BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Congressional Monitoring Of Planning For Indian Health Care Facilities Is Still Needed

In 1977, the Congress imposed a moratorium on hospital construction planned by the Indian Health Service, Department of Health, Education, and Welfare. GAO had reported that the Service's plans would create excessive bed capacity in the Navajo area. The Service was directed to improve its planning for the construction program, but it has only partially complied with the directive.

The Service revised the way it determines the number of acute care beds needed, but GAO believes planning is still not adequate. Plans would still lead to construction of unneeded acute care beds in the Navajo area and could lead to excess beds elsewhere.

The Congress should continue the moratorium until the Service fully complies with the congressional directive.

HRD-80-28
APRIL 16, 1980

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

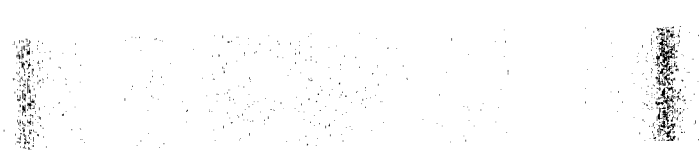
B-198088

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

Our report concerns the adequacy of the Indian Health Service's hospital planning activities. In the report, we discuss how the Service's planned hospital construction will result in the building of new and replacement hospitals with bed capacities that exceed current and probable future demand. We also explain why the Congress should continue its moratorium on planned hospital construction.

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States



COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

CONGRESSIONAL MONITORING OF PLANNING FOR INDIAN HEALTH CARE FACILITIES IS STILL NEEDED

D I G E S T

The Indian Health Service is responsible for providing comprehensive health care to Indians and Alaska Natives. One of the duties of this Department of Health, Education, and Welfare (HEW) organization is to administer a hospital construction program.

The Service estimates that new or replacement hospital construction or modernization and repair projects at 41 hospitals will cost $648 million for fiscal years 1979-85. (See p. 1.)

In May 1977 GAO reported to the House and Senate Appropriations Committees that the Service's methodology for determining the number of hospital beds needed in the Navajo area would result in too many acute care beds. Because the Service used the same methodology for planning hospitals throughout its system, GAO estimated that similar problems probably existed elsewhere. (See p. 3.)

For fiscal years 1978 and 1979, the Congress appropriated more than $3 million for planning eight hospital projects. However, the Appropriations Committees recommended, and the Congress approved, a moratorium on the use of planning funds until the Service recognized the declining need for acute care beds. (See p. 5.)

After the Service made some revisions to its planning procedures, the Congress provided limited funding for two projects--the Chinle, Arizona, and Tahlequah, Oklahoma, hospitals--that were being funded when the moratorium was imposed.

Since September 1978 the Congress has continued the moratorium and indicated that planning funds would not be released nor would additional planning funds be appropriated until the Service further improved the hospital construction program. The Appropriations Committees' fiscal year 1979 conference report directed the Service to develop

--a reliable ranking system for identifying the most urgently needed Indian health facilities,

--a master plan for Navajo reservation health facilities,

--a report on controls to prevent hospital project overruns, and

--justification for the number of acute care beds and square footage recommended for the Tahlequah hospital. (See p. 6.)

The size of the Chinle hospital was limited to 60 beds and 107,000 gross square feet, and the Service was advised that its responsibility for hospital construction would be removed if the program was not improved. (See p. 27.)

During fiscal year 1979 the Appropriations Committees received the Service's (1) revised methodology for determining hospital bed needs, (2) report on controls to prevent hospital project overruns, and (3) criteria for ranking health facility construction needs. GAO evaluated the revised methodology to determine bed needs and the report on controls to prevent project overruns. GAO did not analyze the proposed criteria for ranking health facility construction needs because of pending revisions by HEW.

The revised methodology appears to be a reasonable method for determining the need for acute care beds. However, assumptions the Service used in applying this methodology

to determine the number of acute beds in the entire Navajo area would add more beds than needed. (See p. 8.)

For the Navajo area the Service made assumptions about (1) which Service hospitals Indians enter for care, (2) the use of non-Service hospitals, and (3) changes in the rate of hospital use. The assumptions do not recognize past experience and greatly affect the forecast of the number of beds needed. (See p. 9.)

GAO believes the Service can make health services more available, accessible, and acceptable in the Navajo area by (1) increasing the use of presently unused beds at Navajo referral hospitals, (2) improving routine and emergency patient transportation, and (3) emphasizing construction of more outpatient health facilities and fewer hospitals. (See p. 10.)

In the Oklahoma area, the Service plans to relax ancestry eligibility requirements for health services. This will increase the number of persons eligible for care in Service hospitals. The bed capacity at planned replacement hospitals will be increased to meet the increased number of eligible patients. The changes in ancestry requirements will differ from requirements for Oklahoma tribes' participation in Bureau of Indian Affairs programs and may eventually expand the number of eligible beneficiaries from all tribes for Service programs. (See p. 17.)

Revisions the Service made in its hospital planning and construction procedures are not completely responsive to the congressional directives. Further, the Service has not complied with the congressional directive regarding the submission of a master plan for Navajo reservation health facilities. (See p. 28.)

The Service's report on controls to prevent overruns on hospital projects deals exclusively with projects to be constructed by tribes under contracts authorized by title I of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450). Hospital projects to be contracted for through HEW's Office of Facilities Engineering--the predominate contracting service--are not included. Because some of these projects have experienced overruns, GAO believes the Service needs to further revise the report. (See p. 34.)

The Congress limited the number of acute care beds and the amount of gross square footage for the Chinle hospital, but Service plans call for a hospital and leased annex which, in total, will exceed the square footage limitation. Further, the Service has entered into a contract for designing the Chinle hospital which exceeds the amount specified in the Appropriations Committees' fiscal year 1978 conference report, and the Service recently estimated that construction costs will exceed the original estimate by $6 million. (See p. 34.)

RECOMMENDATION TO THE CONGRESS

The Service has not fully complied with congressional directives to improve its hospital construction program. Until the Service fully complies with the congressional directives, the Congress should continue the funding moratorium.

RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary should:

--Revise assumptions used in the planning methodology for Service hospital projects. The assumptions should recognize (1) unused beds at Service hospitals, (2) the availability of non-Indian community hospitals, and (3) the declining use of acute care beds.

--Limit construction of additional acute care beds to those for which the Service can demonstrate a need.

--Coordinate with the Bureau of Indian Affairs and consult with appropriate congressional committees before taking any action to relax Indian ancestry eligibility requirements for health services in the Oklahoma area.

--Improve routine and emergency transportation services for patients because the Service's plans for locating a hospital in each Navajo service area will not eliminate patients' transportation problems.

--Establish target dates for completing work on the Service's hospital planning proposals that have been mandated by the Congress.

--Require that the Assistant Secretary for Health monitor progress in satisfying congressional directives and direct the Service to (1) use a reliable system for identifying and giving priority to the most urgently needed Indian facilities, (2) develop a master plan for Navajo reservation health facilities, (3) revise the report on controls to prevent hospital project overruns, and (4) construct the specified number of acute care beds and square footage for Service hospital project at Chinle, Arizona, and justify the size of the Tahlequah, Oklahoma, project.

--Assure that proposed Service submissions to the Congress are independently reviewed and evaluated.

--Explain in detail to the Congress the circumstances surrounding the Chinle hospital design contract and the reasons for the escalation of construction cost estimates. (See pp. 22 and 37.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

In commenting on our draft report, HEW said that it has established target dates for completing work on Service hospital planning proposals mandated by the Congress. To eliminate the need for the congressional moratorium, it will reemphasize the need to meet and comply with congressional directives in a timely manner. HEW added that it was prepared to give the Congress a detailed explanation of the circumstances surrounding the Chinle hospital design contract and related construction cost estimates, if requested to do so.

HEW also commented that it had taken actions to comply with the congressional directives, except for completion of the Navajo reservation health facilities master plan. However, GAO found that the Service has only partially complied.

HEW disagreed with several recommendations and only partially agreed with other recommendations that GAO believes are essential to developing and implementing a reliable planning method for hospital beds. HEW disagreed on the need to revise the Service's hospital planning to recognize the declining average daily patient load at Service hospitals. HEW stated that there is no basis that would permit the Service to relax Indian ancestry eligibility requirements based on blood quantum. HEW said that routine transportation of patients on reservations is not a responsibility of the Service. Finally, HEW asserted that the Service's report to the Congress on controls to preclude hospital cost overruns does not need further revision. GAO has evaluated HEW's comments and concluded that HEW should reconsider and implement the recommendations. (See pp. 23 and 38.)

Contents

ABBREVIATIONS

ADPL	average daily patient load
BIA	Bureau of Indian Affairs
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
IHS	Indian Health Service

CHAPTER 1

INTRODUCTION

On August 5, 1954, the Congress passed legislation (42 U.S.C. 2001 et seq.) transferring responsibility for Indian health care from the Department of the Interior to the Department of Health, Education, and Welfare (HEW). HEW's Indian Health Service (IHS) is responsible for providing comprehensive health care to Indians and Alaska Natives through its system of 50 hospitals, 99 health centers, and several hundred field stations. IHS also contracts with 234 private and community hospitals to supplement its own direct health care delivery system. In addition, IHS funds 25 community hospitals to serve Indian beneficiaries in predominantly non-Indian communities.

The Congress enacted the Indian Health Care Improvement Act (Public Law 94-437) in September 1976. Among other things, title III of this act authorizes $234 million from fiscal years 1978-80 for constructing and renovating hospitals, clinics, and staff quarters. The Congress appropriated $71,257,000 and $76,960,000 in fiscal years 1978 and 1979, respectively, for these purposes.

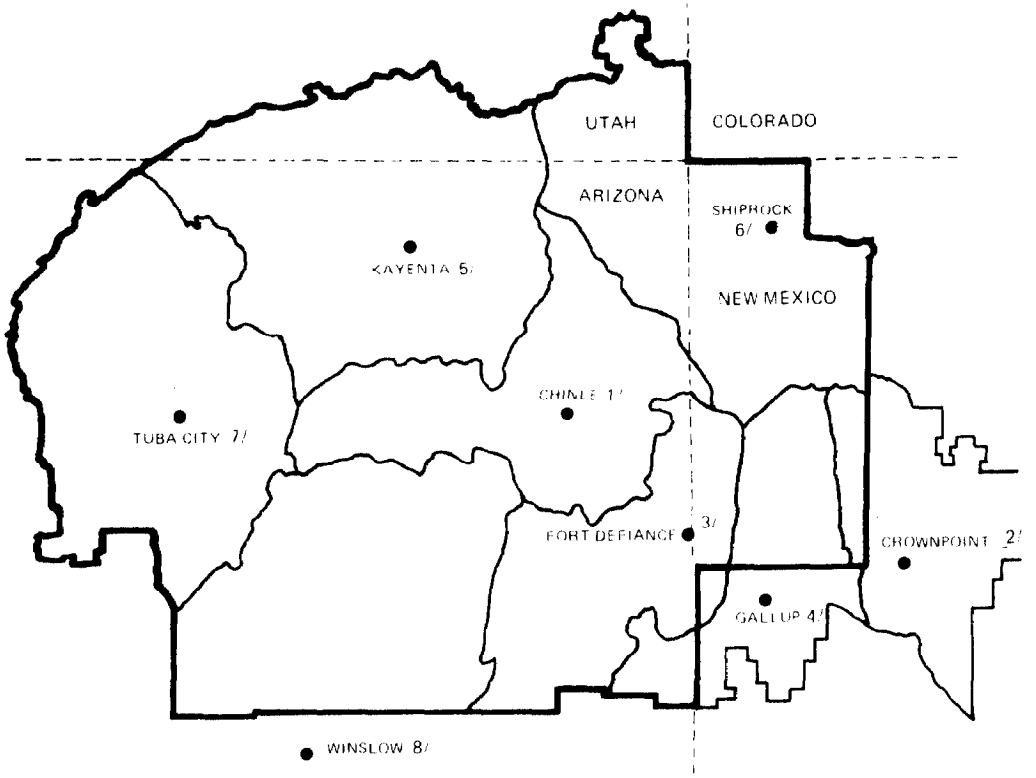
In addition, title IV of this act makes IHS facilities eligible for Medicare and Medicaid reimbursements. The reimbursements may be used for correcting deficiencies noted during surveys by accrediting and certifying groups. IHS collected $2.2 million from Medicare and Medicaid in fiscal year 1978. IHS estimated that it would collect $12 million during fiscal year 1979. Collected reimbursements supplement IHS appropriations for health facilities' maintenance and repairs.

IHS administers its hospital construction program through eight area and four program offices. IHS annually prepares a 7-year plan of its health facilities' construction and modernization. The plan identifies the size (measured by number of beds) of the planned hospitals and the estimated cost of each construction and modernization project. The current IHS health facilities construction program shows a need for new and replacement construction, or modernization and repair, of 41 hospitals, at an estimated cost of $648 million from fiscal year 1979 to fiscal year 1985.

To help the Congress consider funding for IHS' planned construction and modernization, we began reviewing Navajo area hospital construction plans in January 1977. The IHS Navajo area office is responsible for eight service units located on and off the Navajo reservation.

The following map of the Navajo area shows the location of existing and planned IHS hospitals for its eight service areas (the Navajo area encompasses about 25,000 square miles).

INDIAN HEALTH SERVICE
EXISTING AND PLANNED HOSPITALS
FOR THE NAVAJO AREA
AS OF MARCH 1978



Source: Navajo Area Indian Health Service

SERVICE AREA	PLANNED HOSPITAL CONSTRUCTION
1/ Chinle	Construct a new 125 bed hospital; estimated cost: $26,570,000
2/ Crownpoint	Replace the 50 bed hospital with a 64 bed hospital; estimated cost: $19,800,000
3/ Fort Defiance	Modernize the 109 bed hospital to provide 100 beds; estimated cost: $13,440,000
4/ Gallup	None planned. 207 bed hospital was constructed in 1961
5/ Kayenta	Design and plan a hospital at Kayenta which has no hospital; estimated cost: $500,000
6/ Shiprock	Modernize and expand the 75 bed hospital to 150 beds with provision for eventual expansion to 210 beds; estimated cost: $27,273,000
7/ Tuba City	None planned. 125 bed hospital was constructed in 1975
8/ Winslow	Replace 40 bed hospital with a 60 bed hospital; estimated cost: $13,805,000

We selected this area because more hospital construction was planned for it than for any other IHS area. IHS' 7-year plan estimated that $101 million was needed for six Navajo hospital projects.

As depicted in the graph on the following page, our study compared the historical use of hospital (acute care) beds in the Navajo area for fiscal years 1966-76 with the anticipated bed capacity according to IHS original plans. We obtained statistics on both constructed beds 1/ and staffed and available beds 2/ and found that IHS planning would result in the construction of 253 more beds for the Navajo area than are currently constructed even though:

--In 1976 there were over 150 constructed beds and 100 staffed and available beds in excess of beds needed to meet peak patient demand.

--Patient use of hospitals, as measured by the average daily patient load (ADPL), declined from 489 a day in 1966 to 329 a day in 1976, despite an IHS-reported 41-percent increase in population over the same period.

--The combined occupancy rate of the hospitals declined from 86 percent in 1966 to 58 percent in 1976.

We also noted that (1) IHS did not adequately consider the declining trend in the use of inpatient hospital facilities and (2) IHS planning methodology was based on estimates of future need for hospital services, which were usually nonscientific estimates that did not recognize long-range historical trends. For example, 10-year historical trends, required by IHS' hospital planning criteria, were not developed for any of the Navajo hospital construction projects.

In April and May 1977, we advised the House and Senate Appropriations Committees of our concern over the excess bed capacity that would result in the Navajo area and elsewhere

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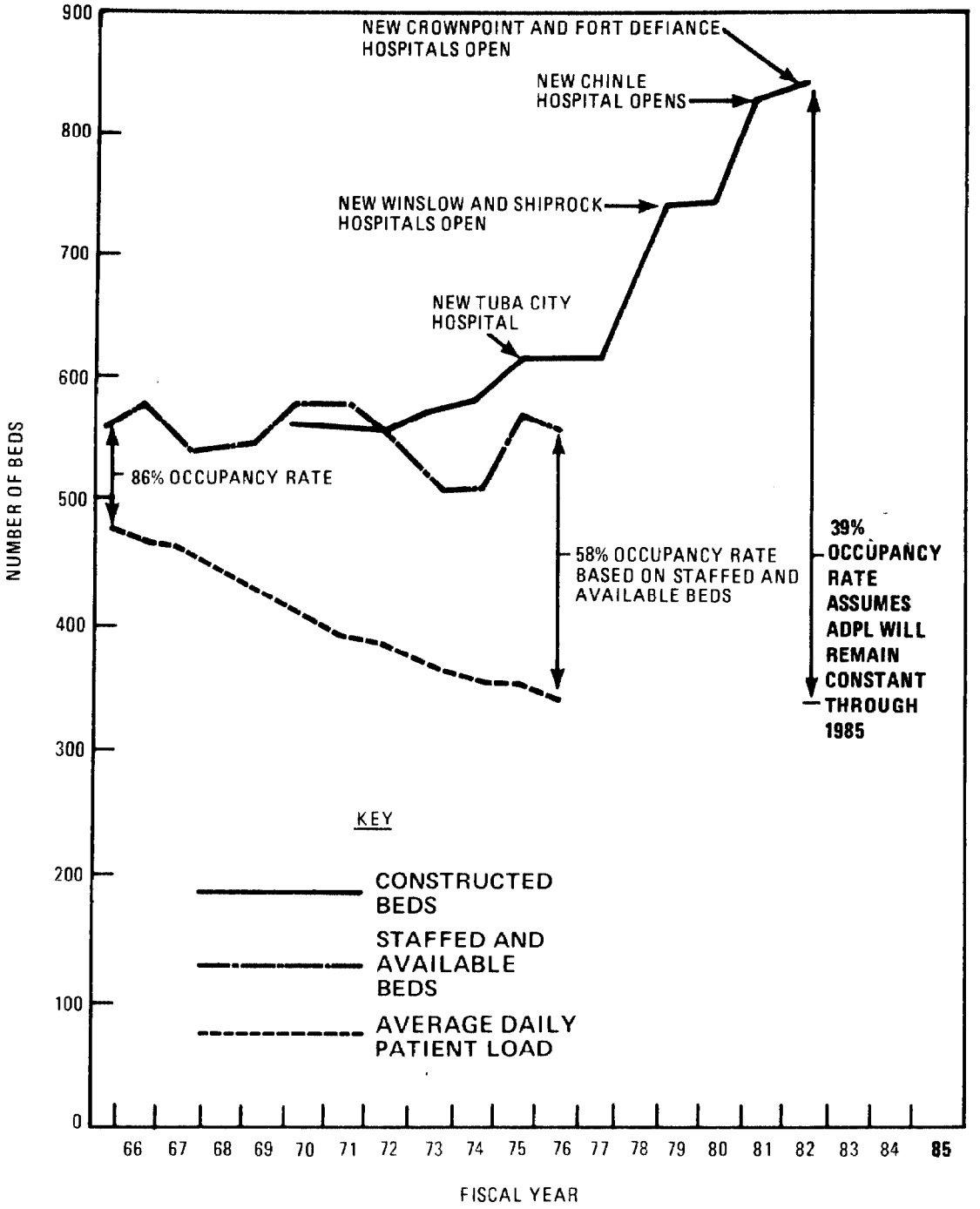
1/Under IHS criteria, a constructed bed is an acute care bed that has been assigned space for inpatient care, including space originally designed or remodeled for inpatient beds even though temporarily not used for such purposes.

2/An available bed is an acute care bed that is or can be used by a patient with adequate staffing and support service.

ACUTE CARE BEDS, AVERAGE DAILY PATIENT LOAD, AND PATIENT OCCUPANCY RATE FOR EXISTING AND PLANNED INDIAN HEALTH SERVICE HOSPITALS IN NAVAJO AREA, FISCAL YEARS 1966-1985



SOURCE: PREPARED BY GAO FROM INFORMATION OBTAINED FROM THE INDIAN HEALTH SERVICE.

because IHS used the same methodology throughout its system. In May 1977 we issued a report to a Senate Appropriations Subcommittee stating that HEW needed to reevaluate IHS' methodology for determining bed needs. 1/

Fiscal years 1978 and 1979 appropriations for planning eight IHS hospital projects--three of which were for the Navajo area--totaled $3,850,000. However, the Congress, at the recommendation of each Appropriations Committee, approved a moratorium on the use of these planning funds until IHS reevaluated its method for determining acute care bed needs, and it directed IHS to improve its construction program. For fiscal year 1980, the Appropriations Committees did not recommend any planning funds for proposed IHS hospital projects. As discussed on page 27, the moratorium was partially lifted in fiscal year 1979 to resume funding of two projects. The hospital projects originally affected by the moratorium were:

--Chinle, Arizona.

--Winslow, Arizona.

--Shiprock, New Mexico.

--Browning, Montana.

--Tahlequah, Oklahoma.

--Pine Ridge, South Dakota.

--Rosebud, South Dakota.

--Sisseton, South Dakota.

The Chinle project is for a new hospital; the other seven projects are for replacement hospitals. (Hereafter, these hospital projects will be referred to collectively in the report as "planned hospitals.")

After we reported our findings to the Appropriations Committees in May 1977, both Appropriations Committees requested that we monitor IHS' efforts (1) to reevaluate its methodology for determining acute care bed needs and (2) to

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1/Letter report dated May 31, 1977, to the Chairman, Subcommittee on Interior and Related Agencies, Senate Committee on Appropriations (HRD-77-112).

comply with the Committees' directives for improving its hospital construction program. In June 1978 we participated with IHS in a briefing to several members of the Senate Appropriations Committee on IHS' progress. We noted that IHS revisions to the methodology reduced the number of acute care beds planned for the Navajo reservation from 827 to 553. We also noted, however, that applying the methodology to the Navajo reservation would increase the number of constructed beds beyond existing levels, and we questioned several assumptions used in applying the methodology. After our briefing, the Appropriations Committees released planning funds for the Chinle hospital, but they did not do so for other hospitals previously approved for planning. According to the Committees' fiscal year 1979 conference report for IHS hospital construction, these funds would be released after IHS provided the Committees with

--a reliable health facility priority ranking system for identifying the most urgent Indian facilities needs,

--a Navajo reservation health facilities master plan,

--a report on controls on hospital project overruns, and

--justification for the recommended number of acute care beds and square footage for the Tahlequah hospital.

In November 1978 HEW submitted IHS' revised bed methodology to the Appropriations Committees and requested that planning funds for the other seven hospitals be released so that the design phase for these replacement hospitals could progress.

The step-by-step process IHS submitted was:

Step 1: Calculate bed needs by two major service components: (a) general acute care service, which includes medicine, surgery, pediatrics, acute alcoholism detoxification, and acute care short-term mental illness, and (b) obstetrics.

Step 2: Determine the ADPL based on hospital data for the last 3 years (1975-77).

Step 3: Add the additional ADPL that will be directly related to the alcohol detoxification program and acute mental health program.

Step 4: Add the ADPL for the services provided at other facilities (3-year average) that will be served directly when an adequate IHS facility becomes available. This calculation will include only patients sent to other IHS facilities or hospitalized under contract care during that period because of staff limitations and/or a lack of adequate facilities. This adjustment will thus reflect anticipated increases in patient load at the local service unit because of reduced inpatient contract care and referrals to other IHS hospitals. Corresponding decreases should be reflected by subtracting from the ADPL at the IHS referral hospital.

Step 5: Apply a factor to adjust for the projected service population in the target year 8 years hence (1985).

Step 6: Add a factor to provide for beds needed to accommodate normal fluctuation, since all of the above data deal only with average needs.

Step 7: Compare the result achieved by these steps with the National Health Planning Guidelines of a maximum of 3.7 beds per 1,000 population, or 80-percent occupancy.

If these criteria are exceeded, adjust the need to an 80-percent occupancy, or 3.7 beds per 1,000, whichever is higher.

HEW stated that these steps would give a reference point and should not be considered a fixed number without taking local factors into account.

Chapter 2 of this report sets forth our continuing concerns with IHS' acute care bed planning. Chapter 3 discusses the basis for our belief that continued congressional monitoring is needed.

CHAPTER 2

IHS BED METHODOLOGY AND ITS POTENTIAL EFFECT ON HOSPITAL SIZE

Assumptions IHS used in applying its methodology for determining the number of acute care beds could result in excess hospital beds. The revised methodology appears to be a reasonable method for determining hospital acute care bed needs, but the method is applied by IHS using assumptions that can greatly affect the number of beds forecast--and erroneous assumptions can result in over- or underestimating future demand. Forecasting errors affect not only funding for hospital construction, but also the facility's fixed operating costs.

The revised methodology is the product of many IHS changes since the congressional moratorium on IHS hospital planning began. Revisions have helped IHS reduce the planned new or replacement acute care beds from the original plan; however, IHS assumptions in applying the methodology could create more hospital acute care beds than needed. Planned hospital construction costs for new or replacement hospitals for the Navajo area total about $101 million; this construction will increase the number of excess beds in the Navajo area.

As discussed on page 3, based on peak patient demand, there were excess available and constructed beds in the Navajo area during fiscal year 1976. Since then, peak patient demand has declined further. If IHS proceeded with its current construction plans for the Navajo area, the excess bed problem would worsen because available bed capacity would increase by 66 beds and the constructed capacity would increase by 128 beds:

Comparison of Existing and Planned Constructed and Available Bed Capacities of Navajo Area Hospitals June 1979

Hospital	Constructed bed capacity		Available bed capacity	
	Existing	Planned	Existing	Planned
Chinle	-	60	-	60
Crownpoint	56	56	46	53
Fort Defiance	109	109	76	67
Gallup	207	207	181	131
Kayenta	-	-	-	-
Shiprock	75	106	69	106
Tuba City	125	125	108	92
Winslow	-	37	-	37
Total	572	700	480	546

NAVAJO AREA

Assumptions used in estimating Navajo area bed needs will permit IHS to build a new hospital and replace several other hospitals with bed capacities that now exceed current and probable future demand. For example, IHS uses a general assumption that each of the eight service areas should have its own hospital facility to improve the availability, accessibility, and acceptability of health services to the Navajos.

IHS plans are also heavily influenced by other assumptions. IHS has assumed that

--Navajos will receive inpatient care at hospitals in the area of their residence,

--ADPLs in the Navajo hospitals will increase because of an increase in population and a decrease in care obtained through contracts with non-IHS hospitals, and

--a planned alcohol and mental health program will encourage Navajos needing inpatient treatment to accept needed care at a hospital.

Our analysis of Navajo patient demand data provides no evidence that future demand will exceed current demand; in fact, demand may decline. We have noted that:

--Increases in IHS hospital admissions continue to be offset by greater decreases in patients' average lengths of stay, although the substantial declines in the average length of stay should eventually taper off. Our comparison of Navajo hospitals with Western U.S. data showed that patients at Navajo area hospitals in fiscal years 1975 and 1976 stayed about 17 percent longer than patients with the same diagnosis stayed at Western U.S. hospitals. This higher length of stay at Navajo hospitals means that bed use will probably decline further.

--Increases in population between fiscal year 1967 and fiscal year 1978 did not result in increased hospital ADPL.

--Substantial increases in patient demand for outpatient services reduce the need for hospital inpatient treatment. Increased use of outpatient services has allowed earlier identification and treatment of diseases, which reduces inpatient hospital care since the disease can often be treated before the patient requires hospitalization.

--Improvements in housing and water and sanitation facilities appear to have contributed to the reduced need for hospitalization--particularly for longer acute care stays.

We believe IHS needs to reconsider its plans to increase the constructed bed capacity for the Navajo area. Navajo patient demand data do not support the assumptions used by IHS in applying its revised bed methodology.

IHS needs to further address problems of availability, accessibility, and acceptability of health services in the Navajo area

IHS is planning more construction in the Navajo area than in any other area. IHS' 7-year plan includes providing acute care beds for each of eight Navajo service areas. IHS assumes that a hospital in each service area will help meet the objective of improving the availability, accessibility, and acceptability of health services to the Navajos.

We concur in this IHS objective. We believe, however, that to accomplish this objective IHS needs to collect

comprehensive data on Navajo health needs and to consider (1) the appropriate mix and location of inpatient and outpatient facilities and (2) the roles of non-IHS health facilities that provide health services on or near the Navajo reservation. IHS has not collected such data. (See ch. 3 for additional discussion of these topics.)

A health care system should include facilities capable of providing inpatient, outpatient, and intermediate care; however, IHS' hospital construction plans have not accounted for a mix of facilities for these levels of care. Our analysis of reservation health care shows that, from fiscal year 1966 to fiscal year 1976, the number of outpatient care visits increased 71 percent while the hospitals' ADPLs declined 33 percent. IHS and tribal officials acknowledge this. They also agree that opportunities exist to increase the use of intermediate and outpatient care facilities. However, IHS health facility planning has not shifted emphasis to more outpatient health facility construction and less hospital construction.

Locating a health facility according to population needs is critical to improving access to health care, particularly for the Navajo reservation, where public transportation is virtually nonexistent and the population is dispersed over a large area. Constructing a hospital in each service area will provide better access for the Navajos, but it will not eliminate their transportation problems. For example, residents in the westernmost portion of the Chinle service area will have to travel at least 90 miles to obtain inpatient care at the new Chinle hospital under construction. This trip can take about 2-1/2 hours because of poor road conditions. According to IHS senior clinicians in the Navajo area, distance and patient transportation problems are the biggest obstacles to IHS efforts to deliver quality health care services. We believe improvements to routine and emergency transportation for patients would help reduce patient transportation problems.

Although transportation for emergency purposes is available through emergency medical services and a fly-in service, there are problems with routine patient transportation. IHS has 21 vehicles usually restricted to routine patient transportation, but only 10 positions are assigned to these vehicles. Five service areas have vehicles, but no positions assigned for patient transportation.

According to HEW, emergency transportation systems are part of the IHS comprehensive health program and are reflected in the planning and construction of IHS health facilities. In the Navajo area, we found the emergency transportation service was predominately operated and staffed by the Navajo Tribe under contract with IHS. HEW said that funding constraints generally do not permit this service to be funded at the level identified as appropriate in the IHS resource allocation criteria.

We believe improvements to routine and emergency transportation for patients would (1) help reduce patient transportation problems, (2) provide the opportunity for greater use of referral hospitals, and (3) reduce the construction needed in the Navajo area.

In addition to IHS facilities, 10 non-IHS providers of inpatient and outpatient care are on or near the reservation. For example, in the Chinle service area a 45-bed hospital is located in Ganado, Arizona. It serves primarily Navajo residents of the Chinle and Fort Defiance service areas. During calendar year 1975, it had an ADPL of 15 and treated 17,216 outpatients. IHS construction plans make no provision for using the 10 non-IHS facilities on or near the Navajo reservation. During 1975 these non-IHS hospitals reported unused available beds totaling 252 on an average day.

Proposed patient relocations

IHS planning for the Navajo area, in essence, removes all patients from existing IHS hospitals and plans a bed for them in the service area where they live. IHS believes this planning assumption is necessary in order to assure the availability, accessibility, and acceptability of planned facilities for each service area.

IHS planning does not demonstrate that patient relocations will occur according to its revised bed methodology. When planning for patients previously receiving care outside their service area, IHS did not adequately recognize that many Navajo patients went outside their service area for treatment either by choice or by medical staff referral. In the Navajo area, three hospitals--Gallup, Tuba City, and Fort Defiance--are frequently used as referral hospitals because they can provide specialized services that are not and will not be available at other Navajo area hospitals.

A Navajo area planning official stated that, except for medical staff referrals to the Gallup Indian Medical Center, patients sent to an IHS referral hospital for specialized treatment were not excluded from the revised bed methodology's inter-service-area transfer calculations. For example, IHS planners included Winslow surgical patients in the Winslow hospital's workload even though they would continue to need more specialized surgical treatment at existing IHS referral facilities. Since not all Navajo hospitals are intended to provide all types of specialty care, we question the IHS assumption for relocating patients, which increases the constructed bed capacity of the Navajo area.

IHS referral hospitals also receive referrals from other Navajo service areas because of patients' requests. This may be caused by such factors as patient confidence in the quality of health services received at IHS hospitals or personal convenience. IHS regulations for Indian beneficiaries do not restrict self-referral patients to their service area. IHS did not identify and consider the frequency with which a patient selects a hospital outside his/her service area. IHS has assumed in its planning that this practice would not continue.

The IHS planning proposal to relocate patients now receiving care at the three referral hospitals will close 75 beds at these hospitals without adequate documentation that planned patient relocations will occur. IHS has not shown that it is cost effective to remove these 75 beds from its available bed inventory, and most of the beds were recently constructed at considerable Federal expense and would remain in the constructed bed inventory. We believe IHS hospital planning should emphasize increased, rather than decreased, use of excess beds at existing Navajo area referral hospitals.

Future population estimates and contract care adjustments

The new IHS methodology bases plans for additional beds on future projections for (1) population increases and (2) the percentage of current inpatient contract health care patients who are expected to be treated by IHS when the replacement hospitals are completed. Based on our evaluation of the IHS population and on contract care data for the Navajo area, we believe the methodology's assumptions about population and contract care estimates are not based on sound information.

Population estimates in the Navajo area vary, and they are of questionable reliability. For example, the Navajo Tribe, IHS, and the Bureau of Indian Affairs (BIA) use different estimates of the Navajo population living on and around the reservation--the estimates ranged from 122,554 to 149,950 in fiscal year 1976. Differences in the estimates arise from differences in the base population used, the geographic area included in the population base, and estimated growth rates. The following table shows the different agency and Navajo tribe estimates:

Component	IHS	BIA	Navajo Tribe
Population base	1970 U.S. census	1962 BIA/ tribal census	Self-revised 1970 U.S. census
Growth rate (FY 1976 to 1977)	4.35%	2.5%	2.2%
Area covered	Reservation and some surrounding areas, including Page, Farmington, Flagstaff, Holbrook, Winslow, and Gallup.	Reservation and some surrounding areas, including Page, Gallup, and Farmington.	Reservation and eastern Navajo-allotted lands.

In addition to the different population estimates, our analysis of IHS population and hospital statistics for the Navajo area shows that IHS proposed hospital bed planning contradicts historical trends. In the Navajo area, patient use of IHS hospitals, as measured by the ADPL, declined from 489 patients a day in 1966 to 329 a day in 1976, despite a 41-percent increase in IHS' reported population over the same period. IHS has used the planning assumption--that population increases will result in proportional increases in the hospital ADPLs--in its prior hospital planning method, which resulted in the construction of surplus acute care beds at various hospitals it has planned within past years.

A 1977 House Appropriations Committee report directed IHS to use Bureau of Census population figures when planning health facilities and services. The revised IHS bed methodology states that IHS prepared population projections using using Bureau of Census data. IHS projected (1) Indian births and deaths and (2) estimates on Indian migration through 1985. However, we noted some instances where the IHS-forecasted population increases were not related to Bureau of Census estimates. IHS estimates for service area population increases range from 5 to 32 percent through 1985. Generally, IHS population estimates were significantly larger than Census estimates.

IHS contracts with non-IHS hospitals for Navajo inpatient care because the Navajo population on the reservation is dispersed and because some specialized services are unavailable. The latter reason is dictated by such factors as IHS' inability to recruit specialists or the low level of demand for such services. According to IHS, its contract care analysis of the Navajo area showed that planned hospital construction will reduce the need to contract for inpatient care by 50 percent.

We recognize that the new and replacement facilities may reduce the need to contract for some inpatient care. However, such a reduction depends on IHS' ability to recruit medical specialists. It will also depend on IHS' ability to demonstrate that such specialized services are economically justified in IHS facilities.

Navajo area officials acknowledged that the IHS analysis of contract care patients who could be treated in IHS facilities did not consider the frequency of inpatient contract care being required because of (1) the lack of IHS staff or equipment to provide required care or (2) emergency conditions necessitating admission to a closer non-IHS hospital. According to Navajo area officials, this information was not considered because IHS records do not show why IHS authorized the patient to use a non-IHS hospital.

Also, comments by various Navajo service area directors cast doubt on the IHS analysis. Several service area directors stated that their facilities use contract care only for cases that require medical specialties not available in the service area or other IHS facilities. For example, Gallup Indian Medical Center and Tuba City Hospital officials stated that contract care funds are generally reserved for specialized cases the IHS hospitals cannot handle (such as

neurosurgery, vascular surgery, second- and third-degree burns, and plastic surgery). We believe, therefore, that more precise planning is needed to justify the assumption that 50 percent of the contract care will continue and that the other 50 percent will be provided at IHS facilities because of the new hospitals' increased bed capacity.

Expanded alcohol detoxification and mental health programs

IHS' methodology cites the Indian Health Care Improvement Act (Public Law 94-437) as the reason for developing a plan to treat alcoholism and mental illness where the problems in the area are severe; this plan is the basis for adding 45 acute care beds in the Navajo area.

According to IHS, there is very little literature on suggested methodologies for effectively treating alcoholism and mental illness among American Indians. Consequently, IHS estimates that 3.5 beds per 10,000 persons will be required for alcohol detoxification, and it bases its mental health acute care bed needs on the prior 3-year experience (1975-77) at the Gallup Indian Medical Center's psychiatric unit. IHS headquarters officials assert that its planning will be adjusted to reflect patient demand for these two services as data become available.

We found, however, that IHS hospitals do maintain the admission data necessary for compiling workload trends on alcohol detoxification and related alcohol abuse and mental health diagnoses. The Navajo area hospitals' admission data showed that both problems caused only a few admissions.

On July 18, 1978, the Appropriations Committees received IHS' implementation plan for expanding its treatment program for alcoholism and mental illness. The plan provides extensive details and statistics on the severity of the Indian and Alaska Natives' alcohol and mental illness problems. However, the plan does not demonstrate that:

--Patients needing alcohol detoxification and psychiatric care are going without treatment.

--It is feasible, based on the small existing workloads, to plan alcohol detoxification and psychiatric units separately from the acute care program.

--A number of presently unserved patients would be willing to submit to acute care treatment if more beds were available.

IHS needs a comprehensive alcohol detoxification and mental health care plan to identify the number of alcoholic and mental patients, and more specifically, it needs an estimate of the number of persons who require and will seek inpatient care for these diagnoses. We believe the methodology's adjustments for additional acute care beds for providing inpatient alcohol detoxification and mental health care are unnecessary. Until IHS can demonstrate that (1) patients needing alcohol detoxification and mental health care are going without treatment and (2) patients needing detoxification and psychiatric care would submit to acute care treatment if more beds were available, IHS hospital plans should not add acute care beds to the Navajo area for these services.

TAHLEQUAH HOSPITAL

IHS provides inpatient care to Indians residing in the Tahlequah, Oklahoma, area from a hospital with 54 constructed beds. IHS plans to replace this facility with a new 79-bed hospital, which will be located next to the new 50-bed Tahlequah community hospital. The two hospitals will be joined by a covered walkway to facilitate sharing services.

We did not make a detailed review of IHS' estimated needs for the Tahlequah hospital. However, we found that the following assumption used in the methodology can significantly affect hospital size.

The relaxation of Indian ancestry eligibility requirements for health services will require additional acute care beds

Once IHS has established the need for hospital construction, IHS health facility planners prepare a program information document. This document contains such information as the specific number of acute care beds, the quantity and quality of space, functional considerations, equipment lists, and environmental requirements. The most recent project using IHS' revised bed methodology is the proposed replacement hospital in Tahlequah.

Many of the planned acute care beds for Tahlequah are based on IHS' plans to relax Indian ancestry requirements for health services. IHS will provide services to any resident of a designated service area who is enrolled in a federally recognized tribe. For Oklahoma Indians, tribal rolls were closed at the turn of this century. As a result, Federal Government policy is to provide services to descendants of enrolled members who possess a blood quantum of one-quarter or more. This policy is unique to Oklahoma tribes.

IHS plans to lower the blood quantum to one-sixteenth, thereby increasing the number of beneficiaries eligible for health care in the Tahlequah service area. IHS plans are based on the HEW General Counsel's opinion that the determination of blood quantum eligibility requirements is an administrative decision. His opinion is premised on the lack of definition of the term "Indian" in the legislation which transferred the administration of the Indian health function from the Department of the Interior's Bureau of Indian Affairs to HEW.

BIA provides most other federally authorized services to Indians. BIA regulations require Oklahoma Indians to possess a one-quarter degree blood quantum to receive financial assistance and social services benefits.

Because of the considerable amount of hospital construction planned in the IHS Oklahoma area, we believe the Congress needs to express its intent on whether IHS can relax Indian ancestry eligibility requirements. If the Congress concurs with IHS, other Indian tribes may wish to have their eligibility requirements changed, and this could affect the number of acute care beds planned for all IHS facilities.

IHS' USE OF HEW NATIONAL HEALTH PLANNING GUIDELINES IS INAPPROPRIATE

As evidence that its methodology produces a realistic estimate of future bed needs, IHS compares the results of its methodology with computations from criteria set forth by HEW as national guidance on controlling the hospital bed supply. When the national criteria gave a lower estimate of bed needs for a planned IHS hospital, IHS reduced the bed size of the planned hospital accordingly.

In its submission to the Congress in November 1978, IHS stated that:

> "The results of the above bed estimation method produce a ratio of beds per 1,000 population which were then compared with the national guidelines. These guidelines call for not more than 4.0 beds per 1,000 population now, looking to 3.7 beds in the future. We applied the more rigid test of 3.7 beds per 1,000 population. In order to conform to the guidelines, the bed need was reduced to meet an estimated 80 percent occupancy or 3.7 beds per 1,000 population. [HEW guidelines allow health facility planners the discretion to select whichever measure best serves their community efforts to control the supply of hospital beds.] In addition, the Navajo Reservation was considered as an HSA [Health Systems Agency] and is below the 3.7 beds per 1,000 guidelines."

The HEW National Health Planning Guidelines cited by IHS were established after the National Academy of Sciences concluded there were excess hospital beds throughout the country. In an October 1976 report, the Academy stated:

> "We believe it is feasible to use a bed population ratio for the purpose of guiding the nation in the desired policy direction, but not as a standard for local application. * * * We emphasize that, in the application of an interim national goal of 4.0, State and local areas which are below that figure should be encouraged to remain below it and, if possible, make further reductions." (Our underlining.)

The Academy acknowledged, and HEW guidelines provide, that a larger ratio of beds to population may be justified in rural areas for several reasons--such as travel time to a hospital and greater fluctuations in demand for hospital services than in urban areas.

We believe that the HEW guidelines provide an acceptable rough estimate of bed needs, but they should not be used when empirical data are available for more precise forecasting. We have taken this position in three previously issued reports on bed forecasting for Federal hospital systems (MWD-76-117, Apr. 7, 1976; HRD-77-5, Nov. 18, 1976; and HRD-78-51, Feb. 6, 1978). We also believe that, in a "closed" hospital system

(such as IHS'), whose doctors can more readily control hospital admissions and lengths of stay by the individual's health needs, applying the national guidelines is inappropriate.

We also believe that using HEW guidelines to determine the acute care bed supply for IHS hospitals is of questionable value because

--estimates of the Indian population vary and are of questionable reliability,

--IHS' planning fails to recognize that other hospitals care for Indians, and

--proposed replacement hospitals cannot expect to achieve an 80-percent occupancy rate by fiscal year 1985, based on the current decline in bed use.

As discussed on page 14, population estimates differ because of differences in estimating base populations, geographical areas used, and estimated growth ratios. Based on the population estimates used, IHS facility planners could conceivably show that an area was either overbedded or underbedded in terms of beds-to-population ratios.

IHS beds-to-population estimates exclude 10 non-IHS hospitals that serve the Navajos. Yet some Navajos used non-IHS hospitals on or near the reservation by choice or through IHS referral. Officials of the 10 non-IHS hospitals located on or near the Navajo reservation estimate that from very few (Flagstaff Community Hospital) to most (70 to 80 percent at Monument Valley Hospital) of their patients are Indians.

The acute care bed capacities for several of the planned hospitals were derived by IHS using HEW's 80-percent occupancy guideline. However, as shown in the following table, planned hospitals probably will not achieve an 80-percent occupancy by 1985:

Projected 1985 Hospital Occupancy Rates for Planned IHS Replacement Hospitals Based on 10-Year Trend of Bed Utilization

Replacement hospital	Trend of ADPL between FY 1967-76	FY 1976 ADPL	Number of beds planned for 1985	Projected 1985 hospital occupancy rate
	(percent)			(percent)
Winslow, Ariz.	-61	18.1	37	49
Shiprock, N. Mex.	-14	48.5	106	46
Browning, Mont.	-23	17.6	26	68
Tahlequah, Okla.	-23	27.6	79	35
Pine Ridge, S. Dak.	-31	26.0	45	58
Rosebud, S. Dak.	-16	27.4	45	61
Sisseton, S. Dak.	-28	11.5	19	61

We calculated projected 1985 occupancy rates for planned hospitals by using fiscal year 1976 ADPL figures, because our analysis of the 10-year trend of patient use data indicates that hospital ADPL can be expected to remain constant or continue declining between now and 1985. Our analysis of the data showed that increases in population and hospital admissions have been offset by greater decreases in hospital average length of stay. Although the substantial decline in the average length of stay should eventually taper off, our statistical analysis suggests that further reductions can be expected.

CONCLUSIONS

Assumptions IHS used in applying its methodology for determining the number of acute care beds could result in excess hospital beds. The revised methodology appears to be a reasonable method for determining hospital acute care bed needs, but the method is applied by IHS using assumptions that can greatly affect the number of beds forecast--and erroneous assumptions can result in over- or underestimating future demand. Forecasting errors affect not only funding for hospital construction, but also the facility's fixed operating costs.

In addition, we believe IHS needs to further address the problems of availability, accessibility, and acceptability of health services in the Navajo area by (1) increasing, rather than decreasing, the use of existing Navajo referral

hospitals that have an unused bed capacity, (2) improving routine and emergency patient transportation, and (3) shifting emphasis to more outpatient health facility construction and less hospital construction.

IHS plans to relax the Indian ancestry eligibility requirements for health services in the IHS Oklahoma area, where a considerable amount of hospital construction is planned. This will increase the number of beneficiaries eligible for care in IHS hospitals and the bed capacity at planned hospitals. Before commitments are made to service area residents and considerable funds are spent on hospital planning, IHS should consult with the appropriate congressional committees before taking any action to relax Indian ancestry eligibility requirements.

We believe that the assumptions IHS used in applying its methodology need further revision before the Congress funds IHS hospital planning and construction projects. Appropriations for IHS hospital planning and construction should depend on IHS' adjustment of its assumptions for planning hospital capacity and size to recognize (1) the historical downward trend in IHS hospital use and (2) the availability of existing non-IHS community hospitals. Where IHS can demonstrate that patient demand exceeds an area's current bed supplies, its planning should provide for constructing additional acute care beds. However, most IHS hospitals have unused beds because of the downward trend in patient use and in the demand for hospitalization. We believe this trend will continue, to a moderate extent, in the future.

RECOMMENDATIONS TO THE SECRETARY OF HEW

To more accurately forecast IHS acute care bed needs and maximize the use of available funding, we recommend that the Secretary:

- --Revise assumptions used in the planning methodology for IHS hospital projects. The assumptions should recognize (1) existing unused beds at IHS hospitals, (2) the availability of non-Indian community hospitals, and (3) the decline of patients' use of acute care beds.

- --Limit the construction of additional acute care beds to instances where IHS can demonstrate they are needed.

--Coordinate with BIA and consult with the appropriate congressional committees before taking any action to relax the Indian ancestry eligibility requirements for health services in the Oklahoma area.

Further, because IHS plans for locating a hospital in each Navajo service area will not eliminate transportation problems faced by many Navajos, we recommend that the Secretary improve routine and emergency transportation for patients.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on a draft of this report (see app. I), HEW agreed to reevaluate and revise, as necessary, assumptions pertaining to population growth and acute care bed needs. It stated, however, that criticisms concerning the need to consider the availability of non-IHS hospitals and the recognition of existing unused beds in IHS hospitals primarily pertain to the Navajo area. IHS disagreed with our recommendations on the need (1) to revise its planning methodology to recognize the probable decline in hospital bed usage, (2) to coordinate with BIA and consult with congressional committees on relaxing Indian ancestry eligibility requirements for health services in the Oklahoma area, and (3) to improve routine and emergency transportation systems in the Navajo area.

HEW's planned recognition in the Navajo facility health plan of our recommendation to consider existing unused beds and the availability of non-IHS community hospitals will improve health facility planning for the Navajo area. We have noted, however, that all 10 of the planned hospitals, 7 of which are outside of the Navajo area, have unused bed capacity and that non-IHS community hospitals now serve some of the targeted patient population of the new and replacement hospitals. Therefore, we believe that conditions beyond the Navajo area warrant HEW to recognize these two elements of hospital bed estimating in planning for all of its hospitals.

HEW disagreed with our report's conclusion and recommendation on the need for revising the bed methodology's planning assumptions to recognize the decline in patient use of acute care beds, as measured by hospital average daily patient load. According to HEW:

"The large declines in ADPL experienced by IHS in recent decades reflect the results of such factors as environmental health programs, prenatal programs, improved housing, and the increased use of ambulatory care services, and cannot be assumed to continue at the same rate in the future."

ADPL measures patient demand for beds based on admissions and average lengths of stay. As discussed in chapter 2, the declining trend in the lengths of stay for IHS hospital patients has offset increased hospital admissions, thus causing a steady decline in ADPL. As discussed on page 3 and graphically presented on page 4 of the report, patient use of Navajo hospitals, as measured by ADPL, declined from 489 patients a day in 1966 to 329 patients a day in 1976. The most recent IHS patient demand data show that ADPL for Navajo area hospitals has not leveled off or increased as asserted by the IHS bed methodology. More specifically, Navajo area hospitals' ADPL declined to 303 patients a day during fiscal year 1979 and further declined to 271 patients a day during the first quarter of fiscal year 1980.

In chapter 2, we also stated that, based on our comparison of Navajo hospital lengths of stay experience with those of Western U.S. hospitals, continued decline in lengths of stay is probable as Indian health improves. Thus, further declines in hospital ADPL are also probable. We fully recognize that the decline in average lengths of stay will eventually taper off. We believe, however, that IHS should recognize the likelihood of further declines in ADPL in its bed planning methodology.

Regarding our report's conclusion and recommendation pertaining to IHS hospital planning for its Oklahoma service area, HEW said there is no statute that establishes blood quantum as a basis for determining eligibility for IHS health services. According to HEW, during BIA's administration of the Indian health program before 1954, blood quantum was not recognized by BIA as a condition for receiving health services, and specific eligibility criteria were not specified for Indian recipients of health and welfare services procured under Johnson-O'Malley contracts. IHS regulations on eligibility for health services provide that:

"Services will be made available, as medically indicated to persons of Indian descent, belonging to the Indian community served by the local facilities and programs, and non-Indian wives of such persons.

"Generally, an individual may be regarded as within the scope of the Indian Health and Medical Service Program if he is regarded as an Indian by the community in which he lives as evidenced by such factors as tribal membership, enrollment, residence on tax exempt land, ownership of restricted property, active participation in tribal affairs or other relevant factors in keeping with general Bureau of Indian Affairs (BIA) practices in the jurisdiction."

HEW added that Indian tribes have the right to decide who is a member and, therefore, who can receive IHS health services. Inasmuch as the scope of this review did not include an evaluation of BIA's prior administration of the Indian health program, we cannot comment on HEW's statements that (1) BIA did not recognize blood quantum as a condition of eligibility for health services before transfer and (2) no specific eligibility criteria were required of Indian recipients for health and welfare services procured under BIA Johnson-O'Malley contracts.

The IHS operations manual provides for the use of blood quantum as a basis for determining eligibility for health services for the major Oklahoma tribes. During discussions with IHS Oklahoma area officials, we were told that receipt of IHS health services by the Oklahoma tribes has historically been conditioned on blood quantum. In addition, the revised IHS bed methodology submitted to the Congress on November 3, 1978, states that IHS planning for the replacement hospital in Tahlequah, Oklahoma, was adjusted to recognize a change in blood quantum from one-quarter to one-sixteenth, thus increasing the overall bed size of the planned hospital to serve an increased beneficiary population.

In view of the contradiction between IHS operating policy in its Oklahoma area and HEW's comments on the use of blood quantum as a basis for determining eligibility for IHS health services, we believe that HEW and IHS should determine whether blood quantum may be used as a basis for determining eligibility for IHS health services. We believe IHS should coordinate with BIA and consult the appropriate congressional committees before acting to relax the Indian blood quantum eligibility requirements for health services in the Oklahoma service area. IHS should exercise such protocol before lowering the blood quantum below one-quarter, because this would be a departure from BIA eligibility requirements for comparable services and would involve a commitment to substantially increase budget requirements for health services.

HEW commented that it did not concur in our recommendation for improving emergency and routine transportation systems essentially because

--emergency transportation systems are already part of the IHS Comprehensive Health Program and are reflected in the planning and construction of health facilities,

--its plans for additional facilities (one IHS hospital in each service unit area) would take health care into remote areas and thereby reduce transportation problems for patients and staff, and

--routine transportation on reservations is not an IHS responsibility.

We noted and HEW comments acknowledge that funding constraints do not permit emergency transportation service to be funded at the level identified as appropriate in the IHS resource allocation criteria. As for routine transportation of patients to health facilities, we noted on the Navajo reservation that, in addition to emergency medical vehicles, most service areas had a complement of multipurpose vehicles (e.g., passenger vans, station wagons, and pickup trucks). As stated on page 11, IHS has 21 vehicles that are usually restricted to routine patient transportation, but IHS had authorized only 10 staffing positions for these vehicles. Five service areas had vehicles but no positions assigned for patient transportation. Therefore, although HEW asserted that it had no responsibility for routine patient transportation, IHS has in fact authorized positions and used its vehicles for this purpose.

We recognize that constructing new facilities where none now exist will reduce transportation problems for some Navajos. We also believe that the increasing trend toward outpatient care in lieu of inpatient care justifies additional outpatient facilities, which would further reduce transportation problems. IHS and tribal officials agree that there are opportunities to increase the use of such facilities. As pointed out on page 11, IHS facility planning has not shifted emphasis to more outpatient facility construction, but we did note that the proposed Navajo reservation health facilities master plan under consideration does recognize this potential. Therefore, as an intermediate step in determining need for and placement of outpatient care facilities, we believe that improving the system for transporting patients to existing health facilities will remove transportation as an obstacle to those who need health care but lack access to the existing facilities.

CHAPTER 3

CONGRESSIONAL OVERSIGHT IS STILL NEEDED TO IMPROVE HOSPITAL PLANNING AND CONSTRUCTION

Since September 1978 the Congress has continued the moratorium and indicated that planning funds would not be released nor would additional planning funds be appropriated until IHS further improved the hospital construction program. The Congress directed IHS to take specific actions to improve its hospital planning activities. IHS has revised its hospital planning procedures, but its revisions are not completely responsive to the congressional directives. Further, IHS has not complied with the congressional directive regarding the development of a Navajo reservation health facilities master plan. Full compliance with congressional directives is necessary for improving the IHS hospital construction program. Continued congressional monitoring will be needed until IHS takes the necessary actions to eliminate the need for the moratorium.

In September 1978 the Congress adopted the conference report on IHS' hospital construction appropriations bill for fiscal year 1979. The conference report provided funding for planning and/or constructing two hospital projects--Chinle and Tahlequah--while recommending that the moratorium on the use of planning funds for the other planned hospitals not be removed until the Appropriations Committees had received and evaluated the following:

--A reliable health facility priority ranking system for identifying the most urgent Indian facilities needs.

--A Navajo reservation health facilities master plan.

--A report on controls instituted to prevent hospital project overruns.

--Justification for the recommended number of acute care beds and square footage for the Tahlequah hospital.

The Committees' conference report also limited the size of the Chinle hospital to 60 beds and 107,000 gross square feet and advised IHS that responsibility for hospital construction would be removed from IHS if the program was not improved.

The House Appropriations Committee also directed its investigative staff to review various aspects of IHS' management of its direct and contract care programs. In February 1979, the Committee's Surveys and Investigation Staff reported a number of weaknesses that hindered IHS in carrying out an effective hospital construction program. According to the report:

> "These deficiencies vary in the impact they have on the program. According to IHS officials, when Congress provides facilities funds, it establishes priorities. Failure to coordinate construction planning has at times resulted in underutilized facilities and a shortage of housing which makes it difficult to attract and retain staff. The lack of construction standards for establishing space requirements has resulted in excess square footage as related to available beds. Apparent irregularities and improper distribution of staff resources have resulted in overstaffing at some facilities while at the same time there were reported shortages at others."

Because IHS has not meaningfully complied with Appropriations Committees' conference report directives, we believe that continued congressional oversight is necessary for assuring that the needed improvements in IHS hospital planning and construction procedures are made.

IHS HAS DEVELOPED A REVISED HEALTH FACILITIES PRIORITY LIST

The Congress' 1979 conference report mandated that IHS develop and apply a reliable and professional new construction priority system before any additional IHS hospital projects are approved for planning and construction. This directive was to assure that future Indian health facilities appropriations would fund the most urgent health facility needs of Indians and Alaska Natives. The Committees issued this directive after learning that IHS' hospital construction priorities used by the Committees for their funding decisions were not based on reliable criteria.

According to the 1979 House Surveys and Investigation staff report:

"Until recently, IHS has made little effort to develop a reliable, objective, and professional construction priority system. No real need for establishing such priorities was perceived because of the limited funds available for construction purposes. The Investigative Staff believes the contrary is true and that limited resources, in particular, require an effective priority system to assure that maximum benefits are derived from available resources. While decisions regarding the construction of facilities were to be made by a headquarters facilities group, in fact, IHS relied on Congressional add-ons as being the dominant determinant of priorities. As there were no guidelines, whatever decisions were made by this group were arbitrary and subjective. Because of these factors, the determination of facility needs and their locations were not always in conformance with the greatest need. Various IHS officials informed the Investigative Staff and have stated at budget hearings that construction priorities are set by the Congress. The Investigative Staff believes IHS must convince higher echelons and the Congress of priorities based on greatest need."

In response to the Committees' directive, on May 22, 1979, HEW submitted a proposed IHS Health Facilities Priority System dated February 1979.

According to IHS, the need for a hospital construction project can be identified by a number of sources--including a tribal request, conditions identified by IHS officials, surveys by HEW's Office of Facilities Engineering, and recommendations by the Joint Commission on Accreditation of Hospitals. The proposed IHS Health Facilities Priority Ranking System was developed to objectively evaluate requests for health facility construction. To determine the priority for hospital construction projects, the proposed priority system uses such criteria as patient access to health care, patient safety, age of structure, functional adequacy, and space availability and use. A point value is given to each factor to give a hospital's ranking among other hospitals.

The following lists IHS' hospital facilities by priority, as based on IHS' development of the proposed point system from IHS' long-range construction plans.

IHS' Proposed Hospital Priority List

Priority number	Name	State	Program area	Type
87.9	Chinle	Arizona	Navajo	New
58.0	Tahlequah	Oklahoma	Oklahoma	Replacement
49.6	Albuquerque	New Mexico	Albuquerque	Expansion
42.2	Crownpoint	New Mexico	Navajo	Replacement
41.0	Kanakanak	Alaska	Alaska	Replacement
37.1	Browning	Montana	Billings	Modernization
34.4	Talihina	Oklahoma	Oklahoma	Modernization
34.3	Sacaton	Arizona	Phoenix	Replacement
33.4	Rosebud	South Dakota	Aberdeen	Replacement
30.0	Kotzebue	Alaska	Alaska	Miscellaneous alterations
29.0	Anchorage	Alaska	Alaska	Replacement
27.8	Crow Agency	Montana	Billings	Modernization
27.4	Harlem	Montana	Billings	Replacement
25.8	Shiprock	New Mexico	Navajo	Modernization
24.7	Keams Canyon	Arizona	Phoenix	Addition alterations
23.4	Ft. Defiance	Arizona	Navajo	Modernization
19.9	San Carlos	Arizona	Phoenix	Addition alterations
18.4	Pine Ridge	South Dakota	Aberdeen	Modernization
17.6	Winnebago	Nebraska	Aberdeen	Replacement
15.8	Case Lake	Minnesota	Bemidji	Modernization
15.2	Eagle Butte	South Dakota	Aberdeen	Replacement
14.8	Ft. Yates	North Dakota	Aberdeen	Modernization
14.4	Sisseton	South Dakota	Aberdeen	Replacement
9.9	Rapid City	South Dakota	Aberdeen	Modernization
6.7	Lawton	Oklahoma	Oklahoma	Miscellaneous alterations

Because the proposed criteria for the new IHS facilities ranking system are still under agency review and consideration, we did not analyze their adequacy. We did note, however, that IHS' application of its proposed ranking system lowers the priority for many of the planned hospital projects under consideration by the Appropriations Committees. The proposed ranking of IHS hospital needs indicate that many hospital projects previously submitted to the Congress, along with the bed methodology, may not have necessarily represented IHS hospital facilities in greatest need.

NAVAJO RESERVATION HEALTH FACILITIES MASTER PLAN

As noted in chapter 1, the IHS Navajo area office is responsible for eight service areas located on and off the Navajo reservation; these areas encompass about 25,000 square miles in Arizona, New Mexico, and Utah. Five service areas have hospitals: Crownpoint, Fort Defiance, Gallup, Shiprock, and Tuba City. Four of the five hospitals have surgical capabilities. IHS also provided outpatient services at 12 health centers, 8 school health centers, and 19 health stations as of October 1978.

The IHS bed methodology and the planned hospitals submitted to the Congress included a request for replacement Navajo hospitals at Shiprock and Winslow and construction of a new facility at Chinle. During our June 22, 1978, meeting with several members of the Senate Appropriations Committee and representatives of IHS and HEW, we agreed that a new facility was needed at Chinle. To receive inpatient services, patients who live in Chinle must travel about

--40 miles to Ganado,

--77 miles to Keams Canyon,

--78 miles to Fort Defiance, or

--97 miles to Gallup.

We recommended, however, that planning funds for other Navajo area hospital projects be withheld until IHS provides the Congress with an areawide plan for the Navajo area that recognizes the effect of planned hospital construction on existing IHS hospitals.

For example, a new Chinle hospital should primarily affect the Fort Defiance hospital, which has received 40 percent of its inpatient workload from the Chinle service area. Even without losing 40 percent of its workload to a new hospital, the ADPL of the Fort Defiance hospital, which had 76 available beds in fiscal year 1977, had declined from 88 in fiscal year 1966 to 45 in fiscal year 1977. The IHS bed methodology,

however, shows a modernized Fort Defiance hospital of 67 1/ acute care beds and a new hospital in Chinle of 60 acute care beds. In this instance, we pointed out to the Committee the need for an areawide plan to assure that any future modernization plans approved by the Congress should reflect the loss of Chinle patients from the Fort Defiance hospital.

HEW agreed on the need for an areawide plan for IHS health facilities in the Navajo area. HEW said that such a plan is being developed that will consider (1) existing unused beds at IHS Navajo area hospitals and (2) the availability of the non-Indian community hospitals on or near the Navajo reservation.

For fiscal year 1979 the Congress made available $650,000 for planning the Chinle hospital and $3 million to initiate hospital construction. However, the House and Senate Appropriations Committees have advised IHS that they must receive and evaluate the Navajo areawide plan before considering future Navajo area hospital projects.

As of January 31, 1979, IHS headquarters officials said that various attempts to develop a Navajo reservation health facilities master plan had been unsuccessful. However, IHS officials believe that IHS Navajo area planners and the various Navajo tribal health planning agencies will be able to finalize a master facilities plan for inclusion in the Navajo Nation's Tribal Specific Health Plan. Tribal Specific Health Plans are currently being developed by almost 300 tribal groups to help IHS determine the tribes' specific health needs.

According to the IHS Director, the Tribal Specific Health Plan process is to serve as the primary tool for developing an IHS report to the Secretary of HEW on the progress of the Indian Health Care Improvement Act. The tribal plans were scheduled to be submitted to IHS during June 1979, and IHS extended the filing period to August 1. The Navajo

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1/The March 1978 IHS 7-year facility construction plan (see p. 2) shows that the existing 109-bed Fort Defiance hospital will be modernized to provide 100 beds. The revised IHS bed methodology, prepared subsequently, provides that the modernized hospital will have 67 beds.

tribe submitted its reservation health facilities master plan to IHS on November 1. IHS said that the plan would be forwarded to the Congress as soon as the plan is reviewed and approved by HEW. As of February 1, 1980, the plan was still under review.

IHS' REPORT ON MANAGEMENT CONTROLS TO PREVENT HOSPITAL PROJECT OVERRUNS

The Congress' 1979 conference report on IHS' hospital construction appropriation for fiscal year 1979 provided about $1 million to cover cost overruns for the IHS Red Lake hospital project being constructed by a tribe under a contract awarded by IHS pursuant to title I of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450). This special appropriation was necessary because the hospital structure was designed and constructed with 10,000 more gross square feet than authorized by the Congress. In regard to this hospital project cost overrun, the conference report stated:

> "That a full and detailed report from the Indian Health Service be made by January, 1979 on controls that have been instituted to prevent project overruns, such as Red Lake hospital facility, in the future. The managers are distressed not only because such a situation was allowed to occur, but also because the IHS failed to notify the Committees promptly of the status of the Red Lake facility. The managers cannot stress too strongly that the Appropriations Committees must be kept fully informed of deviations from the budget justifications or from recorded testimony * * *"

On February 22, 1979, the Appropriations Committees received an IHS report, "Contractual Requirements for Design and Construction of Health Facilities Under P.L. 93-638." HEW's transmittal letter to the Committees stated that IHS has implemented the report's provisions and that its implementation should preclude future hospital construction cost overruns.

At the request of the Senate Appropriations Committee, we examined the project's cost overrun and IHS' report. Our review of the space and cost overruns at the Red Lake facility revealed that IHS had not instructed the tribe to work within the congressionally authorized space and cost parameters; IHS had, in fact, authorized the tribe to exceed the parameters.

In addition, the IHS report deals exclusively with IHS hospital projects to be constructed by tribes under Indian self-determination contracts. The report does not contain data on most IHS health facilities, which are contracted for through HEW's Office of Facilities Engineering. Because some of these IHS hospital projects have experienced space and cost overruns, we believe IHS needs to revise its report on controls to prevent hospital project overruns.

CONGRESSIONAL LIMITATIONS ON ACUTE CARE BEDS AND SQUARE FOOTAGE OF THE CHINLE HOSPITAL

Because IHS made some revisions to its hospital planning procedures, the Appropriations Committees made an exception to their moratorium on IHS planned hospital construction. The Committees released $650,000 in planning funds for the Chinle hospital and appropriated $3 million to initiate hospital construction. The Committees' fiscal year 1979 conference report on IHS hospital construction appropriations specified that the Chinle hospital would be constructed with 60 acute care beds and no more than 107,000 gross square feet. Following is a chronology of congressional action on the Chinle hospital:

April 1977	The House Appropriations Committee recommended the construction of a new hospital at Chinle, Arizona. The Committee's fiscal year 1978 appropriation report specified $650,000 for planning the hospital.
May 1977	The Senate Appropriations Committee's fiscal year 1978 report specified $1,650,000 for planning the Chinle hospital, but recommended a moratorium on the use of the planning funds until IHS reassessed its hospital planning procedures.

June 1977	The House and Senate Appropriations Committees agreed on the amount of planning funds to be provided for the Chinle hospital. The Committees' fiscal year 1978 conference report specified $650,000 for planning the hospital. However, the Committees established a moratorium on the use of the planning funds until IHS reassessed its hospital planning procedures.
May 1978	The House Appropriations Committee's fiscal year 1979 report recommended continuing the moratorium on the use of the Chinle hospital planning funds and recommended no funds for constructing the hospital.
May 1978	The Senate Appropriations Committee's fiscal year 1979 report recommended $3 million to initiate construction of the Chinle hospital after IHS made some revisions to its hospital planning procedures.
September 1978	The House and Senate Appropriations Committees agreed to continue the moratorium on the use of hospital planning funds, except for the Chinle hospital, and specified $3 million to initiate construction of the Chinle hospital.

Accordingly, for fiscal year 1979 IHS had available $650,000 for designing the hospital and $3 million to begin the first phase of construction.

Chinle hospital project

Budget and contract documents prepared by IHS and HEW's Office of Facilities Engineering during fiscal year 1979 showed that IHS acted contrary to the expressed intent of the Congress by:

--Entering into a contract for designing the Chinle hospital that exceeds the amount of funds specified for this purpose in the Appropriations Committees' fiscal year 1978 conference report.

--Using part of the $3 million specified for construction of the Chinle hospital as a source of additional funds for the design contract.

--Planning a hospital and leased annex that, in total, exceeds the square foot limitation established by the Congress.

Further, IHS recently estimated that the construction cost will exceed the original estimate by $6 million.

Budget and contract documents for the Chinle hospital project show that IHS and HEW's Office of Facilities Engineering awarded a design contract on February 23, 1979, for basic architectural and engineering services in the amount of $755,500, thereby exceeding the $650,000 specified for this purpose in the Appropriations Committees' fiscal year 1978 conference report.

IHS did not inform the Committees that the design contract would exceed the $650,000 limitation. To obtain the additional funds needed for the contract, IHS authorized the Office of Facilities Engineering to use part of the $3 million specified for construction in the Appropriations Committees' fiscal year 1979 conference report. IHS did not inform the Appropriations Committees of this action.

Currently, IHS and the Office of Facilities Engineering estimate that the hospital's construction cost will be $6 million more than originally estimated. We believe that HEW should give the Congress a detailed explanation of the circumstances concerning the Chinle hospital design contract and the reasons for the escalation of construction cost estimates.

Finally, in March 1979 HEW engineers stated that current IHS planning provides for constructing a tribal annex building next to the hospital. According to HEW engineers the size of the annex building would be between 1,000 and 8,000 gross square feet. An engineer said the tribally constructed annex would be leased by IHS to provide additional storage space for the hospital.

IHS believes additional storage space is needed to supplement the 6,512 gross square feet specified in the October 1978 IHS program information document. The program information document--prepared after the congressional square footage limitation--provided 10,850 gross square feet for central bulk and sterile storage. IHS apparently revised the October 1978 program information document to provide additional square footage for other hospital functions. During March 1979 appropriations hearings, IHS acknowledged that it was exploring plans to lease a proposed tribal annex building. The planning arrangement between IHS and the tribe will exceed the congressional square footage limitation.

CONCLUSIONS

In September 1978 the Congress approved the continuation of the moratorium until IHS improved its hospital construction program. The Congress directed IHS to take specific actions to improve its hospital planning and construction activities. IHS has revised its hospital planning and construction procedures, but its revisions are not completely responsive to the congressional directives. Further, IHS has not complied with the congressional directives regarding the submission of a Navajo reservation health facilities master plan. Full compliance with congressional directives is necessary for improving the IHS hospital construction program. Continued congressional monitoring will be needed until IHS takes the necessary actions to eliminate the need for the moratorium.

RECOMMENDATION TO THE CONGRESS

In view of the foregoing, the Congress should continue the existing moratorium until IHS has fully complied with the congressional directives.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary improve hospital construction planning by:

--Establishing target dates for completing work on IHS hospital planning proposals that have been mandated by the Congress.

--Requiring that the Assistant Secretary for Health monitor IHS' progress in satisfying congressional directives and direct that IHS (1) use a reliable health facility priority ranking system for identifying the most urgent Indian facilities needs, (2) develop a Navajo reservation health facilities master plan, (3) develop a revised report on controls instituted to prevent hospital project overruns, and (4) construct the specified number of acute care beds and square footage for the IHS hospital project at Chinle, Arizona, and justify the size of the Tahlequah, Oklahoma, project.

--Assuring independent review and evaluation of IHS' proposed submissions to the Congress.

--Giving the Congress a detailed explanation of the circumstances surrounding the Chinle hospital design contract and the reasons for the escalation of construction cost estimates.

AGENCY COMMENTS AND OUR EVALUATION

In commenting (see app. I) on the recommendations in this chapter, HEW said that it concurred in

--the need for target dates for completing the proposals that the Congress mandated and that target dates are established;

--the need for independent review and evaluation of IHS' submissions to the Congress but said that existing echelons within the Health Services Administration, the Public Health Service, and the Office of the Secretary assure independent review and evaluation; and

--providing the Congress with a detailed explanation of circumstances concerning the Chinle hospital, if requested to do so.

In regard to the need for target dates, HEW officials now acknowledge that a target date for submission of the Navajo reservation health facilities master plan was not established. In its comments HEW said that it forwarded the priority ranking system to the Congress in February 1979, but as stated on page 29, the submission was made in May 1979, and the letter transmitting the submission identifies it as a

proposed system subject to revision. HEW officials now also acknowledge that no target date has been established for submitting a finalized priority ranking system for IHS health facilities.

HEW commented that it forwarded to the Congress a report on management controls required to preclude hospital construction cost overruns on projects contracted with tribes pursuant to title I of the Indian Self-Determination Act in February 1979. However, as stated on page 34, the report submitted by HEW excludes discussion of controls over HEW's Office of Facilities Engineering, which is the predominate contracting organization responsible for overseeing the construction of most IHS health facilities. Some of the hospital projects constructed under the guidance of HEW's Office of Facilities Engineering have experienced overruns. In December 1979, HEW informed the Congress of an anticipated 34-percent cost overrun for the planned Chinle hospital project, which is under the guidance of the Office of Facilities Engineering.

GAO believes that controls to preclude cost overruns on all IHS facility construction should be developed promptly, particularly since construction of the Chinle and Tahlequah hospital projects is scheduled to start in fiscal year 1980.

HEW took exception to our suggestion that the Assistant Secretary for Health assign a member of his office specific responsibility for monitoring IHS' progress in satisfying congressional directives, and cited its belief that enough review levels existed. We concur that adequate levels of review have been established and have modified our recommendation accordingly.

CHAPTER 4

SCOPE OF REVIEW

Our review was made at IHS headquarters at Rockville, Maryland; the IHS area office in Window Rock, Arizona; and the eight Navajo service areas.

We reviewed and commented on several draft bed planning methodologies proposed by IHS, including the bed determination methodology submitted to the Congress on November 3, 1978. Our detailed review of the methodology's application focused on hospital projects planned for the Navajo area, where we had concentrated our initial efforts. In addition, throughout fiscal years 1978 and 1979, we have evaluated IHS efforts to comply with the Appropriations Committees' directives for improving the hospital construction program, as summarized in chapter 3. This report's conclusions and recommendations have not been limited to the replacement hospital projects submitted along with the IHS methodology to the Congress, because IHS has disseminated the methodology to tribes for use in developing tribal-specific health plans that will be used for planning hospitals throughout its system.

The data gathered and reviewed consisted of the (1) IHS policies, regulations, guidelines, and appropriations relating to hospital construction and (2) hospital and health center records (including patient files) related to patients' use of existing IHS and contract health facilities for all IHS areas. We chose the period from fiscal year 1966 to fiscal year 1976 to establish long-range trends on IHS hospital use. We interviewed IHS and tribal officials regarding patients' use of existing facilities and planned hospital construction. We used certain computer-generated data supplied by the IHS Data Processing Services Branch in Albuquerque, New Mexico. Our review of the validity of computer-generated data was limited to checking IHS error edit criteria.

APPENDIX I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

19 OCT 1979

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Continued Congressional Monitoring Is Needed For Planning Indian Health Care Facilities." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard B. Lowe III
Acting Inspector General

Enclosure

APPENDIX I

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED "CONTINUED CONGRESSIONAL MONITORING IS NEEDED FOR PLANNING INDIAN HEALTH CARE FACILITIES"

GAO Recommendation

To more accurately forecast IHS acute care bed needs and to maximize the use of available funding, we recommend that the Secretary of HEW:

> --Revise assumptions used in the planning methodology for IHS hospital projects. The assumptions should (1) recognize existing unused beds at IHS hospitals, (2) recognize the availability of non-Indian community hospitals, and (3) recognize the decline of patients' use of acute care beds.

Department Comment

We concur in part with the recommendation. For the most part, the IHS methodology submitted in November 1978 includes the evaluation factors recommended by GAO. However, assumptions pertaining to population growth and acute care bed needs will be reevaluated and revised as necessary. Criticisms on a failure to recognize existing unused beds at IHS hospitals and the availability of non-IHS community hospitals primarily pertain to the Navajo service area and will be considered in developing a master plan for the area.

We do not concur in the GAO position that further declines should be assumed in the average daily patient load (ADPL) of IHS hospital facilities. The large declines in ADPL experienced by IHS in recent decades reflect the results of such factors as environmental health programs, pre-natal programs, improved housing, and the increased use of ambulatory care services, and cannot be assumed to continue at the same rate in the future.

GAO Recommendation

To more accurately forecast IHS acute care bed needs and to maximize the use of available funding, we recommend that the Secretary of HEW:

> --Limit the construction of additional acute care beds to those instances where IHS can demonstrate they are needed.

Department Comment

We concur in part with the recommendation. It is the policy of the Department to construct acute care beds only where there is a demonstrated need. The existing IHS bed planning methodology is consistent with PHS' bed planning standards set forth for the non-Indian communities under the P.L. 93-641, National Health Planning and Resources Development Act of 1974. However, as noted in our response to the first recommendation, assumptions used with the methodology will be reevaluated and revised as necessary.

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GAO Recommendation

To more accurately forecast IHS acute care bed needs and to maximize the use of available funding, we recommend that the Secretary of HEW:

> --Obtain congressional approval for relaxing the Indian ancestry eligibility requirements for health services in the Oklahoma area before commitments are made to service area residents and considerable funds are spent on hospital planning.

Department Comment

We do not concur. There is no statute that establishes blood quantum as a basis for eligibility for health services provided by the IHS, therefore, there is no basis that would permit the IHS to relax Indian ancestry eligibility requirements. Indian Tribes determine their members. Furthermore, it is IHS policy not to use blood quantum to determine eligibility for health services based on advice of the Office of the General Counsel (OGC) that, "the blood quantum rule is an arbitrary method for determining a person's legal status as an Indian which, as far as we know, is without any scientific support." In addition, OGC has advised that:

> "Legally, your decisions must be measured by their relationship to your obligations to the conservation of the health of Indians." IHS is not aware of any relationship between blood quantum and the discharge of such obligation."

Consequently, the IHS by regulation (42 CFR 36) has provided that:

1. Services will be made available, as medically indicated to persons of Indian descent, belonging to the Indian community served by the local facilities and programs, and non-Indian wives of such persons.

2. Generally, an individual may be regarded as within the scope of the Indian Health and Medical Service Program if he is regarded as an Indian by the community in which he lives as evidenced by such factors as tribal membership, enrollment, residence on tax exempt land, ownership of restricted property, active participation in tribal affairs or other relevant factors in keeping with general Bureau of Indian Affairs (BIA) practices in the jurisdiction.

The Office of the General Counsel has also stated that "the BIA did not recognize a particular blood quantum as a condition of eligibility for health services prior to transfer. In the opinion of the Chief Counsel of the Bureau of Indian Affairs, dated November 4, 1954, it was held that there are no "specific criteria of eligibility for Indian recipients of health and welfare services procured under Johnson-O'Malley contracts."

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GAO Recommendation

Further, because IHS plans for locating a hospital in each Navajo service area will not eliminate transportation problems faced by many Navajos, we recommend that the Secretary of HEW take steps to improve routine and emergency transportation for patients.

Department Comment

We do not concur. Emergency transportation systems are part of the IHS Comprehensive Health Program and are reflected in the planning and construction of the health facilities. This is one of those health services normally not found in non-Indian community hospitals and is one of the items that increases square footage for IHS health facilities. On many Indian reservations, including the Navajo, the emergency transportation service is operated and staffed by the Tribe under contract with IHS. Generally, funding constraints do not permit this service to be funded at the level identified as appropriate in the IHS Resource Allocation criteria.

One reason for the additional facilities in the Navajo area is to bring health care into remote areas. This should reduce transportation problems, in that there will be shorter distances for patients and staff to travel, and, therefore, encourage the use of facilities.

In regards to routine transportation on reservations, this is not a responsibility of IHS. It is a problem that is inherent to isolated areas of the United States. IHS has, however, attempted to encourage Tribal governments and other Federal agencies to develop comprehensive tribal transportation systems.

GAO Recommendation

So that needed Indian hospital construction can be resumed, we recommend that the Secretary of HEW eliminate the need for the congressional moratorium on the hospital construction program by:

--Establishing target dates for completing work on IHS hospital planning proposals which have been mandated by the Congress.

Department Comment

We concur. Target dates are established for completing work on IHS hospital planning proposals as mandated by the Congress. However, the need to meet and comply with congressional directives in a timely manner will be reemphasized.

GAO Recommendation

So that needed Indian hospital construction can be resumed, GAO also recommends that the Secretary of HEW eliminate the need for the congressional moratorium on the hospital construction program by:

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--Requiring that the Assistant Secretary for Health assign a member of his Office specific responsibility for monitoring IHS' progress in satisfying congressional directives mandating:

--Using a reliable health facility priority ranking system for identifying the most urgent Indian facilities needs;

--Developing a Navajo reservation health facilities master plan;

--Developing a revised report on controls instituted to prevent hospital project overruns;

--Constructing the specified number of acute care beds and square footage for the IHS hospital projects at Chinle, Arizona; and Tahlequah, Oklahoma.

Department Comment

[See GAO note] We do not concur. The present review levels within the Department consisting of the Health Services Administration, Public Health Service, and Office of the Secretary provide sufficient responsibility for monitoring IHS progress in satisfying congressional directives.

With regard to the four specific congressional directives contained in the GAO recommendation, the following points apply:

1. In February, 1979, IHS submitted to the Congress the Health Facilities Priority System for use in objectively ranking requests for health facility construction.

2. Congress was advised during the FY 1980 hearings by the Director of IHS that the Navajo Tribal Plan must be approved by the Navajo Tribal authority before it can be submitted to the Congress by IHS. As of this date, the Navajo Facility Plan has not been approved by the Tribal authority. As soon as IHS receives the plan and has an opportunity to review it and approve it as appropriate, the plan will be submitted to the Congress.

3. The original congressional request addressed controls required to preclude cost overruns for Indian Self-Determination Contracts. This report was submitted to the Congress in February, 1979.

4. The IHS is constructing the specified number of acute care beds in the square footage authorized by the Congress for the IHS hospital projects at Chinle, Arizona. Construction funds have not, as yet, been appropriated for the Tahlequah, Oklahoma project. IHS will follow all congressional directives when such funds are made available.

GAO note: As shown on page 38, this proposed recommendation was revised in the final version of the report to recognize the existing review levels within HEW.

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GAO Recommendation

So that needed Indian hospital construction can be resumed, we recommend that the Secretary of HEW eliminate the need for the congressional moratorium on the hospital construction program by:

--Assuring independent review and evaluation of IHS' proposed submissions to the Congress.

Department Comment

We concur. The present management echelons within the Department consisting of oversight by the Health Services Administration, Public Health Service, and Office of the Secretary assure independent review and evaluation of IHS' proposed submissions to the Congress.

GAO Recommendation

So that needed Indian hospital construction can be resumed, we recommend that the Secretary of HEW eliminate the need for the congressional moratorium on the hospital construction program by:

--Providing the Congress with a detailed explanation of the circumstances concerning the Chinle hospital design contract and the reasons for the escalation of construction cost estimates.

Department Comment

We concur. The Department is prepared to provide the Congress with a detailed explanation of the circumstances concerning the Chinle hospital design contract and related construction cost estimates if requested to do so.

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