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Report to the Congress; by Elmer B. Staats, Comptroller General.

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The military departments do not have uniform procedures for preparing budget estimates, accounting for costs, measuring workload, and staffing medical facilities. Lacking comparable accounting and workload information, the Department of Defense (DOD) has been unable to make cost comparisons and evaluations of the management of military medical resources.
Findings/Conclusions: Following an interim report, DOD officials developed and are testing a system based on a uniform chart of accounts for hospitals. DOD plans to develop uniform bugeting and staffing procedures for military medical facilities.
Recommendations: The Secretary of Defense should initiate uniform procedures for the accumulation and reporting of the military services' medical facility costs which are to be included in their operations and maintenance budget submissions: develop and issue uniform staffing criteria for military health care facilities; require that responsible Defense managers analyze uniform financial and workload information when it is developed and reported and take the necessary actions to allocate medical resources effectively and efficiently; and require that internal auditors participate in the development of uniform cost and workload systems for military medical facilities in order to assure that sufficient internal controls are included in the systems. (Author/SC)

5090

REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Uniform Accounting And Workload Measurement Systems Needed For Department Of Defense Medical Facilities

The military departments do not have uniform procedures for preparing budget estimates, accounting for costs, measuring workload, and staffing medical facilities. Lacking comparable accounting and workload information, the Department of Defense has been unable to make cost comparisons and evaluations of the management of military medical resources.

Following a GAO presentation and interim report of these matters to Defense officials, Defense developed and is testing a system based on a uniform chart of accounts for hospitals. Defense plans to develop uniform budgeting and staffing procedures for medical facilities. GAO supports these efforts and is making several recommendations to improve information Defense needs for managing its medical resources.

FGMSD-77-8

JANUARY 17, 1978

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

B-133142

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

This report shows that the Department of Defense needs better cost and workload information to manage resources used at military medical facilities. The report also shows that Defense needs uniform procedures for budgeting for and staffing its health care facilities.

We performed our review because we believe there is a need for Defense to institute better controls over the increasing costs of medical care. Defense spends over $2.5 billion annually to provide health care for active and retired military personnel, their dependents, and survivors. The need for better management of military medical resources was the subject of extensive hearings by the Subcommittee on Defense, House Committee on Appropriations, in 1974.

Defense officials concurred with our findings and recommendations and have initiated or planned actions which, when implemented, should result in better information for managing medical resources.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53) and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Defense; and the Secretaries of the Army, Navy, and Air Force.

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

UNIFORM ACCOUNTING AND WORKLOAD MEASUREMENT SYSTEMS NEEDED FOR DEPARTMENT OF DEFENSE MEDICAL FACILITIES

D I G E S T

Deficiencies in the military departments' budgeting, accounting, and workload measurement systems have resulted in the Department of Defense having inadequate information to manage its military health care resources effectively. (See ch. 6.)

Over 9 million active and retired military personnel and their dependents and survivors are eligible to receive health care and services from the Department of Defense. These services are provided primarily through a worldwide system of approximately 180 hospitals and 160 clinics for which Defense spent about $2.3 billion in fiscal year 1976.

NEED FOR UNIFORM PROCEDURES

The military departments do not have uniform procedures for preparing budget estimates, accounting for and reporting operating costs, and measuring workload of medical facilities. Lacking comparable cost accounting and workload information, Defense has been unable to make meaningful interservice cost comparisons or to evaluate the efficiency of the military services' medical departments.

Defense instructions contain little or no guidance to the military departments on maintaining and reporting workload and accounting information for medical activities and on submitting budget data. As a result, each military department has prescribed its own procedures for preparing budget data and accumulating costs and workload information. These independently established procedures lack uniformity. There are variances in the

--types of costs included in the operations and maintenance budgets of each military department,

--accumulation of workload statistics in areas such as outpatient visits, dental procedures, and X-ray exposures, and

--distribution of costs to functions within the hospitals.

The military services also lack uniform criteria for staffing medical facilities. GAO found wide differences in the military services' staffing and workload in some medical functions.

In a recent report, GAO also cited variances in the military services' methods of accounting for health care costs. These discrepancies contributed to Defense's failure to recover about $12 million annually in reimbursable medical services (FGMSD-76-102, dated Mar. 8, 1977). Defense officials agreed that standard accounting procedures are needed to assure that all reimbursable costs are identified.

DIFFICULTIES IN ANALYZING MEDICAL COST AND WORKLOAD INFORMATION

Defense has, for a long time, experienced difficulties in making meaningful comparisons of the cost and workload information provided by the military departments on their need for, and use of, medical resources. Numerous studies dating as far back as 1965 have identified problems that hamper effective management control over Defense's health care facilities. Problems identified in these studies included:

--Lack of central management responsibility in Defense for medical programs of the military departments.

--Inadequate guidelines to insure that uniform workload measurement techniques are used by all Defense health care facilities.

--Differences in accounting practices among the military departments which make meaningful financial comparisons impossible.

Additional Defense studies on these problems and on other management concerns are now being conducted. (See p. 16.)

Although there were differences in the accounting practices and systems being used, this does not necessarily indicate that systems were ineffective or that medical resources were not effectively utilized. GAO believes, however, that information reported to Defense needs to be standardized so that Defense can compare and evaluate cost and workload data. Such comparisons will facilitate decisions on the allocation of resources and help Defense identify areas where efficiency can be improved.

Following a GAO interim report, Defense developed a system based on a uniform chart of accounts and is testing the system at 10 military medical facilities. Defense believes that use of the system will result in uniform cost and workload reporting by medical facilities, and Defense officials stated that worldwide implementation is scheduled for October 1, 1979.

GAO recommends that the Secretary of Defense

--initiate uniform procedures for the accumulation and reporting of the military services' medical facility costs which are to be included in their operations and maintenance budget submissions,

--develop and issue uniform staffing criteria for military health care facilities,

--require that responsible Defense managers (1) analyze uniform financial and workload information when it is developed and reported and (2) take the necessary actions to allocate medical resources effectively and efficiently, and

--require that internal auditors participate in the development of uniform cost and workload systems for military medical facilities in order to assure that sufficient internal controls are included in the systems.

Defense concurred with GAO's recommendations and outlined the steps it will take to implement them. (See app. I.)

Contents

CHAPTER 1

INTRODUCTION

Over 9 million active duty and retired military personnel and their dependents and survivors are eligible to receive military-supported health care. The Department of Defense is responsible for providing this care through its military health care system which includes 180 hospitals and 160 clinics. Supplemental care is also provided from civilian sources under the Civilian Health and Medical Program of the Uniformed Services.

The Congress has been concerned for some time about Defense's budgeting for and management control over its medical programs, especially in view of rapidly rising health care costs. In fiscal year 1976 Defense spent about $2.3 billion to provide health care in military hospitals and clinics. For fiscal year 1977, about $2.5 billion was programed for this purpose. In 1974 the Subcommittee on Defense, House Committee on Appropriations, held extensive hearings and pointed out the need for better management of medical resources.

Increasing medical care costs add to the importance of maintaining and using effective budgeting, accounting, workload measurement, and staffing systems.

REQUIREMENT FOR SYSTEMS APPROVAL

The Accounting and Auditing Act of 1950 requires the Comptroller General to approve executive agency accounting systems when he finds them to be adequate and in conformity with GAO's prescribed principles, standards, and related requirements.

The military services' hospital accounting systems are not separately identified in Defense's official inventory of accounting systems. Hospital accounting systems relating to fund accounting are a part of, or segments of, other much larger systems which are included in the inventory, such as the Air Force's General Accounting and Finance System. To date none of these larger systems have been approved. However, the new uniform accounting system presently being tested by Defense may be subject to GAO approval.

CHAPTER 2

MANAGEMENT OF MEDICAL SERVICES CAN BE IMPROVED THROUGH BETTER WORKLOAD MEASUREMENT

Workload and cost data accumulated by each of the military medical departments has lacked uniformity. As a result, Defense could not make valid interservice comparisons of medical resource utilization. We identified major differences in how data is accumulated and reported for several hospital functions. Further, we found that Defense's prescribed overall measurement of hospital workload is inadequate.

Management of medical services could be improved if Defense had adequate data to evaluate and compare the workload of medical facilities throughout the military health care system. For example, after making some necessary adjustments to reported data, we were able to compare two hospital functions in the six hospitals visited and we found large variances between the number of work units completed and the resources allocated to each hospital. Defense investigation of the cause of such variances could lead to better utilization of its medical resources.

COMPARISONS OF WORKLOAD AND COSTS IN SELECTED MILITARY HOSPITALS

We selected for review and comparison the cost and workload measurement systems supporting three hospital functions--dentistry, food service, and radiology. Procedures for accumulating costs and workload data varied among the three services for all three functions. For the dental function, we were able to make appropriate adjustments so that costs and workload could be compared. The differences in accumulating workload and cost for food service were not significant enough to warrant adjustments in order to make comparisons. For the radiological function, the methods used to measure workload varied so much that it was not practical for us to adjust the data thus precluding any comparisons of cost and workload.

The differences in procedures among the military services is caused by a lack of Defense guidelines. Each service, working independently, has devised its own system.

Details of our review of the three hospital functions follow:

Dental

Although all three services used dental procedures completed as a common workload measurement, each service had a different method for determining what constituted a dental procedure. For example, each service used a different system to define and record procedures for fillings and casts for dentures.

Also, the Air Force measured its workload in weighted procedures which considered the complexity of dental care. The Army and Navy did not use weighted procedures.

The military services also accumulated costs for the dental functions in different ways. Dental laboratory costs in the Air Force were accounted for separately from other dental costs, whereas the Army and Navy systems included laboratory costs with other dental costs. There were also differences in how the Navy accumulated costs because the Navy's dental function is organized differently from the way Army and Air Force dental functions are organized.

To make comparisons of cost and workload data for the six dental activities visited, we made adjustments for the inconsistencies.

For example, we adjusted the Army and Navy data to show dental workload in weighted dental procedures to conform with the Air Force method.

The table on the following page shows our comparison of cost and workload data at the dental activities of three medium-sized hospitals for the first quarter of fiscal year 1976.

Analysis of Workload and Costs of Dental Facilities at Medium-sized Hospitals

Hospital	Weighted number of work units completed (note a)	Total operating costs (note b)	Cost per weighted procedure
Martin Army Hospital Fort Benning, Georgia	167,818	$864,000	$5.15
Naval Aerospace and Regional Medical Center Pensacola, Florida (note c)	103,171	353,962	3.43
Air Force Regional Hospital Eglin AFB, Florida	81,784	323,960	3.96

a/Work unit measurement is in weighted dental procedures completed.

b/Total operating costs shown in tables appearing in this report include military and civilian personnel costs and operation and maintenance costs.

c/Includes staffing, workload, and costs from the Naval Regional Dental Center, Pensacola, Florida.

The table above shows that the Army's cost per weighted procedure is appreciably higher than Navy and Air Force cost per weighted procedure.

The table on the following page depicts variances in dental costs and workload at the three small hospitals for the first quarter of fiscal year 1976:

Analysis of Workload and Costs
of Dental Facilities
at Small Hospitals

Hospital	Weighted number of work units completed (note a)	Total operating costs	Cost per weighted procedure
Noble Army Hospital Fort McClellan, Alabama	27,161	$170,653	$6.28
Naval Hospital, Key West, Florida (note b)	22,854	75,871	3.32
Air Force Hospital, Homestead AFB, Florida	42,752	148,957	3.48

a/Work unit measurement is in weighted dental procedures completed.

b/Includes staffing, workload, and costs for the Naval Air Station Dental Center, Key West, Florida.

This table shows that the Army hospital's cost per weighted dental procedure was again much higher than the cost per weighted procedure at the Navy and Air Force hospitals we visited.

Food service

Each of the military departments accounted for its food service workload by the number of rations served. The military departments defined a ration as three meals--breakfast, lunch, and dinner. In the Army and Air Force, however, rations were computed by applying a factor to the number of people served at each meal, that is, a factor of 0.20 was applied to the number of breakfast meals served and a factor of 0.40 was similarly applied to the number of lunches and dinners served. The Naval hospitals assigned equal weight to each meal served and computed rations served by dividing total meals by three. However, at the hospitals we visited, we found that, for purposes of comparison, this inconsistency did not materially distort the work unit data and therefore we made no adjustments to the reported data.

The table on the following page shows the differences in costs to provide food service for the first quarter of fiscal year 1976 at three medium-sized hospitals:

Analysis of Workload and Costs of Food Service at Medium-sized Hospitals

Hospital	Number of work units completed (note a)	Total operating costs	Unit costs
Martin Army Hospital Fort Benning, Georgia	29,386	$288,000	$9.80
Naval Aerospace and Regional Medical Center Pensacola, Florida	22,013	192,910	8.76
Air Force Regional Hospital Eglin AFB, Florida	25,052	203,285	8.11

a/Work unit measurement is rations served.

Operation of the food service activitiy in the Air Force hospital appears more economical than at the Army and Navy hospitals.

The food service activity at the three smaller hospitals showed apparent variances similar to those in the medium-sized hospitals except that the Navy's unit costs were nearly double those at the medium-sized Navy hospital. The table on the following page shows a comparative analysis of these data for the smaller hospitals during the first quarter of fiscal year 1976.

Analysis of Workload and Costs
of Food Service
at Small Hospitals

Hospital	Number of work units completed (note a)	Total operating costs	Unit costs
Noble Army Hospital Fort McClellan, Alabama	9,546	$ 97,345	$10.20
Naval Hospital, Key West, Florida	6,754	101,460	15.02
Air Force Hospital, Homestead AFB, Florida	9,845	84,868	8.62

a/Work units are in rations served.

Radiology

Army and Navy hospitals measure radiological workload by counting X-ray exposures made. Air Force hospitals, on the other hand, measure radiology workload by counting X-ray films used. Since, in general, more than one exposure is placed on each film, the Air Force's reported workload has been lower than that of the Army and Navy. This difference, as well as varying methods of counting exposures by all three services, made it impossible to compare productivity among service hospitals, and we were unable to adjust the workload data and make the kind of comparisons shown for the dental and food service functions.

OVERALL MEASUREMENT OF HOSPITAL WORKLOAD IS INADEQUATE

Defense officials told us and we agree that Defense's overall measurement of hospital workload has many shortcomings.

For more than 21 years the only aggregate workload statistic computed by all three services has been the average daily composite work unit. This work unit which is required by Defense Instruction 6015.14, dated October 9, 1961, consists of four components--average daily beds occupied, inpatient admissions, outpatient visits, and live births.

One of the more important shortcomings of the measure is that many expensive and time consuming procedures involved in providing medical care, such as performing surgical procedures and processing X-rays, are not included in the computation of the composite work unit.

Further, there are no standard procedures for the services to follow in accumulating data for each of the four components used in computing the composite work unit. This could result in the military services using inconsistent procedures. For example, Air Force instructions allowed telephone consultations by physicians to be counted as an outpatient visit, whereas Army and Navy instructions did not allow telephone consultations to be counted as outpatient visits. Also, the Air Force counted a complete physical examination as only one visit regardless of the number of hospital clinics involved in the examination. The Army and Navy recorded a visit for each hospital clinic involved. Air Force officials told us that three hospital clinics usually provided services during physical examinations.

CHAPTER 3

UNIFORM STAFFING CRITERIA CAN HELP IMPROVE MANAGEMENT OF MEDICAL RESOURCES

In addition to the lack of Defense guidance for cost and workload measurement systems, as described in chapter 2, there is also a lack of Defense guidance for determing medical staffing. As a result, the methods used for determining staff resources, which accounted for three-fourths of the costs incurred at the six hospitals visited, differed among the military services. Standard criteria for determining medical staff requirements would provide Defense with a basis for determining whether medical personnel are being effectively utilized.

CRITERIA FOR DETERMINING STAFFING REQUIREMENTS IN HOSPITALS DIFFER

As shown below, in the absence of uniform Department of Defense staffing criteria, each military service has its own way of determining hospital staffing needs.

Army

The Army determines medical and dental staffing requirements of its hospitals by a manpower utilization survey in which a team from the Army's Health Services Command visits each facility and reviews staffing and workload data supporting the staffing recommendations of the hospital commander. Staffing requirements are established for each organizational element of the hospital, based on workload and productivity. After the survey team completes its review, it indicates what the team considers to be the staffing necessary for the hospital to accomplish its workload.

Navy

The Navy's Bureau of Medicine and Surgery, which is responsible for providing medical care at shore-based health facilities, had not prescribed servicewide staffing criteria for its hospitals. Instead, the Bureau's practice has been to review justifications for additional staffing submitted by each medical facility, primarily in terms of trends in workload and projected changes in mission.

Air Force

The Air Force established staffing standards to determine requirements of medical and dental personnel. Using these standards, the Air Force practice has been to assign staff to major health care activities, such as dental facilities, pharmacies, and radiological facilities, on the basis of the average workload for the type of skills needed to perform the service--physicians, nurses, nurses aides, and technicians.

Comparisons of staffing and workload show large variances

We made comparisons of staffing and workload measurement data for the dental and food service functions in the six hospitals visited. Although we did not determine the reasons for the variances in staffing and workload among the hospitals, differing staffing criteria may have been a contributing cause.

The dental facilities at the medium-sized hospitals showed significant differences in staffing relative to workload. The table below depicts these variances.

Analysis of Staffing and Workload of Dental Facilities at Medium-sized Hospitals

Hospital	Weighted number of work units completed (note a)	Total staffing 12-month average	Weighted dental procedures per staff member
Martin Army Hospital Fort Benning, Georgia	167,818	231	726
Naval Aerospace and Regional Medical Center Pensacola, Florida (note b)	103,171	88	1,172
Air Force Regional Hospital, Eglin AFB, Florida	81,784	84	973

a/Work unit measurement is in weighted dental procedures completed.

b/Includes dental workload and staffing of the Naval Regional Dental Center, Pensacola, Florida.

Workload, as measured in weighted dental procedures per staff member, varied from 726 procedures in the Army hospital to 1,172 in the Naval hospital. Similar variances existed at the smaller hospitals we visited, as shown in the following table.

Analysis of Staffing and Workload of Dental Facilities at Small Hospitals

Hospital	Weighted number of work units completed (note a)	Total staffing 12-month average	Weighted dental procedures per staff member
Noble Army Hospital Fort McClellan, Alabama	27,161	50	543
Naval Hospital, Key West, Florida (note b)	22,854	21	1,088
Air Force Hospital, Homestead AFB, Florida	42,752	44	972

a/Work unit measurement is in weighted dental procedures completed.

b/Includes dental workload and staffing of the Naval Air Station Dental Center, Key West, Florida.

At the smaller hospitals, the Air Force dental staff of 44 completed 15,000 more dental procedures than the Army dental staff of 50. Also, the Navy completed more than twice as many dental procedures per staff member as did the Army.

Tables showing analysis of food service staffing and workload follow.

Analysis of Food Service Staffing
Relative to Workload
at Medium-sized Hospitals

Hospital	Number of work units completed (note a)	Total staffing	Rations served per staff member
Martin Army Hospital Fort Benning, Georgia	29,386	65	452
Naval Aerospace and Regional Medical Center Pensacola, Florida	22,013	41	537
Air Force Regional Hospital Eglin AFB, Florida	25,052	40	626

a/Work unit measurement is in rations served.

Rations served per staff member varied from 452 at the Army hospital to 626 at the Air Force hospital. The Army hospital staff of 65 served about 29,000 rations during the quarter while the Air Force staff of 40 served 25,000 rations during the same period.

Analysis of Food Service
Staffing Relative to
Workload at Small Hospitals

Hosptial	Number of work units completed (note a)	Total staffing	Rations served per staff member
Noble Army Hospital Fort McClellan, Alabama	9,546	22	434
Naval Hospital, Key West, Florida	6,754	22	307
Air Force Hospital, Homestead AFB, Florida	9,845	23	428

a/Work unit measurement is in rations served.

Rations served per staff member varied from 307 in the Naval hospital to 434 in the Army hospital. Also, the Air Force staff of 23 served about 9,800 rations during the quarter while the Navy staff of 22 served only 6,800 rations.

As the above comparisons show, there are wide variations in military hospitals' staffing and workload. Uniform workload measurement and uniform staffing criteria can help in the managing of Defense's medical resources.

CHAPTER 4

STANDARD BUDGETING AND ACCOUNTING SYSTEMS WILL PROVIDE NEEDED MANAGEMENT INFORMATION

Improvements are also needed in the medical budgets being submitted by the military departments to Defense and by Defense to the Office of Management and Budget.

Lack of detailed budget guidance and the use of nonstandard accounting and reporting systems by the military departments have brought about inconsistencies in budgetary and cost information reported by the military departments' medical activities.

Budget and accounting information pertaining to the operation of medical activities by the military departments should be sufficiently accurate and complete to enable management to evaluate effectively the efficiency of these activities and to determine how resources should be allocated.

Better guidelines for preparing budgets and a standard accounting and reporting system would help insure that complete, accurate, and consistent medical costs and productivity information is accumulated and reported by the departments.

DIFFERENCES AMONG THE MILITARY DEPARTMENTS IN BUDGETING AND ACCOUNTING FOR MEDICAL RESOURCES

Some examples of inconsistencies and/or omissions in budgetary and cost information which we noted in budgets submitted by the services to Defense follow.

--During fiscal year 1976, the Navy's medical program budget did not include personnel costs for more than 100 doctors and dentists and over 1,000 other medical personnel (e.g., nurses, medical corpsmen) assigned to activities such as hospitals, clinics, dispensaries, and aid stations. Information was not readily available to accurately estimate these costs which are funded and accounted for by the Naval commands to which such personnel are assigned.

--The Army's medical program budget did not include the costs of providing base operations support to medical facilities. The Navy's and Air Force's budgets showed these costs. Army officials estimated

the costs to be about $46 million for 1 year. These costs are funded and accounted for by Army installations on which the hospitals are located.

--The Army's and Air Force's medical program budgets did not include all food costs in their medical facilities operating costs. Army and Air Force officials estimated these costs to be about $26 million during fiscal year 1976.

--The Air Force's medical program budget did not include funds used to operate about 115 medical aid stations. In fiscal year 1976 about 118,000 outpatients visited these facilities. Using the Air Force's average cost for an outpatient visit, Air Force officials estimated the value of this medical care to be about $2 million. Specific cost information relating to the operation of these aid stations was not available under the Air Force's existing accounting systems.

The above examples indicate a need for uniform accounting, budgeting, and reporting procedures for military medical programs.

CHAPTER 5

PAST AND PRESENT STUDIES

For more than 10 years Defense has been aware of the need to standardize cost accounting and reporting systems and to improve the usefulness of information accumulated by the military departments on the operating performance of hospitals. Defense contracted with a public accounting firm which conducted a study and submitted a report in 1965 on its evaluation of the sufficiency of the cost accounting and reporting systems being used by military hospitals. In its report the firm recommended that Defense prescribe (1) a uniform chart of accounts, (2) standard procedures for compiling statistical information, and (3) standard procedures for allocating the costs of providing base operating support to military hospitals.

Representatives of the Office of Management and Budget, the Department of Health, Education, and Welfare, and the Department of Defense performed a joint study in 1975. According to the group's report, military health care information systems and data bases are made up of three separately organized systems because the military departments have considerable latitude in determining their data base and information requirements. Given this latitude, variations have occurred in both the data elements used and the way information systems are organized.

As a follow-on to the 1975 study, several task groups were formed to make more detailed studies with the objectives of recommending improvements in information systems and increasing productivity in the health care system.

PRIOR GAO REPORTS

An August 23, 1976, interim report (FGMSD-76-70) to the Acting Assistant Secretary of Defense (Health Affairs) commented on the results of our survey work at three military hospitals. We said that the military departments were accounting for and reporting the cost and workload of medical services differently and that Defense had not established standard criteria governing these functions. The report pointed out a persistent lack of consistency and comparability of costs, workload, and staffing information being accumulated and reported. We concluded that it was virtually impossible for Defense officials to make valid comparisons of efficiency and effectiveness of hospital operations in the military departments.

In his response to our interim report, the Principal Deputy Assistant Secretary of Defense (Health Affairs) generally agreed with our comments on the need for improvements in Defense's management control over health care resources in military hospitals. He said the Secretary of Defense recognized the lack of consistency and comparability of cost and workload measurement information and would develop and implement a uniform resource and performance accounting system for military hospitals. Defense officials informed us in a November 1977 letter that the uniform system, consisting of a uniform chart of accounts, is now being tested at 10 military medical facilities. Full system implemention is targeted for October 1, 1979.

Defense also agreed with our findings contained in another recent report which, in part, pertained to hospital cost accounting systems. The report (FGMSD-76-102) entitled "Loss of Millions of Dollars in Revenue Because of Inadequate Charges for Medical Care" was issued to the Congress on March 8, 1977. We pointed out the need for standard and complete accounting data so that rates could be devised to recover from paying patients the full cost of medical services provided. Defense agreed that there was a need to establish uniform accounting systems.

CHAPTER 6

CONCLUSIONS, RECOMMENDATIONS, AND DEFENSE ACTIONS

CONCLUSIONS

There is a need for a standard Defense hospital accounting system and a standard system for accumulating and reporting workload data. Standard hospital accounting and workload systems will result in uniform data which will enable Defense management to make valid comparisons of cost and workload data. Such comparisons will help Defense identify areas where efficiency can be improved and will facilitate decisions on the allocation of resources. Further, there is a need for (1) uniform Defense-wide criteria for hospital staffing and (2) better instructions for budget preparation.

There may be valid reasons for the apparent disparity in resource allocation among the six hospitals we visited. However, to insure equitable allocation and effective use of resources, Defense should routinely identify and investigate these variances and others of this nature.

Defense has recognized the need for better information to use in managing its medical resources. It is now testing a uniform chart of accounts and workload measures. It is also studying ways to improve medical information systems and increase productivity in the health care system.

RECOMMENDATIONS

We recommend that the Secretary of Defense

--initiate uniform procedures for the accumulation and and reporting of the military services' medical facility costs which are to be included in their operations and maintenance budget submissions,

--develop and issue uniform staffing criteria for military health care facilities,

--require that responsible Defense managers (1) analyze uniform financial and workload information when it is developed and reported and (2) take the necessary actions to allocate medical resources effectively and efficiently,

--require that internal auditors participate in the development of uniform cost and workload systems for military medical facilities in order to assure that sufficient internal controls are included in the systems.

DEFENSE ACTIONS

In a November 23, 1977, letter, the Assistant Secretary of Defense (Health Affairs) concurred with our findings and recommendations and stated that he anticipates that uniform budgeting procedures will be developed for all appropriations in time for them to be implemented in conjunction with the system for a uniform chart of accounts. He said that Defense has initiated a project to develop and implement uniform staffing methodologies and that, after uniform accounting and staffing systems are implemented, the necessary data will be available for Defense to analyze cost and workload and evaluate the utilization of medical resources. Internal auditors will review the computerized systems to insure that adequate internal controls exist.

CHAPTER 7

SCOPE OF REVIEW

We reviewed the budgeting and accounting policies and procedures of medical activities in the Department of Defense and the military departments. We also reviewed accounting and information systems used for (1) planning, preparing, and reviewing budgets, (2) determining staffing requirements, and (3) analyzing workload statistics and performance at military hospitals. In addition, we reviewed accounting and workload records and reports at the six hospitals listed below.

Martin Army Hospital
Fort Benning, Georgia

Noble Army Hospital
Fort McClellan, Alabama

Naval Aerospace and Regional Medical Center
Pensacola, Florida

Naval Hospital
Key West, Florida

Air Force Regional Hospital
Eglin Air Force Base, Florida

Air Force Hospital
Homestead Air Force Base, Florida

We also interviewed Defense officials in Washington, D.C., and at the Army Health Services Command, Fort Sam Houston, Texas.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

23 Nov 1977

Mr. D. L. Scantlebury
Director
Division of Financial and
General Management Studies
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Scantlebury:

This is in reply to your letter of September 14, 1977 to Secretary Brown regarding your draft GAO Report, "Uniform Accounting and Workload Measurement Systems Needed for Hospitals" (OSD Case #4716).

As indicated in our response of October 20, 1976 to your interim letter report on this subject, the Department of Defense is in basic agreement with your findings and recommendations. In order to bring you up to date on our progress and plans to improve accounting and workload measurement systems in military hospitals, each recommendation will be separately addressed:

(See GAO note)

GAO note: The deleted comments relate to matters which are not included in this report.

APPENDIX I

Recommendation #2 - "provide the military services with uniform procedures for hospital costs to be included in the military services operation and maintenance budgets."

Comments - We suggest that "operation and maintenance" be deleted from this recommendation. Uniformity in the medical portion of budget submissions applies to all appropriations and is one of our major objectives. Some progress is being made in this area and we anticipate that uniform budgeting procedures will be developed in sufficient time for full implementation in conjunction with the UCA.

Recommendation #3 - "develop and issue uniform staffing criteria for military health care facilities."

Comments - The Department has initiated a project to develop and implement uniform staffing methodologies for determining, budgeting, and allocating medical manpower requirements in DoD. The project began in August 1977 and the initial set of methodologies is expected to be tested by June 1978.

Recommendation #4 - "require that responsible Defense managers (1) analyze uniform financial and workload information when it is developed and reported and (2) take the necessary actions to achieve effective and efficient allocation of medical resources."

Comments - Implementation of the first three recommendations will provide the tools necessary for DoD managers to analyze cost and workload data and to evaluate the utilization of medical resources. Establishment of the Defense Health Council on December 28, 1976 has been a significant step toward better coordination of health policies and resource utilization.

Recommendation #5 - "require that internal audit participate in the development of uniform cost and workload systems for military medical facilities."

Comments - If the intent of this recommendation is to mandate that internal audit must participate in the development of these systems we believe it overly restricts DoD's management prerogatives. We agree that internal audit should review computerized systems to insure that adequate internal controls exist and we routinely seek their advice and guidance when required. In fact, there has been substantial internal audit participation in the validation of computerized DoD accounting systems. DoD audit policies also assign to these audit organizations the responsibility for reviewing accounting systems in their operational phase to ascertain that the systems conform with the principles, standards, and system design approved by the Comptroller General.

APPENDIX I

Other Comments - With regard to Chapter 5, "Past and Present Defense Studies", the report fails to mention that the Department did react to the 1965 report by issuing in 1967 DoDI 7220.23, "Cost Accounting for Department of Defense Hospitals." However, the instruction was cancelled in 1971 because the Office of Management and Budget discontinued its requirement for cost reports, the Office of the Assistant Secretary of Defense (Health and Environment) was not staffed to evaluate costs and make resource allocation decisions, and all centrally prescribed requirements were reviewed at that time for their need and usefulness.

We appreciate your review and analysis of this subject area. We believe we are making progress toward correcting the deficiencies in the medical accounting, budgeting and performance reporting systems within the DoD. The results of your review will be helpful in this regard.

Sincerely,

Robert N. Smith, M.D.

Robert N. Smith, M. D.

PRINCIPAL OFFICIALS RESPONSIBLE FOR ADMINISTERING ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
DEPARTMENT OF DEFENSE		
SECRETARY OF DEFENSE:		
Dr. Harold Brown	Jan. 1977	Present
Donald H. Rumsfeld	Nov. 1975	Jan. 1977
Dr. James R. Schlesinger	July 1973	Nov. 1975
ASSISTANT SECRETARY OF DEFENSE (COMPTROLLER):		
Fred P. Wacker	Sept. 1976	Present
Terence E. McClary	June 1973	Aug. 1976
Don R. Brazier (acting)	Jan. 1973	June 1973
Robert C. Moot	Aug. 1968	Jan. 1973
ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS):		
Dr. Robert N. Smith	Sept. 1976	Present
Vernon McKenzie (acting)	Mar. 1976	Aug. 1976
ASSISTANT SECRETARY OF DEFENSE (HEALTH AND ENVIRONMENT):		
Vernon McKenzie (acting)	Mar. 1976	Mar. 1976
James R. Cowan	Feb. 1974	Mar. 1976
DEPARTMENT OF THE ARMY		
SECRETARY OF THE ARMY:		
Clifford Alexander, Jr.	Feb. 1977	Present
Martin R. Hoffman	Aug. 1975	Feb. 1977
Howard H. Callaway	May 1973	July 1975
SURGEON GENERAL OF THE ARMY:		
Lt. Gen. R. R. Taylor	Oct. 1973	Present
DEPARTMENT OF THE NAVY		
SECRETARY OF THE NAVY:		
W. Graham Claytor, Jr.	Feb. 1977	Present
J. William Middendorf II	June 1974	Feb. 1977
John W. Warner	May 1972	Apr. 1974

APPENDIX II

	Tenure of office	
	From	To
DEPARTMENT OF THE NAVY		
CHIEF, BUREAU OF MEDICINE AND SURGERY:		
Vice Adm. W. P. Arentzen	Aug. 1976	Present
Vice Adm. D. L. Custis	Feb. 1973	July 1976
DEPARTMENT OF THE AIR FORCE		
SECRETARY OF THE AIR FORCE:		
John C. Stetson	Apr. 1977	Present
Thomas C. Reed	Jan. 1976	Apr. 1977
James W. Plummer (acting)	Nov. 1973	Jan. 1976
Dr. John L. McLucas	July 1973	Nov. 1975
SURGEON GENERAL OF THE AIR FORCE:		
Lt. Gen. G. E. Schafer	Aug. 1975	Present
Lt. Gen. Robert Patterson	Aug. 1972	July 1975