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STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ON

THE VETERANS ADMINISTRATION'S MEDICAL CONSTRUCTION PROGRAM

Mr. Chairman and Members of the Subcommittee, I am pleased to be here this morning to discuss the views of the General Accounting Office on the medical construction program of the Veterans Administration. Our work has generally dealt with three of the most important issues of any medical construction project: Is the the project justified? How big should it be? Can it be built for less? I would like to review for you several reports we have issued over the past 5 years and then discuss our current audit of VA's construction program.

We have recently issued two reports on the planning criteria and processes VA uses to justify proposed nursing home construction projects.

In October 1981 we reported that VA had not been effectively planning and coordinating the construction or use of VA, State home, and contract community nursing homes. We concluded that VA and State home facilities may be built in areas having too many

community or State nursing home beds, while not enough beds may be available in other areas to meet VA's anticipated needs. We recommended that the Administrator establish, in coordination with State and local health planning agencies and the National Association of State Veterans Homes, more realistic medical district plans for the construction and/or use of VA, community, and State nursing homes to provide care to veterans. ("State Veterans' Homes: Opportunities To Reduce VA and State Cost and Improve Program Management," HRD-82-7, Oct. 22, 1981.)

We reiterated and expanded on that recommendation in our September 1982 report to the Administrator which concluded that VA did not adequately consider local conditions or less costly alternatives before building new nursing homes. Specifically, we found that VA

--justified new nursing home construction using national demographic and needs projections with little input about the characteristics and resources of the medical districts or the medical centers' primary service areas;

--did not adequately consider the option of providing more nursing home care in community nursing homes by expanding its use of existing legislative authority to contract for care; and

--did not adequately consider converting, renovating, or changing the mission of its existing VA facilities to help meet the need for more nursing home beds.

We were concerned that VA's revalidation of construction projects, recommended by the Administrator in February 1982, was not going to critically review the criteria VA had been using to justify nursing home construction projects. We were also aware of VA's move to decentralized planning (MEDIPP--medical district initiated planning process) and were concerned that the districts' continued reliance on VA's existing criteria could result in an unnecessarily expensive response to projected veterans' nursing home care needs, with over-supplies of nursing home beds in some geographical areas and shortages in others. We recommended that the Administrator ensure that VA nursing home construction projects be proposed to the Congress only after a thorough consideration of less costly options. ("VA Should Consider Less Costly Alternatives Before Constructing New Nursing Homes," HRD-82-114, Sept. 30, 1982.)

Mr. Chairman, in December 1981 we reported to you and this Subcommittee about an opportunity to reduce the time VA takes to complete medical facility construction projects, thus minimizing the effects of inflation on overall project costs. At your

request, we reviewed the reasons for cost growth in VA's medical facility construction program, the reason for large numbers of changes to design and construction contracts, and the cost these changes added to projects. We reviewed several recently completed projects--hospitals, nursing homes, and research and education buildings. We identified changes during the design phase which eventually increased the projects' cost by 18.8 percent and changes made while the projects were under construction which added 6.9 percent to the construction contracts.

We noted, however, that VA's construction program has changed significantly since the projects we reviewed were being designed and constructed. Congressional concerns about cost growth in VA's major construction program prompted (1) the Congress to enact legislation to control the growth of VA projects beyond their original cost estimates and (2) VA to create the Advanced Planning Fund to enable it to provide the Congress better cost estimates. Although it was too soon to fully evaluate the effectiveness of these actions during our audit, we believed they should enable the VA to submit better cost estimates to the Congress and should provide an upper limit cost control on approved projects.

The time it takes to complete medical facility construction projects could be reduced by up to 15 months by extending the

Advanced Planning Fund to allow VA to contract for final design while the Congress reviews the projects. This could reduce overall project costs by minimizing the effects of inflation; however, there would be the added risk that, if the Congress did not approve or fund a project so designed, the final design costs could be wasted. Whether the changes should be made rests largely on the confidence the Congress has in VA's ability to identify and prioritize its construction requirements. ("Opportunity To Reduce the Cost of Building VA Medical Facilities," HRD-82-28, Dec. 30, 1981.)

In May 1977 we recommended that VA adopt a computer-based model which we developed to determine the acute care bed needs of new and replacement hospitals. The basic problem had been that VA's health care system centered around the acute care hospital. Because VA's former planning model relied on past experience in determining what was needed, estimates of hospital size tended to reflect the inefficient system of the past. Moreover, VA's planning model did not recognize in a precise way expected changes in the size and age mix of the veteran population.

We developed a new model which analyzed past practices and determined what different degrees of care should have been provided. Application of this model to projected veterans' population data showed that a mix of medical facilities different from that proposed in 1976 was needed to permit new replacement

hospitals to have a range of health care options consistent with modern medical practice. ("Review of Veterans Administration's Methodology for Determining Hospital Bed Size," HRD-77-104, May 20, 1977. VA's bed sizing methodology was also discussed in the following reports: "Constructing New VA Hospital in Camden, New Jersey, Unjustified," HRD-78-51, Feb. 6, 1978, and "Inappropriate Number of Acute Care Beds Planned by VA for New Hospitals," HRD-78-102, May 17, 1978.) Since then we have been working closely with the VA to improve the current model and expand its capability. Two of our staff are serving in an advisory capacity to VA in its effort to upgrade and refine the model. Just last month, they attended a conference at the VA medical center in Gainesville, Florida, to provide feedback to VA researchers working with the model.

Finally, in March 1981, we reported that VA's criteria for surgical facilities in new or replacement hospitals was resulting in too many operating rooms. We noted that the VA guidelines failed to consider that some occupants of surgical beds do not undergo surgery, and the time needed to perform a surgical procedure varied according to the type of surgery and the surgeon's experience. VA disagreed with some of the specifics of our report but agreed to develop a new model, similar to the one we proposed. ("Better Guidelines Could Reduce VA's Planned Construction of Costly Operating Rooms," HRD-81-54, May 3, 1981.)

We have one audit currently underway which addresses the issues of the cost of VA's medical construction program. We have been concerned about the growing disparity between the cost of constructing VA and community nursing home beds. The four nursing home construction projects approved in VA's fiscal year 1983 budget will provide 360 beds at a cost of about $35.5 million, or about $98,500 per bed. Community nursing homes are reportedly being constructed for under $30,000 per bed. Our preliminary objectives, therefore, are to more accurately determine the cost of constructing VA and community nursing homes and then to isolate specific items which cause the VA beds to be so much more expensive.

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Mr. Chairman, this completes my prepared statement. We will be happy to answer any questions you have.