

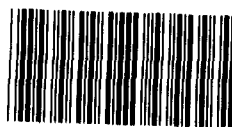
GAO

Report to the Honorable
Daniel K. Inouye, U.S. Senate

July 1991

PEACE CORPS

Long-Needed Improvements to Volunteers' Health Care System



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United States
General Accounting Office
Washington, D.C. 20548

National Security and
International Affairs Division

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July 3, 1991

The Honorable Daniel K. Inouye
United States Senate

Dear Senator Inouye:

This report responds to your request that we review the Peace Corps' health care system for volunteers. In response to problems we identified during our review, the Peace Corps has initiated efforts to improve (1) the quality of care for volunteers during their service and (2) the assistance provided to former volunteers with service-related medical conditions. We recommend that the Director of the Peace Corps follow through on these efforts and also ensure that former volunteers are informed of their health care benefits.

We are sending copies of this report to the Director of the Peace Corps and to other interested parties. Copies will be made available to others on request.

Please contact me at (202) 275-5790 if you have any questions concerning this report. The major contributors are listed in appendix I.

Sincerely yours,

Harold J. Johnson
Director, Foreign Economic
Assistance Issues

Executive Summary

Purpose

Peace Corps volunteers, many of whom work in impoverished countries that have poor health conditions, face a myriad of illnesses and injuries associated with their work. They depend on the Peace Corps to provide them with health care.

Senator Daniel K. Inouye asked GAO to review the adequacy and responsiveness of the Peace Corps' system for providing care to volunteers. GAO's objectives were to determine whether the agency's policies and procedures ensured that (1) volunteers received a level of health care comparable to what they would receive in the United States and (2) former volunteers with service-related medical conditions were aware of and receiving their health care entitlement.

Background

The Peace Corps Act of 1961 (P.L. 87-293) stipulates that volunteers receive health care during their service and health care benefits after they leave the agency for service-related medical conditions. Under the guidance of the Office of Medical Services, medical officers are expected to provide care to volunteers—including preventative and primary health care—that as closely as possible approximates the level of care available in the United States. Medical officers also are required to inform volunteers of the post-service benefits to which they are entitled under the Federal Employees Compensation Act (FECA). The Office of Medical Services must help former volunteers with service-related health problems file a claim for these benefits.

By the 1980s the Peace Corps had replaced most U.S.-trained physicians with registered nurses, most of whom were foreign-trained, for its medical officer positions. The Peace Corps' decision to switch to foreign-trained nurses was made for reasons of economy, lack of available doctors, and to employ more host country nationals.

Results in Brief

Although most volunteers and former volunteers contacted by GAO were satisfied with the quality of health care provided by the Peace Corps, GAO's review disclosed that the Peace Corps' health care system did not ensure that volunteers received a standard of care that closely approximated the level of care available in the United States. Furthermore, the agency did not have reliable and systematic data to know what quality of care was being provided. The capabilities of medical officers were not evaluated, and they received insufficient training and guidance from the Peace Corps. The health care system had not been subjected to a medical review by an independent accrediting organization comparing the

quality of care provided against U.S. standards. Because the Peace Corps had an inadequate health care system, volunteers sometimes received an inferior level of health care.

In addition, a GAO survey showed that from 10 to 30 percent of former volunteers had medical problems related to their Peace Corps service, and of these, about half had not filed a FECA claim for their problem. Some were unaware of these benefits and some had used their private insurance to cover medical expenses. Others who had sought help in filing a claim said they received inadequate assistance from the Office of Medical Services.

The Peace Corps began to correct many of these problems as a result of GAO's review, and some corrective actions, such as improving the FECA system and providing funds for medical officer orientation, had received Peace Corps attention before GAO's review. Although it was too early to assess whether these actions would correct all the long-standing problems, GAO was encouraged by the agency's response to them.

Principal Findings

Peace Corps' System Inadequate to Ensure a U.S. Standard of Health Care

GAO's survey of former volunteers showed that 73 percent were satisfied with the quality of health care that medical officers provided. Nonetheless, GAO found that the agency's policies and procedures for hiring and training its medical officers, as well as for monitoring their activities, were insufficient. For example,

- the Office of Medical Services did not test or otherwise assess its medical officers' ability to provide the required level of care;
- the scope of care that medical officers should be competent to provide had never been defined;
- orientations were not required for new medical officers;
- continuing medical education conferences were sporadic and too short to provide critical health care training and guidance to the medical officers; and
- in-country evaluations, the primary mechanism for monitoring the quality of care provided to volunteers, were conducted at 2-year intervals or longer and were sometimes incomplete.

As a result of these and other deficiencies, some of the medical officers contracted by the Peace Corps (1) may not be qualified to provide the

level of health care required by the specific conditions of a country, (2) were unfamiliar with or untrained in the Peace Corps' diagnostic and treatment procedures, and (3) provided care that was beyond their competence or did not follow Peace Corps guidelines. For example, two medical officers from Latin America had performed, without any training, pap smears on volunteers for 2 years. In addition, GAO's analysis of medical files showed many violations of the Peace Corps' health care guidelines, as well as instances of incorrect diagnosis and treatments. Peace Corps officials agreed that some of these problems could persist for months or even years before being discovered.

Health Care System Had Never Received an Independent Medical Review

Unlike the health care systems for the Department of Defense, the Department of Veterans Affairs, and the National Institutes of Health, the Peace Corps' health care system had never been reviewed by an independent agency such as the Joint Commission on Accreditation of Healthcare Organizations. Such reviews are common in the health care industry as a method of ensuring a uniformly high standard of care. The Joint Commission, for example, certifies most U.S. hospitals after comparing their services with national health care standards.

Inadequate FECA Assistance Provided to Some Former Volunteers

Because medical officers were not adequately trained on FECA benefits, many former volunteers were not aware of their post-service health care entitlement. Our survey of former volunteers showed that from 10 to 30 percent of former volunteers had medical problems related to their Peace Corps service, and about 50 percent had not filed a FECA claim. The survey also showed that from 48 to 68 percent had not received information about their FECA benefits. Former volunteers who had requested assistance from the Office of Medical Services in the past 2 years generally indicated that the assistance was adequate, possibly reflecting improvements in the Peace Corps' FECA program during this period. Former volunteers who had left the Peace Corps prior to this period generally said the assistance was not adequate.

Planned Improvements to the Peace Corps' Health Care System

The Office of Medical Services began to improve its health care system as a result of GAO's findings. These initiatives included (1) a 4-week orientation for all new medical officers, (2) annual training conferences, (3) a quality assurance program to improve health care monitoring and service delivery, and (4) an independent medical review.

In addition, the Office of Medical Services has taken a number of steps in response to problems GAO identified. These included (1) ensuring Office of Medical Services concurrence on the selection of medical officers, (2) institution of a new monitoring form designed to emphasize quality-of-care issues, and (3) development of a video to better inform current volunteers of their post-service health care benefits. Also, improvements to the Peace Corps' management of its FECA program, instituted prior to GAO's review, should help to alleviate some of the post-service problems voiced by former volunteers.

Recommendations

GAO recommends that the Director of the Peace Corps

- follow through on the initiatives announced and those it has begun to implement, including a plan to institute an independent evaluation by the Joint Commission on Accreditation of Healthcare Organizations or a similar organization, to improve the Peace Corps' health care system and
- require that all former volunteers be informed of their post-service health care benefits.

Agency Comments

Peace Corps program officials provided oral comments on this report, and their comments have been included as appropriate. Peace Corps officials generally agreed that the agency's system was inadequate for ensuring that volunteers received a level of care that approximated the care available in the United States. However, they stated that despite the health care system deficiencies identified by GAO, and being acted upon by the Peace Corps, the actual quality of care provided to volunteers was good. They pointed to GAO's survey of former volunteers, most of whom reported satisfaction with the health care they had received, as evidence.

GAO did not assess the overall quality of care the Peace Corps provided to its volunteers, but instead evaluated the adequacy of the Peace Corps' system for ensuring that its own medical guidelines were followed. GAO found, and the Peace Corps agreed, that its system could not provide this assurance. Furthermore, GAO found sufficient evidence of incorrect diagnoses and treatment that resulted from noncompliance of the Peace Corps' health care guidelines to conclude that improvements were needed in the agency's management of its health care program.

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Abbreviations

FECA Federal Employees Compensation Act
GAO General Accounting Office

Introduction

More than 130,000 volunteers have joined the Peace Corps since its inception in 1961 to help improve living conditions in about 100 countries worldwide. Currently, about 6,000 volunteers are working in 73 countries. While overseas, volunteers rely on the Peace Corps to provide them with the assistance and support necessary to do their work.

Among the primary areas of assistance provided to volunteers is health care. The volunteers often work in countries with poor health conditions and inadequate medical delivery systems, and the Peace Corps' goal for providing health care to them is to approximate, as closely as possible, the same level of health care available in the United States. Department of State medical services are not generally available to volunteers. After they leave the Peace Corps, volunteers with service-related illnesses or other medical conditions are eligible to receive health care benefits. The Peace Corps assists them in obtaining those benefits from the Department of Labor.

Foreign-Trained Nurses Replaced U.S.-Trained Physicians

In the Peace Corps' first decade, the health care of overseas volunteers was the responsibility of U.S.-trained physicians who were members of the U.S. Public Health Service. During the early 1970s, however, the Public Health Service was unable to provide doctors to the Peace Corps because of manpower shortages during the Vietnam War.

In response, the Peace Corps began to employ physicians directly, but it experienced the same recruitment difficulties as the Public Health Service. The difficulties of recruiting physicians in the early 1970s coincided with an agency initiative to reduce operating expenses and increase cross-cultural understanding by employing greater numbers of host country nationals, primarily as medical and administrative officers. As a result, U.S.-trained physicians were largely replaced by nurses trained outside the United States. In the mid-1970s, the Peace Corps converted its medical officer positions from employees of the Peace Corps to contract employees, further allowing the agency to reduce personnel costs.

By the 1980s, most Peace Corps medical officers were foreign-trained contract employees—largely registered nurses—hired in the Peace Corps country by the country director. Although the Peace Corps retained the authority to hire U.S.-trained physicians, it employed only a few in Africa. Table 1.1 shows the type and location of training of the 96 Peace Corps medical officers employed as of June 1991.

Table 1.1: Background Training of Peace Corps Medical Officers

Certification	Training location	Number
Registered nurse	Host or third country	48
	United States	21
Physician	Host or third country	14
	United States	9
Nurse practitioner	United States	4
Total		96

Source: Peace Corps.

Peace Corps Has Established Policies and Procedures for Providing Health Care

The Peace Corps Act of 1961 (P.L. 87-293) directs the Peace Corps to provide health care to volunteers. This care is to include examinations before service, immunizations and dental care in preparation for their service, health care during their service, and a health examination after termination of their service. The act also stipulates that former volunteers who suffer from service-related medical conditions are entitled to Federal Employee Compensation Act (FECA) benefits.

Peace Corps policies implementing the act are contained in the Peace Corps Manual. It mandates comprehensive health care for active service volunteers while in the United States and overseas. The manual states that the in-country medical officers are expected to provide the volunteers primary medical care at a Peace Corps medical office or at authorized facilities. Local specialists or consultants may be used as necessary. The manual also requires medical officers to inform volunteers of their medical benefits available under FECA.

The Peace Corps' Technical Guidelines for Overseas Medical Staff establishes uniform procedures and interprets Peace Corps policy as set forth in the Peace Corps Manual. The guidelines combine medical practices, clinical standards, and Peace Corps procedures and experience into diagnostic and treatment approaches for selected conditions. For example, the malaria guideline, written with the advice of the Malaria Branch of the Centers for Disease Control, provides medical officers with information on the prevention and treatment of malaria. The Peace Corps requires that all health care, whether provided by medical officers or local providers, strictly follow the procedures in the technical guidelines.

Office of Medical Services Oversees Health Care System

The Peace Corps' Office of Medical Services is responsible for managing the overall delivery of health care to volunteers. Its primary responsibilities are to establish medical policy and support medical officers in the field. It also is responsible for setting health care standards for medical officers, establishing diagnostic and treatment methods for volunteers' illnesses, conducting evaluations of Peace Corps medical officers and local medical facilities and services, analyzing data on the health conditions of volunteers, conducting medical education conferences for medical officers, and helping former volunteers obtain their FECA entitlement.

The in-county medical officers provide preventative and primary health care to volunteers. This care includes treating common illnesses and injuries in accordance with accepted professional standards as determined by the Office of Medical Services. For illnesses beyond their capabilities, medical officers can refer volunteers to local doctors, clinics, or hospitals, or medically evacuate them to a country with more advanced medical care.

The Office of Medical Services also provides a "close-of-service" medical examination and testing to all volunteers during the 60-day period before their term of service ends or up to 30 days after completion of duty in the United States. The Peace Corps authorizes evaluations in the United States of any service-related medical conditions that require further attention, and if new problems become evident, former volunteers may call the Office of Medical Services for additional authorizations during the first 6 months after they return.

Former volunteers with service-related medical conditions are entitled to health care through FECA. The entitlement, which has no time limit, includes the cost of medical, disability, and compensation for any medical conditions caused or aggravated by Peace Corps service. Volunteers are excluded from FECA coverage if their conditions result from willful misconduct, attempted suicide, or intoxication. Medical officers are required to inform volunteers of their right to file a claim under FECA, and the Office of Medical Services is required to assist former volunteers in completing and submitting a claim to the Department of Labor. The Department of Labor adjudicates all claims filed under FECA.

Objectives, Scope, and Methodology

We reviewed the Peace Corps' health care system at the request of Senator Daniel K. Inouye. GAO's objectives were to determine whether the agency's policies and procedures ensured that (1) volunteers received a

level of health care comparable to what they would receive in the United States and (2) former volunteers with service-related medical conditions were aware of and receiving their health care entitlement.

We reviewed records and interviewed Peace Corps officials, including the Director of the Peace Corps, at Peace Corps headquarters in Washington, D.C. Among the documents we reviewed were a history of medical services developed by the Office of Medical Services, other internal documents that assessed medical conditions at Peace Corps posts, and the Peace Corps Act. We reviewed all medical cable traffic for 1990, as well as reports from support/evaluation visits, the Peace Corps' primary method for assessing the health care provided to volunteers.

We accompanied Peace Corps representatives to Belize to evaluate their support/evaluation visit and to Guatemala to observe their continuing education conference. During the support/evaluation visit, we observed the Peace Corps evaluator assess the medical officer's performance, interview volunteers, and evaluate the local hospital, clinic, and other health care providers used by volunteers. At the continuing education conference, we attended all workshops and interviewed medical officers from Latin American and Caribbean posts to discuss the adequacy of their orientation, education, and Peace Corps support.

In addition, we visited six countries where Peace Corps volunteers were working: Mali, Senegal, Nepal, the Solomon Islands, Honduras, and Guatemala. We chose these locations because Peace Corps management identified them as representative of overall health care conditions in countries where the Peace Corps operates. At these locations, we reviewed health care documents and interviewed in-country staff and representatives of the local health care providers. We also interviewed Peace Corps volunteers about their health care experiences.

To assess the health care assistance provided to former volunteers, we attended the 1990 National Conference of Returned Peace Corps Volunteers, held at the University of Oregon, Eugene, Oregon, which attracted about 1,200 participants. At the conference, we interviewed 34 former volunteers who approached our booth about their overseas health care experiences and obtained their views on the adequacy of the Peace Corps' health care system, whether they had any service-related medical conditions, and their awareness of FECA medical benefits for these conditions.

At both the Peace Corps and the Department of Labor, we reviewed and discussed policies and procedures for providing FECA benefits to former volunteers. We also conducted a telephone survey of 92 former volunteers living in all parts of the United States about (1) the quality of care they received during their service, (2) their knowledge of the FECA health care entitlement, (3) whether they suffered from any service-related health problems, and (4) the adequacy of the Peace Corps' assistance in obtaining FECA benefits. All the former volunteers we surveyed had left the Peace Corps between 1988 and 1989. The survey percentages presented in this report have a 95 percent confidence level plus or minus 10 percent.

Our medical consultant reviewed 218 Peace Corps FECA files to determine whether the medical conditions in the claims had been identified in the close-of-service exams. With the exception of dental claims, these files represented all Peace Corps claims filed in 1990, as well as the 1989 FECA claims for the six countries that we visited. We discussed Peace Corps volunteers' FECA claims with Department of Labor officials.

We also met with representatives of the Joint Commission on Accreditation of Healthcare Organizations to discuss U.S. standards of care and the Peace Corps' health care system.

Peace Corps program officials provided oral comments on this report, and their comments have been incorporated as appropriate.

We conducted our review from June 1990 to April 1991 in accordance with generally accepted government auditing standards.

Peace Corps' Health Care System Was Inadequate to Ensure an Appropriate Level of Care

The Peace Corps' health care system did not ensure that volunteers received approximately the same level of care available in the United States. We found that the selection policy for medical officers was not followed, their in-house training was inadequate, and the procedures for monitoring their activities were insufficient. Specifically, those deficiencies included the following:

- Many Peace Corps country directors hired medical officers without obtaining approval from the Office of Medical Services, as required by Peace Corps regulations.
- The Office of Medical Services did not assess the competency of its medical officers.
- The Office of Medical Services had not clearly defined the scope of care that medical officers should be competent to provide.
- Training procedures, until 1991, did not ensure that medical officers received an orientation.
- The continuing education conferences were sporadic and too short.
- The Office of Medical Services did not adequately monitor the quality of care provided to volunteers.

Without adequate guidelines and controls in its health care system, the Peace Corps hired medical officers who were not trained to provide the level of care required, and some attempted to provide care that was beyond their competence or violated Peace Corps guidelines. In addition, the health care system had not been subjected to a medical review by an independent accrediting organization, which could have identified these deficiencies. The Peace Corps acknowledged the problems we identified and began to take steps to improve its health care system.

Selection Policy Was Not Consistently Followed

The Peace Corps Manual, which delineates the selection process for medical officers, states that the regional director in Washington, D.C., in consultation with the country director, selects the medical officer after the Office of Medical Services determines that the individual has the professional qualifications necessary to meet the health care needs in that country. In making that judgement, the Office of Medical Services is directed to consider (1) the medical delivery system available to volunteers in the country and (2) the past experience in that country concerning endemic diseases, serious diseases, medical evacuations, and environmental hazards. On the basis of that assessment, a medical officer with the qualifications of either a registered nurse, nurse practitioner, physician's assistant, or physician is to be selected.

However, according to officials in the Office of Medical Services, regional management in Washington, D.C., and Peace Corps officials overseas, medical officers were usually not selected in accordance with this policy. According to the Director of the Office of Medical Services, only about 30 percent of the country directors sought the Office of Medical Services' approval before selecting medical officers. The regional directors were even less involved in the selection process. We were told that because registered nurses were the least costly to employ compared with more qualified medical officers, country directors often selected them, and did so without prior Office of Medical Services' approval. Moreover, the Office of Medical Services had not made medical assessments on a country-by-country basis to determine the minimum qualifications necessary to meet the health care needs at each post. As a result, it could not be certain that its medical officers were competent to meet the specific health care needs of each country.

Office of Medical Services officials were unclear about their responsibilities in selecting medical officers until we brought it to their attention. Since then, they have informed country directors that the Office of Medical Services must determine that the candidate has the professional qualifications to meet the health needs in each country before the individual is employed.

Competencies of Medical Officers Were Not Assessed

Foreign-trained nurses generally do not receive training that is consistent with U.S. standards. This is demonstrated by the high failure rate of foreign-trained nurses who take examinations to practice in the United States. According to the Commission on Graduates of Foreign Nursing Schools, 85 percent of the foreign-trained nurses failed U.S. state licensing examinations prior to 1978. As a result of these failures, the U.S. Department of Health and Human Services established the Commission to test foreign-trained nurses in their home countries to assess whether they have the necessary qualifications, knowledge, and language skills to pass state licensing examinations before coming to the United States. Only one-third of the applicants pass the nursing and English portions of the examination on the first try.

Despite this failure rate, foreign-trained nurses hired as Peace Corps medical officers were not required to take the Commission's examination. In addition, the Office of Medical Services did not test any of its medical officers to assess their ability to provide a level of care consistent with Peace Corps guidelines. Without assessments of the medical

officers' skills, the Office of Medical Services had limited knowledge about the quality of care they were capable of providing volunteers.

Scope of Care to Be Provided Had Not Been Determined

The Office of Medical Service had never defined the scope of care its medical officers should be competent to provide. It had not determined whether its medical officers should provide basic diagnostic and curative procedures, referrals to local specialists, or something in-between. Without defining the basic procedures its medical officers should be competent to perform, the Office of Medical Services had been unable to develop the health care standards needed to evaluate their competence. As a result, it had never developed competency-based testing and did not evaluate the competence of its medical officers.

Medical officers told us that they were concerned that the Peace Corps expected them to provide care they were not competent to provide. For example, two medical officers from Latin America, without any training, had performed pap smears on volunteers for 2 years. They did not know whether they were performing the procedure correctly. The new Solomon Islands medical officer, a registered nurse, said that she was expected to prescribe drugs and diagnose and treat many health problems of volunteers. She said this level of treatment was beyond the typical duties specified for a registered nurse. On the basis of our discussions, members of the Joint Commission on Accreditation of Healthcare Organizations and the American Nursing Association confirmed that foreign-trained registered nurses are generally not qualified to perform such procedures.

Orientation Not Provided to Most Medical Officers

Office of Medical Services officials said that orientation training was critical to ensure that volunteers receive adequate care. Such training is a key mechanism to promote an immediate understanding of the medical officer's role and responsibilities and of the importance of complying with the Peace Corps' health care guidelines. However, the Office of Medical Services had no procedures or funding to ensure that orientations were provided to all medical officers, and we found that most medical officers did not receive an orientation.

In the past, the Office of Medical Services had provided orientations on an ad hoc basis. Medical officers might have received an orientation if they were in Washington, D.C., accompanying a medical evacuation or for other business. Office of Medical Services officials said they could

not schedule orientation for medical officers because country directors, not the Office of Medical Services, controlled transportation funds.

In fiscal year 1991, funding was approved to provide a 1-week orientation to new medical officers. Office of Medical Services officials, however, said that 1 week was not long enough to provide all the necessary information on health care guidelines. In contrast, the Peace Corps routinely provided 4 weeks of orientation to local national personnel hired as area directors and administrators.

In the six countries we visited, only one of the medical officers received a formal orientation. In Senegal, the area Peace Corps medical officer, a U.S.-trained physician, said that his orientation was inadequate because it lacked both diagnostic and treatment regimes for local diseases and did not include language training. In the Solomon Islands, the medical officer had not received an orientation and said this could lead to providing treatments that were not sanctioned by the Peace Corps. The medical officer in Mali, a Cuban-trained physician, received no orientation, in spite of her limited experience with Malian health care problems, and she told us that the Peace Corps had not provided her with information on how to meet U.S. health care standards or follow Peace Corps medical procedures. Volunteers we spoke with in some of the countries we visited expressed concern about the diagnosis and treatment that they received for local diseases and whether there was effective communications with local providers.

Continuing Education Was Sporadic

Continuing education conferences are the Peace Corps' primary training forum. A key purpose of the conferences is to ensure that all medical officers receive training in the diagnosis and treatment of volunteers' health problems so that the care conforms with U.S. standards whenever possible. However, the frequency of continuing education conferences has fluctuated over the years, and the information provided at the conferences was not sufficient to produce the required quality of care.

In the past, the conferences had been held in each of the Peace Corps' three geographic regions once every 3 or 4 years. The Office of Medical Services began scheduling the conferences at 2-year intervals beginning in 1989. Office of Medical Services officials believed that even biannual conferences were insufficient to provide the training necessary to ensure the quality of care.

To evaluate the quality of medical officer training, we attended the 1990 Continuing Medical Education Conference for all Latin American and Caribbean medical officers in Honduras. On the basis of our observations, we found that the medical officers were not familiar with the Peace Corps' diagnostic and treatment procedures. During seminars on diarrheal diseases, skin diseases, and antibiotic therapy, medical officers were not familiar with the Peace Corps' approved medical procedures even after the proper diagnosis was identified by the Peace Corps instructor. Moreover, the instructors did not have time to teach the medical officers the correct procedures.

Both the Director of Volunteer Services and the Deputy Director of the Office of Medical Services said the training offered at the conference was insufficient to ensure that volunteers receive health care consistent with the technical guidelines. In addition, a chief of operations from one of the Peace Corps' three regions said that the skills of medical officers were not adequate. She said that foreign-trained nurses could not provide a U.S. standard of care without additional training above the registered nurse level. Peace Corps officials also told us that the problems we identified at the medical education conference were typical of these conferences.

In our review of 1990 medical files, we found many violations of the technical guidelines, as well as instances of incorrect diagnosis and treatment. In all instances, it was the Office of Medical Services that determined that the medical officers had failed to follow Peace Corps guidelines. In Africa and the Solomon Islands, the medical officers provided incorrect malaria treatments to volunteers. A volunteer in Africa contracted hepatitis after a 4-month delay in vaccination, and in Thailand, Cameroon, and Tunisia, volunteers received their vaccinations more than 10 months late. Rabies vaccines were given incorrectly in Belize and several African countries. In Kiribati, a nation of Pacific islands, a volunteer was given a drug for diarrhea that is prescribed only for typhoid. These problems and others were identified only after volunteers had received the substandard care.

In the six countries we visited, all the medical officers, except the new medical officer in the Solomon Islands, had attended a continuing medical education conference. The medical officers whom we spoke with at the conference generally indicated that the training was critical but insufficient. The medical officer in Mali said that her conference training was inadequate because, in spite of her limited experience with

Malian health problems, she had received no training on the diagnosis or treatment of local diseases.

The medical officers in Guatemala said the conferences did not provide enough training on clinical and diagnostic skills or on how to approximate a U.S. standard of care. Although the Solomon Islands medical officer had been recently employed, she said she had not been trained on how to provide health care to volunteers in accordance with Peace Corps guidelines. She said she needed additional training in her diagnostic and treatment skills, as well as information to determine if she was following Peace Corps guidelines. The Honduran medical officers said that they believed the conferences should be held annually and that additional training would improve the quality of health care.

Procedures for Monitoring Health Care Were Inadequate

The Peace Corps has two methods for monitoring the quality of care provided to volunteers—support/evaluation visits and close-of-service reviews. We found, however, that neither mechanism adequately evaluated the appropriateness of the care provided or resolved all identified problems. Office of Medical Services officials acknowledged that, as a result, some of their medical officers could provide care to volunteers that was not consistent with their guidelines for months or years without being discovered.

Support/Evaluation Visits

Office of Medical Services guidelines stipulate that it will conduct a support/evaluation visit to each Peace Corps country once every 2 years. The purpose of the visit is to assess the quality of health care provided to volunteers by the medical officers and the quality of local health facilities used by the Peace Corps, such as hospitals, clinics, and laboratories. After the visit, the Office of Medical Services evaluator is to prepare a report for the medical officer, including guidance for correcting any problems.

The procedures for the support/evaluation visits had several deficiencies that limited their usefulness. Because the visits occurred at 2-year intervals, problems could persist for months or years before they were recognized by the Office of Medical Services. Further, the visits did not always occur every 2 years as required; reports on the visits were not always prepared; and, finally, the visits lacked a follow-up mechanism to verify that the evaluators' recommendations, when made, were implemented.

Chapter 2
Peace Corps' Health Care System Was
Inadequate to Ensure an Appropriate Level
of Care

In addition, the Office of Medical Services had not developed guidelines for evaluating local health care facilities used by volunteers, and the Office of Medical Services' staff were not trained or qualified to accurately assess local hospitals, clinics, and laboratories. Peace Corps officials acknowledged that the evaluations of the local facilities were inadequate to assess the quality of services used by volunteers. Peace Corps documents indicate that one death occurred at least in part because a laboratory used by the Peace Corps did not follow Peace Corps medical guidance and failed to make a complete diagnosis.

During the Belize visit, the evaluation of the hospital lasted only 30 minutes. The Office of Medical Services' evaluator did not meet with the hospital administrator, chief executive officer, president of the medical staff, or with any other representatives except the director of the blood bank. No hospital procedures, policies, or protocols were reviewed, and he did not obtain copies of the providers' certifications, licenses, or curricula vitae to determine their qualifications. The reviews of the dentist and gynecologist were only slightly more thorough. The director of the local laboratory used by the Peace Corps for the past 13 years stated that she could not remember ever being evaluated by the Peace Corps during this period.

In the six countries we visited, we found various problems that diminished the effectiveness of the support/evaluation visits.

- In Senegal and Mali, the medical officers did not know the results or recommendations of the 1990 visits.
- The Office of Medical Services' evaluator who visited Honduras in 1990 said her review of the local health care providers was weak because she was not trained to evaluate local facilities.
- The report on the Solomon Islands visit was incomplete, lacking required information such as an assessment of the medical officer's performance, an evaluation of the post-medical evacuation plan, and a review of the health care contracts and other medical arrangements. In addition, more than 2 years elapsed between visits, and the report of the previous visit took over a year to reach the islands.
- The Office of Medical Services had not conducted a visit in Nepal in 3 years and had never conducted a visit during the current medical officer's tour.
- The medical officer in Belize said that she neither was briefed on the evaluator's recommendations nor saw the 1988 report.

Close-Of-Service Reviews

During the close-of-service reviews, the Peace Corps' other monitoring mechanism, Office of Medical Services nurses review 25 percent of the health jackets of volunteers who recently left the Peace Corps. The review is intended to assess the quality of health care provided to volunteers.

However, the reviews had several deficiencies that limited their effectiveness. They were performed 6 to 9 months after the volunteer left the Peace Corps, allowing any problems to persist for months or longer. In Zaire, for example, the medical officer had not complied with the Peace Corps' technical guidelines for years. Also, the Office of Medical Services staff were not specifically trained to conduct these reviews, and the medical documentation was often inadequate to assess the appropriateness of volunteer care. Furthermore, the review was primarily an administrative assessment and did not focus on the quality of diagnosis and treatment received by volunteers.

Health Care System Had Never Received an Independent Medical Review

The Peace Corps' health care system, unlike the health care systems for the Department of Defense, the Department of Veterans Affairs, and the National Institutes of Health, had never been reviewed or certified by the Joint Commission on Accreditation of Healthcare Organizations or a similar agency. The Joint Commission, which has certified 75 percent of the nation's 7,100 hospitals, is a nonprofit organization that sets national standards of care and evaluates health care systems against those standards.

We, along with Peace Corps representatives, met with Joint Commission officials to obtain their views on the issues identified during our review and to discuss their potential review of the Peace Corps' health care system. On the basis of our description of our findings, the Joint Commission officials said that the Peace Corps' health care system did not appear to have adequate procedures to provide volunteers the level of care to which they were entitled. They also said that because the Peace Corps had not evaluated the ability of foreign-trained nurses to replace U.S.-trained physicians, the agency did not know whether its medical officers were competent to provide volunteer care. The officials said that the Peace Corps' health care system would benefit from a review by the Joint Commission or a similar agency.

The Peace Corps Director of Volunteer Services and the Director of the Office of Medical Services said that they supported a review by the

Joint Commission or a similar agency. According to the Director of Volunteer Services, a review could effectively assess the Peace Corps' health care system against standards, identify areas for improvement, and reassure volunteers and the public that its medical system provided care that was as close as possible to the care available in the United States.

Planned Improvements to Peace Corps' Health Care System

The Peace Corps has initiated steps to improve its health care system. In January 1991, the Director of the Peace Corps approved the allocation of \$386,000 in fiscal year 1991 funds to implement both immediate and long-term improvements, including (1) a 4-week orientation for all new medical officers, (2) annual continuing medical education conferences for all medical officers, (3) establishment of a quality assurance program, and (4) an independent medical evaluation and development of a plan for periodic independent medical reviews by the Joint Commission or a similar agency.

As of June 1991, the Peace Corps had implemented several improvements to its health care system. The Peace Corps had

- held two 4-week orientations for new medical officers;
- hired a contractor and formed a quality assurance committee that have begun to review the Peace Corps' structure, functions, and standards for health care delivery;
- reimposed the Office of Medical Services' selection authority for medical officers as outlined in the Peace Corps Manual; and
- developed a new close-of-service review form emphasizing issues involving the quality of care provided.

The Peace Corps plans additional improvements over the next several years. During fiscal year 1991, it plans to begin annual education conferences and obtain the contractor's preliminary recommendations to improve its health care system. In fiscal year 1992, the Peace Corps plans to (1) implement a quality assurance program, (2) develop new health care standards and guidelines, (3) initiate a strategy that will lead to an outside medical review, and (4) assess information needs for the effective monitoring of its health care system. In fiscal year 1994, the agency plans to have its health care system evaluated by the Joint Commission or a similar organization.

Conclusions

The Peace Corps' procedures for the selection, training, and monitoring of medical officers must be improved if volunteers are to receive a level of care consistent with Peace Corps guidelines. Because of insufficient guidelines and the lack of adequate controls, some volunteers received incorrect diagnosis and treatment by Peace Corps medical officers. The Peace Corps' corrective action plan marked an important step toward improving the quality of care provided to volunteers. An outside medical review, as planned by the Peace Corps, could help institutionalize these and future improvements and help volunteers receive the level of health care to which they are entitled.

Recommendation

GAO recommends that the Director of the Peace Corps follow through on the initiatives announced and those it has begun to implement, including a plan to institute an independent evaluation by the Joint Commission on Accreditation of Healthcare Organizations or a similar organization, to improve the Peace Corps' health care system.

Agency Comments and Our Evaluation

Peace Corps officials who provided oral comments on a draft of this report generally agreed that the agency's system was inadequate for ensuring that volunteers received a standard of health care that approximated the level of care available in the United States. They stated, however, that despite the health care system deficiencies that we identified, and that they were in the process of correcting, the actual quality of health care provided to volunteers was good. They pointed to our survey of former volunteers, most of whom were satisfied with the quality of care received, as well as to their own discussions with volunteers in the field, as evidence that volunteers were provided adequate health care.

We did not assess the actual quality of care the Peace Corps provided its volunteers, and this report draws no overall conclusions about whether the quality of care was good or poor. Instead, we evaluated the adequacy of the Peace Corps' management system for ensuring that its own medical system guidelines were being followed. We found that the agency's management system was inadequate and concluded that the Peace Corps' system could not provide reasonable assurance that its guidelines were being followed and that quality care was being provided. Furthermore, we identified sufficient evidence of violations of the technical guidelines, as well as incorrect diagnoses and treatment resulting from noncompliance with the Peace Corps medical guidelines,

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Inadequate to Ensure an Appropriate Level
of Care

to conclude that not all volunteers had received quality health care and that improvements to the system were needed.

Former Volunteers With Service-Related Health Problems May Not Receive Health Benefits

Although former Peace Corps volunteers are entitled to FECA benefits for any service-related health problems, and although these benefits are described in the Peace Corps Manual provided to each volunteer, we found that many former volunteers were not aware of their FECA benefits. In addition, the Peace Corps had not adequately helped former volunteers file FECA claims. The Peace Corps had already recognized some of these problems and initiated improvements. However, because the agency did not plan to inform all former volunteers of their potential FECA eligibility, some who are suffering from service-related health conditions may not obtain their health care entitlement.

Administrative Processing of FECA Benefits

The Peace Corps' management of its FECA responsibility is split between the in-country medical officers and the Office of Medical Service. The medical officers are required by the Peace Corps to inform current volunteers of their FECA benefits, their right to file a FECA claim, what assistance is available to them, and the appropriate procedures. The Office of Medical Services helps former volunteers complete and file FECA claims, as required by the Office of Personnel Management regulations governing the initiation of medical claims against the federal government. The Peace Corps receives about 85 calls a week from former volunteers unfamiliar with their FECA benefits and procedures.

FECA claims for volunteers are adjudicated by the Department of Labor, which adjudicates FECA claims for all federal agencies. The Department of Labor can refute volunteers' claims that their health conditions are service-related by demonstrating that the conditions existed prior to their Peace Corps service. However, 98 percent of Peace Corps claims are adjudicated in favor of the former volunteers.

Many Former Volunteers Were Not Aware of Their FECA Entitlement

The Peace Corps is required to inform volunteers about their FECA eligibility, both at the beginning of their service and at the end. All volunteers receive a Peace Corps Manual, which includes information on FECA benefits, at the beginning of their service, and medical officers are required to inform volunteers about these benefits before they leave the Peace Corps.

However, the results of our telephone survey and interviews with former volunteers suggested that most former volunteers were not aware of their FECA benefits. On the basis of our sample of 92 former volunteers who had left the Peace Corps within the past 2 years, we estimate that 48 to 68 percent of the former volunteers would say they

had not received information about their FECA benefits. At the National Conference for Returned Volunteers, we spoke with 34 former volunteers who had left the Peace Corps during the 1960s, 1970s, and 1980s. Of these, only five said they generally knew about their post-service health care benefits. Their less favorable comments may reflect the condition of the FECA program before the Peace Corps' improvements to it over the last several years.

Further, the Office of Medical Services was not effective in providing FECA information to its medical officers. We found that medical officers received little or no formal training on FECA benefits or procedures for filing a claim. The Director of the Office of Medical Services said that in most cases medical officers could not answer volunteers' questions about the FECA entitlement.

Assistance in Filing Claims Has Not Always Been Adequate

The Peace Corps has improved its assistance to volunteers over the last several years. This was borne out by our survey, which indicated that volunteers who requested assistance within the past 2 years were generally satisfied with their assistance, whereas former volunteers interviewed at the national conference who had sought assistance prior to these improvements indicated that their assistance had not been adequate.

The Director of the Office of Returned Volunteer Services and the Director of Volunteer Services acknowledged that the FECA assistance program had been inadequate. The two staff members providing FECA assistance were not trained and did not receive guidelines on FECA benefits. They also lacked the medical experience necessary to successfully support FECA claims when initially submitted to the Department of Labor. As a result, FECA claims were being delayed because of paperwork problems.

Over the past 2 years, the Peace Corps has improved its management of the FECA assistance program. The agency hired an experienced FECA administrator, who was also a nurse, to manage the program. The manager (1) developed standard operating procedures on FECA benefits for the FECA staff; (2) initiated new procedures to more effectively support FECA claims and reduce paperwork problems; (3) arranged three meetings between Peace Corps and Department of Labor representatives to increase understanding of the Peace Corps' needs and the Department of Labor's FECA process; (4) presented information on FECA issues at the national conference in Eugene, Oregon; (5) increased the number of staff

to provide FECA assistance from two to four, including two with nursing experience; and (6) provided information on FECA benefits for articles in newsletters for former volunteers.

The Peace Corps also began to improve the FECA information provided to current volunteers. The Peace Corps sent volunteers a one-page FECA information sheet in March 1990 and planned another mailing in 1991. The manager also planned to develop a Peace Corps FECA handbook that would complement a packet of information sent to former volunteers who believe they have service-related health problems and that would list FECA benefits, limitations, and procedures.

In response to our concerns that medical officers were not effectively advising current volunteers about their FECA benefits and procedures for filing a claim, the Peace Corps provided funding for the development of a video on FECA. The Peace Corps planned to develop the video in 1991 and present it at the beginning and end of each volunteer's service.

All Eligible Former Volunteers May Still Not Receive FECA Benefits

A significant number of former volunteers may be affected by service-related medical conditions but may not be aware of their health benefits. Although the Peace Corps has initiated steps to better inform current volunteers of their FECA benefits, it did not plan to inform volunteers who left the Peace Corps before these improvements began. As a result, some former volunteers who are eligible for and need FECA health care benefits may continue to be unaware of the benefits and may not obtain them.

Our telephone survey, questionnaires, and analysis of FECA claims indicated that a significant number of former volunteers could have service-related health problems. On the basis of our survey sample, in which 21 percent said they had a service-related medical problem, we are 95 percent confident that from 10 to 30 percent of the former volunteers would say they have medical problems related to their Peace Corps service. Of these respondents, more than 50 percent said they did not file a FECA claim for their problem. They generally said they did not file a claim because they were not aware of the FECA benefit or the process for obtaining the FECA benefit. The Peace Corps had never surveyed former volunteers about potential service-related health problems. In 1989, the Peace Corps prepared, but never sent out, a survey questionnaire to measure these and other potential problems associated with former volunteers.

In addition, of the 34 former volunteers at the National Conference who we interviewed and who completed questionnaires, 16 believed they had service-related illnesses or other medical conditions. These included hepatitis; parasites; chronic kidney infections; tuberculosis; acute loss of sight, hearing, and use of limbs; malaria; and psychological problems. Only five former volunteers said they were generally aware of their FECA benefits.

Finally, our medical consultant found that in 27 of the 218 Peace Corps FECA cases analyzed, the medical officers failed to identify medical problems present at the close-of-service examination. The fact that the volunteers' medical problems most likely occurred during their Peace Corps service raises questions concerning the adequacy of the close-of-service examination and the potential for volunteers to suffer from service-related problems after their Peace Corps service.

The Director for the Office of Returned Volunteer Services said that, in her opinion, there were many more former volunteers with service-related medical problems than the Peace Corps realized. In general, she said, only former volunteers who knew about FECA and did not have personal health insurance contacted the Peace Corps to file a FECA claim. Those former volunteers who had little or no knowledge about FECA ultimately handled their service-related medical condition by themselves or through private health insurance.

Conclusions

Although the Peace Corps has improved its FECA assistance program, it did not plan to inform all former volunteers of their FECA entitlement, many of whom left the Peace Corps prior to these improvements and may have service-related medical conditions.

Recommendation

We recommend that the Director of the Peace Corps inform all former volunteers of their FECA entitlement. Returned Peace Corps volunteer groups, the National Council for Returned Volunteers, and the Peace Corps publications sent to former volunteers could be used to disseminate this information.

Agency Comments and Our Evaluation

In commenting orally on a draft of this report, Peace Corps officials stated that the agency is planning to at least partially implement our recommendation by sending FECA information to former volunteers for whom it has mailing addresses. The agency did not plan, however, to use

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Health Benefits

the organizations of returned volunteers or Peace Corps publications to ensure a more complete dissemination of this information.

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