BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Military Medicine Is In Trouble: Complete Reassessment Needed

Largely because of an insufficient number of physicians, the ability of the military's direct medical care system to deliver care in peacetime is seriously impaired. Some medical services have been substantially cut back at many hospitals.

GAO surveyed military beneficiaries. Many were unable to obtain medical care at military hospitals, and even more had to or preferred to obtain care outside the direct care system. Of those who went outside the direct care system, most said they obtained the care they believed was necessary and that it was better or much better than the care in the direct care system.

DOD agrees with GAO's basic findings and with the need for the Congress to reevaluate the role and structure of the military's direct medical care system in peacetime. GAO presents a number of alternative proposals for consideration; however, DOD believes some of them could diminish wartime contingency capability. GAO disagrees. Specific recommendations are also made to DOD for improving the direct care system's ability to serve beneficiaries.

HRD-79-107
AUGUST 16, 1979

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

B-133044

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

This report discusses the problems the military direct medical care system is experiencing in providing care to beneficiaries during peacetime. Some of the problems can be reduced if the Secretary of Defense acts on our recommendations to him. However, other problems require congressional action.

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretary of Defense.

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

MILITARY MEDICINE IS IN TROUBLE: COMPLETE REASSESSMENT NEEDED

D I G E S T

Since the draft ended in 1973, the military's direct medical care system has faced a gap between the number of military physicians it needs to provide medical care and the number it actually has.

This has seriously impaired the system's ability to efficiently and effectively meet peacetime medical care demands. The lack of physicians has hindered hospital operations and the ability of active-duty members, as well as others, to get medical care.

The Army, Navy, and Air Force medical departments project that the supply of physicians will not reach the fiscal year 1979 authorized level until 1984. Even this level will be below what the medical departments believe is needed.

The comments of military physicians and hospital administrative officials tended to confirm the military services' estimates--it will be a long time before the physician supply increases substantially. (See pp. 44 to 49.)

Overall data supplied by the Department of Defense (DOD) showed extensive closures and curtailments of medical services during fiscal year 1978. Of 123 military hospitals for which GAO obtained data, 72 (60 percent) either closed some medical services or curtailed them for up to 6 months. All beneficiaries--including active-duty personnel--were affected. Hospital officials attributed the closures and curtailments to physician shortages. (See pp. 24 to 29.)

In visiting seven military hospitals, GAO found that:

--Medical services were sometimes closed and sometimes reopened, depending on physician availability.

--Patients were not served by the military hospital and were told to go elsewhere.

--Patients were moved long distances for medical services that previously were available.

--Increased reliance was placed on nonmilitary physicians, physician extenders, and medical services procured under contract.

--Patients were waiting longer for medical care; they sometimes got no care.

--Physicians were required to spend more time working on emergency room duty and helping out in areas with severe physician shortages. (See p. 23.)

GAO believes that these are strong indicators of a physician shortage; however, it cannot say that the shortage alone impairs the system's ability to deliver medical care. Shortages of administrative and technical personnel shifted some support work to the physicians. Although this may not have been the most appropriate or best use of physician resources, it seemed to be dictated by necessity. (See p. 23.)

GAO's beneficiary survey results give a clearer picture of the difficulty the direct care system is experiencing in serving beneficiaries. A mailgram was sent to a random sample of active-duty and retired families living within 40 miles of military hospitals to determine if they were able or unable to get care in the military system, or had to go or preferred to go outside the system for care. GAO learned that:

--About two-thirds of the active-duty and retired members and their families had tried to get care at a military facility between January 1 and August 31, 1978. (See p. 10.)

--Of those who tried, the following percentages said they were unable to get care: (See pp. 11 and 12.)

	For themselves	For their families
Active-duty	21	35
Retirees	31	33

--Of those who tried, the following percentages said they either had to or preferred to obtain care outside the military's direct medical care system: (See pp. 11 and 12.)

	For themselves	For their families
Active-duty	24	52
Retirees	40	51

Particularly notable were the significant percentages of active-duty members themselves who said they either had to or preferred to obtain care outside the system.

Based on the mailgram results, GAO estimates that, of the 1,009,000 active-duty and retired members who tried to get care at military facilities between January 1 and August 31, 1978, about 104,000 active-duty members and 157,000 retirees were unable to get care, and about 124,000 active-duty members and 201,000 retirees had to or preferred to obtain care outside the system.

In addition, GAO estimates that, of the 1,012,000 active and retired family members who tried to get care during the same period (assuming only one family member required care for each positive mailgram response), about 344,000 were unable to get care and

520,000 either had to or preferred to obtain care from outside sources. (See pp. 12 and 13.)

To learn more about beneficiaries' experiences, GAO sent a followup questionnaire to active-duty and retired families who had stated that they had tried to get care at a military medical facility and either had to or preferred to obtain care from outside sources. Responses indicated that the primary reasons beneficiaries went elsewhere for care were that no doctors were available or there were long waiting lists for appointments at military facilities.

Once these beneficiaries had decided to go or were referred elsewhere, most (87 percent) got the care they believed necessary. The beneficiaries who went outside had a very favorable impression of the overall quality of care and attention they received--56 percent said it was better or much better than that received in military hospitals.

It is interesting to note that 66 percent of the active-duty members and families who went outside the direct medical care system said the care was better or much better. Also, 61 percent of all beneficiaries who went outside for care said they experienced only limited difficulties in paying for their care. Those who had difficulties tended to be lower ranking active-duty members or retirees with limited financial resources. (See p. 20.)

Military medical beneficiaries responding to GAO's questionnaire also expressed some concern about the Civilian Health and Medical Program of the Uniformed Services. The concern was not about the benefit package, but its administration, its payment practices, and the reluctant civilian physician participation. (See pp. 15 to 17.)

The comment of one of GAO's questionnaire respondents seems to reasonably portray the condition of much of the military's direct medical care system today:

"It seems by trying to be all things to all people, the system is not effective for anyone."

RECOMMENDATIONS

The Congress should reevaluate the role and structure of the military medical care system and direct DOD to establish a structure to improve its ability to serve beneficiaries in peacetime. (See p. 55.)

A fundamental requirement for improvement is to clarify and formally recognize the mission and role of the military's direct medical care system as a peacetime health care delivery system as well as an instrument of national defense.

To do this, the Congress should clarify and adopt clear policies regarding two basic questions:

1. Whom will the military's direct medical care system serve in peacetime?

2. How and to what extent would those beneficiaries who are unable to obtain care in the direct care system--as a result of the policy adopted relative to question 1--receive the assistance needed to obtain medical care from other sources? (See p. 55.)

These questions are complex and difficult, and a wide range of alternative responses is possible. Each could have a different effect on what medical personnel and facilities are needed and where beneficiaries would receive care.

The Congress should consider three alternatives, along with other proposals that might be made, in deliberating on this issue:

--Staff military facilities to adequately meet peacetime requirements and provide care to all beneficiaries. (See p. 53.)

--Continue to provide care in military hospitals and finance care in civilian hospitals, but restrict access to care in the military hospitals by enrolling beneficiaries up to a hospital's ability to provide care or by eliminating entitlement in the direct care system for certain beneficiary groups. (See p. 53.)

--Continue to provide care in military hospitals and finance care in civilian hospitals, but reduce the military hospitals in operation to a number that could be efficiently and effectively staffed by existing and projected military physicians and other support personnel. (See p. 54.)

GAO also makes several recommendations to the Secretary of Defense to improve the direct care system's ability to serve beneficiaries. (See p. 55.)

AGENCY COMMENTS AND GAO'S EVALUATION

DOD agreed (1) that a gap exists between the number of military physicians needed and the number available in the direct care system to provide medical care to beneficiaries, (2) that this has hampered the system's responsiveness to beneficiaries, and (3) that the role and structure of the military health care system need to be reevaluated.

However, DOD said that GAO's report largely ignored the relationship between the peacetime and wartime missions of the military health care system and that GAO's second and third alternatives could result in diminished wartime/contingency capability.

In GAO's opinion, its proposals--particularly alternative 3--could enhance wartime/contingency capability by consolidating the peacetime system and making it more efficient and effective. Such action could offer more stimulating and rewarding careers for physicians and other medical personnel and could increase the likelihood of recruiting and

retaining medical personnel who would be available to meet DOD's wartime/contingency mission.

Concerning GAO's recommendations for improving the direct care system's ability to serve beneficiaries, DOD said that the problems addressed by GAO were recognized and that efforts were being made to alleviate them. (See pp. 55 to 60 and app. I.)

Contents

ABBREVIATIONS

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
GAO	General Accounting Office

CHAPTER 1

INTRODUCTION

The military health care system is composed primarily of the direct care systems of the Army, Navy, and Air Force and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The direct care systems are to provide medical care to support U.S. military forces and to maintain high morale by providing comprehensive, high-quality medical care to military members and other eligible beneficiaries in peacetime.

The Army Surgeon General elaborated on this mission in 1978 congressional hearings by stating that the Army Medical Department's four principal objectives were to

--maintain physically and mentally fit soldiers and trained health manpower to support Army combat, contingency, and mobilization plans;

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

--provide health services for dependents of soldiers, retired members and their dependents, and dependents and survivors of deceased soldiers; and

--provide a major incentive for soldiers, including health professionals, to select military service as a career.

The Army Surgeon General concluded that trained health manpower is the basis for a responsive Army medical care system and that providing health care to the dependents of active-duty members and retired members and their dependents is a beneficial byproduct of military preparedness. The following table shows the size of the Department of Defense's (DOD's) direct care medical operations worldwide:

Military service	Number of Hospitals U.S.	Hospitals Other	Clinics U.S.	Clinics Other	Estimated expenditures for hospitals and clinics (FY 1978) (millions)	Hospital admissions	Outpatient visits
Army	33	15	61	41	$1,072	370,500	19,247,915
Navy	27	9	132	32	545	234,785	12,219,675
Air Force	66	17	22	16	708	306,000	14,978,905

The medical facilities within the direct care system range from small clinics with limited medical capabilities to large medical centers with extensive medical specialty capabilities and medical teaching programs. To assure patients access to all necessary medical care, DOD operates a medical air evacuation program for transporting patients between its hospitals and finances supplemental care when medical care must be obtained from civilian hospitals.

ELIGIBILITY FOR THE MILITARY HEALTH CARE SYSTEM

An important distinction concerning DOD's responsibilities for providing care to eligible beneficiaries is made in 10 U.S.C. 1074 and 1076. These provisions of the law provide that active-duty members have first priority for care in military medical facilities, and their eligibility has no conditions attached. Other beneficiaries, including dependents of active-duty members, retirees, and dependents of retired and deceased members can receive care subject to the availability of space and facilities and staff capabilities.

A 1974 House Armed Services Committee report suggested there was a further distinction on eligibility. 1/ The report stated that dependents of active-duty members or of members who died while on active duty have second priority, and are entitled to medical care subject to the availability of space and facilities and staff capabilities. Next, retired members and their dependents may be given care in a military facility also subject to the same limitations. This report suggests that active-duty dependents have a greater right to medical care in military facilities than retirees and their dependents. However, it is clear that the law only guaranteed medical care in military facilities to active-duty members.

Although the guarantee extends only to active-duty members, the actions of the military services over the years may have conveyed a different impression to military beneficiaries. This impression was discussed in the 1974 Armed Services Committee report, which characterized providing medical care to retirees and their dependents as a high moral obligation of the military. This obligation was based

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1/Report of Subcommittee No. 2 of the House Committee on Armed Services, "CHAMPUS and Military Health Care," Dec. 20, 1974.

primarily on promises the services made over the years as inducements to enlist or reenlist in the military. The promises, as characterized by the report, were that the retiree and his family need not worry about medical care because it would be available in military facilities. This moral obligation, according to the report, has been stated and restated many times in service regulations. 1/

The Committee report also suggested that dependents and retired individuals were protesting the increasing difficulty of obtaining medical care after many years of general satisfaction with their treatment in military facilities. According to the report, many individuals said that the inability to get care amounted to a breach of faith by the military, which long touted the benefits of a complete medical package for dependents and retired families as an inducement for enlistment, reenlistment, and careers. Other individuals were convinced that, since the law provided for medical care to dependents and retired families, the inability to get that care violated the Congress' intent.

Responses to our questionnaire, which was sent to military health care beneficiaries, reaffirmed many observations from the 1974 Committee report. Of the beneficiaries responding

--24 percent believed that the medical benefits they were entitled to were greater than those provided under the law;

--many mentioned retiree manuals, the military press, military officials, recruitment/reenlistment literature, and career or retirement counselors as sources for medical benefits information; and

--49 percent believed they were receiving only part of the care to which they were entitled.

1/The Defense Resource Management Study report, issued in February 1979, also stated that inaccurate, vague, or misleading recruiting and advertising literature apparently contributed substantially to false expectations and frustration on the part of beneficiaries.

CHAMPUS: THE ALTERNATIVE FOR OBTAINING MEDICAL CARE

CHAMPUS provides medical care from civilian sources to dependents of active-duty members, retirees and their dependents, and dependents of deceased members. When originally authorized in 1956, the program was intended to assure that the dependents of active-duty military members would receive medical care if they could not obtain such care at a military facility. In that context, CHAMPUS could be considered a safety valve for obtaining medical care that could not be provided by the military system. From fiscal years 1959 to 1966, costs remained relatively stable, ranging from $53 million to $76 million. Expanded benefits and additional categories of beneficiaries added in 1966, increased use, and inflation have increased costs since that time. For fiscal year 1980 DOD has requested $754 million for CHAMPUS.

Generally, before using civilian facilities for nonemergency inpatient care, all beneficiaries living within 40 miles of a uniformed services medical facility must obtain a nonavailability statement from that facility, certifying that it is not practical, or that the facility is unable, to furnish the inpatient care.

Medical costs are shared by the Government and beneficiaries. For basic benefits, dependents of active-duty members pay $25 (or $4.65 a day, whichever is greater) for inpatient care; other beneficiaries pay 25 percent of total charges. For outpatient care, there is a deductible of $50 for each beneficiary ($100 maximum deductible for each family) each fiscal year, after which dependents of active-duty members pay 20 percent and other beneficiaries pay 25 percent of the remaining charges. No limit is set on the Government payment under the basic program. For handicap benefits, which apply only to dependents of active-duty members, a specified monthly amount is charged ranging from $25 to $250 (depending on the rank of the active-duty member), and the Government pays the remaining charges up to $350 a month. The active-duty member pays any charges exceeding these amounts.

THE MILITARY PHYSICIAN SHORTAGE

Whether the military services have now and will have in the future enough physicians to meet beneficiaries' medical needs has been discussed frequently in hearings before congressional committees, particularly since the end of the military draft in 1973.

For example, during hearings concerning DOD's fiscal year 1978 budget request, questions were raised about whether DOD had a physician shortage and, if so, whether DOD and military service officials expected it to continue. DOD officials believed that the shortage existed and would continue for some time.

However, making absolute statements about the existence of a physician shortage is difficult because there is no single baseline from which to measure it because:

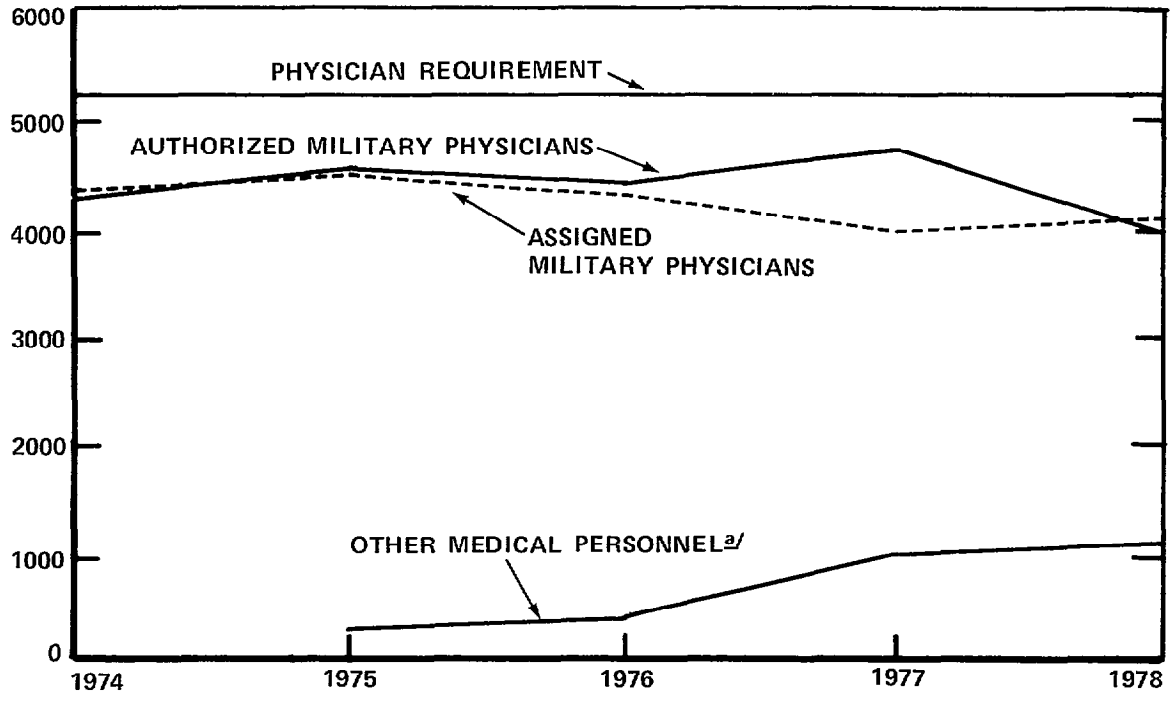
--There are different mobilization and peacetime medical care requirements.

--Mobilization requirements vary, depending on the wartime scenario involved, and these requirements generally substantially exceed peacetime requirements.

--Peacetime requirements can vary, depending on which group of beneficiaries the system is designed to serve.

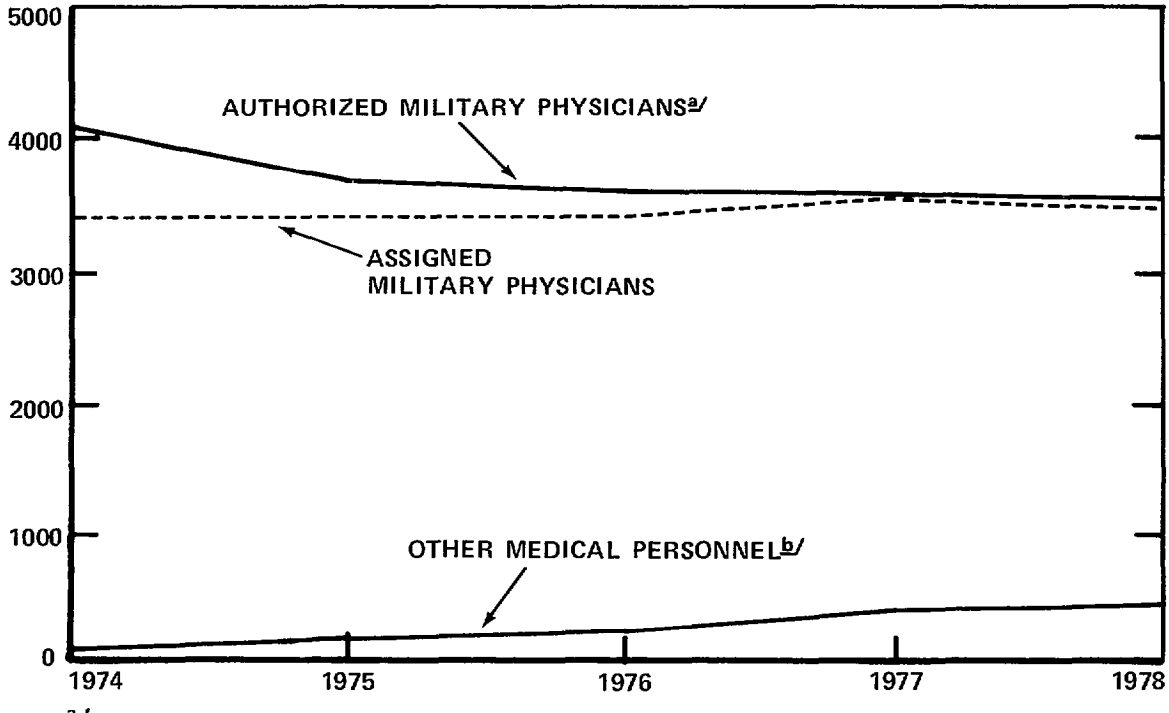
The following charts show that there has been a constant gap between the number of military physicians authorized and those available to provide medical care over the past 5 years and that the military services are attempting to fill the physician gap with other medical care providers. (The number of authorized military physicians in the charts does not necessarily reflect what the services believe is required to meet their peacetime needs.)

ARMY



[a/] Other medical personnel includes civilian physicians, medical services obtained under contract, nurse practitioners, and physician assistants.

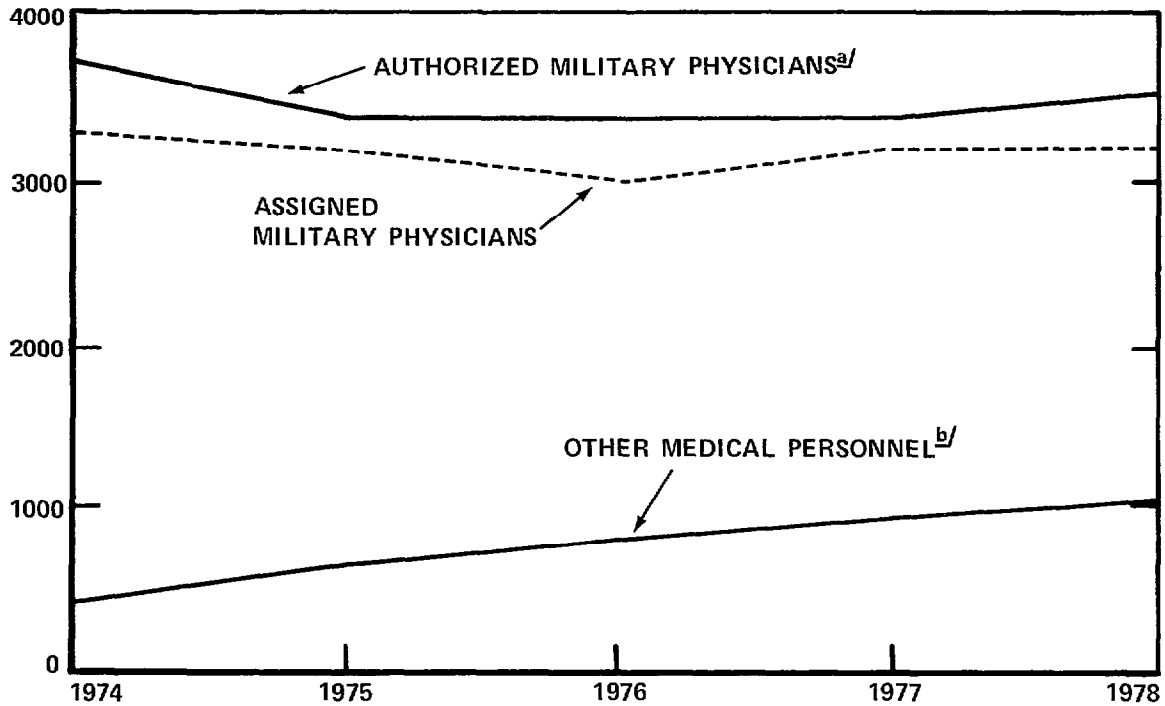
NAVY



[a/] The Navy does not maintain data on peacetime physician requirements.

[b/] Other medical personnel includes civilian physicians, physician assistants, and physician extenders.

AIR FORCE



[a] The Air Force does not maintain data on peacetime physician requirements.

[b] Other medical personnel includes civilian physicians, physician assistants, nurse practitioners, and nurse midwives.

A DOD health studies task force developed a model for assessing what effect certain assumptions about the military's ability to acquire and retain physicians would have on the number of available physicians in the future. The model indicated that the services could reach their fiscal year 1979 authorized staffing levels by 1981. However, the indicated recovery dates were very sensitive to the military's ability to annually recruit volunteer physicians. None of the services has been able to recruit volunteers at the rates assumed by the model, and the Army, Navy, and Air Force all estimate that it will be at least 1984 before they can reach those manpower levels.

DOD has undertaken several short- and long-term initiatives to alleviate the physician shortage. Short-term initiatives include increasing the employment of civilian

physicians, contracting for medical services, purchasing supplemental care from civilian medical facilities, and intensifying physician recruitment efforts. According to the Army Surgeon General, some relief has been obtained by these efforts. However, they are expensive and inefficient, and nonmilitary physicians cannot be deployed for mobilization.

Long-term efforts are directed toward increasing the supply of military physicians through the Armed Forces Health Professions Scholarship Program and stabilizing military physician compensation and incentive pay at a level reasonably competitive with the civilian sector. A legislative proposal for improving military physicians' pay was submitted to the Congress in April 1979.

CHAPTER 2

MANY BENEFICIARIES ARE OBTAINING CARE OUTSIDE DOD'S DIRECT MEDICAL CARE SYSTEM

The results of a survey we made of individuals eligible for military medical care showed that many beneficiaries were unable to get care in the military direct medical care system. Even more beneficiaries either had to or preferred to obtain care outside the direct care system. The survey results confirmed our observations at the military hospitals visited that beneficiaries were experiencing considerable problems obtaining military medical care. Beneficiaries were very favorably impressed with the overall quality of care and attention received outside the direct care system. Also, few beneficiaries--including active-duty personnel--said they had difficulties paying for outside care.

OUR MAILGRAM SURVEY

We made a random mailgram survey of Army, Navy, Air Force, and Marine Corps active-duty members with dependents, 1/ and retirees and survivors living within 40 miles of military hospitals in the continental United States.

DOD's Defense Manpower Data Center compiled data for us on the size of the beneficiary population; it totaled 1,544,907 eligible beneficiaries--676,209 active-duty members with dependents and 868,698 retirees and survivors. The population was divided into six subgroups (or strata) based on the service affiliation of the hospital that beneficiaries would normally be expected to use--in other words, active-duty beneficiaries using Army, Navy, and Air Force hospitals and retired and survivor beneficiaries using Army, Navy, and Air Force hospitals. Random samples were drawn for each of the six subgroups. The random samples totaled 2,719 persons--1,513 active-duty and 1,206 retirees and survivors.

1/Active-duty members without dependents were not included in the mailgram or questionnaire analysis because we believed that the experiences of individual active-duty members who had dependents, together with our hospital visits, would give sufficient insight into the steps being taken to provide medical care to active-duty members.

Mailgrams were sent to 2,719 individuals; 2,379 were delivered and 2,042 were returned. Our response rate was 86 percent based on the mailgrams delivered. The mailgram asked about beneficiaries' experiences in obtaining health care between January 1 and August 31, 1978, by asking:

1. Have you or your family tried to obtain medical care at a military health care facility?

2. Have you or your family been unable to get medical care at the facility?

3. Have you or your family been sent to another military facility to obtain medical care?

4. Have you or your family had to or preferred to obtain care from sources outside the military system?

5. Have you or your family had difficulty in obtaining or paying for care from sources outside the military system?

Access to care is a problem to beneficiaries

Based on 2,042 returned mailgrams, we estimate that about two-thirds of all beneficiaries had tried to get care at a military facility--about 1,009,000 active-duty members, retirees, and survivors and about 1,012,000 of their family members. The table on the following page presents data on the active-duty beneficiaries who answered "yes" to mailgram question 1. It shows the percentages of active-duty members who also answered "yes" to questions 2 through 5 for themselves and their families, and the military service affiliation of the hospitals where beneficiaries had tried to get care.

The data in the table show that the access to care problems are widespread and affect each service's facilities rather equally. We believe that the responses to questions 2 and 4 clearly demonstrate that many active-duty members, and their families, are now obtaining medical care outside the military direct care system. This would tend to confirm our observations at military hospitals, where strong reliance was put on CHAMPUS for meeting the medical care needs of beneficiaries who could no longer be served because of physician shortages.

Active-Duty Members' Responses

Question	Percent of "yes" responses at hospitals (note a) Army	Navy	Air Force	Weighted average
2. Have you or your family been unable to get medical care at the military facility?				
Self	22	20	19	21
Family	33	34	37	35
3. Have you or your family been sent to another military facility to obtain medical care?				
Self	13	23	15	16
Family	16	27	17	19
4. Have you or your family had to or preferred to obtain care from sources outside the military system?				
Self	29	20	22	24
Family	52	53	52	52
5. Have you or your family had difficulty in obtaining or paying for care from sources outside the military system?				
Self	18	11	11	14
Family	33	27	27	29

a/Sampling error information is shown in appendix III.

The following table, which presents data for the retirees and survivors who answered "yes" to question 1, shows the percentages of retirees and survivors who answered "yes" to questions 2 through 5 for themselves and their families. The problems indicated by the responses are again spread fairly equally among Army, Navy, and Air Force facilities. As with the active-duty beneficiaries, we believe the responses to questions 2 and 4 confirm our observations that the military hospitals' ability to provide care is seriously impaired.

Retirees' and Survivors' Responses

Question	Percent of "yes" responses at hospitals (note a) Army	Navy	Air Force	Weighted average
2. Have you or your family been unable to get medical care at the military facility?				
Self	28	32	35	31
Family	30	30	38	33
3. Have you or your family been sent to another military facility to obtain medical care?				
Self	12	11	14	13
Family	11	10	11	11
4. Have you or your family had to or preferred to obtain care from sources outside the military system?				
Self	35	39	46	40
Family	46	49	56	51
5. Have you or your family had difficulty in obtaining or paying for care from sources outside the military system?				
Self	23	30	31	28
Family	28	33	36	32

a/Sampling error information is shown in appendix III.

Based on our mailgram results, we estimate that, of the 1,009,000 active-duty and retired members who tried to get care between January 1 and August 31, 1978:

--About 104,000 active-duty members and about 157,000 retired members were unable to get care at military medical facilities.

--About 124,000 active-duty members and 201,000 retired members either had to or preferred to obtain care outside the military direct care system.

In addition, we estimate that, of about 1,012,000 active and retired family members who tried to get care during the same period (assuming only one family member required care for each positive mailgram response):

--About 344,000 family members were unable to get care in the direct care system.

--About 520,000 family members had to or preferred to obtain care from outside sources.

OUR QUESTIONNAIRE SURVEY

To supplement our mailgram, we sent a questionnaire to some beneficiaries to find out what happened to those who tried to get medical care at a military hospital but either had to or preferred to go elsewhere for care (individuals who answered "yes" to questions 1 and 4 of the mailgram). The questionnaire covered several topics, including:

--The beneficiaries' family profile.

--Their experiences in the military direct care system.

--Their experiences outside the system.

--Their perception of their military medical benefits.

Beneficiaries feel the direct care system is not meeting their needs

We received 490 responses as of June 1979--252 from active-duty families and 238 from retired families. 1/ Both groups believed that DOD's direct care system was not meeting their needs and that it was a declining benefit.

Beneficiaries said they went elsewhere for care primarily because no doctors were available and there were long waiting lists for appointments. Also, most beneficiaries said they were told little or nothing about returning to the military facility. Once they decided to go elsewhere or had been referred elsewhere, most beneficiaries said they received the care they believed necessary. However, some beneficiaries experienced difficulties with certain administrative aspects of CHAMPUS.

1/Questionnaires were mailed to 817 beneficiaries, and 749 were delivered. The number of usable questionnaires returned totaled 490--65 percent of those delivered. The other returned questionnaires could not be used primarily because they were not sufficiently complete to permit analysis. Our analysis of the nonrespondents showed that they were not concentrated in any particular branch of the service, hospital group, or duty status.

Both beneficiary groups considered the overall quality of care and attention received outside the direct care system superior to that received in the system. Also, few beneficiaries said they had difficulties paying for outside care.

We also asked beneficiaries what they believed they were entitled to and what they were getting from the direct care system. Most beneficiaries believed they were receiving only a limited amount of the medical care they were entitled to.

Questionnaire results

The following questionnaire results indicate the reasons beneficiaries went outside the military system and their attitudes toward their experiences outside. 1/ Also included are beneficiaries' comments about military medicine that are typical of many others we received. Many of the comments are unfavorable to military medicine. However, they are from beneficiaries who were unable to receive care in the military's direct care medical system. Therefore, we believe that their comments, exactly as told to us, can help clarify the feelings of those not being served by military medicine today.

Why did beneficiaries go outside the direct care system for care?

Military medical beneficiaries said they had to or preferred to go outside the direct care system because doctors were unavailable, there were long waiting lists for appointments, or the facility was very busy. The medical services that beneficiaries went outside the system to obtain were--in the order most frequently mentioned--general medicine, ophthalmology, obstetrical and gynecological, orthopedics, surgery, internal medicine, pulmonary care, emergency medical services, radiology, pediatric care, and ear, nose, and throat. Following are beneficiaries' comments about why they went or had to go elsewhere for care:

> An active-duty enlisted member using an Army hospital: "Doctor (EENT) was getting out and there still is no replacement."
>
> An active duty officer using a Navy hospital: "Prefer private pediatric care for same doctor availability. Prefer personal relationships with doctor so that we

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1/Complete details for all questionnaire responses are included in appendix II.

may call him any time day or night if we need him. Since doctor knows children he can prescribe over telephone which military can not do."

An active-duty enlisted member using an Air Force hospital: "Myself and my family, including my children, would much prefer to receive medical care from civilian doctors because of the more personal relationship between doctor and patient."

An active-duty enlisted member using an Air Force hospital: "My wife was told she could not receive treatment because she was a civilian. It was my decision to go elsewhere."

An active-duty enlisted member using an Air Force hospital: "Appointments were set up with PA [physician's assistant] not a doctor. Could not understand doctors English."

A retired officer using an Army hospital: "I was sick in October and had some tests made and was never told what the results were. I started going to a civilian doctor in January 1978. I had respiratory failure. Was in I.T.C. unit for 15 days--hospital 5 weeks. I feel like if I had gotten the attention I needed in Oct. this would have never happened. If I had not found a civilian doctor I would be dead."

An enlisted retiree using a Naval hospital: "The doctors attitude made me decide that it was to my best interest to go elsewhere. We have never been told to go elsewhere, we've been told there was long waiting lists or the drs. attitude."

An enlisted retiree using a Naval hospital: "I was told retired people came last on a long list of people needing care."

What happened to beneficiaries outside DOD's direct care system?

Once beneficiaries and/or their families went outside the military direct care system, most of those responding (87 percent) obtained some or all of the care they believed they needed. Of those who obtained care, 75 percent did not have a difficult time getting it. Those who had difficulties cited the following problems: paying for care while waiting for reimbursement from CHAMPUS, making arrangements, finding a doctor who would accept CHAMPUS, and having to start

treatment all over again. Many questionnaire comments gave a clearer picture of the beneficiaries' experiences.

A retired officer using an Air Force hospital: "CHAMPUS care is incomplete and type of care seems to vary by location and interpretation of local hospital commanders. Older retired civilian drs. working part time at military hospitals are often not interested and not current with modern medicine. Military drs. attitudes are not always the best nor are they interested in the patient. Serve their time and enter private practice. This gives the younger enlisted medics little incentive for dedication."

An enlisted retiree using a Naval hospital: "Paid bill and waited for reimbursement from CHAMPUS, received $7.25 from CHAMPUS for $110.00 dr. bill. Most times I pay out of my own pocket because CHAMPUS is too much red tape."

An active-duty officer using a Naval hospital: "Medical care in the military is becoming almost nonexistent. CHAMPUS covers only 25 percent of medical charges in this area."

An enlisted retiree using an Air Force hospital: "Frankly it [military medicine] doesn't provide the general care I feel it should and CHAMPUS doesn't pay enough or timely because of restrictions I don't understand so next open season on the Supplemental Insurance I carry, I'll up it again for the third time."

An active-duty enlisted member: "I have paid medical bill because I was told I could not have CHAMPUS in one case my wife was very ill, after calling [Naval hospital] I was told to take her to [Naval clinic] from ther we were sent to [Naval hospital] emergency from ther to [Naval hospital] labor room. After approximately 6 hrs. she saw a dr. He said he was busy for her to come back tomorrow. From there we went to civilian hospital. I paid $150.00 to find out * * *. I asked for reimbursement I was told I did not qualify for CHAMPUS. I told a superior I was going to file a complaint and was told it would do no good it would just start trouble."

An enlisted retiree using an Army hospital: "Almost impossible to find CHAMPUS accepted willingly. Usually a supplementary insurance is desired."

An enlisted retiree using an Air Force hospital: "The base CHAMPUS referral office is very weak, improper forms were utilized at first and their knowledge in general with us was unsatisfactory."

An active-duty officer using an Air Force hospital: "Few private doctors in my community will accept CHAMPUS patients."

Beneficiaries' impressions of care outside the direct care system

We asked beneficiaries who obtained care outside the direct care system three questions about their impression of the quality of care they received. We first asked whether they got all the care elsewhere that they felt they would have obtained at the military facility. Most beneficiaries (62 percent) who obtained care outside the military answered "yes."

We also asked how they would rate the quality of the overall care and attention they received elsewhere compared to that usually received at the military facility. The combined statistics for active-duty members and retirees show that 56 percent of the beneficiaries who went outside the military believed care was better or much better.

More active-duty than retired beneficiaries said that the care received elsewhere was better than that provided in the military direct care system. Sixty-six percent of active-duty beneficiaries who obtained care outside said it was better (25 percent) or much better (41 percent). Twenty-five percent thought outside care was just as good, and only 1 percent thought it was worse.

Many retired beneficiaries also believed the care was better elsewhere, but not quite as strongly as active-duty beneficiaries. Of those who obtained care outside, 46 percent of retired beneficiaries thought it was better or much better; 30 percent, just as good; 4 percent, worse; and 2 percent, much worse.

We also asked what effect, if any, going elsewhere for medical care had on beneficiaries' or their families' health. Most beneficiaries (53 percent) thought it had a good or very good effect on their health, some (23 percent) said it had little or no effect, and a few (7 percent) said it generally had a bad or very bad effect. Eleven percent said they had no basis to judge.

Comments on the questionnaires express many of the reasons why beneficiaries are dissatisfied with military medicine and, perhaps, why so many believed the care outside was better:

> An active-duty officer: "I believe medical care in terms of treatment and physician expertise is sorely lacking in [Army] hospital and its troop medical clinics. Waiting lists for routine appointments can extend as long as 2-3 months. Emergency medical treatment is also an exercise in 'hurry and wait,' at times for several hours before a physician will conduct a 5 minute examination/ interview."
>
> An enlisted retiree using a Naval hospital: "This facility does not have enough doctors. I have waited as long as 6 hrs to see a doctor and was then seen by a PA [physician's assistant]."
>
> An active-duty enlisted member using an Army hospital: "The doctor said they didn't have time to run tests and recommended we go elsewhere and pay for it ourselves. They didn't want to waste their time trying to find out what it was. Didn't feel I should have to go to a civilian doctor."
>
> An active-duty enlisted member using an Air Force hospital: "Losing medical data, important to treatment. Personnel not caring one way or the other because the medical care you receive is free, so they are doing you a favor not a service."
>
> An enlisted retiree using an Air Force hospital: "Myself and some fellow retirees, have had problems with the way we are treated. When you call for an appointment and tell them you are retired your treated like a second class citizen."
>
> An active-duty officer using a Naval hospital: "Main reason for using civilian instead of military facilities is undue and extensive waiting time; preemptive attitude, and generally severe overcrowding of military facilities. It is simply easier to pay a civilian doctor to care for dependents rather than fight the problems at the military facilities."
>
> A retired officer using an Air Force hospital: "The turnover of doctors in the military service destroys the confidence of the patients, particularly where a

'chronic' condition exists. In many cases, we prefer civilian facilities as more convenient, more personal interest, less red-tape, easier to get appointments, etc."

An active-duty officer using an Air Force hospital: "Very long waiting for treatment of dependents. Doubt the competency of some hired civilian doctors. Sometimes the doctors are quite surly."

An active-duty enlisted member using a Naval hospital: "We check in to the counter around 2100 [9 p.m.] and the doctor see us around 3:30 in the morning. We waited for 6 hrs. for 5 months baby to be seen by the doctors. Six agonizing hours and I can't do anything but to wait for the doctor. And my little boy is gasping for breath for that long hours wait. When the doctors seen my boy they can't find what's wrong with him so they send us home again without any relief on us as a parents. They told us to go back again around 8:00 AM. We went back on the time stated above and he got admitted to the ward right away. Thats the only time we have some relief. They found out that he had phneumonia. What a hassle before he got admitted * * *. This is our experience that will never be erased in our minds. If this will always be the case I will apply CHAMPUS for my dependents."

An active-duty officer using an Air Force hospital: "For those times when I have not had access to the service of the flight surgeon, I have experienced mass treatment at its worst. People are herded into crowded waiting rooms where they must stew for over an hour (if they're lucky) before seeing an overworked, tired, and angry physician. In effect, there are two tiers of service at military medical facilities--one good for the aircrews, missle crews, air traffic controllers and one not so good for all the rest. On top of that, the dependents receive generally grudging and surly care which embarrasses more than helps them."

An enlisted retiree using an Air Force hospital: "He who expects nothing from this hospital is never disappointed."

Financial difficulties are not a major concern to most beneficiaries going elsewhere for care

Our questionnaire results showed that most people who went outside the military direct care system did not experience major difficulties in paying for their care. Actually, 61 percent said they experienced (1) little or no financial difficulties or (2) some financial difficulties. For those individuals that said they did experience difficulties

--13 percent said they were moderate,

--5 percent said they were substantial or great, and

--4 percent said they were very great.

As might be expected, lower ranking active-duty members and retirees with low gross annual incomes ($11,000 and below) experienced the highest percentage of financial problems.

Other than comments about problems with CHAMPUS policies, procedures, and payments, we did not receive many dealing directly with financial difficulties. Examples of difficulties included:

A retired officer using an Air Force hospital: "CHAMPUS should pay higher reasonable fees. i.e. Doctor charges $350.00 CHAMPUS allowable charge $240.00."

An enlisted retiree using an Air Force hospital: "We had to sell our home in * * * and move to * * * we were told that if serious condition were encountered we would be taken to [military hospital] but we were sent over to [private hospital], we have to pay $7,500.00 which we don't have."

An active-duty enlisted member using a Naval hospital: "A large portion of our pocket money spent for health care elsewhere is for transportation and lodging. If the military hospitals were properly staffed this type of hardship would not be placed on the service member."

An active-duty warrant officer who did not mention the service hospital: "Most dr. will not give care unless I pay direct. Military sends person off to outside care thinking Champus will pay a good portion. Champus disallows so much of doctors cost that patient pays the bill and Champus is not out a cent. My last bill was

$70. Champus disallowed all of cost but $35 which ment I didn't even meet the deductibles and had to pay the full $70."

Beneficiaries indicate declining military medical benefits

We asked what people believed their benefit rights were, how they came to understand those rights, and how well they believed benefits have been provided.

Most beneficiaries who responded (66 percent) believed their medical benefit rights included care in a military hospital and under CHAMPUS if the military hospital did not have enough space or physicians. However, many (24 percent) believed they were entitled to free medical care in a military hospital. Beneficiaries generally learned about these rights from a number of sources (retiree manuals, the military press, military officials, recruitment literature, career or retirement counselors). Many respondents (77 percent) believed they were receiving entitled medical care only to a moderate or little extent. Of particular importance, 79 percent of the responding active-duty beneficiaries held this belief.

Whatever beneficiaries' perspectives or sources on medical rights were, their responses gave a final unmistakable message. Their benefits are declining, and they are receiving only a limited amount of the medical care in military facilities to which they feel entitled:

An enlisted retiree using a Naval hospital: "I know that the medical staff at our military hospital are good, but understaffed, worked longer hours. This in itself slows a man or woman down. Though they desire to help they have no time. And when I see this and my family is in pain, I move on to other areas for help. Bypass CHAMPUS so there will be no hang-ups. What we served for and expect we do not get on retirement."

An active-duty enlisted member using a Naval hospital: "When I entered the service in 1976, medical benefits were promised for my spouse too. What little treatment my wife has gotten from so-called military medicine has been slip-shod and infrequent. Most doctors won't take CHAMPUS. The major reasons I am not re-enlisting are the broken promises and cutbacks in medical care."

said they were either leaving the military or seriously considering it.

MILITARY DATA SHOW MEDICAL SERVICES BEING CUT BACK

DOD provided data on medical service closures and curtailments at 123 military hospitals. The information on closures and curtailments has been divided into two time periods: (1) indefinite duration and (2) at least 6 months in duration. 1/ Information on affected beneficiaries has been classified as (1) some or all categories, including active duty, and (2) some or all categories, except active duty.

As shown in the charts on pages 25 through 29, 72 (about 60 percent) of the 123 hospitals experienced medical service closures or curtailments in 12 primary care medical specialties during fiscal year 1978. All beneficiary categories were affected--including active-duty members. Hospital officials stated that these closures or curtailments were caused by physician shortages.

PHYSICIAN STAFF REDUCTIONS COMPLICATE AND REDUCE HOSPITALS' ABILITY TO DELIVER MEDICAL CARE

We visited seven military medical facilities to assess what effect physician staff reductions were having on the hospitals' ability to deliver medical care to active-duty members and other beneficiaries. The hospitals selected represented all three services, covered isolated and non-isolated areas, and included facilities serving many active-duty members.

The hospitals' ability to deliver medical care to all beneficiaries has been seriously impaired in areas hit with physician staff reductions. The effects of physician staff reductions varied widely among hospitals--medical services sometimes disappeared, patients sometimes had to go long distances to get medical care previously available, and patients sometimes waited a long time for care or got no care at all. We believe that our observations at hospitals reflect what our mailgram and questionnaire respondents experienced and show that sporadic care is now being provided to many beneficiaries.

1/Many additional medical services were closed or curtailed for less than 6 months.

REDUCTION IN PROFESSIONAL SERVICES TO BENEFICIARIES – ARMY – DURING FY 1978

HOSPITAL	ANESTHESIOLOGY		DERMATOLOGY		ALLERGY		INTERNAL MEDICINE		OB/GYN		OPTHALMOLOGY		ORTHOPEDIC SURGERY		OTO-LARYNGOLOGY (ENT)		NEUROLOGY		PEDIATRICS		PSYCHIATRY		UROLOGY	
	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.
FT. ORD					● a				○ b				○ b		● b									
FT. CARSON														○ b	○ b									
FT. RILEY	● b			● a											● b		● a				● a			
FT. LEAVENWORTH				● b				○ a		○ a	● b		● b		● a									
FT. HUACHUCA												● a	● a			● a								
WM. BEAUMONT AMC																					○ b			
FT. HOOD													○ b											
FT. SILL								○ b		○ b			○ b							○ b		○ b		
FT. POLK										● b														
FT. LEONARD WOOD							● b					● b	● b		● b			● a						
FT. KNOX			○ b		○ b			○ b	○ b		○ b		○ b		● b		● b							
FT. CAMPBELL												● b										● a		
FT. RUCKER										● a			● a											
REDSTONE ARSENAL								○ b						○ b										
FT. McCLELLAN								○ b		○ b		● a		○ b	● a					○ b		○ b		● a
FT. BENNING										○ b				○ b										
FT. BRAGG													○ b											
FT. LEE																● a						● a		
FT. EUSTIS										● a														● a
FT. JACKSON								● b	● a			● b				○ b		● a				○ b		
FT. DEVENS			○ b							○ b			○ b											
WEST POINT													○ b		● a									
FT. MONMOUTH								● b		● b				● b		● a								● a
FT. DIX						○ b			● a			○ b		○ b								○ b		
FT. BELVOIR			○ b													○ b						○ b		
FT. MEADE									● b					● b										

REDUCTION IN SERVICES TO:

● SOME OR ALL CATEGORIES OF BENEFICIARIES INCLUDING ACTIVE DUTY
○ SOME OR ALL CATEGORIES OF BENEFICIARIES EXCEPT ACTIVE DUTY

SERVICES:

a – CLOSED
b – CURTAILED

REDUCTION IN PROFESSIONAL SERVICES TO BENEFICIARIES – NAVY – DURING FY 1978

HOSPITAL	ANESTHESIOLOGY		DERMATOLOGY		GENERAL SURGERY		INTERNAL MEDICINE		OB/GYN		OPTHALMOLOGY		ORTHOPEDIC SURGERY		OTO-LARYNGOLOGY (ENT)		NEUROLOGY		PEDIATRICS		PSYCHIATRY		UROLOGY	
	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.
BREMERTON NRMC											●				○ b									
LEMOORE NH				● a	○ b								● b											
LONG BEACH NRMC					○ b					○ b														
CAMP PENDLETON NRMC																				○ b				
PORT HUENEME NH										● a				● b										
CORPUS CHRISTI NRMC											● a				● a									
GREAT LAKES NRMC			● a					● b		○ b	● b		○ b		● b									
MEMPHIS NRMC													○ b											
KEY WEST NH									● a				● a		● a						● a			
CAMP LEJEUNE NRMC													○ b										○ b	
CHERRY POINT NH							● a						● b		● a									
PHILADELPHIA NRMC	● b		● b		● b				● b				● b		● b		● a		○ b		○ b		● b	
QUANTICO NH								○ b	● a				● a											
PATUXENT RIVER NH													● a											
BETHESDA NNMC		● b															○ a							

REDUCTION IN SERVICES TO:

● SOME OR ALL CATEGORIES OF BENEFICIARIES INCLUDING ACTIVE DUTY
○ SOME OR ALL CATEGORIES OF BENEFICIARIES EXCEPT ACTIVE DUTY

SERVICES:

a – CLOSED
b – CURTAILED

REDUCTION IN PROFESSIONAL SERVICES TO BENEFICIARIES – AIR FORCE – DURING FY 1978

HOSPITAL	ANESTHESIOLOGY		DERMATOLOGY		GENERAL SURGERY		INTERNAL MEDICINE		OB/GYN		OPTHALMOLOGY		ORTHOPEDIC SURGERY		OTO-LARYNGOLOGY (ENT)		NEUROLOGY		PEDIATRICS		PSYCHIATRY		UROLOGY	
	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.	INDEF.	6 MOS.
TRAVIS AFB																							● b	
MATHER AFB			● a				○ b						○ b											
NELLIS AFB						● b		● b					● b		● a									
VANDENBERG AFB	● b						● b						● a										● a	
GEORGE AFB														● b										
ELLSWORTH AFB									○ b				● a											
MINOT AFB													● a											
HILL AFB					○ b								● a											
F.E. WARREN AFB													● b											
McCONNELL AFB													● a											
OFFUTT AFB			● a						○ b				● b											
DAVIS-MONTHAN AFB										● b														
HOLLOMAN AFB									○ b															
LUKE AFB												○ b			● b									
CARSWELL AFB																		● b						
BERGSTROM AFB													● b											
ENGLAND AFB													● b											
WHITEMAN AFB					● b																			
SCOTT AFB																		● a						
EGLIN AFB													○ b											
TYNDALL AFB									○ b				● a											
COLUMBUS AFB								● a																
HOMESTEAD AFB													○ b		● a									
MACDILL AFB													○ b											
ROBINS AFB													● a											
LANGLEY AFB									○ b				○ b										● a	
SHAW AFB							● a		● b				● a											
DOVER AFB									○ b															
LORING AFB													● a											
GRIFFISS AFB									● a				● a											
ANDREWS AFB										○ b							● b							

REDUCTION IN SERVICES TO:

● SOME OR ALL CATEGORIES OF BENEFICIARIES INCLUDING ACTIVE DUTY

○ SOME OR ALL CATEGORIES OF BENEFICIARIES EXCEPT ACTIVE DUTY

SERVICES:

a – CLOSED

b – CURTAILED

Certain practices at the military hospitals could preclude the most efficient use of physician resources. They were, according to hospital officials, actions of necessity rather than choice. For the most part, these practices were efforts to deal with dwindling physician staffs.

Following are examples of conditions at each military hospital visited. The medical services having problems with providing medical care were often those fundamental to the operation of a hospital and in great demand. This detailed information is to provide a better understanding of the situations that medical officials and many beneficiaries face at the military hospitals. We have not, however, included examples of all medical services that were adversely affected by physician staff reductions or services that were not experiencing difficulties.

Air Force Hospital,
Nellis Air Force Base, Nevada

In April 1977 the Air Force Surgeon General informed the major command Surgeons General of upcoming critical physician shortages in some specialties, particularly radiology and the primary care specialties (such as internal medicine). He said that many Air Force medical facilities would have too few, and less than an ideal mix of, health care providers. Also, priorities would have to be established because more beneficiaries would be trying to get medical care than the system could handle. For nonemergency care, active-duty personnel were to have first priority; all other beneficiaries would receive care subject to the availability of space, personnel, and facility resources. Eliminating all medical care for an entire category of beneficiaries was to be avoided if possible.

To serve beneficiaries who could not be handled at Nellis, hospital officials used several sources, including other military hospitals, CHAMPUS, and civilian sources. Generally, active-duty personnel were sent to other military hospitals, and other beneficiaries were sent to the civilian sector. Services were not totally curtailed to entire beneficiary categories. However, hospital officials said that patients often did not know whether they would receive care at Nellis, at other military hospitals, or from civilian sources.

Services affected by
physician staff reductions

The general surgery department lost one of its two surgeons in December 1977, and no replacement was expected until September 1978. As a result, many patients were referred to CHAMPUS or other military hospitals. Even minor surgery cases (such as for simple hernias) had to be sent out. The remaining surgeon had been on call every night from December 1977 to July 1978.

No internal medicine services were provided between May 1977 and December 1977, except part-time services by the hospital commander. One physician was assigned to the Nellis internal medicine department in January 1978; however, patients still had to be referred to CHAMPUS and other military hospitals. The internal medicine physician was on call 7 days a week and worked an average of 12 hours a day; patients had to wait 6 to 8 weeks for an appointment. According to hospital officials, Nellis is authorized one internal medicine physician, but needs another to serve about 45,000 beneficiaries, including 20,000 retirees.

In June 1978, Nellis's only orthopedic surgeon left the Air Force. The remaining orthopedic technicians and a consultant were able to treat only simple fractures. Patients needing orthopedic care were sent to civilian sources or other military hospitals. At the time of our fieldwork, Nellis did not expect a replacement.

Active-duty personnel sent on
temporary duty for appointments

Hospital records showed that, from May 1977 to June 1978, 1,044 active-duty personnel were sent to other military hospitals for various medical appointments, evaluations, and treatments. The associated costs for per diem and travel alone were about $116,000. A review of the records of 568 patients sent to other military hospitals from January to June 1978 showed that 244 (43 percent) went to March Air Force Base, Travis Air Force Base, and the Naval Regional Medical Center at San Diego for ear, nose, and throat; orthopedics; internal medicine; and surgery outpatient appointments. Active-duty personnel included both officers and enlisted personnel from the rank of colonel to basic airman. Patients usually traveled by commercial bus or aircraft, and they all received a 3-day temporary duty assignment to make the visit. The following table summarizes the travel, per diem, and salary costs associated with having the 244 persons travel for outpatient appointments.

Active-Duty Personnel Sent to Other Military Hospitals Between January and June 1978

Type of appointment	Number of patients	Costs			
		Travel	Per diem (note a)	Salary (note a)	Total
Ear, nose, throat	140	$ 7,154	$5,712	$21,644	$34,510
Orthopedic	77	6,727	3,075	9,759	19,561
Internal medicine	13	675	543	2,105	3,323
Surgery	14	1,387	616	2,874	4,877
Total	244	$15,943	$9,946	$36,382	$62,271

a/Costs for 3 days involved.

This is a conservative estimate of costs and lost time because it does not include patients who had to return for further treatment. According to hospital officials, these cases would normally have been handled by military physicians at Nellis had they been available.

General Leonard Wood Army Hospital, Fort Leonard Wood, Missouri

A declining physician population and an isolated location have created difficulties for patients and hospital personnel at Fort Leonard Wood. From fiscal year 1977 to fiscal year 1978, the number of authorized military physicians declined from 62 to 39--a 37-percent decrease. The hospital had 34 military physicians at the time of our fieldwork in August 1978. The military physician staff was augmented by five full-time civilian physicians, three part-time civilian physicians, nine physician's assistants, five nurse clinicians, and several medical corpsmen.

Fort Leonard Wood is situated in a medically underserved area; therefore, there are few opportunities to obtain medical care under CHAMPUS. Only 83 CHAMPUS nonavailability statements were issued from June 1977 to May 1978. Medical care is available in Springfield (about 100 miles away) and St. Louis (130 miles away).

Hospital officials were very concerned about the reduction of physicians, particularly in view of the patients' lack of alternatives. The hospital commander stated that a concerted effort has been made to continue providing care to

all eligible beneficiaries despite a decline in the number of physicians to 39 in the past 3 years.

Services affected by physician staff reductions

The orthopedic service lost two of its four physicians in July 1978. No replacements were expected, except for a general surgeon who could provide some assistance. In August 1978 orthopedic appointments were filled until October 1978. Patients had not been totally denied services, but they were told they would have longer waits and shorter appointments. According to the acting chief of the service, patients who should have been seen could not get appointments, and future appointments and some surgery would have to be further curtailed. Dependents and retirees were affected by the curtailments.

The internal medicine service had 10 physicians in 1975. The number dropped to eight in 1976, six in 1977, and four by August 1978. Internal medicine care was curtailed by limiting appointments. Appointments for September and October 1978 were opened in August, and all were filled by 10:30 a.m. on the day they opened. An internist told us that the demand for care could not be met, and that probably two-thirds of the patients who should be seen could not get appointments. He said patients would have to do without care, be seen by general medical officers, or be transferred to Fitzsimons Army Medical Center in Colorado.

According to hospital officials, five physicians were needed for the obstetrical and gynecological service. At the time of our visit, three physicians were assigned and one civilian was expected, but his arrival date was uncertain. Appointments were filled for 4 to 6 weeks in advance, and routine surgery had been postponed.

Other indicators of diminishing ability to deliver care

A review of air evacuation and clinic appointment records from May through July 1978 showed that 133 patients were sent to Fitzsimons Army Medical Center for various medical services. The following table shows the number of patients and medical services hospital officials said would have been provided at Leonard Wood had the normal complement of physicians been available.

Specialty	Number evacuated (1978) May	June	July	Total
Oncology	2	5	4	11
Cardiology	6	3	2	11
Hematology	1	3	-	4
Pulmonary disease	2	3	2	7
Internal medicine	2	3	1	6
Endocrinology	2	-	-	2
Rheumatology	-	-	2	2
Gastroenterology	-	2	1	3
Orthopedic surgery	7	10	9	26
Ear, nose, throat	2	1	1	4
Urology	1	-	-	1
Hearing loss	-	2	3	5
Ophthalomology	2	1	1	4
Total	27	33	26	86

According to hospital officials, the 800-mile air evacuation trip to Fitzsimons can be hard on patients. Also, when it rains, patients must be taken by ground transportation to Springfield (about 100 miles away) to meet the air evacuation plane because Fort Leonard Wood does not have an all-weather airstrip. Officials estimated that about 40 percent of the air evacuations involve this additional 100-mile trip. There were 18 such trips involving 66 patients from January to July 1978.

Hospital records also showed that many patients could not schedule clinic appointments because physicians were not available. The following table shows the number of patients who telephoned the hospital but could not obtain appointments in various medical specialties between January and July 1978.

Month	Appointments that could not be scheduled Medical	Orthopedics	ENT	OB/GYN	Total
January	229	32	23	428	712
February	99	85	35	424	643
March	114	24	16	862	1,016
April	82	43	84	623	832
May	118	44	136	823	1,121
June	158	98	125	477	858
July	248	247	43	645	1,183
Total	1,048	573	462	4,282	6,365

Actions taken to help
alleviate physician shortages

Hospital officials said that several steps were taken to alleviate physician staff reduction problems. Physicians were provided good equipment, facilities, and support staff. Several civilian physicians were also hired to augment the military physicians, and physician extenders were used. Hospital officials said that, using a combination of physician extenders and military and civilian physicians, Leonard Wood was trying to do the best for patients.

Naval Hospital,
Cherry Point, North Carolina

The Cherry Point Naval Hospital experienced a serious shortage of primary care physicians between June 1977 and late July 1978. To relieve this situation, specialists were used in the outpatient clinic, in the emergency room, and for medical officer of the day duties. This improved the hospital's ability to provide primary care, but it reduced the availability of specialists and increased referrals to CHAMPUS and other military hospitals for specialty care.

Beginning in June 1978, the problem reversed itself when several primary care physicians were assigned to Cherry Point and several specialists left and were not replaced. To complicate the situation, Cherry Point's referral hospital, the Naval Regional Medical Center at Camp Lejeune, could no longer accept some patients from Cherry Point because it too was experiencing physician staffing problems. (See p. 39.)

Services affected by
physician staff reductions

According to hospital physicians most patients seen at Cherry Point's outpatient clinic after June 1977 had to be referred elsewhere for care. A family practice physician said patients had to wait up to 6 weeks for an appointment before June 1978, and some could not be seen at all. Appointments were only made on a day-to-day basis, and patients who could not be served were sent to civilian physicians under CHAMPUS and to Camp Lejeune (about 50 miles away). However, primary care services improved when, after July 1978, six family practice physicians were assigned to Cherry Point.

Once the primary care situation improved, specialty care--particularly orthopedics--began to deteriorate. Cherry Point's only orthopedic surgeon was transferred in June 1978, and hospital officials had to refer patients to CHAMPUS and Camp Lejeune. However, Camp Lejeune notified Cherry Point that, beginning in October 1978, it could no longer accept referrals of retirees or any dependents because it was also short of orthopedic surgeons. This situation would require sending more patients to CHAMPUS, and hospital officials were concerned that the civilian physicians might not be able to absorb the workload.

Cherry Point had no military radiologist from June 1977 to February 1978. During this period all radiology work was done by two civilian radiology groups in New Bern, North Carolina (about 25 miles away). In February 1978 these groups told Cherry Point officials that they could no longer handle the workload. Consequently, a civilian radiologist was hired under a 1-year contract. The contract terms require one radiologist to work at the Cherry Point hospital from 8:00 a.m. to 4:30 p.m., Monday through Friday, and to be on call for emergency service. Services to be provided included only routine X-rays, not specialized scans and tests. Costs for the year were estimated at $121,000.

Patients were referred to Camp Lejeune

We reviewed Cherry Point's appointment records to determine how many patients were referred for medical services. From June to October 1978, 511 appointments were made primarily at Camp Lejeune for various medical services, including orthopedics; ear, nose, throat; dermatology; opathalomology; and urology. Orthopedics accounted for 204 (40 percent) of the 511 appointments.

Beneficiary category	Number of orthopedics
Active duty	180
Dependents of active duty	21
Retired	1
Dependents of retired	2
Total	204

Naval Regional Medical Center, Camp Lejeune, North Carolina

According to Camp Lejeune's commanding officer, the physician shortage becomes acute during the summer months, when some physicians leave and others arrive, but it is a problem throughout the year. Further, hospital management doesn't know which medical services may be severely curtailed from one year to the next. Physician shortages at Lejeune have affected all beneficiary categories--active-duty personnel must wait longer and are being sent to other military facilities. Dependents and retirees face curtailed services, and increased reliance must be placed on civilian sources. However, Camp Lejeune is also situated in a medically underserved area.

In the summer of 1977, Camp Lejeune experienced physician departures which hampered its ability to deliver care in nine medical services and eliminated two other services--neurology and cardiology. In the summer of 1978, physician departures adversely affected eight medical services--including four that were not affected in 1977.

Services affected by physician staff reductions

Camp Lejeune's obstetrical and gynecological service started referring maternity patients out in June 1977, when the physician staff was reduced from nine to eight. The staff had dwindled to five as of February 1978. In November and December 1977 many beneficiaries who were expected to deliver babies during the summer of 1978 were referred to CHAMPUS because military physicians would not be available. Because of the reduced number of physicians, each doctor had to be on duty in the service for 24 or more straight hours once or twice a week. According to hospital officials, the increased pressure on physicians frustrated doctors and patients. To help alleviate the situation, outside assistance was obtained--including residents from the National Naval Medical Center at Bethesda, Maryland; medical students from Duke University; and two nurse practitioners.

According to hospital officials, it had been extremely difficult for beneficiaries to get an appointment during the past 2 years because appointments would fill up quickly after opening. By October, additional physicians were assigned and appointments were available within 10 days. However, hospital officials said that the problem could recur in 1980 because many physicians would be leaving.

Six orthopedic physicians were assigned to Camp Lejeune and one to Cherry Point during 1977. By October 1978, Camp Lejeune had only four orthopedic physicians and Cherry Point had none. This reduction affected all beneficiaries.

--Active-duty personnel were waiting longer for appointments, which were 4 weeks behind in October 1978.

--Dependents and retired beneficiaries from Camp Lejeune were being seen for followup only.

--Dependents and retired beneficiaries from Cherry Point were not being seen.

About five people a day were going to civilian physicians under CHAMPUS. Most of these were dependents of junior enlisted personnel, who had limited financial resources. The hospital was trying to improve clinic scheduling to keep active-duty waiting time to a minimum and was sending an orthopedic physician to Cherry Point twice a month. No substantial improvement was expected, however, unless more orthopedic physicians became available. The chief of orthopedic service considered this highly unlikely.

Martin Army Hospital,
Fort Benning, Georgia

The authorized and assigned numbers of military physicians at the Martin Army Hospital have declined over the past 5 years. The 96 physician staff authorized in fiscal year 1973 was reduced to 48 by fiscal year 1978. The low point was 45 military physicians in 1977; the following table shows the anticipated service curtailments hospital officials associated with this staffing level:

Medical service	Beneficiary category affected: Active duty	Dependents of active duty	Retired	Dependents of retired
General outpatient			L	L
Internal medicine		L	O	O
Gastroenterology		L	O	O
Allergy	O	O	O	O
Oncology			L	L
Cardiology				L
Neurology			L	L
Dermatology			L	L
Neuropsychiatric		L	O	O
Orthopedic				O
Eye		L	O	O
Ear, nose, throat			L	L
Podiatry		L	O	O
Radiology and nuclear medicine		(note a)		
General surgery		L	L	L

Note: O-no care available
L-limited reduction

a/Contract service status unknown.

In the summer of 1977, hospital officials believed that action had to be taken if the hospital was going to provide continuous, comprehensive care, and they began hiring civilian physicians. From this time until May 1978 Martin's physician shortages and service curtailments were widely publicized in the local and base newspapers. The number of civilian physicians at Martin increased from 6 in July 1977 to 24 by October 1978.

Civilian physicians replace diminishing military physician staff

The chief of primary care and community medicine began recruiting civilian physicians in July 1977 to assist in the primary care clinic. Primarily through his efforts, the number of civilian physicians increased from 6 to 24 by October 1978. These physicians constituted 30 percent of the total physician force of 80, excluding medical residents.

The 24 civilian physicians were all civil service employees, and they worked in several medical services throughout the hospital. However, about 80 percent were in the primary care area. All but 1 of the 24 worked full time,

and all but 2 worked a regular 8-hour day. Those on the flexible shift worked a normal 8-hour day on Wednesday and Thursday and 24 hours straight beginning at 8:00 a.m. on Friday. Civilian physician salaries ranged from $29,000 to $44,000. The average base salary for the 24 physicians was nearly $38,000; with overtime, it increased to about $40,000.

The chief of primary care and community medicine said that, by using Army and private sources, he had identified about 30 interested civilian physicians. To recruit the physicians, he personally contacted them, made himself available for meetings, and brought them to the hospital for interviews. According to the chief, he tried to make it as comfortable as possible for the civilian physicians in order to interest them in joining the hospital staff. When the civilian physicians visited Martin, they were told that the hours worked would not be as long as in civilian life and that they would get emergency room duty (with extra pay) only once every 8 or 10 weeks.

By October 1978, Martin was able to offer all services except neurosurgery and allergy. The chief was trying to recruit a civilian allergist and orthopedic surgeons at the time of our visit.

The chief, as well as other physicians and hospital officials, voiced some concerns about hiring large numbers of civilian physicians to replace or substitute for military physicians because the civilian physicians received a higher salary, worked only 8 hours a day, had no emergency room duty unless they received overtime pay, and had no field duty or night duty. The military physicians performed these duties. This situation was a definite concern to military physicians, particularly if more civilians were to be hired, as appeared to be the trend.

Radiology services obtained under contract

In addition to hiring 24 civilian physicians, Martin contracted for radiology services from civilian sources. It began sending radiology films to a civilian firm in Atlanta in October 1977. This arrangement, which supplemented the work of two military radiologists, cost $195,000 for the year ended September 1978.

Both military radiologists left Martin during the summer of 1978. As a result, a new radiology contract was awarded to provide diagnostic interpretations of X-ray

examinations and some special studies for October 1978 through June 1979. Estimated costs for the 9-month period were $410,000. All X-rays and studies were to be performed at Martin by hospital employees and to be interpreted by two civilian radiologists. A radiologist was also on call 24 hours a day. This service was estimated to be expensive for the Army since the equivalent annual salary for each of the two civilian radiologists was about $273,000.

Naval Regional Medical Center,
Long Beach, California

To the staff and patients of this Naval Regional Medical Center, physician shortages have been a recurring and continuing problem which has decreased the hospital's ability to deliver medical care. Long Beach lost 29 of its 73 assigned physicians in calendar year 1977. Although the hospital received 27 replacements, many did not specialize in the same areas as the departing physicians. As a result, several specialty clinics had to curtail services and disengage patients to civilian physicians.

Medical services curtailed

Internal medicine referred about 1,080 individuals to CHAMPUS in 1977. In June 1977 patients were notified that 6 of the 11 internal medicine physicians would leave with no immediate replacements and only minimal replacements after the summer. Patients were told that medical care for retirees and their dependents would have to be curtailed so that internal medicine could meet its primary mission of caring for active-duty personnel and their dependents. As a result, about 1,080 patients (mostly retirees and dependents of retired or deceased personnel) were sent elsewhere for medical care.

Several other medical specialties have been adversely affected by physician shortages since 1977, including family practice and orthopedics. In the fall of 1977 the family practice clinic had to operate the hospital's screening clinic because no physicians were available. With this additional responsibility, family practice could no longer serve all beneficiaries. In November 1977, letters were sent to all retired families being treated by the clinic, advising them to seek care elsewhere. Incoming retired families were also given disengagement letters. In all, over 900 retired families were affected. The disengagement letter stated, in part:

"For many retirees and their families with multiple medical problems or conditions, requiring thorough ongoing evaluations, their health needs would be better served by seeking the services of a civilian family practitioner, internist, or other appropriate physician through CHAMPUS, rather than obtain sporadic care through continued association with the Family Practice Service." (Underscoring added.)

Beneficiaries in the Long Beach area were notified in early April 1979 that the number of orthopedic physicians at the hospital would drop from five to one because of a Navy-wide shortage. As a result, only active-duty personnel would receive routine orthopedic services after April 15, 1979, and emergency orthopedic service after May 15, 1979.

Naval Hospital,
Port Hueneme, California

According to the hospital commander, Port Hueneme had a year-round shortage of physicians in all specialties during 1977. This situation was aggravated by the loss of physicians during summer months without immediate replacements. To cope with this situation, the hospital limited the services offered by specialty clinics, scheduled fewer appointments, and sent patients to civilian physicians.

Medical services limited

During 1977, care had to be curtailed in the internal medicine, gynecology, orthopedics, and optometry services. Care was provided to active-duty personnel, but most retirees, dependents of active-duty personnel, and dependents of retired and deceased personnel were referred to civilian physicians. Hospital officials believed that many patients did not come to the hospital because announcements were made that certain types of care were no longer available. Although no records were available to support this, the CHAMPUS representative of Port Hueneme said that she received 10 to 15 calls a day from individuals who could not schedule clinic appointments.

Information available for patients already in the system showed that 791 were sent to civilian physicians between May and October 1977; hospital officials attributed 700 of these to physician shortages, as shown below.

Clinic	Number of patients disengaged
Internal medicine	261
Obstetrics/gynecology	291
Orthopedics	48
Ophthalmology	27
All others	73
Total	700

Problems with obtaining care through CHAMPUS

Patients disengaged from Port Hueneme were told to obtain medical care from CHAMPUS. However, hospital records showed that the Navy surveyed 450 local physicians and found widespread reluctance to accept CHAMPUS patients. Of the physicians responding, only 13 percent were willing to accept CHAMPUS reimbursement as full payment for services rendered. About 72 percent said they would accept CHAMPUS patients only if they agreed to pay, at the time care was received, the difference between their fees and the reimbursement allowed by CHAMPUS. According to Port Hueneme's commanding officer, about 85 percent of the active-duty population are in pay grades E-5 and below and, therefore, would have difficulty paying the out-of-pocket cost.

PAY INEQUITIES AND OTHER FACTORS MAY ADVERSELY AFFECT MILITARY PHYSICIAN MORALE, PRODUCTIVITY, AND RETENTION

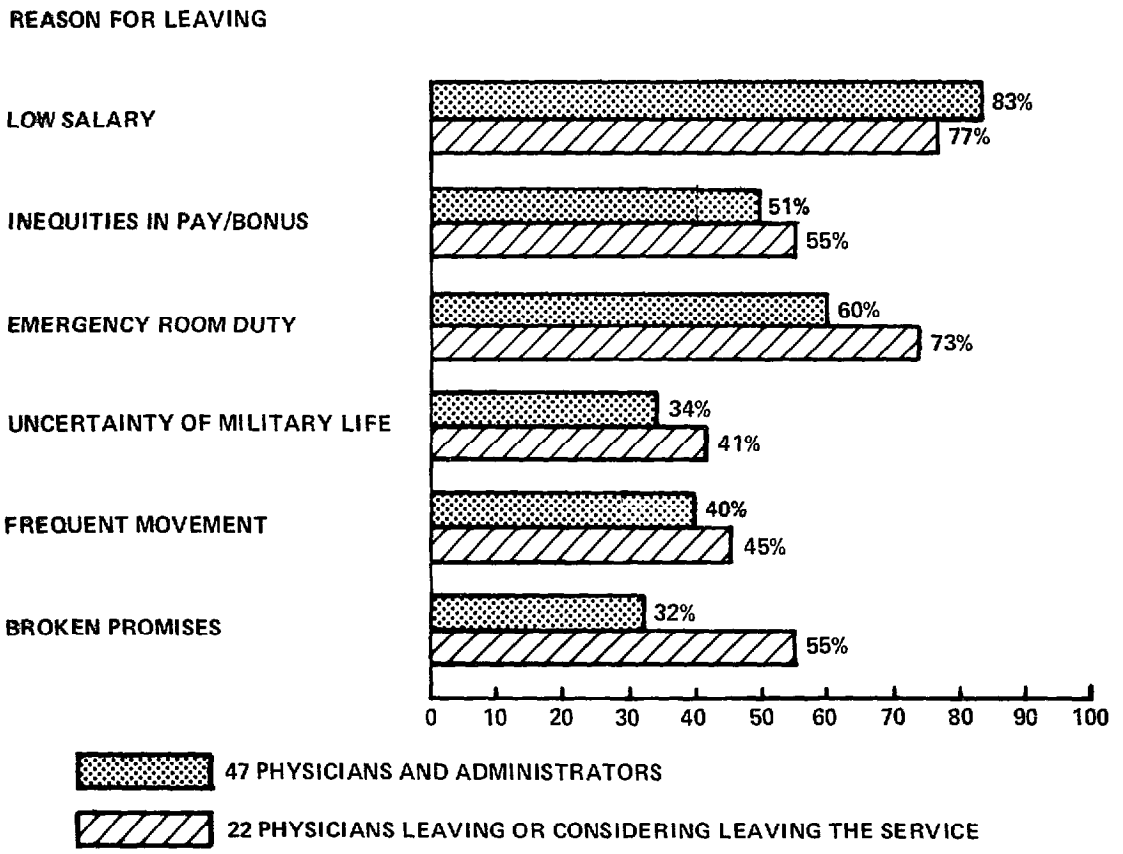
During our military hospital visits, we interviewed 47 physicians and hospital administrative officials to find out why physicians were leaving the military, what practices they resent, and what conditions create inefficiencies and waste their time.

Salary and pay inequities were the most common concerns mentioned that caused physicians to leave the military. Other factors were assignments to emergency room duty, the uncertainties of military life, frequent movements, and broken promises. Also, several factors, including administrative work and the lack of support staff, were cited as affecting physician morale and efficiency.

Why military physicians leave the service

Thirty-eight physicians and nine administrators gave their opinions on why physicians are leaving the military. The following table categorizes these reasons, as well as those given by 22 of the 38 military physicians (58 percent) who said they were either leaving or considering leaving the service.

REASONS WHY MILITARY PHYSICIANS LEAVE THE SERVICE



Low salary

Low salary was the most commonly mentioned reason for military physicians leaving the service. Of the 47 physicians and administrators interviewed, 39 (83 percent) believed low salary was an important factor. Seventeen (77 percent) of the 22 physicians leaving or considering leaving the service cited this factor. Many physicians we interviewed believed their military salary was far lower than they could earn in civilian practice.

Military physician concerns over low pay are supported by a DOD physician survey released in July 1978. 1/ The survey showed that 58 percent of 2,895 Army, Navy, and Air Force physicians responding had a total annual pay, before taxes and deductions, of less than $34,000. This is compared to a median net income for civilian physicians of $62,800 in 1976. 2/ Some civilian specialties were higher, and some (such as general practice) were lower.

Inequities in pay

Variable incentive pay is an additional form of compensation to military physicians which was authorized in 1974 and has been extended annually since then. But not all physicians receive variable incentive pay. For example, obligated physicians who accepted medical school scholarships from the military or were draft deferred under the Berry Plan are not eligible for variable incentive pay until the end of their initial obligation. On the other hand, physicians who volunteer for military service are immediately eligible. Because of this, a foreign medical graduate, for example, can volunteer and receive incentive pay, but U.S. medical school graduates who were supported by military scholarships would not until their initial obligation is completed. This is an inequity, according to physicians, because it amounts to physicians doing the same work for different pay.

1/"Physician Survey, 1978: A Summary of Responses," Health Studies Task Force Report, Office of the Assistant Secretary of Defense (Health Affairs), July 24, 1978.

2/"Doctor's Earnings: Staying ahead of inflation. . . But for How Long?" Medical Economics, Nov. 14, 1977.

One physician said it did not make sense for the Army to train a person and then not provide incentive pay during their obligated service. He believed that these are the physicians most likely to stay in the Army and are supposed to be the ones who will teach new scholarship students. In his opinion, very few of the young teaching cadre and obligated physicians will be staying in the service because of the way they have been treated.

Emergency room duty

Being medical officer of the day generally involves working a shift of 24 hours or more in the hospital's emergency room. The emergency room is normally covered on a rotating basis by the military physicians. Thus, the fewer physicians a hospital has, the more frequently a physician will have this duty.

Of the 47 physicians and administrators interviewed, 60 percent said emergency room duty was a reason why physicians leave the service. A hospital commander stated that the physicians resent having emergency room duty--particularly at the smaller installations, where it occurs four to six times a month.

Also contributing to the problem are physicians' feelings about having doctors work in the emergency room who do not usually participate in general medicine. Examples are psychiatrists and radiologists who have had some general medical training but are out of their element trying to treat emergency room patients. One doctor said physicians consider using doctors who are not familiar with treating emergency room cases to be poor patient care.

Other factors affecting retention

Of the 47 physicians and administrators we interviewed, 16 (34 percent) mentioned the uncertainty of military life as a factor for physicians leaving the military. Of the 22 physicians who said they were leaving the military, 41 percent cited this reason.

The uncertainty of military life relates to several things, including pay, promotion, duty station, and staff availability. Physicians and administrators stated that benefits (such as variable incentive pay) are always subject to change, and policies (such as promotion) seem to constantly change. This uncertain climate makes the military life very unstable.

According to 19 (40 percent) of the physicians and administrators interviewed, frequent movement causes physicians to leave the military. An Army physician stated that stabilizing assignments is very important, particularly to specialists who want to stay at a location long enough to develop a practice and not move for the sake of moving. DOD's physician survey also recognized assignment stability as being important to military physicians.

Out of the 22 military physicians who said they were leaving or considering leaving the service, 12 (55 percent) noted broken promises as a factor. Broken promises typically involved delayed promotions and curtailed continuing education opportunities.

Factors affecting physicians' morale and medical practice

In addition to the reasons why physicians leave the military, we were told about and observed several other factors that could affect physicians' morale and their ability to effectively practice medicine in the military environment. Included were having to perform administrative work and lacking adequate support staff.

Several physicians said their medical practice was constrained by administrative paperwork. Physicians said they must locate and keep track of medical records and perform patient workups, including taking medical histories. Many physicians and administrators also noted that, for physicians to rise in their military career, they must go through the normal administrative command and channels. Some we interviewed considered this poor use of physician resources. Several individuals advocated a separate career plan for physicians, allowing them to progress within their specialties without administrative and command duties.

A situation frequently described to us involved the environment in which physicians were practicing medicine. In several hospitals one or more medical services had been cut back because of physician shortages. Physicians stated that they are frequently on call, work long hours, perform the same or more work with reduced resources, and have to turn patients away.

A lack of support staff, inadequate office space, and problems in quickly obtaining updated equipment also affected the physicians' environment. One Army physician stated that because neither personnel nor any support staff (such as secretaries or chaperones) work directly for physicians, physicians receive inadequate support from these personnel. Physicians have much less control over their clinic personnel than they would in private practice.

CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS AND OUR EVALUATION

CONCLUSIONS

Since the end of the military draft in 1973, the military's direct medical care system has been faced with a constant gap between the number of military physicians it needs to provide medical care and the number it has available. This situation has seriously impaired the system's ability to efficiently and effectively meet the peacetime demand for medical care.

The Army, Navy, and Air Force medical departments estimate that the physician supply will not meet fiscal year 1979 authorized levels until fiscal year 1984. However, even that level would be below what the medical departments believe is needed to meet demand. The lack of physicians has hampered hospital operations and beneficiaries'--including active-duty members'--ability to get medical care.

DOD data showed extensive closures and curtailments of medical services in military hospitals during fiscal year 1978; all beneficiary groups--including active-duty personnel--were affected. Hospital officials said the physician shortage was the primary reason for these closures and curtailments.

Our visits to seven military hospitals showed several hospital-level problems:

--Medical services sometimes closed and sometimes reopened, depending on physician availability.

--Patients were told to go elsewhere for care.

--Patients were moved long distances to other military hospitals for medical services that were previously available at the military hospital they normally used.

--Increased reliance was placed on civilian physicians, including foreign doctors and foreign medical graduates; physician extenders; and medical services procured under contract.

--Patients were waiting longer for medical care; they sometimes got no care.

--Physicians were required to spend more time working on emergency room duty and helping out in areas with severe physician shortages.

The above are strong indicators of a physician shortage. However, we cannot say that a shortage alone is impairing the system's ability to deliver medical care; shortages of administrative and technical personnel shifted some support work to the physicians.

Physicians we interviewed stated that pay inequities, emergency room duty, frequent movement, and a lack of adequate technical and administrative support staff were decreasing the morale of physicians and causing them to leave the military. About 58 percent of the physicians interviewed said they were either leaving or considering leaving the military.

Our mailgram and questionnaire survey results present a clear picture of the military system's ability to serve beneficiaries today. From a random sample of beneficiaries living within 40 miles of military hospitals in the continental United States, we learned:

--About two-thirds of the active-duty and retired families said they tried to get care at a military facility between January 1 and August 31, 1978.

--Of those who tried, the following percentages said they were unable to get care:

	For themselves	For their families
Active-duty	21	35
Retirees	31	33

--Of those who tried, the following percentages said they either had to or preferred to obtain care outside the military direct care system:

	For themselves	For their families
Active-duty	24	52
Retirees	40	51

Particularly notable were the large percentages of active-duty members themselves who said they either had to or preferred to obtain care outside the system.

Statements of beneficiaries who had tried to get care in military hospitals but either had to or preferred to go outside the direct care system were very revealing. Their responses and comments generally conveyed a strong sense of frustration and disappointment with the medical care system they believed was built to serve them, but now seemed to reject them with increasing frequency. Also, beneficiaries provided a clear message about medical care outside the direct care system--they liked it better than care received from the military system. Also, few beneficiaries had difficulties paying for care outside the system. Those who had difficulties tended to be lower ranking active-duty members and retirees with low incomes.

We believe that a comment on one questionnaire response reasonably portrays the condition of a large portion of the military system today: "It seems by trying to be all things to all people, the system is not effective for anyone."

In view of the inability of the military's direct medical care system to adequately serve the large number of DOD beneficiaries in peacetime, the Congress needs to re-evaluate the role and structure of the system and direct DOD to improve its ability to serve those beneficiaries.

A fundamental requirement for improvement is to establish and formally recognize the mission and role of the direct medical care system as a peacetime health care delivery system as well as an instrument of national defense. To do this, the Congress should clarify and adopt clear policies regarding two basic questions:

1. Whom will the military's direct medical care system serve in peacetime?

2. How and to what extent would those beneficiaries who are unable to obtain care in the direct care system--as a result of the policy adopted relative to question 1--receive the assistance needed to obtain medical care from other sources?

These questions are complex and difficult, and they have been previously addressed, to some extent, in the context of DOD's health facilities construction programs (that is, whom

should new health facilities be built to serve). However, the questions now need to be reevaluated in the context of DOD's eroding ability to meet its peacetime health care responsibilities through the use of its direct system. In addressing these questions, a wide range of alternative improvement measures is possible. Each alternative could have a different effect on what medical personnel and facilities are needed and where beneficiaries would receive care.

Below are some alternatives that DOD and the Congress should consider in deliberating on this issue.

Possible courses of action

Alternative 1--Staff military facilities to adequately meet peacetime requirements and provide care to all beneficiaries.

This alternative would increase the number of military physicians immediately available for national emergencies and improve beneficiaries' access to care in military hospitals during peacetime. In addition to requiring added incentives or other methods for obtaining physicians, it would require necessary support staff, equipment, and possibly more facilities.

Serious consideration would have to be given to how this alternative might affect civilian hospitals, since so many military beneficiaries are now served in such facilities. Consideration would also have to be given to the potential effect of a comprehensive national health insurance program, which could give some beneficiaries the option of using other sources of care, thereby drawing them out of the military system in the future.

Alternative 2--Continue to provide care in military hospitals and finance care in civilian hospitals, but restrict access to care in military hospitals.

Restricting access would involve enrolling beneficiaries up to a hospital's ability to provide care or eliminating entitlement in the direct care system for certain groups of beneficiaries, such as retirees and/or their dependents. Beneficiaries no longer served in the direct care system could go directly to other Federal or civilian hospitals. This alternative could be enhanced by upgrading and simplifying CHAMPUS payments and procedures or by substituting a choice

of health insurance programs--perhaps similar to those available to Federal employees or those offered by large corporations. This alternative would make it easier for beneficiaries to obtain medical care, but would retain many of the operating inefficiencies now found in many military hospitals because of physician and other medical staff shortages.

Alternative 3--Continue to provide care in military hospitals and finance care in civilian hospitals, but reduce the military hospitals in operation to a number that could be efficiently and effectively staffed by existing and projected military physicians and other support personnel.

As in alternative 2, beneficiaries could be enrolled in the military hospitals that remained in operation up to the hospitals' abilities to provide care, or entitlement could be eliminated for certain groups of beneficiaries. Beneficiaries who could not be served by those hospitals, together with beneficiaries no longer near an operating military hospital, could go directly to other Federal or civilian hospitals. This alternative would also be enhanced by upgrading and simplifying CHAMPUS payments and procedures or by providing a choice of health insurance programs.

To accomplish this alternative, DOD and the Congress would have to make difficult decisions about how many and which military hospitals to place in inactive status. However, recent actions by the Navy to close and lease the New Orleans Naval Hospital to a civilian group shows that these decisions can be made and that this approach can yield financial benefits to the Government (estimated to be more than $100 million over the potential 25-year life of the lease), while still permitting access to the facility in a national emergency. This alternative would also mean sending many beneficiaries directly to the civilian sector under CHAMPUS or some other program. The results of our mailgram and questionnaire survey show clearly that this approach would be acceptable to beneficiaries because many of them are already using the civilian sector and like it.

This alternative would also give the military flexibility in constraining the size of its direct care system if a national health insurance program were adopted that provided some beneficiaries with other options for obtaining care and thereby reduced demand on the military system. This alternative as well as the others would require developing adequate methods for quickly obtaining substantial numbers of physicians and access to additional facilities in the event of a major military conflict.

RECOMMENDATIONS TO THE CONGRESS

To improve DOD's ability to effectively provide medical care to beneficiaries, we recommend that the Congress:

--Clarify and formally recognize policies regarding:

(1) Whom the military's direct medical care system will serve in peacetime.

(2) How and to what extent beneficiaries unable to obtain care in the direct care system as a result of the policy adopted from (1) above would receive the assistance needed to obtain medical care from other sources.

--Reevaluate the role and structure of the military medical care system and direct DOD to establish a structure that will improve its ability to serve beneficiaries in peacetime.

As part of its deliberations, we recommend that the Congress consider the alternatives discussed on pages 53 and 54 as well as others that may be presented from other sources. We believe that particular attention should be given to alternative 3, because of its potential for improving beneficiaries' medical care and the flexibility it provides in adjusting to future changes in national health care policy.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

We recommend that the Secretary of Defense improve the environment in which military physicians practice medicine to the extent practical by:

--Reducing or eliminating emergency room duties for specialists--particularly those who do not have routine exposure to general medical practice.

--Reducing physicians' nonmedical duties.

--Increasing the length of physicians' assignments at specific hospitals.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on our report (see app. I), DOD agreed that a gap exists between the number of military physicians

needed and the number available to provide medical care to beneficiaries, that this situation has hampered the direct care system's responsiveness to beneficiaries, and that the role and structure of the military health care system need to be reevaluated.

However, DOD also said that our references to the inability of beneficiaries--including active-duty personnel--to get care at military facilities did not consider DOD's historical use of supplemental care, contract services, and air evacuation.

Supplemental care and contract services were intended to provide medical services that could not be provided at a particular hospital primarily because they were highly specialized or were not in continuing demand. The data on closures and curtailments of medical services, together with the discussions of the results of our hospital visits (see ch. 3), suggest that supplemental care and contract services must now be used to obtain primary medical care services at both small hospitals and large medical centers. The military services do not maintain uniform, centralized information on the costs of supplemental care and contract services. However, the Army estimates that it spent over $7 million per year in 1977 and 1978 for supplemental care, and about $3 million in 1977 and $6 million in 1978 for contracted services (radiology, pathology, anesthesiology, and contract surgeons).

The Air Force routinely uses its domestic air evacuation system to move patients from the smaller installation hospitals to the major military medical centers with greater capabilities. It moved 21,471 and 23,039 inpatients between its U.S. hospitals during calender years 1977 and 1978, respectively. DOD data show that many major medical centers, which receive large numbers of air-evacuated patients, have relatively large physician staffs in view of the numbers of active-duty personnel in their service areas. Conversely, several installations with high concentrations of active-duty personnel had relatively low numbers of physicians to serve them. This situation again raises the question: "Whom does the military's direct care system serve in peacetime?" If the answer is the active-duty population, then some DOD medical care resources are apparently in the wrong places to meet the needs of the active-duty population most effectively.

DOD also commented that the information we obtained about the percentage of beneficiaries that had to or preferred to obtain care outside the direct care system did not

--distinguish between those who elected to go elsewhere and those who were referred,

--identify why these persons went outside the direct care system, or

--address the payment practices associated with getting care elsewhere.

Before examining these objections, we believe it is important to reemphasize what our mailgram did show. It demonstrated clearly that many active-duty personnel, as well as retirees and dependents, were not able to get medical care at military facilities when they tried to between January and August 1978. The data were particularly significant, in our opinion, for active-duty personnel, because the direct care system was established to serve them.

Regarding DOD's first objection, it is true that the responses to mailgram question 4--which show that 24 percent of the active-duty members who tried to get care either had to or preferred to obtain care outside the system--do not, by themselves, distinguish between those who elected to go elsewhere and those who were referred elsewhere. However, the responses to mailgram question 2 show that 21 percent of the active-duty members who tried said that they were unable to get medical care at a military facility. Looking at the responses to questions 2 and 4 together, we believe it is reasonable to infer that most of the 24 percent who said they obtained care from sources outside the direct care system did so because they were unable to get medical care at a military facility. This is further supported by the questionnaire results (see question 5), which show that only 13 percent of the total reasons given by beneficiaries for going outside the direct care system were because they preferred to.

Regarding the second objection, we developed question 5 of our followup questionnaire specifically to elicit beneficiaries' reasons for going outside the direct care system to obtain their medical care. Fifty-three percent of the responses to this question said that beneficiaries went elsewhere because no military doctor was available to treat their case or because they were advised to go elsewhere because of a long wait for appointments.

Regarding DOD's last objection, we recognize that many beneficiaries--particularly retirees--have other insurance that covers the cost of all medical care or the portion not covered by CHAMPUS. Because of this, we attempted--using questions 23 and 29 in the followup questionnaire--to get an overall impression of the degree of financial difficulty being experienced by beneficiaries who obtained care outside the direct care system. As discussed on page 20, the questionnaire results showed that most beneficiaries did not experience financial difficulty paying for medical care and those experiecing difficulties tended to be lower ranking active-duty members and retirees with low incomes.

DOD said that our report largely ignored the relationship between the peacetime and wartime missions of the military health care system and that, as a result, our second and third alternative proposals could result in diminished wartime/contingency capability. Although our report concentrates on the problems being experienced by the direct care system in peacetime, we believe that our alternatives--including alternative 3, which suggests reducing the number of facilities operated by DOD in peacetime but not peacetime personnel or wartime expansion capability--would not diminish DOD's wartime medical capability. Discussions with Defense medical planners suggest that DOD will not use its existing U.S. hospital system to full capacity during the initial phases of a major conflict because of (1) the need to deploy military medical personnel resources to the theatre(s) of military operations and (2) the time required to obtain reserve personnel and civilian hires to augment the staffs of U.S. military hospitals. Also, it is questionable whether the military services would consider it desirable to staff all of the U.S. military hospitals because some are far from U.S. locations where casualties would be returned. DOD plans to rely heavily on civilian medical capability in the event of a major conflict--even during the early phases of hostilities. Consequently, DOD is now considering a means to establish an organization--within the Office of the Assistant Secretary of Defense (Health Affairs)--to contract with civilian sector hospitals for medical care capability in a major conflict.

In view of the above, we believe that our proposals--particularly alternative 3--could enhance DOD's medical readiness posture by consolidating the peacetime direct care system, thereby making it more efficient and effective. Such action could offer more stimulating and rewarding careers for military physicians and other medical personnel and, in our

opinion, increase the likelihood of recruiting and retaining medical personnel, who would then be available to meet DOD's wartime/contingency medical mission.

In commenting on our specific recommendations to the Secretary of Defense, DOD said that:

--Emergency rooms give physicians exposure to acute trauma conditions and, therefore, provide a medium for training physicians in the kind of conditions they may encounter during contingency operations. DOD also said that it does not have enough non-specialists in the direct care system to staff emergency rooms without placing undue hardship on them.

--Reducing physicians' nonmedical duties has been recognized as a problem, and efforts are underway to identify solutions. DOD noted however, that improvement in this area will require additional support personnel.

--It recognizes the importance of increasing the length of physician assignments and that its current practice is to reassign physicians only when necessary to meet operational requirements.

Emergency room duty may be of value in providing wartime/contingency mission training. However, it is questionable whether certain specialists (such as psychiatrists) who have little exposure to surgery or general medicine in peacetime, could or would be expected to provide surgical or other trauma-related care as part of a wartime/contingency mission. Therefore, we believe that, during peacetime, emergency rooms should be staffed with physicians who have the necessary skills to meet the demand placed on them. Also, the fact that there are not enough nonspecialists to staff emergency rooms seems to support our argument that DOD could provide medical care more effectively by spreading its limited physician staff resources over fewer hospitals. Therefore, while it is possible that DOD would need additional support personnel if physicians' nonmedical duties were reduced, it is, in our opinion, equally possible that these personnel--like physicians--could be used more effectively if they were assigned to a smaller number of hospitals.

- - - -

Our evaluation of DOD's comments reinforces our belief that the serious problems confronting DOD in attempting to serve all eligible beneficiaries in its direct care system require congressional attention to resolve the question of whom the military's direct medical care system should serve in peacetime.

CHAPTER 5

SCOPE OF REVIEW

We made our review at the headquarters offices and selected DOD medical care facilities. We also mailed questionnaires to certain beneficiaries of military medical care. Our general objectives were to (1) assess whether the physician supply was sufficient to meet the demand for medical care and (2) analyze the effect of any shortages on beneficiaries and on hospital operations. Our work was limited to the military medical care system's peacetime mission.

From military headquarters offices we obtained information on legislation and regulations and overall data on closures and curtailments of medical services. The headquarters offices involved were the Office of the Assistant Secretary of Defense (Health Affairs) and the offices of the Surgeons General of the Army, Navy, and Air Force.

We visited the following military hospitals and interviewed hospital administrators and physicians there:

--U.S. Air Force Hospital, Nellis Air Force Base, Nevada.

--General Leonard Wood Army Hospital, Fort Leonard Wood, Missouri.

--Naval Hospital, Cherry Point, North Carolina.

--Naval Regional Medical Center, Camp Lejeune, North Carolina.

--Martin Army Hospital, Fort Benning, Georgia.

--Naval Regional Medical Center, Long Beach, California.

--Naval Hospital, Port Hueneme, California.

To learn about military beneficiaries' experiences in obtaining medical care, we sent a mailgram to 2,719 beneficiaries. We sent a more detailed questionnaire to 817 people who stated in their initial responses that they had tried to obtain care in military facilities and had to or preferred to obtain medical care outside the military system. The statistics in the report were compiled from the

responses received as of June 1, 1979. The elapsed times from mailout to the cutoff date for the mailgram and followup questionnaire were 33 weeks and 16 weeks, respectively.

The data base for the mailgram and questionnaire survey was developed in conjunction with the Defense Manpower Data Center in Monterey, California.

APPENDIX I

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

9 JUL 1979

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

Dear Mr. Ahart:

This is in reply to your letter to the Secretary of Defense regarding your draft report dated May 10, 1979, on "Military Medicine Is In Trouble: Complete Reassessment Needed" (OSD Case # 5176).

We concur in the basic findings of the report--that a severe gap exists between the number of military physicians needed and the number available to render care to the beneficiaries of the Military Health Services System, that this shortage has had adverse effects on its responsiveness to military beneficiaries, and that there is a need to reevaluate the role and structure of the Military Health Services System.

As regards the recommendations directed to the Secretary of Defense, the following comments are provided. Emergency rooms provide an opportunity to expose physicians to acute trauma conditions. This provides a medium for training of physicians for the type of conditions they may encounter during contingency operations. Additionally, there are not sufficient numbers of non-specialist physicians within the direct care system to staff these areas without placing an undue hardship on these non-specialist physicians. Not withstanding these observations, the military departments are attempting to attract and retain emergency room specialists.

Reducing the physicians' non-medical duties has been recognized as a problem by the Department of Defense. Improvement in this area will require an increase in ancillary support personnel. Currently, there is a special Tri-Service/OSD study underway to identify initiatives in this area. However, it must also be noted that some of the tasks identified by the report are not administrative, such as taking of medical histories.

APPENDIX I

The Department of Defense recognizes the importance of increasing the length of time that physicians are assigned to specific hospitals. Current practice is to reassign physicians only when necessary to meet operational requirements.

Confusion exists as to whether the report is referring to the direct care system of the Military Health Services System or the entire system which includes the CHAMPUS and the supplemental care financing mechanisms. This infers that CHAMPUS and the supplemental mechanisms are not a part of the Military Health Services System.

The references to the inability of beneficiaries---including active duty personnel---to get care at the military facility, do not consider the historical use of supplemental care mechanisms, contract services and air evacuation.

The reference throughout the report to "had to or preferred to obtain care outside the military system" does not distinguish those who elected to go elsewhere from those who were referred elsewhere. It does not address the supplemental care option as a component of the Military Health Services System, the reasons for using services other than the local direct care system, and the payment practices associated with getting the care elsewhere.

The report ignores, in large part, the relationship between the wartime/contingency readiness mission of the Military Health Services System and the health benefit mission; one interfaces with and impacts the other. Failure to deal with this relationship, implies the conceptualization of the system into two discrete and separate entities leading to analyses and conclusions that ignore the reality of the dual mission. Alternative proposals which ignore the dual mission can result in the solution of one mission problem to the detriment of the other mission. Such appears to be the case in the limited proposals presented in the report. The failure to recognize the wartime/contingency readiness mission can result in a diminished wartime/contingency capability.

Thank you for the opportunity to comment.

Sincerely,

Vernon McKenzie
Principal Deputy Assistant Secretary

APPENDIX II

U.S. GENERAL ACCOUNTING OFFICE

SURVEY OF MILITARY FACILITY PATIENTS SEEKING OR ASKED TO SEEK CARE ELSEWHERE

INSTRUCTIONS

The purpose of this questionnaire is to find out what is happening to people like yourself who have called or gone to the military hospital, either to get care or a "Non-Availability Statement" for CHAMPUS, and who have had to go elsewhere for medical care.

This questionnaire should be filled out by the person who is serving or has served in the military or his or her survivor. However, so that nothing will be forgotten, we request that husband, wife and other family members work together

Please check the responses or fill the blanks which best describe your opinions or experiences. You should be able to complete this questionnaire in 30 minutes or less. If you have trouble reading because of illness or other problems, have someone read the questions to you and write down your answers for you.

We realize that some of you may consider this issue to be sensitive. So we have not put any information on the questionnaire that could identify you. It is just like a secret mail ballot. So please complete and return the form in the self-addressed, stamped envelope, marked "Questionnaire" within 10 days.

Also, we have given you a post card with a number on it. Mail this card back separately. Do not return it with the questionnaire. This card goes to a different address and no one can associate the number on the card with the questionnaire. The only purpose of this card is to tell us that you have returned the questionnaire so that we will not have to bother you with reminder notices.

We appreciate your help since we cannot make a meaningful study of this subject unless we hear from you and others like you.

If you have any problems with the questionnaire, please call William Gadsby at (202) 693-1201, GAO Headquarters, Washington, D.C. He will be happy to help you.

Thank you.

Summary of Responses:

Active duty	252
Retirees and Survivors	238
Total	490

a/These are median figures

FAMILY PROFILE

1. What is the rank of the person who has served or is serving in the military? *(Check one.)*

1. [46]	E1 – E4	5. [35]	O1 – O3
2. [156]	E5 – E6	6. [78]	O4 – O5
3. [133]	E7 – E9	7. [28]	O6 and above
4. [9]	Warrant Officer		

2. Approximately, what will be your gross family income from all sources this year? (That is all income monies before anything is deducted.) *(Check one.)*

1. [6] Under $3000
2. [3] $3000 to under $4000
3. [5] $4000 to under $5000
4. [18] $5000 to under $6000
5. [32] $6000 to under $11,000
6. [114] $11,000 to under $17,000
7. [108] $17,000 to under $25,000
8. [99] $25,000 or more

3. Please provide us with some information about the military medical facility from which you or your family were referred or went elsewhere?
   1. Name of facility? Army-113, Navy-147, AirForce No Response-52 178
   2. Distance of facility from your home? 12a/ *(miles)*
   3. Travel time to facility-one way? 20a/ *(minutes)*

4. Between January 1 and December 31, 1978
   1. About how many times did you or your family call or visit this facility to seek care or a "Non-Availability Statement" for CHAMPUS? 5a/ *(no. of times)*
   2. About how many times were you or your family told that care would have to be obtained elsewhere or given a "Non-Availability Statement" for CHAMPUS? 2a/ *(no. of times)*

4 b. How many people are in your family? (Include yourself, spouse and dependents.) 3a/ *(No in Family)*

APPENDIX II

EXPERIENCE AT MILITARY MEDICAL FACILITY

5. What reasons best explain why you or your family went or had to go elsewhere for care? *(Check one or more.)*

1. [230] No doctor(s) was available to treat your particular case
2. [139] There was a very long waiting list for an appointment so you were advised that it was better to go elsewhere
3. [94] The equipment required for your care was not available at that facility
4. [94] The facility was very busy and you preferred to go elsewhere for care
5. [9] No reason was given
6. [131] Other *(Describe.)* _____

6. How were you or your family told that you would have to go or could go elsewhere for care?

1. [12] By letter
2. [90] By telephone
3. [268] During a visit to the hospital
4. [72] Other *(Describe.)* _____

If you know, what kind of medical service did you or your family go elsewhere for? *(Check one or more.)*

1. [148] General Medicine for diagnosis, checkups or for illnesses usually treated in the doctor's office or usually treated by a general practitioner
2. [65] Emergency Medical services for such things as broken bones, burns, accidents, and cuts etc
3. [74] Surgical services
4. [118] Medical services for pregnancy and other care specifically for women. In other words Obstetrical or Gynecological care
5. [61] Pediatric or baby and child services
6. [64] X-rays of any type Radiology Service
7. [68] Internal Medicine services for treatment of organs kidney, liver, stomach digestive system, diet
8. [66] Treatment of heart, lungs, blood, respiratory or circulatory systems or Pulmonary Medical services
9. [48] Urology Services urinary tract infection and related problems
10. [78] Medical services for conditions of the bones, muscles, tendons such as breaks, strains or sprains In other words Orthopedic Services
11. [126] Eye care, diagnosis or treatment Opthalmology
12. [61] Ear, nose and throat care ENT
13. [24] Mental Health or Psychiatric Service
14. [34] Medical care for the nervous system; in other words Neurological Services
15. [30] Test or treatment of tumors or cancer
16. [31] Arthritis or rheumatism treatment
17. [41] Allergies
18. [59] Skin problem or Dermatology
19. [46] Other *(Describe.)*
20. [3] Don't know what type of care we were sent elsewhere for

APPENDIX II

8. Do you or anyone in your family have any long term disability or chronic illness such as diabetes, emphysema, multiple sclerosis, heart condition, cancer, hypertension, etc.

1. [177] Yes **(Continue.)**
2. [302] No **(GO TO 10.)**

9. If yes, did you or anyone in your family have to go or go elsewhere for treatments for this illness?

1. [130] Yes
2. [44] No

10. When you or your family were seeking care elsewhere, what did the military hospital people say about coming back later to the military facility for other visits? *(Check as appropriate, for you and/or your family, the statement that best describes what you or your family were told.)*

	FOR YOURSELF	FOR FAMILY
1. Told that while treatment was not available for this visit, it would be available in the future	[33]	[54]
2. Told that this particular illness could not be treated	[32]	[55]
3. Told that this and certain other particular illnesses could not be treated	[14]	[32]
4. Told that no treatment for any illness could be provided	[12]	[16]
5. Told little or nothing about future visits	[116]	[161]
6. Other *(Specify)* _____	[38]	[64]

REFERRAL INFORMATION

11 When you or anyone in your family were told that you would have to or could go elsewhere for medical care, how often, if ever, did the people at the facility tell you that it was important for you or your family to receive this care? *(Check one.)*

1. [142] Always or almost always
2. [23] Usually (about 3/4 of the time)
3. [19] About half the time
4. [26] Sometimes (about 1/4 of the time)
5. [208] Seldom if ever

12. When you or your family were told you would have to or could go elsewhere for care, how often, if ever, were the explanations on how to get care complete and useful? (Did they tell you what kind of care was needed, the kinds of facilities or doctors that would provide this care, how to locate and choose a doctor, what you could expect in terms of the quality of the care, the cost, the availability?) *(Check one.)*

1. [107] Always or almost always
2. [29] Usually (about 3/4 of the time)
3. [22] About half the time
4. [22] Sometimes (about 1/4 of the time)
5. [243] Seldom if ever

REFERRAL EXPERIENCE

13. After you or your family had been told to go some place else for health care, did you or they obtain some or all of this care? *(Check one.)*

1. [428] Yes **(GO TO 17.)**
2. [61] No **(Continue.)**

APPENDIX II

14. If no, why didn't you or your family obtain this care? *(Check all that apply.)*
    1. [10] Didn't know where to go or how to make arrangements
    2. [10] Couldn't find a doctor who would take CHAMPUS
    3. [24] I couldn't afford to pay for care myself
    4. [10] Didn't think this was serious enough
    5. [4] Couldn't find another place I trusted
    6. [3] Couldn't find the right type of doctor
    7. [16] Other *(Specify)*_____

15. Did not receiving this medical care have a bad effect on the health of you or your family? *(Check one.)*
    1. [14] Yes
    2. [16] No
    3. [27] Undecided

16. In your opinion, do you still need the medical care you did not obtain?
    1. [30] Yes
    2. [11] No
    3. [17] Undecided

GO TO 33 IF YOU DID NOT OBTAIN CARE.

17. Did any of the care you or your family obtained require spending time as a patient in the hospital overnight? *(Check one.)*
    1. [152] Yes
    2. [245] No

18. Did you have a difficult time getting some or all of the care you went elsewhere for? *(Check one.)*
    1. [77] Yes **(Continue.)**
    2. [320] No **(GO TO 20.)**

19. If yes, what kinds of difficulties did you have? *(Check all that apply.)*
    1. [30] Making arrangements
    2. [26] Finding a doctor who would accept CHAMPUS patients
    3. [38] Paying for care while waiting for reimbursement under the CHAMPUS program
    4. [22] Had to start treatment all over again
    5. [12] Other _____

20. Based on past experience, did you or your family get all the care elsewhere that you felt you would have obtained at the military facility? *(Check one.)*
    1. [267] Yes
    2. [83] Sometimes yes – Sometimes no
    3. [43] No

21. In general, how would you rate the quality of the overall care and attention you and your family received elsewhere compared to the overall care and attention usually received at the military facility? *(Check one.)*
    1. [141] Much better
    2. [100] Better
    3. [117] Just as good
    4. [11] Worse
    5. [5] Much worse
    6. [16] Sometimes better – Sometimes worse
    7. [14] No basis to judge

22. If payment was required, how was the care that you or your family obtained elsewhere paid for? Check the one box that best describes the way your total bill was paid. If no payment required (i.e. military hospital emergency room, VA or PHS Hospital, charity etc. Check No. 8)
    1. [140] Entirely out of your own pocket
    2. [77] CHAMPUS paid the doctor directly, and we paid a portion out of our pocket
    3. [55] We paid for all the care and then got reimbursed later by the CHAMPUS program
    4. [12] Medicare paid the doctor directly, we paid a portion out of our pocket
    5. [29] All or part was paid by a private health insurance program
    6. [29] Part was paid for by CHAMPUS, part was paid for by a supplemental insurance program, and part was paid for out of our own funds
    7. [27] Other *(Specify)*_____
    8. [36] No payment **(GO TO 32.)**

APPENDIX II

23. If you had to use any of your own money, regardless of whether or not you were later reimbursed by CHAMPUS or another insurance program, about how much did you have to use? *(Check one.)*

1. [180] $300 or less
2. [89] $301 to $600
3. [32] From $601 to $900
4. [19] From $901 to $1,200
5. [6] From $1,201 to $1,500
6. [20] From $1,501 to $3,000
7. [4] From $3,001 to $4,500
8. [2] From $4,501 to $6,000
9. [1] From $6,001 to $7,500
10. [1] Over $7,500 *(Specify)* _____

24. Again, if you had to use your own money, were you or do you expect to be reimbursed by CHAMPUS or an insurance program (i.e., private, medicare, medicaid etc.?) *(Check one.)*

1. [162] Yes **(Continue.)**
2. [190] No **(GO TO 29.)**

25. If yes, have you completed filing for reimbursements?

1. [117] Yes **(Continue.)**
2. [39] No **(GO TO 29.)**

26. If yes, have you received all the reimbursement you expect to get?

1. [74] Yes **(Continue.)**
2. [42] No **(GO TO 29.)**

27. If yes, how many months did it take to get reimbursement?

2[a/] *(number of months)*

28. About what percent of the money you have had to use has been reimbursed? *(Check one.)*

1. [13] 90% or over
2. [25] 75% – 89%
3. [14] 60% – 74%
4. [10] 45% – 59%
5. [7] 25% – 44%
6. [1] Below 25%

29. What financial difficulties, if any, were caused by your having to use your own money? *(Check one.)*

1. [152] Little or no financial difficulties.
2. [107] Some financial difficulties
3. [58] A moderate amount of financial difficulties
4. [23] A substantial or great amount of financial difficulty
5. [17] A very great deal of financial difficulty or hardship

30. So far we have been talking only about medical expense for care obtained elsewhere rather than at the military facility. Now we would like you to tell us about other additional medical expense which you may have had or have to pay. Consider health insurance, dental and eye care, other illnesses not considered by this questionnaire, transportation and other tax deductable medical costs. The question is between January 1 and December 31, 1978 did you or your family incur any other such health care expenses?

1. [271] Yes **(Continue.)**
2. [79] No **(GO TO 32.)**

31. If yes, approximately what was the total cost of these additional expenses? *(Check one.)*

1. [109] $300 or less
2. [82] $301 to $600
3. [39] From $601 to $900
4. [21] From $901 to $1,200
5. [11] From $1,201 to $1,500
6. [11] From $1,501 to $3,000
7. [2] From $3,001 to $4,500
8. [1] From $4,501 to $6,000
9. [-] Over $6,000 *(Specify)* _____

32. Forget about financial difficulties for the moment, and please tell us what effect, if any, did going elsewhere for medical care have on the health of you or your family? *(Check one.)*

1. [122] A very good effect
2. [104] Generally a good effect
3. [98] Little or no effect
4. [23] Generally a bad effect
5. [8] A very bad effect
6. [47] No basis to judge

APPENDIX II

PERCEPTION OF BENEFIT ENTITLEMENT

PLEASE NOTE: The questions below are designed to determine what you understand your benefit rights to be, how you came to understand those rights and how well you feel those benefits have been provided.

33. What do you believe your medical rights are, at this time? *(Check one.)*

1. [118] Free medical care in a military hospital or facility for both you and your family for as long as you live and until your dependents reach their 21st birthday.
2. [23] Free medical care in a military facility for you and your family if the facility in your area has enough space and the doctors to provide it. Otherwise you would have to pay for care yourself.
3. [324] Free medical care in a military facility if the facility in your area has enough space and the physicians to provide it Otherwise you would be able to receive care from private physicians and have some part of it paid by CHAMPUS.
4. [24] Other *(Describe.)* _____

34. Where did you get information about the medical benefits you believe you are entitled to? *(Check all that apply.)*

1. [103] Statements made to you by recruiters
2. [132] Information in recruitment or re-enlistment literature or advertising
3. [186] Information in the military press
4. [51] Statements made by elected officials
5. [179] Statements made by military officials
6. [65] Statements made by the leaders of retiree organizations
7. [192] Information in retiree guides or manuals
8. [80] Discussions with fellow retirees
9. [129] Discussions with career or retirement counselors
10. [77] Other *(Describe.)* _____

35. To what extent do you believe that you and your family are receiving the medical care to which you believe you are entitled?

1. [21] To a very great extent
2. [78] To a great extent
3. [135] To a moderate extent
4. [155] To some extent
5. [86] To little or no extent
6. [14] No basis to judge

36. Please tell us anything else you believe is important about your medical benefits, about the effects your experiences have had upon you or your family, or anything else which you think is of importance to our study which our questionnaire may have missed. Use the space below or an additional page if you need more space. Thank you for your help.

Sampling Errors of Active-Duty Members'

Responses Tabulated on Page 11

Question	Percent of "yes" responses at hospitals			
	Army	Navy	Air Force	Weighted average
2. Have you or your family been unable to get medical care at the military facility?				
Self	5.3	5.1	4.7	3.0
Family	5.8	5.8	5.4	3.3
3. Have you or your family been sent to another military facility to obtain medical care?				
Self	4.3	5.3	4.2	2.6
Family	4.6	5.4	4.2	2.7
4. Have you or your family had to or preferred to obtain care from sources outside the military system?				
Self	5.8	5.0	4.9	3.2
Family	6.2	6.1	5.6	3.5
5. Have you or your family had difficulty in obtaining or paying for care from sources outside the military system?				
Self	5.0	4.0	3.7	2.6
Family	5.8	5.4	4.9	3.2

Note: Sampling errors are stated in percentages. Sampling errors are given at the 95-percent confidence level. This means the chances are only 1 out of 20 that the estimates tabulated on page 11 could differ by more than the sampling errors shown above from the results that would be obtained if mailgrams were sent to all active-duty members.

Sampling Errors of Retirees' and Survivors' Responses Tabulated on Page 12

Question	Percent of "yes" responses at hospitals: Army	Navy	Air Force	Weighted average
2. Have you or your family been unable to get medical care at the military facility?				
Self	6.2	6.6	6.9	3.8
Family	6.6	7.2	7.1	4.0
3. Have you or your family been sent to another military facility to obtain medical care?				
Self	4.5	4.5	5.0	2.7
Family	4.5	4.7	4.6	2.7
4. Have you or your family had to or preferred to obtain care from sources outside the military system?				
Self	6.6	6.9	7.2	4.0
Family	7.2	7.8	7.2	4.3
5. Have you or your family had difficulty in obtaining or paying for care from sources outside the military system?				
Self	5.8	6.5	6.7	3.6
Family	6.5	7.4	7.0	4.0

Note: Sampling errors are stated in percentages. Sampling errors are given at the 95-percent confidence level. This means the chances are only 1 out of 20 that the estimates tabulated on page 12 could differ by more than the sampling errors shown above from the results that would be obtained if mailgrams were sent to all retirees and survivors.

Sampling Errors of Active-Duty and Retired Members and Family Members Who Tried To Obtain Medical Care

Descriptions of estimate (note a)	Number of persons	Sampling error (note b)
	(thousands)	
Active-duty and retired members who tried to obtain medical care	1,009	32
Unable to obtain medical care at military facilities:		
Active-duty members	104	15
Retired members	157	21
Obtained medical care outside the military system:		
Active-duty members	124	17
Retired members	201	23
Family members who tried to obtain medical care (note c)	1,012	31
Family members unable to obtain medical care at military facilities (note c)	344	28
Family members who obtained medical care outside the military system (note c)	520	32

a/Refers to estimates discussed on pages 12 and 13.

b/Sampling errors are given in terms of the number of persons. Sampling errors are stated at the 95-percent confidence level. This means the chances are only 1 out of 20 that the estimates could differ by more than the sampling errors shown from the results that would be obtained if mailgrams were sent to all active-duty members, retirees, and survivors.

c/Assumes only one family member required medical care for each positive mailgram response.

(101006)

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