The General Accounting Office (GAO), an arm of the Congress, was established to independently audit government agencies. GAO’s Health, Education, and Human Services (HEHS) Division [formerly the Human Resources Division (HRD)] reviews the government’s health, education, employment, social security, welfare, and veterans programs administered in the Departments of Health and Human Services, Labor, Education, Veterans Affairs, and some other agencies.

This booklet lists the GAO products issued on these programs. It is divided into two major sections:

- **Most Recent GAO Products:** This section identifies reports and testimonies issued during the past 5 months and provides summaries for selected key products.

- **Comprehensive 2-Year Listings:** This section lists all products published in the last 2 years, organized chronologically by subject as shown in the table of contents. When appropriate, products may be included in more than one subject area.

You may obtain single copies of the products free of charge, by telephoning your request to (202) 512-6000 or faxing it to (301) 258-4066. Additional ordering details, as well as instructions for getting on our mailing list, appear at the end of this booklet.

Janet L. Shikles
Assistant Comptroller General
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<td>ADEA</td>
<td>Age Discrimination in Employment Act of 1967</td>
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<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
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<td>AoA</td>
<td>Administration on Aging</td>
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<td>Bureau of Prisons</td>
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<td>CHAMPUS</td>
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<td>Certified Public Accountant</td>
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<td>District of Columbia</td>
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<td>disability determination services</td>
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<td>Social Security Disability Income</td>
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<td>DOD</td>
<td>Department of Defense</td>
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<td>DOE</td>
<td>Department of Energy</td>
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<td>Education and Deaf Act of 1986</td>
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<td>ESA</td>
<td>Elementary and Secondary Education Act</td>
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<td>General Services Administration</td>
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<td>Philadelphia Accessible Services System</td>
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<td>human immunodeficiency virus</td>
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<td>Indian Health Service</td>
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<td>metropolitan statistical area</td>
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<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
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<td>Pension Benefit Guarantee Corporation</td>
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<td>Acronym</td>
<td>Full Form</td>
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<td>total quality management</td>
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Health

Selected Summaries


Hawaii has the highest level of insurance coverage of any state in the nation. Hawaii’s residents lacking health insurance in 1991 ranged from an estimated 3.75 to 7.0 percent in comparison to the national average of 14 percent. Nevertheless, Hawaii’s employer mandate and government programs do not ensure coverage for everyone in the state. Further, even some residents with insurance encounter problems obtaining access to health services and need community health centers and other safety net programs. Hawaii has experienced the same trend of rising costs as the rest of the nation. Although Hawaii has a requirement that employers provide health insurance, large disruptions in Hawaii’s small business sector have not resulted.


Between January 1989 and September 1991, the Health Care Financing Administration (HCFA) conducted a study to determine whether giving carriers greater management discretion over medical review, as well as additional funding, would result in program improvements. The study involved five carriers: three carriers (referred to as demonstration carriers) were given added management flexibility and funding, and two carriers continued performing medical review operations with no modifications to their medical review process and funding. The demonstration carriers intensified efforts to identify unusual spending patterns and trends. These efforts netted increased savings, making the greater funding of medical review activities worthwhile. With additional resources, they were able to focus on examining spending data for individual procedures.


A common feature of many health reform bills is the creation of health-purchasing groups, commonly called alliances, which pool risks and have the market power of a large group of purchasers. Three major
bills incorporate alliances. Decisions on alliance boundaries are left to the states except for provisions in all three bills that require Metropolitan Statistical Areas (MSA) remain intact. There is some potential that procedures for defining MSA and alliance boundaries could become political decisions that might affect existing health markets. The three issues often raised in regard to the drawing of alliance boundaries are (1) the impact on the provision of care, (2) the potential concentration of higher-risk populations, and (3) the redistribution of health care costs.


Inmates with special needs, including women, psychiatric patients, and patients with chronic illnesses, were not receiving all of the health care they needed at the three medical referral centers we visited. There were insufficient numbers of physician and nursing staff to perform required clinical and other related tasks. While the centers had quality assurance programs, two of the centers failed to correct identified quality assurance problems. Physicians at each of the centers were qualified to perform the work they were assigned. However, many physician assistants did not meet training and certification requirements of the medical community outside Bureau of Prisons (BOP). To reduce its reliance on community hospitals, BOP is considering constructing six large acute tertiary care hospitals, acquiring several military facilities, or both. BOP needs to determine its basic requirements and consider the costs and benefits of other alternatives before proceeding with the construction or acquisition of facilities.


Although many employers believe that, in principle, managed care plans save money, little empirical evidence exists on the cost savings of managed care. Most studies that compare firms' health care costs for employees under managed care to those under indemnity plans do not adequately control for key factors affecting cost, such as employees' age or health status. Some managed care plans have a potential for cost savings. Restrictions on employee choice of health care provider is viewed as the major constraint on employee acceptance of network-based managed care plans. Increasingly, employers are taking steps to address the need for adequate information on health plans' costs and quality.
Long-Term Care: Private Sector Elder Care Could Yield Multiple Benefits (Report, 1/31/94, GAO/HEHS-94-60).

About 2 million working Americans are providing significant unpaid care to their elderly relatives, who live in the community and need assistance with everyday activities. An additional 6 million employed persons have disabled parents or spouses who may also need assistance with these activities. The number of employed caregivers is expected to grow as the population ages. Work and family responsibilities often conflict, and many caregivers provide assistance long distance. Companies' support for their employed caregivers could be strengthened if managers identified and actively supported the use of flexible working schedule options for elder care. Caregivers struggling to balance work and family responsibilities may find useful company services that offer them flexible schedules and needed information, while employers may see reduced work disruption, such as turnover and absenteeism. Employer-sponsored elder care can also benefit the elderly persons being helped.


Families USA's 1993 national estimate that 1.8 million senior citizens were eligible for but not enrolled in the Qualified Medicare Beneficiary (QMB) program is a reasonable estimate. Federal and state governments have taken a number of actions to alert potentially eligible people about the program. The reasons cited by federal and state officials for more people not enrolling include (1) eligible people perceiving a welfare stigma attached to the program, (2) the complicated application process, and (3) eligible people believing that the benefit of enrolling is not worth much in monetary terms. One action proposed to increase enrollment is to authorize the Social Security Administration (SSA) to determine QMB eligibility. SSA has opposed this option for a number of reasons, including insufficient resources to carry out the function.

Prescription Drugs: Companies Typically Charge More in the United States Than in the United Kingdom (Report, 1/12/94, GAO/HEHS-94-29).

We found significant differences in the prices that manufacturers charge wholesalers for identical, frequently dispensed prescription drugs sold in retail pharmacies in the United States and the United Kingdom. A market basket of 77 frequently dispensed drugs that we analyzed would cost wholesalers 60 percent more in the United States than in the United
Kingdom. Price differentials tended to be dramatically smaller for more recently introduced drugs in our sample than for older products. Price differentials tended to be smaller for single-source brand-name drugs in our sample than for brand-name drugs that have generic substitutes. We found that U.S.-U.K. drug price differences are primarily due to the regulatory constraints that manufacturers face in pricing their drugs on the U.K. market and to the lack of similar constraints in the United States.


While fewer adolescents report alcohol and illicit drug use in current surveys than in past years, adolescents still report use. Alcohol remains the drug of choice among adolescents, with more than 57 percent of high school seniors reporting current use. Our analysis of the National Longitudinal Survey of Youth identified some risk factors. Risk factor research reveals no simple answers to explain why young people use alcohol and/or drugs. Neither our work nor other research done on risk factors to date can provide answers for the optimum mix of prevention programs and strategies.


Although state insurance departments are responsible for overseeing health insurers and protecting consumers, their authority extends over only part of the insurance market and varies widely among states. State insurance departments perform a variety of regulatory activities to protect consumers from insurer failures, unfair policy provisions, excessive premiums, and unscrupulous insurer business practices. However, each state insurance department's role in regulating health insurance is affected by its legal framework and regulatory philosophy. The resources state legislatures allocate to their insurance departments and the proportion the departments dedicate to regulating health insurance also varies among states. In analyzing various health care reform proposals, the Congress needs to consider what role, if any, state insurance departments will play in enforcing new requirements that may be imposed on health insurers.
Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (Report, 11/22/93, GAO/HRD-94-40).

The Public Employees' Retirement System (CalPERS) record of controlling the growth of health insurance premiums for participating employers has improved since 1992, outperforming most other employers. The recent trend toward slower growth in premiums, due in part to the weakened California economy, followed several years in which the average CalPERS premium increased at rates near or above nationwide averages. Several factors contributed to the System's success. CalPERS incorporates many features of a "health alliance" as proposed under managed competition in health care reform.

Other Health Products


Bone Marrow Transplantation (Report, 3/7/94, GAO/PEMD-94-10).


Safe Medical Devices (Letter, 2/10/94, GAO/HEHS-94-88R).


Hospitals: Chief Executives' Compensation (Testimony, 12/7/93, GAO/HRD-94-70).


Medicare/Medicaid Data Bank Issues (Letter, 11/15/93, GAO/HRD-94-63R).

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (Testimony, 11/12/93, GAO/HRD-94-59).

Health Care Reform: Supplemental and Long-Term Care Insurance (Testimony, 11/9/93, GAO/HRD-94-68).

Education

Selected Summaries

School-Age Children: Poverty and Diversity Challenge Schools Nationwide (Testimony, 3/16/94, GAO/T-HEHS-94-125).

The face of school-age America is changing dramatically. By 1990, one out of every six children lived in poverty and many were from diverse racial and ethnic backgrounds. Along with these changes, schools face additional problems—one-sixth of the nation's third-graders change schools frequently, attending at least three different schools since the beginning of first grade. Many school districts are also teaching a large number of immigrant students, often who are limited English proficient. This testimony discusses changes in the demographic characteristics of
America's school-age children and the implications these changes have for America's schools and for education policy.


One in six of the nation's children who are third-graders—over a half million—have changed schools frequently, attending at least three different schools since the beginning of first grade. Unless policymakers focus greater attention on the needs of children who have changed schools frequently—often low-income, inner city, migrant, and limited English proficient (LEP)—these children may continue to be low achieving in math and reading. Local school districts generally provide little additional help to assist children who move frequently. The Department of Education can play a role in helping these children receive appropriate educational services in a timely manner. Specifically, the department could develop strategies to ensure that all children have access to Migrant Children and Chapter 1 services. School districts need access to a system that provides information on a more timely basis.


The nation's ability to achieve the national education goals is increasingly dependent on its ability to educate LEP students. Many LEP students in the five districts that we visited received limited support in understanding academic subjects, such as math and social studies. Educators and researchers have developed approaches to provide academic subject instruction to LEP when native language instruction is not possible. The effectiveness of these programs, however, has not been definitely established. Federal programs targeted to LEP students provide important types of services for improving the education of these students; however, federal funding has not kept pace with the increase in the LEP population.

Student Loans: Millions Loaned Inappropriately to U.S. Nationals at Foreign Medical Schools (Report, 1/21/94, GAO/HEHS-94-28).

The U.S. Department of Education has not met its statutory responsibility to ensure the comparability of foreign medical schools to schools in the United States before authorizing their participation in the student loan program. As a result, GAO estimates that Education made $118 million in loans between 1986 and 1991 to students attending foreign medical
Most Recent GAO Products
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schools without assuring that the schools met U.S. standards. State medical boards are often unable to get information they need to evaluate the education of foreign-trained physicians before licensing them. As a result, educationally underqualified physicians may be entering the mainstream of American medicine.


Although many schools awarded minority-targeted scholarships, these scholarships accounted for a small proportion of total scholarships and scholarship dollars in the 1991-92 academic year. Most schools awarding minority-targeted scholarships used race or ethnicity as an eligibility requirement, while few used gender, religion, or other minority status. Race or ethnicity was rarely the sole criterion; most minority-targeted scholarships used additional criteria, such as financial need or academic merit, for awarding funds. Students receiving race- or ethnicity-based minority-targeted scholarships made up a small percentage of all racial or ethnic minority students. Four of the six schools we visited used minority-targeted scholarships to a great extent and found them valuable tools in recruiting and retaining minority students.


During the 1980s, the total number of rural children declined and the number of poor children in rural areas increased. In addition, other risk factors were prevalent among poor rural children, including a growth in the number of single-female-parent families and a continued high percentage of parents with low education levels. Rural poverty was concentrated by region and by race and ethnicity. Rural counties make up over 80 percent of the counties that, under the administration's proposed county eligibility changes in the Chapter 1 program, would no longer be eligible for basic or concentration grants.


Many different models exist for coordinating human services in schools, and no two are exactly alike. Despite the variety of program models, we found that strong leadership was one of several common characteristics of the comprehensive school-linked programs we reviewed. Some programs
increase the likelihood that at-risk students will stay in school; however, few impact evaluations of these programs are available. The federal government could play an important role in promoting effective comprehensive programs for school-age children by providing support and guidance for the development of impact and cost effectiveness evaluations of these programs.

Other Education Products


Deaf Education: Improved Oversight Needed for National Technical Institute for the Deaf (Report, 12/16/93, GAO/HRD-94-23).

Food Assistance: Schools That Left the National School Lunch Program (Report, 12/3/93, GAO/RCEJ-94-36BR).


Employment

Selected Summaries


By GAO's count, at least 154 programs administered by 14 federal departments and agencies provide about $25 million in employment training assistance. Too often the current fragmented system of programs (1) creates confusion and frustration for clients and administrators, (2) does not tailor services to the needs of those seeking assistance, and (3) creates the potential for duplication of effort and unnecessary administrative costs. In addition, some programs lack basic tracking and monitoring systems needed to ensure that assistance is provided efficiently and effectively. GAO is convinced that a major structural overhaul and consolidation of employment training programs is needed. The result would be to create a customer-driven employment system consisting of significantly fewer programs that embodies four guiding

Federal agencies closely monitor their expenditure of billions of dollars for employment training assistance for the economically disadvantaged. However, most agencies do not collect information on participant outcomes nor do they conduct studies of program effectiveness. For about half the programs in GAO’s analysis, agencies did not collect data on what happened to program participants after they completed a particular program (i.e., neither whether they obtained jobs nor what wages they earned). Only about a third of the training programs in GAO’s analysis used oversight and monitoring to assess participant outcomes. The federal agencies responsible for these programs seldom conducted studies that measure program effectiveness or impact.


The Occupational Safety and Health Administration’s (OSHA) oversight of state-operated safety and health programs continues to have substantial weaknesses like those identified 6 years ago by GAO and the Office of Inspector General (OIG). OSHA focuses primarily on measures of program activities (for example, number of inspections conducted) rather than program outcome measures (such as reductions in workplace injuries). OSHA made some changes to its oversight process in the special evaluations conducted after a serious industrial accident in 1991, but few changes were incorporated since that time. OSHA and state programs pursue generally similar approaches to improving workplace safety and health. However, all state-administered programs differ from OSHA in that they cover state and local government employees, while OSHA does not.


The amount of time a person may wait to have the Equal Employment Opportunity Commission (EEOC) process a discrimination charge under the Age Discrimination in Employment Act of 1967 (ADEA) and other
Nondiscrimination laws could more than double and approach 21 months by fiscal year 1996. The current trend of a steadily increasing workload without commensurate increases in resources is expected to continue. Former and current EEOC officials and civil rights experts have suggested several options that they believe could improve the federal government's ability to enforce nondiscrimination laws in the workplace. The one mentioned most often is increased use of alternative dispute resolution approaches, such as mediation. GAO believes that the Congress should establish a commission of experts to consider this and other options for improvement. EEOC officials do not believe EEOC will initiate substantially more systemic charges or litigate significantly more charges under ADEA and other nondiscrimination laws because resources are limited.


Many federal employment training programs target the same populations. The overlap in client groups targeted by federal programs ranged from a low of 4 programs each, serving refugees and older workers, to a high of 18 programs, serving veterans. This overlap can add unnecessary administrative costs at each level of government—federal, state, and local. Individually, each employment training program generally has a well-intended purpose. However, collectively these programs create the potential for duplication of effort, raising questions concerning the administrative costs associated with the multitude of federal, state, and local agencies involved in operating these programs.


Conflicting eligibility requirements and differences in annual operating cycles are hampering the ability of programs to provide participants needed services. Despite decades of efforts to better coordinate employment training programs, conflicting requirements continue to make it difficult for program staff to coordinate activities and share resources. Differences in eligibility criteria make determining who is eligible for which program a complex process that confuses clients and frustrates administrators. Within each target group, differences in annual operating cycles also hamper the ability of program administrators to plan together to ensure participants receive the services they need.
Occupational Safety and Health: Differences Between Programs in the United States and Canada (Report, 12/6/93, GAO/HRD-94-15FS).

Programs to ensure occupational safety and health in the United States compared with those in Canada differ in three major areas: (1) the governmental entity responsible for operating and funding the programs, (2) the extent of worker involvement, and (3) the type of enforcement action taken. Several state-operated programs in the United States use program elements similar to those used in Canada. These states provide some information on how these programs might work in the United States. Little information is available on the effectiveness of the programs in Canada, although employer and worker representatives with whom we spoke expressed general satisfaction.

Other Employment Products


Dislocated Workers: A Look Back at the Redwood Employment Training Programs (Report, 12/13/93, GAO/HRDQIGBR).

Dislocated Workers: Proposed Re-employment Assistance Program (Report, 11/12/93, GAO/HRD-94-61).


Social Security & Welfare

Selected Summaries


GAO is encouraged by the Social Security Administration's (SSA) efforts to make the continuing disability review process more efficient and cost-effective through the use of computer profiling and beneficiary self-reported data. GAO is concerned, however, that SSA continues to do too few continuing disability reviews, particularly for beneficiaries with the greatest likelihood of being removed from the disability rolls. In GAO's view, finding ways to provide SSA with more money to do the reviews is worthwhile.


The number of addicts receiving disability benefits has grown substantially during the last 5 years. Currently, about 250,000 addicts receive disability benefits at an annual cost of about $1.4 billion under the Social Security Administration's Disability Insurance (DI) and Supplemental Security Income (SSI) programs. Under SSI, certain addicts are required to participate in treatment for their addiction and have a representative payee manage their benefits. As of August 31, 1993, about 70,000 were covered by that requirement, which provides benefits to addicts who
would not qualify for disability if their addiction ended. The DI program has no similar requirement. Virtually all of the addicts in the SSI drug addiction and alcoholism (DA&A) program have representative payees. However, for the rest of the addict population receiving benefits, less than half have payees. GAO believes that all addicts should have payees. In those situations where payees are present, it is questionable how tightly these payees control the use of benefits. GAO makes a number of recommendations to strengthen controls over benefit payments to addicts.


In 1993, the SSA actuary forecasted that DI rolls would continue growing and would nearly double to over six million disabled workers in the next 10 years. Insured persons are applying for benefits at a higher rate, higher percentages of applicants are accepted for benefits, and the rate at which beneficiaries leave the program has been declining. Changes in the characteristics of new beneficiaries have accompanied this growth. Several reasons for the growth and change in the DI rolls have been identified. However, quantitative data on the impact of these reasons are lacking, and important questions remain. Without better information, neither SSA nor the Congress can be sure whether the current growth will continue or whether the trends might reverse as they have done in the past.


Residential care appears to be a viable treatment option for some high-risk youths. Each of the 18 programs we contacted reported benefits for some youths in such areas as maintaining attendance in school and avoiding drug abuse and criminal behavior. However, the programs seldom conducted controlled or comparison studies to determine how outcomes are linked to their treatment efforts, and few programs have conducted studies to show what happened to participants more than 12 months after they left the programs.

Older Americans Act: Title III Funds Not Distributed According to Statute (Report, 1/18/94, GAO/HEHS-94-37).

The method followed by the Administration on Aging (AOA) in allotting funds under title III of the Older Americans Act is inconsistent with the
act's basic requirement that the distribution of funds among the states be proportional to their elderly populations to the maximum extent possible. Under AOA's method, the amounts allotted per elderly person are not equal in similarly populated states, and states with more rapidly growing elderly populations are underfunded.


Claim backlogs and processing times for Social Security DI and SSI programs reached an all-time high in fiscal year 1992. GAO found that between 1990 and 1992 these backlogs and processing times increased nearly 50 percent. In addition, some states take more than 5 months to process claims. SSA and the states' disability determination services (DDS) have not been able to keep up with the high rate of claims submitted for benefits. Problems resulting from increased workloads include increased workforce stress and use of overtime, employees not performing their normal duties, a decline in workforce morale, an increase in claims being set aside, and a decline in automated systems support.

Other Social Security & Welfare Products


Davis-Bacon Act (Letter, 2/7/94, GAO/HEHS-94-95R).

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1993 (Report, 12/22/93, GAO/HRD-94-73).

Breastfeeding: WIC's Efforts to Promote Breastfeeding Have Increased (Report, 12/16/93, GAO/HRD-94-13).
Grant Administration: CDC Oversight of Grantees' Activities Needs Improvement (Report, 12/10/93, GAO/HRD-94-12).


Veterans and Military Health

Selected Summaries


GAO conducted a limited follow-up to its January 1992 report on improvements needed in the Department of Veterans Affairs' (VA) provision of health care services to women veterans. Since 1992, VA's central office has repeatedly stressed the need for its facilities to improve services for women veterans and has issued guidance to its medical centers intended to address the problems identified in our report. Although its central office has not effectively monitored field facilities to ensure that they improved service for women veterans, VA has had great success in improving privacy for women veterans.


Despite the good-faith efforts of VA program staff, the capacity at VA's programs to serve homeless veterans is far short of the demand for such services. Further, VA services for homeless veterans are not available in many localities in the United States. Prior to release of a patient from a VA medical center, Homeless Chronically Mentally Ill or Domiciliary Care for Homeless Veterans program, VA staff are expected to refer the veteran to other VA or community providers when further care is needed, and follow
up with veterans after discharge to monitor their post-treatment status. VA staff seldom monitored the veterans' progress after release from VA inpatient facilities. In addition, VA has made little progress in compiling a comprehensive inventory of the needs of the homeless veteran population as required by Public Law 102-405.

VA Health Care: VA Medical Centers Need to Improve Monitoring of High-Risk Patients (Report, 12/10/93, GAO/HRD-94-27).

High-risk patients leaving a treatment setting without staff authorization is a significant problem at 39 of VA's 158 medical centers. Systemwide, about 7,000 searches were conducted for high-risk patients who were reported as missing from their treatment settings during the two-year period of October 1, 1990, through September 30, 1992. While 99 percent of these patients were ultimately found unharmed, VA officials discovered that 34 others were dead and 19 were injured. Further, 25 remained unaccounted for as of June 1, 1993.

Other Veterans and Military Health Products


VA Health Care: VA Medical Centers Need to Improve Monitoring of High-Risk Patients (Report, 12/10/93, GAO/HRD-94-27).

VA Appropriations (Letter, 12/10/93, GAO/HRD-94-72R).

Veterans Benefits: Redirected Modernization Shows Promise (Report, 12/9/93, GAO/AIMD-94-26).

Disabled Veterans Programs: U.S. Eligibility and Benefit Types Compared With Five Other Countries (Report, 11/24/93, GAO/HRD-94-6).
Most Recent GAO Products
(November 1993 - March 1994)

Department of Veterans Affairs Appropriation (Letter, 11/12/93, GAO/HRD-94-57R).

VA Health Care: Tuberculosis Control Receiving Greater Emphasis at VA Medical Centers (Report, 11/9/93, GAO/HRD-94-5).

Armed Forces Retirement Home (Letter, 11/3/93, GAO/HRD-94-49R)

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### Access and Infrastructure

- **Health Care Access:** Innovative Programs Using Nonphysicians (Report, 8/27/93, GAO/HRD-93-128).
- **Nonprofit Hospitals:** For-Profit Ventures Pose Access and Capacity Problems (Report, 7/22/93, GAO/HRD-93-124).
- **Indian Health Service:** Basic Services Mostly Available; Substance Abuse Problems Need Attention (Report, 4/9/93, GAO/HRD-93-48).
- **Health Care:** Rochester's Community Approach Yields Better Access, Lower Costs (Report, 1/29/93, GAO/HRD-93-44).
- **Emergency Departments:** Unevenly Affected by Growth and Change in Patient Use (Report, 1/4/93, GAO/HRD-93-4).
- **District of Columbia:** Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care (Report, 12/29/92, GAO/HRD-92-28).
- **Bone Marrow Transplants:** National Program Has Greatly Increased Pool of Potential Donors (Report, 11/4/92, GAO/HRD-92-11).
- **Federally Funded Health Services:** Information on Seven Programs Serving Low-Income Women and Children (Report, 5/28/92, GAO/HRD-92-73PS).
- **Small Group Market Reforms:** Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (Letter, 3/12/92, GAO/HRD-92-27R).

### Employee and Retiree Health Benefits

Family and Medical Leave Cost Estimate (Letter, 2/1/93, GAO/HRD-93-14R).


Summary Information on Farmworkers (Letter, 4/10/92, GAO/HRD-92-30R).


Hospitals: Chief Executives' Compensation (Testimony, 12/7/93, GAO/HRD-94-70).

Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (Report, 11/22/93, GAO/HRD-94-60).


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Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (Testimony, 3/8/93, GAO/T-HRD-93-8).


Removal of Breast Implants (Letter, 12/7/92, GAO/HRD-93-5R).

Trauma Care Reimbursement: Poor Understanding of Losses and Coverage for Undocumented Aliens (Report, 10/15/92, GAO/PEMD-93-1).

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (Report, 9/22/92, GAO/HRD-92-128).

Hospital Costs: Adoption of Technologies Drives Cost Growth (Report, 9/9/92, GAO/HRD-92-120).

Health Insurance: More Resources Needed to Combat Fraud and Abuse (Testimony, 7/28/92, GAO/T-HRD-92-49).


Maternal and Child Health: Block Grant Funds Should Be Distributed More Equitably (Report, 4/2/92, GAO/HRD-92-5).

Health Care Reform Related Issues


Veterans' Health Care: Potential Effects of Health Financing Reforms on Demand for VA Services (Testimony, 3/31/93, GAO/T-HRD-93-12).


**HHS Public Health Service Agencies**

Safe Medical Devices (Letter, 2/10/94, GAO/HEHS-94-86R).


CDC Activities Are Appropriate and Non-Duplicative (Letter, 8/30/93, GAO/HRD-93-82R).

FDA Regulation of Dietary Supplements (Letter, 7/2/93, GAO/HRD-93-28R).

Hospital Sterilants: Insufficient FDA Regulation May Pose a Public Health Risk (Report, 6/14/93, GAO/HRD-93-79).

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FDA Premarket Approval: Process of Approving Lodine as a Drug (Report, 4/12/93, GAO/HRD-93-81).


Women's Health: FDA Needs to Ensure More Study of Gender Differences in Prescription Drug Testing (Report, 10/29/92, GAO/HRD-93-17).


Nonprescription Drugs: Over the Counter and Underemphasized (Testimony, 4/8/92, GAO/PEMD-92-5).


Long-Term Care

Long-Term Care: Private Sector Elder Care Could Yield Multiple Benefits (Report, 1/31/94, GAO/HEHS-94-90).


Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (Report, 8/25/93, GAO/HRD-93-129).
VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (Report, 7/27/93, GAO/HRD-93-68).

Long-Term Care Forum (Discussion Paper, 7/13-14/93, GAO/HRD-93-1-SP).


Massachusetts Long-Term Care (Letter, 5/17/93, GAO/HRD-93-22R).

Long-Term Care Case Management: State Experiences and Implications for Federal Policy (Report, 4/6/93, GAO/HRD-93-52).

Long-Term Care Insurance Partnerships (Letter, 9/25/92, GAO/HRD-92-44R).

Medical Malpractice: Maine's Use of Practice Guidelines to Reduce Costs (Report, 10/25/93, GAO/HRD-93-48).


Medical Malpractice: Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses (Report, 8/11/93, GAO/HRD-93-126).

Medical Malpractice: Experience With Efforts to Address Problems (Testimony, 5/20/93, GAO/HRD-93-24).

Health Information Systems: National Practitioner Data Bank Continues to Experience Problems (Report, 1/29/93, GAO/IMTEC-93-1).
Managed Care


Managed Health Care: Effect on Employers’ Costs Difficult to Measure (Report, 10/19/93, GAO/HRD-94-3).

Medicaid Managed Care: Healthy Moms, Healthy Kids—A New Program for Chicago (Report, 9/7/93, GAO/HRD-93-121).

Defense Health Care: Lessons Learned From DOD’s Managed Health Care Initiative (Testimony, 5/10/93, GAO/T-HEHS-93-21).


Medicaid: Factors to Consider in Managed Care Programs (Testimony, 6/29/92, GAO/T-HEHS-92-43).

Medicaid: Oregon’s Managed Care Program and Implications for Expansions (Report, 6/19/92, GAO/HRD-92-89).

Medicaid: Factors to Consider in Expanding Managed Care Programs (Testimony, 4/10/92, GAO/T-HEHS-92-26).

Medicare and Medicaid


Medicare/Medicaid Data Bank Issues (Letter, 11/15/93, GAO/HRD-94-63R).

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (Testimony, 11/12/93, GAO/HRD-94-59).


HCFA Payment Rate for Erythropoietin (Letter, 10/13/93, GAO/HRD-94-11R).

Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays is Needed for Federal Health Programs (Report, 9/17/93, GAO/HRD-93-92).

Medicaid Managed Care: Healthy Moms, Healthy Kids—A New Program for Chicago (Report, 9/7/93, GAO/HRD-93-121).

Medicaid: Alternatives for Improving the Distribution of Funds to States (Report, 8/20/93, GAO/HRD-93-112FS).

Medical Malpractice: Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses (Report, 8/11/93, GAO/HRD-93-126).


Medicare: Separate Payment for Fitting Braces and Artificial Limbs Is Not Needed (Report, 7/21/93, GAO/HRD-93-98).
Medicare Physician Payment: Geographic Adjusters Appropriate But Could Be Improved With New Data (Report, 7/20/93, GAO/HRD-93-93).

Medicaid Estate Planning (Letter, 7/20/93, GAO/HRD-93-26R).

Overhead Costs: Unallowable and Questionable Costs Charged to Medicare by Hospital Corporation of America (Testimony, 6/23/93, GAO/T-NSIAD-93-16).


Medicaid: HealthPAS 8—An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (Report, 5/7/93, GAO/HRD-93-67).


Medicare: Funding and Management Problems Result in Unnecessary Expenditures (Testimony, 2/17/93, GAO/HRD-93-4).

Medicaid: Changes in Drug Prices Paid by HMOs and Hospitals Since Enactment of Rebate Provisions (Report, 1/15/93, GAO/HRD-93-6).

High-Risk Series: Medicare Claims (Report, 12/92, GAO/HRD-93-5).

Medicare: Millions in End-Stage Renal Disease Expenditures Shifted to Employer Health Plans (Report, 12/31/92, GAO/HRD-93-3).

District of Columbia: Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care (Report, 12/29/92, GAO/HRD-93-2).

Medicaid: Disproportionate Share Policy (Letter, 12/22/92, GAO/HRD-93-3).

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Health Insurance: Medicare and Private Payers Are Vulnerable to Fraud and Abuse (Testimony, 9/10/92, GAO/HRD-92-5).

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (Report, 8/26/92, GAO/HRD-92-7).


Resource-Based Relative Value Scale (RBRVS) and Administrative Costs (Letter, 7/13/92, GAO/HRD-92-3).

Medicare: Program and Beneficiary Costs Under Durable Medical Equipment Fee Schedules (Report, 7/7/92, GAO/HRD-92-7).
Medicaid: Factors to Consider in Managed Care Programs (Testimony, 6/29/92, GAO/T-HRD-92-43).

Medicaid: Oregon's Managed Care Program and Implications for Expansions (Report, 6/19/92, GAO/HRD-92-89).


Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments (Report, 6/12/92, GAO/HRD-92-54).


Medicare: Contractor Oversight and Funding Need Improvement (Testimony, 5/21/92, GAO/T-HRD-92-32).

Medicaid: Factors to Consider in Expanding Managed Care Programs (Testimony, 4/10/92, GAO/T-HRD-92-26).

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Prescription Drugs: Companies Typically Charge More in the United States Than in the United Kingdom (Report, 1/12/94, GAO/HEHS-94-29).


Prescription Drug Prices: Analysis of Canada's Patented Medicine Prices Review Board (Report, 2/17/93, GAO/HRD-93-61).

Prescription Drugs: Changes in Prices for Selected Drugs (Report, 8/24/92, GAO/HRD-92-128).


Homelessness: Appropriate Controls Implemented for 1000 McKinney Amendments' PATH Program (Report, 2/22/94, GAO/HEHS-94-82).


Breastfeeding: WIC's Efforts to Promote Breastfeeding Have Increased (Report, 12/16/93, GAO/HRD-94-13).


Community-Based Drug Prevention: Comprehensive Evaluations of Efforts Are Needed (Report, 3/24/93, GAO/GGD-93-75).


Childhood Immunizations (Letter, 2/8/93, GAO/HRD-93-12R).


Women's Health Information: HHS Lacks an Overall Strategy (Testimony, 8/5/92, GAO/T-HRD-92-51).

Health Care: Most Community and Migrant Health Center Physicians Have Hospital Privileges (Report, 7/16/92, GAO/HRD-92-98).

Foreign Assistance: Combating HIV/AIDS in Developing Countries (Report, 6/19/92, GAO/NSIAD-92-244).
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Bone Marrow Transplantation (Report, 3/7/94, GAO/PEMD-94-10).


VA Health Care: VA Medical Centers Need to Improve Monitoring of High-Risk Patients (Report, 12/10/93, GAO/HRD-93-27).

Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays is Needed for Federal Health Programs (Report, 9/17/93, GAO/HRD-93-92).

Medicaid: HealthPASS—An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (Report, 5/7/93, GAO/HRD-93-87).


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VA Health Care: Medical Centers Are Not Correcting Identified Quality Assurance Problems (Report, 12/30/92, GAO/HRD-93-20).


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**Health Care:** Reduction in Resident Physician Work Hours Will Not Be Easy to Attain (Report, 11/20/92, GAO/HRD-93-24BR).

**Home Health Care:** HCFA Properly Evaluated JCAHO’s Ability to Survey Home Health Agencies (Report, 10/25/92, GAO/HRD 93-39).

**AIDS:** CDC’s Investigation of HIV Transmissions by a Dentist (Report, 9/20/92, GAO/PEMD-92-31).

**Medical Technology:** For Some Cardiac Pacemaker Leads, the Public Health Risks Are Still High (Report, 9/23/92, GAO/PEMD-92-20).

**Health Care:** Most Community and Migrant Health Center Physicians Have Hospital Privileges (Report, 7/16/92, GAO/HRD-92-98).

**Screening Mammography:** Federal Quality Standards Are Needed (Testimony, 6/5/92, GAO/HRD-92-39).

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**Drug Control:** Reauthorization of the Office of National Drug Control Policy (Report, 9/29/93, GAO/GGD-93-144).

**Drug Use Measurement:** Strengths, Limitations, and Recommendations for Improvement (Report, 6/25/93, GAO/PEMD-93-18).

**Indian Health Service:** Basic Services Mostly Available; Substance Abuse Problems Need Attention (Report, 4/9/93, GAO/HRD-93-48).

**Drug Education:** Limited Progress in Program Evaluation (Testimony, 3/31/93, GAO/T-PEMD-93-2).

**Community-Based Drug Prevention:** Comprehensive Evaluations of Efforts Are Needed (Report, 3/24/93, GAO/HRD-93-75).

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Employee Drug Testing: Estimated Cost to Test All Executive Branch Employees and New Hires (Report, 6/10/92, GAO/GGD-92-96).

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**Student Loans: Millions Loaned Inappropriately to U.S. Nationals at Foreign Medical Schools** (Report, 1/21/94, GAO/HEHS-94-28).


**Direct Student Loans: The Department of Education's Implementation of Direct Lending** (Testimony, 6/10/93, GAO/HRD-93-26).


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**Stafford Student Loans: Prompt Payment of Origination Fees Could Reduce Costs** (Report, 7/24/92, GAO/HRD-92-61).

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Deaf Education: Improved Oversight Needed for National Technical Institute for the Deaf (Report, 12/16/93, GAO/HRD-94-23).

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