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REPORT TO THE HEALTH SUBCOMMITTEE, COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

74-0629

Review Of Certain Aspects Of The Hill-Burton Health Facilities Construction And Modernization Program

Department Of Health, Education, and Welfare

B-164031(2)

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

MAY 3, 1974

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

MANPOWER AND WELFARE
DIVISION

B-164031(2)

The Honorable Edward M. Kennedy
Chairman, Health Subcommittee
Committee on Labor and Public Welfare
United States Senate

Dear Mr. Chairman:

Your October 26, 1973, letter requested that we provide information on (1) the need for constructing and modernizing hospitals and constructing ambulatory care facilities, (2) the sources of financing for construction and modernization, and (3) the extent to which recovery of depreciation expense through third-party reimbursement programs serves as a revenue source for new construction.

We gathered information at Department of Health, Education, and Welfare (HEW) headquarters; HEW Regions I, V, and IX; State Health Departments in California, Illinois, and Massachusetts; and the American Hospital Association (AHA) in Chicago.

BACKGROUND

In August 1946 the Congress enacted the Hospital Survey and Construction Act (Public Law 79-725, which added title VI of the Public Health Service Act (42 U.S.C. 291)). The legislation serves as the basis for the Hill-Burton program of Federal assistance to the States for constructing and modernizing health facilities.

Under the Hill-Burton program, Federal assistance is available in the form of grants, direct loans, and loan guarantees with interest subsidies for constructing and modernizing hospitals and outpatient, long-term care, and rehabilitation facilities.

The Hill-Burton program operates in each State through a designated State agency. According to the authorizing legislation, a State can participate in the program only if a State plan for hospital and medical facilities construction and modernization is submitted to the Public Health Service for approval. The State plan, from the year of initial approval, is to be revised annually. It must (1) designate the number of general hospital beds and long-term care beds needed to provide adequate facilities for inpatient care for people residing in the State and (2) provide for the distribution of such beds and facilities in service areas throughout the State.

In the early years of the Hill-Burton program a bed-to-population ratio was used to determine the need for beds. In 1963 a formula for computing bed needs was adopted. This formula includes three basic variables--population projection, use rate, and an occupancy factor. (See appendix.)

The State agencies must also determine whether existing hospitals conform to established Hill-Burton fire safety, design, and structural standards. The application of the standards requires each existing health facility to be inspected and evaluated by a survey method called the Hill-Burton Plant Evaluation System. (See appendix.)

CONSTRUCTION NEEDS

Hospitals

Although HEW headquarters officials feel that the Hill-Burton formula provides reasonable estimates of hospital construction needs, they have some reservations about using the 85-percent occupancy rate provided by the formula in determining the construction needs. AHA hospital statistics for 1972 show the average occupancy rates for hosptials in the (1) 50-to 99-bed range to be 66.4 percent, (2) 200-to 299-bed range to be 77.3 percent, and (3) 400-to 499-bed range to be 81.2 percent. An HEW official stated that the 85-percent occupancy rate was established arbitrarily. (Using the higher occupancy rate in the formula shows fewer beds needed.)

HEW regional officials' and AHA officials' opinions varied on the validity of the Hill-Burton formula results. Some HEW officials felt that the Hill-Burton method for determining needs was the best available. Other HEW and AHA officials criticized the formula for providing unrealistic determinations, mainly because the formula assumes that all hospital beds provide the same type of medical service and, therefore, are used to the same extent. They said the assumption was invalid since beds may be used for medical-surgical, obstetric, and pediatric services and have varying degrees of use, depending on such factors as the age of the patients served and the birth rate in the geographic area served. In June 1973 States were given the option of planning on the basis of separate medical services; however, few States have adopted the option.

California Department of Health officials had conflicting opinions as to the reasonableness of the Hill-Burton formula for determining bed needs. One official believed that the formula provided reasonable estimates of need considering the available data. Another believed that the formula was too simplistic and needed improvement.

These officials told us that the need determinations made by areawide Comprehensive Health Planning (CHP) agencies and by the Hill-Burton agency differed. As a result, the areawide CHP agencies

have approved license applications for construction, expansion, and modernization projects in hospital service areas for which the Hill-Burton plan shows no need. Consequently, the Hill-Burton agency had to turn down applications for funds from some construction projects which had areawide CHP agency approval. A planned consolidation of CHP and Hill-Burton planning activities, to be effected by January 1, 1975, should prevent other similar situations.

Illinois' need determinations by the Hill-Burton agency and the State CHP agency also differed. For example, the Hill-Burton plan indicates that 55,900 general hospital beds are needed in Illinois, while the CHP agency estimates that only 40,900 are needed. The difference resulted from using different formulas.

Massachusetts Department of Public Health officials stated that the Hill-Burton State plan does not reflect a true assessment of construction needs. The department's own Determination of Need Program[1] shows that, statewide, an additional 175 beds are needed, while the Hill-Burton plan shows that 535 additional beds are needed.

The formula for determining construction need is discussed in more detail on pages 4 and 5 of the appendix. Hospital construction needs by the HEW regions and States visited and the opinions of informed officials concerning the Hill-Burton formula are also presented in the appendix.

Outpatient facilities

HEW headquarters officials stated that the Hill-Burton program has no acceptable method for determining outpatient facility needs. CHP agencies in California and Illinois have not developed estimates of outpatient facilities needs, and in Massachusetts there are no reliable estimates for such needs. State Hill-Burton officials claimed that they knew of no method by which outpatient care needs could be quantified for an area. Despite the lack of data on outpatient facility needs, several State, AHA, and HEW officials with whom we discussed this matter felt that outpatient care centers were needed. Pages 17 through 19 of the appendix provide further information on outpatient facility needs.

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[1]In addition to the Hill-Burton agency, Massachusetts has a State Determination of Need Program which issues or denies a Certificate of Need for new health facility construction. A Certificate of Need is required of an applicant before he can apply for Hill-Burton financial assistance.

MODERNIZATION

HEW headquarters officials said that the Hill-Burton Plant Evaluation System has not changed since its development in the early 1960s. The officials admit that the system needs revision. The major problems these officials see with the system are that it uses beds as units of measurement for indicating the extent of need and has not been updated for technological advances in delivering hospital services.

AHA officials believe that the Hill-Burton Plant Evaluation System is outdated and illogical and produces misleading results. One AHA official said that the system is not geared to modern technological advances and allows for beds to be reported as nonconforming for minor deficiencies or for deficiencies related to a hospital's ancillary services.

In California, the last comprehensive plant evaluation survey of all general hospitals was completed in fiscal year 1965. Some nursing homes in the State have never been surveyed. State officials stated that a lack of necessary personnel and financial resources prohibits annual plant evaluation surveys.

We reviewed plant evaluation reports prepared in 1970 and 1971 for an urban and a rural service area in California. This review disclosed that most of the general hospital beds in the urban service area rated as nonconforming were rated so because of fire and safety deficiencies. In the rural service area deficiencies in the service departments (i.e., pharmacy, dietary, laboratory, etc.) caused most of the general hospital beds to be listed as nonconforming.

In Illinois, hospital evaluation reports for one rural and for one urban service area showed that 20 percent of the urban service area beds and 52 percent of the rural service area beds were reported as nonconforming to Federal standards. The major reason for nonconformity in both service areas was that rooms lacked adequate toilet and bathing facilities.

The last evaluation survey of general hospitals in Massachusetts was conducted in 1965. Consequently, the modernization needs as shown in the current Hill-Burton plan are based on the 1965 survey. Modernization needs as determined by the Massachusetts Determination of Need program are drastically different than those shown in the Hill-Burton plan. For example, in four selected service areas the Hill-Burton plan shows that 1,186 beds need to be modernized while the Determination of Need program shows that only 330 beds need to be modernized.

See pages 21 through 25 of the appendix for additional information on modernization needs.

FINANCING

The major Federal sources for financing health facility construction and modernization are through the Hill-Burton program--which provides grants, loan guarantees with interest subsidy, and direct loans--and the Federal Housing Administration, Department of Housing and Urban Development, program of mortgage insurance for loans to qualified applicants to build new hospitals or modernize existing ones. (See appendix.)

HEW, Hill-Burton State agency, and AHA officials told us that funds are generally available to institutions for health facility financing, if such institutions can show the ability to repay an outstanding debt through historical earnings or have reliable community support. The officials added that most institutions in poverty and rural areas generally incur operating losses and lack community backing, which makes it difficult for them to finance construction or modernization without Federal grant funds.

In California, Illinois, and Massachusetts, State officials indicated that there is little need for Federal financial assistance for new hospital construction. Illinois and Massachusetts State officials added that the exception would be for constructing health facilities in rural and poverty areas.

During fiscal year 1974 congressional budget hearings, the Secretary of HEW stated that, in 1974, reimbursements for depreciation by Medicare and Medicaid and private insurance will amount to about $800 million and $1 billion, respectively. The Secretary pointed out that this should permit funds to be set aside for facility improvement or to pay back loans for construction over the useful life of a facility, thereby eliminating the need for Federal grant assistance.

Depreciation reimbursements from third-party sources do provide a revenue source for hospitals but amounts must be accumulated and set aside (funded) if they are to be used as a source of funding for replacing assets. HEW and AHA officials indicate that it is not likely that such funds will be set aside in large amounts. We were told that funds recovered through reimbursement for depreciation probably would be used to repay existing loans or to offset operating losses.

We were unable to obtain information which would show the extent to which funded depreciation has served as a source of funds to finance new construction or modernization.

Pages 26 through 28 of the appendix show the funding sources for fiscal year 1971 Hill-Burton projects in California, Illinois, and Massachusetts as well as information from AHA identifying sources of funding of construction projects begun during 1973 by AHA member hospitals. The appendix also includes the opinions of responsible officials on funding of depreciation as a source of financing future construction projects.

HEW officials have been given an opportunity to comment orally on the matters in this report, and we considered their comments in preparing it. We are sending a copy of this report to the Secretary of HEW. We do not plan to distribute this report further unless you agree or publicly announce its contents.

Sincerely yours,

Comptroller General
of the United States

Contents

ABBREVIATIONS

AHA	American Hospital Association
CHP	Comprehensive Health Planning
FHA	Federal Housing Administration
FNMA	Federal National Mortgage Association
HEW	Department of Health, Education, and Welfare
PHS	Public Health Service
SSA	Social Security Administration

APPENDIX

BACKGROUND INFORMATION

In August 1946 the Congress enacted the Hospital Survey and Construction Act (Public Law 79-725, which added title VI of the Public Health Service Act (42 U.S.C. 291)). The legislation serves as the basis for the Hill-Burton program of Federal assistance to the States[1] for constructing and modernizing health facilities.

The initial legislation authorized grants to States for

--surveying needs and developing plans for constructing medical facilities and

--assisting in constructing and equipping needed public and voluntary nonprofit general, mental, tuberculosis, and chronic-disease hospitals and public health centers.

Federal financial assistance under the Hill-Burton program, as amended since the initial legislation, is available as grants, direct loans, and loan guarantees with interest subsidies for constructing and modernizing hospitals, including general, mental, and tuberculosis hospitals; public health centers; and outpatient, long-term care, and rehabilitation facilities.

The Federal agency administering the Hill-Burton program is the Health Care Facilities Service of the Health Resources Administration, within the Public Health Service (PHS) of the Department of Health, Education, and Welfare (HEW).

From July 1, 1947, through January 1, 1973, a total of 11,062 projects had been approved under the Hill-Burton program which involved constructing 481,483 inpatient care beds in hospitals and nursing homes and 3,233 beds in other health care facilities.

The Hill-Burton program operates in each State through a designated State agency. Each State is entitled to an allotment of Hill-Burton funds under a formula set forth in the Hill-Burton legislation.

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[1]As used in this report, "States" means the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, Virgin Islands, and the Pacific Islands Trust Territory.

THE STATE PLAN

According to the authorizing legislation, a State can participate in the Hill-Burton program only if a State plan for hospital and medical facilities construction and modernization is submitted to PHS for approval. The State plan, from the year of its initial approval, is to be revised annually. The HEW regional offices are responsible for reviewing and approving the individual State plans.

PHS'Health Grants Manual, part 23-2, defines the State plan as:

"* * * a public document for guiding and influencing the development of patient care service through the construction and modernization of hospitals and related medical facilities serving each area of a State. It describes the present system of hospitals and related health facilities serving each area of a State, including interstate areas. It presents a coordinated, comprehensive program for the orderly development of needed health services and facilities designed to assure high quality patient care. It serves as the basis for the allocation of funds from all sources for modernization and construction purposes as well as public grants-in-aid funds for these purposes."

Requirements for determining new construction and modernization needs in the State plan are included in part 53 of the Public Health Service Regulations. The Hill-Burton program, however, permits the States flexibility in determining needs. State agencies may subjectively adjust the need determinations, provided that each adjustment is explained to and approved by HEW.

Section 604(a)(4) of the act, as amended, requires that State plans must set forth (1) the number of general hospital beds and long-term care beds and the number and types of hospital facilities and facilities for long-term care needed to provide adequate facilities for inpatient care of people residing in the State and (2) a plan for distributing such beds and facilities in service areas throughout the State. Thus, the law specifies a service area concept for determining the need for and distribution of health facilities. The following factors are considered in determining service area boundaries:

--Patient origin data.

--Socioeconomic data.

--Trade patterns.

--Transportation.

--Geographic boundaries.

--Time-distance studies.

--Distribution of manpower.

An HEW analysis of 1970 State plans showed that most States use county lines to delineate service areas.

COMPREHENSIVE HEALTH PLANNING

The Comprehensive Health Planning (CHP) program was established in November 1966 by the Comprehensive Health Planning and Public Health Service amendments to the Public Health Service Act (42 U.S.C. 201) to assist States and local communities through Federal grants to develop a continuing planning process to produce comprehensive plans for meeting their current and future health needs. The CHP program is commonly known as the Partnership for Health program.

The CHP program is carried out at the State level by a designated State agency and at the area, or community, level by a public or nonprofit private agency or organization. State and areawide CHP agencies, with broad participation of health providers and consumers, are charged with doing comprehensive and continuing health planning to promote the most effective and efficient use of existing and future health resources in meeting the health needs of the people.

Functions of CHP Agencies

The legislation and HEW guidelines generally permit State and areawide agencies to carry out their planning mission in the style and manner they choose and according to their own priorities and needs. According to HEW guidelines, the process of CHP involves:

--Identifying health needs.

--Assessing available resources for meeting these needs.

--Establishing goals and objectives reflecting unmet health needs.

--Assigning priorities for meeting health needs through available new health resources.

--Developing both current and long-range policy and action recommendations for meeting identified health needs through public, voluntary, or private efforts.

--Developing criteria for evaluating health programs and their contribution to attaining the established health goals and objectives.

Recommendations produced by this process are to form the basis for developing a comprehensive health plan.

State Hill-Burton agencies are required to give the appropriate CHP agency an opportunity to consider project applications within its area before the Hill-Burton agency may approve and recommend a project for Federal financial assistance. In addition, authority for CHP review and comment on Hill-Burton State plans is contained in regulations which became effective January 6, 1972.

Some CHP agencies have review and approval responsibility for health facility construction projects. This responsibility was acquired through certificate of need legislation enacted by certain States. Although there is little uniformity among the certificate of need laws presently enacted, all of the laws do include CHP agencies in the certification process through the review and approval function.

Additional controls over the construction of hospitals and other health care facilities were established by Public Law 92-603, which amended title XI of the Social Security Act (42 U.S.C. 1301). This act provides that operators of health care facilities will not receive reimbursement from Medicare, Medicaid, or the Maternal and Child Health programs for depreciation, interest, or return on equity capital (for proprietary facilities) for capital expenditures which have not first received a favorable recommendation from a designated State CHP agency. The law applies to capital expenditures which exceed $100,000, change the bed capacity of the facility, or substantially change the services provided.

CONSTRUCTION NEED DETERMINATION

Hospitals

In the early years when the Hill-Burton program was first established, the Congress determined that general hospital beds were critically needed throughout the country. Initially, to determine needs, States were required to use a bed-to-population ratio provided by law as a maximum allowance beyond which Hill-Burton funds could not by provided for construction. Since the national average during the early years was only 3.4 beds per 1,000 population against a recommended 4.5, a more precise method of establishing bed needs did not appear necessary. In 1963, after the method of computing bed need was examined,a new formula was adopted, which includes three basic variables--population projected for 5 years from the planning year, use rate (patient days per 1,000 population), and an occupancy factor. This formula, prescribed in section 53.11(a) of the Public Health Service Regulations, is described below.

(1) $\dfrac{\text{area patient days}}{\text{current area population (in thousands)}}$ = area use rate

(2) $\dfrac{\text{area use rate X projected area population (in thousands)}}{365 \text{ days}}$ = projected average daily census

(3) $\frac{\text{projected average daily census}}{\text{0.85 occupancy factor}^2} + 10 \text{ beds}^1 = \text{area bed need for general hospitals}$

Hospital beds to be added are determined by subtracting existing conforming hospital beds and hospital beds to be modernized or replaced from the total bed-need figure.

The Medical Facilities Construction and Modernization amendments of 1970 (Public Law 91-296) directed that the Secretary of HEW study the present formula for allotting Hill-Burton funds among the States. As a result of this study, hospital planning was changed to give States the option of planning on the basis of separate service areas for medical-surgical, maternity, and pediatric services. If States plan on the basis of the three services, the occupancy rates used in the needs determination formula are 90 percent for medical-surgical beds and 75 percent for maternity and pediatrics beds.

Outpatient facilities

An outpatient facility is defined in the Public Health Service Act (42 U.S.C. 291o(f)) as:

> "* * * a facility (located in or apart from a hospital) for the diagnosis or diagnosis and treatment of ambulatory patients (including ambulatory inpatients) -
> (1) which is operated in connection with a hospital, or
> (2) in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the State, or, in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the State; or
> (3) which offers to patients not requiring hospitalization the services of licensed physicians in various medical specialties, and which provides to its patients a reasonably full-range of diagnostic and treatment services."

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[1]A June 26, 1973, HEW policy memorandum allows the automatic addition of 10 beds to be deleted from the formula.

[2]An occupancy factor of 0.90 is used in determining long-term care bed need.

Standards for determining outpatient care facility needs are included in section 53 of the PHS regulations. Although Hill-Burton officials feel that the standards are inadequate, there has been practically no other Federal guidance given to States for determining these needs. Some States have developed their own need determination criteria.

MODERNIZATION NEED DETERMINATION

Hospital modernization needs in each service area are based on the number of beds in facilities which do not meet Hill-Burton fire safety or structural standards (i.e., nonconforming beds). A service area's modernization needs, however, are limited to the difference between its total bed needs as determined by the Hill-Burton formula and the number of existing beds in conforming facilities.

HEW guidelines provide four standards for plant evaluation surveys to determine modernization needs:

--Fire resistance of buildings.

--Fire and other safety factors of buildings.

--Design and structural factors affecting the function of patient care units.

--Design and structural factors affecting the function of service departments.

Each State is responsible for making plant evaluation surveys of hospitals to determine their conformity or nonconformity with established standards.

The application of the standards requires each existing health facility to be inspected and evaluated by survey method referred to as the Hill-Burton Plant Evaluation System. If a hospital (or part of a hospital) is found not to be in conformance with standards A, B, or C, all the beds in the hospital (or part of the hospital) are considered as nonconforming. However, if a hospital's service departments are found to be nonconforming under standard D, HEW guidelines indicate that 50 percent of the hospital's beds which are conforming under A, B, or C should be rated as nonconforming, except in the case of the maternity service department which would affect only the maternity beds; therefore, the 50-percent factor is applied against only the maternity beds.

No Federal standards exist to determine conformity of outpatient facilities. However, some States have adapted the hospital plant evaluations survey to outpatient facilities.

NEEDS ESTIMATES

The following table shows the most current nationwide Hill-Burton construction and modernization need estimates by number of facilities and number of beds for general hospitals, long-term care facilities, and outpatient care facilities.

INPATIENT & OUTPATIENT CARE FACILITIES (note a)

Condition and Number of Facilities and Beds with Projected 1977 Needs United States and Territories--January 1, 1973

Category	Number existing (note b)			Projected 1977 needs (note c)	Need to be added (note d)	Need to be modernized
	Total	Conforming	Nonconforming			
	(Number of facilities)					
General hospitals	6,439			5,792	77	2,415
Long-term care facilities (note e)	13,233			13,003	1,198	4,630
Outpatient facilities	(not known)			1,358		1,352
	(Number of beds)					
General hospitals	892,524	675,770	216,754	917,228	69,238	189,179
Long-term care facilities	955,616	689,698	265,918	1,012,039	127,976	227,730

[a]Excludes Federal facilities, except a few Indian hospitals serving the community population.

[b]Represents evaluation by the Hill-Burton State agencies as conforming or nonconforming to minimum Federal standards relating to construction and patient safety.

[c]Represents the sum total of facilities or beds needed as computed by the Hill-Burton State agencies using a 5-year population projection and recent hospital occupancy experience and other factors affecting use.

[d]Represents total facilities and beds that need to be added in individual geographic service areas within the States. Although many geographic service areas need additional facilities and beds, some have more than needed. Therefore, national totals of existing facilities and beds, plus those that need to be added, will not equal the projected national needs for numbers of facilities and beds.

[e]Includes skilled nursing homes, long-term units of hospitals, and chronic-disease hospitals.

FINANCING OF CONSTRUCTION AND MODERNIZATION

The major Federal programs providing funds for the construction and modernization of health facilities are briefly described below.

Grants--Hill-Burton

Grant funds for new construction are allotted to each State on the basis of the State's population and its per capita income. Funds for modernization are distributed in accordance with a formula which considers each State's modernization needs.

To receive Hill-Burton assistance, a project must be included in the State plan and must meet Hill-Burton program requirements. A State agency is responsible for selecting and initially approving a project.

Matching requirements for individual projects are set by the State agency, with a general maximum of 66-2/3 percent of total project cost for the Federal share. States have considerable flexibility in establishing the Federal share for projects, especially since the 1970 amendments which made it possible to provide 90-percent Federal funding for priority projects. Priority projects are those which will (1) provide services primarily for persons in an area determined by the Secretary of HEW to be a rural or poverty area or (2) offer potential for reducing health care costs through shared services among health care facilities, through interfacility cooperation, or through the construction or modernization of freestanding outpatient facilities. As shown on pages 26 through 28 the rate of Federal participation in total project costs has been considerably less than the authorized rate.

Loan guarantee with interest subsidy--Hill-Burton

Assistance under the Hill-Burton program is also available through loan guarantees with interest subsidies. Under the loan guarantee authority, HEW guarantees payments of principal and interest on loans made by non-Federal lenders to private nonprofit organizations. The loan guarantee includes an interest subsidy to reduce by 3 percent the net effective interest rate paid by the borrower.

As stated before, applications must be submitted through the State Hill-Burton agency. The agency reviews the application for conformance to Hill-Burton requirements and establishes the amount of the loan to be guaranteed. The loans are obtained by the applicant from a non-Federal source and must be at reasonable interest rates. The Federal National Mortgage Association (FNMA) average auction yield rate for 4-month commitments at the time of approval is used to measure the reasonableness of the interest rate for a specific loan guarantee.

Loan guarantees may be made in combination with grants for a specific project; however, together the grant and loan guarantee cannot exceed 90 percent of the total project cost.

Direct loans--Hill-Burton

Under Hill-Burton, direct loans are also available for constructing and modernizing health care facilities. The loan application is submitted through the State agency and must comply with all program requirements. If the application is approved, the interest rate is the FNMA average auction yield rate for 4-month commitments, minus 3 percent, plus an interest differential factor to offset the amount of interest which the applicant can reasonably expect to earn through investment loan proceeds during the construction period. As with the loan guarantee with interest subsidy, no loan may be made, alone or in combination with a grant, in excess of 90 percent of the total project cost.

Periodically the Secretary of HEW sells the notes for direct loans either on the private market or to FNMA. The proceeds from the sale of the notes are used for new loans to public agencies.

Mortgage insurance program

Another available program is the Federal Housing Administration (FHA) program of mortgage insurance for constructing, modernizing, and equipping hospitals. No application for mortgage insurance is to be approved without Hill-Burton certification that a need exists. Application review under this program is much the same as for a Hill-Burton grant.

The FHA-insured mortgage is limited to $50 million or 90 percent of the replacement cost of a project, whichever is less. The mortgage may bear interest at a rate which shall not exceed the prevailing rate established by FHA.

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The following schedule shows Hill-Burton grant activity by type of facility for July 1, 1970, to June 30, 1973, and loan activity for January 1, 1972, to June 30, 1973.

APPROVED HILL-BURTON GRANT PROJECTS

BY TYPE OF FACILITY

July 1, 1970, to June 30, 1973

Type of facility	Number of projects	Percent of total number of projects	Total project cost	Hill-Burton funds
			(thousands)	
General hospitals	309	39.4	$1,103,741	$196,465
Long-term care facilities	125	15.9	179,647	51,538
Mental health hospitals	4	00.5	1,809	705
Tuberculosis	1	00.1	2,544	1,170
Outpatient care facilities	200	25.5	254,771	81,772
Rehabilitation facilities	71	09.1	90,750	27,664
Public health centers	72	09.2	34,696	12,061
State health laboratories	2	00.3	40,954	1,696
Total	784	100.0	$1,699,912	$373,071

LOAN AND LOAN GUARANTEE PROGRAM

January 1, 1972 to June 30, 1973

163 projects

	Amount (millions)	Percent of estimated total cost
Estimated total cost	$1,351.7	-
Hill-Burton loan amount	593.4	43.9
Direct loans	39.6	2.9
Guaranteed loans	553.8	41.0

CONSTRUCTION NEEDS

HOSPITALS

HEW headquarters officials believe that the Hill-Burton formula for determining bed needs is reasonable and provides an "in the ball park" type of estimate. They did, however, indicate some reservations about the 85-percent occupancy rate used in the formula. According to an HEW official, this rate was established arbitrarily. The officials added that using a higher occupancy rate figure should tend to offset the States' practice of overplanning for beds since using the higher occupancy rate in the formula shows fewer beds needed.

Officials in HEW Regions I and IX felt that the Hill-Burton method for determining hospital construction needs was the best available and was sufficiently flexible to permit States to establish their needs. One official in HEW Region I added that the States should also do detailed studies of need for each of their service areas. He pointed out, however, that most State agencies do not have sufficient manpower to perform such studies.

HEW Region V and American Hospital Associates (AHA) officials told us that the use of the Hill-Burton formula for determining hospital construction needs results in unrealistic determinations. Their basic objection to the formula is that it assumes that all hospital beds provide the same type of medical service and, therefore, are used to the same extent. They noted that the assumption was invalid since beds may be used for medical-surgical, obstetric, and pediatric services and thereby have varying degrees of use, depending on such factors as the age of patients served and the birth rate in the geographic area served.

Furthermore, HEW Region V officials stated that the formula assumed that the population in each service area used hospitals in that area. They stated that in large metropolitan centers, such as Chicago, patients frequently crossed service area boundary lines to obtain medical services. As a result, the formula does not measure bed need for the populace of a service area but measures demand on the basis of current hospital use in the area.

CHP officials in HEW Regions I and V believe that the Hill-Burton formula results in unrealistic determinations of bed needs. In HEW Region I, the CHP officials criticized the formula for relying on historical data which tends to perpetuate existing patterns of health care.

A CHP official in HEW Region V stated that needs should be stated by the type of bed (i.e., medical-surgical, obstetric, and pediatric). He also added that the use rate in the formula does not

take into account the fact that many patients use health facilities outside the service area in which they reside.

California

The administration of the Hill-Burton program in California has been primarily the responsibility of the Department of Health facilities construction section. However, the Department of Health's Comprehensive Health Planning Program was given responsibility for developing the 1972-74 California State Plan for Hospitals (Hill-Burton plan).

In addition to the health facility planning done by the Department of Health under the Hill-Burton program, California has 12 Federally funded areawide CHP agencies which have health facility planning responsibility under certificate-of-need legislation enacted by the State in 1969. This State law gave the areawide CHP agencies responsibility for reviewing and approving (or denying) licenses for health facilities "proposed to be constructed, expanded, or altered for the purpose of increasing bed capacity of changing license category."

The certificate-of-need law required that the State Health Planning Council, a voluntary advisory council to the Director of the Department of Health, develop general principles to guide the areawide CHP agencies in their facility planning responsibilities.

The State Health Planning Council has required that each of the areawide CHP agencies develop health facility plans as a basis for its review and approval of licenses for health facility construction, expansion, or alteration. Each facility plan must be approved by the State Health Planning Council. Until an areawide CHP agency has an approved plan, the State Health Planning Council has required that it use the Hill-Burton plan estimates of need as a basis for the Council's review and approval. Most areawide CHP agencies have developed facility plans based primarily on the Hill-Burton formula.

State officials told us that needs determinations by the areawide CHP agencies and by the Hill-Burton agency have differed. We were told that the recent designation of the Comprehensive Health Planning Program as the office responsible for developing the Hill-Burton plan is intended to solve this problem. According to a Comprehensive Health Planning Program official, his office will develop a unified Hill-Burton plan from a compilation of the 12 areawide CHP agency plans by January 1, 1975.

The chart below summarizes the need as defined in the 1972-74 Hill-Burton plan and estimates cost for inpatient facility construction in California's 127 hospital service areas. Department of Health

officials provided the construction cost estimates. The plan was completed at the time of our field work but had not been submitted to the HEW regional office for approval.

Hospital service areas	Beds to be added		Estimated construction costs	
	General hospital	Nursing home (note a)	General hospital	Nursing home (note b)
			(thousands)	
Urban (61 areas)	257	3,714	$16,705	$81,708
Rural (66 areas)	30	1,407	1,950	30,954
Total	287	5,121	$18,655	$112,662

[a]California uses the term nursing homes instead of long-term care facilities.

[b]Facility construction section officials estimated general hospital and nursing home construction costs as $65,000 and $22,000 per bed, respectively.

Department of Health officials had conflicting opinions on the reasonableness of the Hill-Burton formula for determining bed need. One Department of Health official stated that the Hill-Burton bed-need formula provides the most accurate estimates of need, considering available data. He believed that any refinement of the methodology would require increased funding which would be better spent on constructing health facilities. However, a Comprehensive Health Planning Program official believed the formula was too simplistic and could be improved.

Each of California's 12 areawide CHP agencies has developed a health facility plan which consists of construction need estimates. The facility plans of the 12 areawide CHP agencies include estimates that there is a statewide need for 68,596 general hospital and 104,539 nursing home beds as compared with 63,499 general hospital and 114,722 nursing home beds included in the 1972-74 Hill-Burton plan.

According to a Comprehensive Health Planning Program official the differences in the estimated bed needs by the areawide CHP agency and Hill-Burton plan are due to the areawide agencies' (1) using different occupancy level statistics and/or different census data, (2) projecting needs for a different time period, or (3) in one case, using a different formula for computing needs.

Most areawide CHP agencies have used the basic HEW formula to estimate health facility construction needs. Only one agency used an entirely different method for estimating needs; the Los Angeles CHP agency used a modified version of a personal health services model.

The model involves such factors as rates of illness by age, sex, and diagnostic category. When applied to the population of a hospital service area it provides an estimate of beds needed by medical service and manpower, equipment, and financial resources needed. The model has not been completely tested and refined.

State officials told us that areawide CHP agencies have approved license applications for construction, expansion, and modernization projects in hospital service areas for which the Hill-Burton plan shows no need. Subsequently, the Hill-Burton agency had to turn down applications for Hill-Burton funds from these projects with areawide CHP agency approval. The Comprehensive Health Planning Program officials believe this inconsistency will be resolved when California develops its unified Hill-Burton plan.

Illinois

The need for new hospital beds, as reported in the Illinois State plan, is computed by the State Hill-Burton agency for each of the 65 geographic service areas in the State by dividing the number of beds meeting Hill-Burton standards, as determined by periodic inspections, by bed needs computed by using the Hill-Burton formula. This computation provides a percentage of bed need satisfied. Each service area in the State is ranked by the percentage of bed needs satisfied, and priorities for constructing new beds are assigned accordingly.

We were told, however, that the priorities assigned to the service areas were generally inoperative since State Hill-Burton personnel had no control over the development of projects and requests for funds depend on the initiative of local hospital officials. Practically all requests for fiscal year 1971 funds were approved regardless of the priority assigned to the projects by the State.

Officials of the Illinois State CHP agency stated that, to demonstrate the need for a redistribution of medical facilities and to arrive at more realistic service area needs, they developed need formulas using minimum and maximum use-rate limitations. Furthermore, they stated that their formulas considered the age characteristics of the population in each service area, recognizing that a high percentage of elderly residents resulted in greater hospital use.

The following table compares the need for hospital facilities and beds in Illinois as computed by the State Hill-Burton agency and the State CHP agency. The data shown was taken from the most current plans available.

Category	Type of facility			
	General hospital		Long-term care	
	Hill-Burton	CHP agency	Hill-Burton	CHP agency
Beds				
Existing	53,100	53,800	43,600	44,200
Needed	55,900	40,900	50,800	30,200
To be added	4,400	400	8,700	-0-
To be modernized	9,900	1,800	17,500	3,800
Facilities				
Additional needed	7	-	54	-
Needs met	(percent)			
Construction	95	132	86	146
Modernization	79	111	57	98

As shown above, the CHP agency determinations of need are significantly lower than those reported by the State Hill-Burton agency.

Massachusetts

Massachusetts Department of Public Health officials stated that hospital construction need determinations as stated in the State Hill-Burton plan do not reflect a true assessment of needs. The Department's own criteria and methods, used in the State's Determination of Need program[1], produce much lower bed-need figures than the Hill-Burton formula. The Department's method results in a statewide need for 175 additional beds while the Hill-Burton plan shows that 535 are needed.

Currently, there is a statewide average of 4.7 general hospital beds per thousand population in the State. The most recent Hill-Burton data available shows a statewide average need of 4 beds per thousand by 1980. In contrast, the State Determination of Need agency uses a goal of 2.44 beds per thousand by 1985. We compared the most current bed need determinations for four service areas using both methods and found the following differences.

[1]In addition to the Hill-Burton agency, Massachusetts has a State Determination of Need program which issues or denies a Certificate of Need for new health facility construction. A Certificate of Need is required by an applicant before he can apply for Hill-Burton financial assistance.

Area	Beds needed		Difference	
	State determination of need	Hill-Burton	Number	Percent
Fall River	411	766	355	86.4
Somerville	170	239	69	40.6
Berkshires	414	813	399	96.4
Lynn	344	599	255	74.1
Total	1,339	2,417	1,078	80.5

State officials' major criticisms of Hill-Burton need determination methods are: (1) Hill-Burton's reliance on historical use data and (2) the inappropriateness of current Hill-Burton service areas for hospital planning for such reasons as large geographic size, consumer preferences for certain hospitals, and transportation patterns. The State uses different service areas for the Determination of Need program.

OUTPATIENT FACILITIES

HEW headquarters officials told us that the Hill-Burton program has no acceptable method for determining outpatient facility needs.

California

The need for outpatient facilities is determined on the basis of population. Hospital service areas or parts of them are designated as outpatient facility planning areas on the following basis.

Hospital service area population	Number of outpatient facility planning areas
Under 100,000	1 to 3
100,000 to 300,000	2 to 4
300,000 to 500,000	3 to 5
500,000 to 700,000	4 to 7
Over 700,000	5 to 8

California has 224 outpatient planning areas--152 urban and 72 rural. According to the State plan, the number of outpatient planning areas within a hospital service area is based on the following criteria.

--Size of population.

--Population distribution.

--Routes of travel.

--Existing planning areas of other health agencies.

--Trade patterns.

--Socioeconomic characteristics.

--The presence of a large number of nonresidents for recreational or other purposes.

--Availability of physician's services.

It had been established that each planning area needs at least one outpatient facility. The need for additional facilities is estimated on the basis of one facility for each 50,000 people or major fraction of that number. Funding priority for new construction is based on the percent of need met within the outpatient facility planning area.

California certificate-of-need legislation does not cover outpatient facilities. A Comprehensive Health Planning Program official stated that because of this and the lack of available data, the areawide CHP agencies have not developed an estimate of the number of outpatient facilities which need to be constructed or modernized.

Illinois

The Illinois State plan states that, in determining the need for outpatient facilities, consideration is given to the scope and availability of existing facilities and services, the particular needs of the population to be served, and the type of services to be available in the proposed facility.

The State plan provides for outpatient facilities on the basis of not more than:

--One for each service area with a projected population of 50,000 or less
--Two " " " " " " " " 50,001 to 100,000.
--Three" " " " " " " " 100,001 to 200,000.
--Four " " " " " " " " 200,001 to 400,000.
--Five " " " " " " " " 400,001 to 800,000.
--Six " " " " " " " " over 800,000.

Funding priority for outpatient facility projects is determined as follows:

A--Areas determined to be a rural or urban poverty area.

B--Areas with no outpatient facilities.

C--Areas with outpatient facilities physically limited because of obsolescent or functional inadequacies.

D--Areas with acceptable outpatient facilities but in need of additional service, especially more comprehensive service.

We noted that, of the seven outpatient facility projects which received fiscal year 1971 Hill-Burton funds, one was priority A, one was priority B, and five were priority C.

An official of the State CHP agency stated the agency had not yet developed methods to determine outpatient care facility needs but planned to do so by June 1974.

Massachusetts

No reliable estimates were available for outpatient facility needs. State Hill-Burton officials stated that the need as shown in the State plan is not realistic. (The plan shows the need for only one additional facility in the entire State.) The Hill-Burton plan data represents only emergency rooms or diagnostic and testing units which are a part of a hospital. The plan does not include freestanding clinics.

The State Department of Public Health had no information on the outpatient facility construction or modernization needs. State Hill-Burton officials claimed that they knew of no method by which outpatient care needs could be quantified for an area.

All officials felt strongly that, despite the lack of data on outpatient facility needs, such facilities are greatly needed.

CONSTRUCTION NEED ESTIMATES

The following table shows the construction needs by States within the HEW regions reviewed. The figures were taken from the most current approved State Hill-Burton plans, except for California and Massachusetts whose figures were obtained from a revised plan not yet approved. Although we did not examine long-term facilities needs, we have included in the following schedule needs for such facilities reported in the State plans.

APPENDIX

CONSTRUCTION NEEDS

	Most current approved State Plans	General hospitals: Beds to be added	Long-term care facilities: Beds to be added	Outpatient car facilities: Facilities to be added
HEW Region I				
Massachusetts	(a)	535	3,034	1
Connecticut	FY 73	[b](140)	2,910	65
Rhode Island	FY 73	102	1,092	0
Maine	FY 72	7	4,726	5
New Hampshire	FY 71	244	1,622	4
Vermont	FY 73	21	0	0
Total		769	13,384	75
HEW Region V				
Illinois	FY 72	4,367	8,708	137
Indiana	FY 73	1,056	957	20
Michigan	FY 72	946	574	0
Minnesota	FY 73	87	2,009	0
Ohio	FY 72	3,005	3,808	0
Wisconsin	FY 73	168	1,514	0
Total		9,629	17,570	157
HEW Region IX				
California	(a)	287	5,121	183
Arizona	FY 72	31	118	33
Nevada	FY 73	44	144	10
Hawaii	FY 72	79	308	2
Guam	FY 73	5	15	1
American Samoa	FY 73	0	0	0
Pacific Islands Trust Territory	FY 72	104	0	38
Total		550	5,706	267

[a]Figures were obtained from revised plans not yet approved.

[b]Indicates excess of existing beds over total needed.

HEALTH FACILITY MODERNIZATION

Hill-Burton headquarters officials stated that the plant evaluation system as explained on page 6 was developed to provide a uniform measurement of hospital conditions and to set priorities for improving hospitals. The system has not changed since its development in the early 1960s. The officials admitted that the system has its problems and definitely needs revision; however, they believe it is still usable. The major problem they see with the system is that it uses beds as a unit of measurement for indicating the extent of need. For example, deficiencies found in such service departments as surgical or laboratory are expressed in terms of nonconforming beds. In addition, Hill-Burton officials agreed that the system has not allowed for technological advances such as the "no nursing station"[1] concept. In this respect they hope that the individual conducting the survey is "up with the times" and uses proper judgment in his work.

HEW Region I officials felt that the Hill-Burton methods for determining modernization needs were the best available and the HEW Region IX officials believed them to be realistic. However, Region V officials claimed that the Hill-Burton method of determining modernization needs resulted in unrealistic determinations. AHA officials felt that the Hill-Burton modernization determinations are outdated, illogical, and sometimes misleading. One AHA official said that, although the plant evaluation system is based on adequate construction standards, it is not geared to modern technological advances and allows beds to be reported as nonconforming for minor deficiencies or for deficiencies related to the facilities' ancilliary services.

CALIFORNIA

The HEW plant evaluation system is used to determine a facility's need for modernization except for the allowed computation for the nonconforming maternity services department. (See p. 6.)

Plant evaluation surveys of all general hospitals were last done in fiscal year 1965. However, some nursing homes in the State have never been surveyed.

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[1] A concept in nursing unit design in which the centralized nursing station is eliminated. The no-nursing station concept decentralizes many nursing duties and transfers nonnursing administrative duties to nonnursing personnel.

According to facilities construction section officials, plant evaluations of hospitals, nursing homes, and outpatient facilities[1] are not done annually because they do not have the necessary personnel or financial resources. Instead, when an application for Hill-Burton funds is received from a project in a high-priority hospital service area, plant evaluations of all the hospitals in that area are made. When an application for modernization of an outpatient facility is received, an evaluation is usually made. The facilities construction section senior architect estimated that about 60 plant evaluations, predominantly of general hospitals, are done annually. By comparison, the 1972-74 Hill-Burton plant inventory contains 573 hospitals and 1,376 nursing homes.

A facilities construction section official estimated that approximately 25 percent of existing outpatient facilities have been surveyed and that his staff has some knowledge on other outpatient facilities through information other than plant evaluations.

We reviewed the available plant evaluation reports of nonconforming facilities in an urban and a rural hospital service area. The Hill-Burton plan indicated that these two areas had five hospitals and four nursing homes containing nonconforming beds. We found that two of the four nursing homes had never had plant evaluation surveys. Survey information for the facilities follows.

Service area	Total beds	Nonconforming beds Standards (note a) A, B, or C	Nonconforming beds Standards (note a) D	Total nonconforming	To be modernized
San Mateo (urban):					
General hospitals	841	307	0	307	195
Nursing homes	872	105	0	105	105
Salinas (rural):					
General hospitals	440	92	147	239	162
Nursing homes	386	111	0	111	111

[a]see p. 6 for an explanation of standards A, B, C, and D.

San Mateo--80 nonconforming hospital beds were contained in one general hospital which had numerous standard B and C deficiencies due to inadequate fire safety conditions and below standard patient room size. The remaining 227 nonconforming hospital beds were in a hospital

[1]California has adapted the hospital plant evaluation survey to outpatient facilities.

which had several standard B deficiencies. For example, it had fire safety deficiencies in the areas of construction, exit facilities, and interior finish. We were unable to determine the type of the deficiencies in the nonconforming nursing homes in the area because one did not have a plant evaluation survey and the evaluation of the other indicated that there was no nonconformity. State officials were unable to explain how the beds in the nursing homes had been classified as nonconforming.

Salinas--the Hill-Burton plan indicated that one facility contained 140 of the 239 nonconforming general hospital beds. The survey of that hospital stated that 45 beds were nonconforming due to a standard A structural deficiency, 51 due to standard C patient room deficiencies involving inadequate size and lack of a nurse's call, and 48 due to standard D service department deficiencies (a total of 144 beds which was adjusted to 140 when the hospital discontinued use of some beds).

Standard D deficiencies resulted from the maternity service department being located in a standard A nonconforming structure and inadequate space in other service departments. Two other hospitals had 87 and 12 nonconforming beds respectively due to standard D deficiencies involving inadequate space and equipment in their service departments. We were unable to determine the type of the deficiencies in one of the area's two nonconforming nursing homes because it had no plant evaluation survey. The other nursing home contained 60 nonconforming beds due to a standard A structural deficiency.

ILLINOIS

The Illinois State plan combines the number of beds categorized under standards A, B, and C, and we could not, without reviewing individual plant evaluation forms for each hospital, assess the relative severity of the health or safety problems uncovered; e.g., whether the medical facility was a fire hazard or whether the reasons for nonconformity were related to nursing units.

We did review the physical plant evaluation forms to determine the reasons for nonconformity for one urban and one rural service area in Illinois. The results are shown in the following table.

Service area	Existing beds	Number of nonconforming beds by standard				
		A	B	C	D	Total
Urban (7 general hospitals)	2116	94	0	326	0	420
Rural (4 general hospitals)	216	30	0	57	25	112

As shown, about 20 percent of the urban area beds and 52 percent of the rural area beds were reported as not meeting Hill-Burton standards. The major reason for nonconformity under standard C was that rooms lacke adequate toilet and bathing facilities. The reason for nonconformity under standard A was that buildings did not comply with fire-resistive requirements.

MASSACHUSETTS

The last facility survey for the Massachusetts Hill-Burton program was done in 1965. The conforming/nonconforming bed statistics in the current Hill-Burton plan are based on this survey, updated to reflect actual modernization projects which come to the attention of the Hill-Burton agency through applications for financial assistance.

An official of the State's Determination of Need agency has indicated that he feels all standard D nonconforming beds by Hill-Burton standards should be added back to the inventory of conforming beds. This would decrease modernization needs shown in the State Hill-Burton plan.

The extent of the need calculated by the Hill-Burton method greatly exceeds needs calculated by the methods used by the State's Determination of Need program. For the Hill-Burton service areas for which we could obtain State Determination of Need modernization data, we compared modernization needs using the State's method with the Hill-Burton method and found the following for four service areas.

Area	Beds to be modernized		
	Hill-Burton	State determination of need	Difference
Fall River	455	142	313
Somerville	169	70	99
Berkshires	227	66	161
Lynn	335	52	283
Total	1,186	330	856

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The following table shows the modernization need estimates for the States in the HEW regions reviewed. The figures were taken from the most recently approved plans, except for Massachusetts and California.

		General hospital	Long-term care facilities	Outpatient care facilities
	Most current approved State plans	Beds to be modernized	Beds to be modernized	Facilities to be modernized
HEW Region I				
Massachusetts	(a)	7,044	20,747	60
Connecticut	FY 73	2,648	10,019	20
Rhode Island	FY 73	319	1,914	9
Maine	FY 72	1,042	386	33
New Hampshire	FY 71	757	1,104	9
Vermont	FY 73	127	0	5
Total		11,937	34,170	136
HEW Region V				
Illinois	FY 72	9,852	17,464	30
Indiana	FY 73	5,062	16,338	53
Michigan	FY 72	4,924	2,502	25
Minnesota	FY 73	4,158	3,819	29
Ohio	FY 72	5,018	34,596	20
Wisconsin	FY 73	1,885	8,108	1
Total		30,899	82,827	158
HEW Region IX				
California	(a)	2,402	4,141	101
Arizona	FY 72	306	192	17
Nevada	FY 73	176	175	2
Hawaii	FY 72	70	452	8
Guam	FY 73	173	33	3
American Samoa	FY 73	0	0	5
Trust Territory of Pacific Islands	FY 72	394	0	85
Total		3,521	4,993	221

[a]Figures were obtained from revised plans not yet approved.

FINANCING OF CONSTRUCTION AND MODERNIZATION

FUNDING SOURCES--HILL-BURTON PROJECTS

We reviewed applications submitted for Hill-Burton funding of construction projects in California, Illinois, and Massachusetts during fiscal year 1971, to determine the various funding sources and also the amount of Hill-Burton participation.

California

Sources of funds as indicated by 12 applicants awarded Hill-Burton assistance during fiscal year 1971.

Funding source	Amount	Percent
Hill-Burton grants	$10,763,616	11.2
Direct Federal loans	376,933	0.4
Hill-Burton loan guarantees	53,264,748	34.7
Other loans and mortgages	16,350,973	17.1
Credit lines with banks	8,750,000	9.1
Cash and securities	18,966,608	19.8
Donations	1,200,755	1.2
Bonds	5,150,000	5.4
Prepaid expenses (note a)	1,093,349	1.1
Total	$95,916,982	100.0

[a]Project expenses incurred at the time of the application for Hill-Burton funds.

Illinois

Sources of funds as indicated for 15 Hill-Burton projects approved in fiscal year 1971.

Funding source	Amount	Percent
Hill-Burton grants	$ 7,690,000	9.5
Hill-Burton loans	700,000	0.9
Hill-Burton loan guarantees	2,050,000	2.6
Other Federal funds	10,791,000	13.4
Other loans and mortgages	29,431,000	36.6
Cash and securities	10,118,000	12.6
Donations	6,738,000	8.4
Bonds	3,795,000	4.7
Other (not specified)	7,514,000	9.3
State and local funds	1,720,000	2.1
Total	$80,547,000	100.0

Massachusetts

Funding sources for the 12 projects receiving fiscal year 1971 Hill-Burton funds.

Funding source	Amount	Percent
Hill-Burton grants	$ 6,903,000	12.8
Hill-Burton loan guarantees	16,475,000	30.5
Other Federal funds (FHA)	1,489,000	2.7
Other loans and mortgages	10,772,000	20.0
Cash and securities	5,738,000	10.6
Donations	2,877,000	5.3
Bonds	8,666,000	16.1
Prepaid expenses	1,071,000	2.0
Total	$53,991,000	100.0

In addition, we obtained the information shown in the following table from preliminary results of a survey being conducted by the AHA to identify the various sources of funding of construction projects. These projects were initiated during 1973 by AHA subscriber hospitals. The construction projects involve modernizing existing buildings and constructing new buildings.

Source of Funding for Non-Federal Hospitals for Construction Begun in 1973

Type of hospital	Federal Grants	Other (note a)	Philan-throphy	Internal	Debt: Bond Issues: Private loans	Debt: Bond Issues: Taxable	Debt: Bond Issues: Non taxable	Debt: Bond Issues: HUD	Debt: Hill-Burton Loans/LG (note b)	Debt: Other	Financing costs	Total
	(Percent funds)											
Short-term general	6	9	12	17	16	5	20	4	9	4	(2)	100
Long-term general	4	20	10	1	18	0	10	0	0	38	(1)	100
	Total funds (millions)											
Long-and short-term general	$131	$231	$286	$405	$397	$125	$483	$97	$219	$134	$49	$2,458

[a]Other Governmental grants and nonrepayable contributions (such as funds obtained from Governmental units that issue bonds to be repaid with tax revenue).

[b]Loan guarantees.

Our discussions with officials of HEW, the Hill-Burton State agencies, and AHA, indicated that funds are generally available to institutions for health facility financing if they have the ability to repay an outstanding debt through historical earnings or have reliable community support. We were told that most institutions in poverty and rural areas generally incur operating losses and lack adequate community backing and therefore, find it difficult to finance construction or modernization without Federal grant funds.

California State officials told us that there is little need for new hospital construction and therefore little need for Federal financial assistance in this area. However, these officials did state that there is a need for Federal financial assistance for modernizing all types of health facilities. One official stated that Federal financial assistance endorses a project and helps attract local financing which would otherwise be unattainable.

Illinois State officials said that the need for Hill-Burton grant funds for construction and modernization projects should gradually decrease as other funding sources (such as State tax-exempt revenue bonds, various Federal loan-guarantee and direct loan programs, and private long-term debt financing) are used more extensively. An exception to this premise would be projects for health facilities in poverty areas which could not obtain sufficient funds from any of the above sources.

According to Blue Cross, hospital, and State officials in Massachusetts Hill-Burton grant funds are needed for hospitals in rural or economically depressed areas. We were told that funds for financially sound hospitals are generally available from private sources.

DEPRECIATION AS A FUNDING SOURCE

During fiscal year 1974 HEW budget hearings before the House Committee on Appropriations, the Secretary of HEW stated that approximately $800 million in depreciation reimbursements to hospitals and medical facilities will be provided through Medicare and Medicaid in 1974 and that private insurance will provide over one billion dollars for depreciation reimbursements which, according to the Secretary, should permit funds to be set aside for facility improvement or to pay back existing loans for construction over the useful life of the facility.

The Secretary's figures, which were prepared by the Office of Research and Statistics, Social Security Administration (SSA), were based on:

--Medicare data from hospital cost reports submitted to SSA, which indicated that payments for depreciation represented 6-1/2 percent of the total Medicare payments to hospitals for inpatient and outpatient hospital services.

--Medicaid estimates of payments to hospitals for depreciation which were assumed to represent 6-1/2 percent of total reimbursements because the Medicaid program pays hospitals on a basis similar to that of Medicare.

--Private health insurance estimates which also assumed that depreciation represents 6-1/2 percent of total benefit payments.

Depreciation reimbursements from third-party sources, such as Medicare, Medicaid, and private insurance plans, do provide a revenue source for hospitals, but amounts collected must be accumulated and set aside (funded) if they are to be used as a source of funding for replacing assets.

An HEW official told us that depreciation reimbursements are likely to be used to repay loans for the cost of existing facilities, rather than for future replacement. According to AHA officials, funds realized from depreciation are likely to be used to offset operating losses rather than being held in reserve for capital replacement. AHA information on 3,126 nonprofit hospitals showed that 1,845, or 59 percent, of the hospitals reported an operating deficit in 1972.

A report on an evaluation of State Hill-Burton agencies by an HEW consultant stated that:

"The States believe that the Federal Government should stop propagating the fiction that the backlog in health care facility needs can be met through the medium of depreciation. They cannot. Even when considering future needs, rather than the backlog, depreciation funding, when it does occur, is based upon historical cost which events of the last several decades have shown is far below replacement cost. Furthermore, the older the facility the less its original cost and hence the less depreciation funded. Yet, these are the very facilities most in need of modernization, and incidently, most likely to serve populations with the least ability to pay for care. The inability of elements in these populations to pay for care, or have it paid for them, imposes additional operating cost burdens on the facility and decreases the likelihood that the facility has been, in the past, or will be in the future, able to fund depreciation in any event."

We are unable to obtain information showing the extent to which funded depreciation has served as a source of funds to finance new hospital construction or modernization.

The information gathered on the source of funds for Hill-Burton projects in the three States reviewed (see p. 26 and 27) and the AHA information on the source of funding for 1973 construction projects (see p. 28) provides some indication as to the extent to which health facilities used accumulated internal funds for construction or modernization purposes. For example, the AHA information for short-term general hospitals shows that 17 percent of the construction costs was provided by internal funds.