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BY THE U.S. GENERAL ACCOUNTING OFFICE  
**Report To The Secretary Of Defense**

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**Better Controls And Data Needed To  
Distribute Defense Medical Supplies**

Defense medical supply distribution is hindered by inventories that are too large and too old, limited monitoring of purchasing and delivery systems, and overstocked supply systems. Pacific area medical facilities were maintaining millions of dollars of inventory above their authorized operating levels. During the first quarter of fiscal year 1979, \$10 million of the Defense Logistics Agency's perishable inventory was unusable or restricted for issue because shelf life would expire soon.

Consolidating medical support functions in  
hould reduce costs and improve

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B-198914

The Honorable Harold Brown  
The Secretary of Defense

Dear Mr. Secretary:

This report discusses the Department of Defense's multiple systems for distributing medical supplies to the military services. We considered medical supply purchasing, inventory control and distribution, and possible duplication among systems.

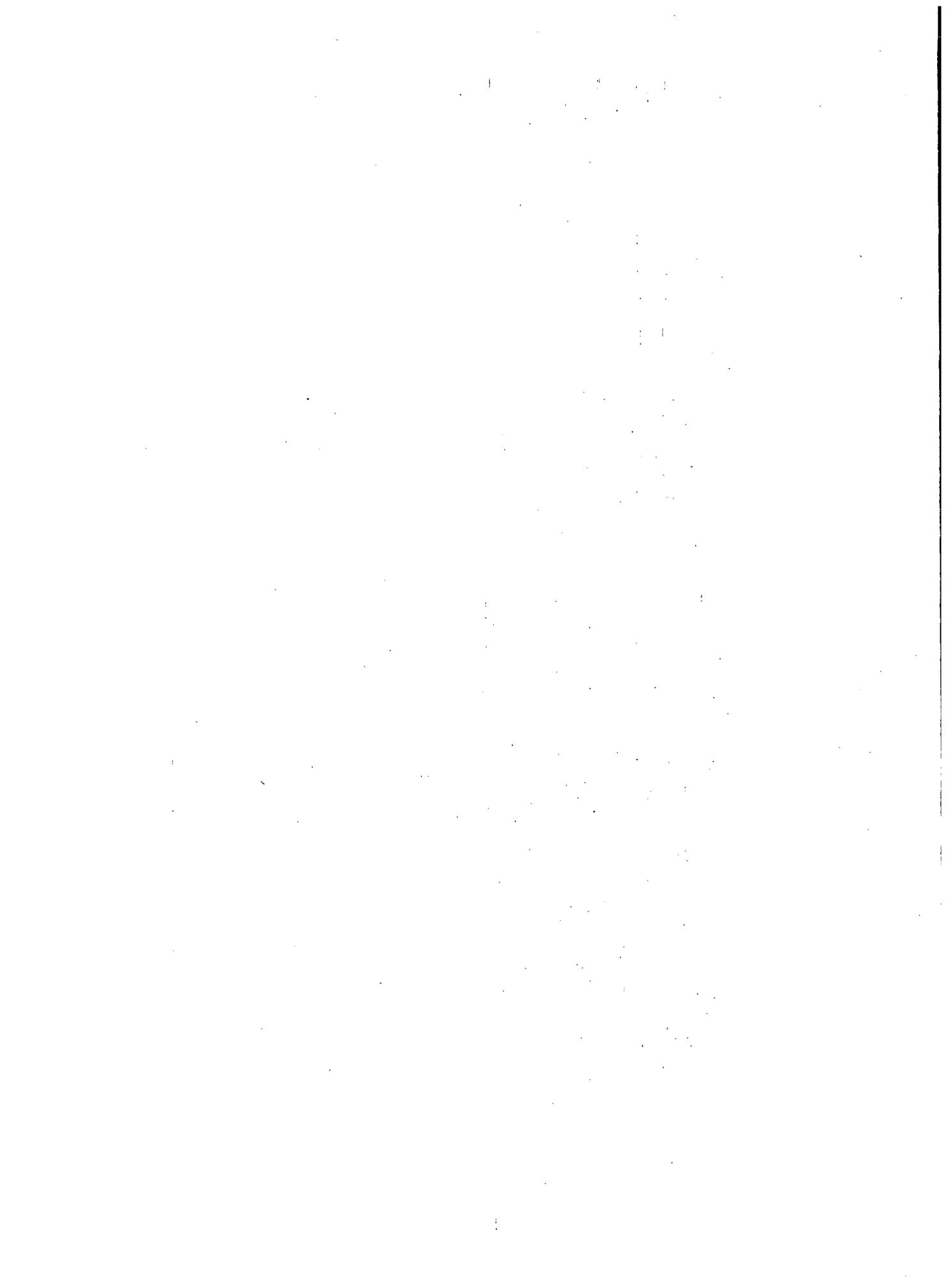
The report contains recommendations to you on pages 9, 17, and 24. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Director, Office of Management and Budget; the Chairmen, Senate Committee on Governmental Affairs, House Committee on Government Operations, and Senate and House Committees on Appropriations and on Armed Services; the Secretaries of the Army, Navy, and Air Force; and the Director, Defense Logistics Agency.

Sincerely yours,

*for*   
R. W. Gutmann  
Director

**NCJRS****DEC 10 1980****ACQUISITIONS**



D I G E S T

In recent years, the Defense Logistics Agency (DLA) and the three military services delivered medical supplies costing over \$300 million annually to worldwide Department of Defense (DOD) activities. (See p. 1.)

This distribution was hindered by excessive and old inventories, limited DLA monitoring of the diverse DOD purchasing and delivery systems, and weaknesses in DLA's centralized supply system. If support functions in the Pacific were consolidated, costs could be reduced and controls improved. (See pp. 4, 10, and 20.)

High medical supply inventories throughout the system increase cost and handicap control over perishable items. DLA's personnel support center disposed of \$12 million (7 percent) of its fiscal year 1978 medical inventory because the supplies were either outdated or no longer needed. Overseas depots stocked up to two and three times authorized levels.

GAO believes that the high inventories and inventory control weaknesses contribute to high rates of loss for perishable supplies. During the first quarter of fiscal year 1979, \$10 million (17 percent) of DLA's \$59 million perishable medical supplies were unusable or were of limited use because shelf lives would expire soon. Similarly, field activities experienced unnecessary losses when they received outdated supplies or did not properly store perishable items. Furthermore, reporting on disposals was inadequate. (See p. 4.)

DLA monitoring of about \$118 million worth of local purchases by the military services is weakened by reports that are incomplete and do not provide comparable data. These weaknesses limit DLA's ability to identify common items which should be centrally managed. (See p. 10.)

DLA and the services could reduce the cost and time needed to distribute medical supplies. DLA depots ship too many supplies out of their assigned regions. Out-of-area shipments cost over 80 percent more than within-area shipments and often hinder, rather than improve, timeliness. The out-of-area shipments of medical supplies cost about \$274,000 during 4 months in 1978--over \$800,000 more a year. DLA has often considered ways to limit out-of-area shipments for lower priority supplies but does not plan to change current practices in the foreseeable future. (See p. 12.)

Only Air Force requisitions regularly reach DLA within DOD's 2-day standard. The Army and Navy reduce timeliness of their orders to DLA by sequential edits and reviews by intermediate organizations. The reviews, if needed, might be done on extra copies of order forms to expedite processing. Performance against DOD's standard shows that delays result in additional Army inventory costs of \$575,000. (See p. 14.)

DLA has encountered serious difficulty in delivering nonstocked medical supplies within its goal--30 days after receiving the requisition. Although DLA had not yet met its goal, it improved requisition processing during GAO's review and was trying to expedite delivery as well. DLA response to customer inquiries still took unreasonably long--40 to 60 days. Local officials believe automated system improvements not yet completed should reduce response time, but GAO believes interim actions could improve service now. (See p. 15.)

Consolidating medical support functions in Japan, Korea, and Hawaii could reduce cost and improve control. An Army and Air Force support agreement in Japan demonstrates that interservice medical support can work well, but the Navy in Japan is not now participating. Also, GAO identified large medical supply activities in Korea and Hawaii which should have little difficulty serving smaller local activities. (See p. 20.)

GAO believes that the weaknesses discussed in this report inhibit DOD's ability to adhere to the Office of Federal Procurement Policy's directive to purchase products through commercial distribution channels when possible. (See p. 16.)

The Secretary of Defense should

- reduce medical supply inventories to authorized levels and improve control over perishable items;
- improve control over military services' local purchases by uniform coding, expanded monitoring, and a DOD-wide directory of nonstandard medical supplies;
- reduce transportation costs by finalizing plans to limit unnecessary out-of-area shipments from DLA depots, and by setting a specific timetable for implementation;
- reduce time needed to process orders for nonstocked medical supplies by eliminating marginally useful edits or by at least minimizing the resulting delays;
- augment current DLA efforts to improve timeliness through interim changes now, even where changes to the automated system are planned; and
- reduce support cost and improve control by further using interservice support among medical supply activities in Japan, Korea, and Hawaii. (See pp. 9, 17, and 24.)

## AGENCY COMMENTS

DOD agreed on the need to improve responsiveness to overseas requisitions and to review potential consolidations. It advised GAO that it would look to see where local purchases could be improved. DOD believed that high incidence of outdated perishable stocks, however, resulted from causes beyond its control. DOD disagreed with GAO's recommendation to limit out-of-area shipments. (See pp. 9, 18, 25 and app. III.)

# C o n t e n t s

		<u>Page</u>
DIGEST		i
CHAPTER		
1	INTRODUCTION	1
	Medical supply organization and responsibility	1
	Medical supply procurement and distribution	2
	Scope of review	3
2	DOD ACTIVITIES NEED TO BETTER MANAGE THEIR MEDICAL SUPPLY INVENTORIES	4
	Excess stocks at overseas depots	4
	Improvement needed in manag- ing perishable inventory items	6
	Problems in managing perishable inventories overseas and in Hawaii	7
	Disposal actions require more management attention	8
	Conclusions	8
	Recommendations	9
	Agency comments and our evaluation	9
3	DLA COULD BETTER CONTROL PROCURE- MENT AND DISTRIBUTION OF MEDICAL SUPPLIES	10
	Need to improve monitoring and control over nonstandard medical supplies	10
	Transportation costs can be reduced by limiting out-of-area shipments	12
	Impediments to meeting medical supply needs in a timely manner	14

CHAPTER		<u>Page</u>
3	Army and Navy requisitions to DPSC are not timely	14
	DPSC problems in delivering and following up on nonstocked supplies	15
	Conclusions	16
	Recommendations	17
	Agency comments and our evaluation	18
4	OPPORTUNITIES TO REDUCE COSTS BY CONSOLIDATING MEDICAL SUPPORT FUNCTIONS IN THE PACIFIC	20
	Some progress with opportunities for further interservice support in Japan	20
	Opportunities for interservice support in Korea	22
	Opportunities for interservice support in Hawaii	22
	Conclusions	24
	Recommendations	24
	Agency comments and our evaluation	25
 APPENDIX		
I	DLA medical depots	26
II	Organizations visited during our review	27
III	Letter dated May 30, 1980, from the Principal Deputy Assistant, Office of the Assistant Secretary of Defense (Manpower, Reserve Affairs and Logistics)	29

#### ABBREVIATIONS

DLA	Defense Logistics Agency
DOD	Department of Defense
DPSC	Defense Personnel Support Center
DRIS	Defense Retail Interservice Program
GAO	General Accounting Office

## CHAPTER 1

### INTRODUCTION

This report discusses how the Department of Defense (DOD) manages and controls its vast inventories of medical supplies. It covers various elements of the total distribution system, including how supplies are requisitioned, purchased, stored, and distributed worldwide to DOD customers. Our objective was to determine how well DOD's medical distribution system was working; that is, whether it was responsive to the needs of users and whether it was being managed efficiently and economically.

### MEDICAL SUPPLY ORGANIZATION AND RESPONSIBILITY

The Defense Logistics Agency (DLA) is responsible for the overall management of all DOD medical materiel, including drugs, surgical instruments, equipment, and supplies. DLA's Defense Personnel Support Center (DPSC), Philadelphia, Pennsylvania, is the integrated manager for medical supplies and the inventory control point for wholesale stocks. DPSC centrally manages over 15,000 standard items. About 10,000 of these items are at Defense depots in Mechanicsburg, Pennsylvania; Memphis, Tennessee; and Tracy, California; and at the Naval Supply Center, Norfolk, Virginia, a specialized support depot. In fiscal year 1978, DPSC bought over \$200 million in medical supplies and had over \$181 million in inventory. Sales of medical items to the military services totaled over \$220 million. In fiscal year 1979, medical supply inventories climbed to \$230 million and sales climbed to over \$280 million.

The Defense Medical Materiel Board, which consists of representatives from each of the three Surgeons General of the military services, coordinates with DPSC and provides advice and assistance on the professional/technical aspects of medical materiel. In addition, the Board identifies for DPSC medical items which are candidates for standardization and central management. Using the Board's input, DPSC evaluates the candidate items.

Each service also purchases a large volume of medical items and manages the inventory at medical activities worldwide, including over 750 military hospitals, clinics, and dispensaries. In fiscal year 1978, the services purchased about \$118 million worth of medical supplies either directly or through DLA contracts. The services have

different systems and policies on how they purchase standard items from DPSC; how they select, identify, and purchase nonstandard items; and how they store and distribute these supplies to their user activities.

In another area of responsibility, DLA administers the Defense Retail Interservice Support Program under the direction of the Assistant Secretary of Defense (Manpower, Reserve Affairs and Logistics). Among the objectives of this program are the development of uniform policy and procedures in DOD and promotion of interservice support among the services.

#### MEDICAL SUPPLY PROCUREMENT AND DISTRIBUTION

DOD medical supplies may pass several distribution points before reaching the ultimate user, depending on how the items are bought and stored. Standard items stocked by DLA can move from DLA depots directly to the ultimate user or to major service stocking points; that is, depots, supply centers, and hospitals. These activities may store and use the medical materiel or distribute it to other medical facilities for their use or for further distribution if necessary. (See app. I for the locations of DLA depots.)

Medical items which are not standard items centrally controlled by DLA are called nonstandard items. The services choose and identify their own nonstandard items and buy them directly from suppliers through local purchases. Nonstandard items may be delivered by the supplier to major service stocking points or may be shipped to the medical facilities buying and using the materiel.

A nonstandard item, such as gold used for dental fillings, may be completely different than a standard medical item carried in the central system. In many cases, however, the nonstandard item may be the same product except for differences in size, strength, or unit of pack. For example, certain 8-ounce bottles of bath oil are standard stock, while 2-ounce bottles are nonstandard. Packages of phenobarbital tablets with a strength of 30 milligrams are standard stock, while the same size packages of phenobarbital tablets with a strength of 60 milligrams are nonstandard.

Distinguishing between standard and nonstandard items also depends on the demand and costs of the items. For an item to be considered for standardization, demands must amount to \$10,000 annually and at least 12 activities must report the use of the item. We discuss DOD efforts to monitor and evaluate nonstandard items on pages 10 to 12.

Our recent reviews have considered DOD efforts to carry out a single, Government-wide system for buying medical materiel and to comply with the Acquisition and Distribution of Commercial Products policy of the Office of the Federal Procurement Policy. 1/ This report, however, discusses only the distribution of medical supplies within DOD's system.

The following chapters detail problems in managing DOD's worldwide distribution network for medical supplies and describe what can be done to make DOD's system more responsive, efficient, and cost effective.

#### SCOPE OF REVIEW

We evaluated distribution of medical supplies to DOD activities. We met with officials at the Office of Federal Procurement Policy; DOD and DLA headquarters; and Offices of the Surgeons General of the Army, Navy, and Air Force.

We visited the Defense Personnel Support Center; two DLA depots; Air Force, Army, and Navy headquarters; and field medical activities in the United States, Japan, Korea, and the Philippines. (See app. II for listing.) At these activities, we discussed how medical supplies were being distributed and analyzed data provided by the activities on supply distribution effectiveness.

We also discussed our work with DOD, Army, Air Force, and Navy internal auditors and reviewed recent internal audit reports concerning management of medical supplies.

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1/"Implementation of Federal Policy on Acquiring and Distributing Commercial Products Is Faltering Badly" (PSAD-80-13, Jan. 14, 1980).

"Review of Prescription Drugs" (HRD assignment code 101016)

## CHAPTER 2

### DOD ACTIVITIES NEED TO BETTER

#### MANAGE THEIR MEDICAL SUPPLY INVENTORIES

Defense medical supply inventories are too large and often too old. High inventory levels exist throughout the system, controls over perishable items do not safeguard quality and minimize loss, and reporting on medical supply disposal and destruction is erratic. Improved management of medical supply inventories by DLA and the military services could save millions of dollars in inventory investment and maintenance costs, minimize loss from outdated supplies, and improve supply effectiveness.

DOD's medical supply system is overstocked at depot, intermediate, and user levels. Some overseas activities stocked over twice the authorized levels. Excessive stock levels not only increase inventory investment but aggravate problems in maintaining, rotating, and disposing stocks. Medical supply problems can be particularly severe because many items are perishable and must be watched closely.

We did not try to independently determine the amount and cost of unneeded inventory in DOD's medical supply system, but DPSC disposed of \$12 million--about 7 percent--of its fiscal year 1978 inventory of \$181 million because the supplies were either outdated or no longer needed. As discussed below, overseas field depot inventories were particularly large.

#### EXCESS STOCKS AT OVERSEAS DEPOTS

Although shortages may have existed for some individual items, Pacific area medical facilities were maintaining millions of dollars of inventory above their overall authorized levels. In many cases, all stock locations within the system were overstocked. These conditions existed at medical facilities of all three military services.

The 6th Medical Depot, Seoul, Korea, stocks medical and dental supplies for all Army units in Korea. The depot is authorized a stock level equivalent to about 6.8 months of supply to support its customers. As of March 31, 1978, the depot reported stocks on hand and due-in of \$2,765,000, excluding war reserves, which is equal to almost 9.8 months of supply, or almost 45 percent above the authorized level.

Overstocking continued below the depot level in Korea. A medical supply office at Camp Casey, Korea, was authorized a 1-month inventory but actually had a 3-month level during our visit. Similarly, a medical treatment facility supported by the supply office had twice the authorized level.

Navy inventories in the Pacific also exceeded authorized levels at supply depots and at nearby medical facilities. The Naval Supply Depot, Subic Bay, the Philippines, had 8.8 months of medical supply inventory on hand during our visit, more than twice the authorized 4.25 months. Navy medical and dental centers within a few miles of the supply depot also held several months of inventory which duplicated depot stocks. The medical center had about 2.5 months of inventory worth about \$92,000 and the dental center had 3.5 months of inventory valued at \$32,000.

The Navy Regional Medical Center at Yokosuka, Japan, was maintaining about 4.2 months of medical supplies valued at \$189,000, even though the stocks were within walking distance of a naval supply depot. The Navy could eliminate this center's stocks entirely. The Regional Medical Center, Pearl Hawaii, does not stock medical supplies. Instead, it uses supplies on hand at the nearby supply center.

Air Force activities in the Pacific monitored their medical supplies closely. Although their inventories also exceeded optimum levels, the excesses were less severe. We visited Air Base medical activities at Yokota, Japan; Osan, Korea; and Clark, the Philippines. Their optimum stock levels ranged from about 3.3 months at Yokota to 3.9 months at Osan, with a total cost of about \$731,000. Actual inventories exceeded the optimum levels by amounts ranging from about 0.7 months at Osan to 1.5 months at Yokota, with a total excess of about \$257,000.

A portion of the excess stocks may qualify as economic retention stocks; that is, they exceed an activity's needs, but are considered by the activity to be more economical to retain and use than to redistribute. Where identified, such stocks were not the major portion of the excesses. For the Air Force, only \$92,000 of the total excess inventories of \$257,000 were classified as economic retention stocks.

Military supply officials in the Pacific told us that field organizations ordered in excess of their authorized inventory levels to compensate for delays in receiving medical items. They said the delays resulted both from

transportation time and from DLA being out of stock. In Korea, a customer service assistance team reported that excess inventory was temporarily held to ensure adequate supply during upgrading of an automated supply support system.

#### IMPROVEMENT NEEDED IN MANAGING PERISHABLE INVENTORY ITEMS

In the first quarter of fiscal year 1979, DLA depots stocked over \$59 million in medical supplies with limited useful lives. Although DLA and the services have established additional controls to monitor such perishable items, millions of dollars of costly drugs and other medical items become unusable. During the first quarter of fiscal year 1979, \$10 million (17 percent) of DLA's perishable inventory was unusable or was restricted for issue because shelf life was to expire soon.

The useful lives of new perishable medical supplies stored by DLA range from 1 to 5 years. To manage aging inventories, DLA depots assign codes to categorize their stocks by relative length of remaining useful lives. For example, a new item with an 18-month useful life is coded "A" and may be issued to customers worldwide. When the remaining useful life of the item falls below 9 months, it is coded "B" and may only be issued to customers in the United States. Three months before expiration, the item is coded "C" and may only be issued with customer approval.

Since customer requisitions are processed through DPSC's automated materiel management system, it is essential that DLA depots advise DPSC of any changes in not only the quantity, but also the condition of their inventories. Inventory managers at DLA depots are responsible for periodically inspecting and coding medical supplies. As inventories change, these managers submit inventory adjustment documents to DPSC.

If inventory adjustment documents are not accurate and do not include all data needed to satisfy computer input and processing requirements, DPSC's automated system will reject the changes. DLA depots are submitting incomplete and inaccurate adjustment documents. The resulting rejected data must be reconciled and corrected, delaying the updating of DPSC's master control records by an average of 60 days, and in some cases, as long as 220 days.

The effect of outdated master control records can be critical and costly where perishable inventory is concerned because the clock continues to run on such stocks. Old, but usable, stocks may not get shipped out first, resulting in their going out-of-date. These errors contributed to the quantity of usable or restricted supplies at DLA, since outdated master control records could show such supplies as still being usable. Furthermore, shipment of supplies which are older than desired can aggravate inventory management at the field level as well.

Problems in managing perishable inventories overseas and in Hawaii

Medical activities in Hawaii and overseas also are experiencing problems managing perishable medical stocks. In some instances, perishable items were received with little or no shelf lives remaining, possibly resulting from DLA's problems described above. In other cases, the overseas activities created the problem. They had not stored perishable supplies properly to prevent deterioration. The following examples highlight what is happening and point out the need for the military services to better manage perishable stocks.

- The Army's 6th Medical Depot in Korea held expired and outdated items in its inventory. For example, it had nearly 700 bottles of outdated cholera vaccine and 92 bottles of outdated polio vaccine.
- At the Clark Air Base Hospital, items requiring controlled temperatures were stored in overheated warehouse areas. To illustrate, 17,484 bottles of a nerve-agent antidote were not in refrigerated storage as required.
- The Navy Supply Depot in Yokosuka reported that 360 bottles of pralidoxime chloride, standard supplies ordered in May 1978, were outdated on receipt in June 1978.

In June 1979 we recommended 1/ that DOD appoint a shelf life program administrator, and DOD has appointed such an

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1/Report by the Comptroller General, "Need For A DOD Shelf-life Program Administrator," (LCD-79-220, June 19, 1979).

administrator. The administrator may be helpful in bringing the problems noted above to management's attention for corrective action.

#### DISPOSAL ACTIONS REQUIRE MORE MANAGEMENT ATTENTION

DPSC instructions require that item managers report disposals at DLA depots and identify those over \$500 for management survey. In actual practice, DPSC's automated inventory control system does not include a summary report of disposal activity. DPSC recommendations for disposal differed greatly from quantities actually disposed of at DLA depots. For example, DPSC forecast that medical stocks valued at \$8 million were earmarked for disposal from DLA depots for fiscal year 1978. The depots actually disposed of \$12 million during the year. Instead of following up the discrepancy, DPSC merely adjusted its accounts using the quantities reported by the depots.

We could not estimate with any degree of accuracy the volumes and types of perishable medical supplies that were routinely disposed of at military activities. Available records varied in content. Some installations could identify dollar amounts of items destroyed or sent to disposal, while others only had records of their disposals or destruction of controlled items, such as narcotic drugs. Summary reports showing the class, type, volumes, and values of items disposed of, however, were not prepared for management analysis. Consequently, large quantities of unusable inventory were disposed of without a management determination of what went wrong. The following examples illustrate some of the disposal actions occurring at military medical activities primarily because of expired shelf life:

- In January 1978 the Army Audit Agency reported that Tripler Army Medical Center medical supplies were not properly controlled in storage. In addition, supplies valued at about \$75,000 were destroyed primarily because the potency period had expired.
- Between July 1977 and June 1978, the Yokosuka Naval Supply Depot suspended medical supplies costing over \$29,000 due to expired shelf lives.

#### CONCLUSIONS

Management of DOD medical supply inventories needs improvement to eliminate overstocking, to better control perishable medical stocks, and to meet the objectives of the Government's

Acquisition and Distribution of Commercial Products policy. Many perishable supplies become outdated and worthless before they can be used. Better reporting on disposal of stocks which deteriorated in storage would help.

#### RECOMMENDATIONS

We recommend that the Secretary of Defense direct DLA and each military service to

- eliminate excess medical supply inventories and maintain future inventories more in line with authorized levels and
- review and improve inventory management practices and controls over perishable medical supplies.

#### AGENCY COMMENTS AND OUR EVALUATION

DOD provided additional reasons for the high stock levels and large disposals at the time of our audit. The additional reasons provided may have contributed to the stock levels and disposals observed. However, the change in the Army's mode of delivery, cited by DOD as a reason for the high stock levels, was not relevant because it occurred after our audit. Also, disposals of medical supplies by DLA depots remained high in the following year, amounting to almost \$9 million in fiscal year 1979.

DOD stated it will defer directing DLA and the services to eliminate excess medical inventories pending the results of a retention and disposal study due in September 1980. We are encouraged by DOD's study and will monitor actions taken by DOD on the study's completion.

DOD does not agree that a uniform system for reporting medical supply disposals is needed. However, DOD is implementing a uniform shelf life report which will include medical supply disposal data. The report will be submitted to the DOD shelf life program administrator beginning December 1980. In view of the planned DOD report, we deleted our recommendation to establish a uniform reporting system on disposal of medical materials.

## CHAPTER 3

### DLA COULD BETTER CONTROL PROCUREMENT AND DISTRIBUTION OF MEDICAL SUPPLIES

DOD designated DLA as its integrated manager to centralize management control of medical supplies, but DLA has not fully achieved this goal. The services buy almost a third of their medical supplies from local sources, and these purchases are not adequately monitored by DLA. Consequently, DLA is poorly informed about much of the medical supplies the services are using. These local purchases, mostly nonstandard items, totaled about \$118 million in fiscal year 1978.

We reported similar weaknesses to the Congress and DOD in a December 1973 report. <sup>1/</sup> The Assistant Secretary of Defense (Health and Environment) responded that each military department would follow standard reporting criteria for local purchases, and that a uniform reporting system for all pharmaceutical purchases would be put into use as soon as practicable and cost effective. After over 6 years, however, DOD efforts have neither eliminated duplication among services nor provided DOD with the information needed to effectively manage a large element of its supply system.

DLA could also improve the way it meets the needs of field activities. It could reduce its shipping costs by limiting out-of-area shipments from DLA depots. DLA has made numerous efforts to improve timeliness, but success at overcoming impediments to timely medical supply service has been variable.

#### NEED TO IMPROVE MONITORING AND CONTROL OVER NONSTANDARD MEDICAL SUPPLIES

Defense agencies purchased about \$118 million of non-standard medical supplies in fiscal year 1978, about 37 percent of the reported total for all medical supplies. DLA's control over nonstandard supplies is hampered because it buys only a portion of such supplies, and it does not now have the means to effectively monitor the remaining supplies purchased by field medical activities. In fiscal

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<sup>1/</sup>"How To Improve The Procurement And Supply Of Drugs In The Federal Government" (B-164031 (2), Dec. 6, 1973).

year 1977, only \$27 million (25 percent) of nonstandard supplies was purchased by DLA, while \$83 million in supplies (75 percent) was purchased by field medical activities.

Each military service independently selects, purchases, catalogs, and stores most nonstandard supplies. Differing procurement and supply practices preclude effectively coordinating these actions, even though services often buy essentially the same item. The prices paid for locally purchased items not only vary among services, but also among activities within a service. For example, 35 Air Force medical activities purchased a simple medical laboratory tool (pipetting tips) at prices ranging from \$15.13 to \$48.

DOD started a local purchase reporting system in 1976 to improve interservice coordination. The U.S. Army Medical Materiel Agency was designated to receive and summarize local purchase data from all services for presentation to the Defense Medical Materiel Board. The Board uses the information to standardize and classify medical supplies. The Board reviews a semiannual, triservice report of locally purchased medical supplies and recommends high-cost and frequently used supplies for induction in the standard supply system.

This program is only marginally successful because reporting systems vary and each service assigns its own stock numbers to locally purchased items. Therefore, commonly used items cannot be readily identified because service reports are difficult to compare.

If the triservice report captured essential data, it could be an effective management tool to help manage military buying of medical supplies. Unfortunately, the report is incomplete and therefore of limited use in capturing local purchase data to identify candidates for DPSC's central supply system or for DPSC-awarded contracts.

The Air Force's automated system is the only system which reports all medical supplies over \$10. The Army's automated system should also, but it does not include data from locations without computer capability. The Navy has a manual reporting system, and some Navy locations report only medical supplies, such as drugs, which bear a national product identification number.

Some medical activities simply neglected to report all local purchases. For example, the Defense Audit Service reported in May 1979 that eight Army and Navy activities did not report \$16 million in locally purchased medical supplies during fiscal year 1977.

Data collection and reporting require comparable codes to identify locally purchased supplies. At present, however, each service independently assigns its own control numbers. The Army and Air Force maintain separate central directories and use different numbers to identify many of the same supplies. The Army's directory contains over 6,000 items and the Air Force's contains about 4,400. The Navy has no central numeric code. Each Navy activity assigns its own local number, creating multiple control numbers for many common items even within the Navy.

Since 1974 DLA unsuccessfully has tried to assign national stock numbers to commonly purchased nonstandard items. A program scheduled to be carried out in March 1979 was delayed because of disagreement among DLA, DPSC, and the Medical Board on the potential workload and the needed resources. DLA did not determine the feasibility and cost of the program and had planned to implement the program without a uniform procedure to collect and report data on supply purchases.

Assigning national stock numbers to nonstandard medical items is a good idea, but should include (1) cost-effective criteria for when to assign or delete stock numbers and (2) standard procedures for collecting and reporting the data.

We should note, that to better manage supplies, DOD has implemented a plan to maximize use of commercial distribution channels. Under the plan, the total cost (inventory investment, storage, distribution, overhead, and acquisition), rather than merely the acquisition cost, is to be used in determining the method to manage and purchase commercial items.

#### TRANSPORTATION COSTS CAN BE REDUCED BY LIMITING OUT-OF-AREA SHIPMENTS

DLA depots (see app. I) provide supplies to customers within their assigned boundaries unless a particular depot is out of stock. If another depot has the desired supplies, the customer's order is routinely passed to that depot for disposition. Although a good idea for high priority items, indiscriminate use of this procedure has unnecessarily increased transportation costs and delayed receipt of items in some cases.

An analysis of about 17.4 million pounds of medical supplies shipped from the three DLA depots during the last 4 months of fiscal year 1978 showed that the average out-of-area shipping cost per hundred pounds was \$8.88--84 percent more than the average for within-area shipments. Using this difference, we computed additional transportation costs for the 4-month period to be about \$274,000--more than \$800,000 a year. The estimate does not include the additional costs from shipments totaling almost 4 million pounds for which costs were not readily identifiable. Nor does the estimate include an unknown quantity shipped from Mechanicsburg, Pennsylvania, to Memphis, Tennessee, depot customers.

In some cases, DPSC began out-of-area shipments even though receipt of the supplies in question was imminent at the assigned depot. Such replenishment stocks were frequently received within a few days of the more costly out-of-area shipments. The following example illustrates the problem.

DPSC had back orders for over 27,000 bottles of erythromycin tablets, and each of the three DLA depots expected replenishment. The Memphis, Tennessee, depot received its replenishment of about 32,000 bottles first, so all back orders were passed to Memphis during November 3 through 8, 1978. The Tracy, California, and Mechanicsburg, Pennsylvania, depots received their replenishments of over 20,000 bottles each on November 8 and 10, respectively. The following table shows the distribution made by the Memphis depot.

<u>Priority of order</u>	<u>Shipments within Memphis area</u>	<u>Out-of-area shipments</u>	<u>Total shipments</u>
I (1-3)	5	2	7
II (4-8)	18	35	53
III (9-15)	<u>40</u>	<u>46</u>	<u>86</u>
Total	<u>63</u>	<u>83</u>	<u>146</u>

As the table shows, only 2 of the 83 out-of-area shipments would have been required if DPSC had limited referrals to priority group I orders. The remaining 81 back orders could have been shipped about as fast and more cheaply by the assigned depots. In fact, over 3,000 of the back ordered bottles were shipped from Memphis, Tennessee, to California on November 11--3 days after the assigned depot had already received its replenishment.

Also worth noting is that the out-of-area shipments resulted in unbalanced inventories. For example Memphis was left with only 5,000 bottles, while the Tracy and Mechanicsburg depots were left with over 20,000 bottles each. This imbalance increases the likelihood of a future shortage at the Memphis depot, resulting in even more out-of-area shipments.

DLA officials are aware that the automated back order procedure increases out-of-area shipments. Programers incorporated the procedure into their system because they could not agree how long a back order should be held pending replenishment of depot stocks. In 1976 and 1978, DLA supply officials proposed changes to reduce out-of-area shipments and the associated extra transportation costs. A study was underway during our review.

Under DLA's 1978 proposal, the first depot replenished would get all back orders for its assigned customers, as well as all other depots' priority group I back orders. All other priority group II and III back orders would be held for 5 and 10 days, respectively. New requisitions received during the "hold period," however, would be referred to the depot with stock and would also trigger referral of all back orders with the same or higher priority.

DLA officials advised us that the changes may be carried out, but probably not for another 3 years or more. They said DLA has other, higher priority changes underway involving DPSC's materiel management system.

#### IMPEDIMENTS TO MEETING MEDICAL SUPPLY NEEDS IN A TIMELY MANNER

Field medical activities had particular problems in getting nonstocked standard supplies. These medical supplies are ordered from DPSC but are shipped to the field activities directly from vendors rather than from DLA depots. Delays have been encountered by the Army and Navy in getting requisitions to DPSC and by DPSC in getting supplies to field activities. Further, DPSC does not use a fully automated direct delivery method of supply support and is not providing timely status information when customers inquire.

#### Army and Navy requisitions to DPSC are not timely

Electronically transmitted Army and Navy requisitions do not reach DPSC terminals within the 2-day standard established by DOD. In July 1978 the average elapsed time from

requisition preparation to receipt by DPSC was 7.9 days for Navy orders and 4.3 days for Army orders. Only the Air Force's 1.2 days average met the DOD standard.

When medical activities expect delays in receipt of supplies, they order more supplies to compensate for delays. This is necessary to avoid stock outages. The Army estimates this medical supply "pipeline inventory" to cost about \$250,000 per day of delay. The Air Force estimated cost is about the same. We did not obtain Navy data. Using the Army and Air Force cost to put a price tag on performance against the DOD standard results in an inventory savings of \$200,000 for the Air Force, but additional costs of \$575,000 for the Army.

Requisition delays occur at least partly because many Army and Navy requisitions receive edits and reviews at intermediate organizations before arriving at DPSC. We noted that during June 1978 to February 1979, Army edits of overseas requisitions added from 1 to 5 days to processing time. Records at the Navy Supply Center, Oakland, California, did not show the time required for their reviews. All Air Force orders are sent directly to DPSC with no intermediate processing.

In a January 1979 report, the Army Audit Agency criticized delays in processing Army requisitions--not only from overseas, but stateside as well. Regarding edit and review of overseas requisitions, the report concluded that the small percentage of requisitions rejected by the U.S. Army Medical Materiel Agency did not justify the delays introduced by their edit. Army medical officials advised us they disagreed with the report and planned to continue processing as before.

#### DPSC problems in delivering and following up on nonstocked supplies

DPSC has encountered serious difficulty in meeting its 30-day goal to deliver nonstocked medical supplies to customers after receiving their requisitions. Service to overseas activities appeared to be a particular problem area with the Army reporting 90- to 100-day service.

DPSC officials acknowledged the problems and made improvements during our fieldwork. In January 1979 DPSC's backlog of medical requisitions totaled 9,200--over six times greater than its goal of 1,500. By adding staff and improving the automated supply program, DPSC reduced the backlog to below 1,500 by May 1979 and held that level in June.

A programming error had aggravated DPSC problems by deleting over 2,000 old requisitions from automated records. By June 1979, DPSC had reconstructed most data and processed all but 600 of the requisitions.

As discussed above, requisition processing was improved. Also, DPSC officials were trying to rush deliveries by such means as shipping all overseas nonstocked supplies by first class mail. Its procurement administrative lead-time of over 18 days still hampered meeting the desired 30-day goal. If alternative means to improve performance do not work, DLA and the military services may need to reconsider the reasonableness of their 30-day goal.

When customers requested status of their orders, DPSC took from 40 to 60 days to respond--the goal is 35 days. DPSC officials believe that system improvements not yet completed during our review should alleviate this problem. We noted, however, that interim actions could assist getting data and improve service. For example, since few vendors notify DPSC when they send shipments to customers, DPSC could use response cards or even could telephone to keep up with such data.

## CONCLUSIONS

To better manage local purchases by individual services, and to effectively carry out the Government's Acquisition and Distribution of Commercial Products policy, DOD needs to improve data reporting by the services and data collection and analyses by DLA. DLA needs to have a better picture of what is being purchased locally, by whom, and in what quantities.

An essential step is assigning worldwide stock numbers to nonstandard medical items when demand and cost warrant a separate number. Then, DOD can publish a single directory of nonstandard medical items instead of the directories being separately published by the Air Force and Army. Only then can the various organizations described in this chapter fulfill their roles in determining how medical supplies should be purchased and distributed. Options include having supplies

- centrally purchased by DPSC and stocked at DLA depots,
- centrally purchased by DPSC for direct delivery by vendors,

- purchased by field units under DPSC contracts, and
- purchased by field activities under their own contracting authority.

DPSC could reduce the transportation costs associated with indiscriminately passing all back orders to whichever depot has stock. DPSC's system should consider whether replenishments are due-in at assigned depots before beginning out-of-area shipments. We recognize that higher priority system changes may prevent immediate correction of the current problem. We are concerned, however, that deferring problematic matters 3 or more years could presage indefinite deferral.

Army auditors and program managers appear at an impasse regarding the apparently inconsequential edits which contribute to requisition processing delays. If Army and Navy managers believe they need the edits and reviews--apparently the Air Force managers do not believe their service needs them--then they should work to minimize the impact from such extra steps. Perhaps the edits and reviews can be a parallel function performed on requisition copies, while the original requisitions are already on their way to or in process at DPSC.

We commend DPSC efforts to improve timeliness of procurements and deliveries and to overcome problems associated with an unexpectedly high volume of requisitions and automated system weaknesses. However, DPSC has been only marginally successful and can do more. We believe, for example, that even if changes to the DPSC automated system are planned for the future, interim steps now could improve DPSC's responses to customer inquiries.

#### RECOMMENDATIONS

To improve DLA management of locally purchased nonstandard items, we recommend that the Secretary of Defense instruct the Director, DLA, to take the following actions and require the military departments to cooperate in the DLA efforts:

- Establish a uniform numbering system for locally purchased nonstandard medical supplies.
- Develop uniform criteria for reporting such supplies.
- Prepare a DOD-wide directory of nonstandard medical supplies.

--Expand monitoring of local purchases to include all medical supplies shown on triservice reports, so that all possible candidates for central management can be considered.

To reduce transportation costs, we recommend that the Director, DLA, prepare and approve a plan to reduce unnecessary out-of-area shipments by DLA depots and set a specific timetable to carry out the plan.

To improve timely processing of requisitions for medical items, we recommend that the Secretary of Defense direct the military departments to reconsider the need for sequential edits of such requisitions being sent to DPSC. We further recommend that the Director, DLA, increase current efforts to improve timeliness of service by carrying out interim changes now, even where changes to the automated system are planned for the future.

#### AGENCY COMMENTS AND OUR EVALUATION

DOD advised us that it sees a need to improve responsiveness to overseas requisitions by eliminating intermediate edits where feasible, to look for possible improvements over local purchase controls, and to develop standard methods for determining use of new commercial items. DOD did not agree to the need for a uniform numbering system and a DOD-wide directory of locally purchased, nonstandard medical supplies. DOD told us such a system would be expensive and of little value.

We believe a uniform numbering system could well be less expensive than the disparate systems now used by each DOD component. Similarly, one DOD-wide directory need not be more expensive than the present situation where the Army and Air Force prepare separate directories. Consequently, we reaffirm our recommendations to establish a uniform numbering system and a DOD-wide directory.

DOD officials cited a DLA study which, in their opinion, showed only minimal savings possible by suggested limits on out-of-area shipments. They saw no value in pursuing our recommendation in this matter. The cited study, however, did not include medical supplies.

The cited study's sample included only Defense Industrial Center items, which are unrelated to our recommendations. Since many Industrial Center items are stocked only at one location, we agree that limiting industrial out-of-area shipments might not be productive. Medical items, however, are generally stocked in at least three locations, and limiting medical out-of-area shipments could save over \$800,000 a year. Therefore, we believe our recommendation still warrants action.

## CHAPTER 4

### OPPORTUNITIES TO REDUCE COSTS BY CONSOLIDATING

#### MEDICAL SUPPORT FUNCTIONS IN THE PACIFIC

Several medical support functions in the Pacific offer potential for consolidation and should be considered under DOD's Defense Retail Interservice Support (DRIS) program. By consolidating medical support functions in Japan, Korea, and Hawaii, we believe DOD could reduce inventory investment and maintenance costs, better control perishable inventory, and better control purchases of nonstandard supply items.

DOD has recognized the need to reduce the cost and duplication of effort that exist in support service programs within and among its military services and Defense agencies. The DRIS program is designed to promote interservice and interdepartmental support between retail activities of DOD by having one service provide common support services to others when it can be achieved without jeopardizing the mission.

DLA, under the direction of the Assistant Secretary of Defense (Manpower, Reserve Affairs and Logistics), administers the DRIS program. Executive coordinating agents represent the heads of each military department for resolving interservicing problems at that level. Aggressive use of interservice support is the responsibility of management at all DOD operating levels, and interservice support agreements are to be accomplished at the lowest possible level of command.

The commanders of the overseas unified commands are responsible for establishing joint interservice support study groups to efficiently achieve DRIS objectives and for coordinating the interservice support program within their areas of jurisdiction. The Commander in Chief, Pacific, has this responsibility for the Pacific theater.

#### SOME PROGRESS WITH OPPORTUNITIES FOR FURTHER INTERSERVICE SUPPORT IN JAPAN

The Army and Air Force in Japan negotiated one of the few Pacific area interservice support arrangements for general medical supply support. The hospital supply activity at Yokota Air Base agreed to provide medical logistical support to the Army Health Clinic at Camp Zama, Japan. Under the agreement, the Air Force is to

--provide medical supply support to the Army clinic and its supported activities,

--provide computer services to assist Army inventory management,

--maintain accounting data for an Army cost center, and

--pack and prepare supplies for pickup by Army units.

The Army Health Clinic is to

--order medical supplies from the Air Force by telephone or written requisitions;

--continue ordering medical equipment and nonmedical supplies and equipment from normal U.S. Army sources; and

--designate Army personnel who may order, receive, and pick up medical supplies and controlled items.

To support the agreement, the Air Force developed a computerized listing of items needed by the Army on a regular basis. The listing contained nearly 460 line items in 12 classes, but most items were in the drug class. Air Force officials at Yokota did not expect increased inventory levels or many new line items.

In April 1979 officials at the U.S. Army Medical Materiel Agency and the Air Force Medical Materiel Field Office reported that both services were pleased with the arrangement.

We believe that the Navy should also consider participating in the consolidated supply arrangement in Japan. Consolidation should improve general inventory management effectiveness and management of perishable stocks. The following reasons favor consolidating:

--Navy air shipments arriving via the Military Airlift Command are already trucked daily to Yokosuka Naval Base from Yokota Air Base, less than 50 miles away.

--Nearly 52 percent of the standard medical stock items (over 700 items) carried at the Naval Supply Depot were also stocked by the Yokota Air Base Hospital.

--The Air Force has a computerized supply management system whereas the Naval Supply Depot relies on a manual system.

We discussed the potential for Air Force medical supply support to the Navy in Japan with officials of the Naval Regional Medical Center and Naval Supply Depot at Yokosuka. These officials favored an interservice support agreement and stated that Air Force automated data processing capability would improve naval requisition processing and would provide computerized data printouts for inventory management. They also noted that consolidation would provide a centralized supply point in Japan, and that the Air Force at Yokota had adequate medical warehouse space available.

#### OPPORTUNITIES FOR INTER-SERVICE SUPPORT IN KOREA

The Army and the Air Force operate separate retail level medical supply programs in Korea. These service medical supply operations have strong potential for interservice support because they perform similar functions and are not far apart.

The Army's Medical Depot in Seoul, Korea--about 50 miles from Osan--carries a wide range of medical and dental supplies (about 4,500 items) to support all Army and Navy activities in Korea. The Army depot stocks about 80 percent of the items carried in the Air Force inventory at the Osan medical supply activity.

The Air Force hospital at Osan, Korea, stocks only about 1,100 medical and dental supply items to support itself, five Air Force medical aid stations, and a small Air Force surgical hospital located in Kunsan, Korea. The Osan supply activity generates about 6,800 requisitions annually and receives about 80 percent of its supplies through the DLA depot in Tracy, California.

An Air Force official told us that at one time the Air Force had relied on the Army depot for medical logistics support but discontinued this arrangement. One reason given was the timeliness of Army support. This reason may no longer be a problem since the Army is now airlifting medical supplies to Korea and has reduced the order-ship-time from 80 to about 30 days.

#### OPPORTUNITIES FOR INTER-SERVICE SUPPORT IN HAWAII

Even though a single hospital serves all military personnel in Hawaii, longstanding efforts have failed to establish interservice support for the services' medical supply needs.

In June 1978 Tripler Army Medical Center had agreements to meet medical supply needs of over 20 military and civilian organizations. Agreements with the Navy and Air Force, however, provided emergency service only. These military services continue to independently provide routine medical supplies to their own medical facilities in Hawaii.

Tripler provides medical supplies to about 230 customers: 145 at the hospital and 85 outside the hospital. During the year ended June 1978, Tripler bought an estimated \$8 million in medical supplies and stocked 3,352 standard medical items worth about \$2.1 million. The Pearl Harbor Naval Supply Center stocked only about \$270,000 in medical supplies with annual sales of about \$920,000. Hickam Air Force Base Clinic was smaller yet, with annual sales of about \$280,000.

Tripler already carries a sizable portion of Navy needs. As of February 1978, the Pearl Harbor Naval Supply Center carried 1,523 line items in medical stocks. Comparing these with Tripler's list of medical supplies in stock, on a sample basis, we found that 56 percent, or 853, of the center's line items were also stocked by Tripler.

Various efforts have been made in Hawaii to establish an interservice support arrangement for medical supplies. An organization called the Hawaii Sub-zone Group, made up of the heads of the military medical facilities, met in October 1971 to discuss the feasibility of consolidating all medical and dental supply functions in Hawaii and concluded that a study was needed. About 2 years later, the group's study of logistical consolidation proposed an expanded role for Tripler and estimated savings of \$239,000 from reduced investment in inventory. The Navy did not concur in the study results. Although the study was revised, a majority of the Hawaii Sub-zone Group later agreed to defer action on it until after Tripler had converted to a new computer system, scheduled for implementation in September 1976. The conversion has been completed, but the consolidation recommended by the study has not been carried out.

We believe Tripler should provide medical supplies to all military medical activities in Hawaii to improve supply support and reduce support costs. Tripler has the capability to provide complete medical support to the other services, and it carries many standard and nonstandard items enabling it to offer the Navy and Air Force an even wider selection of medical supplies than available under present arrangements.

Also, the Navy has had problems supporting the submarine forces in the Pacific Fleet. A June 1978 letter to the Commander in Chief, U.S. Pacific Fleet, cited the following problems:

- Stock levels of many medical items were depleted or nearly depleted.
- Some medical items with expiration dates were nearing those dates.
- The selection of medical items carried was not sufficient for personnel stationed on submarines.

Medical corpsmen from the fleet at Pearl Harbor also expressed concern to us about the responsiveness of the supply center to meet fleet needs.

#### CONCLUSIONS

Although apparent opportunities exist for interservice medical support in the Pacific, very little consolidation is occurring. Centralized support of medical items in Japan, Korea, and Hawaii seems feasible and is consistent with DOD policy. By consolidating medical support functions at these locations, DOD should reduce inventory investment and distribution costs; improve visibility over medical supplies, including perishable items; and increase supply effectiveness.

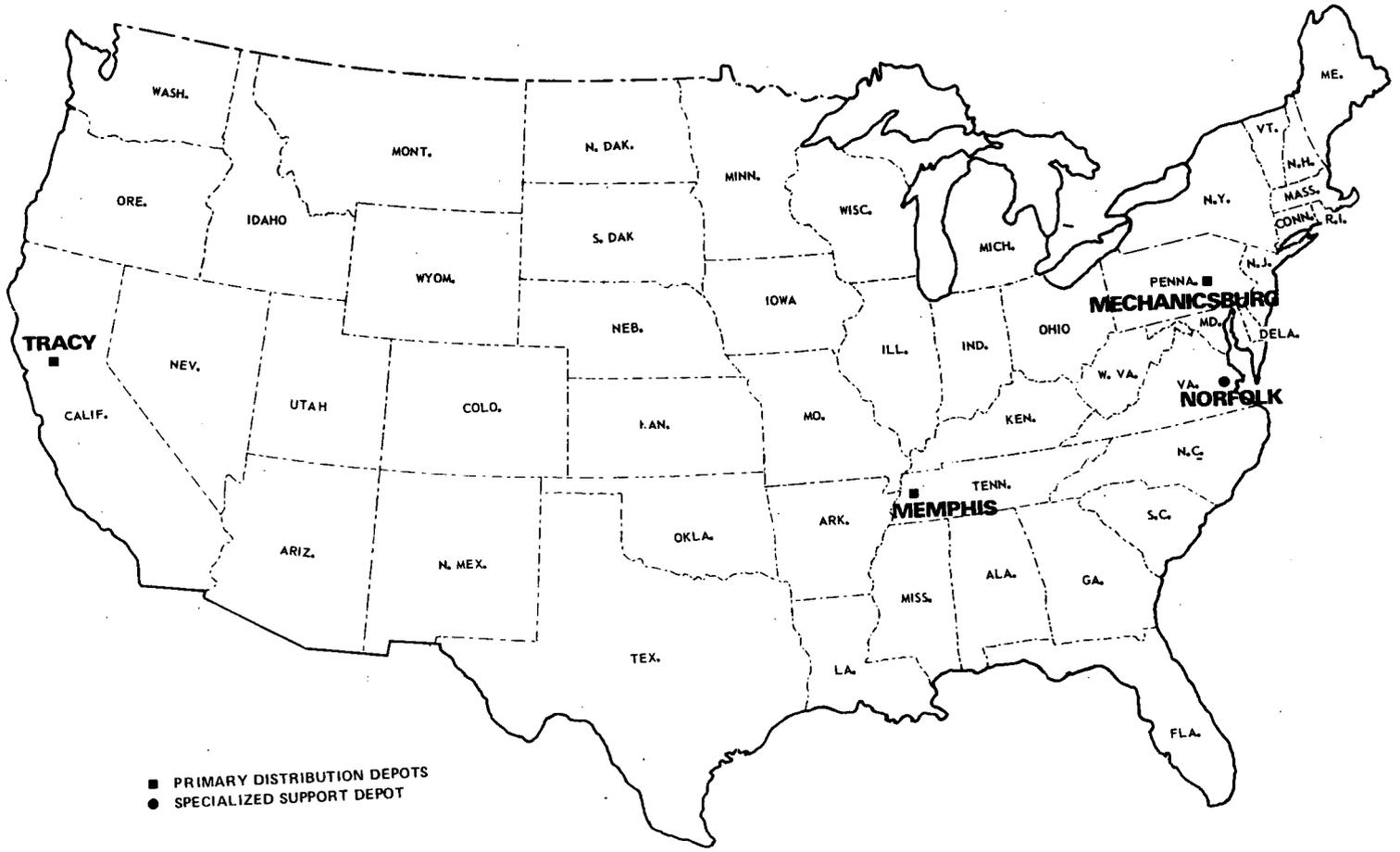
#### RECOMMENDATIONS

We recommend that the Secretary of Defense direct DRIS program managers to prepare implementation plans to consolidate medical supply support in Japan, Korea, and Hawaii. Where the plans show opportunities to reduce medical support costs and to increase supply effectiveness, we recommend that the Secretary direct the military services to consolidate these functions.

## AGENCY COMMENTS AND OUR EVALUATION

DOD agreed on the need to review the consolidation of medical support functions in the Pacific, but suggested that our recommendation be rewritten to account for work underway. Our recommendation addresses the need to prepare implementation plans, whereas the work underway consists of feasibility studies. Where such studies have already demonstrated the feasibility of consolidation, like in the Pacific, DOD needs to prepare implementation plans. Further feasibility studies will only delay implementing needed consolidations. Therefore, we have not changed our recommendation.

### DLA MEDICAL DEPOTS



ORGANIZATIONS VISITED DURING OUR REVIEWOffice of Management and Budget

Office of Federal Procurement Policy, Washington, D.C.

Department of Defense

Office of the Assistant Secretary of Defense for  
Manpower, Reserve Affairs and Logistics (MRA&L),  
Washington, D.C.

Defense Medical Materiel Board, Fort Detrick, Maryland

Military Ocean Terminal, Bayonne, New Jersey

Defense Logistics Agency

Headquarters, Cameron Station, Virginia

Defense Personnel Support Center, Philadelphia,  
Pennsylvania

Defense Depot, Mechanicsburg, Pennsylvania

Defense Depot, Tracy, California

Air Force

Office of the Surgeon General, Washington, D.C.

Air Force Medical Materiel Field Office, Fort Detrick,  
Maryland

Headquarters, Pacific Air Forces, Hickam Air Force Base,  
Hawaii

Medical activities at:

Andrews Air Force Base, Maryland

Clark Air Base, the Philippines

Hickam Air Force Base, Hawaii

Osan Air Base, Japan

Yokota Air Base, Japan

Army

Office of the Surgeon General, Washington, D.C.  
U.S. Army Medical Materiel Agency, Fort Detrick,  
Maryland  
25th Infantry Division, Schoefield Barracks, Hawaii  
Tripler Army Medical Center, Hawaii  
U.S. Medical Command, Korea  
Army 2d Division, Korea  
Medical activities at:  
Fort Dix, New Jersey  
Fort Shafter, Hawaii

Navy

Office of the Surgeon General, Washington, D.C.  
Naval Supply Systems Command, Washington, D.C.  
Navy Medical Materiel Field Office, Philadelphia,  
Pennsylvania  
Navy Supply Center, Norfolk, Virginia  
Headquarters, Pacific Fleet, Makalapa, Hawaii  
Medical activities at:  
Pearl Harbor Naval Base, Hawaii  
Subic Naval Base, the Philippines  
Yokosuka Naval Base, Japan



SR  
MANPOWER,  
RESERVE AFFAIRS  
AND LOGISTICS

## ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

May 30, 1980

Mr. R. W. Gutmann  
Director, Logistics and Communications Division  
General Accounting Office  
Washington, D.C. 20548

Dear Mr. Gutmann:

This is in response to your draft report, "Distributing Defense Medical Supplies: Managers Need Better Controls and Data," dated April 1, 1980 (GAO Code 943453)(OSD Case #5408).

We exchanged views on the Draft Report with members of your staff in a meeting held on April 17. At that meeting we explained that DoD experiences shelf life expiration on medical items because of war reserve requirements and discussed some of the additional reasons that led to the relatively high levels of short shelf life stocks on hand at the time of the audit. Those levels were principally influenced by a change in mode of delivery in the Army and a change in shelf life policy made by the Food and Drug Administration.

Regarding the section of the Draft Report dealing with the need for better control over local purchases, we will take a look at our present system to see where it can be improved. However, in the discussion on limiting out-of-area shipments by the Defense Logistics Agency (DLA), we advised your staff of a DLA simulation study which indicates that the kinds of changes suggested would produce only a one-percent reduction in such shipments. There does not appear to be any value in pursuing this matter further.

We agreed there was a need to improve responsiveness to overseas requisitions and to review the consolidation of medical support functions in the Pacific.

Detailed responses to your recommendations, including some page-by-page comments, are set forth in the enclosure to this letter. We appreciate the opportunity to comment on this report in draft form and request that our views be incorporated in the Final Report.

Enclosure  
As stated

Sincerely,

Richard Danzig  
Principal Deputy Assistant  
Secretary of Defense (MRA&L)

DEPARTMENT OF DEFENSE COMMENTS

GAO Draft Report "Distributing Defense Medical Supplies:  
Managers Need Better Controls and Data," April 1, 1980  
(OSD Case #5408)

1. GAO Draft Report, page 5, "...DPSC disposed of \$12 million--about 7 percent--of its fiscal year 1978 inventory of \$181 million because the supplies were either outdated or no longer needed."

DoD Comment

During FY 78, there was an unprecedented high dollar value of disposals (\$12.4 million). The reasons for this high level of disposals were a large volume of stock residual from the late stages of Vietnam combined with a change in policy on the part of the Food and Drug Administration (FDA) to continue to test and grant shelf life extensions. With this change in policy, it was necessary to implement stringent manual controls for managing shelf life items. Maximum allowable stock-on-hand levels have been vigorously adhered to since 1978.

2. GAO Draft Report, page 6, "The depot (Sixth Medical Depot, Seoul, Korea) is authorized a three-month inventory stock level to support its customers..." but had inventory"...equal to 6.5 months of supply ..."

DoD Comment

Authorized stockage levels vary according to the inventory management model used. In the technique called "Days of Supply" a 90-day Operating Level is authorized along with a 30-day Safety Level and actual "by item" Order-Ship Time (OST). In total, these levels constitute the Requisitioning Objective (R/O) which is defined as the maximum quantity of stock authorized to be on hand and on order to meet supply requirements. Since the 6th MEDSOM (Depot) is supported by the Standard Army Intermediate Level Supply System-Expanded (SAIL-ABX) three inventory management models are available: Days of Supply, fixed quantity levels, and Economic Order Quantity (EOQ) levels. The majority of items are managed by EOQ levels at 6th MEDSOM. This model requires variable operating levels based on lowest total order and holding costs, variable safety levels, and actual "by item" OSTs. The December 31, 1978 Quarterly Stratification Report reflected an R/O of 204 days (about 6.8 months) of supply. The R/O is composed of 27 days of safety level, 84 days of OST and 93 days of operating level. Fringe item "dues in" to supply specific non-stockage item customer "dues out" amounted to approximately 27 additional days of supply.

The Army, as a matter of policy, used computer-based economic inventory procedures to reduce inventory carrying cost and procurement and transportation expenses. Therefore, some low-dollar items are ordered on an annual basis while the most costly are ordered monthly. The limited records available in Washington indicate that the depot had approximately \$570 thousand excess as of October 31, 1979. We believe this excess resulted, in part, from the implementation of air delivery of supplies to Korea, which dramatically reduced OSTs, thereby producing a temporary excess. (See GAO note 1)

3. GAO Draft Report, page 13, "In February 1978, the Army's 2nd Division Medical Supply office in Korea destroyed varying quantities of 117 different line items. Large quantities of some items were destroyed, including 1729 bottles of benzalzonium chloride and 2320 bottles of procaine penicillin."

DoD Comment

This unit does not have the capability to rotate all materiel needed at the onset of war, particularly potency-dated materiel in its medical assemblages. These medical supplies must be available for immediate use if mobilization occurs. (See GAO note 2)

4. GAO draft Report, pages 13 and 14, "We recommend that the Secretary of Defense direct DLA and each military service:

- to eliminate excess medical supply inventories and maintain future inventories more in line with authorized levels;
- review and improve inventory management practices and controls over perishable medical supplies; and
- establish a uniform reporting system on disposal of medical materials so that management can analyze the cause and magnitude of disposal actions and take action to minimize or prevent future losses."

DoD Comment

We will defer any action on directing DLA and the Services to eliminate excess medical inventories. We have a contractor performing a study of DoD retention and disposal policies and prefer to await the results of that study (due in September 1980) before deciding on specific actions concerning holding or eliminating stocks.

We agree that inventory management practices and controls over perishable medical supplies can be improved and consider this an ongoing DoD effort.

In the absence of better documented rationale in the Draft Report, we do not agree that uniform systems for reporting on disposing of medical materiel are needed. It is not clear what GAO envisions would be gained from such systems.

5. GAO Draft Report, pages 26 and 27, "To improve DLA management of locally purchased nonstandard items, we recommend that the Secretary of Defense instruct the Director, DLA to take the following actions, and require the military departments to cooperate in the DLA efforts:

- Establish a uniform numbering system for locally purchased nonstandard medical supplies.
- Develop uniform criteria for reporting such supplies.
- Prepare a DoD-wide catalog of nonstandard medical supplies.
- Expand monitoring of local purchases to include all medical supplies shown on tri-service reports, so that all possible candidates for central management can be considered.

"To reduce transportation cost, we recommend that the Director, DLA prepare and approve a plan to reduce unnecessary out-of-area shipments by DLA depots, and set a specific timetable to implement the plan."

"To improve timely processing of requisitions for non-stocked medical items, we recommend that the Secretary of Defense direct the military departments to reconsider the need for sequential edits of such requisitions being sent to DPSC. We further recommend that the Director, DLA augment current efforts to improve timeliness of service by implementing interim changes now even where changes to the automated system are planned for the future."

DoD Comment

We do not agree that a uniform numbering system and a DoD-wide catalog of all locally purchased nonstandard medical supplies is feasible. It would be expensive to develop and maintain such a system and would be of little value to DoD managers. However, we do agree that a standard, cost-effective method needs to be developed to determine quantitative use of new commercial items to assist in our determination of the management system which is most cost effective and meets our military readiness needs.

We do not agree with the need for a DLA plan to reduce out-of-area shipments for the reasons earlier cited.

We agree that timeliness of overseas requisition processing needs to improve. Where feasible, intermediate edits will be eliminated and we will continue to review DLA's efforts to reduce their segment of the total processing time.

6. GAO Draft Report, page 35, "We recommend that the Secretary of Defense direct DRIS program managers to prepare implementation plans to consolidate medical supply support in Japan, Korea, and Hawaii. Where the plans show opportunities to reduce medical support costs and to increase supply effectiveness, we recommend that he direct the military services to consolidate these functions."

DoD Comment

We suggest that the recommendation be rewritten as follows to take into account the work already underway:

" We recommend that the Secretary of Defense direct the Joint Interservice Resource Study Group (JIRSG) Chairmen to conduct studies to ascertain the feasibility of consolidating medical supply support in Japan, Korea, and Hawaii. Where the studies show opportunities to reduce medical support costs and to increase supply effectiveness, we recommend that he direct the military services to consolidate these functions."

GAO note 1: The body of our report was modified to reflect the use of an EOQ model.

GAO note 2: The cited was dropped because of the additional information provided by DOD.



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