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[Level and Range of Services Provided by the Public Health Service Hospital System]. HRD-77-111; B-164031(5). May 26, 1977. Released May 31, 1977. 4 pp.

Report to Sen. John L. McClellan, Chairman, Senate Committee on Appropriations; by Robert F. Keller, Deputy Comptroller General.

Issue Area: Health Programs: Quality Care and its Assurance (1213).
Contact: Human Resources and Development Div.
Budget Function: Health: Health Care Services (551).
Organization Concerned: Public Health Service.
Congressional Relevance: Senate Committee on Appropriations.
Authority: Department of Defense Appropriation Authorization Act [of] 1974 (P.L. 93-155).

The Public Health Service (PHS) hospital system should attempt to maintain a level and range of direct patient care services comparable to 1973, as required by law. Findings/Conclusions: However, in attempting to maintain these services during a period of spiraling inflation and limited budget increases, the PHS hospital system has been unable to: prevent a reduction in the level and range of other health-related activities, including training and research; maintain authorized staff ceilings; maintain adequate inventories of drugs and other supplies; maintain an adequate program for replacing obsolete equipment or purchasing new equipment required by advancements in modern medical practice and technology; and spend funds needed to maintain and repair existing facilities and equipment, resulting in the continued deterioration of the hospitals. Recommendations: In considering funding for the PHS hospital system, the Congress should address whether or not the United States intends to realize the potential of the PHS hospital system as a resource for medical care at a reasonable, controllable cost. Congress should consider the potential savings from providing health care services to military dependents and to Medicare and Medicaid beneficiaries in federally controlled PHS hospitals and clinics; the economics and efficiencies of PHS hospital participation in regional and local health planning and resource allocations; and the potential role of the PHS hospital system as a primary or standby health care provider in any future national health insurance program. (SC)

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

B-164031(5)

May 26, 1977

The Honorable John L. McClellan
Chairman, Committee on Appropriations
United States Senate

Dear Mr. Chairman:

The Committee's March 24, 1977, report on the Supplemental Appropriations Bill, 1977, directed us to report within 60 days as to whether or not all services and personnel at the Public Health Service (PHS) hospitals and clinics are operating at the 1973 level as required by law (section 818(a) of the Department of Defense Appropriation Authorization Act, 1974, P.L. 93-155). The law specifically requires the PHS hospitals to provide a level and range of services at least equal to that provided on January 1, 1973.

We obtained and verified selected work measurement, budget, and other indicators of the level and range of services provided by the PHS hospital system for fiscal year 1973 through December 1976. However, it should be recognized that merely maintaining services at the 1973 level may not reflect optimal health care delivery because (1) in the era before 1973 the PHS hospital system was under threat of closure and (2) since 1973 there have been advancements in medical practice and technology. Also, systemwide utilization trends, funding experience, etc., cannot be applied to every hospital and clinic.

Because we had to respond to the Committee's directive within 60 days, our verification of the data and comments provided by PHS officials and employee union representatives was limited. However, the PHS statistical and budgeting data provided us was generally accurate and, with minor exceptions, correctly reflected inpatient and outpatient utilization and expenses incurred to operate the PHS hospitals and clinics.

Our review indicated that, although some direct patient care services have been terminated since fiscal year 1973, others have been added. Also, PHS hospital and clinic officials identified additional services needed to keep pace with advancements in modern medical practice and trends in patient care. Because of the limited time available, we could not verify either the need for or the cost effectiveness of such services.

Data provided us shows that on a systemwide basis, admissions to PHS hospitals were about the same in fiscal years 1973 and 1976. In actual patient days, the systemwide average daily patient load decreased by 5 percent during that period. The decline in patient load was offset by a 6 percent increase in outpatient visits to the PHS hospitals and clinics. However, taking into account the PHS estimate of the increase in the population eligible to receive services (a figure we did not attempt to verify), the ratios of admissions, average daily patient loads, and outpatient visits to eligible population decreased by 9 percent, 13 percent, and 4 percent, respectively, from fiscal year 1973 to fiscal year 1976. The PHS data also shows that, while the number of staffed and available beds declined by over 285 (13 percent) during the same period, the systemwide bed occupancy rate remained below 71 percent.

Since data on the population eligible to receive services was not available for each hospital, we could not determine if the systemwide changes in ratios of admissions, average daily patient loads, and outpatient visits to eligible population were applicable at every location. Although some hospitals reported overall increases in both inpatient and outpatient services, the increases could not be adjusted to reflect population changes.

The statutory language does not provide guidance as to how the level and range of services are to be measured. Thus, depending on which key indicators are considered, the level of services provided by the PHS hospital system now could be interpreted as ranging from a point substantially below that provided in 1973 to a point slightly above. We believe that the PHS hospital system is attempting to maintain a level and range of direct patient care services comparable with 1973. However, in attempting to maintain these services during a period of spiraling inflation and limited budget increases, the PHS hospital system has been unable to

--prevent a reduction in the level and range of other health-related activities, including training and research;

--maintain authorized staff ceilings;

--maintain adequate inventories of drugs and other supplies;

--maintain an adequate program for replacing obsolete equipment or purchasing new equipment required by advancements in modern medical practice and technology; and

--spend funds needed to maintain and repair existing equipment and facilities, resulting in the continued deterioration of the hospitals.

Most of the hospital and clinic officials and employees we interviewed expressed concern that, if the current trend continues, it may become necessary to set priorities in patient care and reduce the level and range of services provided. The data we collected indicates that some hospitals and clinics are reducing direct patient care services or are increasing the waiting time to obtain such services.

We believe that our findings raise additional issues that merit congressional consideration. The data we have obtained indicates that the Federal Government is supporting a hospital system which has not been able to (1) keep pace with advancements in medical practice and technology, (2) comply with minimum safety and professional accreditation standards, and (3) maintain optimum utilization and productivity levels.

We believe that in considering funding for the PHS hospital system, the Congress should address whether or not the United States intends to realize the potential of the PHS hospital system as a resource for medical care at a reasonable, controllable cost. In deliberating on this matter the Congress should consider the following factors:

--The potential savings from providing health care services to military dependents and to Medicare and Medicaid beneficiaries in federally controlled PHS hospitals and clinics.

--the economics and efficiencies of PHS hospital participation in and cooperation with regional

and local health planning and resource allocations. This would include facility and other resource sharing among the Department of Defense, Veterans Administration, and PHS hospital systems (an area that we are reviewing).

--The potential benefits to be derived by developing Federal health care research and health manpower training at the PHS hospitals similar to that conducted by the National Institutes of Health.

--The potential role of the PHS hospital system as a primary or standby health care provider in any future national health insurance program.

We have discussed the contents of this letter with officials of the Department of Health, Education, and Welfare. They said that the letter is a fair appraisal of the current status of the PHS hospital system.

We trust that the preceding information satisfies the Committee's needs.

Sincerely yours,

R.F. Keller

DEPUTY Comptroller General
of the United States