaison officials in Guam and Hawaii cite a lack of sufficient patient care coordinators as one cause of this problem. Each liaison office has only one or two patient care coordinators to attend to the various needs of referral patients. We observed that patient care coordinators in Guam and Hawaii are on call seven days a week, often working very long days for an extended time. Officials told us that at times of peak referral activity of 30 or more patients, one or two patient care coordinators cannot adequately provide all the required services.

We believe the local governments should assess the cost effectiveness of the patient care coordinators versus the cost of family escorts. If the coordinators are providing cost-effective service, the governments should consider hiring more of them and reducing the number of family and medical escorts.

#### REDUCING EXCESSIVE PATIENT STAY AT REFERRAL HOSPITALS COULD LOWER COSTS

Prolonged hospital stays increase medical referral program costs. Micronesian and Pacific Territory health officials agree

that closer monitoring of patient progress, with subsequent requests for expeditious services and discharge, would help to reduce patient stays and lower costs. An increase in patient monitoring would have an additional effect of verifying that only government-authorized treatments are being performed. Also, when the diagnosis is unclear, or perhaps unknown, a medical monitor would be beneficial in keeping the home government apprised of the potential liability for patient hospital charges.

Home island governments  
should increase monitoring  
of patient progress

Acting upon the recommendations of a private health care management consultant, American Samoa hired a Hawaii-based physician in early 1982, on a part-time basis, to improve control of their referral program by

- communicating with the referral physician and referral committee before and after patient departure and return home to maximize continuity of care;
- monitoring the referral patient's progress;
- facilitating early patient care and discharge; and
- becoming familiar with the American Samoa health care system, its capabilities and staff, and communicating these capabilities to attending physicians and staff.

Our analysis of American Samoa's off-island referral program found that the physician monitor helped to reduce patient hospital stay by an average of 12 percent. For fiscal year 1983, the net program savings for American Samoa is estimated to be \$85,000. The health consultant reviewed the fiscal year 1982 Marshall Islands referral program and concluded that substantial savings could have been realized if a program similar to American Samoa's had been operational.

The Marshall Islands, Ponape State, and the NMI have on occasion used a referral committee physician to travel to the referral centers to provide the monitoring and consulting oversight similar to American Samoa's on-island physician representative. Although travel costs have constrained periodic visits by local physicians, these experiments have proved successful in reducing patient hospital stays. For example, a Marshall Islands physician visiting referral patients at Tripler Army Medical Center during March 1983 concluded that more than half of the 29 patients were well enough to be discharged or treated locally. As a result, they were sent home.

## Improved communications could reduce program costs

Effective continuous communication between the Pacific Basin governments and the medical referral centers is needed to minimize patient hospitalization. Medical providers in Guam and Hawaii agree that their lack of knowledge concerning on-island medical capabilities, including staff, supplies, and equipment, leads to additional treatments and longer patient hospital stays. Periods of post-operative observation have been unduly extended because of the attending physician's concern that little or no medical follow-up care will be afforded to the returning referral patient. Since early 1983, physicians at Tripler have made an effort to learn more about the on-island medical capabilities. Tripler is now using this information in planning medical services and subsequent discharges. However, Tripler's high staff turnover inhibits a continual working knowledge of the Pacific Basin's medical capabilities, which results in treatments which could have been performed at the home island.

Pacific Basin medical referral programs have no systematized methods for identifying referral patients who require follow-up treatment once they return home. We learned, for example, that some patients requiring follow-up treatment believe they have no further need for physician care since they feel better. The lack of a system for identifying patients who may require further follow-up treatments has led to recurrence of illness and future referral requirements. Referral committee members we spoke with attribute a lack of communicating with the referral hospitals before, during, and after referral as the primary cause for this information gap.

Because of heavy patient workloads, the attending physicians at referral hospitals often do not provide timely information about a patient's treatments upon hospital discharge. This inhibits the continuity of health care as the patient returns home. A Tripler official disclosed that it was not uncommon for patient discharge summaries to be completed about 3 months after a patient's discharge. The information in a discharge summary normally includes the course of treatment, discharge diagnosis, status on discharge, medication, and plan for follow-up care. Improved communications and the timely completion of discharge summaries are important to reducing medical referral costs.

## CONCLUSIONS

The medical referral programs administered by the Pacific Basin jurisdictions lack the proper controls to ensure a cost-effective system. Improving the approval process to ensure that referrals have medical needs which cannot be treated locally is necessary to controlling program costs. Once the referral is approved, more emphasis needs to be given to selecting the most cost-effective referral center, assessing the need for family escorts, and monitoring patient progress.



# United States Department of the Interior

OFFICE OF THE SECRETARY  
WASHINGTON, D C 20240

MAY 7 1984

Mr. J. Dexter Peach  
Director  
National Security and International  
Affairs Division  
General Accounting Office  
441 G Street, NW.  
Washington, D.C. 20548

Dear Mr. Peach:

I would like to take this opportunity to provide comments on the GAO draft report entitled, "Reducing the Cost of Medical Referral Programs in the U.S. Pacific Territories and Micronesia," on behalf of Secretary Clark.

We agree generally with the conclusions in the report; that is, that the Pacific governments are responsible for the medical referral debts incurred. (Some outstanding bills from fiscal year 1979 through fiscal year 1981 may be the responsibility of the Trust Territory headquarters, and the DOI Inspector General is scheduled to perform an audit of these bills.)

The report recommended that the Federal government help the Pacific governments develop means to reduce medical referral costs in the future. I would like to point out some of our efforts in this area to date.

Through this office's Technical Assistance program, we have agreed to fund liaison doctors in Honolulu for the governments of the FSM and the Marshalls. As the study of medical referral costs (prepared by Siegal and Associates and funded by TIA) showed, these actions should reduce costs significantly as was the case for the American Samoa government.

TIA continues to work with a non-profit organization called the Sisters of Mercy, who provides valuable on-site training and support staff to the Trust Territory. The work they perform has been useful both to us and to the governments. We also are exploring expanding the use of Public Health Service personnel in these areas as well as attempting to utilize the free services of medical doctors who wish to donate their services for a definite period each year.

These efforts are short-term remedies to some of the problems outlined in the GAO report. One long-term solution could be the establishment of a medical officer training school in Ponape. This was briefly discussed in the GAO report and its feasibility is being explored by my office.

Sincerely,

A handwritten signature in black ink that reads "Rick Montoya".

Richard T. Montoya  
Assistant Secretary  
Territorial and International Affairs

GAO note: Page number references may not correspond to the page numbers in the final report.



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Office of Inspector General

7 MAY 1964

Mr. Richard L. Fogel  
Director, Human Resources  
Division  
United States General  
Accounting Office  
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report "Reducing the Cost of Medical Referral Programs in the U.S. Pacific Territories and Micronesia." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

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

Sincerely yours,

Richard P. Kusserow  
Inspector General

Enclosure

Department of Health and Human Services Comments on  
U.S. General Accounting Office Draft Report Entitled  
"Reducing the Cost of Medical Referral Programs in  
the U.S. Pacific Territories and Micronesia"

In general, the Department agrees with the major findings in this report. It is clear that the large outstanding debt to the U.S. Government and private hospitals due to the high cost of medical referrals is a problem with significant potential impact on health care in the Pacific territories. The report is comprehensive and addresses both the major issues which create the medical referral funding and management problems and the areas which must be pursued to reduce medical referral costs.

The Department believes that improvements in the physical plants of indigenous hospitals, equipment and supply systems, and the availability of adequate numbers and types of trained health professionals will reduce the need for referrals and its attendant high costs. With adequate ambulatory primary care and general inpatient hospital services, only those patients requiring specialized services, deemed necessary through a reliable professional review process, would require referral.

Finally, there are several substantive issues and technical areas which, we believe, should be addressed in the GAO final report.

Federal policy and administrative responses

The report should identify alternative Federal policy and administrative responses to the problems. A discussion of options to be considered by DOI, DOD, and HHS should be included, as well as those recommendations for changes in territorial policies and procedures that have been identified by GAO staff.

Compact of Free Association

The report should make clear that, as regards the soon to be free associated states, direct DOI concern with the problem will end with the signing of the Compacts. However, it is not clear that all issues regarding those entities will be resolved prior to the signing of the Compact. For example, the report should indicate whether Tripler will accept referrals from the free associated states after termination of the trusteeship, and if so, whether as a practical matter, the hospital can limit treatment to citizens of entities that are current in their reimbursements. In addition, although signing of the Compact may eliminate a problem of future debts, it is likely that funds will still be owed to DOI or DOD at that time. If the Compact makes no provision for such debts, there is an issue of how they will be handled.

Analysis of debt

An analysis of the age and nature of the debts may indicate corrective action that is not apparent from a presentation that lumps all debts together. For example, certain types of bills may be paid, while others are not. If GAO has such information, it may be useful to include it. In addition, it would

## Page 2 - DHHS Comments on GAO's Draft Report

be helpful to have a table showing the amounts paid to each provider and what percentage the unpaid amounts are of the total billing to that provider. Furthermore, the tables on pages 10, 11, and 59 indicate that while excessive debt is a problem for all the Pacific Basin governments, the reasons for the debt may differ. For example, CNMI seems to budget appropriate amounts but continues to have a large debt. On the other hand, Palau's debt is about equal to its expenditures over its budgeted amounts for referrals. There is no analysis in the report which explains these differences, and the recommendations do not take them into account.

Guam

It may be useful to explain briefly why there is no analogous problem on Guam.

Adequacy of Federal funding

DOI asserts that the Federal budgets for medical care are adequate. Given the report's recognition of the substantial rates of inflation in medical care costs as well as transportation, an analysis should be provided showing the history of Federal funding of medical care by DOI and the impact of increasing costs on the purchasing power of these funds.

Patient contribution

In several instances the report indicates support for actions by the Trust Territory to institute or adjust fee schedules to repay a greater proportion of the costs of medical referrals. GAO should review, and where necessary revise, those sections of the report to make clear that the report limits itself to describing the budgetary consequences of the policy of free health care for the territories and U.S. Government.

The report also should contain a discussion of per capita income in the territories as well as any information which may be available on the income of the individuals utilizing the medical referral program. Without a discussion of the economic constraints that can limit the amount of potential contribution which realistically can be expected from Pacific Basin residents, it is impossible to assess the appropriateness of proposals to increase user fees.

Interior reimbursement policy

It would be helpful to know whether Interior is in fact reimbursing the Department of the Army in accordance with the Army Surgeon General's request of October 1983.

Agreements with DOD facilities

The report discusses in detail the agreement between DOI and DOD for care provided at Tripler Hospital. The report also mentions services provided by DOD at the Kwajalein Missile Range Hospital on pages 35 and 36 and the Navy Regional Health Center is cited as a referral site in Appendix I.



## Page 3 - DHHS Comments on GAO Draft Report

It would be helpful to describe the agreements in effect for the referral of patients to these sites, along with information on problems, if any, regarding reimbursement for services rendered.

Specialized and nonspecialized medical referrals

The report does not describe in sufficient detail the medical basis for cases referred and assumes a definition of "specialized services" as one to require resources only available in referral sites. An expanded medical explanation would be useful to substantiate the need for referral for specialized care. Page 36 and 37 of the report provide data on the numbers of nonspecialized referrals which would have been treated locally if sufficient medical capability was available. These data were provided by the referral committees themselves and may present a biased view of the appropriateness of the referral. These data should be validated, either through an independent medical evaluation or by conferring with the referral sites, on at least a sample basis, to assure that the conclusions reached are appropriate.

National Health Service Corps

At the time of the GAO study, National Health Service Corps physicians were assigned to the States of Kosrae and Truk within the Federated States of Micronesia. The information on page 44 should be changed to reflect these assignments. Corps assignments accounted for 33% of the physician staff in Kosrae and 40% in Truk.

Cost-effective referral sites

The discussion on page 53 emphasizes savings possible by selecting U.S. military versus private referral sites. This section does not discuss the potential for savings, particularly in transportation costs for patients and escorts, through referrals to the closest geographical source of care. To the extent needed services are available, patients from Saipan, Palau, Yap, Truk, and Ponape can be treated in Guam more economically than Hawaii. It would seem appropriate to further explore the possibility of expanding Guam's role as a Pacific referral site both with the Naval Regional Medical Center under an arrangement similar to that between DOI and Tripler hospital and with the Guam Memorial Hospital possibly under an arrangement providing preferential rates. Similarly, referrals to mainland sites should be made only for services not available in Hawaii.

Page 4 - DHHS Comments on GAO's Draft Report

Pacific Basin Health Initiative

The discussion of the HHS Pacific Basin Health Initiative on pages 48 and 49 should be expanded to clarify that the University of Hawaii's role is limited to the data collection and analysis portions of the project. Based upon the data provided by the University, the Public Health Service will evaluate the effectiveness of health systems in the Pacific, including the current Federal health programs and prepare a report to be submitted by the Department to the Congress as required by P.L. 97- 276. The recommendations of the GAO report will be incorporated to the extent possible into the work currently underway on the Pacific Health Initiative.



# Commonwealth of the Northern Mariana Islands

## Office of the Governor

Saipan Mariana Islands 96950

Cable Address:  
Gov NMJ Saipan

MAY 11 1984

Mr. Samuel W. Bowlin  
Associate Director  
United States General  
Accounting Office  
Washington, D.C. 20548

Dear Mr. Bowlin:

Thank you for your letter of April 2, 1984, and the enclosed draft copies of your report on Reducing the Cost of Medical Referral Programs in the U.S. Pacific Territories and Micronesia.

The report is, indeed, very comprehensive as it encompasses a number of issues which address the concerns of the Department of Interior, Department of Defense and, most certainly, the Government of the Commonwealth of the Northern Mariana Islands, especially those areas which relate to a) financing the medical referral program; b) the level of care provided locally and its impact on medical referrals and; c) the management and policies of the medical referral program. Additionally, the report also provides a number of realistic recommendations by which the Territorial Governments may, at their discretion and initiative, deal with on their own terms; in particular, those recommendations dealing with budgeting and cost effective measures for reducing medical referral costs.

While we generally agree with the draft report, we would like to make a few comments on certain sections of the report.

1. We believe the report should include, somewhere in the general language, that those territories which are unable to settle their accounts may jeopardize continuation of medical referral privileges and services for other entities. We are very serious and conscientious about clearing our accounts with all health providers.
2. Nowhere in the report was it mentioned that the CNMI Government obligates funds for all patients and all referral costs, irrespective of where the service is to be delivered. If the bills arrive and we find that insufficient funds were obligated on the original authorization, we amend the Travel Authorization to include additional funds to cover all expenses.
3. The Commonwealth Government provides referral assistance to Trust Territory Government personnel who work on Saipan. The medical bills generated by these patients are not the responsibility of the CNMI, and we cannot pay them. Oftentimes, the CNMI Government is billed for TTPI beneficiaries. A system of identification should be established whereby the responsible government entity is billed and not necessarily the referring institution.

Page Two  
Mr. Bowlin

4. On page 13, the CNMI should not be implicated as being a part of the comments made by Micronesian officials, "...According to Micronesian officials, unrealistic medical referral budgets, and resulting unpaid bills, are caused by inadequate funding to meet their needs. Local officials believe the United States is responsible for health care as provided under the Trusteeship Agreement. As a result, Micronesian officials believe if they cannot afford to pay their debts, the United States should."

The CNMI Government agrees with the American Samoan officials inasmuch as referral debts are largely a local fiscal management problem and no one is to be blamed or be used as a scapegoat for the problem.

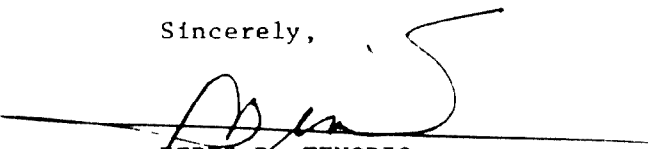
5. On page 21, where the report indicates "...patients pay 10% of referral costs based on ability to pay", it should be pointed out that this was a proposed amendment which has not as yet been implemented.
6. The report should include, with respect to Micronesian and CNMI Medical Officers, that there was reluctance on the part of U.S. hospitals to provide actual experience and training because U.S. hospitals are concerned about medical malpractice, since Medical Officers do not possess medical degrees and cannot be licensed to practice in the U.S. The only "training" available to the MOs is by observation, not by actual practice.
7. Not only for the reasons mentioned in the report, but the CNMI Government is reluctant to send patients to foreign country hospitals because our health officials are concerned about quality control of care, since other countries may not have utilization review mechanisms and, also, the drugs they may be using might not be compatible with those which we have.
8. With respect to the Tables provided in Appendix A, the figures need to be re-evaluated by the auditors for the following reasons:
  - a. The CNMI had cleared all bills with Tripler Army Medical Center up to September 30, 1983.
  - b. The CNMI Government has never utilized Letterman Army Medical Center; therefore, the CNMI should have no outstanding bills with that facility.
  - c. Referral billings for Naval Regional Medical Center/Guam are not correct. Our actual outstanding bills are considerably less than the amount stated.
  - d. Outstanding bills for Guam Memorial Hospital are triple the amount actually owed.
  - e. Outstanding billings for Air Carriers should not be as high as indicated. We use travel agents who work very closely with our Department of Finance to assure prompt payment.

Page Three  
Mr. Bowlin

We would like to thank you and the General Accounting Office for providing this audit. The information generated by this audit will be invaluable in our effort to resolve medical referral cost containment. Your recommendations will certainly be very useful in our efforts to reduce costs.

We want to thank you also, for your continued assistance and support to the people of the Northern Marianas and other Pacific Basin entities.

Sincerely,



PEDRO P. TENORIO  
Governor

cc: CNMI Representative to the United States



PIILERIALI COLEMAN  
Governor

AMERICAN SAMOA GOVERNMENT  
OFFICE OF THE GOVERNOR  
PAGO PAGO AMERICAN SAMOA 96799

TUFELE LI'A  
Lt Governor

May 17, 1984

Serial: 588

Mr. Samuel W. Bowlin  
Associate Director  
National Security and International Affairs  
Division  
U.S. General Accounting Office  
441 G Street, N.W.  
Washington, D. C. 20548

Dear Mr. Bowlin:

This is in reply to your letter of April 2, 1984 in which you enclosed 5 copies of your draft report on reducing the cost of medical, referral programs in the Pacific basin.

We have reviewed your draft with interest and therefore submit the following comments in response:

1. In general the report gives an accurate description of the issues and problem areas related to the Pacific area jurisdictions.
2. There are statements and conclusions, however, particularly relating to non-payment of off-island medical care bills, which label American Samoa together with the other jurisdictions. This gives the reader the impression that American Samoa has an equally bad record of non-payment as certain other jurisdictions. The fact of the matter is, American Samoa's record of payment has been excellent over the years (with the brief exception of a delay of 3-4 months during our recent financial crisis). The table on page 59, showing outstanding medical referral bills of \$363,846 as of September 30, 1983 reflects this isolated instance because of the particular timing of the GAO study. This is an unfavorable and incorrect reading of American Samoa's long term record of payments. As a matter of fact this particular amount listed as outstanding for American Samoa Government (ASG) at Tripler Hospital has been paid as of February 1984. Mr. Sherman Dang, of Tripler's business office would be the first to confirm our excellent record of payments. Therefore, such statements as found on pages iii (line 16), page 11 (last paragraph); page 12 (first sentence, last paragraph); and, page 14 (last paragraph - unwarranted) should be revised to indicate that the statements do not apply to all Pacific jurisdictions.



AMERICAN SAMOA GOVERNMENT  
 OFFICE OF THE GOVERNOR  
 PAGO PAGO, AMERICAN SAMOA 96799

- 2 -

The addition of the word "some", such as is used on page 9, line 6, in these statements would be an appropriate choice. Also, if the paragraph in the middle of page 13, starting with "American Samoan officials said ...", would be revised to read: American Samoan officials said their referral debts are recent and temporary occurrences, and largely a local fiscal management problem, which should be rectified shortly; a more accurate picture of American Samoa's payment practices would then be portrayed.

3. Page 11, paragraph 3 - "Pacific basin governments are not sufficiently budgeting their own funds and funds received from DOI to cover medical program costs."

It should be pointed out that it is impossible to control actual expenditures unless the decisionmakers are willing to put at risk the life or well-being of patients. The budget amounts are estimates based upon prior experience.

4. Page IV - "Pacific basin governments should be held accountable for medical referral debts."

The Government of American Samoa is accountable for its medical debts. We have paid all bills submitted to us.

5. Page V - "GAO believes the Pacific basin governments should consider increasing patient cost-sharing arrangements..."

This is a policy decision that should remain with local governments. Each has to arrive at its own position in relation to its particular local charges, fees and other taxes. It should also be pointed out that a large proportion of the population is not eligible for referral and must pay the full costs on their own. We disagree with your perception of the medical referral programs as being "loosely managed and lack the controls needed to prevent the unnecessary and costly referral of patients for off-island treatment." We feel, while our program may need improvements, its management and controls are being exercised judiciously.

6. Page 15 - "...medical referral debts in particular, must rest with each government."

We have never denied our responsibility for our obligations. In the past, we have attempted to generate federal support due to the heavy need for medical services.



AMERICAN SAMOA GOVERNMENT  
OFFICE OF THE GOVERNOR  
PAGO PAGO AMERICAN SAMOA 96799

- 3 -

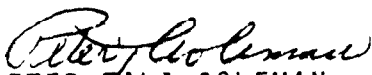
In addition to the above observations, we further offer the following suggestions in support of the initiatives to minimize the costs of off-island referrals.

1. We concur with your views on how to resolve medical personnel shortages as you address the problem in pages 46-49 of the draft report.
2. We suggest a system be worked out with Tripler, Letterman, University or Medical Group to organize regular visits to the territories to do consultation, training and perhaps treatment of those cases that can be attended to locally. An example of such a system are the bi-annual visits by the urology team from TAMC.

We appreciate the effort you have devoted to this review. We feel that the report adequately depicts the magnitude and urgency of the problem, regionwide, and also points out some critical issues related to our own referral program that need to be addressed.

We hope that our observations and suggestions will contribute favorably to the perpetual search for possible solutions to the runaway costs of the medical referral program.

Sincerely,

  
PETER TALI COLEMAN  
Governor of American Samoa

cc: Assistant Secretary for  
Territorial and International Affairs  
Director of Medical Services  
Director of Administrative Services  
Audit Report Coordinator





# Federated States of Micronesia

KOLONIA POUAPE EASTERN CAROLINE ISLANDS  
TELEPHONE 228-4611 FAX 228-4612

June 8, 1984

Mr. Samuel W. Bowlin  
Associate Director  
United States General Accounting  
Office  
National Security and International  
Affairs Division  
Washington, DC 20548

Dear Mr. Bowlin:

Thank you for sharing with us at the National Government of the Federated States of Micronesia copies of the recent assessment report on medical referral programs in the Pacific Basin.

As you instructed in your letter of April 2, 1984, I have handled the content of the report with discretion and care. In line with this, I am enclosing for your review, the comments and recommendations provided to my office by the FSM Division of Health Services. I wish to inform you that the statement by the Division of Health Services represents the official position of this government on the GAO report.

I will personally be monitoring any further development on this critical issue. Let me know if you need further information from me on this matter.

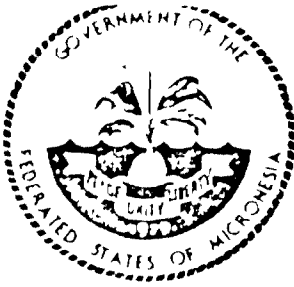
Thank you for your continued interest and assistance to the Federated States of Micronesia.

Sincerely,

Tosiwo Nakayama  
President

mrb  
Enclosure

xc: Assistant Secretary Montoya



GOVERNMENT  
OF THE  
FEDERATED STATES OF MICRONESIA

Office of the Chief Division of Health  
Department of Social Services

KOLONIA, PONAPE, EASTERN CAROLINE ISLANDS 96941  
Cable: FSM Pres Ponape TEL: 643

May 11, 1984

The Honorable Tosiwo Nakayama  
President  
Federated States of Micronesia  
KOLONIA, Ponape 96941

Dear Mr. President:

Thank you for the GAO draft copy of the Proposed Report on Medical Referral Program, which you so kindly shared with our Office of Health Services. I commend the manner in which the report is organized, documented and presented. I accept with humility and with a sense of profound gratitude for the attempts made, through the report, to point out complex issues and solutions on medical referral programs in various Pacific Nations, specifically, the portion on Federated States of Micronesia - Truk, Ponape, Yap and Kosrae. Indeed, the report will serve many purposes, and perhaps the most profound one for us, at this time, will be the way in which we use the report to improve our programs in health care, specifically medical referral services. Language in the report is direct, simple and informative. Please be assured that the report will be used extensively by our Office of Health for future developments and improvements.

Admittedly, the general outline presented in the report is self-explanatory. Our Division of Health Services has been contemplating ways of improvements in referral billings and payments, referral subsidy policies, referral review and screening, referral capability and improvements of local facilities for secondary and tertiary care. Both departments of health in FSM and in four respective state health services, have had to deal with these many issues with a very limited resource base. In fact, funds have not been adequate to accommodate all the needs of these hospitals, not to mention, the many referrals to outside facilities in Guam, Honolulu and the Mainland United States. Let me point out, by this statement, that if the Health Services have had more resources to work with, many of these problems would not have been cited, especially under unexpected emergencies.

It is obvious from the document that availability of funds is not the sole solution to this dilemma. I agree that what the island governments need most, besides money, is the need to establish an

The Honorable Tosiwo Nakayama

May 11, 1984

Page 2

organization structure with relevant policies and definite guidelines for adjustments and actions in the medical referral program.

Likewise, I view the issue of non-payments of outstanding obligations a most serious one. It is, in fact, an issue that needs immediate attention. I am alerting my counterparts in the states health offices to initiate actions to pay their debts as soon as possible. I further add that I disagree with Interior's position expressed in the report opposing any 'bail outs' to various governments to cover medical referral debts. To me, the Interior officials must continue to work with the FSM Government in finding avenues to obtain extra funds to cover medical referral debts. Indeed, medical referral is a complex one, and everyone must deal with it to find solutions to rectify the problem, and that the Interior Department must continue to be a willing partner in these efforts.

I agree that various medical referral committees in respective FSM states must be reorganized under a new administrative framework with responsible people in the committees who will have clear delineation of functions and power to best serve the purpose of the medical referral programs. I accept major listings and recommendations made in the report as possible guidelines that could be used to reorganize the medical referral committees in respective states in the Federated States of Micronesia.

Rising consumer demands for out-of territory referral can be the result of the belief that off-island care is better quality medical care and that expensive medical care means improved health. The situation is worsened by the lack of any specific plan to avoid the over-utilization of specialized services. This is, in a sense, the most complex and most difficult issue to address in the report. In light of this, however, the Division is designing possible ways to deal with the situation and just recently, I have had the opportunity to identify two potential candidates to take care of our hospital utilization and length of stay program in Hawaii. I am convinced that the assistance of a Doctor in this program, will reduce patient length of stay, hence medical referral costs.

I support prudent measures to be established to include patients and escorts in medical referral screening and decisions for referrals. The patients and the escorts, as I view it, must also share the costs of medical referrals. The Republic of Palau has done it, and it has proven successful. Ponape State, in FSM, has initiated the share cost program, but has not fully implemented it. I hope that this kind of shared responsibility will be formalized in FSM in the very near future.

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The idea of intensive training and improvement of local capabilities to handle secondary and tertiary care in FSM has been consistently and locally supported by our island leaders, and I assure you that Health Services will continue to seek ways to upgrade our health personnel through training and education toward that end. Positive indications have also been reported, in medical supply, equipment repairs and facility improvements. These major health support issues are not totally ignored by the respective governments in FSM states. Moreover, I fully support the idea of designating one of the health facilities in FSM to become a tertiary care facility for the islands in the Federated States of Micronesia. No conclusive statement has been provided to my office opposing our proposed plan to upgrade the Ponape State hospital into a tertiary care facility. I wish to inform you that I am actively pursuing this possibility.

I have voluntarily chosen and briefly responded to the issues above in order that I may present my own recommendations for consideration, both by your Office or the General Accounting Office.

Indeed, the measurement of costs and benefits of the medical referral program is hard to assess. The problem of too few trained, experienced personnel available to hire is perhaps even more a problem in the Federated States of Micronesia than it is in other governmental entities. There have been serious problems in determining proper utilization of medical services provided. The Federated States of Micronesia has had a free medical program for its people for many years.

Obviously, existing grants and operation funds in the Federated States of Micronesia are not sufficient to meet high costs of medical referral services. The economic implication of the medical referral system, in large part, does not seem to solve the ever growing problems of medical care in terms of resources available for care. The costs have been risen dramatically during the last several years, and medical referral services has become one of the fastest growing expenditure items in the Federated States of Micronesia. Likewise, in the United States, a widely talked about economic concern in the minds of many American citizens today is the rising cost of medical care. Health care costs in the United States rose from \$42 billion in 1966 to \$192 billion in 1978...consuming a growing share of America's total resources, rising from 5.8 percent of the GNP in 1966 to 9.1 percent in 1978...

Clearly, FSM is not the only Nation that has had to make adjustments to meet rising costs of medical care. In a world of finite resources, the benefits of health care must essentially be balanced against the costs and such discussion here will require sophisticated cost-benefit analysis. (The GAO report barely touched on any

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cost-benefit analysis of the FSM medical referral program).

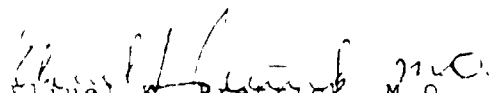
The cash incomes of most FSM residents are quite low. It is estimated that about 80-85% of the population in FSM will, on the basis of cash incomes, be eligible for government subsidy in medical care. It seems that some source of financing is necessary to bridge the gap between the present, in which health services are about 100% governmentally funded, and the future, when local self sufficiency is desired. (In the absence of viable plan to cover medical referral costs, the U.S. Government should continue to provide assistance).

An idea of a prepaid health insurance demonstration program is in the making in FSM to establish a unified health care system and a budget which can be expressed as a monthly per-capita amount. Through this plan, there would be options for people who, on the basis of income, would be required to contribute to pay their health care costs. (The GAO Report did not mention anything about Guam with respect to medical referral costs).

The priorities for improvement of basic health services identified by local health officials center on several major organizational improvements which include health care financing as one of the major priorities to be addressed immediately. (The GAO Report did not point to any recommendations toward U.S. Legislative changes for more funds). Under this concept, the FSM Health Services asserts that the U.S. Government must seek necessary changes in the U.S. Public Law 95-134, Title V, Offshore Territory Legislation, to give FSM the option to develop and place all available federal grants now available to the Territory for Health under one Block grant, i.e. Medicaid, Medicare, etc. This procedure will simplify the overall management of wide range of federal grants. This will also allow greater flexibility favoring local autonomy and control of an independent health budget and accounting procedure. Through this autonomy of program implementation, the Territory can take care of some of its debt.

That is all I have to say. Thank you for the opportunity you gave our Division of Health to offer comments.

Sincerely yours,

  
Etuel K. Prettick, M.O., M.P.H.  
Chief, Division of Health Services

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