FUTURE OF THE VETERANS HEALTH ADMINISTRATION

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BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

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HOUSE OF REPRESENTATIVES

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MATERIAL SUBMITTED FOR THE RECORD

FUTURE OF THE VETERANS HEALTH ADMINISTRATION

WEDNESDAY, JUNE 26, 1996

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room 334, Cannon House Office Building, The Honorable Tim Hutchinson (chairman of the subcommittee) presiding.

Present: Representatives Hutchinson, Smith, Bilirakis, Quinn, Stearns, Ney, Fox, Edwards, Kennedy, and Tejeda.

OPENING STATEMENT OF CHAIRMAN HUTCHINSON

Mr. HUTCHINSON. Subcommittee will now come to order.

Subcommittee meets today as part of its responsibility to oversee and assist the Veterans Health Administration as they plan for the development of a revamped health care delivery system in the 21st Century. The objective of these hearings is to examine various possible futures for both health care delivery in general, and health care delivery within VHA. To assist us in this examination, we've drawn upon a diversed group of expert, each of whom brings a different perspective on health care.

The confluence of rapidly changing medical practice, medical technology and health care delivery system theory has created the most dynamic period of change the health care industry, both public and private, has ever experienced. In this rapidly changing environment, Dr. Kizer has taken on the Herculean task of reorganizing VHA. I want to personally applaud the efforts of Dr. Kizer to lead the VA into the 21st Century through his *Prescription for Change*.

As all of you are aware, we currently spend billions of the taxpayers' dollars for care to be provided in the future, such as investments in technology and fixed facilities. It is imperative that we not only have an organization that can adapt to the future, but that we have a vision of that future. We cannot make the claim that the future is too difficult to predict, but then commence to appropriate billions in support of that undefined future.

To assist us in this examination today, we are drawing upon some of the most forward thinking organizations and experts in the country. These are individuals who think outside the box of traditional health care. Some of these futurists have already designed specific futures for VHA. Others have developed scenarios which are now being played out in the private sector. Other witnesses will

provide a future vision based on historical experience from within the VA.

Tomorrow, we will examine the Department of Defense as it attempts to define its health care role in the next century, and examine the work of management consultants who have looked at the VA within a quasi-governmental context. And lastly, we will hear from the veterans' service organizations who can provide us with the most important perspective of all, that of the veteran patient.

I talked with Ranking Member Edwards several months ago about the need for these kinds of hearings. Much of what we'll hear will be controversial. Some we will like, some we may not like. But I think it is essential, as we look to the 21st Century, that we be willing to move outside the box of traditional thinking and examine and be open to new possibilities.

I thank our witnesses for joining us this morning, and recognize my friend and colleague, the ranking member of this subcommittee, Chet Edwards, for his opening statement.

OPENING STATEMENT OF HON. CHET EDWARDS

Mr. EDWARDS. Mr. Chairman, thank you.

I'd like to submit my written testimony for the record with your support?

Mr. HUTCHINSON. Without objection.

Mr. EDWARDS. Thank you.

Mr. Chairman, I'll be brief. I simply want to commend you for holding these hearings. If I have one frustration about this process, it is that between phone calls and daily walks to the floor and committee meetings, we very seldom, as Members, get a chance to take a look at big picture issues and look at the future, ask questions we normally don't get to ask. I think this would be healthy for all committees to do what we are doing today and tomorrow, to perhaps think of some fresh ideas in our approach to VA health care. I may not like the big picture that some of the witnesses paint. I may vehemently disagree with them. I may do everything I can to oppose some of their suggestions. I don't know, frankly.

But I approach the hearing with an open mind and with an appreciation for the fact that as part of our oversight responsibilities, you've recognized it's important for us to step back a few feet in very busy times and look at the long-term future of the VA. I hope some very positive good will come out of these hearings, and some fresh perspectives as well.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Edwards appears on p. 81.]

Mr. HUTCHINSON. Thank you, Chet.

The chair would now recognize members who might have an opening statement.

Mr. Quinn.

OPENING STATEMENT OF HON. JACK QUINN

Mr. QUINN. Thank you, Mr. Chairman.

I'd like to thank you and Mr. Edwards for your holding the hearings today and tomorrow and into next month, for the proactive position you've taken on these kinds of items. Mr. Edwards just said,

in very, very busy times, sometimes it's a good idea to just pause, take a deep breath, step back and see where we are and where we're headed.

We're doubly challenged, not only by budgetary constraints but also by the execution of a strategic restructuring plan. I'm encouraged by recent discussions through my office and Dr. Kizer, who's office has been working on this for some time, on that outside the box line of thinking that you talk about, Tim. That we need to look at some alternatives to traditional thinking and funding and so forth.

So, I think we're headed in the right direction. It will be new for a lot of us. I applaud your efforts and stand ready to help both of you in any way I can as a member of the subcommittee and the full committee.

Thank you.

Mr. HUTCHINSON. Thank you, Jack.

Mr. Tejeda.

Mr. TEJEDA. Thank you very much.

I certainly look forward to the testimony here, and I thank you very much for putting this together. And again, thank you very much. I look forward to working with you.

Mr. HUTCHINSON. Thanks, Frank.

Mr. Kennedy.

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY II

Mr. KENNEDY. Mr. Chairman, I want to very much commend you for the hearings that you've put together here. I think it's a very interesting list of witnesses that you've put forward.

I just want to point out to the members of the subcommittee that there are some interesting statistics that the VA is going to face in the next few years. In the last decade, the VA has reduced the total number of hospital beds it operates by 35 percent, and has cut its medical staff by more than 7,000 positions since 1993. At the same time, the demand for VA health care is heavy and growing. Since 1987, the numbers who use the VA health care system has increased by a full 12 percent. In addition, older veterans require more care and that care is more expensive. By the year 2000, the number of veterans who are 65 and older will increase 35 percent. The number of veterans 85 and older will increase by 174 percent.

That combination of a shrinking health care budget with the veterans' population getting older and older has put just an attenuated strain on the existing system. That's where I think we ought to commend Dr. Kizer for the innovations that he has brought to the VA health care system. I think his innovations in terms of trying to get a much greater amount of health care for a shrinking amount of dollars is something that anybody that has looked and followed this system over the last 10 years or so ought to be very, very thankful and appreciative of your efforts, Doctor.

I think that it is also—and I'm sure Dr. Kizer would welcome, is it Mr. Coile—is that how you pronounce it?—Mr. Coile's ideas and other ways of looking at the system. I don't think that we're prepared in this country, either politically or in any other way, to deal with ending the VA system as we know it today. I think the one concern that I think we ought to keep in mind is that we don't

want to view this system as simply a system that we have to take the existing budget and shrink it down. The commitment that the Congress makes to the veterans is that we're going to take care of their health care needs. Now, we can make some priorities in terms of whether or not they're service-connected disabilities, or whether or not they're very poor veterans, and things like that. But we ought not to get into a situation where we're simply, I believe, just capitating the system without looking at what the real growing demand is for the health care benefits that the patients need.

And so, with keeping that in mind and keeping in mind the fact that we have, I think, just begun on the road towards paring down significantly, the cost structures which have been in place. The fact that I think that there's a range of new and innovative approaches that we can take, I really look forward to the hearing.

And Mr. Coile, I look forward to hearing your ideas. But I think we ought to just keep in mind in your testimony, the fact that our commitment, unlike the commitment of maybe Medicare and Medicaid and a lot of the other systems that people are talking about these days, we have a very, very fundamental commitment to serving the veterans' needs. We ought not to worry as much about the budget pressure as we ought to making certain that we fulfill the basic mission of this health care system.

Thank you very much, Mr. Chair.

Mr. HUTCHINSON. Thank you, Mr. Kennedy.

Mr. Bilirakis, do you have an opening statement?

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Well, just a very brief one, Mr. Chairman. I want to commend you, of course, for scheduling these hearings.

I want to thank the good doctor for appearing before us again. We're getting to know you real well, and of course, your staff.

Mr. Chairman, I know this is 2 days of hearings and I have a markup tomorrow morning that starts exactly at the same time over in Health and Environment. So, I will not be able to be here. But given the topic, of course, I wanted to be here today.

I don't know what the answer is. That's why we hold these hearings. I do feel very, very strongly that we use that word entitlement. We throw that around very readily and obviously, I think all of us are supportive of some of the other entitlements. Most of them, if not all of them. But the one true entitlement ought to be the veterans who are entitled by virtue of their conduct, by virtue of having served, not by virtue of hitting a certain age or having possessed some sort of a disability or something of that nature. So, when it comes to entitlement, that's really, I think, maybe where it should be limited to.

I am anxious to hear what our witnesses have to say. I know that we have a series of votes coming up in a very little while, right after the one minutes. So, I guess we ought to get at this as quickly as we can.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Bilirakis appears on p. 83.]

Mr. HUTCHINSON. Thanks, Mike.

This morning the subcommittee will hear testimony from the first of our three panels during the two day hearing. The panel is comprised of four very distinguished individuals.

Mr. Russell Coile of the Health Forecasting Group is an internationally renowned futurist who specializes in the health care industry.

Dr. Kizer, whom we know well, the Under Secretary for Health at the VA has once again graciously accepted our invitation to share his vision for VHA. He is accompanied by Mary Lou Keener, the General Counsel.

Erica Mayer of the Institute for Alternative Futures is with us. She co-authored the paper entitled "Visionary Leadership and a Future of the VA's Health System," and has worked extensively designing the futures of organizations as complex as the Department of Defense.

And we're glad to have Marjorie Quandt, who was the executive director of the Commission on the Future Structure of Veterans Health Care which convened in 1990. She is the former director of the North Chicago VA Medical Center and has served in a variety of capacities in the VA for over 30 years. Her aggressive foresight has always been, and continues to be, a valued commodity in the VA community.

I would ask the witnesses to summarize their testimony in the requisite 10 minutes. The full text will be entered into the record. For the purposes of questioning the witnesses, the subcommittee will operate under the 5-minute rule.

The chair now recognizes Mr. Coile.

STATEMENTS OF RUSSELL C. COILE, JR., PRESIDENT, HEALTH FORECASTING GROUP, SANTA CLARITA, CA; KENNETH W. KIZER, M.D., M.P.H., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION; ACCOMPANIED BY MARY LOU KEENER, GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS; ERICA MAYER, ASSOCIATE, INSTITUTE FOR ALTERNATIVE FUTURES; MARJORIE R. QUANDT, CONSULTANT

STATEMENT OF RUSSELL C. COILE, JR.

Mr. COILE. Thanks very much. Good morning to the subcommittee, and thank you very much, Mr. Chairman, for the invitation and the opportunity to meet with you. I'll be brief.

I'm a California-based health care market observer and forecaster, and as is well known, California is the hot bed and perhaps the cradle of HMO development and managed care. I bring you this morning a set of recommendations, a short of list of recommendations, which basically recommend that the VA, over the next 5 to 7 years, consider a strategy of privatization and capitation of the VA eligible, health care eligible population. As a veteran myself, a former member of the U.S. Public Health Service Commission Corps, I'm a potentially impacted beneficiary of such a strategy, but I'm also a 20-year Kaiser enrollee and have had extensive experience in managed care markets.

I've got with me a copy of Sunday's *L.A. Times*. It talks about the changing state of managed care, first page of the business sec-

tion, and looks at the impact that managed care has had on health care benefit expenses, both for the State of California through its public employee retirement system and that other large employers have experienced through using managed care and capitation approaches.

In California, market competition has driven the price of a commercial HMO product down below the level of $100 per member per month. In California, Medicaid capitation is pricing a comprehensive program to Medicaid beneficiaries at below $85 per member per month. This is the kind of economic impact that martialling, in essence, purchasers' clout has begun to show in California. As is the committee is well aware, HMO price cuts over the past 2 years have lead to an important slowing of national health costs. We now have national health costs that are closer to the consumer price index than at any point in recent memory.

In my State, in California, California hospitals are currently occupied about 45 percent. So, there's a substantial excess capacity, not simply in California but on a broader national basis. It has been achieved through cost effective, managed care controls and utilization. Not only is hospital utilization at a low level, but Californians use hospitals at a rate of about one bed per 1,000. On a national basis, this is about 50 percent below our U.S. experience. So, we've got extensive experience on the West Coast in the capitation of Medicare beneficiaries, of Medicaid beneficiaries, and of the commercial population, more than half of whom now in California, are in a managed care plan.

So, I understand, as Mr. Kennedy outlined the health needs of some of the special populations within the VA-eligible population, that's an important consideration. But at the same time, a number of our Medicare and Medicaid HMOs now have experience in dealing with some of those difficult sub-populations. In any such conversion program, I would assume that special attention would be paid to protecting and assuring appropriate range of services for those special populations, as well as a special cap rate appropriate to those populations.

Putting this in just a little bit of a historical perspective, the VA currently operates about 170 acute inpatient facilities and has the capital capacity to at best replace about one or one-and-a-half hospitals a year. It can't be expected that the VA population can and would wait 120 years for the entire system to get replaced. At the same time, we have a substantial inpatient excess capacity in the private sector, and at this point about 600 health maintenance organizations across the country, of whom 10 percent are community sponsored by hospitals, local health systems, and local physician groups. So, there is a substantial managed care infrastructure that could take on the special health needs of the eligible VA population.

I'm certainly mindful of the conversion and the implementation and the difficulties that would come with any such program, but at the same time, we see extensive Department of Defense experience now through TRICARE and through CHAMPUS contracting, and taking a capitation strategy. So, my bottom line recommendation here is that the community health system and our managed care organizations have the capacity to appropriately and effec-

tively and cost efficiently manage the future health needs of the veterans. I think that's the wave of the future.

Mr. HUTCHINSON. Thank you, Mr. Coile.

Mr. COILE. I certainly welcome any questions.

[The prepared statement of Mr. Coile appears on p. 89.]

Mr. HUTCHINSON. I'm sure we'll have plenty in just a few minutes. Dr. Kizer.

STATEMENT OF DR. KENNETH W. KIZER

Dr. KIZER. Thank you and good morning, Mr. Chairman and members of the subcommittee.

I'll have relatively brief comments. I would note at the outset that Mary Lou Keener was not able to make it here this morning and sends her apologies for not being here.

I'd also note that I've had the benefit of Mr. Coile's thinking for well over a decade—during my involvement with California's health care system, as well as since then. I would also note that it's reassuring to hear that many of the things which I was instrumental in putting in place in California in the 1980s are now viewed as models for managed care and publicly funded programs, as well as the private sector.

As you know, we have laid out a template for the future of the VA over the next 5 years, or so, in two documents which you all are familiar with: *The Vision for Change* and *Prescription for Change*. These define, and especially *Prescription for Change*, what I think will be the environment for health care during this time period and into the future. In this regard, I doubt that there would be much disagreement among this panel as to the overall health care environment that the VA must participate in in the future.

In this plan, we are focusing on achieving a number of key objectives, things such as less bureaucracy, more timely decision making, easier access to care, and greater consistency in the quality of care across the system, and most importantly, providing better health care value. Indeed, as I've said in a number of forums, my basic operating premise is that the genesis of the entire revolution in health care is a quest for value. On saying that though, one has to ask, "what does value mean?"

From the VA's perspective, we have operationalized value into five domains, and we are putting in place an infrastructure to measure these domains. These five domains of value are cost, or the price of the care that we provide; the accessibility of that care; its technical quality; the functional status of our patients; and finally, customer satisfaction. I believe we now have the basis for defining those domains in precise terms, and we'll certainly refine these measurements as we go forward.

But, as an extension of my basic premise, I believe that the VA has to demonstrate that it provides equal or better health care value than Medicare or Kaiser Permanente or any of the other providers out there if it's going to be a part of the health care landscape of the 21st Century. I further believe, certainly on the experience of the last 20 months or so that I've been at the VA, that the VA will be able to demonstrate its value quite effectively.

I would also note that having been in the public sector, both at the state and federal levels, having sat on the board of a large

managed care company and otherwise participated in the private sector; having been in the academic arena and participated on the faculty both from an intellectual point of view as well as a health care provider, there is a very definite role for publicly funded and publicly provided health care in this country. I don't think the private sector can provide all of the services that are needed, and certainly not at the rate that government will be able to pay in the future, despite the incredible excess capacity that exists in the private sector. Indeed, as an aside, I find it of interest that people criticize the VA because 20 to 25 percent of its beds in recent years have not been filled. Yet, in a State like California, as Mr. Coile has already noted, 55 percent of the beds in the private sector lie unfilled. So, certainly, in some respects, the VA is doing better in that regard, although there is much efficiency to be achieved in the veterans health care system.

In this vein, let me cite a few numbers. I think as a result of the changes we've put in place and the much greater focus on efficiency and cost accounting, we can point now to some hard numbers that indicate both the direction and the magnitude of the change that's occurring in the VA. In the last 20 months, we've closed over 5,000 beds. We've pared our staff down by 9,000. We've merged the management of 24 institutions, and several more consolidations are on the horizon. In fiscal year 1995, our outpatient visits were up 2.4 million, an increase of 9.2 percent in 1995 versus 1994. At the end of the second quarter of fiscal year 1996, we were running 7.6 percent ahead of where we were in 1995. That 9.2 percent compares with a little over just to compare 3 percent in the private sector in 1995.

Our bed days of care have also decreased dramatically. Indeed, we expect to end fiscal year 1996 at about 30 percent less bed days of care than in fiscal year 1994.

The major complaint that I hear from our employees, from our academic partners, from a number of your colleagues, members of Congress, is that the rate of change in the VA is so fast that they can't keep up with it. We are changing so dramatically so fast that people are having a hard time keeping up with all the changes.

Having said those things, I would also note that I appreciate the opportunity to participate in this discussion of where we might be in the third decade of the 21st Century. But I think that that is very hard to speculate on. Indeed, most people would view long-term planning in health care today as a 3 to 5 year time frame because it is changing so dramatically that it's impossible to think in any sort of concrete terms 10 years down the road. And certainly, when we look 25 ahead and consider the sorts of changes that are occurring in informatics and in communications and in things like genetic engineering and our ability to treat diseases, it becomes almost unimaginable where we will be 25 or 30 years from now.

I also think that there are some very pragmatic things that will have a profound effect on the future of the VA that have to be, and that inescapably must be, dealt with in the next 5 to 6 years. The first of those things is what's going to happen with Medicare. With the Medicare Trust Fund likely to go broke at the end of the year 2000, there's going to have to be some substantive changes made in that program. Likewise, if we look further at the future of Medi-

care, the number of Medicare-eligible will more than double between 2010 and 2030. That has, again, profound implications for the program.

In my judgment, it would be a major mistake to think of VA in isolation of Medicare and Medicaid. We are all part of the federally funded health care delivery system, albeit the VA is the only direct provider of services. But what happens in Medicare and Medicaid will have very substantial effects on what happens in the VA. How Medicare is dealt with and how medicaid is dealt with will profoundly influence the future of the VA.

So, let me stop at this point. I welcome the opportunity to respond to your questions and to engage in a dialogue this morning. Thank you.

Mr. HUTCHINSON. Thank you, Dr. Kizer.

Ms. Mayer.

STATEMENT OF ERICA MAYER

Ms. MAYER. Thank you, Mr. Chairman.

This morning, I'll be talking about visionary leadership and the future of the VA's Health System. As the VA moves towards implementing its new system of VISNs, the need for visionary leadership is clear. This type of leadership is needed if the VA is to thrive in the 21st Century health care environment. Of course, the future is highly uncertain. Although the VA is a great asset, the question remains as to whether it will need to exist in the future.

As a futurist, it is not my job to answer that question, but to help you explore the future and the wide range of possibilities that are open to you. We'll start off by talking about some macro trends that the Institute has identified as being highly influential and having a great impact in the 21st Century. Then I'll go on to discuss the four scenarios that the Institute created for the VA, identifying some leverage areas and some techniques that VA can use to foster visionary leadership within its organization and change from a conventional to a transformational organization of the 21st Century.

The first macro trend is the use of expert systems in telemedicine. Use of these systems will allow the best specialists to treat people anywhere in the world at any time. Advancing communication in health technologies will make it possible for doctors to deliver care through devices such as telesurgery and virtual reality interaction.

The second trend we call home based health care. Home based heath care will give people the power to do health maintenance better, faster, and cheaper themselves than any doctor could do today. Large amounts of health information are becoming available over the Internet. We forecast the use of things such as personal biomonitors, online support groups, and digital coaches being used by people in their homes in the future to help monitor their health.

The third trend is a shift towards looking at disease as syndromes of risk. The greatest way to create health is to attack the syndromes that give rise to it such as poverty, lack of education, and lifestyle behavior such as smoking. Health care will come to realize that in order to create health, it must work on the syndromes of risk that create ill health.

And finally, the fourth trend points out that today's health care treats disease after the fact. We must move towards what we call the forecast, prevent and manage paradigm where the focus is on forecasting disease through new, more powerful diagnostic tools to better manage disease and hopefully stop it before it occurs.

As futurists, once we've identified the major trends that we feel will have an impact on the future, we assemble them into coherent stories that we call scenarios. The Institute has created four scenarios that show the different paths the VA could take in the future.

The first scenario is the one that we consider to be in the most likely. In this scenario, the VA maintains its unique status and the VISNs compete and collaborate with other integrated delivery systems.

The second scenario we designed to be a worst-case scenario. In this scenario, the VA disappears, its assets are sold off, and its research is subsumed by the National Institutes of Health and the Department of Defense.

Our third scenario is the market scenario. In this scenario, only the competitive VISNs survive while the other non-competitive ones are forced out of the marketplace and disappear. The competitive ones thrive by aligning themselves with HMOs to provide prosthetic services, substance abuse counseling, and spinal cord injury treatment.

Our fourth scenario is one that we consider the most visionary and will probably be the preferred future for the VA. The VA becomes a premier virtual organization in health care. The VISNs thrive and become a driving force in the creation of health in their communities for the poor, homeless, and chemically dependent.

No matter which one of these scenarios plays out in the future, Congress is going to need to support VA while it is making its transformation and working towards its vision for change. Congress can reinforce the VA with its own visionary leadership. Whether the VA's destiny is to thrive or to disappear, it is still the government's responsibility to make sure that injured and poor veterans are provided the best care possible.

How can visionary leadership help VA to create its preferred future?

One way is to identify leverage points that will help move the organization towards the vision for change. The first way could be to increase research in areas that are deemed important for the future. Things such as telemedicine and online services which I spoke about earlier.

The second would be to collaborate with organizations such as the Advanced Research Project Agency to create new and innovative research goals for the VA. VA could refocus its education towards prevention and community health training, establishing collaborative relationships with organizations that lack VA's expertise in spinal cord injury care, substance abuse, and mental health counseling.

Finally, the VA could become more community focused and strive to reverse the ill effects of poverty on health.

In order to maximize your leverage points once you've identified them and agreed upon them, you need the right people to lead you.

There are a number of ways that VA can attract and cultivate visionary leaders within its organization. The first—develop a system of promotions that reward visionary leadership and action and promote community service outside the VA in order to build up networks and contacts inside and outside the health care arena.

The VA could redo hiring practices to seek out and recruit visionary leaders in various fields of expertise that they feel would be important in working towards the leverage points once they've been identified.

Finally, the VA can offer training on futurist techniques, long-range strategic planning and trend analysis to persons who have been identified as being potential visionary leaders. Once your leaders are in place, they will help the VA to change from the conventional to the transformational organization.

The key to implementing visionary leadership techniques is to be aware of the tensions that exist while an organization is in transition. Change is never easy or painless. The Institute has identified four areas of tension that normally exist when an organization is striving to make bold changes.

The first would be to move from business planning towards a system of shared vision. This will help managers focus on their long-term goals. The prescription for change is a shared vision within the VA that will allow them to focus their energies on long-term goals which is better for problem solving and issues management.

The second would be to move away from minimizing risk and focus on mastering change. In order to be truly visionary, you must focus on mastering changes in your environment, other than simply reacting to them. Managers need to view change as an opportunity for growth and learning.

The third is moving from a system of linear thinking to systems thinking prospective. You must adopt a systems thinking prospective to view the entire spectrum of forces that are going to be shaping and affecting your future. This will give you advantage over linear thinking organizations because you will have better prepared yourself for the challenges of the uncertain future. And also, by knowing what challenges you're going to face, help to shape the future that you prefer.

Finally, the VA needs to shift its mission from simply treating disease to reinforcing health. Although treating disease will still be a big part of what VA does, it does not work to maximize health gains. VA should work towards promoting wellness and healthy lifestyles in order to create and minimize the need for treating disease in the communities that they serve.

In conclusion, the VA needs to be aware of the trends that are working in the environment to affect the future. This will give them a better sense of the opportunities and challenges that they are going to face. The VA needs visionary leadership in order to identify these trends and to find the leverage areas on which to concentrate on. These visionary leaders will help transform the VA from a conventional to a transformational organization of the 21st Century. The VA will need support from Congress to have the resources and flexibility to reach the goals set forth in the *Vision for Change*.

Finally, visionary leadership is what the VA needs to move it in the right direction and foster health gains for all the people that it serves.

Thank you.

[The prepared statement of Ms. Mayer appears on p. 92.]

Mr. HUTCHINSON. Thank you, Ms. Mayer.

Ms. Quandt.

STATEMENT OF MARJORIE R. QUANDT

Ms. QUANDT. Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you for coming today. I look forward to your testimony.

Ms. QUANDT. My testimony recapitulates what the Commission on the Future Structure for Veteran Health Care tried to accomplish. Originally, when that commission was considered within the Department, it was meant to be a Congressionally mandated commission, not unlike DOD's. It was a hope that coming from that commission would be votes, up or down, on the mission changes of hospitals.

That did not transpire and the commission was essentially an advisory commission. It worked on four themes: improving access, financing the future, restructuring the system, and enhancing quality of care. Eighteen recommendations came from that commission, 16 of which were adopted by Secretary Derwinski. I have, in my testimony, outlined nine of the most important that deal with today's situation.

I was asked two other questions, what the system should look like in the future and what should be done now? It is my hope, because for the Under Secretary of Health in a very political health care system to make progress, he or she must be freed from some of the rules and regulations that apply today. Therefore, I have hoped at least since 1967, and above all since the commission, that the Veterans Health Administration could be established as a quasi-governmental organization. This frees that executive from funding, personnel, and contracting requirements which are very difficult to follow while you're trying to modernize and change. Therefore, I look towards a quasi-governmental organization.

Also, I would see in the future that VA, if you follow the trend that Dr. Kizer has started, will be operating essentially what Mr. Coile says happens in California. You're going to have one bed per 1,000 veterans, or even less. And much of the care will be given outside the VA system, either by contract or through what I call insurance type payments.

I gave the committee four maps: a map of VA facilities in 1990 with the veteran population; VA facilities in 2010 with the veteran population; a chart from 1994 on where the uninsured are; and a recent chart on the growth of rural counties. No matter how you look at it, in what I call the great upper Middle West, you will not have enough population to support a direct care VA facility. And if you were to be wise, you would handle that by insurance through the community rather than direct VA provision.

This leaves a lot of real estate to be sold because this organization has probably $33 billion in assets in facilities. If budgets are tight, one would hope that a quasi-governmental organization could

sell those facilities or lease those facilities to corporations such as Marriott and others, who would establish assisted living places for veterans. If the broadest view of the future is to be taken, somehow or other, that system must be allowed to function in many ways as another health provider would function.

I was asked "what should be done now?" First of all, if you will not pass eligibility reform, I would hope you would blink or establish a moratorium on the regulation and Congressional history that says obviate the need can not be provided to low income, non-service connected veterans with a chronic illness. That's why we designed it in 1972 so we wouldn't have to put those people in a bed. That never fulfilled its promise because the AMA objected.

I would also like to hope that by allowing some blinking at the law, more money could be diverted from what is now inpatient to outpatient care. I counted up the other day from 1995, at least $193 million, that because of what you do with obviate the need will not allow that money to be diverted towards outpatient. It is my assumption that this health care program will never get money to cover more than 10 percent of the veteran population. That goes back to President Carter's regime when we went to him and said, "ambulatory care is such a success. We're going to need more money." The answer that came back from the bearer of the budget was, "you keep doing what you're doing, but you're not going to get anymore money."

So, it is from that point in time that the Veterans Health Care Program began to, what we say, cannibalize itself. It began taking on more patients, not necessarily with more money. I don't think that's going to change because of the Medicare funding situation, because of the entrepreneurship in the private sector. As we've heard, they're looking for business. So, I don't think VA will be allowed to grow because of pressures coming from the private section.

And you are busy this year with an election year. I hope, if nothing else—I hope Congress will do something to give some leeway to the change in the health care system. I would like to see the health care system become more entrepreneurial than it is. It has a marvelous niche in health care that no one else that I know of in the private sector has in a fully integrated health care system. Those are the special emphasis programs which have made VA important since the second World War.

There are many communities where those programs don't exist. I'm quite sure in Iron Mountain, MI, they don't have an alcohol rehab program. That would be of value in the upper peninsula of Michigan. I'm quite sure they don't have a drug rehab program. That would be of value. So, there are programs which VA can offer in return for income. I think that's just as important as the effort to try and utilize Medicare funds through the system. I think what you have in long-term psychiatry, you no longer find in many States.

But there are some other bold steps I would like to see the Under Secretary take. He's very wisely decided that in 1997, on fee basis care, he's going to pay Medicare rates. I would like to see him, within VA, say to hospitals "we're going to pay you the acute rate based on Medicare rules." That will cut that average length of stay

which is now said to be, for 1997, 14.3 days. I don't know of any other acute system that would be proud of 14.3 days. There are things that can be done to move the shift to a virtual hospital system, one without walls.

I think the thing that has held VA back for 4 years is reluctance—and I said in my testimony, fear on the part of Congress, some fear on the part of veterans' service organizations and reluctance and fear on the part of people in headquarters. The devolution that was to come about from the commission I do not see happening. That's one of my concerns. Basically, the Commission's recommendations were sound if they're followed, I think there's a great future for VA and I hope it will come to pass.

[The prepared statement of Ms. Quandt appears on p. 102.]

Mr. HUTCHINSON. Thank you, Ms. Quandt.

You stated when you testified, I think, before the Senate Veterans' Affairs Committee that there were 50 hospitals that could be closed. Is that still——

Ms. QUANDT. I'll stick by my figure, Mr. Chairman.

Mr. HUTCHINSON. Okay.

Ms. QUANDT. In fact, at one time, I had it up to 70. It should be understood, I want those to be decommissioned as hospitals, converted to nursing homes which have attached to them, ambulatory primary care clinics with community clinics.

Mr. HUTCHINSON. Okay. And I think you called it your vision of the VA as one health care system without walls.

Ms. QUANDT. That's right.

Mr. HUTCHINSON. Mr. Coile, I think you said that you envisioned a health care system in which there are few fixed assets as being a goal.

So, Dr. Kizer, please react, please respond.

Dr. KIZER. Well, the first thing I would say, I wish Congress would respond. There are a number of things that have been talked about here that the impediments to are not found in the VA. The major impediments are the silly laws that exist that don't allow us to do what needs to be done. We've had this discussion on a number of occasions.

Mr. HUTCHINSON. Well, I won't argue with that. Excuse me, if you'll yield. But the ideas, the concepts that have been presented, I would like your—forget that Congress is an impediment. I'll grant that. That will be a basic assumption at the beginning.

But to the ideas that have been presented: the quasi-governmental for the VHA; the idea of closure of hospitals and so forth, the concepts?

Dr. KIZER. The concepts are not really anything different than what is espoused in documents that you have reviewed before. We've talked much about how we would become a virtual organization.

The basic premise, or the operating premise, is that we would look at what we could do as an integrated system with our own assets of care, and then we would look at what we can do as a virtual organization contracting for services. We would assess the five domains of value and see which is a better health care value in a given community, and then proceed accordingly.

That's the sort of analysis that I think the VA has the luxury of doing that the private sector really doesn't have because we do have a number of fixed assets. We need to look at them and see what the return is. And then we can see whether we can get a better deal, whether it's in our clinical outcomes, whether it's in our customer satisfaction, whether it's in accessibility, whether it's in functional status or cost, by working with the private sector. Of course, the impediment here is that we don't have the flexibility to contract and to do some of those partnerships and arrangements that we have talked about on a number of occasions before.

The same goes with the notion that we might close institutions. I have testified before this committee and others saying that in the VA future that I see, we should be looking at closing facilities. We should be looking at remissioning facilities to address some of our long-term care needs which are going to skyrocket over the next 25 years.

There's a number of other things that, frankly, conceptually it's hard to argue against them. It's more the pragmatics of how do we make it happen? For example, consider the opposition that we see in some sectors in merging the management of facilities that are located only 6 miles apart and serve essentially the same population. There are large amounts of money that could be saved from that, yet look at the opposition that we have to deal with in doing some of these very common sense sorts of things.

So, I really don't find much conceptually to disagree with from any of the speakers. I think we could quibble with the numbers. For example, the average length of stay that was quoted, 14.3 days, is not correct. I think it's more like 9.6, but that's something that we could check as far as our acute days. One of the problems I would note in that regard is that the VA has often kept records and data in a different manner than the private sector. And so, doing some of those comparisons is difficult because it is a system that has grown up, if you will, rather isolated and separate from the rest of the health care system it and just hasn't maintained its records the same. It is in many ways like some of the consulting work that I've done with foreign countries in the past. It's not that their systems are wrong, they're just different. In many ways, how the VA has kept its records and accounted for things is different than how the private sector has. Therefore, it's often difficult to make the direct comparisons. One of the major changes that has been underway over the last 2 years is to try to normalize this so that we are tabulating data the same way that other folks are so you can do real apples-to-apples type of comparisons.

Mr. HUTCHINSON. Okay. We've got a vote. What I'd propose is I'd go ahead and take my 5 minutes. Then that we suspend while we go vote and then come back and finish the first round.

Dr. Kizer, I guess since I'm only probably going to get to ask one more question, in your testimony you said that we've got a Medicare crisis, that the trust fund is going bankrupt. That we've got a Medicaid situation in which the spending continues to grow much, much faster—couple of times faster at least than private sector health care spending. And that we should not deal with VA, the future of the VA, in isolation, that we have to look at it in the context of these other medical government health care programs.

But isn't your prescription for change really the VA changing and reorganizing in isolation of the other? We're not talking now, as you said, about the far distant future. We're talking in the next 5 years.

Dr. KIZER. No, it's really not because what we've laid out is basically a template for where health care is going. And what the funding source is, whether it's a direct appropriation or whether it be from some other source is really immaterial to where the organization is going now.

So, I don't think it's at all either in isolation or in conflict with any of the changes that are occurring in the private sector and other publicly funded health care. Indeed, as you know, we are in the midst of negotiating with HCFA to become a Medicare provider. We have negotiated and are now a CHAMPUS provider under the DOD's TRICARE program, similar to private sector providers. So, there is not at all, the conflict that I think you alluded to.

Mr. HUTCHINSON. But the kind of systemic changes that you said were necessary for, for instance Medicare, those are not something the VA has any control over. How do you see that changing? What changes are needed?

Dr. KIZER. What's my prescription for Medicare?

Mr. HUTCHINSON. Yes, what's your prescription for Medicare?

Dr. KIZER. I will defer that for the moment. I think that's probably a discussion that is longer than the time allowed and would certainly be something that would probably get me into trouble in any case.

Mr. HUTCHINSON. Okay.

Ms. Quandt, I asked Dr. Kizer to ignore the political sensitivities of trying to do what you have proposed, to get rid of facilities, close hospitals, and so forth. I'll ask you just the opposite. How would you deal with the political sensitivities? How would you accomplish what you are proposing? How do you deal with the VSOs, with Congress, with all of the political implications of what you've suggested?

Ms. QUANDT. Very carefully.

One can not do this overnight. But I think it's necessary that Congress persons understand that giving up a hospital does not necessarily mean a huge growth in unemployment in their district. When I was in VA, we were very cynical. We used to have two statements. We'd go up and down the hall and say, "we're not a health care system. We build hospitals." The other one was, "VA is the modern WPA." That's what insiders come to look at as they try to change.

Now, it takes a long time. One would have to sit down—let's say you're going to close the hospitals in Wyoming because they're very low in occupancy. One has to worry about staff incompetency. One would have to sit down with the Congressional representatives and the service organizations in the State and lay out a well prepared plan on how you would take care of the veterans, and that they're not going to be abandoned. In fact, if you did close those hospitals, you'd improve the accessibility for veterans in that State to get care compared to what happens today.

When it comes to the actual employees, I would propose—I had proposed in 1992, which nobody accepted, that the canteen service which is a non-appropriated fund, be allowed to establish businesses. They could establish the housekeeping business and those employees then have a job. They're not thrown out of work. Those employees then have a chance to work more places than the VA hospital at which they work. It would take a long time. You can not do it in a month.

Mr. HUTCHINSON. Now, did I hear you correctly in your testimony where you were hoping that the Commission, when they completed their work, would have been similar to the BRAC process where there would have been an up or down vote by Congress on this?

Ms. QUANDT. Yes, sir. That was the original intent behind the Commission, coming out of the Department.

Mr. HUTCHINSON. Are you an advocate of a BRAC-type process for VA facilities?

Ms. QUANDT. Yes. This BRAC-type process diminishes political influence on the decision until Congress votes on the list.

Mr. HUTCHINSON. Okay.

I'm going to suspend at this point. I see smiles there of people wanting to respond. I know that when I come back, I will immediately yield to Mr. Edwards for his questions.

We'll be back in 10, 15 minutes.

[Recess.]

Mr. HUTCHINSON. Mr. Coile, panel, thank you for your patience.

Mr. Coile, I understand you have to leave us at noon. So, we regret, we apologize for our interruption of votes. I think we have a little while now.

I have a number of questions and I'm sure other members do, that perhaps you would be good enough to give us written answers to. So, we'll submit those to you.

Mr. COILE. Thank you. I'd be glad to.

Mr. HUTCHINSON. And I'll go ahead, awaiting other members who are on their way, we trust.

Nobel Laureate Milton Friedman suggested a close analogy between managed care and the Soviet health care system. He wrote an article in the Wall Street Journal recently in which he touted the benefits of medical savings accounts as the VA and as the Department of Defense and as other federal agencies expand upon contracts with HMOs and other health care organizations for managed care services, how can we assure that we don't end up with a Soviet style health care system? Are there ways that you see that MSAs could be incorporated into even VA health care reform, and Medicare and so forth?

Mr. COILE. I'm certainly very interested in the MSA concept. It has not had broad scale testing here, as you know. In California, there have been some local projects in the Bank of America. San Francisco had the largest experiment I'm aware of with about 6,000 employees in the medical savings plan concept. In that program, by the way, the employer, instead of giving the money back at the end of the year, the employer held the dollars until the employee terminated. So, potentially, it could be quite a large sum

passed along to the employee at the termination of employment or at retirement.

In the mean time, of course, the employer got to arbitrage the float and so the plan began to pay for itself after only a couple of years. Because the employer kept not only the unspent monies, but also the interest off of the unspent pool. So, there was a real economic incentive for the employer. But B of A took the tactic that, basically, this was sending the wrong message to the employees. Don't take care of your health. Postpone treatment until the last moment. Don't take a preventive attitude.

I know Dr. Kizer, as a public health physician, would not be in favor of that. But I'd certainly be curious to see some limited experiments with this to see whether or not this might be one of the pieces of a set of new arrangements that would make the overall cost system more cost effective, if we can perhaps reconceptualize the VA as a very large managed care organization. What I think Dr. Kizer and his staff could use though is more of the kind of market freedom that today's HMOs have in terms of make-buy decisions about whether or not to deliver services through a staff model physician group, or through a wholly owned set of facilities, or whether or not to contract out with Columbia HCA or community health providers to do some of these services at a more cost effective level.

The impression I get from the VA is that they're doing those things, but they're experiments at the margin rather than at the core of the new system. So, I think in any closing comment that I would make here, it would simply be to try to accelerate that transformation curve; take advantage of the lessons that we've learned about managed care; encourage the utilization of those mechanisms.

Length of stay in California, by the way, is half of the VA's. It's 5 days instead of 9 days and that's for our total population. And the most aggressive—and I'll refer to them as the physician groups from hell—the capitated medical groups, some of them have got their days down to three-and-a-half. So, it's an extremely efficient mechanism when you align the economic incentives.

Mr. HUTCHINSON. Is the kind of progress that you've seen in HMOs and the private sector a good benchmark for improvement that we could expect in the VA? Or is the VA population so dramatically different, and the services provided so different that you really can't use that as a——

Mr. COILE. The VA population is different, but it isn't that different. We could factor in the demographic differences, the utilization differences, apply a capitation rate to, in effect, the entire VA population and appropriately sub-capitate those sub-populations at a higher rate in a process in the managed care industry known as carve-outs. Dr. Kizer is familiar with all of this stuff. He employed it in California with Medicaid contracting. So, I think the mechanisms are well established.

One last comment. He began a discussion of, in essence, what are called report cards in the value equation, indicators of customer satisfaction, clinical indicators. That report card movement in the private sector is now coming through as a strong message from Fortune 500 companies and business coalitions on health care.

Here's an opportunity, I think, also to pick up. It's still pretty crude, these report cards. But here's an opportunity, I think, to do some benchmark comparisons, both within the VA as well as with the private sector, and to let some of these experiments roll out, perhaps, on a smaller regional basis.

Mr. HUTCHINSON. I yield to Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Chairman.

Thank you all for your testimony. I thought it was very interesting and I found some common sentiment among all of you. Change is a given. We must look at the entire health care environment, not just the VA system. We must certainly push for efficiencies with the limited dollars we know we're going to have. And the question is not whether we will provide care to veterans, the issue is how we're going to provide that care. I think on that common ground, we can develop some new ideas and thoughts.

Mr. Coile, I understand you have to leave. Let me perhaps ask you and Dr. Kizer this question, since you're both familiar with the California HMO system. You know, clearly, if we could take care of every veteran for less than $100 a month and see that they had all the care we feel they deserve, we'd do it tomorrow. Mr. Coile and Dr. Kizer, could you both tell me what you think are the potential shortcomings of the California HMO model that we would have to address?

Mr. Coile, you addressed that to some degree just a moment ago.

Mr. COILE. Yes.

Mr. EDWARDS. But some other issues I'd want to ask about are the effects of long-term psychiatric care, for example. Are there limits? I'm not familiar with the California system. What kind of care is not covered under the HMO system? Are there places where people would fall through the cracks? Not to tear down the system as an option, but I think we realistically need to know what are the shortcomings. Obviously, if there were no shortcomings, we could and should do it tomorrow at $100 per veteran per month.

Mr. Coile.

Mr. COILE. I'd have really only two major concerns in any such conversion process. One would be, I think, at least a moderately rigorous credentialing process on the part of the managed care plans. Dr. Kizer very well remembers a set of experiments in the early 1970s in California called pre-paid health plans, where some of those plans paid as little as five cents on the dollar in patient care and ran off with the rest of the money. So, I'm assuming we know a great deal more about managed care credentialing today than we did in those times, but that would be a concern. To make sure that we had strong, effective, quality-minded organizations that would be the potential vendors and managed care organizers here.

The second here, particularly on alcohol, mental health, drug abuse, VA special sub-populations, I'll be quick to reinforce some concerns you might have. As those have been carved out in southern California, we've seen not only the use of inpatient hospital days slashed, but I think a very short-term focus with regard to some of those sub-capitated approaches. I think the VA with its long-term commitments to its enrollees, would have a chance, I

think, to experiment with some new models that go beyond what the commercial HMOs can do with their year-to-year contracting.

We still don't have in the private sector, three to five year contracts, for example, that really lock in a set of enrollees so that we can do the kinds of prevention, promotion and risk management approaches that I think would be very doable in the VA system under a set of longer-term relationships where we can take the long view about patient care and outcomes and not just the quarter-to-quarter profitability emphasis that we have seen with some of those plans.

Mr. EDWARDS. Yes.

Dr. Kizer, would you care to comment?

Dr. KIZER. I'll just make a couple of comments. I'm not sure where the $100 figure comes from. Medicare contracting today would be more like $350 to $400 a month for its enrollees under Medicare managed care, which would be a much more comparable population to the VA based on age. Certainly, from a risk adjustment point of view, a number of efforts have looked at this, and we are way off to the right or left, depending on your political persuasion, I guess, on the risk side; that is, we have much higher rates of illness among our populations. There are many more comorbid conditions.

Given that 50 percent of the VA's population has a chronic psychiatric diagnosis and a large number of services that are provided in that regard, one of the concerns would be, as you have correctly identified, how would you deal with that in an HMO environment where that is typically something that is carved out or set aside? The same with substance abuse treatment and a number of the other things that really go to the core of much of what VA does.

On the capitation side, as you know, we are planning to capitate the bulk of our patients in fiscal year 1997, if things continue on track. I think what you will find is that our rates, or what we are envisioning for rates at this point in time, would compare very favorably to Medicare rates. There is a sub-population, indeed it's a substantial sub-population, of very complicated and difficult patients that we are still looking at, and would not envision being able to capitate them until fiscal year 1998. Those would probably be at a payment rate an order of magnitude higher because of the complexity of their illness and the degree of care that they need.

Mr. EDWARDS. Very good.

Dr. Kizer, you know, I don't favor totally privatizing the VA health care system, but I don't think those of us that want to defend the present system and also want to reform it, as you have been doing, should also be afraid of the hard questions. From time-to-time, somebody suggests we're spending $16 billion a year on VA health care. Let's take that same amount of money and provide eligible veterans with vouchers and let them go out into the marketplace.

Could you tell me your response to what the shortcomings would be of that type of a program?

Dr. KIZER. Let me respond in a couple of ways. One, I think if you were to do that today in the private sector, you would buy far less care than what the VA is providing. There's a number of bases for that. If you just look at under Medicare, for example, if you

were to voucher in that system, the average community hospital is getting a 6 percent profit. If you look at what we pay for supplies and goods and services and compare that with what Medicare pays, they are substantially higher in many areas—as documented by GAO and others. You can go down the list of the things that we purchase, from pharmaceutical products to home oxygen.

The bottom line is that the VA does provide good value. Now, there are certainly ways of making the system more effective and efficient and we are embarked on doing, as we've discussed. But I think what we will find when we start doing the sorts of apples-to-apples comparison of the risk adjusted costs, you'll see that we compare very favorably on a cost basis.

Just to go, perhaps, to the heart of your question, my whole premise since I've been here and which underlies our transformation efforts, is that if the VA cannot demonstrate that it is providing good health care value, operationalized along the lines that we talked about earlier, then you really have to question why the system exists.

VA will either provide good health care value or you should be looking to alternatives to it. I think that that's a message that folks are taking to heart. We're operationalizing this, and providing the evidentiary base to prove it.

I expect in a year or two that you could take a condition and we'll be able to tell you what it costs in the VA; what our technical quality is as relected in our outcomes; how accessible care is; what's our customer satisfaction; and what sort of functional status our patients are returning to. Whether you're a Fortune 500 company or whether you're the government, those are the sorts of questions and the sort of analysis that should be looked at in deciding whether the government should be a direct provider of services, or whether we should contract it all out to the private sector.

Mr. EDWARDS. Very good. Thank you.

Dr. KIZER. You're welcome, sir.

Mr. EDWARDS. Mr. Chairman, my time is up, so I'll defer back to you.

Mr. HUTCHINSON. I think by unanimous consent, we can allow you to continue.

Mr. EDWARDS. Well, and I'd like to. Thank you.

Dr. Kizer, Mr. Kennedy mentioned some demographics about the number of elderly veterans that we're going to have. I think he said by the year 2000, the number of veterans aged 65 and older will increase 30 percent. The number of veterans 85 and older will increase 174 percent. That's not long-term. That's within the foreseeable range that you've discussed in your comments.

Everything else given equal, is the demand for VA health care going to increase significantly because of these demographics?

Dr. KIZER. In my judgment, the demand for both acute care and long-term services will go up, simply as a reflection of the aging of the population and the demand for services that's commensurate with an aging population. That's for both acute care and long-term care services.

Now, if we're going to provide those services within the fiscal reality that we're confronting, we have to be able to do that in a more efficient way. We have to stretch our dollars further. We have to

be able to do more in the outpatient setting. We have to find ways of providing long-term care services in non-institutional settings that both address the need and can be done more cheaply. And we have to do a number of other things that we've talked about on prior occasions, as well as earlier today.

Mr. EDWARDS. Okay. Very good.

Ms. Mayer, you talked about a number of issues, but one of them you discussed in terms of trends was home based health care. You didn't present that as a panacea, but I assume it is one way to try to deal in a more preventative way to health care.

Are you talking specifically about computer-based self analysis? Are you talking about the home health care system as we have under the Medicare system?

Ms. MAYER. Pretty much the computer-based analysis, the home health care trends that we're examining, and especially in light of what we're talking about here with the increased elderly population in the future. A lot of these people would probably benefit from having something like a personal biomonitor, access to information and things online if they are confined to their home or a hospital setting.

So, when we talk about home based health care, in this instance, that's what I meant was the computer applications.

Mr. EDWARDS. Right. I see.

You know, as with all technology, I can see tremendous opportunities and also tremendous pitfalls. Is there any way we can have quality control in a system like that? I know some of the people that have put systems in, I understand are getting millions of calls or contacts per month. I'm just wondering how many quacks might be attracted into the system? They put something on the system and make a lot of money at it, but they're, you know, causing individual veterans or citizens to defer truly medically necessary treatment.

Did you see that as a problem?

Ms. MAYER. Well, that is always a danger that people are going to misuse the technology. There are going to be people out there that are going to try to exploit people that don't know better or don't really know how to use the technology well. But there are experiments that are going on now in trying to—Disney Celebration Health. There's a town that the Disney Corporation is establishing down in Florida where all the homes are electronically linked, for health care purposes, to E-mail your doctor, to get health information online as sort of a test site to see how these sort of things would work.

I don't really have an answer for how, in the future, you would be able to protect yourself against these things. But I do know there are several organizations, the American Cancer Society included, that are starting to put more of their services online, recruiting and educating volunteers online. They're making more of a commitment to put more of the information out there so that they can get more access to the general public about health information on how to prevent and control cancer and things like that.

So, I know a lot of organizations are putting a lot of faith in these technologies. Hopefully, as the technologies progress and as people become more aware of how to use them, and more aware of

the good and bad that is out there, they'll be able to see for themselves and judge for themselves.

Mr. EDWARDS. Very good. Thank you.

Dr. KIZER. If I might just make a comment?

While I think that these technologies offer some intriguing possibilities for the future, they also have to be considered within the demographics of one's service population. Certainly, when we look at many of the patients that we take care of, it's nice to think of providing home based care. It would be even nicer to think that they would have a home in which that care could be provided. It's nice to think of them using computers. It would be nicer to think that they knew how to read though, in addition. And there are many other characteristics that while the technology may offer intriguing possibilities, we have to adjust the technology to our actual service population.

Mr. EDWARDS. Certainly. And certainly, psychiatric care would be difficult in that situation.

Ms. Quandt, could I ask you, on the visionary approach that hospital system without walls. It's very interesting to hear your insights since you have been a medical center director. I'm going to ask you a much more limited question, but I hope a practical one in the short-term. Tim and I have supported an Eligibility Reform Bill that we'd like to see get passed this year. But unfortunately, some numbers crunchers have put an unfair number on it, in our opinion, and that might make it impossible for us to pass even that fairly limited Eligibility Reform Bill.

Do you see anything—and perhaps, Dr. Kizer, you also—let's assume we say, is it CBO that's sticking with the $3 billion cost for our Eligibility Reform Bill? Say they stick with that. That kills that bill this year. Is there anything even much more narrow than that that isn't going to make headlines? It isn't going to be revolutionary, but it would be the kind of eligibility reform we could pass without getting a Ways and Means Committee approval or joint referral of the bill to the other committees. It wouldn't have a price tag on it, but it would simply let us do a better job of defining eligibility in dealing with, perhaps encouraging outpatient care?

Anything narrow enough that would be fairly non-controversial, but would be helpful? Do you, Dr. Kizer? Both of you, if you would care to comment on that.

Ms. QUANDT. It was my understanding that the Department of Veterans Affairs priced your proposal as almost being neutral.

Mr. EDWARDS. That's correct.

Ms. QUANDT. And I believe that for several reasons. All my experience with CBO when I was in medical administration, and ACMD for administration that any new laws always came across with figures that blew the proposal out of the water or never came to pass if it became law.

The other issue is, in order to let veterans know about new laws, we used to put a stuffer in their compensation checks, or pension check. If that isn't done, you're not going to see a big wave of demand. I also think that is an estimate based on "oh, this is going to happen." But for many changes, there is no new market and the veterans do not come. The most explosive I ever saw was for obvi-

ate the need. We had a 10 percent increase, and that 10 percent increase lasted 1 year.

The veteran population is very stable. I do not think you will have a budgetary explosion. The other study, I believe was done by the Department when they went back and did a very short-term longitudinal trace on Social Security numbers. Several hundred thousand die in a year. Several hundred thousand new take their place. At one time, we knew that a person might come once in 3 years. So, while there may be large numbers—they show since 1986 or 1987 a great increase in veterans taken care of—it is very stable year-to-year. I don't think your change is going to increase.

Mr. EDWARDS. Well, I agree with you. I wish you'd stop by and talk some common sense to the CBO numbers crunchers.

Dr. Kizer, while I'm sure we would agree with that comment, the fact is we may not be able to get around their numbers. Is there anything much more limited, but yet in the real world actually helpful to our Nation's veterans, that we could consider doing if at some point we have to admit defeat on the Eligibility Reform Bill now before Congress?

Dr. KIZER. Well, I would certainly concur that CBO's estimate is off-the-wall. But, to answer your question, I think anything that gave clear direction that the VA is to provide care in the most efficient and effective manner possible, even simple verbiage to that effect, would be a step in the right direction.

Now, having said that, I don't think I'm prepared at this point to identify what all the nuances may be. Something as simple as just a directive that we're to provide care as efficiently and effectively as possible may have some pitfalls in operationalizing such language. But, in my judgment, anything that started with that would be a step in the right direction.

Mr. EDWARDS. Thank you.

Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Chet. I hope that if we're not able to get CBO to change estimates or not able to move forward with that, that we will be able to reach a consensus on the more narrow reform bill that will provide some help, and that we'll be able to get through this session.

Ms. Mayer, one of the scenarios that you discussed in your testimony was one in which competitive visions flourish and non-competitive visions disappear. In that kind of a scenario, how do you see the VA's Central Office evolving to meet the challenges of managing care in that scenario? In particular, how will the Central Office ensure the quality of care delivered by non-VA managed care entities and coordinate the treatment which would span, perhaps both systems?

Ms. MAYER. Well, first of all, I think we see the system in the future becoming more decentralized with the visions. I was calling them VISN.

The market would be consumer driven, especially in that scenario. As we said before the amount of health information and outcomes measurements that would be available to people online once everything—there's going to be an electronic medical record for patient records. All this information will be accessible to consumers. We'll have a lot more informed consumers out there and they will

be able to judge for themselves which would be the best services for them to go to, which are the most cost effective, the best quality.

I think that the VA's role could be to do quality assurance for these people, setting up outcome measure systems, doing customer satisfaction surveys, to keep tabs on the work that is contracted out, and then to ensure their own quality of work for the stuff that they maintain as part of their services.

Mr. HUTCHINSON. Ms. Mayer is a futurist.

How would you react, Dr. Kizer, to what was just said?

Dr. KIZER. Well, I'm not sure that I would disagree in concept. I mean, that's how we are oriented now. We have put in place performance contracts with our managers. We're operationalizing outcome measures. We've created a whole office to focus on these things. I think that the future is to be able to operationalize the value concept—to be able to measure the domains of value that we've talked about in very specific terms, whether they be in customer satisfaction, or whether they are in the clinical outcomes. How do you define these things? How do you track them, monitor them and ensure, whether we are the direct provider of care or whether it's being provided by some other provider, that we are getting a good return on our investment?

Mr. HUTCHINSON. Ms. Mayer, I think another point that we've discussed some is the improved technologies that are going to be available in the future. You note that the more powerful diagnostic tools will allow us to prevent disease, manage it better, and reduce morbidity. I think there's historical precedent that when we have these kinds of better and more powerful diagnostic tools that the result has been increased costs in health care.

Do you project in the future that that kind of improved diagnostic ability and improved technologies will ultimately, because of dramatic changes in morbidity or whatever, that we will experience savings from that? Or can we expect more inflation in health care spending?

Ms. MAYER. I think overall, there will be savings if these technologies are truly used for prevention. If the diagnostics are so powerful that they can detect disease even before it starts and it can be prevented, that cost savings would be—over the long-term, you would prevent people from getting cancer, from getting long-term illnesses that require great amounts of care and great amounts of drain on costs, overall.

So, if we have high power diagnostics, they may be expensive tests to run, but you only have to run them once. Once you do, you've got the entire medical profile for someone and you can prevent disease throughout their lifetime if you monitor them closely enough. So, the savings would kind of be in the long-run in that sense, depending on which diagnostic tools we're talking about, whether it's genetic mapping, self therapy, things like that, which are all, of course, in the theoretical stages right now and some in the experimental stages.

Mr. HUTCHINSON. Dr. Kizer?

Dr. KIZER. I'm glad you added that caveat that they are still in the theoretical stages. I think it's nice to talk about technology that can prevent cancer. It would be nice to first know what causes it,

the hundreds of types of cancer. I think that this is wonderful, futuristic thinking, and we need to think futuristic. However, much of this remains quite theoretical and, at this time, it is hard to envision these technologies.

I must say, on an editorial note, that I don't think that we have any good idea of what the incredible demand for services and the incredible price tag that's going to be associated with these technologies in the future. When you look at the technology that is in the pipeline—that is, that which is not theoretical, but that is actually in the pipeline, some of it may well save cost, but the potential for increased expenditures for health care is dramatic. Our future ability to treat diseases that are currently not treatable knows no limits. The explosion in biomedical information that is going to provide the basis for new treatment and new technologies is almost unimaginable.

When you look at things like the human genome project and the potential for genetic engineering to alter the course of diseases in the future, this is going to come with a considerable price tag. I think when you look at the system as currently practiced, ala Medicare going broke in 5 years, yet the number of people demanding services is going to double in the not-too-distant future and the number of diseases that we're going to be able to treat and the technologies available to treat them are going to rise astronomically, it is clear that the cost for health care in this country is going to increase dramatically in the future. I know that's not what you want to hear.

Mr. HUTCHINSON. He said that with a smile.

Why is it that in the private sector—not the private sector, but in non-medical, non-health care related fields technology, while there's a big initial cost and there's a high price tag to it, over the course of time the price tag on those technologies decreases to where it becomes quite affordable. Why do we not see that in the health care field? Or why will we not in the future see that in the health care field?

Dr. KIZER. Oh, I think you do see it in the health care field. For example, you can show now, let's say, Computerized tomography scanning or, in some cases, Magnetic Resonance Imaging and some of the other technologies that are quite expensive now can show that they are actually cheaper than doing a number of other tests that were done before. But the numbers of new technologies and the explosion of knowledge about treating new diseases is far surpassing the savings that is being accrued from better use of existing technology.

One of the—and again, this should be viewed as an editorial, the focus on research has been so much on new discoveries, new knowledge, new technology, and we have largely ignored the fact that we have all this technology available. How do we use it better? In my judgment, the focus of research, the priorities for research today should be just as much on how we better use the technology that exists today as in discovering new technology. But the research mechanism, the research structure today is really not anywhere near in balance with where it probably needs to be if we're going to get optimal use, or more cost effective use, of the technology that currently exists.

Mr. HUTCHINSON. Dr. Kizer, when you say though that the health care spending is going to be astronomical in the future, I mean, the fact is the dollars may not be there for astronomical spending, even though the technologies may be there and the price tag on that technology.

What you're really saying is that we're going to be forced to make difficult decisions, even more difficult decisions in the future, as to where those limited resources go?

Dr. KIZER. I think in your tenure in the Senate, you'll have lots of opportunities to make those difficult decisions.

Mr. HUTCHINSON. I hope you're a futurist.

Ms. Quandt, going back to ancient history. In 1991 when the Commission made its report, it suggested "that one-half of the current short hospital stays could be provided in ambulatory settings by the year 2010." Based upon the pace of innovation in the field of ambulatory care in the last 6 years and the pace of change in the VA, would you make any modifications in that prediction, or would you care to comment? How prophetic were you?

Ms. QUANDT. I think we were very prophetic because of what has happened with managed care. If you look at the figure that Dr. Kizer cited for 1995 in which he had 2.5 million, I believe, outpatient visits which is quite an increase, the slope at which he is increasing is beyond what we expected in our, what I call, major model of change. I think it's very possible.

Mr. HUTCHINSON. Okay, so that's a very positive indicator.

Dr. Kizer, Dr. Mongan—I hope I'm saying that name right—a member of the Commission noted in the report that VSOs—this kind of capsulizes our dilemma sometimes—but VSOs "seem to have enough power to keep the beds open but they don't seem to have enough power to keep the beds adequately funded. It leads to empty beds in some regions and empty promises in other regions."

What's our way out of that dilemma? How can that problem be addressed?

Dr. KIZER. I think it's a great opportunity for partnership, a partnership between the funding entity—the government, the provider-the Department, and the constituents or users, the veterans' service organizations (VSOs) and others. There's much education that needs to be done about what the future holds and what we can afford in the future, and what are the best ways to provide those services.

Frankly, I've been encouraged by the dialogue and the discussions that I've had during my short tenure with the VA, regarding what I think are the views of the VSOs, at least where they seem to be today versus where they may have been when those comments were made. I don't have a long history here to base it on, but I think there are some very forward-thinking individuals among the VSOs, although there is a range in thinking, just as there is within Congress and within the Department. We have to, I think, work together to find solutions that provide the best that we can.

Mr. HUTCHINSON. I think that's a good answer. I would concur with that. From what I was led to believe on the attitude of VSOs, I have been pleasantly surprised at not only, as you said, the diver-

sity of views within the veterans' service organizations, but a willingness to look at positively, changes that may be necessary.

Mr. Edwards.

Mr. EDWARDS. Mr. Chairman, I just have one other question for Dr. Kizer.

When you talked about in the years ahead, the explosion of demand for long-term care facilities, do we have a plan to deal with that? Is the VA going to have to get in the business we used to be in in hospitals and inpatient care? Are we going to have to build nursing homes all over America? Do we have a plan in place, or considering one to contract out that care? What is our approach?

Dr. KIZER. Let me respond to that in several ways. One, we will be naming, within the next few weeks, a group similar to some of the other groups I've convened in the past, to develop the basis for a long-term care plan. We certainly have some ideas and thoughts, but we want to solicit the input of an array of people from outside the organization. I will be naming, as I say, within the next few weeks, a group that will be tasked to specifically focus on where we should be going in long-term care over the next 5 to 7, to 10 years. They will have, as with the Residency and Research Realignment Committees, about a six month time frame to come back with some recommendations. After that, we expect to be having further dialogue on what that means operationally.

Long-term care remains discretionary, and so we are going to continue to have to operate within our budget. I think we can achieve better value than what we have in the past. Some of our efforts along the lines of the multi-State nursing home contract initiative through which we will be contracting with fewer providers. I find it mind-boggling that we have 3,200 contracts in place to take care of our roughly 9,000 patients in community nursing homes that we have each day. We're doing some things to make that process more efficient, as well as to enhance the quality of care and drive the price down.

But I don't see us, to answer, I think, the last part of your question, embarking on a major construction effort at all. I think that we will be remissioning some of our facilities as we empty the wards and shift acute care to the ambulatory care setting. There will be opportunities to reconfigure some of the existing structures. But if the demand does go up and if we're able to pay for it, as much as I think the demand will be, the only way we'll be able to do that is through contractual arrangements with private providers. We'll have to find ways to do that.

Mr. EDWARDS. Do you have some budget assumptions—of course, all of this is money-driven, unfortunately, but that's the real world. You said if we met the demand that's out there, do you have some sort of projections in the next several years on budget?

Dr. KIZER. I don't have a number in my hip pocket—partly because I'm afraid to carry it around because it's so large. It's a very large number and there's no way that I think we'll be able to satisfy the demand that exists. We need to do more with what we have.

The other thing I would add is that we have to do much more in the way of non-institutional care than what we've done in the past. Currently, about 5 to 7 percent of our contract care dollars

go for non-institutional care. I would hope that we can increase that substantially in the future, and in doing so, provide for the needs of a larger number of patients than we do now for no net increased cost.

Mr. EDWARDS. All right, thank you.

Mr. HUTCHINSON. My last questions will be very general.

I would like each of you, given your experience with the VA and health care in general, to give me the two or three most important things that have to be done within the VA to ensure its viability in the 21st Century.

And if I could begin with Ms. Quandt and Ms. Mayer, then over to Dr. Kizer.

Ms. QUANDT. The most important thing is that Congress must pass proper enabling legislation. And if you can't pass that, then please suspend some of the laws. Congress can suspend the law. If you do not do that, there is no flexibility for this Chief Executive.

The other is that with that aging population which is going to have more severity of illness, and with inflation, you will have to increase the budget. Those, I think, are the two most important.

Mr. HUTCHINSON. Ms. Mayer?

Ms. MAYER. As I said before, one would be to institute a policy of visionary leadership within the VA to carry them through into the 21st Century, to make sure that they are prepared for the changes and challenges in a 21st Century health care environment.

The second one would be to shift their mission from treating disease to maximizing and reinforcing health by becoming a creator of healthy communities in each community that they serve.

And finally, moving away from minimizing risk to mastering change which is, again, as I said before, having a visionary focus to work to master the changes coming in your environment so you can shape the future that you want rather than merely reacting to circumstances in the current environment.

Mr. HUTCHINSON. Dr. Kizer.

Dr. KIZER. I would just note as a preface that many of the things that were just mentioned are things that are already in the works, although some of them also require change in the laws.

I guess my list is probably more than two or three, and I would just briefly note that I think the change in the eligibility laws that we've talked about is a critical component, or at least somehow getting us out from under the current statutory constraints. I say this for somewhat different reasons than you might think; if we're going to have accountability in the system and if we're going to be able to plan a system that is truly efficient, then we can't have these laws that clutter up and remove accountability and make the system, from a management point of view, very difficult, if not unmanageable.

We need increased flexibility in our contracting abilities and our ability to enter into partnerships and sharing relationships. Again, that's a topic that we've talked about before.

We need to devise a different personnel system, one that gives us more flexibility to deal with being a health care provider, rather than a civil service organization. We need to diversify our funding base so that we are not so totally reliant on an annual appropria-

tion and so we also have some mechanism to retain some of those funds that we recover.

There are probably some other things, but since you asked for a limited list, I'll stop there.

Mr. HUTCHINSON. That was four quick ones. That was four good ones.

Mr. Edwards, do you have anything else?

Mr. EDWARDS. Mr. Chairman, I think this is very interesting. I think there were a lot of common points made. It's clear to me Dr. Kizer is already implementing some of the forward thinking ideas that have been presented here. Some of the others we'll have to debate and move forward. But I think it has been a very productive hearing. Thank you, Mr. Chairman.

Mr. HUTCHINSON. I want to thank the panel for the good presentations, the good answers, and your patience with our delayed hearing today.

The subcommittee stands adjourned until 10 a.m., tomorrow, June 27 when this hearing on the future of the Veterans Health Administration will continue. Thank you.

[Whereupon, the hearing was adjourned at 12:42 p.m.]

FUTURE OF THE VETERANS HEALTH ADMINISTRATION

THURSDAY, JUNE 27, 1996

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10:02 a.m., in room 334, Cannon Building, Washington, DC, the Honorable Tim Hutchinson, (chairman of the subcommittee), presiding.

Present: Representatives Hutchinson, Ney, Fox, Edwards and Kennedy.

OPENING STATEMENT OF CHAIRMAN HUTCHINSON

Mr. HUTCHINSON. The subcommittee will now come to order.

The subcommittee meets today in day two of hearings on the future of VA health care. Yesterday's hearing provided an overview of the rapidly changing health care environment and allowed us to examine the views of noted individuals who think outside the box of traditional health care.

It seemed that an overriding theme of yesterday's witnesses was the critical need for the VA to be an integral partner in the changing health care landscape. The role and vision for the VA varied vastly from one of a completely privatized system, where VA was no longer a direct provider of services, to a scaled-back system with niche markets that generates revenues through the sale of mental health services through its extensive network of psychiatric facilities.

There was general agreement by the witnesses that change was coming at such a rapid pace that ultimately no one could predict with any great degree of certainty what technology would bring in the next 20 to 30 years.

When asked what is needed to make the VA a viable health care organization for the 21st Century, the witnesses offered recommendations along the lines of eligibility reform, visionary leadership, increased flexibility and accountability and a diversified funding base.

Today we will examine the efforts of the Department of Defense as they look to chart a health care future for military medicine and we'll hear testimony from a diverse panel of experts with specific views on VA's medical education mission, its management information and telemedicine capabilities and needs for the next century, and the plausibility of managing the veterans health care system as a quasi-governmental corporation.

We will also hear from representatives of the veterans groups who provide the most important perspective to any future that may be contemplated for the veterans health care system, that of the veteran consumer.

I'd now like to recognize the ranking member, my friend and colleague, Mr. Chet Edwards.

OPENING STATEMENT OF HON. CHET EDWARDS

Mr. EDWARDS. Mr. Chairman, thank you and I'll be brief. I just would reiterate what I said yesterday and that is that one of the things that we don't do enough in this process in Congress is to sit back and take a look at the big picture and think creatively rather than just fighting the day-to-day brush fires.

So I appreciate the hearings that you have held. We heard a lot of creative thoughts yesterday and while I don't agree with all of them, I think it's important for us to listen to these presentations with an open mind.

Also, as a side note, I'd just say, Mr. Chairman, I thought the bipartisan support that we had in the House yesterday and with the strong support of the veterans' service organizations for the Stump-Montgomery Amendment to add additional funds to VA health care was very helpful and a positive sign.

So I look forward to hearing from the very distinguished witnesses today. I want to thank all of you in advance for taking the time to be here.

Mr. HUTCHINSON. Thank you, Chet.

This morning the subcommittee will hear testimony from two panels. The first panel is composed of six distinguished individuals. Rear Adm. William Rowley is a physician, a futurist and the commander of the Portsmouth Naval Medical Center. He's the chairman of the Military Health Services System 2020 Project, which is the Department of Defense's look into the future of military medicine.

Mr. David Baine, director of the Health Care Delivery and Quality Issues Health, Education and Human Services Division of the U.S. General Accounting Office.

Dr. Daniel Winship, dean of Stritch School of Medicine, Loyola University Chicago.

Dr. Robert Kolodner—I hope I said that right—deputy chief information officer of the Veterans Health Administration.

Mr. Thomas Mannle, senior manager of The Lewin Group, Fairfax, VA.

And Mr. Drew Valentine, senior manager for Federal Strategic Services, Arthur Andersen here in Washington, DC.

Because of the size of the panel I'll ask the witnesses to summarize their testimony, as your full text will be entered into the record. For purposes of questioning the witnesses, the committee will operate under the 5-minute rule.

The chair now recognizes Admiral Rowley.

STATEMENTS OF REAR ADM. WILLIAM R. ROWLEY, MC, USN, COMMANDER, NAVAL MEDICAL CENTER PORTSMOUTH, PORTSMOUTH, VA, ACCOMPANIED BY CAPTAIN STEVE RICE, MSC, U.S. NAVY, DIRECTOR, CONGRESSIONAL AND LEGISLATIVE AFFAIRS, BUREAU OF MEDICINE AND SURGERY, DEPARTMENT OF THE NAVY; DAVID P. BAINE, DIRECTOR, HEALTH CARE DELIVERY AND QUALITY ISSUES, HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; DANIEL H. WINSHIP, M.D., DEAN, STRITCH SCHOOL OF MEDICINE, LOYOLA UNIVERSITY CHICAGO, MAYWOOD, IL; ROBERT M. KOLODNER, M.D., DEPUTY CHIEF INFORMATION OFFICER, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY GREGG PANE, M.D., CHIEF, POLICY, PLANNING AND PERFORMANCE OFFICE, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; THOMAS E. MANNLE, JR., M.P.A., SENIOR MANAGER, THE LEWIN GROUP, FAIRFAX, VA; AND DREW VALENTINE, SENIOR MANAGER, FEDERAL STRATEGIC SERVICES, ARTHUR ANDERSEN, WASHINGTON, DC

STATEMENT OF REAR ADM. WILLIAM R. ROWLEY

Admiral ROWLEY. Good morning. Thank you for inviting me to this session. In my written statement I listed 11 trends which are affecting American medicine and obviously will also affect the Department of Veterans Affairs. I'd like to concentrate on a couple of trends which usually aren't discussed, and then give a couple of recommendations.

First off, as we look at health in America we realize that about 50 percent, maybe even more, of the disease in America is created because of our lifestyles—things such as not wearing seat belts, smoking, drinking, eating the wrong kind of food, not getting enough exercise, and not dealing with stress.

In order to have a successful health care system in the future, we need to deal with these issues. America does not have enough money to pay for all the disease that we're creating. Therefore, we need to design diseases out of our system. That's a very important thing.

American medicine in the past has really focused on disease. As soon as somebody got well, physicians would say, "You're free of your disease. We don't want to see you anymore."

I think that we're going to see a shift in focus so that rather than just focusing on disease, we're going to try to make people truly healthy, better than just free of disease. As we put the emphasis in that arena, we're going to save money because there will be fewer diseases and patients will be treated earlier, before they require extensive medical care.

I think this concept is important for the Department of Veterans Affairs. This approach may require more resources in order to reach out to the community to educate, to mentor, and to guide veterans as we attempt to ensure that they live healthy lifestyles. Hopefully, these changes will decrease the amount of chronic diseases that we have to treat.

One way to reach into the community is to develop programs where mid-level employees with training go out into the home, into the workplace, into the community to work on preventive-type measures, rather than waiting for people to come into the hospital. I see that as a major shift in America where we focus on wellness rather than on disease.

As we enter the information age, we can imagine the effects on American medicine. Computer networks are tying departments and hospitals together. We can use the Internet to get information for doctors, rather than going to medical libraries. Soon DOD will have a computerized medical record. This will allow patients to go anywhere within our system and ensure that patient information is always available. I believe somebody this morning is going to talk about telemedicine and how we can bring the specialists to rural areas and things like that so I will not discuss this topic.

In the future virtual reality is going to be a real training tool. Presently we teach pilots in flight simulators; in the future we're going to be able to teach surgeons in virtual reality, where they practice their skills in an artificial environment, after once they've got the technique down, they will perform the procedure on an actual patient.

But I think the real benefits in the information age are not what it's going to do for American medicine; it's what it's going to do for the consumer, for the American public. The information age is empowering individuals. Individuals need to learn to take responsibility for their own health in our future.

Presently sensors are being developed to noninvasively detect diseases. In the future I think we'll be able to put these sensors, for instance, on a wrist watch so that if a patient has diabetes, high blood pressure or heart disease, the sensors can monitor the management of those diseases and alert the patient when the disease is getting out of control.

In the future we will also be able to imbed in the wrist watch mechanisms that evaluate patient's need for an emergency drug and automatically administer the medicine if they're having a life-threatening cardiac problem.

The information which is accumulated through these sensors can be stored in a "personal medical assistant," a computer at home, that contains a life-long medical record of how the individual's progress. As computers which are able to recognize and synthesize voice become available the patient will be able to talk to this home computer and say, "Well, how am I doing?" The computer, which should be able to provide mentoring and coaching, would reply, "Well, your diabetes is getting out of control. You need to exercise more or let's change your diet."

In other words, a great deal of health care in the future can be provided in the home with individuals taking responsibility for their health and with the assistance of information technology. Periodically the patient can communicate with the medical system, via telemedicine or through the Internet or something similar, and even get advice through the medical system while remaining at home.

I think that these advances are going to make a tremendous difference. Obviously it's going to be a few years before this happens,

but if we can get individuals to take responsibility for their health, provide a lot of health care where they live and have the health care system do the coaching and the mentoring, it's going to revolutionize the way medicine is practiced.

There are a couple of recommendations that I'd like to talk about. Health care is a local phenomenon. It's a system that's built up in the community, based on the needs of the population and the resources available in the community.

I think that we're going to see more and more of this interaction in the future, where private enterprise, and government agencies, including the Department of Veterans Affairs, establish a local health care system that meets the needs of their beneficiaries and also conserves resources.

As these systems are created, I think it's important to ensure that we save the culture of the VA. The core missions must be retained; in other words, we must ensure that veterans come first, rather than focusing more on business than on people who need care.

I think when veterans' health care facilities build partnerships with the military, with the Public Health Service, or with local private community hospitals, it should be in the mutual best interest of all parties involved.

By building partnerships the VA will be able to utilize the resources in the community, to shift resources around in a region so that increased health care will be provided for veterans and cost controlled at the same time. I see this as a real opportunity.

There are some things that have to occur and they're occurring right now. Number one is we have to build relationships between these government agencies so that they know and trust each other. The doctors and the health care administrators have to feel comfortable with each other.

We also have to streamline some rules so that it's easier to create agreements and to establish memorandums of understanding.

The last thing I'd like to mention is that the Department of Veterans Affairs has some national treasures and I think it's very important that we make sure they stay intact and sound. The VA has centers of excellence for treatment of patients with spinal cord injuries, for examples, which the military is very dependent upon. These centers of excellence must continue to be funded.

The VA is also a cornerstone of American graduate medical education. For-profit, managed care does not worry about and does not fund training and education. I think an important part of the Department of Veterans Affairs in the future is to continue those relationships that provide medical education and research.

Thank you very much for the opportunity to speak.

[The prepared statement of Admiral Rowley appears on p. 112.]

Mr. HUTCHINSON. Thank you, Admiral Rowley.

Mr. Baine.

STATEMENT OF DAVID P. BAINE

Mr. BAINE. Good morning, Mr. Chairman, Mr. Edwards. Thank you for inviting us to discuss the future of VA health care.

Mr. Chairman, significant changes are occurring in the types and volume of services provided under the VA health care system. The

average daily workload in VA hospitals has dropped by about 56 percent in the last 25 years. In contrast, the demand for both outpatient care and nursing home care has increased steadily over the same period of time.

Nine out of ten veterans now have public or private health insurance that meets most of their health care needs. Still, about 10 percent of the veteran population has neither public nor private insurance to pay for basic health care services. These veterans tend to rely on public hospitals and clinics and on VA to meet their health care needs.

A small group of veterans report that they have been unable to obtain needed care and outpatient services. Most of these veterans do not live near a VA hospital or clinic.

While the acute care needs of most veterans are met through private or public health care programs, veterans needing specialized services, such as treatment of spinal cord injury and war-related stress, are more likely to find private sector providers unable to meet their needs.

In addition, neither public nor private sector programs provide extensive coverage of the nursing home and other long-term care needs that will be generated by an increasingly aging population.

There are a number of ways, in our opinion, that VA could address the unmet needs of veterans within existing resources and legislative authority. For example, it could reduce the resources spent on providing care to higher income veterans with no service-connected disabilities and use those resources instead to purchase care from private providers for service-connected veterans who do not live near a VA facility. Such resources could also be retargeted into expanding the availability of specialized services.

Similarly, VA could increase the equity of veterans' access by improving the way it allocates resources to its facilities.

While such actions would enable VA to more effectively meet veterans' health care needs in the short term, the declining hospital workload, in our opinion, makes it imperative that more fundamental decisions be made about the future of the direct delivery system.

Two approaches could be pursued to increase the workload of VA hospitals and prevent or delay their closure. First, actions could be taken to attract a larger market share of the veteran population to the VA system, since now only about 20 percent of veterans have ever used VA care. Attracting enough new users to maintain the work load of the hospitals could, however, add significantly to the government's cost of operating the system unless new sources of revenue are generated.

The second approach, and this has been mentioned before, would be to authorize VA hospitals to treat dependents or other non-veterans on a reimbursable basis. This kind of an approach might also strengthen VA's medical education and research missions by bringing a wider range of patients into the system.

Converting VA hospitals to provide nursing home and other long-term care services might also help to preserve the direct care system.

Several approaches could be considered that would reduce the role of VA's direct delivery system. These include expanding VA's

health financing programs to purchase more care from private providers, issuing vouchers to allow veterans to purchase their own health care, and including veterans under existing health care programs.

Because these approaches would address the primary reasons many veterans give for not using VA care, that is, perceptions of poor quality and customer service and limited accessibility, they would be likely to generate significant new demand. In our view, though, they could be structured to supplement, rather than duplicate, veterans' coverage under other health programs.

As you know, Mr. Chairman, VA has a number of fundamental changes under way to change the way it operates its health delivery and financing systems. As part of its reorganizations into VISNs, facilities are increasingly encouraged to contract with private providers to provide health care services to veterans, rather than provide such services directly.

In addition, VA is seeking authority to significantly expand eligibility for health care benefits and also its authority to both buy health care services from and sell health care services to the private sector.

The potential effects of these actions on the future of the VA health care system depend largely on the funding of the system. If VA appropriations remain constant or decline over the next several years, then increasing the contracting portion of the system would expedite the closure of facilities. On the other hand, if appropriations are increased, then the changes are likely to generate sufficient demand to preserve the system.

Decisions regarding VA's restructuring efforts and future funding of the VA health care system will have far-reaching effects on veterans, taxpayers and private providers. We believe that attention such as that provided by these hearings in the last 2 days is very much needed to position VA to ensure that veterans receive high quality health care in the most cost-efficient manner, regardless of whether that care is to be provided through VA facilities or through arrangements with the private sector.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Baine appears on p. 117.]

Mr. HUTCHINSON. Thank you, Mr. Baine. Dr. Winship.

STATEMENT OF DANIEL H. WINSHIP, M.D.

Dr. WINSHIP. Good morning, Mr. Chairman and members of the subcommittee. I am Dr. Daniel Winship, dean of the Stritch School of Medicine at Loyola University Chicago and I am an attending physician at the Loyola University Medical Center and the Edward Hines, Jr. VA Hospital. I have served on the staff of four VA medical centers, as well as at the VA central office in Washington during the last 30 years. This morning I am representing the Association of American Medical Colleges.

I want to underscore the AAMC's strong belief that the VA is a critically important national asset and worthy of preservation. The VA health system delivers excellent health care to veterans and is recognized as a national leader in many specialized areas of medicine that are of significant importance to veterans and to the Nation's citizens.

In addition to supporting and participating in the education of tens of thousands of medical students and residents every year, the VA health system also contributes significantly to the growing list of advances in medical procedures and treatments attributable to our Nation's biomedical research enterprise.

The VA research program is also an important feature in the ability of the VA to recruit and retain highly qualified physicians. Therefore, protecting the quality and size of the research program will allow the VA to retain these highly qualified physicians who, in turn, will provide excellent care to the Nation's veterans in a reformed delivery environment.

The VA faces serious challenges, similar to the ones that medical schools and teaching hospitals are encountering in the emerging environment of health care delivery. Although academic medicine and the VA provide health care of unparalleled quality, both have been more costly because of our roles in education, research and care for underserved populations.

Over the last few years, outside forces have begun pressing both academic and VA medical centers to provide health care more cost-efficiently. For academic medicine, the impetus has been the growth of managed care and the unwillingness of employers and insurers to assume some of the costs associated with health care provided by institutions with additional missions, those of undergraduate and graduate medical education and research.

For the VA health system, the impetus has been federal appropriations for medical care that have failed to keep pace with inflation and the needs of its patient population and the requirement to medical progress and innovation.

In response to these transformations, both academic medicine and the VA are moving away from the traditional hospital-based model of health care delivery to a structure that emphasizes the delivery of care in ambulatory and outpatient sites. Moreover, academic and VA medical centers are establishing new partnerships with other health care providers to increase efficiency, to rationalize resource distribution, and to manage effectively in the emerging health care marketplace.

Loyola University Medical Center, a national leader in many specialized areas of medicine, recently announced a major affiliation with West Suburban Hospital Medical Center, an important provider of primary health care to the citizens of Chicago and its outlying suburbs. Together under one leadership, this partnership will complement each institution's strengths and provide a comprehensive continuum of health care to the populations we serve.

The synergy imbued by partnerships with complementary providers is vitally important to the ability of most academic medical centers to survive in an increasingly cost conscious and competitive arena.

Similarly, the VA is developing a new health care delivery structure that seeks to eliminate inefficiencies and duplication and to maximize its limited health care dollars and resources. Under the leadership of Secretary Jesse Brown and Under Secretary for Health Dr. Kenneth Kizer, the Veterans Health Administration has organized its 171 medical centers into 22 regional systems known as Veterans Integrated Service Networks or VISNs.

Under each VISN umbrella, several VA medical centers and their associated or affiliated partners are expected to work collectively to deliver health care to the veterans in their region most efficiently and effectively.

The success of the VISN concept, just like Loyola's partnership with West Suburban Hospital Medical Center, depends upon strong and trusting coordination and collaboration among all partners and affiliates. Newly created VISNs should rest upon the foundation created by the joint medical school-VA partnership. This foundation will allow for a more coordinated, integrated and comprehensive health care delivery system for our Nation's veterans.

The VA health system's future success will be based on its ability to respond directly and efficiently to the needs of its veteran patients.

The AAMC believes that Congress, the veterans' service organizations and the academic community should continue to support the efforts made by Dr. Kizer and his colleagues to restructure and rationalize VA's health resources.

Toward this end, the AAMC believes that Congress must tackle the reformation of the arcane and sometimes irrational rules governing a veteran's eligibility for care in the VA health system. Eligibility reform, properly crafted, will allow the VA to focus its resources on a well defined patient population, particularly service-connected veterans and veterans who rely on the VA as their only source of health care. Every eligible patient should be provided with comprehensive health care that runs the gamut from basic preventive care to the specialized services that are the hallmark of VA medicine.

The AAMC believes that eligibility reform should be done in tandem with the reformation of the VA and we appreciate the leadership that you, Chairman Hutchinson, are providing toward this goal.

The more than 100 medical schools currently affiliated with VA medical centers also have roles to play in securing a strong future for the VA health system. As each VISN strives to use wisely its human, fiscal and capital resources, the roles of the various medical centers and other facilities within each network are likely to change.

However, most VA medical centers have a close relationship that has evolved over years, if not decades, with a neighboring medical school. At the Hines VA, virtually all of the clinical service chiefs are Loyola physicians. Sometimes medical equipment is jointly purchased and shared, and medical residents and faculty rotate seamlessly between the two medical centers and other affiliated facilities in a truly integrated training program.

Clearly, changes in the roles that some VA hospitals may play within their networks would carry major ramifications for the relationship between the hospital and its affiliated medical school because the VA hospital is one of the major sites for the clinical education of the school's medical students and residents.

At my institution, for instance, the Hines VA is second only to Loyola's own teaching hospital in importance as an educational resource.

To protect the integrity of the VA's and our own mission in health care, education and research, medical schools must rethink together how best to use VISN's research and educational capabilities. However, if a VISN needs to consolidate services at certain facilities within each network, the VISN director should consult carefully with the VA medical center directors and the deans of affiliated medical schools to devise strategies that enable the VA to allocate its resources more efficiently and the deans to formulate new relationships that preserve the educational and research objectives of their schools.

Openness by all parties to new ideas and arrangement for patient care, education and research will bode well for the success of each VISN and, in turn, the VA health system as a whole. At the same time, the AAMC encourages the VA to communicate proposed policy changes in a timely fashion so that all interested parties may engage in discussions and negotiations throughout the process.

We are committed to making these changes, but we will need adequate time to move in new directions. Thank you.

[The prepared statement of Dr. Winship appears on p. 143.]

Mr. HUTCHINSON. Thank you, Dr. Winship. Dr. Kolodner.

STATEMENT OF ROBERT M. KOLODNER, M.D.

Dr. KOLODNER. Good morning. Mr. Chairman and members of the subcommittee, it is a pleasure for me to represent the Veterans Health Administration at today's hearing. I am pleased to have this opportunity to discuss in more specific detail some of the issues raised in broader terms by Dr. Kenneth Kizer, our Under Secretary for Health, at yesterday's hearing before this subcommittee.

Dr. Gregg Pane, our Chief, Policy, Planning and Performance Office, has accompanied me to today's hearing to join me in responding to any questions you might have.

Mr. Chairman, I know you and other members of the committee have received a copy of Dr. Kizer's *Prescription for Change*. It challenges us as clinicians, managers, policy-makers and planners, to move the VA system as it has never been moved before.

Today I will try to give the subcommittee a sense of the magnitude of this change and some particular examples from my own area of responsibility, in telemedicine and information management.

As you know, VHA has created 22 new management units in the field, as Dr. Winship alluded, called Veterans Service Integration Networks (VISNs), and these 22 executive staffs are now empowered to change the very nature of VA health care. They are encouraged to be bold, to take responsible business risks to improve the delivery system, to shift modes of care, to be more focused on providing care in the most accessible and cost-effective ways, and less fixed on providing all care in VA facilities.

We are also restructuring VHA headquarters, Mr. Chairman. Headquarters in the context of the new VHA is not involved in local operations of the health care system. Instead, we intend to ensure that VHA provides high quality, compassionate and economical care by focusing on national coordination of policy, future systems direction, economies of scale, consolidations, and standardiza-

tion in those areas where the system, as one enterprise, can profit from collective coordinated action.

Now if I may, Mr. Chairman, turn to some of my own responsibilities within the information management arena. The *Prescription for Change* specifically calls for a telemedicine strategic plan. Telemedicine will enable scarce diagnostic and therapeutic resources to be used network-wide, especially in rural areas, and will be used as a tool for consultative back-up to primary care.

Management of veterans in their homes will rely on the patient using simple monitoring systems to transmit periodic information that will be continuously analyzed to detect potential problems and will alert the health care team to contact the patient before serious problems develop. Every home will become a potential access point of care.

The VA system already uses telemedicine more than any other health care provider in the Nation, and we have been using telemedicine in one form or another for over 13 years.

As you can see on the map in front of you, and in the 60-page compilation of VA telemedicine projects that we have provided you in hard copy and on computer disks, our current inventory now includes hundreds of applications in every state, at every VA medical center. These activities cover the full spectrum of telemedicine from very simple, inexpensive systems used by our veteran patients to new, high-technology ones used by VA staff.

For example, we routinely monitor the ECGs of veterans with cardiac pacemakers in their homes, using standard telephone lines. A recent news item described a lawsuit related to a pacemaker malfunction. This did not occur in veteran patients because, through our monitoring program, we had detected the potential malfunction long before the manufacturer's alert and had taken steps necessary to ensure that no veteran suffered adverse consequences. VA even provided data to the manufacturer and to the FDA to document problems in a wider range of units than they had known about.

This pacemaker monitoring not only improves health care quality but it also is convenient to veterans, since he or she can be in touch with us for immediate monitoring 24 hours a day from anyplace that has a telephone.

Many other commercial telemedicine products are used routinely in the VA. A recently implemented system allows pathologists at one VA medical center to actually manipulate and interpret pathology slides located at a remote site where there is no staff pathologist, using a remote controlled microscope. This telepathology system is the first of its kind in the Western Hemisphere and one of only a few in the world.

The VA-developed imaging system allows us to capture, store and transmit a variety of color medical images, such as endoscopic, dermatologic and dental images, which then provide clinicians visual and text information for medical decisionmaking.

It is important to note that the efficiency benefits from this system are not limited just to the VA. Both the Department of Defense and the Indian Health Service use parts of VA's imaging system on a daily basis.

VA even has a prototype system which uses a standard Internet browser to pull data directly from our existing DHCP system and then link this data across the Internet to a decision support system at the Harvard Medical School. This is an exciting new capability becoming available in medicine and the VA is actively examining how we might best use it to benefit our veterans.

We believe that the use of telemedicine plays an essential role in the transition the VHA is making from hospital-based activity to an outpatient, network-focused system. As extensive as it is, telemedicine is but one small step we are taking in administering the *Prescription for Change*.

Mr. Chairman, once again on behalf of the Department of Veterans Affairs, thank you for the opportunity to testify today. Dr. Pane and I would be pleased to respond to your questions.

[The prepared statement of Dr. Kolodner appears on p. 147.]

Mr. HUTCHINSON. Thank you, Dr. Kolodner.

Mr. Mannle.

STATEMENT OF THOMAS E. MANNLE, JR.

Mr. MANNLE. Good morning, Mr. Chairman, Mr. Edwards, members of the committee. On behalf of my colleagues at The Lewin Group, a health policy research and consulting firm located in Fairfax, VA, I am pleased to appear before the subcommittee this morning as it explores the future of the Veterans Health Administration (VHA).

The Lewin Group, in partnership with the Klemm Analysis Group and Arthur Andersen, has been working closely with VHA over the past 10 months to study, in response to direction by the Congress, the feasibility and advisability of alternative organizational structures, such as the establishment of a wholly owned government corporation or government-sponsored enterprise, for the effective provision of health care services to veterans.

Over the course of our work, we evaluated alternative organizational structures, conducted a comprehensive review of prior studies and analyses, performed intensive interviews within various levels of VHA, met with representatives of the veterans' service organizations, and extensively analyzed the characteristics of the current VHA's health care delivery system. We used the framework provided by VHA's Vision for Change; that is, the concept of organizing VHA as a system of 22 geographically-based integrated service delivery networks, called VISNs. We included in our analysis a number of dimensions, using comparative data from both the public and private sectors.

Because the report currently has not been transmitted yet from VHA to the Congress in response to its direction, my testimony this morning will cover several broad areas that we pursued during the analysis, which may be of continuing interest to the subcommittee as it pursues its deliberations.

One of the first things we found in our analysis (and my colleague, Drew Valentine, from Arthur Andersen, will be addressing some aspects of this), is that there is no current existing government corporation that we felt would serve as a useful model for purposes of converting the VHA.

In terms of analyzing the business of the Veterans Health Administration, especially the delivery of health care, is the enterprise, the question became: is the Veterans Health Administration one business with 22 retail or geographically separated subdivisions, or is it in reality 22 separate businesses? Further, do the pressures of the local environment, the nature of the needs of the veterans in the local environment, the distribution of the physical assets, the staff and the capabilities of the staff, really mean that there ought to be different decisions made at the local level in order to best serve the needs of veterans?

Lastly, what we were pursuing here was the shape of those decisions, what needed to be done in the human resource, financial, structural, contracting, and purchasing areas, that we could then incorporate into recommendations as to what form of government corporation would be best.

I have two exhibits here I'd like to talk about in terms of what we were looking at in trying to analyze the delivery of health care in the Veterans Health Administration.

The analytic questions that we were trying to answer were who's being served, who could be served or should be served; with what types of services; how should the VHA, given that the answers are apparent to the first two questions, what strategy should be pursued in terms of specific service delivery strategies; what should the new service delivery system look like, what are the various combinations and alternatives of those; and what capacities and capabilities does the new system need, given responses to the other questions?

In our interviews and as a result of our research, we also noticed that there were really four related areas of strategy that kept cropping up: the tension between serving the VHA's current customers and concentrating on them versus pursuing new customers; whether the VHA should be a full service provider of health care, as is the trend in the private markets these days, or should it really concentrate on being a specialty niche provider, concentrated but not necessarily limited to the 11 special areas of care that are currently in VHA; whether it should make its services, in other words, provide them out of its own staff capacity and assets of its physical resources, or purchase services, buy them from external suppliers when that is appropriate; and lastly, whether it should retain or divest its capacity. Second slide, please.

We organized these into a framework which we think in any particular VISN level or at the VHA as a whole really is the way in which the questions ought to be addressed. The first two questions—who is the VA serving and what services does it provide—are really essentially the operationalization of the mission. To whom am I providing services? Who is eligible for care in our facility and with what services? And the continuing deliberations around the eligibility question really drives, especially at the field level, all the decisionmaking that is subsequent to that.

So expanded eligibility reform or the nature of eligibility reform would really have a profound effect on what decisions are made or could be made at the local level in order to pursue both whether those services should be provided out of the current existing assets or whether they should be purchased from other vendors.

One suggestion I'd like to make is that we had "efficiency" on the slide, really the make-or-buy decision, but in response to Dr. Kizer's testimony yesterday I'd like to encourage the committee to think about it as not really a simple efficiency issue. It's really the components of value. Can the VHA provide more value—can the VHA provide more value in terms of delivering the services it has decided to deliver, out of its own resources, or really is the best value to be pursued by purchasing from the outside? So all the components of value are there and should go into that deliberation. It's not necessarily simply a dollars and cents issue.

Given that there's a make-or-buy decision, there may be a variety of strategies of full service network, of virtual network, a specialty or niche centers of excellence strategy, all of which—these are not necessarily exclusive in one VISN area or another—all of which may be pursued in combination in a particular market for particular classes of services.

As several witnesses have noted this morning, to the extent that one purchases or buys services or care from outside of the VHA, that will put pressure on the VHA to divest, over time, the capacity that it's currently not using. To the extent that it retains its capacity as a result of deciding to provide services, then that both creates an incentive to retain the capacity and also creates an opportunity to sell those services to other players in the health care markets.

That concludes the main points of my testimony. I'll be happy to answer questions at the appropriate time.

[The prepared statement of Mr. Mannle, with attachments, appears on p. 151.]

Mr. HUTCHINSON. Thank you, Mr. Mannle.

Mr. Valentine.

STATEMENT OF DREW VALENTINE

Mr. VALENTINE. Mr. Chairman, Mr. Edwards, I'd like to thank you for this opportunity to testify on the future of the VHA.

As Mr. Mannle of The Lewin Group has previously indicated, the team of Arthur Andersen, The Lewin Group and Klemm Analysis has recently completed an important study which was commissioned by the Congress to look at alternative organization structures for the VHA.

We believe that Dr. Kizer has recently developed and pursued some important initiatives at the VHA. We feel strongly that the VISN concept recently implemented is the right move at the right time for the right reason.

Our recommendations are not only consistent with the VISN concept but, in fact, are intended to maximize the impact of the recent VHA reorganization.

Basically what we've attempted to do is answer the question: could a new organization structure improve the likelihood that both the VHA and the VISN concept will be a success? After an exhaustive study and analysis of VHA's past performance and the early performance, very early performance of the VISNs, we believe that more change is still necessary.

Thus, we're recommending a restructured VHA. Specifically we're recommending consideration of converting the VHA to a

wholly owned government corporation. A restructured VHA as a corporate entity will move toward specific improvements in both overall management and performance.

As a result of great interest exhibited by Congress in alternative structures for the VHA, we examined four basic options for possible application to VHA: first, converting to a government corporation; second, a mixed ownership corporation; third, a government-sponsored enterprise; and fourth, a performance-based organization.

After careful review of various options and the questions described in our written statement, we determined that two structures are feasible for the VHA. First, converting VHA to a government corporation, a wholly owned government corporation, or, less dramatically, transitioning VHA to a performance-based organization.

If we converted VHA to a government corporation, it would be a wholly owned government corporation, it would be directed by a board of directors and we would recommend the following as illustrative of the type of members on such a board: five directors appointed by the President with the advice and consent of the Senate, not more than three of the members of the board to be the same political party; at least two members of the board selected from representatives of the veterans service organizations; two ex officio members, the Secretary of Veterans Affairs and the Under Secretary of Health; a chairman of the board, to be elected by a majority of the board; and the term of the board members to be 4 years, with appointment to new terms occurring in the first 6 months of a new President's term.

As far as management of the corporation, the Under Secretary of Health would function both as the chief executive officer and the chief operating officer, responsible for day-to-day operations of the VHA corporation.

No change is envisioned when transforming the agency to a government corporation vis-á-vis the VISN structure. This recommendation is meant to be supportive of that concept.

The VHA corporation, as newly constituted, would be a Title 31 executive agency of the United States government. The corporation would remain, in some aspects, under the purview of the Department of Veterans Affairs, to ensure coordination with common programmatic mission and activities.

The VHA corporation would be subject to two major pieces of legislation; namely, the Government Corporation Control Act and the Government Performance and Results Act. Specific legislation would also be required to create a new government corporation, spelling out its charter, reauthorization time frame and exemptions requested or required.

We see some very real advantages to considering a move of this type. First, we think it would result in a VHA which is more customer-driven, specifically, by formally including representatives of the VSOs on a newly created board of directors.

Second, a VHA would focus more specifically on strategic, as well as short-term goals. A functioning board would better develop a strategic plan and direction for VHA, which could delineate long-term goals, resources required, strengths and weaknesses, and obstacles to be overcome.

Third, a VHA which is even more results-oriented, with a more business-like organization, the VHA should be able to define outputs and results to be achieved and hold people accountable for these.

A VHA which is more flexible and replicates the best practices in health care delivery today. And fifth, upgraded staff competence and expertise at senior levels in all the VISNs.

With a corporate structure and a more business-like approach to accomplishing its mission, the VHA potentially could become a more attractive place for senior health care professionals to work. Let me add, though, that adopting a corporate structure is justified only if the VHA is willing to pursue major or significant changes related to one, its customers, two, the service mix, three, the making and buying of services, and finally, the divesting of selected services.

While we think the advantages of moving towards a government corporation outweigh the disadvantages, there are some difficulties associated with such a move. Primary among these is the impact of such a transition coming on top of the recent reorganization and introduction of the VISN concept.

Many of the changes we recommend will impact VHA and VISN operations and will require significant changes in outlook and orientation. Nevertheless, we believe such a transition is manageable and will, in the long run, benefit VHA and its customers.

As an alternative and a less dramatic change, the move to a performance-based organization, which recently is taking place relative to six other agencies and organizations in the government, offer several advantages. Primary among these is creating contractual relationships through the use of performance contracts, which sharpens the intended results of VHA program activity and increases accountability for results.

Flexibility could be negotiated between the VHA, OMB and appropriate congressional oversight authorities. These may include statutory exemptions or regulatory waivers from departmental requirements or government-wide controls in procurement, Civil Service, budget, or support services from GSA, GPO and other organizations.

Either of these two organization models appears to be feasible and would better position VHA to carry out its basic mission and function within the new dictates of the emerging health care environment. Both a government corporation and a performance-based organization, accompanied by exemptions to federal regulations and requirements in certain areas, would be consistent with and supportive of the recent organization and VISN initiative, as well as the structural requirements outlined in our written report.

The corporate structure, once implemented, would offer the greatest degree of independence and flexibility to VHA. A PBO would probably be easier to implement and take less time to put in place but would not give as much flexibility and latitude to the VHA.

After reviewing the relative advantages and disadvantages of these two options, we believe that a government corporation is a very real option and represents the strongest of the two. Thank you, Mr. Chairman.

[The prepared statement of Mr. Valentine appears on p. 159.]

Mr. HUTCHINSON. Thank you and I want to thank all the members of the panel.

Mr. Valentine and Mr. Mannle, has the report been issued?

Mr. MANNLE. We have briefed Dr. Kizer on the report and we are currently making some revisions. We hope to have a final deliverable to the VHA on July 1 and I believe it will be delivered to the Congress later this summer, although I don't know that exact schedule.

Mr. HUTCHINSON. And the recommendation—did I get this right, that the recommendation was for the conversion to a wholly owned government corporation?

Mr. VALENTINE. That's correct, Mr. Chairman.

Mr. HUTCHINSON. And you said that in order for that to be feasible, there were certain things that the VHA had to be willing to do. What were those again?

Mr. VALENTINE. I think it relates back to some of the items that Mr. Mannle went through as to expanding the customer base——

Mr. HUTCHINSON. By that you mean?

Mr. MANNLE. Well, there is no question that there's a tension in terms of the organization that we noticed before in terms of the number of people who are being served and whether those populations who are utilizing the facilities can be maintained in certain selected areas over time, given the decline in the population of veterans who are eligible.

In terms of being a government corporation, it kind of depends on the entire existence of whatever you provide. With the current population of veterans, if you're going to need to attract new customers into the facilities in order to retain the capacity to provide services to anyone, then it seems to us that having more flexibility to be able to pursue those initiatives would be facilitated by having a corporate structure; then that's probably the way to go.

The key words here are flexibility and authority.

Mr. HUTCHINSON. Excuse me. Are we saying nonveterans? Are we saying dependents?

Mr. MANNLE. Well, only about 10 percent of veterans right now currently use VA facilities. Depending on where eligibility reform goes, in other words, who the Congress and the VHA decide are eligible, there's probably a significant number of people who are veterans but are not now eligible under the current rules who may be able to use the facilities or could be attracted into using the facilities in local markets.

So it's not necessarily clear that, as you saw from our graphic, we had first current customers, who are currently using them, then eligible veterans, and we put eligibility in quotation marks there because we understand that eligibility reform is a continuing issue. Then, after that, perhaps people who are veteran-related, spouses and dependents, and after that perhaps the general public.

So we think that there's a progression here that needs to be examined fairly carefully before—it's not simply a matter of throwing the doors open.

Mr. VALENTINE. I think, Mr. Chairman, implementing a government corporation would require, of course, enabling legislation. It would also offer an opportunity to include in that legislation a vari-

ety of exemptions—from federal procurement regulations, federal personnel regulations and some of the things that VHA has pursued unsuccessfully in the past, as well as some other ideas which are spelled out in the written statement.

Mr. HUTCHINSON. Are there any current wholly owned government corporations that would parallel what you're proposing that have those kinds of exemptions in place? What's the best parallel you can give me?

Mr. VALENTINE. There is no best parallel. What we've found, surprisingly, is that under the Government Corporation Control Act, every government corporation that has been set up—there is no one model—the enabling legislation really determines what the nature and the scope and the characteristics of that corporation are.

So what we are proposing is a specific sort of tailored government corporation to the VHA mission and function, which is similar to what every other government corporation, how it has been developed, which is specific to the mission, and the exemptions from federal regulations are the ones that were deemed necessary due to the specific mission of that organization.

Mr. HUTCHINSON. You were very specific about the composition of the board so that the report is very detailed in the recommendations as to how this corporation could be—what kind of enabling legislation would be necessary?

Mr. VALENTINE. Yes. I think the board, of course, could be composed in any way that the Congress determined. Probably the board's most important feature is representation by the customer, having at least two representatives of VSOs appointed by the President on the board which, in some ways, we believe makes the organization even more customer-oriented than it is today.

Mr. HUTCHINSON. Mr. Edwards.

Mr. EDWARDS. I want to thank you all for your presentations.

Mr. Valentine, you talked about how through a government-owned corporation VA could have a more business-like approach in its provision of medical care to veterans. Once we recognize that there are some fundamental differences between a nonprofit entity, such as the government, and a profit entity, such as a business, I'm always open to trying to find a way to make government more business-like, at least in the sense of more efficiency in its provision of services.

Could you be specific in terms of four or five, aside from structurally, organizationally, could you give me four or five specific examples of where you think the VA needs to be more business-like in its providing of medical care to veterans?

Mr. VALENTINE. I'd like to anchor it in the VISN concept, which is the recently implemented initiative which is really sort of the map for VHA in the future, and I would start with the VISN directors themselves.

Today they are selected, they're hired, they're paid, and motivated under federal personnel relations. We could see a lot of advantages to opening that up a bit so that people could have different salary structures, for example, higher salaries offered to attract better people. The sense of holding the VISN directors and the VISN operations more accountable to a set of performance measures, through performance contracts, other items like that.

Also, greater flexibility and latitude for the VHA to both buy and sell services that were dictated as being appropriate, and a variety of other things that we think would just, as Mr. Mannle said, give the VHA even greater flexibility.

What we're recommending is not contrary to the recent developments in VHA; it's meant to support the recent developments and take it one step further.

The other thing I'd like to mention, Congressman Edwards, is that we are not saying that we want VHA to replicate private sector health care practices just because they're private sector health care practices. We are trying to pick what we call best practices from the private sector and allow the VHA, under the oversight of the Congress, to make decisions on which of those best practices they're going to pursue, and then have the flexibility to do it.

Mr. EDWARDS. Let me ask you, all of you touched on flexibility in different sorts of ways. Perhaps Dr. Winship or Admiral Rowley, through your experiences with the VA and the Department of Defense medical care respectively, is there a way to balance out this need on one hand for a standardization at the national level of services provided to the customers and yet, on the other hand, trying to provide flexibility for local medical centers or regions to take their given resources and be creative with them? How do we balance it? It seems to me there's a creative tension there between, on the one hand, national standardization versus local flexibility.

Dr. WINSHIP. My own view of that, Mr. Congressman, is that there is need for and place for central guidelines but not central management, and that the beauty of the VISN so far, in my opinion, is that it really does decentralize not only the management but also the authority. That authority has to be, I believe, carefully spelled out in terms of the guidelines under which that authority is exercised in the field.

But there will be major differences—always have been, always will be—major differences in individual VA medical centers, in individual affiliations and in individual groups of hospitals that must be taken into account; this decentralization with guidelines gives them the opportunity to take those differences into account.

Central management does not give that opportunity. Central guidelines and performance standards for achievement of meeting those guidelines does, in my opinion.

Mr. EDWARDS. Thank you.

Admiral, would you care to comment on that?

Admiral ROWLEY. Yes, sir. First, there has to be a central vision and the vision in this case is that we're in the business of providing veterans needed medical care. It's not saving empires; it's focusing on human beings.

Second, I think there health care benefits are defined. I know that in the military, the extent and kind of health care that we provide our beneficiaries is defined by law.

Within the framework of these two things, medical care is a local solution. For instance, I'm responsible for all the military medical care in North Carolina and Southern Virginia. Some of my beneficiaries are located in areas where there are no military facilities. It makes sense for me to buy the highest quality, most cost-effective care in the local area that I can find. In some cases the De-

partment of Veterans Affairs can be providing that care for my beneficiaries and in other situations, the care is purchased in the private sector.

That's the flexibility part. It doesn't make any sense to keep hospitals open with a small census, and to duplicate services which are already available in the community. We need to cooperate with all medical care facilities and spend the American public's tax money in a cost effective manner.

Mr. EDWARDS. Thank you all. Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Chet.

Mr. Kennedy.

Mr. KENNEDY. Thank you very much, Mr. Chairman.

I want to follow up, based on your last statement, Admiral Rowley, and maybe ask Dr. Winship his thoughts about this.

It seems to me that you've got a situation now in the VA where first and foremost, we've seen this incredible explosion of costs that are associated with an elderly veterans population that is just going to get much more elderly over the course of the next decade. There's a time period—I think it goes to 2012 or something like that, where it begins to—I don't know; Dr. Winship, you probably know the number better than I—where the numbers are anticipated to begin dropping off again.

If you look at not only those veterans that are hitting 65, that is a very, very large number, some 30 percent, an increase of 30 percent, I believe, in the next couple of years; then, above that, I think the number of veterans over the age of 85 is going to go up about 175 percent.

So what you've got is an incredibly elderly population that is much more dramatic than the numbers that you see in either the Medicaid or the Medicare population. So the costs associated with taking care of those veterans is going to be much more dramatic.

Now, I understand from Dr. Kizer, and I think that the chairman and Mr. Edwards and myself have been involved with discussions with Dr. Kizer and, under the chairman's leadership, we were able to get some legislation moving that would allow for eligibility reform, which, I think, triggers the ability of the VA to actually go out and purchase care outside the system in a way that hasn't been done before. In other words, it would give the flexibility to the chief medical officer to begin to look to the most cost-effective kinds of purchases, health care purchases, at the local level, that we have not seen them do before.

For instance, a year or two ago I met with all the medical center directors in the New England area and every one of them felt responsible for meeting every single health care need that every veteran faced whenever they walked in the door of that particular health facility.

And so unlike the major hospitals in Boston that might specialize in particular areas, the VA feels a very different mission than, it seems to me, you sense with private health care providers, even the very big hospitals that are in that business.

What I'm driving at is yesterday we passed, on the House floor, a budget which, after a lot of wrangling, essentially maintained the existing budget for the VA. All of us know that the budget is going to have much more dramatic demands put on it.

Is it possible for the VA to meet its obligations to this elderly population of veterans without dramatic increases in funding if we are going to provide them with the kind of flexibility that you're suggesting? Either Admiral Rowley or Dr. Winship or anybody else.

Admiral ROWLEY. Yes, I think the VA can meet its obligations. There are two things necessary to accomplish this. Number one is we have to do everything possible to keep our elderly population healthy and out of the hospital.

Second, in order for the Department of Veterans Affairs to meet its obligations to our veterans they must have the flexibility to do whatever makes smart business sense. If we spend our money wisely, it means the money is going to go further and we can provide more services for veterans.

The focus ought to be on doing whatever makes good sense to provide the veterans the care that we are obligated to give them. We need to think of innovative ways to use services from the private sector and from other governmental agencies, consolidate service when appropriate, and to try to provide more health care services on an outpatient basis. The money saved by those efforts can be spent elsewhere for veterans.

Mr. KENNEDY. One of the points that Dr. Kizer makes is that we should take into account what the VA is currently doing well. I'm not sure that that is necessarily compatible with the plan that you've just outlined because even if, in fact, the VA is doing some particular medical procedures very, very well, in fact, even better in some cases than the private sector is providing, if, in fact, that does not fit with the model that says what you're really trying to do is meet, in a cost effective way, the absolute medical needs of the populations that the VA has promised to serve, then don't you think that, in fact, you're talking about a dramatic change in the way that they are currently doing business that requires the same kind of dramatic sort of look at in terms of what specifically the veterans' needs are going to be, converting a lot of these beds perhaps into long-term bed facilities, farming out a vast number of the day-to-day operations in terms of if you need open heart surgery you're going to go to one of the local private hospitals that provide that and dramatically change what has been a sense of a mission where the VA facilities themselves were going to take care of everything, soup to nuts.

Admiral ROWLEY. The VA, like most government agencies, serves several masters and has several missions. I think it's important to maintain those missions that the VA excels at, their centers of excellence. The VA is an important treasure for America.

Please keep in mind, it's not just the Department of Veterans Affairs which is struggling with budget realities; it's all of us. The VA has many facilities with excellent cardiac surgery programs. Maybe in the future, as we learn to combine services, the VA can be the institution that provides cardiac surgery services to the community, using veterans physicians, medical school physicians and private physicians working out of one institution. In that way we will be serving everybody but not duplicating unnecessary resources.

Mr. KENNEDY. That's a good answer. Thank you, Admiral.

Dr. Winship, do you have any thoughts? Oh, I'm sorry; I'm out of time.

Mr. HUTCHINSON. Thank you, Mr. Kennedy.

If you'd like to respond, Dr. Winship, go ahead.

Dr. WINSHIP. Let me just make a quick comment or two.

I believe that Dr. Kizer's plan really talks about having a comprehensive VA health care system, part or all of which may be a virtual health care system such that portions of the system are not made but bought; that makes a lot of sense because comprehensiveness is what the mission has always been and what people are struggling for and feeling like that they've needed to provide on the scene in each locale. I think that's what you're getting at.

I think the numbers that you were searching for, the plateau of numbers of the elderly before it begins to fall off indeed does go out somewhere between 2010 and 2020, around 2015 or something like that, in which there will be a continued increase in the demand for VA services, mainly because of the elderly population. And I don't see any way, very frankly, how that will not translate into increased costs for that population of people.

That's reflected in mature HMO markets right now where the standard HMO premium is around $100, give or take, per member per month but for the Medicare HMOs, it's around $400 or $500 per member per month, and that simply reflects the increased need of that elderly population. And that's going to happen, even if we are successful, in the VA and out of the VA, in pulling those costs down and being as cost-efficient as possible, simply because that population needs more health care.

One way or the other, it's going to cost more for that population to have health care. I see no reason, however, why that should mean that we abandon the VA program, and particularly with Dr. Kizer's plan, to have this as a virtual health care system where services are purchased as necessary to complement the services of the VA, but all of this being under the guideline and the rule of real cost-effectiveness. That's got to be the driver.

Mr. KENNEDY. Thank you, Doctor. Thank you, Mr. Chairman.

Mr. HUTCHINSON. Let me just comment on the budget that was passed for VA-HUD yesterday and join Mr. Edwards in commending the bipartisan effort led by Mr. Stump and Mr. Montgomery to add into that medical care budget.

The committee mark that came out at just over $17 billion, through the Stump Amendment we added $40 million and through the Tiahrt amendment we added another $20 million, which put us at $17.068 billion, $60 million above the President's request.

So let me say that while all of us would like to be able to do more, I think this committee, the authorizing committee, is to be commended for the bipartisan effort to strengthen that budget.

Mr. Baine, you said in your testimony that we needed to convert many of the existing facilities to nursing homes. We hear that quite often.

Yesterday Ms. Quandt, in her testimony, recommended that between 50 and 75 VA medical centers should either be closed or converted to nursing homes. Do you agree with that assessment?

Mr. BAINE. I don't know, Mr. Chairman, whether the numbers that Miss Quandt quoted are exactly right. I think I can envision a VA health care system where those numbers would be in the ballpark, yes, sir.

Mr. HUTCHINSON. And Admiral Rowley, in your written testimony you referred to the political pressures that exist to maintain the status quo in the VHA. The Department of Defense has been pretty successful in overcoming some of those political pressures through the BRAC process.

What is your attitude, what's your feeling about the feasibility of using a similar process on realigning veterans? Is that necessary or can the current reorganization under Dr. Kizer, can it insulate itself from political pressures satisfactorily to see those changes made?

Admiral ROWLEY. Two things have impressed me. First, I think that Dr. Kizer has an excellent plan.

Second, from my perspective, and I'm really an outsider, it seems that the culture of the 200,000 employees within the Department of Veterans Affairs is changing. They're aware of the changes in American medicine. They understand the political realities and they're willing to focus more on their obligations and less on the buildings.

I think there's a good possibility that the changes can be made without a BRAC-like process; however, if it gets to the point where there are facilities that need to change and people are reluctant to make those changes for the best interest of the VA, there may be the need for a very objective process to look and make those decisions.

Mr. HUTCHINSON. Admiral, I appreciate that. My concern would not be nearly so much about the culture of the VA today, because I agree with you that it's dramatically changing. Nor would my concern be about the leadership of Dr. Kizer, because I think he has laid out a good prescription.

My concern would be about the political pressures that would exist in Congress to continue the status quo, as opposed to embracing and encouraging the kind of changes that Dr. Kizer is suggesting.

Admiral ROWLEY. If the American people realize that the focus is providing quality health care to the veterans and that changes are going to provide better care with easier access, then maybe people will be agreeable to change because in the long run, the veterans are going to benefit from the changes. Whether that's going to sell or not, I'm not sure, but that's where I think the focus should be.

Mr. HUTCHINSON. Thank you.

Mr. Valentine, I think this report coming out is going to be interesting. I think it's going to be controversial, to say the least.

In the proposal to the government corporation, if you could go back to your testimony, you mentioned several things that would have to happen in order for this to be feasible. One of those was the increase of the service population for the veterans system, but there were a couple of other factors. If you can find that—do you know what I'm referring to?

Mr. VALENTINE. Right. Let me clarify one thing. Those items were not things that were essential for a government corporation to happen. They were items that would maximize the effectiveness of a government corporation and second, to make the effort worth-

while, because converting to a government corporation will be a very politically charged concept.

Therefore, if you're going to go to the trouble of converting to a government corporation, we think that it will imply a maximum amount of change in other things that Mr. Mannle talked about in the mix of customers, in the buying and selling of services, in perhaps the divesting of certain services.

Mr. HUTCHINSON. I think that one thing I picked up on was the divesting of certain services because there would be red flags that would go up very quickly with an awful lot of veterans groups, and rightly so, if the idea, in order for the government corporation concept to work, for it to be feasible, if you need to do these things. Not that legally it's required but for it, as you said, to maximize it, to make it feasible, to make it workable, these are the things that would need to happen. If one of those means that the VA would have to be divesting certain services currently offered, does that mean specialized services, the most expensive? What does it include? What are we talking about there?

Mr. VALENTINE. I think a government corporation gives you more flexibility and power to make those basic decisions. It does not presume a decision about any of those items going into it.

Mr. HUTCHINSON. Okay. Well, if you don't presume, if Congress is going to give them the kind of flexibility that you're talking about, where those kinds of decisions would be made by the board, as opposed to being made under the current process, I think the concern immediately will be that the decisions will be made on the basis of dollars and cents and the bottom line, as opposed to providing the kind of services traditionally offered to veterans.

Mr. VALENTINE. Mr. Chairman, even the relationship between the board and the Congress would have to be spelled out in the enabling legislation. The degree of freedom that the board would have in decisionmaking is another thing that really could be crafted in the legislation.

That really was the surprising thing we found when we looked at seven models of government corporations, everything from the Federal Reserve, Export-Import Bank, TVA, Amtrak. We found that every one was specifically crafted and not one of them had a whole raft of exactly similar provisions or exemptions from federal regulations.

Tom, you might want to comment on that.

Mr. MANNLE. I think the issue in terms of the services in our report, in our part of the report, we looked at the issue of full service versus specialty service and we came down fairly, I think, clearly on the idea that for the present, VHA is not set up to be a full service provider beyond providing services to the current population of veterans with special health care needs—spinal cord injury, blind rehabilitation, prosthetics, etc.

In other words, if someone is in the system based on those specific eligibilities, then the VHA should take upon itself the ability to provide for all of their health care needs.

What we were talking about, and I think in response to Mr. Edwards' comment before about balancing the need for local flexibility and national standards, we would see something like there's a certain core set of people and conditions, which is part of eligibility,

that the VA must [Emphasis added] do, must take care of in whatever cost-efficient methods are appropriate; and then there may be a series of things that they may [Emphasis added] do.

One of the criteria for whether they may or may not has to do with the extent to which it fosters their ability or facilitates their ability to deliver services more effectively or more cost-efficiently to the core set.

The VA is an example of what we, in our other types of consulting work, are calling a mission-driven type of organization, not so much motivated by the bottom line but by a sense of values, and that there are other large health care systems in the Nation which also take it upon themselves to deliver care and where the financial reimbursement is not the game, it's merely the way in which you keep score, and that the rules of the game are determined by values and your sense of purpose and your sense of mission that you're trying to inculcate into the enterprise. And we would put the VHA squarely into that.

So any decision about whether certain services should or should not be provided, we do not feel that should be simply dollars and cents, but it relates back—it has to be clearly related back to the mission of the organization and what it's about in those circumstances.

Mr. VALENTINE. Getting back to the issue you brought up, Mr. Chairman, I guess another way of saying it is that if, relative to your customer base, you are not going to change anything, if, relative to your service mix you were going to maintain the status quo, and if, relative to making what we call make-or-buy decisions, if basically there was not going to be any change other than at the margins relative to those four key elements, then I think realistically we would say it probably isn't worth the pain to pursue a government corporation because it will be a very politically sensitive issue.

But if the trend as we see that is envisioned in the VISN concept is going to continue, where you will really be slowly—in other words, VISNs is not the end of change in VHA; I would argue it's the beginning of change in VHA. And if you're willing to consider things like basic changes in customer service mix and other items, then I think a government corporation is a logical end point somewhere down the line.

Mr. HUTCHINSON. I guess conceivably the government corporation, if given a degree of latitude from Congress, could make some of those kinds of changes, not prior to the establishment of the corporation but subsequent to it.

Mr. VALENTINE. Yes.

Mr. HUTCHINSON. They might then be insulated from some of the political pressures that would prevent those changes from taking place.

Mr. VALENTINE. I think that's one advantage potentially.

Mr. HUTCHINSON. It's also a risk and the risk is that the mission changes. That's something that this committee weighs every day.

Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Chairman.

Let me ask all of you, one of the comments that came out yesterday and has been mentioned today is you can't just look at the VA

health care system in isolation; it's part of our entire country and larger health care system.

Mr. Baine, do you or anybody else care to respond to this? Dr. Kolodner and others, Dr. Winship, have any feeling that if we began to reduce the rate of increase for Medicare and Medicaid services, do we impact the demand for VA services? Will we see an influx of veterans, assuming there is some—I don't want to get into the debate of is it a cut in Medicare or not. We can have that debate another day.

But if, in fact, you started to cut down those costs where you do reduce services to Medicare and Medicaid, given that assumption, what does that do to demand for VA health care services?

Mr. BAINE. I think, Mr. Edwards, there's no question that if Medicare and Medicaid were significantly affected by a lack of funds, the demand for care in VA, assuming all things being equal, would probably go up.

Our information indicates that the veterans' demand for care is quite dependent on whether they have private or public insurance such as Medicare. If they do have such insurance, their general inclination is, as Mr. Valentine said, to go seek care closer to their homes. Only 10 percent a year of the eligible veterans are really cared for in the VA.

Mr. EDWARDS. Does anybody else care to comment on that?

Dr. WINSHIP. I certainly agree with that. I believe that it would have a fairly substantial impact on the demand for VA services and particularly so as those increased numbers of elderly veterans we were talking about earlier moves forward over the next decade or two. It's likely to be perhaps 20 years before that plateau begins to decline. I think we will certainly see that played out.

Mr. EDWARDS. Very good. Thank you.

Mr. Baine, you commented that one option, and we've discussed this in our committee, is to allow the VA to treat the entire veteran's family.

Could I ask any of you if we were to take that approach, how well equipped is the VA to provide that kind of broad-based care for children, on up? What kind of capital investments would that require or different mix of physicians, nurses, health care providers?

Mr. BAINE. My own opinion, Mr. Edwards, is that it would require a pretty significant change in the capital investment that VA would have to make. It is not well equipped, of course, to treat children.

I believe the issue of whether to include dependents and perhaps other beneficiaries in the VA system has been tried one or two times before and I believe Secretary Derwinski would tell you that it had some impact on his employment. But times are changing and, as you said, the VA system cannot any longer operate in a vacuum.

So we raised that possibility as one of a number of possibilities across the spectrum as the decisions that the Congress is ultimately going to have to make about what the system is going to look like, who it's going to serve, and who it's going to serve for free and who might end up having to pay for some of the care provided in VA.

Mr. EDWARDS. Very good.

Admiral, could I also ask you, you talked about the information age that we're in the middle of and you talked about the potential for improvements in care through the information technology we're seeing coming on line.

Are there any demonstration projects you'd recommend that Congress should consider authorizing for the VA to test some of these projects?

Admiral ROWLEY. I'm not quite sure how far along we are with the development of the sensors. I think that once the technology is applicable, a governmental agency such as the Department of Veterans Affairs or the military would be an ideal demonstration site.

In private medical care, health care providers don't usually feel the responsibility of owning the patient for a lifetime. In governmental systems, though, they're our responsibility until they die. There are real incentives for us to do things that help people stay healthy. If we can keep them healthy, we're going to save money in the long run.

While I think it's an area that we need to look at, the technology is probably not far enough developed for it to be a viable demonstration project yet.

Mr. EDWARDS. Very good. Thank you. My time is up. Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Chet.

Mr. Ney.

Mr. NEY. Thank you, Mr. Chairman.

The question I wanted to ask, what's the feasibility of taking the ideas of forming a government corporation, for example, expansion of HMO networks, managed care, types of small group reform, the basic building blocks of changing the health care system, and taking those concepts and applying them to the VA but don't form a government corporation?

In other words, you don't have your board structure and you don't have the reporting mechanism of the president down, but you take the concepts that you've outlined here, where it becomes a general consensus and agreement of what can further open up the system or change health care, manage the care, whatever the change is, and you can say, "Here," to the VA, "go ahead and do it." Why do you have to have, or why should you have the government corporation?

Mr. MANNLE. As several of the witnesses have mentioned this morning——

Mr. NEY. I apologize, by the way, for not being able to get here in time.

Mr. MANNLE. You've probably heard this before. Health care is local. Certainly what we found when we were doing the study is that within 22 or whatever number of geographic market areas, the specifics of the local market and the VA's position within that are going to drive in several respects the decisionmaking about how you organize your resources, what types of partnerships and alliances you make with other private vendors, what types of partnerships and alliances you make with academic medical institutions, and the number of veterans, the number of eligible veterans and their specific conditions all have to be factored in at the local level.

And so we would very strongly say that the VA provision of care in any market is going to look different from place to place. The real question is given that you're going to need flexibility in being able to both purchase services from the outside, potentially sell your services to other people who may be willing to pay for them—this is all assuming that you get the authority to do that—and other types of arrangements, the question is you could do that under the current status quo if you could get the authority and permission to do that.

The real question, I guess we would say, is what's the best way to ensure—I think when I was reading the testimony yesterday—what's the best way to ensure that those types of changes, up to and including the divestiture of capacity or the cutting off of certain types of services, can be sustained in the long run?

There's nothing that says it can't be done in the current structure, but I think our collective feeling is that the best way to ensure that those changes can be institutionalized over time may be with an organization that has some degree of insulation from continuing—pressure is probably too strong a word but——

Mr. NEY. Politics. It's not a bad word. What I'm saying is that what scares me when I hear the words "government corporation" in regard to a veteran and what scares me is government corporation institutes a system that leads to "privatization." Then you have privatization, a private company running basically the affairs of veterans down the road.

I mean, when you say to me "government corporation," that's what coming up scary in my mind. Can we privatize in certain areas? Yes, throughout the government. When it comes to veterans, no. I'm just speaking what's in my mind.

It goes back to my original point or question: why can't we just agree upon certain structures—open enrollment periods and changes we're going to make? And from hearing your answer I guess we could do that but it would probably be a rockier road to do it. If you have the government corporation in place I'm assuming that that, in fact, takes some decisions out of Congress's hands that we may not make, but it still makes me question the need for a government corporation.

We could take the good points of a government corporation and the good policies we could institute but we could have a consensus of agreement.

I guess the problem I see with the government corporation is it sets in an institutional mechanism that probably makes the decisions and takes them out of our hands that we, in fact, still should make, with a lot of debate. I fear it leads to privatization, which would make a different complexion upon how veterans' programs are run.

Dr. WINSHIP. It seems to me, Mr. Ney, that the corporation, as corporation, is really not the issue but that what our colleagues are talking about is using the corporation as a vehicle to provide or to assure the kind of flexibility that is going to be required for the VISNs to be successful, and that makes a lot of sense to me.

Mr. HUTCHINSON. Thank you, Mr. Ney.

Mr. Fox.

Mr. FOX. Thank you, Mr. Chairman. I have a couple of questions and I appreciate the panel's help today.

In following up on Congressman Edwards' line of questioning with the panel, I notice there are some areas of the country where we have hospitals that are quality, and yet some of the beds, because of DRGs and other facts of life, we have shorter visits for patients because of the system. Whether or not we couldn't, following up on the idea of the demonstration grant or departmental activity in a metropolitan area where we don't necessarily have a VA hospital existing—there may be some distance from the location involved—yet we do have a hospital nearby that has unused beds.

Is there any chance we could talk about the possibility of marrying the two? Is that something we ought to be thinking about? Even though we have an existing health care system within the VA, could this be an adjunct to better service for the veteran, as well as using space that's already been paid for presumably through one government or another, to provide quality health care, understanding overall that people are living longer and hopefully living better and we, on this committee, obviously along with you, have our first obligation and interest being the veterans?

Dr. KOLODNER. Congressman, the idea of the VISNs, the idea that we talked about both an integral and a virtual organization, in the instance that you are talking about, what we would expect will happen is that the VISN will look at the needs of the veterans in that area and figure out the best way, the most cost-effective way of delivering those services. And we recognize that one of the major changes that needs to occur is that we need to bring care closer to the veteran.

Mr. FOX. Are we now using private hospitals or public hospitals other than VA for purposes of veterans' service?

(Subsequently, the Department of Veterans Affairs provided the following information:)

VHA provides needed medical services to eligible veterans in non-VA facilities under three very limited authorities. These authorities are fee basis care, contract hospitalization, and medical sharing. Medical services purchased under a VA sharing agreement are most often provided in an affiliated medical school hospital or clinic. In all cases these services are provided outside VA because the needed services are simply not available at a VA facility or in the case of outpatient fee basis care, the service needed by a service-connected veteran was available at a more convenient location to the veteran's home.

Program totals for FY 1995 are as follows:

Contract Hospitalization	$ 83.9 million
Fee Basis Outpatient	$157.9 million
Medical Sharing	$ 56.2 million
Total	$298.0 million

VHA does not anticipate a significant increase or decrease in total expenditures for contract hospitalization or fee basis care for FY 97. Expenditures and revenue received from medical sharing could change significantly in FY 97 due to VHA's transition from a hospital based operation and the proposed legislative changes to existing sharing authority.

Dr. KOLODNER. I don't know the specific instances. I know we do have some sharing agreements with a variety of institutions, including private facilities. We could get you more information.

Mr. FOX. Has there ever been a study to do what I'm talking about on a wider scale?

Mr. BAINE. Mr. Fox, there are areas around the country where VA provides care or pays for care on what they call a fee basis. VA's fee-basis program is essentially a program under which VA pays private providers to care for certain categories of veterans, most notably service-connected veterans.

So VA does have some experience in terms of relationships with private providers, both hospitals and private physicians, physicians' offices, and so forth. So that has been done for a long time. It's just been done on a very small scale.

Mr. FOX. Is there any material you can give to the committee so we can study that for purposes of whether or not it could be expanded?

Mr. BAINE. Yes, one of the options that we included in our testimony had to do with the possibility of expanding the fee basis-like program.

Mr. FOX. I guess the other question I would have would be in terms of the proposed government corporation, what could they be doing in the area of preventive care that could be of benefit to our veterans? Preventive and home-based.

Mr. MANNLE. We did not examine that question specifically during the course of our study. If you go to a full service, what is called in other contexts a continuum of care, then that would include primary care, preventive services, wellness in the traditional meaning of the term. And the question that we were trying to address is for what populations does that make sense?

For everyone who's currently in the system as a result of a special need, service-connected, certainly the VHA, at least in our own personal observations, does a great deal of that already because they take the patient and they treat them as a full service patient.

Whether that concept ought to be expanded to other populations who may or may not come into the system at some point in the future, I think, as several of the other witnesses have talked about, is a cost-effectiveness issue.

There's no question that prevention is cost effective in the overall provision of health care, but whether you're going to be a full service provider for certain populations I guess remains to be seen.

Mr. FOX. It's something that can be explored in the next round of studies?

Mr. MANNLE. Sure.

Mr. FOX. Just taking a page out of the general health book.

Dr. WINSHIP. Mr. Fox, one of the things that's happening in health care at large is that we are finally beginning to move from the traditional system of sick care to a system of true health care, where we are dealing with the health of the population, rather than episodes of illness. The VA is very much caught up in this move, just as are the academic centers, the private centers, the systems, et cetera, that are developing out there in the country. Some of the HMO's are really on the forefront of this kind of activity.

I believe that the VA is going to have to do that, will do that. Whether it's in a corporate system or the system that it already has, that's something that just has to happen and is happening.

Mr. FOX. Thank you very much.

Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Mr. Fox.

Mr. Edwards.

Mr. EDWARDS. No questions.

Mr. HUTCHINSON. Mr. Ney, do you have any more questions?

Mr. NEY. No, thank you, Mr. Chairman.

Mr. HUTCHINSON. Mr. Fox, do you have any further questions?

Mr. FOX. No, I do not. Thank you very much.

Mr. HUTCHINSON. I want to thank the panel for your time and for your testimony and we can be grateful we didn't have votes all morning, anyway. Thank you very much.

The chair calls panel number two to the witness table. Our second panel is composed of Mr. Gordon Mansfield, executive director of the Paralyzed Veterans of America; Mr. James Magill, director of the National Legislative Service of the Veterans of Foreign Wars; Mr. Joseph Violante, legislative counsel of the Disabled American Veterans; Mr. John Vitikacs, assistant director for resource development, veterans affairs and rehabilitation, the American Legion; Ms. Kelli Willard West, director of government relations of the Vietnam Veterans of America; and Mr. Larry Rhea, deputy director, legislative affairs of the Non Commissioned Officers Association.

So I think shifting of panels turned into a rest room break, as well. I think so.

[Pause.]

I thank all of you for being here today. I look forward to your testimony and I would recognize Mr. Mansfield.

STATEMENTS OF GORDON H. MANSFIELD, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; JOHN R. VITIKACS, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; JOSEPH A. VIOLANTE, LEGISLATIVE COUNSEL, DISABLED AMERICAN VETERANS; JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; KELLI R. WILLARD WEST, DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA; AND LARRY D. RHEA, DEPUTY DIRECTOR, LEGISLATIVE AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION

STATEMENT OF GORDON H. MANSFIELD

Mr. MANSFIELD. Thank you, Mr. Chairman, Mr. Edwards and members of the subcommittee. I'd like to thank you for having this timely and pertinent hearing. Perhaps before we look to the future it might be wise to stop and see where we've been.

In the context of the needs of a VA hospital patient, a veteran, a PVA member, what we've seen over the course of the last couple of decades is a downsizing in the number of hospital beds from over 110,000 down to maybe half of that. We've seen a squeeze on appropriations, which have not kept up with inflation. We've seen pressures on the FTEEs in the hospital system. And we've seen a lack of the ability for the system to acquire needed medical equipment, and we've seen a physical plant deterioration.

In the context of where we are right now, we have the Secretary and the Under Secretary for Health, Dr. Kizer working to reform the hospital system. Their plan is to decentralize the health care system, changing its focus, as Dr. Kizer indicated yesterday, to look at what the values of the system are and what many in the veterans service organization community think may be the last best chance to preserve the system.

Some thoughts I have as we look at where we are and where we're going and what the future might bring are first, last and always that the focus has got to be the veteran patient. As we go through all these convolutions, sometimes I get confused whether I'm a stakeholder or whether I'm a customer. I guess the next iteration here, if we get a corporation, to run the system will I become a shareholder or a bond holder.

What my people are looking for is the ability to get timely, appropriate and quality health care, whether it's in a bed or as an outpatient, in a VA hospital or with a sharing agreement.

I think the other thing we need to do is stop and have a review of government responsibilities. In my mind, VA health care is one definite federal responsibility. Providing for veterans is at least one step removed in the Constitution to the congressional responsibility to raise and maintain armies, and to the congressional responsibility to declare and support the waging of war.

Armies and wars create casualties, and casualties create medical need. One way or other, this government, in the process of raising and maintaining armies and navies and fighting wars, has been undoubtedly the best country in the world in taking care of its veterans. I think it would be a shame if we lose that position.

The other point I want to make is no matter what might be going on in the political arena, the government is not a business. The government is not a business.

I think, in looking to the future, what we need is to have this subcommittee and the full committee reaffirm that veterans are going to be taken care of, as promised in the statutes and regulations. And, as a consequence of that, this Congress has to provide the funds or the ability to raise funds to do so in a timely and quality manner.

The VA needs to reaffirm that the veteran patient is the primary focus of its effort, not its own bureaucracy or medical schools or research or congressional employment programs. The veteran has got to be the focus.

I would suggest to you that when the Secretary and the Under Secretary for Health Care come down here, when the veterans service organizations representing the veterans come down here to Capitol Hill, and all of them say, one way or another, that eligibility reform is needed to make this system work better, that Congress needs to act. That's a fundamental concern.

And I would make the point that while we are sitting here talking about the future, and whether it's 2010 or 2020 or 2000 whenever, failure to act in 1996 on eligibility reform is going to affect where we're going to be from here on out.

Mr. Chairman, PVA has been involved in some futuristic activities in the preparation of and presentation of our vision for the future of VA health care or "Strategy 2000," "Strategy 2000, Part 2,"

and a new project called "Horizons." I would suggest that no matter where we're going or what we're doing, there are some principles that remain constant in each of these long range planning documents.

The special programs, such as spinal cord injury, must remain the core reason for the existence of a Veterans Health Administration. The continuity of care that's been mentioned here is something that needs to be paid attention to. Long-term care, as we've heard, is something that we have to focus on. Quality care and timeliness of care, also.

If these requirements are met, then the VSOs will work with Congress and the department to find the best way to do the job.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Mansfield appears on p. 168.]

Mr. HUTCHINSON. Thank you very much.

Mr. Vitikacs.

STATEMENT OF JOHN R. VITIKACS

Mr. VITIKACS. Mr. Chairman and members of the committee, the American Legion appreciates the invitation to testify at today's hearing.

Mr. Chairman, the future role of the VA health care system is a national policy matter. The VA health care system must be improved because it will not survive with only minimal reform, and the status quo is unacceptable. This subject merits an open and honest discussion, with the development of a strategic plan that we can all support.

The current missions and roles of the VA have evolved over the past 50 years. The reality today is that most veterans find obtaining health care from VA to be an extremely complex and difficult exercise. The system is hampered by so many restrictions, exclusions and limitations that only a small number are eligible.

Those that do get in often find that the VA will not treat all of their ills, just those that qualify. There are many reasons for these Catch-22s but the main reason, Mr. Chairman, is a lack of funding.

The American Legion's vision of VA health care in the 21st Century is contained in the GI Bill of Health. This proposal will expand VHA's patient base and increase its funding through new revenue sources. For the past 50 years, the primary constraints placed on VA health care have been artificial funding limitations. The GI Bill of Health will not only reform current eligibility criteria, but will also improve and reinforce the current appropriations process.

Mr. Chairman, in addition to its many inherent problems, the VA health care system has many assets. The VA has been described as both a national asset and a second rate health care system. For too long, VA has not received the resources necessary to carry out its increasing congressionally imposed and too often unfunded mandates. Yet VA continues to treat more patients, provide high quality medical care, educate and train medical professionals, and pioneer new medical programs and research technologies, among many other accomplishments.

The GI Bill of Health recognizes the necessity of generating additional VA health care funding to complement the current federal appropriations process. The plan not only addresses the challenges

of shrinking resources but the growing changes in the practice and delivery of health care services.

The GI Bill of Health incorporates the recommendations of the Commission on the Future Structure of Veterans Health Care that released its findings in 1991. The four themes of the commission's findings—improving access, financing the future, restructuring the system and enhancing the quality of care—are incorporated into the GI Bill of Health.

The American Legion believes that any VA health care reform proposal that does not allow VA to retain third party collections, including Medicare payments, and thereby increasing its funding base and reducing its sole reliance upon federal appropriations, will be incomplete. Included in this scenario would be a provision that allows veterans' dependents and category C veterans access to VA health care through a health insurance program.

The GI Bill of Health avoids the funding pitfalls of current law. One of its main features calls for opening the VA to all veterans and includes a plan for financing nonmandatory care and making VA solvent so it can effectively and efficiently serve all veterans for generations to come.

In essence, the GI Bill of Health will change how care is provided, who receives care, and how it is paid for. The American Legion is currently promoting the GI Bill of Health and hopes to have it introduced as legislation.

Mr. Chairman, that concludes my statement.

[The prepared statement of Mr. Vitikacs appears on p. 174.]

Mr. HUTCHINSON. Thank you very much.

Mr. Violante.

STATEMENT OF JOSEPH A. VIOLANTE

Mr. VIOLANTE. Thank you, Mr. Chairman and members of the subcommittee. On behalf of the more than 1 million members of the DAV and its auxiliary, I'm pleased to present our views on the future of VHA.

While it is useful to keep in mind how future changes in VHA will impact upon local communities, physicians, nurses and technicians, researchers, universities and medical schools and suppliers, we must never forget that the VA health care system was established and is there for the sole purpose of taking care of the medical needs of our country's sick and disabled veterans.

It is our firm belief, and the bottom line, that the needs of the sick and disabled veterans must be paramount when the future of the VHA health care delivery system is considered.

All of us interested in preserving a viable health care delivery system acknowledge change is required. Frankly, a radical change is needed. The entire movement screaming for reform of VHA is motivated by a singular recognition that it has been an ineffective, inflexible health care delivery system. However, this is not exclusively the fault of the VA.

While some of the inefficiencies and inflexibility aspects of the health care system have been eradicated by the reorganization of VHA into 22 VISNs, more needs to be done. As we've previously stated in testimony, we believe in and endorse the concept of

VISNs. We are optimistic for VISNs success and eager for it to make the necessary changes to bring VHA into the 21st Century.

As DAV looks to the future, we believe the VA will be faced with a number of unique challenges. It is extremely important that VHA be prepared for these changes. It is of paramount importance that these changes not adversely impact upon the sick and disabled who use the system. In my written testimony I've indicated what those challenges are and I will not go over them here again.

Mr. Chairman, we believe that there is a viable plan that will assist VHA in caring for veterans in the future. The proposal in the 1996 *Independent Budget* ensures comprehensive medical care for service-connected disabled veterans and allows other Category A veterans, including catastrophically disabled veterans, to be treated in the most appropriate care settings, provides greater access to veterans who are eligible on a discretionary basis, and would authorize VA to collect and retain third party payments, including Medicare, from certain veterans and their dependents.

We believe these initiatives are imperative to creating the appropriate balance in VA's health care delivery system.

Mr. Chairman, the VA health care system must be given the legal authority to make necessary changes we all support. Current laws contain disincentives to change by restricting treatment options available to certain eligible veterans or requiring they first be hospitalized. In many cases, this is not the most economic or preferred treatment setting.

These law changes cannot occur without the leadership of this subcommittee. The issues addressed by the *Independent Budget* will only be realized through this subcommittee's support and the support of the full committee.

As you know, there is remarkable agreement among veterans service organizations on the direction that these changes must take. We also appreciate this subcommittee's leadership on the issue of VA health care eligibility reform. We support, as a good first step, H.R. 3118.

Mr. Chairman, I'm extremely troubled by the fact that the vast majority of the witnesses appearing here before this committee yesterday and today, including the VA and members of Congress and others, believe that health care eligibility reform is necessary for the VA to survive in the future. And most of us believe that CBO's cost estimates are way out of line.

Yet here we sit today with our hands tied, unable to do anything more to move VA forward. It is unbelievable to think that one agency's nearsightedness could cripple a plan to improve the VA and save American taxpayers tax dollars. And Congress is unable to resolve this impasse, even with bipartisan support and the support of the major stakeholders. This is unconscionable. Congress must not let this impasse continue.

Mr. Chairman, the DAV is certainly not wed to the current system. If eligibility reform, as described by the IB, or as contained in H.R. 3118 occurs, and as the VA continues to implement its field reorganization and the veteran population declines as predicted, we believe a close hard look at the VA's physical plants should be undertaken.

The DAV is not automatically opposed to looking at the system with an eye towards major changes. There is little doubt that these changes need to occur. However, it cannot be done prematurely, nor nearsighted.

Mr. Chairman, I would conclude my testimony with these major themes. VA must remain an independent system and be the responsible federal provider of care to eligible veterans. A voucher system that mainstreams VA care must not occur.

Eligibility reform, as proposed by the IB or in H.R. 3118, must proceed rapidly. No service-connected disabled veteran should have their priority to health care benefits diminished or terminated. Appropriate changes and alternatives to the existing physical plant of VA must be made in a reasonable, strategic process. And a bottom line mentality must not be the driving force for reform of VA's health care system.

Mr. Chairman, this concludes my testimony and I'd be pleased to respond to any questions.

[The prepared statement of Mr. Violante appears on p. 177.]

Mr. HUTCHINSON. Thank you, Mr. Violante. We certainly share your frustration with CBO on a bipartisan basis. Our committee is as frustrated as you are.

Mr. Magill.

STATEMENT OF JAMES N. MAGILL

Mr. MAGILL. Thank you. As we have learned today and we've known in the past, VA is being faced probably with its most challenging time. VA knows it must change and we're happy to see that VA is changing.

Dr. Kizer, as we're all aware, is now in the process of implementing the VISN plan. VFW has the highest regard for Dr. Kizer. His dynamic leadership is having VA move away from the status quo, which we all agree it must do. But we also recognize that the jury is still out on the VISN plan.

Without the total support of Congress through legislation that would grant VA more management authority and, of course, with the proper funding, we can see that the plan is really nothing more than just shuffling the deck chairs on the Titanic. Without the support of the Congress, the VA health care will only be put on what can be a equated to life support, awaiting the cure for what could be a terminal illness. I think we all agree that everybody must be patient and let the plan work.

It's no secret, of course, that the veteran population is on the downswing, but I'm happy to hear that people are finally realizing that the veteran patient population is increasing. Veterans are coming to VA with more complex illnesses and, of course, this takes more time to treat. VA must be prepared for this long-term care.

We believe, as has been mentioned by the people on this panel, that eligibility reform is the answer to VA's role in the future. We've appeared before this committee numerous times espousing what we believe is eligibility reform, and so I won't go into those things now.

Just in a nutshell, of course, getting away from the inpatient mode to the outpatient is essential. Third party is essential, too.

The independent budget that was just recently released is a blueprint for that and we, of course, encourage the committee to review our recommendations.

In closing, I would just like to mention two things. We've heard government corporation here today. I agree with Congressman Ney that this sort of scares me a little bit when we're talking about treating our Nation's veterans in a corporate setting.

We know change has to come about, but I think the bottom line is what is the purpose of change? It should be for better health care. It should not be for economic reasons.

This concludes my statement and I'll be happy to respond to any questions.

[The prepared statement of Mr. Magill appears on p. 182.]

Mr. HUTCHINSON. Thank you, Mr. Magill. I think when it came to the government corporation suggestion in the report, the whole purpose of these hearings was to put some new things on the table and to kind of prompt our thinking, and maybe that scares all of us.

As Chet has said a number of times, we don't necessarily agree with all the testimony. I think it's been productive to hear a lot of the ideas that are out there right now.

Thank you for your testimony.

Ms. West.

STATEMENT OF KELLI R. WILLARD WEST

Ms. WEST. Good morning, Mr. Chairman and Mr. Edwards. VVA appreciates the opportunity to discuss one of the most complicated and critical issues facing American veterans today.

Veterans health care reform has long been a matter of deep concern to the veterans community and to Congress. The goals are admirable, aiming to enhance government efficiency, create less reliance on federal tax dollars, and last, but not least, improve services to our Nation's veterans. Certainly the veterans community, as hard-working tax-paying citizens, shares the goals of making VA a more efficient, responsive health care provider.

The problems of obscure eligibility rules and inefficient resource allocation continue to be a burden on the very veterans this system was designed to serve. Significant changes must be implemented, both administratively and through legislative remedies.

As a single generation organization representing Vietnam Era veterans, VVA has a unique perspective on VA health care. Vietnam veterans represent currently the largest subgroup of the veterans population and are only now approaching middle age. Many Vietnam veterans have spouses and family members who need improved access to affordable health care, as well.

A 1995 VVA convention resolution calls for legislation ensuring that all veterans and their families have access to health care coverage meeting minimum requirements, which is provided at a reasonable cost to both the veteran and his or her family.

We favor the concept of caring for veterans' dependents within or through the VHA system with affordable cost-sharing and copayments which could then be reinvested by the system into improvements and more care for the core group veterans. The issue of Vietnam veterans spina bifida-afflicted children may pose an interest-

ing test for the issue of caring for veterans' dependents within the system.

Like many of our colleagues, VVA hopes that some measure of eligibility reform can be accomplished during the 104th Congress. This would serve as an important complement to Dr. Kizer's reorganization efforts. By improving VHA programs to enhance efficiency, it is hoped that more benefits could be provided to more veterans within the same allocation of federal tax dollars.

VVA favors an incremental approach to veterans eligibility reform for two reasons. In theory, an incremental approach should address the inflated CBO cost estimates, which have thus far inhibited more comprehensive reforms. Also, an incremental approach should provide VHA with time to adjust to the changing dynamics of health care delivery, time that will be critical as the evolution of a large system is not easy.

We believe the provisions of Chairman Stump's bill that were passed by this committee in H.R. 3118 represent a pragmatic approach to an uncertain demand for VHA services and volatile budgets.

We look forward to full implementation of the VHA reorganization with a great deal of hope, but also some apprehension. We're pragmatic about the changes that must occur and have supported Dr. Kizer's reorganization. But, at the same time, we're somewhat concerned about protecting VA's core mission in a private sector modeled health care system.

The emphasis on capitated budgeting and managed care practices may be a good method of moving the VA health system into more modern practices of medicine; however, we all know that private sector managed care providers attempt to preclude patients from seeking specialized services.

The veteran population is generally older and sicker than mainstream managed care patients, and veterans using the VA often have very unique needs for specialized services. Care must be taken to ensure that access to VA's specialized programs are protected. In most cases private sector substitutions to these services just simply don't exist or the quality is inferior.

A number of recent calls from VVA members around the country have raised concerns in this regard with relation to inpatient PTSD and substance abuse programs. We have raised these concerns to Dr. Kizer and I've detailed them in the written statement, as well.

When examining how to create new VA outpatient access points, the unique community-based vet centers are a distinct asset. The benefit of coordination already being done by vet centers and VA medical centers around the country will be critical to VA's expansion to outpatient and primary care access points. The vet centers essentially are a ready-made model in which to expand outpatient care.

In closing, I'd like to comment on the role VA plays in providing care to nonservice-connected, low income veterans. This is an important mission which should continue into the foreseeable future. We see appallingly high statistics of veterans among the homeless. One third of the Nation's homeless are veterans.

A recent VA study of hospitalized veterans showed that 23 percent had been homeless at the time of their admission and an addi-

tional 7.4 percent were at risk of becoming homeless after discharge. Without VA, many indigent veterans would have no access to health care services at all.

We look forward to working with you, Mr. Chairman, and the committee to achieve a more efficient, accessible and enhanced quality health care system for American veterans. This concludes my prepared statement and I'll be happy to answer any questions.

[The prepared statement of Ms. West appears on p. 184.]

Mr. HUTCHINSON. Thank you for your testimony.

Mr. Rhea.

STATEMENT OF LARRY D. RHEA

Mr. RHEA. Thank you very much, Mr. Chairman, and good afternoon to you and Mr. Edwards. It's a pleasure to see you both again. As always, the Non Commissioned Officers Association is grateful to have any opportunity to discuss veteran health care and we appreciate your including us in the line-up of witnesses at this hearing.

At the onset, Mr. Chairman, NCOA wants to direct our comments to you personally. The association realizes that the topic of the hearings today and yesterday have been the future of VA, but what we want to see initially deals with your future. Not knowing how many more opportunities we will have to sit before you in your capacity as chairman of this subcommittee, we certainly want to take this occasion to express publicly our deep and sincere appreciation for your efforts during this Congress.

NCOA believes that you would probably be the first to admit that much remains to be accomplished but it is our sincere hope that what remains to be done does not diminish your personal evaluation of what you have done. In NCOA's view, you have accomplished a great deal and we are grateful for that.

We're also thankful for the continuous and candid dialogue that you have maintained with veterans organizations. Those discussions have been helpful at the very least, and I believe, as you indicated yesterday, to dispel the notion that VSOs are a horrible bunch to deal with and clearly those discussions have moved the dialogue forward, and I believe these hearings are evidence of that.

In addition to our thanks, we extend to you our best wishes, and that's neither a paid nor an unpaid political endorsement.

Mr. HUTCHINSON. Thank you.

Mr. RHEA. As indicated in our prepared testimony, a lot of the visionary and futurist things that were the topic of this hearing, we chose to leave some of that discussion to the experts in those fields, particularly on such matters as the rapidly changing medical practices and the emerging technologies and things like that.

But for the purposes of our oral comments, I would like to address a couple of the points that were made yesterday. I believe it was Mr. Edwards who, in remarks at yesterday's panel, said that change is a given. He went on to say that the question now is how medical care will be provided in the future, not whether it will be provided.

NCOA has no quarrel with that assessment given by Mr. Edwards. In fact, we believe you're absolutely right, but we would

suggest to you that there is an another important part in that assessment that deserves comment.

As an association, NCOA believes Congress will continue to care for veterans. The thought of Congress abrogating its responsibility to veterans with service-connected disabilities is something that this association believes will never happen. That's the association's view.

Don't overlook, though, Mr. Chairman and Mr. Edwards, the perception that there's a lot of veterans out there who think that their care is going to be taken away. There was discussion earlier this morning about a cultural attitude that we've seen change within VA. There's also a perception thing that you're going to have to deal with as you look to the future in VA, and certainly don't overlook that.

When you talk of change, whether it's change in eligibility, change in the way care is delivered, or in converting a hospital to an ambulatory clinic, the fear that somebody is going to lose is inevitably heightened. So as you look to the future, don't overlook those perceptual sorts of things that you're going to have to deal with.

We also want to comment on two other points that were made towards the close of yesterday's session. Mr. Chairman, I believe you asked the witnesses yesterday to give the two or three most important things that could be done right now to improve the VHA. Among the answers were eligibility reform and I believe it was Dr. Kizer that said enhancing partnerships and sharing agreements.

Honestly, Mr. Chairman, when we approached this hearing we had no intent of replowing the previously tilled ground of eligibility reform but inevitably, when we talk about the future of veterans health care, that nagging malady still comes around. And that's certainly not a criticism at you or any member of this subcommittee.

But one point that was raised yesterday suggested that if we could not overcome CBO on H.R. 3118 that the subcommittee should consider a simple piece of legislation to maybe suspend some of those eligibility rules and simply tell the VHA that they can deliver health care in the most appropriate manner, using common sense.

That suggestion seems reasonable to NCOA and this association would support that as a fall-back position, if H.R. 3118 cannot be enacted. And on that suggestion, I don't know what hurdles CBO could place in our path on that but we would not understate their creativity over there. This association was one of those who believed that H.R. 3118 was cost-neutral.

But not only did Dr. Kizer list eligibility reform; he commented on partnerships and sharing agreements. And I see I've got the red light but I'm just going to have to insist that I make this point, Mr. Chairman. Certainly partnerships and sharing agreements are something that NCOA has supported, and we will always continue to support.

As you know, NCOA's membership is diverse. It includes veterans and it also includes military retired veterans. I shouldn't have to make that distinction, but it's necessary for reasons that this association made clear in its prepared testimony.

Under present law, DoD and DVA are authorized to share resources and they've done a pretty good job of it. They've benefitted the recipients of care and it's been a savings to the taxpayer.

But under a recent memorandum of understanding between DoD and DVA which recognized VA as an authorized provider for the CHAMPUS program, they require military retired veterans to meet cost-sharing deductibles and make copayments to the VA for treatment received under sharing agreements.

And under current law, DVA routinely waives copayments from other nonservice-connected veterans, even when third party insurance is involved. Even DoD does not charge veterans for care they receive in military facilities under the sharing agreements. Only the military retired veteran is required to bear such a burden. And as a matter of equity among veterans, NCOA believes this is a practice that is fundamentally wrong and should be discontinued.

So in saying this to you, Mr. Chairman, and as you look to the future, partnerships and sharing agreements offer great potential. But as you further explore this area, and in addition to looking at how DoD can help VA, look at the other side of the coin or, as you say, outside the box on this one, also look at ways VA can help the military retired veteran and their beneficiaries. Military retirees are veterans and they, too, served under a pretty clear and explicit promise.

And just briefly in closing, this hearing is about vision and NCOA wants to be on record as saying that this association believes that VHA has visionary leadership. In NCOA's view, Dr. Kizer is the right person at this critical juncture in the transition and the veterans of NCOA consider it indeed fortunate to have him right where he is.

Thank you and I apologize for going over my time.

[The prepared statement of Mr. Rhea appears on p. 199.]

Mr. HUTCHINSON. Mr. Rhea, I think that you knew, after all those nice things you said, I wasn't going to cut you off.

Mr. RHEA. I was counting on that.

Mr. HUTCHINSON. Thank you for the testimony and I think your cautions to us as a committee and to Congress were very appropriate, as well.

Mr. Vitikacs, let me just ask a couple of questions. I know the hour is late and I'll try to be very brief.

On the American Legion's GI Bill of Health, this is a very, very bold, some would say grandiose, plan. Has the organization estimated the amount of money that it would take to improve the VA's health care facility infrastructure to make the system competitive with the private sector, which would, of course, be necessary under the plan? Do we have any cost estimates regarding that kind of infrastructure improvement?

Mr. VITIKACS. Assuming that most infrastructure improvement would need to occur in the ambulatory care facilities, the previous panel this morning—there was a question that was addressed to them on dependence of veterans and does the VA have the infrastructure capacity, as well as the staff expertise, to provide care to children dependents of veterans.

Our bill does not presume that VA would provide those services in-house. We look at that as a contractual arrangement where VA

would not be able to provide those services. We do not recommend that VA institute those services in-house, as well as for, say, female dependents of veterans.

Where there is capacity, where there is expertise, that service would be provided in-house. Where it does not currently exist it would not be built up within the system. It would be a contractual arrangement for those services.

So we really believe that when you would be bringing in additional veterans, the bed capacity already exists in VA. There's been thousands of beds closed over the past several years. So we don't see that there would be any need for infrastructure improvements on the inpatient side of the house. And if the trend is going to be moving towards ambulatory care services in VA, with or without a substantial expansion of the patient base, we think this is going to occur even without a substantial expansion of the patient base.

So therefore, the cost of increasing facility construction, renovations, modernizations would not be significant, in our opinion, over and above what VA will undertake anyway.

Mr. HUTCHINSON. I think——

Mr. VITIKACS. A long answer to a short question.

Mr. HUTCHINSON. I appreciate your answer. I think an awful lot of people who are studying the plan and looking at it would question the ability of the VHA to attract large numbers of veterans without offering a full range of services. If I heard you correctly, you were saying basically they wouldn't have to offer that full range of services and yet would still be able to attract large numbers of veterans.

Mr. VITIKACS. In particular. In particular. As VISNs is moving forward with its facility mission, identification, review and changes within existing facility missions, I'll just make the presumption that VA would expand its population base by 10 to 20 percent over a period of 3 to 5 years under the GI Bill of Health.

The mission changes that are now occurring, if there is an expansion of those veterans who choose their care in VA, now VA will have several options in how to provide that care. One of the options is going to be in-house, with in-house capability and resources. Another option is going to be through expanded contractual and partnership sharing arrangements, which is one of the goals of Dr. Kizer's VISN reform right now.

So there will be various options on how to provide those services.

Mr. HUTCHINSON. Aside from the services, other issues have been raised concerning the ability to attract veterans without amenities comparable to what is offered currently in the private sector, like television, carpets, telephones, single rooms, all the kinds of things that are normally expected in the private sector that would be upgrades and improvements in many of the VA facilities. Those issues have been raised, as well.

One of the estimates, and there are a lot of issues I guess we could talk about as we look to the future and I'm trying to keep a very open mind concerning the Legion proposal, but one of the estimates done, my understanding is in-house, found that the average monthly premium for an insurance plan under the Legion proposal would be $476 a month assuming a minimum enrollment of

at least a million veterans, while the most expensive FEHB plan, which is the envy of the Nation, is about $293 a month.

So it seems to me that there are going to be some major issues that have to be addressed as the proposal is examined in the future and as CBO comes in, hopefully in the future, with a formal cost estimate.

Let me just say before I yield to Mr. Edwards that while I have tried to keep an open mind concerning the Legion plan, it wasn't too long ago that we met—I say we—myself, Mr. Montgomery, Mr. Stump, Mr. Edwards—with representatives of major VSOs, pleading, asking, begging for their support on H.R. 3118 and a small step but yet a very important step on eligibility reform. And I think we have seen over the last 2 days how critical eligibility reform is for the future of the VA and the great obstacles that we face with the Budget Committee and with CBO in accomplishing that in this Congress.

So for the most part, I would say thank you to the VSOs for their strong work and great efforts to bring that about. It is with disappointment that the Legion, I think, has taken a position, to put it mildly, lukewarm, if not, in some articles, in active opposition to the proposal. And with the obstacles that we face in moving forward H.R. 3118, it makes that job that much more difficult without a absolutely unified stand with the veterans service organizations.

With that, I will yield to Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Chairman.

Let me first thank each of you individually and the organizations you represent for what you've done for many years, long before Tim and I were here in the House, for veterans and veterans health care. Clearly, if it had not been for you and your organizations, the veterans of America wouldn't have the health care that they do have today, despite its shortcoming.

For the record, perhaps in a written response, I'd like to ask each of you if you could fairly briefly summarize your response to proposals we heard yesterday, one being let's consider putting the VA health care system on an HMO basis and sell off our assets. The other would be to take the money we spend in the VA budget each year for health care and provide vouchers for veterans.

I think those are ideas that to the average layman sound very attractive initially. When you have someone testifying that gosh, in California it only costs $100 a month per participant, again, to the average taxpayer, if they see that in an article somewhere, he's going to say, "My goodness; there's the government wasting my money again."

I think it would be helpful to me and others on this committee to have your written responses, again, as brief or as long as you want to make them, so that we can respond to some that might suggest that's a panacea.

And perhaps there are some ideas within managed care that we can use to improve the VA system, but I think we need a response to what might be, from some, a simplistic approach to taxpayers, through articles and speeches, that we ought to just totally dismantle the VA system with a simple voucher or a simple HMO, we could solve all the world's problems for our veterans, which, I think, is a simplistic approach.

Let me follow up in a bipartisan manner to the chairman's comments on H.R. 3118. Mr. Vitikacs, I'd like to direct my questions to you, if I could. I have in front of me the June 13 Dispatch article written by Ken Scharnberg where he says that H.R. 3118 could be—"It might just as easily be named the VA Health Care Liquidation Bill."

Could you explain to me, do Mr. Scharnberg's views represent the views of the American Legion? Could you explain to me are those his personal views? Are those the views of the American Legion Magazine? Can you give me some context as to the meaning of that statement coming from him?

Mr. VITIKACS. Mr. Edwards, I anticipated that question this morning. Mr. Scharnberg writes—he's based in Indianapolis, Indiana at our major headquarters location there and he writes for a publication called The American Legion Dispatch, which is a biweekly publication with an extensive mailing list of recipients. And the Dispatch's primary purpose is to disseminate information to our membership in a timely manner on a broad range of Legion programs and activities.

The protocol for having articles published in the Dispatch, when someone who's based in Indianapolis is writing on a program that is operated out of our Washington office, the protocol is for a draft of that article to be sent to our Washington office for review, comment and for concurrence. This would be accomplished at the level of our director of legislative affairs, as well as the director of our veterans affairs and rehabilitation program.

This did not occur with this article. Had that article been sent to our Washington office for review, comment and concurrence, I can assure you that the article would not have been published in the manner that it was published.

So that is the whole truth to that issue. It is under review at this time, if there was a misunderstanding, if he had sent the article in and he believed that somebody reviewed it. But it's very succinct that there is a process in place where I or the director of the legislative affairs division would sign off on that article, which we did not in this case.

So it does represent his personal views, not the organization's views.

Mr. EDWARDS. And he is the editor of the American Legion Magazine; is that correct?

Mr. VITIKACS. No, sir, of the Dispatch publication. It is a different publication, separate and distinct from the American Legion Magazine.

Mr. EDWARDS. In the Dispatch, at the very end of the article, it says "Ken Scharnberg is veterans affairs editor of the American Legion Magazine."

Mr. VITIKACS. Well, maybe he's received a recent promotion. I do not know.

Mr. EDWARDS. I hope it wasn't based on this article.

Mr. VITIKACS. It might be a demotion now.

Mr. EDWARDS. Well, I appreciate your comments on that. We have staff and processes and things sometimes slip through the cracks.

I had the same impression that Tim did, that we made a good faith effort to meet with all of you before we decided to push H.R. 3118 and I don't think the Legion ever indicated it would be out there cheerleading for the bill, but I never, in my worst nightmare, would have thought that someone in such a position with the Legion would write an article for the Dispatch which you said, in your words, had an extensive mailing list, calling this the VA Health Care Liquidation Bill.

I know Mr. Montgomery would be disappointed to hear that he was, after so many years of dedicating himself to veterans, was part of trying to liquidate the VA health care system.

But again, I know things fall through the cracks and veterans fought for people to have the right to have their own views, so I even respect somebody's views.

I guess my question would be is there some sort of effort to make it clear to the extensive mailing list that's received this by now that these were not necessarily the views of the Legion?

Mr. VITIKACS. Mr. Edwards, I would be able to provide an answer to that question for the record. At this time I do not know what is occurring with that issue.

Mr. EDWARDS. Because you did say the Dispatch has an extensive mailing list. Is that correct?

Mr. VITIKACS. Yes, sir.

Mr. EDWARDS. I assume that goes to veterans leaders throughout the United States?

Mr. VITIKACS. That is correct. There certainly could be a follow-up retraction or modification of the tone of that article.

Mr. EDWARDS. And it goes out biweekly?

Mr. VITIKACS. Yes, that's correct.

Mr. EDWARDS. Because I would hope, if you decide to try to have some sort of response to this, it's done quickly because I assume the kind of people that receive this publication are veterans leaders and they will be talking to other veterans and you get this out in the public and who knows. It's like toothpaste, trying to get it back in the tube once it's gotten out. It's a lot easier to keep it in the tube.

I guess my real problem with the article is not that someone doesn't have the right to express—we all wear two hats here together, you and the two of us together. On one hand, we want to fight for what we believe veterans should have and have the right to receive in terms of medical care, and that needs to be fought in elections. It needs to be fought in the Budget Committee.

Then the other hat we all wear is given the certain size of the pie, all of us together have to try to figure out how to take those limited resources and use them to best help veterans.

And what really bothers me is not his right to have an opinion but I think this article is blatantly misleading and, in some ways, totally inaccurate. One of his attacks on the bill, it says one phrase pretty well sums up the bill's shortcomings. It would "enable VA, within appropriations, to provide all needed hospital care and medical services to eligible veterans."

I don't know if Mr. Scharnberg wants to change the Constitution of the United States to where the VA discretionary programs don't

have to operate within appropriations, but my understanding of the Constitution and the law of this land is that's the law of the land.

And to suggest in an article going out to veterans leaders that somehow, by saying this bill will operate within appropriations somehow hurts veterans, which he later implies, is, to me, either a purposeful misleading of veterans or a real lack of knowledge of the process. I have a hard time believing Mr. Scharnberg doesn't understand that we operate within the limits of the appropriations process on discretionary programs.

And the other point that I have great concern with, and please correct me if I'm mistaken, but he says in here that for the first time, Congress is proposing that service-connected veterans be treated on a space resource-available basis. That makes it sound like we're taking a huge step backwards, compared to present law.

It's my understanding, from what I hear from staff, that is simply not true. It's simply not true.

So it's not so much as the right to have an opinion that bothers me because again, that's what our veterans fought for people to have the right to express, but just the facts appear to be inaccurate.

Again, I don't mean to belabor the point because you expressed that this wasn't reviewed by the Washington office and gosh knows, if I had to defend myself before a committee hearing every time I made a mistake in sending out a letter or something that wasn't absolutely accurate, I'd spend all my life in hearings.

So I don't mean to belabor it for that purpose but because of the importance of the American Legion and because of the large mailing list that receives this, because those people are veterans leaders, I would certainly not presume to tell you what the American Legion should do, but I'd certainly hope that somehow there's a way to correct what I think are the inaccuracies in this article.

Thank you for your response and hopefully this will be a moot point in the near future.

Mr. VITIKACS. Just to follow up, I can't answer for Mr. Scharnberg. And the organization, as we stated earlier, neither actively is endorsing H.R. 3118; nor are we actively opposing H.R. 3118, and that remains our position.

Mr. EDWARDS. So it is your position that H.R. 3118 is not a barrier to passing your health care reform bill. Is that correct?

Mr. VITIKACS. That is correct. As our previous discussion emphasized, we believe, and this is previous to today, we believe that H.R. 3118 does fall short on the revenue side. I mean, we have been given certain assurances by Chairman Stump that this is not the end of the process of bringing VA into the 21st Century.

Mr. EDWARDS. Absolutely.

Mr. VITIKACS. And we accept that. And so we feel that the GI Bill of Health will be able to build on H.R. 3118 if H.R. 3118 is passed in the 104th Congress.

Mr. EDWARDS. Thank you for your position. That was my understanding of the Legion's position——

Mr. VITIKACS. That is correct.

Mr. EDWARDS. I respect that and appreciate your response to my questions. Thank you again and I thank all of you for what you do on a week-in, week-out basis to help our veterans.

Mr. NEY (presiding). Any other questions? [No response.]

Also I'd like to thank you for everything you do for the veterans or our country.

I'd like to thank everybody who's testified today. And also at this time I want to extend a special thanks to Doug Dudevoir. Stand up Doug and identify yourself. Doug is a graduate student intern on the subcommittee. He played an important role in putting the hearing together as part of his masters program in health care economics at George Washington University. So I want to thank everybody.

[Whereupon, at 12:42 p.m., the subcommittee was adjourned.]

APPENDIX

Statement of Chairman Tim Hutchinson
Hearing on the Future of the Veterans Health Administration
June 26 and 27, 1996

The Subcommittee meets today as part of its responsibility to oversee and assist Veteran's Health Administration as they plan for the development of a revamped health care delivery system in the 21st century. The objective of these hearings is to examine various possible futures for both health care delivery in general and health care delivery within VHA. To assist us in this examination we have drawn upon a diverse group of experts, each of whom brings a different perspective on health care.

The confluence of rapidly changing medical practice, medical technology and health care delivery system theory has created the most dynamic period of change the health care industry, both public and private, has ever experienced. In this rapidly changing environment, Dr. Kizer has taken on the Herculean task of reorganizing VHA. I applaud the efforts of Dr. Kizer to lead the VA into the 21st Century through his "Prescription for Change."

As all of you are aware, we currently spend billions of the taxpayers dollars for care to be provided in the future, such as investments in technology and fixed facilities; it is imperative that we not only have an organization that can adapt to the future, but that we have a VISION OF THAT FUTURE. We cannot make the claim that the future is too difficult to predict but then commence to appropriate billions in support of that undefined future.

To assist us in this examination today we have drawn some of the most forward thinking organizations and experts in the country. These are individuals who think outside the box of traditional health care. Some of these futurists have already designed specific futures for VHA. Others have developed scenarios which are now being played out in the private sector. Other witnesses will provide a future vision based on historical experience from within the VA. Tomorrow, we will examine the Department of Defense as it attempts to define its health care role in the next century and examine the work of management consultants who have looked at the VA within a quasi-governmental context. And, lastly we will hear from the Veterans Service Organizations, who can provide us with the most important perspective, that of the veteran patient.

OPENING STATEMENT
REP. CHET EDWARDS
HEARING ON THE FUTURE OF THE VETERANS HEALTH ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
JUNE 26, 1996

Mr. Chairman, in one sense we examine the future of the Veterans Health Administration every year when we review the Administration's proposed budget. But it has been several years since this Committee last formally reviewed this subject independent of the budget, and it is timely that we do so.

I commend you for scheduling this hearing and for assembling such an impressive lineup of witnesses. Understandably, they don't all agree on how best to provide health benefits to veterans in the future. But I believe they would agree that health care is among the most dynamic, rapidly changing sectors in our society, and that further dramatic change is inevitable. We should expect breakthroughs in such areas as medical technology, drugs, computer applications, and surgical technique. Yet we can only speculate on how dramatic that change will be, and

what our nation's health care delivery system will look like in another ten or 15 years. Yet we must plan for change to be prepared to meet the needs of our veterans.

In that regard, we can't talk about the future without acknowledging the dilemmas of VA health care budgeting. While Federal health care spending on Medicaid and Medicare have risen dramatically, VA budget increases have been much smaller. Some of my colleagues will remember that one of the most daring ideas to emerge from this Committee's discussions three years ago on national health care reform was then-Chairman Montgomery's proposal to provide VA with a guaranteed, fixed payment for every veteran who seeks care from VA. That idea is very pertinent today because of the projected squeeze on domestic discretionary spending. I welcome the witnesses' views on that funding proposal, and on how VA can plan effectively for the future without any formula for projecting the size of its future budget.

Mr. Chairman, I do have concern about some of the testimony I have read, as it relates to keeping faith with our commitment to our veterans. But we can all profit from a healthy exchange of views, and I look forward to this important discussion and debate.

THE HONORABLE MICHAEL BILIRAKIS

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
JUNE 26, 1996

"FUTURE OF THE VETERANS' HEALTH ADMINISTRATION"

THANK YOU, MR. CHAIRMAN.

FIRST, I WANT TO COMMEND YOU FOR SCHEDULING THESE TIMELY HEARINGS ON THE FUTURE OF VA HEALTH CARE. I MAY NOT BE ABLE TO ATTEND TOMORROW'S HEARING BECAUSE OF A SCHEDULING CONFLICT WITH MY HEALTH AND ENVIRONMENT SUBCOMMITTEE BUT GIVEN THE TOPIC OF THE HEARINGS, I DID WANT TO BE PRESENT FOR AT LEAST ONE OF THEM.

AS THE REPRESENTATIVE FROM A CONGRESSIONAL DISTRICT WITH ONE OF THE HIGHEST CONCENTRATIONS OF VETERANS IN THE COUNTRY, THE FUTURE OF THE VA HEALTH CARE SYSTEM IS EXTREMELY IMPORTANT TO ME. I HAVE LONG BELIEVED THAT THE VA HEALTH CARE SYSTEM IS A NATIONAL ASSET, AND I AM COMMITTED TO ENSURING THAT IT CONTINUES TO BE ONE.

THEREFORE, I AM ANXIOUS TO HEAR WHAT OUR WITNESSES HAVE TO SAY ABOUT WHERE THE VA SHOULD BE HEADED IF IT IS GOING TO REMAIN A VIABLE HEALTH CARE PROVIDER. WE ALL AGREE THAT THE VA MUST ABLE TO ADAPT TO CHANGES IN THE HEALTH CARE FIELD IF OUR VETERANS ARE GOING TO BE ABLE TO CONTINUE TO RECEIVE THE HEALTH CARE THAT THEY HAVE EARNED.

SO WITH THAT, MR. CHAIRMAN, I WILL CONCLUDE MY STATEMENT. AS ALWAYS, I LOOK FORWARD TO WORKING WITH YOU AND THE OTHER MEMBERS OF THE SUBCOMMITTEE ON THE ISSUES BEFORE US TODAY.

THANK YOU, MR. CHAIRMAN.

THE HONORABLE CLIFF STEARNS
SUBCOMMITTEE ON HOSPITALS AND HEALTHCARE
STATEMENT ON VETERANS HEALTH ADMINISTRATION
HEARING ON JUNE 26 AND 27, 1996

THANK YOU, CHAIRMAN HUTCHINSON, FOR HOLDING THIS IMPORTANT HEARING. I WOULD LIKE TO THANK OUR DISTINGUISHED PANEL OF WITNESSES FOR JOINING US TODAY.

VETERANS HAVE GIVEN UNSELFISHLY OF THEMSELVES, THUS THE RESPONSIBILITY LIES IN OUR NATION'S HANDS TO PROVIDE FOR THEIR CARE AND PROTECTION. WE NEED TO ENSURE THE VETERAN'S HEALTH ADMINISTRATION ACCOMPLISHES ITS MISSION OF PROVIDING HIGH QUALITY HEALTHCARE IN A CONVENIENT, RESPONSIVE AND CARING MANNER. CAREFUL CONSIDERATION MUST ALSO BE LENT TO ENSURING SERVICES ARE AVAILABLE AT A REASONABLE COST. WE MUST MAKE EFFORTS TO GUARANTEE EXCEPTIONAL ACCOUNTABILITY, THAT WILL IN PART BE DEFINED BY PATIENT SATISFACTION.

WHAT IS THE PROPER DIRECTION FOR THE VETERAN'S HEALTH ADMINISTRATION TO TAKE? IN EXPLORING THE FUTURE DIRECTION OF THE HEALTH CARE SYSTEM, WE MUST CONSIDER THE CHANGES IN THE VETERAN POPULATION, AND THE RESULTING

DEMAND ON SERVICES. WE MUST LOOK INTO ACTIONS THAT MAKE USE OF EXISTING RESOURCES AND LEGISLATIVE DIRECTIVES TO INCREASE EQUITY OF ACCESS TO CARE.

AS WITH LARGE HOSPITALS, THE VHA IS UNDER INCREASING EXTERNAL AND INTERNAL DEMANDS TO CHANGE ITS TRADITIONAL METHOD OF OPERATIONS. WHEN CONSIDERING THIS CHANGE, IT IS IMPORTANT THAT THE FEATURES UNIQUE TO THE VHA THAT ARE VALUED BY VETERANS ARE PRESERVED. THESE FEATURES INCLUDE ITS EXPERTISE IN SERVING DISABLED AND MENTALLY ILL VETERANS, AS WELL AS ITS VAST CONTRIBUTIONS TO TEACHING AND RESEARCH

AGAIN, I WOULD LIKE TO THANK ALL OF YOU FOR COMING BEFORE US TODAY. I LOOK FORWARD TO HEARING YOUR INDIVIDUAL PERSPECTIVES ON THE FUTURE OF HEALTH CARE DELIVERY IN THE VETERANS HEALTH ADMINISTRATION.

Statement by Rep. Luis V. Gutierrez
Subcommittee on Hospitals and Health Care
June 26-27, 1996

Good morning.

Mr. Chairman, I would like to thank you for holding this ambitious hearing to discuss the future of health care delivery in the Veterans Health Administraton (VHA).

Mr. Chairman, I am encouraged to see this subcommittee take a long-term view of the health care needs of veterans. Congress must assess the societal and industry dynamics that will influence the manner in which the VHA accomplishes its mission of providing the best possible health care for veterans thoughout our nation.

Increasingly, the VHA is looking toward the private sector for ideas and solutions.

In this era of fiscal belt-tightening the VA is forced to search for methods of change that offer the most cost-effective services to those they care and provide for. These are pressures the private sector has always dealt with.

I do believe that the private sector can provide some answers for the VHA. Private health providers have made the transition from inpatient to outpatient and ambulatory care and this may provide a broad model for the VA to follow

However, there remain sharp differences between the goals of private sector insurers and those of the VHA.

Why?

Because the VHA is not profit-motivated. The VHA is not on the New York Stock Exchange and does not produce quarterly reports for stockholders.

The VHA has one motivation and one constituency, the veterans of America.

These men and women bought their stock in Normandy and Vietnam and were guaranteed by Congress the dividends of health care and compensation.

Irregardless of what market trends arise or how the private sector changes, the mission of the VHA, to serve the needs of America's veterans, will remain the same.

I believe the VHA has taken some steps in the right direction. The new VISN structure will enable the VHA to bring services closer to veterans, recognizing varying local conditions and needs.

I am also supportive of the expanded access point strategy, to offer veterans more convenient and applicable care including preventive medical services at outpatient clinics.

These steps should enable the VHA to improve resource distribution and service delivery while offering veterans a wider variety of options and more applicable treatment.

This is something we all can support. But not without scrutiny and caution.

Mr. Chairman, I am very concerned by some of the ideas proposed for the future of VA health care. I believe that proposals to privatize VA hospitals, outpatient clinics and staff are premature.

We have hardly allowed the VISN structure to work or permit the VA to set up hundreds of access points in areas of our nation that have been neglected by the VA in the past.

Nor has this Congress passed comprehensive eligibility reform. Reform we promised veterans and the VA.

At the same time, proposals to privatize the VHA contradict our nation's longstanding commitment to maintain the independence and unique population base of the VA.

Before we consider ideas that run contrary to 40 years of veterans health care we should give the VHA the chance to improve service and efficiency.

Mr. Chairman, once again I thank you for holding this important hearing. I look forward to our witnesses testimony.

June 2, 1996

Testimony of Russell C. Coile, Jr., President, Health Forecasting Group, Santa Clarita, CA

to the

U.S. House of Representatives, Committee on Veterans Affairs, Washington, D.C.

"Competition, Capitation and Consolidation:
'Millennium' Strategies for the Veterans Health Care System"

As a market forecaster specializing in the health field, I will concentrate my brief comments on the challenges facing the Veteran Administration's health care system, and market-oriented set of recommendations for its future for the next 5-10 years -- a relatively short period of time, from a futurist's perspective. *My "bottom-line" is to privatize the medical care program of the Veterans Administration over the next 5-7 years*

I propose three inter-related strategies to meet veterans' health needs in the 21st century:

(1) **Competition** - Put VA medical care out to bid, and encourage the VA's "VISN" (Vertically Integrated Service Networks) to compete with private-sector HMOs.

(2) **Capitation** - Shift VA medical care from a program budget to an enrollee-based capitation formula, as part of the competition strategy.

(3) **Consolidation** - Consolidate VA hospital, ambulatory facilities and clinical staff into community-based networks which can cooperatively bid for VA capitated enrollees.

A **BACKGROUND** - I am Russell C. Coile, Jr., president of the Health Forecasting Group, Santa Clarita, California. My testimony today is as a 25-year healthcare consultant with an MBA in Health Services Administration who provides market forecasts and strategic advice to hospitals, medical groups, HMOs and insurers, and suppliers.

My recommendations are based on my experience in Southern California, the "Bosnia" of American healthcare. From Los Angeles to San Diego, Southern California is a hotbed of "managed care," with the following characteristics:

- Market competition has driven the price of a commercial HMO plan down below $100 per member/per month (PM/PM)
- Healthcare providers are accepting "global capitation" to provide comprehensive medical care for $75-85 PM/PM.
- Medicare HMOs are providing comprehensive services to seniors at rates of $450-550 PM/PM.
- Commercial HMO (under age 65) hospital use rates are 120-150 days per 1,000, and Medicare HMO inpatient days average 900-1000. These rates are approximately 50% lower than comparable hospitalization data for the U.S.
- Hospital utilization in California is below 45% of licensed capacity, and demand for the total population averages 1.07 beds per 1,000 My year 2,000-2,005 forecast for the California Healthcare Association is for 0.8 and 0.7 beds per 1,000 in the 21st century.

How does the current VA health system compare with these prices and performance indicators?

B. FUTURE CHALLENGES TO THE VETERANS HEALTH CARE SYSTEM -

The challenges that the VA's medical care program faces in the 21st century are not fundamentally different from those of America's voluntary health system·

- o Aging of the population
- o Increasing acuity and complexity of health needs
- o Rising costs of service delivery
- o Purchasers' demands for lower prices
- o Aging infrastructure of facilities
- o Need for capital
- o Accountability demands for outcomes and health status data

The challenge of providing health services to America's eligible veteran population is in many ways similar to other federal health programs -- Medicare and Medicaid Veterans present special circumstances, such as multiple chronic illnesses, addiction, and HIV, but these are also found in Medicare and Medicaid populations. Both Medicare and Medicaid are now rapidly shifting to capitation and privatization. So is the Department of Defense, through CHAMPUS contracting and the DOD's innovative "Tri-Care" managed care program. The Veterans Health Care System is overdue for conversion to managed care.

After 200 years, it is time for the federal government to get out of the direct health care business, and turn this over to the private sector, where it can be managed more efficiently and effectively, with the high level of customer service which VA eligibles deserve.

C. "MILLENNIUM STRATEGIES" TO MEET VETERANS' HEALTHCARE NEEDS

Beginning with pilot projects, plan the conversion of the current Veterans Health Care System to a competitive model of community-based capitation within a 5-7 year period. Bring together a Conversion Commission of VA,

(1) **Competition** - On a regional and statewide basis, put VA medical care out to bid. The VA's "VISNs" (Vertically Integrated Service Networks) should be encouraged to compete with private-sector HMOs. I would urge VA facilities to link with community-based providers (see recommendation #3) to develop comprehensive regional and statewide delivery networks.

(2) **Capitation** - Implement a managed care conversion of the total VA health system's beneficiaries. Shift VA medical care from a program budget to an enrollee-based capitation formula, as a transitional strategy for 1997-98, while conducting pilot projects in managed care contracting. For the long-term, out source the total VA healthcare program on a capitated basis. VISNs would compete with HMOs on a regional (i.e., federal/VA) or statewide basis

(3) **Consolidation** - Consolidate VA hospital, ambulatory facilities and clinical staff into community-based networks which can cooperatively bid for VA capitated enrollees. Privatize VA hospitals, ambulatory facilities, and staff, converting them to nonprofit 501(c)(e) community health organizations. This would free VA facilities to affiliate or merge with local health delivery systems. VA healthcare professionals would become staff of the nonprofit organizations. Physicians, for example, would be free to form private medical group practices, or join existing physician organizations in the community.

D. **CONCLUDING COMMENTS**- The timing is overdue for a systemic rethinking of the best long-term approaches to meeting the health needs of America's veterans in the 21st century. Privatization and managed care conversion are well-tested solutions to meeting the health needs of federal beneficiaries. Congress faced a similar dilemma with the U.S. Public Health Service, and privatized those facilities. The Department of Defense has made considerable progress in applying out sourcing and managed care contracting of the CHAMPUS program. Medicare and Medicaid HMO enrollments are rising at annual growth rates of 15.4% and 23.1%, respectively, according to InterStudy in St. Paul, Minnesota. According to HCFA's Office of Managed Care, Medicare HMO enrollment grew 29% in 1995.

There will be many issues in such a managed care conversion. I will highlight two which I believe need special attention.

(1) **Teaching and research** - In my brief argument to convert this federal program to managed care, I have not directly addressed the VA's substantial role in teaching and research, which must be factored into any conversion process. Training of primary care physicians and applied health services research would be especially useful in providing managed care services to VA enrollees. Less relevant training and research activities could be consolidated with other federal grant programs.

(2) **Special needs populations** - Any conversion to managed care must insure access for veterans with special health needs, e.g., multiple chronic illnesses, addiction or HIV. Managed care contractors must demonstrate they have appropriate care management and outreach programs for these veterans, and these sub-populations will need a higher capitation rate.

My testimony and recommendations recognize the tremendous progress made by Dr. Kizer and the highly dedicated VA staff who are working hard to modernize the VA's medical infrastructure.

From a futurist perspective, the rationale for privatization of veterans' health care is simple: the number of veterans is shrinking, community health facilities are under used, and capitated managed care is a highly cost-effective solution for reducing health costs.

Russell C. Coile, Jr.
HEALTH FORECASTING GROUP
25044 Peachland Ave., Suite 203, Santa Clarita, CA 91321
(805) 286-1085

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VISIONARY LEADERSHIP AND THE FUTURE OF VA's HEALTH SYSTEM

Erica Mayer, Institute for Alternative Futures

As the U.S. Department of Veterans Affairs (VA) deploys its newly created Veteran Integrated Service Networks (VISNs), the need for better leadership is apparent. VA has a new vision for its future; it therefore requires new, visionary leadership if it is to thrive in the emerging 21st century U.S. health care system.

Not only is VA a valuable service provider, providing care for injured and poor veterans, but it is also the nation's largest provider of graduate medical education as well as one of the US's largest research institutions. These unique attributes can enable VA to transform into an organization with tremendous potential for the creation of health gains for veterans and their communities in the 21st Century.

Of course, the future is highly uncertain. VA is now faced with many choices as it prepares to provide service in the health care environment of the 21st Century. Although the VA is a great asset, the questions remains as to whether it will still need to exist in the 21st Century. As a futurist my job is not to answer that question, but to help you explore the future and the wide range of possibilities open to you.

In thinking about VA's transformation, IAF drafted a set of four scenarios depicting different paths that the future of the health care system could take and the changes possible in the role and mission of VA. We at IAF believe that the dramatic changes sweeping the U.S. health care industry--including VA--require visionary leadership, no matter what scenario ultimately plays out.

Trends Affecting the Future of Health Care

Based on our research in health futures IAF has developed a list of what we believe are some important "macro" trends that are affecting or will affect health care well into the 21st Century:

- **Telemedicine and Expert Systems** -- Advancing communication and health technologies will make it possible for doctors to deliver care through devices such as tele-surgery (already being tested in simulators by the Advanced Research Projects Agency (ARPA) and the U.S. armed forces) and virtual reality interactions with physicians. These expert systems will allow the best specialists to treat patients anywhere in the world at any time.

- **Home Based Health Care** -- will give people the power to do far better health maintenance themselves faster and cheaper than any doctor could do. In the future tremendous amounts of health information will be available over the Internet and as technology advances and becomes more accessible to more people that is where they will go for health advice. There will be on-line support groups for various groups (i.e., cancer survivors, drug and alcohol abuse, etc.) and video links will make it possible to have a consultation with a health care professional over the computer. Personalized, digital health coaches and virtual reality doctors doing routine checkups are just some of the possibilities that could be available in the early 21st Century.

- **"Syndromes of Risk"** -- The greatest way to create health is to attack the syndromes the give rise to ill health and disease such as poverty and smoking. There is a shift toward a new way of looking at illness as syndromes of risk. Societal issues such as poverty, lack of health education and crime will recognized as being contributors to ill health and the health care system will respond by taking initiatives to help relieve these societal ills.

- **Forecast, Prevent and Manage Paradigm** --Today's health care treats disease after the fact. Focus on forecasting disease through new, more powerful, diagnostic tools

will increase the ability to prevent disease or better manage it to reduce morbidity (and hopefully mortality) when it does occur. Health providers such as VA will need to offer a different set of products and services that reflects this new paradigm shift.

Scenarios for the Future of the VA

In order for an organization to remain competitive and effective in the future its leaders must understand the threats and opportunities that the future presents. One proven technique for better understanding the future is the use of scenarios. Scenarios are alternative pictures of how the future might unfold. The scenarios created for the VA range from one in which VA is completely dismantled to one in which it becomes a premier "virtual" health organization, maintaining and improving the health of many of its core population of veterans, the poor and their communities.

The following table highlights the difference between the four scenarios in terms of the VA, the macro health care system, and leadership skills required of the VA within each scenario. (The full text of these scenarios appear at the end of this document.)

Scenario	VA Health Care System	Macro Health Care System	Required VA Leadership Skills
Scenario 1- VA Maintains --**VA Maintains its Unique Status and Competes to Provide Care for Veterans**	• maintains unique status within greater community • VISNs compete and collaborate with other integrated systems	• paradigm shifts to forecast, prevent, and manage • 17% of US GNP • limited access for poor and near-poor	• adapt to the needs of the "forecast, prevent, and manage paradigm" • devise strategies for the continuing downsizing of in-patient care • balance service for the under funded, unfunded, and well insured
Scenario 2- VA Disappears--**VA No Longer Exists as an Independent Provider**	• VA's assets sold off or traded • VA research activities subsumed by NIH and DOD	• 11% of US GNP by 2005 • 2 tiered health care system	• deal with community obligations of the health care provider • prepare customers to deal with rationing
Scenario 3- Competitive VISNs Flourish--**Remaining VISNs Provide Capitated Care to Veterans and Non-veterans While the --Non-competitive VISNs Disappear**	• non-competitive VISNs disappear • competitive VISNs care for the poor and severely handicapped veterans and align with HMOs to provide prosthetic services, substance abuse treatment, and spinal cord injury treatment	• high quality care • better delivery • lower costs • greater innovation • universal access	• adjust services and communications for shift toward greater personal responsibility • adapt to system of non-physician primacy • prepare providers to maximize competitive outcomes
Scenario 4 - VA Challenges Poverty--**VA Creates Healthier Communities for Underserved Populations**	• VISNs create healthier communities for poor, homeless, and chemically dependent	• managed care system • high tech, alternative therapies common • emphasis on healing and spirituality (expanded definition of health)	• embody the characteristics of visionary leadership described below

Scenarios such as these have been used with health care leaders around the country and beyond, as tools for learning and clarifying commitments. Scenarios stretch thinking and

test assumptions. Unfortunately, leaders in many organizations prepare for the most likely scenario and therefore, tend to make it a self fulfilling prophecy. We have found that a compelling vision is needed to focus an organization on creating their environment rather than reacting to it (or becoming overwhelmed by it). However, it seems clear that under any scenario, the changes in store for VA are so dramatic they will require a visionary style of leadership.

Fostering Visionary Leadership Within the VA

Rapid changes within VA and outside forces such as national health care reform and technological innovations will test VA's ability to grow, change and continue to deliver the quality health care they pledge themselves to provide. As futurists we study this challenge of how to create visionary leadership that will carry an organization through period of rapid change and make it sustainable through times of crisis and beyond.

The bottom line is VA needs visionary leadership right now. Congress needs to appoint the right people who will enable VA to be all it can be. Congress can help the VA through its transitions by reinforcing it with your own visionary leadership and supporting VA no matter what future path it takes. Whether VA's destiny is to be transformed into a creator of healthy communities or go out of existence it is the government's responsibility to ensure that injured and poor veterans are still able to get the best care possible.

Several elements need to be incorporated into an organization's design for effective visionary leadership to be fostered. Visionary leaders view change as an opportunity for the creation of new alternatives and calculated risk-taking. They also employ an approach called "systems thinking," which views any system in terms of its interrelationships. This method is useful in understanding interrelationships and patterns of complex problems. By applying systems thinking to VA's current organization, VA leaders can better identify leverage points to effect the greatest improvements.

Some leverage points VA might consider in working toward its vision include:

increase research efforts in areas that are identified as necessary for the future; collaborate with ARPA to dramatically create new research goals and priorities refocus education toward prevention and community health training; and establish collaborative relationships with non-VA health organizations who lack VA's expertise in areas such as spinal cord injury care, substance abuse and mental health counseling, etc.

Basic Characteristics of a Visionary Leader:
- positive, proactive outlook towards the future
- embraces diversity of people and ideas
- is a creative, "out of the box" thinker

Basic Skills of a Visionary Leader:
- ability to turn crisis into opportunity
- strong, motivational communicator
- ability to think in the long-term and plan backwards from the future
- creates and maintains contacts, allegiances and partnerships within and without of the health care industry

Aspirations Held by a Visionary Leader:
- desire to create health gains for individuals and communities
- expanding definition of health beyond the physical encompassing spiritual, emotional and social aspects of being
- develops community partnership with the goal of designing out health problems such as poverty, lack of education and environmental decline

Source IAF adapted from Bert Nanus "Visionary Leadership"

A visionary leader must:

- engender a "never-satisfied" attitude, which supports a continuous process to improve the value of clinical and service outcomes.
- strive to weld a social mission to their organizational goals, objectives and actions.
- empower themselves and their employees in the work environment. They should also empower patients so that they can be assured of getting the best care for themselves and their families; and harness technology to use it to offer three advantages: access, speed and flexibility.

The creation of a shared, powerful vision along with knowledge of your long- and near-term environment (the macroenvironment as well as your operating environment) can help you best take advantage of your strengths and realize your full potential. In an effort to leverage health gains for the majority of its users, VA should become more community focused, particularly exploring, inventing and investing in ways to reverse the negative effects poverty on health.

In order for managers within VA to generate the health gains that VA is striving for they must share in the powerful vision of VA's mission. Health gains may have different meanings for different people and different divisions of VA. We recognize that not all divisions have the same needs or the same obstacles facing them. True visionary leadership within this organization will mean all managers within VA will be able to work with the overall vision to create their own, individual health gains in their communities.

There are a number of ways that VA can attract, develop and reward the desired leadership skills needed to successfully reorganize. Changes in the VA's hiring and promotion policies and procedures are critical. Examples of some changes that could be implemented include:

- establish employee reward programs (e.g., increased vacation time, employee awards, theater tickets and other non-monetary bonuses) for improved patient outcomes (outcomes measures) and increased productivity;
- change promotion criteria to reward visionary thinking and community service outside VA;
- reconfigure hiring practices that seek out visionaries with a proven track record in their area of expertise; and
- offer training on futures techniques, long-range strategic planning and trend analysis to persons with potential as visionary leaders.

Implementing Visionary Leadership Techniques

Key to implementing visionary leadership techniques is being aware of how to shift from "conventional practices" to "transformational practices" that will move VA into the 21st Century health care arena. Some specific tensions between conventional leadership and visionary leadership have been identified.

Business Planning v. Shared Vision: It is not enough to just plan for the short term future. If your managers are only dealing reactively with issues and problems as they arise they could be missing the opportunity to position themselves for the future. Having a shared vision within VA allows managers to focus their energies on long term goals which is better for problem solving and issues management. It is essential that the new VA VISNs not only have effective business plans, but in order to produce real health gains will require the VISNs to discover whole new business practices.

Minimizing Risk v. Mastering Change: Organizations are currently focused on minimizing risks that the future presents. In order to be a visionary organization you must change your perspective so that you manage the changes in your environment rather than react to them. Organizational managers should view change as an opportunity for growth and learning

Repairing Body Parts v. Reinforcing Health: VA's work repairing body parts has and will continue to be a major contribution of VA. However, it is insufficient in itself to maximize health gains, nor to build competitive integrated health delivery systems. By promoting wellness, healthy lifestyles and actively working to create healthy communities VA can reinforce values and lifestyle changes that promote better quality of life for all. This included the challenge of creating healthier communities for the poor.

Maximizing Short Term Efficiency and Returns v. Serving the Public and Community: As VA creates its VISNs, those VISNs must create partnerships with other community organizations in areas of housing, education, and local law enforcement. They can better leverage resources within communities to help their patients achieve more health gains People cannot lead healthy lives in an unhealthy environment. Some of these efforts have long lead times and do not yet show up in clinical or administrative guidelines.

Linear Learning v. Systems Thinking: Adopting a systems perspective toward the health care system and the operating environment of VA is important because it allows an organization to view the entire spectrum of forces that are shaping the future. This in turn gives you an advantage over linear learning organizations in that you are better prepared to face the challenges of the future and even help to shape the future you prefer.

Conclusion

Health care in the 21st Century will be vastly different from that of today. Rapidly changing technology, economic changes and demographic shifts will lead to different operating environment for VA. As VA makes it transition to VISN's the need for visionary leadership cannot be ignored. Leaders who possess a commitment to continuous quality improvement, continuous learning for the organization and a vision that reaches beyond VA and into the surrounding communities in which they operate will be needed to sustain VA's commitment to more efficient, patient-centered health care

VA's effort to be a competitive and ongoing service provider to injured and poor veterans must be nurtured to go on in the right direction to achieve this goal. Support from Congress is needed for VA to reach the goals set forth in their vision for change. Instilling visionary leadership within the VA will give it the direction and focus it needs to expand its influence and reach and foster health gains for the people it serves.

The full text of the VA Scenarios are reprinted here below:

Scenario 1: VA Maintains its Unique Status and Competes to Provide Care for Veterans

Health care reform's long-term upward path was continued. While economic growth was irregular, it was also persistent and the US held its own in global competition. The majority of Americans are better off, though the percent who are poor has continued to rise beyond the 15% it was in the mid 1990's (having climbed from 11% in 1980). Technology advanced on all fronts of society and business. The information revolution provided advanced tools for learning, entertainment, and personal/home management (including health).

Health care reform devolved to the states and most of those states left reform to the marketplace. Outcome measures and the growing consolidation within the health care industry brought some consistency at the level of therapeutics, but access and specific coverage varies widely.

As the percentage of poor rose and states had to carry the Medicaid burden, more states limited access and borrowed from Oregon's approach of having the public share in the decisions over the priorities for what would be available in the state funded health plans. Malpractice problems went unresolved in courts or legislatures, however practice protocols and electronic record keeping did mitigate the problem.

A Profound Shift

Advances in biomedical knowledge and technology made it possible to forecast and increasingly manage an individual's health and illness over his or her life course, profoundly altering health care delivery to the insured. This "forecast, prevent, and manage" paradigm linked the talents of geneticists, clinicians, behavior specialists, and multimedia software and game developers. They produced very powerful but relatively inexpensive tools that provided the expertise of the best specialists, health forecasts based on each individual's "DNA fingerprint" and entertaining game programs that allowed people to identify and reinforce their own appropriate health promotion strategies.

The result of the shift was profound. No longer do health care providers allow symptoms to grow acute, and then enter late in the game, guns blazing against symptoms of disease. Major changes in health care after the year 2000, for those who could afford it, were not achieved through policy reform but through implementation of this "forecast, prevent and manage" paradigm.

High-tech interventions--vaccines for cancers, medications that prevent plaque build up in the arteries, and the replacement of islet cells for persons prone to diabetes--became common. The affluent and the well insured also have access to organ transplants (both human and transgenic organs), organoids (a new organ or part of an organ grown outside the body and then attached to it), cosmetic surgery, biosensors that augment "closed loop" processes in the body (an oxygen sensor in the kidneys, for example, triggers erythroprotein--EPO--to make more red blood cells), and performance-enhancing bionic implants (for hearing, vision, mobility and athletic performance, and memory/cognition). If a patient has adequate resources of insurance, high-tech medicine can prevent or fix most of his or her health problems.

Health care delivery became more effective and efficient. Multi-specialty physician groups direct most care, aided by other health care providers and supported by expert systems. These expert systems constrain physician's clinical discretion but have improved their outcomes.

Hospitals faced challenging times. As early as the late Eighties, approximately half of the capital investment in the hospital arena went to ambulatory care settings. Hospitals were generating strategic alliances with physicians, pursuing more profitable opportunities, and dealing with the decline of inpatient care. Integrated systems emerged.

VA evolved into the Veteran Integrated Service Network (VISN) providing integrated care for their clientele and positioned to take advantage of this new high technology health care delivery. Since the majority of VA's clients are the poor, home health care advances enabled them to begin to provide cheaper yet more effective home-based preventative care. This was very beneficial for those living in rural areas.

Fewer, Smaller Hospitals

Community hospital beds were reduced from more than 900,000 in 1989 to about 450,000 in 2001 and 300,000 by 2010. Hospitals became smaller and their number declined proportionately as the number of beds fell. Hospitals with a large share of insured or private payers could take advantage of the evolving technology and were able to accelerate their diversification into ambulatory care. Most consumers who receive consistent care, even the poor on Medicaid are able to have their major illnesses, including heart disease, cancer, arthritis, and Alzheimer's forecast, prevented or cured. The more affluent or fully insured also have access to a broad variety of function-enhancing therapies.

Those with full access to care are satisfied. The number of uninsured among the "working poor" and their families grew to 50 million and while some states provide preventive services to this group, they have benefited least from the revolution in health care.

As the system enhanced its capacities, health care expenditures grew to 17 percent of GNP by 2001. By 2010 health care's percentage of GNP declined to 15 percent as morbidity reducing effects of the new paradigm and the fully decisive cures in many areas offset the high-tech, function-enhancement and life-extension technologies used by many.

Economists in 2010 argue that the percentage of the GNP devoted to health care could be reduced further if the country did not spend so much on life extension and

performance enhancement. Politicians, however, recognize that the groups benefiting from the system continue to wield more clout than those who are dissatisfied or benefit little.

Scenario 2: VA No Longer Exists as a Independent Provider

Times were tough for the economy as a whole and for health care. The depression of 1998 was preceded and followed by recessions Innovations in health care and throughout society moved far more slowly than had been promised in the Nineties.

Hard times made it easier for the political liabilities of health care to surface. The relative affluence of physicians irked most consumers. Scandals emerged in the Nineties involving doctors, hospitals, insurers (both for profit and non-profit). Health care expenditures were at 15% of the GNP, yet covering only 80% of the population when the recession of 1998 began. As unemployment grew, so did the costs to the states for their Medicaid. There was a severe reaction to the decentralization to the states in the mid-1990s. The Federal Government took back health care, created universal access to very frugal capitated or severely restricted fee for service care. The federal government as the single payer, sets prices and keeps them low but gives states discretion over what types of care will be eligible for payment and over the priorities among these. The "Oregon approach"--involving the public in consciously setting priorities for the services available--was taken not only for the poor but now for vast bulk of the population. VA is no longer exists as an independent provider of veterans services. In the Government's efforts to downsize in these frugal times, VA's assets were sold off and their research were taken over by NIH and the Department of Defense.

This new system was like Canada's in many respects, except that Americans could "buy up" beyond amenities to additional, better, and more costly treatments. Thirty percent of Americans now do this, either through direct payment for services or through supplementary insurance.

The federal government levied a heavy tax on these private health expenditures to help fund public health care. To keep costs down, malpractice reform limited damages that could be awarded, expedited adjudication, and set policies to lower the incidence of malpractice.

Only bargain innovations need apply

Health care innovation slowed dramatically. Because the system favored expenditures with the greatest return on limited funds, and VA hospital's proximity to academic medical centers and other research facilities allowed them to become obsolete in the face of the competition. To become widely available, an innovation had to have both a low price tag and quickly lead to lower overall costs. For example, certain cancer vaccines, low-cost bioelectric therapies, and homeopathic remedies are widely available. While ultrasound diagnostic devices, and bionic enhancers, developed more slowly and were available only to those who opted to "buy up."

Affluent consumers, the 30% who "buy up", are satisfied (though some grumble about the extra charges they pay). Some members of the middle class still resent their lack of choice, yet most are as satisfied as the Canadian health care consumers were in their system in the mid- Nineties. The formerly uninsured are better off because of the greater emphasis on services for all. Per capita employment in health care has been reduced, physician incomes have dropped significantly, and non-physical practitioners provide more services. With hard times and increased poverty came greater illness, yet this was somewhat offset by the movement toward the "forecast, prevent and manage" paradigm. The affluent are able to use higher levels of care and technology to significantly improve their health status and functioning.

Scenario 3: Non-competitive VISNs Disappear: Remaining VISNs Provide Capitated Care to Veterans and Non-veterans

The stock market crossed 5,000 in 1996 and kept on climbing. Technology advanced rapidly on all fronts. While social policy relied more heavily on the market, it did a better job of providing for those left out of the marketplace. The US followed the more progressive European countries in the areas of employment, housing and welfare policy

As expert systems and automation, as well as corporate restructuring, reduced more jobs than other sectors of the economy more social support was necessary. New forms of community development, aided by advanced home information systems, helped people left out of the job market develop and maintain meaningful roles.

The dramatic shift toward the market in health policy was prompted by the growing cost and growing dissatisfaction with health care. When the cost of health care reached $1 trillion and 14% of GDP in 1995, a powerful coalition emerged. Policy-makers, employers, and consumer groups became convinced that modest changes would not work: Responsibility for health and health care expenditures should be returned to the consumer. A major philosophical shift took place. First-dollar coverage by third parties was largely removed from the non-indigent.

National health policy was formulated to make all individuals and families who were not poor or "near poor" responsible for their health expenditures up to the equivalent of 8 to 10% of their income. Individuals could buy insurance (either indemnity or managed care) though the insurance had to meet certain criteria and the individual was penalized a percentage equivalent to the administrative cost and profit of the insurer. Medicare and Medicaid coverage was adjusted to ensure that all poor and near poor individuals had basic health care. Due to VA's experience with elderly and poor populations and work in the area of mental health, VA created a niche market for special needs individuals who required both in-home as well as out-patient services. These "special needs" clientele are composed of the growing elderly population, homeless veterans and mental health patients needing help with stress related disorders, wellness programs, and nutritional guidance.

Thus formerly insured portion of the population lost the tax deductions on their benefits but gained a frugal catastrophic care plan (as did those better-off among the 30 million formerly uninsured population). The poor and near-poor among the formerly uninsured individuals joined those on Medicaid to receive a more nationally consistent, frugal, yet cost-effective set of services. For Medicare recipients, capitated managed care approaches that take full advantage of the "forecast, prevent and manage" capacities of health care are required.

In the this new health care marketplace VA carves out a niche for itself in serving the poor and homeless veterans. VA's expertise in dealing with mental health issues such as depression, substance abuse and stress related disorders allowed many of their VISNs to become leaders in innovations in these areas of treatment. In addition, many of the VISNs took advantage of market demands and became back-up vendors to the larger HMOs for prosthetics devices and services. Their research efforts shifted to focus on creating marketable home medical equipment devices such as pharmacological agents that accelerate growth-promoting axons in the spinal cord, voice activated wheel chairs, self monitoring devices that could be used in the home (e.g., hospital of the wrist, smart toilets, etc.) Recognizing VA's advantage in these growing market areas, Congress voted to relax its restrictions on VA and expand the clientele that VA can serve.

Physician lose their grip

Regulation of the health professions changed as dramatically as health care financing. Consumers and leading politicians concurred in acknowledging that as a group, physicians had benefited more from physician licensure than had the system as a whole. Several scandals in the early Nineties--involving physicians benefiting directly from over-utilization of testing procedures, hospital payments to physicians for supplying patients, inexplicable practice pattern variations--lessened physician's ability to maintain their grip on licensure.

Systems were put in place at the state level that certified health care providers on the basis of their knowledge and competence. Local consumers, insurers, and managed care providers reinforced effective care deliverers and shunned poorly performing providers; buyers and markets became smarter. Once physician control of health care via licensure was pulled back, nurses, other conventional health care providers, and alternative providers quickly sought to practice more independently. VA recognized this growing trend and placed more emphasis and dollars behind training more non-physician health care providers.

In-home information systems compare the outcome of various health care providers and enable consumers to manage their own diagnosis and treatment for most nonacute conditions. And the capacity to forecast and develop better behavioral and medical strategies to prevent or manage disease allows many even greater freedom from health care providers. These home information systems can now decentralize the expertise of the best specialists in any field.

The bulk of the population learned enough to improve their health conditions and better manage their health care needs. This awareness includes a greater sophistication about which, if any, treatments make sense in the very late stages of life. Combined with

greater acceptance of death throughout our society, this has lowered expenditure in the days and months before death.

Health care's portion of the GNP was reduced from its mid-Nineties' high of 15% to 12% by 2000 and 10% by 2010 as a result of several factors including better health, better and cheaper diagnostics and therapeutics, and the acceptance of dying. The percentage might have dropped lower, except for the fact that the services of alternative providers such as acupuncturists and various physical therapists are now often sought by consumers on a recurring preventive basis. Placing responsibility back on the individual for health and for managing his or her health care expenditures has led to better and to improved and more cost-effective care.

Scenario 4 - VA Creates Healthy Communities for Underserved Populations

Generating health gains, in the context of healthier communities became the dominant objective of the most successful health care organizations. Healing the body, mind and spirit of individuals and communities became the focus. The specific paths taken are as diverse as American communities. But together they have helped to reinvent a 21st Century American democracy that is sustainable and healthy in communities throughout the country. VA is now fully integrated. VA acts an overview organization for all government health care after the mandate by Congress in 2002. VISN has adopted this health community approach and strives to create partnerships with schools, parks departments, community voluntaries, and small business leaders to maximize health gains for each member of the community.

By 2010 health systems had integrated, disintegrated, and "virtualized". Some large players remain, often a fraction of their inpatient bed size in the 1990s, with more ongoing life enhancing relationships (rather than covered lives). But the new environment allowed small players, particularly those with strong support in their communities, to be successful. The partnerships between Microsoft, Disney, and AT&T with major insurers and health care providers including VA accelerated the development of intelligent systems. Once that intelligence reached a certain level, and intelligent local information infrastructures were in place, the cost to compete diminished. By 2000, the ability to monitor the track record of all health care providers and make this accessible in consumer's homes allowed successful new entrants to build a reputation quickly. Simultaneously decreases in health providers contributions to health gains, or a decrease in cost competitiveness became visible within six months in most communities.

. Most of the health care players who have long term loyalty in communities also allow their members to direct the priorities and deployment of the system. In the 1990s health systems and the communities they served realized that they could join together to "design out" pathologies, like drug problems, teenage pregnancy, and the effects of poverty. Shared vision and leadership focused on health gains was proven capable of that task. A parallel step was allowing consumers to determine how health care systems should be designed and deployed. The information revolution had already meant that much could be done in consumers' homes. State governments shift to tracking outcomes for health care practitioners, along with the "flight simulator" approaches to medical training and testing for credentialling has expanded the design options for health care. It has also dramatically altered the fragmentation and specialization of the health professions.

Health care's focus on healthy communities was important, in overcoming problems with both the environment and unemployment. The dominant feature of VA's vision is to become the leading health care provider for the poor. This manifests itself in the way VA creates partnerships with other Veteran's organizations to leverage community health gains. They achieve this by creating alliances in each of the communities the VISNs serve to ensure better health, housing ,education, transportation, nutrition, etc. which all act together to promote healthier lifestyles for all community members.

As the information revolution made most workers more productive, or replaced many workers altogether, unemployment had grown to 25% by 2005. Communities worked hard to make it easier to live there in spite of high unemployment. Volunteering for various personal and community health enhancing activities became an important source of personal identity. Making communities sustainable -- environmentally and economically viable places for families, in the face of declining "paid work" became the challenge that health care organizations helped achieve.

Sophisticated polling of the members of health care organizations on the design and operation, and priorities for care was significant training for other dialogues that enhanced the nature of democracy. The discussions have generally reinforced the commitments that most health care organizations made to building communities and a world that works for everyone, humans, other species and nature as well.

In some communities, where much community development is now done through health organizations, expenditures have risen. But generally the expenditures for what we thought of as medical care expenditures and which accounted for roughly 15% of the GNP in 1995, now account for less 10%, with far higher health gains. Disabling morbidity has been compressed to a smaller period late in life because of better nutrition, exercise, social interaction, mental stimulation, personal and spiritual growth, and the opportunity to contribute in rewarding ways in the community. Institutionalization in long term care settings has been diminished because of this compression of morbidity. When significant degradation does occur bionics, robotics, smarter homes and more caring neighborhoods do much to allow the disabled elderly to remain at home. In addition the "forecast, prevent and manage" paradigm in health care (with its community focus), improved environmental and social conditions, more productive but often far less costly diagnostics and therapeutics, and greater acceptance of death, have all contributed to both the rise in health gains, and the decrease in cost. VA's visionary leadership helped to create significant health gains among the poor in communities throughout the US and served as a model for health care systems world-wide.

STATEMENT OF MARJORIE R. QUANDT
SUBMITTED TO THE
COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
UNITED STATES HOUSE OF REPRESENTATIVES
JUNE 26, 1996

Mr. Chairman, I appreciate your inviting me to participate in this hearing. I have watched with dismay these past four years as DVA and VHA have squandered both time and potential system changes which would bring the veterans health-care system closer to a modern healthcare system.

Before I review for you the recommendations of the Commission on the Future of Veterans Health Care let me refresh your memory as to what VHA knew about the health care delivery industry of the future: noninstitutionalization leading to the hospital without walls, ambulatory/primary care and preventive care as opposed to acute care, direct contracting for care, integrated health plans, mobile operating and recovery suites, more low technology programs such as case managers, home health care or subacute facilities, and self care. A superb survey of the future of medicine, entitled *Peering into 2010*, appeared in the March 19, 1994, THE ECONOMIST. This reiterated the use of "knobots","robodocs", endoscopic surgery, "trackless" surgery and other image guided therapy, tele-presence surgery, computerization of health records and information shared across the information super highway, gene therapy, and gene vaccinations. These changes would be accompanied by health conglomerates and foster managed care with a more discerning patient (public).

The Commission on the Future Structure of Veterans Health Care had one prohibition from the Secretary of Veterans Affairs: no hospitals were to be closed. Secretary Edward J. Derwinski asked the Commission "to determine if the system is balanced. Then, probably the most difficult thing of all is the mission changes. Can we do a better job of serving our veterans by adjusting our mission changes by concentrating our specialties, especially forms of surgery? Can we add new missions? Can we eliminate outdated ones? Those are questions that we'd like to have you look at..... We also have no preconceived agenda, no preconceived blueprint. We want you to tell us where we're to be going in the future....."

The year 2010 was used as the Commission's planning target. The Commission chose four themes around which to make eighteen recommendations: 1) improving access, 2) financing the future, 3) restructuring the system and 4) enhancing quality of care. Congress plays a major role in implementing these recommendations as many require legislative change. I believe you or your staff read the report when it was released so I will not go over all eighteen recommendations. Instead I will cover those which I think have the greatest potential for improving services to veterans.

Some of the more critical recommendations for theme one - improving access - were:

Reform eligibility by removing different requirements for inpatient, outpatient and long-term care.

Establish a benefits package that provides service-connected and poor veterans the full range of needed health-care services.

2

Distribute health care resources nationwide to match veterans' needs.

In making recommendations for theme two - future financing, the Commission recommended that VA be enabled to:

Receive and retain reimbursements from Medicare and others for veterans with dual eligibility.

Operate with a multi-year budget authority for the medical care appropriation.

The primary recommendations concerning theme three - restructuring the system - called upon the VA to:

Reorganize VHA to limit Central Office to the role of national policy-maker and to delegate operational authority to geographic service area managers.

Develop alternatives to VHA's current construction program, such as leasing, lease-purchasing, and sharing; and implement a new construction management process where construction is appropriate.

For theme four - enhancing quality of care - the Commission recommended that VHA be authorized to:

Develop a comprehensive human resources management program that effectively links recruitment, retention, classification, compensation, education, training and other human resources management and development activities.

Sixteen of the eighteen recommendations were accepted and a few are now in the process of being implemented. Unfortunately, several of the more critical changes recommended, especially those requiring legislative action, have not been accomplished.

One recommendation was left to the VA to study. This was development of a self-financed program for higher income veterans and their spouses for continuing care retirement communities. It was envisioned these could be built contiguous to VA facilities and offer three levels of care: independent living, assisted living and nursing home. In addition to a buy in fee paid the operator, VA would provide health care in return for a portion of the monthly maintenance fees. Such facilities are approved by the Continuing Care Accreditation Commission. No such study was carried out by VHA. This type of facility should not be confused with the assisted living program talked about in VHA documents. The latter are the veteran's home at which a health care technician visits (home care) to provide the necessary daily living assistance.

"BEEN THERE; DONE THAT"

Do not assume the VA failed to initiate efforts to change its delivery system prior to the Commission. In 1972 the medical program experiment with ambulatory care for non-service connected veterans entered USC 38 as "obviate the need for hospitalization," a title meant to assuage fears of the AMA. Congressional budgetary concerns weakened the program when Dr. Marc Musser was forced to state "we would not use this for chronic diseases." (Diabetes, for example.) During the presidency of Lyndon Johnson, the

medical program began its first hospital consolidations, but soon found out the desired savings were not as expected. To the extent that VA has always paid for contract hospitalization for service connected veterans until an emergency passed; too ill to travel to a VA facility at all, or it provided fee basis care through over 200,000 community physicians, dentists and others, it has networked. Capitation was tested in VA in the mid-1970s. We concluded that it would work. Fear on the part of VSOs prevented its implementation. At last VA will adopt capitation for its health care program in FY 1998; still, some VISN and medical center directors demand that FY 1997 be a "test" year. The movement of psychiatric patients to the community with regular health team follow-up has been operational for over 25 years. This is a feat in psychiatric care decentralization still not matched in the private sector and some state mental health systems. Finally, VHA published a position statement in 1995 on clinical decision making aids which encompasses clinical practice guidelines, clinical pathways, clinical algorithms. The statement was developed by a multidisciplinary, VA/non-VA committee. The key question now is how long will it take VHA to accomplish these guides. Another question is whether or not these guides will have a national component so there is some consistency in treatment of veterans across the nation.

OPPORTUNITIES LOST

The VHA has been limping toward system revision since 1992. I lost count, but at least a minimum of $9 million was spent on multiple CO and field task forces between 1992 and 1995 only to have the resulting reports shelved. The worst strategy was to drop everything on re-organization and devote all energy to the VA version of Ira Magaziner's health care reform exercise. Unlike the private sector some in VA headquarters did not see health care reform as a wake up call, although some astute field directors did. VHA has been a victim of self-induced paralysis by analysis.

The private sector, however, immediately began merging, consolidating, networking and outsourcing during the debate on health care reform and immediately after the bill failed HMOs, PPOs and other physician organizations expanded and continue to multiply. Wall Street and the health care insurance industry continue to drive reform. VHA could well be too late in many geographic areas in attempting to develop quality, cost effective, strategic alliances with non-VA institutions and organizations.

ONE ACCOMPLISHMENT (VISNs)

VHA settled upon VISNs as a geographic base for care in 1995, and implemented them in 1996. These have been instituted without clear mission enunciation, mere lip service to devolution and a paucity of policy statements pertaining to the special programs of SCI, prosthetics, blind rehabilitation, rehabilitation, psychiatry/mental health programs, nursing homes, geriatrics, and PTSD. In fact, when the Under Secretary for Health sent the Chairman of the House oversight committee a draft of proposed Criteria for Potential Realignment, the Chairman's response cited the dearth of emphasis on the special programs The Under Secretary responded these programs are the "heart and soul" of veterans' care. There are, however, VHA officials who continue to fear for the welfare of these unique programs; that they will be lost for lack of commitment and direction. Others believe current leadership does not care.

In this same period VA has sent forward a legislative proposal requesting eligibility reform and relief from some contracting laws. This package has yet to be enacted. Until

there is some relief on contracting law, the realignment in VISNs is hampered. I would add this warning; the proposal as related to contract liberalization could lead to contracting out the entire VHA in bits and pieces. At this point in time headquarters staff view contracting liberalization as more of a priority than eligibility reform. VSOs, however, view eligibility reform as a long delayed necessity and higher priority.

A CHAIRMAN SPEAKS HIS MIND

Mr. Chairman, on November 29, 1995, you commented in the House of Representatives on H.R. 2099, the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriation Act, 1996. Your concern was the construction budget, but you tied that concern to a declining veteran population and declining use of VA hospitals. You went on to say, "It might interest you to know that on any given day between 23 percent and 50 percent of all beds in VA hospitals lie vacant." You also had some things to say about the cost of care per patient in VA as compared to costs for Medicare and private sector payors. I suspect your remarks shocked some members of the House, and I am positive they shocked some VA employees.

On the face of it, a hospital occupancy rate of 77 percent (23 percent empty) of staffed beds in this day and age of health care is a rather remarkable figure. Some esteemed university medical school hospitals are running closer to 50 percent, and not just on any given day. Their lack of workload has persisted for months. The scramble for networks in the private sector has made it difficult for some university institutions to develop networks. Purchases by for-profit corporations have also had an impact. You may have read recently about several community hospitals in the New York area which will probably close because they are broke; patients are not there and Medicaid is months late in payment for workload accomplished. On June 18, 1996, THE NEW YORK TIMES carried news of the merger of Mount Sinai Medical Center and Medical School with New York University Medical Center and Medical School. The hospitals will become one institution, and the medical schools merge. This merger is a direct result of financial pressures as managed care increases and a response to the spending slowdown of government funded health-care programs.

The Chairman of the SVAC, The Honorable Alan K. Simpson, expressed a similar message of concern to your remarks on the op-ed page of The Washington Post, November 13, 1995. His point was to focus on veterans and their care, not on hospitals or hospital beds. He decried the amount of project funding devoted to inpatient projects. In effect, the VA was putting buildings first, not putting veterans first.

Shortly after Senator Simpson became Chairman of the SVAC I wrote his Staff Director a letter and suggested that there were some 50 hospitals with an average occupancy of 50% or less which should be closed. All of them could be converted to a nursing home with an attached ambulatory care clinic and multiple geographically dispersed primary care clinics. Acute hospital care capability could be purchased in the community or in VA at the nearest facility. It is worth noting that the Abt Corporation performed a study for the Commission which involved each VA facility, and evaluated the care available in the private sector within a radius of 25 miles, 50 miles, 75 miles, and so forth. Except for some of the special emphasis programs, medical specialists and acute hospital care are available in the communities where VA exists. While the Staff Director sent a polite reply, he never pursued the possibilities.

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There are, of course, many reasons for a hospital's low occupancy. One is the financial well being. As I recall several West Coast facilities believed they would not have enough funds to operate through FY 95. Second is the severity or intensity of patient illness treated and availability of staff. Third, a move to ambulatory care without new patients cuts into the flow of inpatients. Last and most serious, there are VA hospitals which are in the wrong place; their communities cannot support them. A real case in point is Miles City which was on the closure list thirty years ago. There are others. What is most disturbing about the list I proposed to send the Staff Director of the SVAC is that there are some excellent affiliated institutions on the list, Nashville and Little Rock being two examples. I suspect Nashville has experienced some impact from TennCare, and Little Rock moved patients to ambulatory care rather than inpatient care.

WHAT ABOUT THE FUTURE OF THE VETERANS HEALTH ADMINISTRATION?

On May 5, 1994, Uwe E. Reinhardt, Ph. D., James Madison Professor of Political Economy, Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, testified before the SVAC about VHA under health care reform. He noted that in competing with the private sector for the veteran's favor, the system would have to be much more customer-oriented than is any system simply relying on budgets..... The hoped for reform did not occur, but an informal, widespread one has developed and continues to develop. This makes Dr. Reinhardt's final statement more important in light of major changes. He assumed that under a changed system, the VA would meet the challenge. "If not, nothing would be amiss in its graceful exit."

James J. Mongan, M. D., formerly Executive Director, Truman Medical Center and Dean, University of Missouri-Kansas City School of Medicine, testified at the same hearing. He described for the Committee "the slippery slope from universal coverage." His summary for the VA was: "You, the Congress must enable and authorize appropriate on-going funding streams and the VA system must enhance its financial systems and the user friendliness of its operations if both dollars and patients are to continue to flow and ensure an ongoing role for the VA under health reform..... And finally, I would return to my opening comment. With or without reform, a reconfiguration and a downsizing of the system, to shed unnecessary beds and locate facilities where they are needed will be absolutely critical to future survival of the Veterans Administration health care system."

For the VA to survive the members of the "iron triangle" must be accountable:

Congress:

You must define in USC 38, the policy for veteran health care and what population will be included: enable and authorize appropriate funding for an aging veteran population as well as indigent veterans and those who are catastrophically ill and in need of VA's special emphasis programs. Congressional budget policy has settled the funding of care at 10 percent of the veteran population. We can thank the Carter administration for that. In view of the current Medicare fund difficulty and balanced budget initiatives I doubt you can obtain more funds, and there may be resistance to collection of Medicare moneys other than end stage renal disease.

Congress would do well to protect the special emphasis programs by recognizing in USC 38 that they are the core of VA care and other programs are modules arrayed around

the core. There are no changes to be made in the four missions of VHA; only changes in execution which do not appear in law, but in Manuals and VA Regulations.

Congress must also recognize the system is no longer to be bound by physical plant in providing care. Thus, you will have to answer the question raised by the Under Secretary for Health at a recent Subcommittee hearing of the SAC: "Will Congress allow VA to close hospitals?" This needs to be done now to shift resources to where veterans reside, and to shift resources to ambulatory/primary care programs.

In my 1992 testimony I noted two disappointments in Commission recommendations. One was a technical matter dealing with the planning module. The other was that there was no recommendation to make VHA a quasi-governmental organization. The model I prefer is the Tennessee Valley Authority. The US Postal Service model is less desirable.

No other patient care system in the country operates as VHA does. For each change in Administration and each change in leadership of the medical program there is loss of productivity. VHA tends to drift. It often takes six months or more to find a new Under Secretary. It is not unusual to have two years of wasted energy. Worse yet, if the new Administration is very different in outlook from the predecessor Administration, some hard-won improvements can be reversed. Look at the successful hospitals or health care provider systems. Their executives last more than three to three and half years. Furthermore, making VHA a quasi-governmental corporation will begin to introduce bottom line recognition to executives who are accustomed to adding onto current services.

Congress should enact legislation that will make VHA a quasi-governmental corporation. Congress will continue to have oversight through the Board of Directors of the Corporation; veterans service organizations and other interested groups (AAMC and so forth) would have seats on the Board.

Congress needs to free VHA from constraining laws pertaining to personnel, fiscal systems, and contracting rules.

This is an election year, and with its many priorities I do not believe Congress will get around to acting on the various legislative proposals on eligibility, contracting and other matters pertinent to VHA. **At least do this, so the health-care system does not fall further behind the private sector: Place a moratorium on Congress' intent that VA <u>not</u> provide "obviate the need for hospitalization" to non-service connected patients with chronic conditions, such as diabetes, hypertension and so forth. Place a similar moratorium on such contracting laws as those pertaining to A-76 and other constraining paragraphs in USC 38. Set a specific time period, such as five fiscal years. Require VA through the Under Secretary to provide annually a report of workload changes, system configuration changes, cost shifting between levels of care. The moratorium should recognize that in this period some facilities will have major mission changes, and a few may be closed and sold.**

Veterans Service Organizations (VSOs)

Since, as Dr. Mongan observed, VSOs no longer have the clout to obtain the necessary budgets to keep beds open, they must abandon their preoccupation with hospitals. I recognize some organizations are more sophisticated than others, and have adopted this stance. What VSOs must concentrate on is holding Congress and DVA

accountable for a patient driven, quality, cost effective, modern health-care system whether it is offered in VA or through VA auspices.

It is probably time VSOs abandoned their dream of opening the system to other populations. Forces in the market place are not about to let that happen. Everyone is scrambling for paying patients or those with insurance. Bringing in veterans' families is a lost opportunity; it was lost some 35 years ago when Norman Jones, then Executive Director of the VFW, pleaded for such legislation. As happens today, the VSOs could not coalesce around this goal.

DVA/Veterans Health Administration

First, the Under Secretary must lead, and in the clearest, simplest terms. A document such as *Prescription for Change, DVA, Healthcare Value Begins with VA, 1996,* is a public relations document. Now that the VISNs are in place, what is the next goal of the Under Secretary? Surely, from a headquarters standpoint he has espoused a one-year tactical plan, a two or three year strategic plan and five-year strategic targets. This can be done even though VISN input will eventually modify the original statement.

History indicates that recent Chief Medical Directors/Under Secretaries do not survive their full appointment. The current Under Secretary is the first true outsider since General Joseph McNinch was Chief Medical Director. It would be too bad for the future of VHA if the return to a non-VA physician leader were not successful. VHA should benefit from leadership experienced in market forces within the health care sector for the next several years. In my opinion, however, the Under Secretary has squandered at least two years in redesigning VHA.

VHA would do well to determine what capacity exists in the special emphasis programs which can be offered to the private sector. Health care is turning into a niche market, and VHA has a unique array of services to offer as its niche. If there is no excess capacity what shifts of resources can come from closed bed services to develop capacity? Just as it moves towards a health care system without walls, VHA needs to be entrepreneurial about the programs it does best. Congress should provide enabling legislation; there are communities which could benefit by access to VA's special emphasis programs through means other than sharing. Any funds received for providing such care should remain within VA, split between the system and the field facility offering care.

WHAT SHOULD VHA LOOK LIKE IN THE FUTURE?

Mr. Chairman, your staff asked that I address this question. First, left me state the assumptions in my view of the future VHA:

> Service connected, low income non-service connected and those veterans with catastrophic illness are eligible for inpatient, outpatient and long-term care. By this I mean the full range of service in the vertically integrated program, wherever offered.
>
> Congress will continue to fund VHA at 10 percent of the veteran population with the appropriation adjusted for patient age and inflation.

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In order to bring stability to the program, Congress has made VHA a quasi-governmental corporation.

With those assumptions, VHA might look as follows, and I use a target date sometime after 2005:

VHA will offer the full range of care through its own facilities, or purchase from another provider. It will assess its special emphasis programs to determine which can be sold to non-VA providers, insurers or institutions. It will form multiple alliances (contracts) at the system and local level with other health care providers, social organizations and educational institutions. The use of information technology will be pervasive.

Edgar Bronfman, Jr., President and CEO, The Seagram Company Ltd. noted in 1995 at a Sloan Management School CEO Thought Summit that "any company has two assets: its products and its people. Firms spend far more time worrying about the first than the second." VHA will have corrected that practice by developing into a "learning organization." It develops support, trust, discipline, leadership skills and risk-taking among its employees. In order to downsize without "dumbsizing" in the near term VHA will spend considerable money on training displaced employees for new careers. There will be considerable increase in the numbers of primary health care technicians, health care integrators, physician implementors, teleconsultation specialists, actuaries, insurance specialists and so forth. Retraining due to displacement, and skill maintenance training will be continuous.

Outsourcing will be used at headquarters and in VISNs to reduce the cost to the government and to lower direct medical care costs. Some of the activities involved will be centralized fee basis activities, CHAMPVA collection offices, all MCCR personnel except those involved in policy decision making, eligibility verification. At the VISN level outsourcing will involve all of environmental management, food service, grounds maintenance, transportation, painting, drafting services, construction project management, security, payroll, border/hotel bed activity and other indirect care personnel. Chaplain Service will no longer exist; pastoral care will be provided by local clergy.

VHA will be an insurer as well as a provider. Because of the size of some veteran populations in 2005-2010, there will be insufficient population to support a VA operated facility.

VHA will provide seed money to physicians and other health professionals to establish private practices or clinics in rural communities where facilities are closed. (The Dakotas, Wyoming and West Virginia are good examples.) These seed loans will retain in those areas of health personnel shortages trained professionals who can support VA and community patients.

It is conceivable that by 2010 VHA will operate less than 19,000 beds for its entire health-care system. All other care is provided in the veterans place of residence, VHA facility clinics, community based clinics, mobile clinics and mobile operating room/recovery suites, state veterans homes, or in the private sector at VA expense. (For some an operation will be coming to a parking lot near their home!) Only the most difficult 5 percent of surgery will be performed on an inpatient basis, and VA hospitals will be used only for the most difficult, intense cases.

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With so many of VHA's physical plants no longer needed, these assets are sold or leased and the proceeds plowed back into the system to purchase modern, state-of-the-art equipment, leased space for hundreds of community based clinics and buses outfitted as mobile clinics and operating suites. Other funds will be used to remodel and upgrade retained physical plants.

WHAT SHOULD VA/VHA BE DOING NOW TO GET THERE?

First, let me state that watching VHA change is a lot like watching paint dry or the Maytag repair man wait for a service call. The only thing I know that inspires VISN and local facility management to action is the goal of moving money to where veterans live.

Second, I should inform you I firmly believe in the theory of earthquake management. It works.

The Secretary and his key staff must realize that losing beds and hospitals in return for increased treatment sites, more modern treatment plans and other improvements is not a public administration sin or abandonment of avid, pursuasive veteran advocacy.

The Under Secretary must lead and instill in his staff at all levels a sense of urgency. Time is running out. In 1992 the Medical School Dean who testified at the same hearing I did informed the Committee staff director when the hearing was over that VA was not needed. As the national fixation on reducing health expenditures continues, organizations outside government will look upon veteran care as a plum to be plucked.

The Under Secretary should practice some of the risk taking he admires and do the following: Pay acute inpatient care at VA hospitals on the basis of Medicare criteria; all additional inpatient care would be at a skilled nursing facility or some other subacute rate. Declare that cases normally admitted for surgery, which Medicare and other insurers consider ambulatory surgery, be treated as outpatients, and not admitted to bed care. (It is preferable, however, that Congress recognize through an intent of Congress or a law change that "obviate the need" has no restrictions.) Recognize that while VISN standards for care are desired, VHA is a national system and should have national criteria against which to measure the VISNs. If not, I see little hope for moving money toward veteran populations.

VHA must become a good neighbor. By this I mean that when the fortunes of outpatient funds or nursing home money shift down or up, relationships with the non-VA partner remain consistent if quality and cost remain the same. Every time VHA gets in a budget crunch it decides to bring fee basis, contract hospital or nursing home care in house. This is no way to build bridges to networks. Negotiation of rates is the key.

VHA should begin to build partnerships/networks (contracts) beginning first with its affiliated medical school hospitals. After that VHA should actively seek network agreements with other close and remote providers

The original designers of the sharing law always hoped VHA would sell more than it buys in service, or at least have an even trade. This has yet to happen. I believe part of the fault lies with the failure to keep equipment up to date and part due to the resistance

to have a large number of non-veterans treated by VHA. Whatever the reasons, the program should be revitalized. Why are not Tennessee hospitals selling some services to TennCare instead of just buying?

Financial management needs to be strengthened at VISN and facility management. I do not believe many employees view VHA in a business sense, and that is what must happen if it is to be revitalized and to provide the best possible care.

Finally, the enhanced-use activity of Construction should be totally overhauled, including new personnel. It is unconscionable that West Los Angeles, for example, has been waiting for five years to have closure on a childrens' day care center for employees and others. If the proposed leaseholder backs out time and again, there are other alternatives immediately at hand. Day care centers are not the major activity of the enhanced-use office, but if these leases are not done promptly and well it bodes ill for the day when major leases and contracts are required.

SUMMARY

The recommendations of the Commission on the Future Structure of Veterans Health Care were sound and provided a blueprint for the future. Mr. Chairman, given a change in mind set among the iron triangle participants, there is no reason VA cannot practice innovative health care delivery. Its track record has shown that it can, and in some cases it leads. I believe that with the increasing number of aged veterans, and conservative budget policy now existing in Congress, public policy will hold at funding for only 10 percent of the total veteran population. The greatest problem is fear: Congress does not want to lose control; VSOs are not certain promises will be kept which makes giving up such tangible things as buildings and beds difficult; headquarters staff is not totally happy with giving up power (devolution). The only group not afraid, but desparately wanting leadership and the promised devolution, is the cadre of field facility staff. They were not afraid of the future when the Commission was formed; in fact, three teams designed innovative scenarios. What the field wants is a system that is "well framed, properly funded and not politically fixed."

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THE HOUSE
VETERANS' AFFAIRS
COMMITTEE

WITNESS STATEMENT OF

REAR ADMIRAL WILLIAM R. ROWLEY, MEDICAL CORPS

UNITED STATES NAVY

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

HOUSE VETERANS' AFFAIRS COMMITTEE

27 JUNE 1996

NOT FOR PUBLICATION
UNTIL RELEASED BY
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COMMITTEE

Mr. Chairman, I would like to thank you for the opportunity to present my views to your Committee on the future of health care in the United States. My experience as the Chairman of the Military Health Services System 2020 project, Department of Defense's look into the future, has allowed me to participate in a comprehensive analysis of the health care industry. American health care has recently undergone major changes and the rate of change will probably accelerate for at least the next few years I would like to address 11 trends which I feel will significantly affect the future of the Veterans Health Administration (VHA) and then make some observations and recommendations based upon these trends

1. SHIFT TO PRIMARY CARE

Managed care organizations are using primary care physicians and physician extenders, such as physician assistants and nurse practitioners, to provide all routine care and make referrals to specialists only when necessary Primary care providers give continuity for all aspects of care, encourage healthy lifestyles, and generally treat common medical problems with fewer tests and less expensive therapies. This trend has resulted in a shortage of generalists and a surplus of specialists which will gradually be corrected by market forces and shifts in medical education.

2. SHIFT TO OUTPATIENT CARE AND AMBULATORY SURGERY

The high cost of hospitalization has led to changes in medical practice allowing the majority of illnesses and at least two-thirds of surgical procedures to be treated on an outpatient basis. Hospital days per 1000 enrollees in managed care have been reduced by two-thirds and eventually almost half the nation's hospital beds will be eliminated

3. SHIFT TO MANAGED CARE AND TAILOR-MADE LOCAL SYSTEMS

Managed care plans are rapidly increasing as payers of health care, both businesses and government, look for ways to control medical costs which until last year were increasing 2-3 times the rate of inflation There are many different arrangements such as health maintenance organizations (HMO), preferred provider organizations (PPO), independent practice associations (IPA) and integrated health care networks They all strive to control costs through incentives (such as capitation), eliminating unnecessary services (utilization management), quality control and economical business practices

Under capitation financing, diagnostic departments and inpatient wards are cost centers rather than revenue generating centers. Because of this, the trend is to eliminate unnecessary infrastructure and not duplicate expensive services when there are opportunities in the community to share high-priced inpatient beds and diagnostic technology Relationships between competitors often bring mutual benefit to both parties in terms of reduced costs and high quality services

4. INFORMATION AGE MEDICINE

The digital revolution is having a profound effect on society in that it changes the way wealth is produced, decentralizes power, and empowers individuals to take increased responsibility for their lives Information systems tie all the elements of an integrated health care system together for efficient management The computerized medical record will soon be a reality allowing patients freedom to change the location of medical care while giving all care-givers access to necessary medical information The Internet allows instant access to libraries full of medical information and dialog with experts on tough diagnoses. Video telemedicine brings specialty expertise to primary care providers in remote areas and promotes continuing medical education. Virtual reality is ideal for learning, practicing surgical procedures, and testing the competence of clinical skills.

All the above assist medical professionals in delivering care, but the most dramatic benefits of the information age will be for the public People are responsible for maintaining their own health through healthy living Sensors are being developed which could be part of a wrist watch to monitor an individual's health status The wrist watch could also immediately administer medication in life-threatening situations. Information from sensors would be automatically stored and analyzed by a "personal medical assistant" (PMA), a small computer with artificial intelligence software, to determine if there were trends requiring changes in lifestyle or medical assistance The PMA would have voice recognition and speech synthesis so that it could answer the individual's health questions and coach healthy lifestyles The patient could use the Internet or video teleconferencing

to confer with medical professionals who would have access to sensor data and a lifelong medical record The patient could also communicate electronically with support groups

5. SHIFT TO HOME CARE

Information age technology mentioned above will allow many patients to manage their health status at home with the aid of computer sensoring, self-care information and health coaching through artificial intelligence software. Consumer information services will rate health care providers "Electronic house calls" with medical professionals could be accomplished by the Internet, interactive television or telemedicine Electronic patient support groups would provide useful advice and relieve isolation and fear Some people will need the support of visiting health care professionals to provide treatment or assist in daily living. All these support resources will eliminate the majority of visits to clinics and hospitalizations

6. AGING OF THE POPULATION

The first "baby boomers" just turned 50 and in 15 years one-third of Americans will be over 55 years old The fastest growing segment of the population is those over 85 years old. The requirement for medical care and hospitalization increases dramatically over the age of 65 and a significant amount of Medicare money is spent during the last year of life. In spite of vigorous cost containment, medical costs will continue to escalate The need for long-term care will significantly increase

7. SHIFT TO HEALTH PROMOTION AND PREVENTION

The life expectancy of men increased from 45 years to 75 years during this century Only five of those years are attributable to medical care whereas the other 25 years were due to better sanitation, nutrition and safety Of all the things one could do to reduce illness or prevent premature death, 50 percent of the total benefit is related to lifestyle changes - not smoking, limiting alcohol consumption, wearing seat belts, proper diet and exercise, and so on Another 20 percent can be achieved by creating a safe and healthy environment Twenty percent is related to heredity, whereas preventive medical care represents only 10 percent of the total benefit Probably more than half of our trillion dollar yearly health care expenditure could be eliminated if individuals would take responsibility for living healthy lifestyles and respected the environment. We do not have enough money to pay for the amount of disease we are generating Rather than trying to treat all of our diseases, our goal must be to design them out of our society through healthy lifestyles and other appropriate measures

8. PARADIGM SHIFTS TO PREDICTION OF DISEASE AND CUSTOMIZED INDIVIDUALIZED THERAPY

American medicine has been organized around the episodic treatment of acute illnesses due to external agents such as infections and trauma. Most chronic diseases originate within our genetic makeup Current efforts to map the human genome will soon lead to understanding and a means to control these genetically inherited diseases. We will soon be able to predict who has a predisposition to disease and then make alterations to either prevent the disease or control its onset and severity With better understanding of diseases and more precise measurements of the individual, therapies will be customized to choose the right treatment and optimum amount for success for that particular person

9. SHIFT TO QUALITY AND REENGINEERING

The quality improvement movement has taught us that quality reduces costs and this is achieved by reducing variability and improving processes High-tech tests, costly procedures and expensive medications often do not produce better outcomes than more conservative therapies Clinical pathways and practice guidelines suggest optimum ways to diagnose and treat illnesses with a minimum of wasted time, fewer tests and simpler therapies The focus is on emulating the practices of the most successful clinicians rather than looking for the "bad apples." Reengineering of processes eliminates unnecessary steps and wastage, often saving hundreds of thousands of dollars a year for a health care system while improving outcomes In the future our licensure and certification procedures will be replaced by periodic skills testing in simulators much like airline pilots do today

10. TRENDS IN GRADUATE MEDICAL EDUCATION

Most studies conclude there are too many physicians in America and far too many specialists in many fields as judged by managed care staffing standards Medical schools and graduate medical education programs have been slow to accept these findings and embrace change because of human nature's desire to protect the status quo However, the realities of the marketplace for physician skills and the need of government to reduce funding for education will eventually reduce the number of medical schools and shift residency training toward primary care specialties in numbers that are sustainable. The transition must be done so that the right number of fine medical schools and research institutions remain and maintain their high quality There is also a shift toward utilizing physician extenders such as nurse practitioners and physician assistants where their services are equally effective.

11. BUDGET REALITIES

In 1980 about 43 percent of the federal budget went toward entitlements (Social Security and Medicare/Medicaid) and interest on the national debt. In 1997, it is projected that almost 70 percent will go to entitlements and interest. It is estimated that Medicare will exhaust its trust fund within the next five or six years, and Social Security will exhaust funds in about 2029. Americans may well prefer cuts in other programs to protect their Medicare and Social Security benefits

WHAT DO THESE TRENDS SUGGEST FOR THE FUTURE OF THE VA MEDICAL SYSTEM?

The VA Medical System is not immune to the quality, access, and budget pressures facing the United States health care industry as a whole. The biggest change in the future will be a transformation of our mental models about health care and how government should participate. I believe the following considerations are important guideposts for developing a high-quality, cost-effective VA Medical System in the future

A. VA health care is going through the same transition as the rest of American medicine with shifts to outpatient care and ambulatory surgical procedures. Hospital beds are being reduced and unnecessary inpatient facilities may need to be closed or converted to outpatient care only. Soon there will be movement toward delivery of health care in the home supported by information technology.

B. The key for future success in American health care is a shift in our culture to the point where each individual accepts personal responsibility for his or her health and actively participates in living a healthy life-style. It may be difficult to get some older veterans to give up life-long habits and learn new ways of living. However, I believe we should devote more resources in educating, guiding and supporting beneficiaries. Much of this can be done by trained low and mid-level employees. They must reach out into the home, workplace and community rather than just within the medical center after the problems are already severe. Policy makers must realize that the payoff of these efforts may not occur for several years.

C. Information technology is essential for efficient integrated health care delivery systems. The VA should be a national leader in its development.

D Local health care solutions require partnerships with other federal agencies and the private sector to share and complement facilities and services Agreements must be of mutual benefit to each party and provide high quality services to veteran beneficiaries while wisely utilizing precious taxpayer dollars. In the end there will likely be fewer VA hospitals, and many of those remaining may also treat other federal beneficiaries. Communities may have one remaining civilian or governmental facility with a mixed staff serving everybody in the community. There are unlimited possibilities to do this, but they require flexibility and a willingness to change. Present federal acquisition regulations, civil service rules, facility construction processes and other policies are not very flexible and can hinder sound business decisions in a rapidly changing environment. These processes and regulations must be reengineered if federal institutions are to survive and the public get best value for its taxes If this effort is not successful, there will be great pressure to privatize services and get out of the health care business.

E The Department of Veterans Affairs is already reengineering to streamline processes and empower employees at the local and regional level to provide innovative care while reducing overhead Efforts are underway to develop practice guidelines which ensure high quality outcomes without unnecessary tests and procedures These processes must be encouraged and embraced by all

F. The Department of Veterans Affairs has national treasures which must be protected and nurtured There are centers of excellence for specialized care such as the long term rehabilitation of brain and spinal cord injuries which are essential for military personnel who become disabled Research centers provide medical advances which benefit all Americans Veterans hospitals are cornerstones to our system of medical schools and residency training Although medical education needs "rightsizing" and redirection, it is important to keep the quality high and innovative advances coming - especially as for-profit managed care organizations rarely support education and training

America has always kept its commitment to those who served and later needed medical care Our future offers increased opportunities to provide for their needs in innovative ways which promote health and keep costs under control If needy veterans remain the primary focus, we will keep our promise and assure value to taxpayers

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Testimony

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Committee on Veterans' Affairs, House of Representatives

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VETERANS' HEALTH CARE

Challenges for the Future

Statement of David P. Baine, Director
Health Care Delivery and Quality Issues
Health, Education, and Human Services Division

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the future direction of the Department of Veterans Affairs (VA) health care system. The VA health care system, with a $16.6 billion budget, includes both (1) a health benefits program for over 26 million veterans and (2) a health care delivery and financing program including 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries.

VA has a number of fundamental changes under way in how it operates its health care delivery and financing systems. In addition, it is seeking authority to (1) significantly expand eligibility for health care benefits and (2) both buy health care services from and sell health care services to the private sector.

In exploring the future direction of the veterans' health care system, we will focus on

-- changes in the veteran population and demand for VA health care services;

-- how well the current VA health care system, and other public and private health benefits programs, meet the health care needs of veterans;

-- actions that could be taken using existing resources and legislative authority to address veterans' unmet health care needs and increase equity of access;

-- how other countries have addressed the needs of an aging and declining veteran population; and

-- approaches for preserving VA's direct delivery system, alternatives to preserving the direct delivery system, and combinations of both.

During the past several years, we have conducted a series of reviews focusing on the relationships between the VA health care system and other public and private health benefits programs and the effects changes in those programs could have on the future of the VA health care system. We have also conducted a series of reviews to identify ways to improve the efficiency and effectiveness of current VA programs. My comments this morning are based primarily on the results of these reviews.[1]

In summary, significant changes are occurring in the types and volume of services provided under the VA health care system. The

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[1]A list of related GAO testimonies and reports appears at the end of this testimony.

average daily workload in VA hospitals dropped about 56 percent during the last 25 years, and further decreases are likely, thereby threatening the continued viability of VA hospitals. In contrast, demand for both outpatient and nursing home care increased steadily over the 25-year period.

Nine out of 10 veterans now have public or private health insurance that meets most of their basic acute care needs. Still, about 10 percent of the veteran population has neither public nor private insurance to help pay for basic health care services. Such veterans tend to rely on public hospitals and clinics, and on VA health care facilities, to meet their health care needs. These programs, however, are unable to meet the basic health care needs of all veterans who need them. A small group of veterans report that they have been unable to obtain needed hospital and outpatient services. Most of these veterans do not live near a VA hospital or outpatient clinic.

While the acute care needs of most veterans are met through public and private health care programs, veterans needing specialized services, such as treatment for spinal cord injuries, blindness, and war-related stress, are more likely to find private-sector providers unable to meet their needs. In addition, neither public nor private-sector programs provide extensive coverage of nursing home and other long-term care services needed by an increasingly aging veteran population.

There are a number of ways that VA could address the unmet needs of veterans using existing resources and legislative authority. For example, it could reduce the resources spent in providing care to higher-income veterans with no service-connected disabilities (discretionary care category veterans) in VA facilities and use those resources instead to purchase more care from private providers under the fee-basis program for veterans with service-connected disabilities who do not live near a VA facility. Such resources could also be retargeted into expanding the availability of specialized services. Similarly, VA could increase the equity of veterans' access to VA care by improving the way it allocates resources to facilities and the consistency of its coverage decisions.

While such actions would enable VA to more effectively meet veterans' health care needs in the short term, the declining hospital workload makes it imperative that more fundamental policy decisions about the future of the direct delivery system be considered. Australia, Canada, and the United Kingdom reacted to similar declining utilization of their veterans' hospitals by closing those hospitals and integrating veterans' health care into their overall health care systems. These countries were able to preserve and enhance veterans' health care benefits without

preserving the direct delivery system. In contrast, Finland continues to operate a direct delivery system but has essentially converted its hospitals into long-term care facilities.

Two approaches could be pursued to increase the workload of VA hospitals and prevent or delay their closure. First, actions could be taken to attract a larger market share of the veteran population to the VA system--only about 20 percent of veterans have ever used VA care. Attracting enough new users to maintain the workload of VA hospitals could, however, add significantly to the government's cost of operating the VA system unless new sources of revenues are identified. A second approach for maintaining VA hospital workload would be to authorize VA hospitals to treat dependents or other nonveterans on a reimbursable basis. Such an approach might also strengthen VA's medical education and research missions by bringing a wider range of patients into the VA system. On the down side, it might raise questions about the extent to which the government should compete with private-sector hospitals.

Converting VA hospitals to provide nursing home and other long-term care services might also help preserve the direct delivery system. With the expected eight-fold increase in the number of veterans 85 years of age and older, demand for VA-supported nursing home care is expected to increase dramatically over the next 15 years. While the cost of converting hospital beds to nursing home care is generally less expensive than building new nursing homes, the cost of operating VA nursing homes is higher than the cost of purchasing nursing home care from private-sector nursing homes. Establishing cost-sharing requirements patterned after those used by states in their veterans' homes could enable VA to serve more veterans within available resources.

Several approaches could also be considered that would reduce or eliminate VA's direct delivery system. These approaches include (1) creating or expanding an existing VA-operated health financing program to purchase care from private providers; (2) issuing vouchers to allow veterans to purchase private health insurance; and (3) including veterans under an existing health benefits program, such as Medicare, the Federal Employees Health Benefits Program, or TRICARE. Under VA's current restructuring efforts, facilities are being increasingly encouraged to contract with private providers to improve access to care and reduce health care costs.

Because these approaches would address the primary reasons many veterans give for not using VA care--limited accessibility and perceptions of poor quality and customer service--they would be likely to generate significant new demand. They could, however, be structured to supplement, rather than duplicate, veterans' coverage under other health programs.

BACKGROUND

The VA health care system was established in 1930, primarily to provide for the rehabilitation and continuing care of veterans injured during wartime service. VA developed its health care system as a direct delivery system with the government owning and operating its own health care facilities. It grew into the nation's largest direct delivery system.

Over the last 65 years, VA has seen a significant evolution in its missions. In the 1940s, a medical education mission was added to strengthen the quality of care in VA facilities and help train the nation's health care professionals. In the 1960s, VA's health care mission was expanded with the addition of a nursing home benefit. And, in the early 1980s, a military back-up mission was added.

The types of veterans served have also evolved. VA has gradually shifted from primarily providing treatment for service-connected disabilities incurred in wartime to increasingly focusing on the treatment of low-income veterans with medical conditions unrelated to military service. Similarly, the growth of private and public health benefits programs has given veterans additional health care options, placing VA facilities in direct competition with private-sector providers.

VA is in the midst of a major reorganization of its health care system. It has replaced its four large regions with 22 Veterans Integrated Service Networks (VISN), intended to shift the focus of the health care system from independent medical facilities to groups of facilities working together to provide efficient, accessible care to veterans in their service areas. The reorganization also includes plans to downsize the central office, strengthen accountability, and emphasize customer service. Under the reorganization, VA facilities are being encouraged to contract with private-sector providers when they can provide services of comparable or higher quality at a lower cost. VA sees the reorganization as creating "the model of a flagship health-care system for the future."

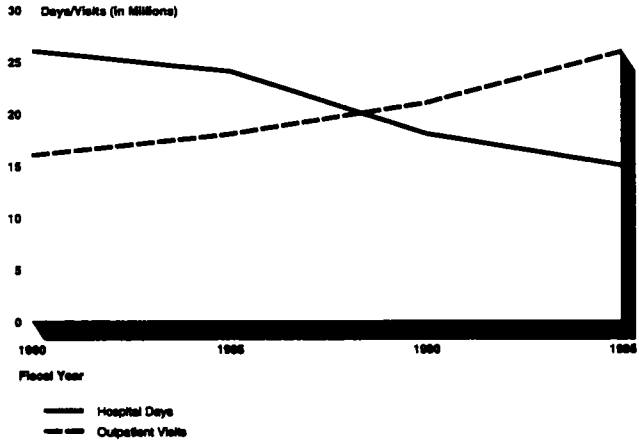
AS THE VETERAN POPULATION DECLINES AND AGES, DEMAND FOR VA SERVICES IS SHIFTING

The veteran population, which totaled about 26.4 million in 1995, is both declining and aging. VA has estimated that between 1990 and 2010, the total veteran population will decline 26 percent. The decline will be most notable among veterans under 65 years of age--from about 20 million to 11.5 million. In contrast, over the same period, the number of veterans aged 85 and older is

expected to increase from 0.2 million to 1.3 million and will make up about 6 percent of the veteran population.

Coinciding with the declining and aging of the veteran population are shifts in the demand for VA health care services from inpatient hospital care to outpatient care. From 1980 to 1995, the days of hospital care provided fell from 26 million to 14.7 million, and the number of outpatient visits increased from 15.8 million to 26.5 million. (See fig. 1.)

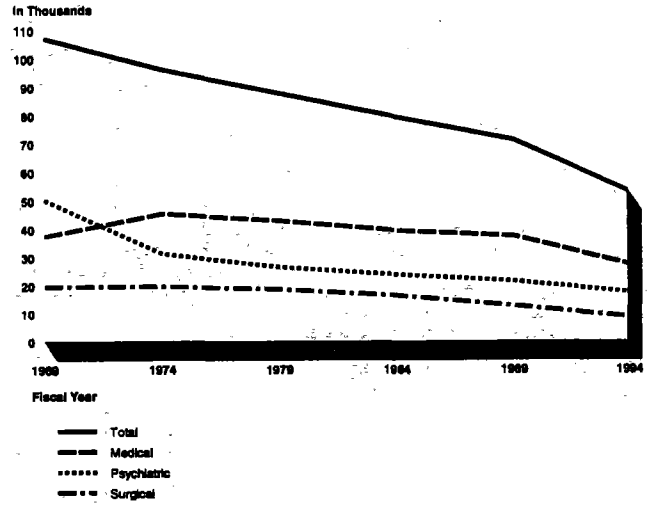
Figure 1: Changes in VA Facilities' Workload, Fiscal Year 1980-95



Over the same period, the average number of veterans receiving nursing home care in VA-owned facilities increased from 7,933 to 13,569, and VA's medical care budget authority grew from about $5.8 billion to $16.2 billion.[2]

Between 1969 and 1994, VA reduced its operating hospital beds by about 50 percent, closing or converting about 50,000 to other uses. The decline in psychiatric beds was most pronounced, from about 50,000 in 1969 to about 17,300 in 1994. (See fig. 2.) In fiscal year 1995, VA closed another 2,300 beds.

Figure 2: Operating Beds in VA Hospitals, 1969-94



[2]Not adjusted for inflation.

Further Decline in Hospital Workload Likely

Several factors, such as the following, could lead to a continued decline in VA hospital workload.

-- Veterans who have health insurance are much less likely to use VA hospitals than veterans without public or private insurance, and the number of veterans with health insurance is expected to increase even without further national or state health reforms. This increase is expected because almost all veterans become eligible for Medicare when they turn 65 years of age, including those unemployed or employed in jobs that do not provide health insurance at the time they turn 65. Health reforms, such as those that have been debated in the past year, that would increase the portability of insurance and place limits on coverage exclusions for preexisting conditions would also increase the number of veterans with health insurance.

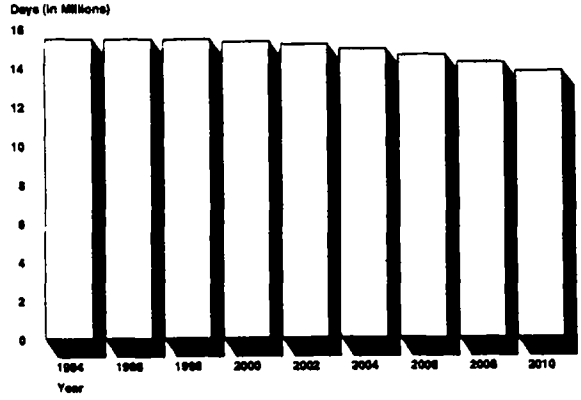
-- The nature of insurance coverage is changing. For example, increased enrollment in health maintenance organizations (HMO)--from 9 million in 1982 to 50 million in 1994--is likely to reduce the use of VA hospitals. Veterans with fee-for-service public or private health insurance often face significant out-of-pocket expenses for hospital care and have a financial incentive to use VA hospitals because VA requires little or no cost-sharing. Veterans' financial incentives to seek hospital care from VA are largely eliminated when they join HMOs or other managed care plans because such plans require little or no cost sharing. Proposals to expand Medicare beneficiaries' enrollment in managed care plans could thus further decrease the use of VA hospitals.

On the other hand, health reforms that would create medical savings accounts could increase demand for VA hospital care because veterans might seek free care from VA rather than spend money out of their medical savings account to pay for needed services. Finally, increased cost-sharing under fee-for-service programs could encourage veterans to use the VA system.

-- The declining veteran population will likely lead to significant reductions in use of VA hospitals even as the acute care needs of the surviving veterans increase. If veterans continue to use VA hospital care at the same rate that they did in 1994--that is, if VA continues services at current levels--days of care provided in VA hospitals should decline from 15.4 million in 1994 to about 13.7 million by 2010. (See fig. 3.) Our

projections are adjusted to reflect the higher use of hospital care by older veterans.[3]

Figure 3: Projected Age-Adjusted Days of VA Hospital Care, 1994-2010



Source: Based on VA annual reports, fiscal years 1980-94, and VA projections of the veteran population by age through 2010.

[3]The declining veteran population will lead to significant declines in VA acute hospitalization even as the acute care needs of the surviving veterans increase. The veteran population is estimated to decline from about 26.3 million in 1995 to just over 20 million in 2010. Although the health care needs of veterans increase as they age, the overall decline in the number of veterans will more than offset the increase and should lead to a further reduction in the number of days of VA hospital care. In addition, many veterans reduce their use of the VA system when they become Medicare-eligible.

-- Establishing preadmission certification requirements for admissions and days of care similar to those used by private health insurers could significantly reduce admissions to and days of care in VA hospitals. Currently, VA hospitals too often serve patients whose care could be more efficiently provided in alternative settings, such as outpatient clinics or nursing homes. Estimates of nonacute admissions to and days of care provided by VA hospitals often exceed 40 percent. Preadmission certification would likely reduce these admissions.

VA is currently assessing the use of preadmission reviews systemwide as a method to encourage the most cost-effective, therapeutically appropriate care. The Veterans Health Administration is also implementing a performance measurement and monitoring system containing a number of measures that should reduce inappropriate hospital admissions. Several of these measures, such as setting expectations for the percentage of surgery done on an ambulatory basis at each facility and implementing network-based utilization review policies and programs, are intended to move the VA system towards efficient allocation and utilization of resources.

Eligibility and Clinic Expansions Contribute to Increase in Outpatient Workload

Between 1960, when outpatient treatment of nonservice-connected conditions was first authorized, and 1995, the number of outpatient visits provided by VA outpatient clinics increased from about 2 million to over 26 million. The increase in outpatient workload, due in part to changes in medical technology and practice that allow care previously provided only in an inpatient setting to be provided on an ambulatory basis, corresponds to expansions in VA eligibility and opening of new VA clinics.

In its fiscal year 1975 annual report, VA noted the relationship between "progressive extension of legislation expanding the availability of outpatient services" and increased outpatient workload.[4] Among the eligibility expansions occurring between 1960 and 1975 were actions to authorize (1) pre- and posthospital care for treatment of nonservice-connected conditions (1960) and (2) outpatient treatment to obviate the need for hospitalization (1973). Workload at VA outpatient clinics increased from about 2 million to 12 million visits during the 15-year period.

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[4]Veterans Administration, Annual Report of the Veterans Administration, Fiscal Year 1975 (Washington, D.C.: Veterans Administration, 1975).

Even with the expansions of outpatient eligibility that have occurred since 1960, most veterans are currently eligible only for hospital-related outpatient care. That is, they are eligible for those outpatient services needed to prepare them for, obviate the need for, or follow up on a hospital admission. Only about 500,000 veterans are eligible for comprehensive outpatient services. VA and others have proposed further expansions of VA outpatient eligibility that would make all veterans eligible for comprehensive outpatient services, subject to the availability of resources.

Just as eligibility expansions increased outpatient workload, VA efforts to improve the accessibility of VA care resulted in increased demand. Between 1980 and 1995, the number of VA outpatient clinics increased from 222 to 565, including numerous mobile clinics that bring outpatient care closer to veterans in rural areas. Between 1980 and 1995, outpatient visits provided by VA clinics increased from 15.8 million to 26.5 million.

VA has developed plans to further improve veterans' access to VA outpatient care through creation of access points.[5] VA would like to establish additional access points by the end of 1996.

Aging Population Results in Increased Demand for Nursing Home Care

As the nation's large World War II and Korean War veteran populations age, their needs for nursing home and other long-term care services are increasing. Old age is often accompanied by the development of chronic health problems, such as heart disease, arthritis, and other ailments. These problems, important causes of disability among the elderly population, often result in the need for nursing home care or other long-term care services.

Between 1969 and 1994, the average daily workload of VA-supported nursing homes more than tripled (from 9,030 patients to 33,405). With the veteran population continuing to age rapidly, VA faces a significant challenge in trying to meet increasing demand for nursing home care. The number of veterans 85 years of age and older is expected to increase more than eight-fold between 1990 and

[5]VA defines an access point as a VA-operated, -funded, or -reimbursed private clinic, group practice, or single practitioner that is geographically separate from the parent facility. In general, access points provide primary care to all veterans and refer those needing specialized services or inpatient stays to VA hospitals. To date, nine hospitals have opened 12 new access points. Of the 12 new access points, VA staff operate 4 and contract with county or private clinics to operate the remaining 8.

2010. Over 50 percent of those over 85 years old are expected to need nursing home care, compared with about 13 percent of those 65 to 69 years old.

VETERANS MORE LIKELY TO HAVE UNMET NEEDS FOR SPECIALIZED AND LONG-TERM CARE SERVICES THAN FOR ACUTE CARE SERVICES

Veterans are more likely to have unmet needs for specialized and long-term care services than they are for acute hospital and outpatient care. With the aging of the veteran population and prospects for insurance reform, veterans' unmet needs for acute care services are likely to decline in the future.

Most Veterans' Needs for Hospital and Outpatient Care Are Met

With the growth of public and private health benefits programs, more than 9 out of 10 veterans now have alternate health insurance coverage. Still, about 2.6 million veterans had neither public nor private health insurance in 1990 to help pay for needed health care items and services. Without a demonstrated ability to pay for care, individuals' access to health care is restricted, increasing their vulnerability to the consequences of poor health. Lacking insurance, people often postpone obtaining care until their conditions become more serious and require more costly medical services.

Most veterans who lack insurance coverage, however, are able to obtain needed hospital and outpatient care through public programs and VA. Still, VA's 1992 National Survey of Veterans estimated that about 159,000 veterans were unable to get needed hospital care in 1992 and about 288,000 were unable to obtain needed outpatient services. By far the most common reason veterans cited for not obtaining needed care was that they could not afford to pay for it.[6]

While the cost of care may have prevented the veterans from obtaining care from private-sector hospitals, it appears to be an unlikely reason for not seeking care from VA. All veterans are currently eligible for hospital care, and about 11 million are in the mandatory care category for free hospital care. Other veterans are required to make only nominal copayments.

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[6]About 55 percent cited inability to pay for care as the reason for not obtaining needed hospital care. Veterans cited a variety of other reasons, but none was cited by more than 10 percent of the veterans unable to obtain needed hospital care.

Many of the problems veterans face in obtaining health care services appear to relate to distance from a VA facility rather than their eligibility to receive those services from VA. For example, our analysis of 1992 National Survey of Veterans data estimates that fewer than half of the 159,000 veterans who did not obtain needed hospital care lived within 25 miles of a VA hospital. By comparison, we estimate that over 90 percent lived within 25 miles of a private-sector hospital.

Of the estimated 288,000 veterans unable to obtain needed outpatient care during 1992, almost 70 percent lived within 5 miles of a non-VA doctor's office or outpatient facility. As was the case with veterans unable to obtain needed hospital care, those unable to obtain needed outpatient care generally indicated that they could not afford to obtain the needed care from private providers. Only 13 percent of the veterans unable to obtain needed outpatient services reported that they lived within 5 miles of a VA facility, where they could generally have received free care.

Distance from VA health care facilities plays a role both in the likelihood of using VA health care services and in the volume of services used. The likelihood of using both VA hospital and outpatient care declines significantly for veterans living more than 5 miles from a VA facility. For example, among veterans living within 5 miles of a VA outpatient clinic, there were 131 users for every 1,000 veterans compared with fewer than 80 users per 1,000 veterans living at distances of over 5 miles from a VA outpatient clinic. Similarly, veteran users living within 5 miles of a VA outpatient clinic made over twice as many visits to VA outpatient clinics as veterans living over 25 miles from a VA clinic.[7]

Veterans Have Uneven Access to VA Services

Even those veterans living near VA facilities, however, can have unmet needs because of unequal access to care. Veterans' ability to obtain needed health care services from VA frequently depends on where they live and which VA facility they go to. VA spends resources providing services to high-income, insured veterans with no service-connected disabilities at some facilities, while low-income, uninsured veterans have needs that are not being met at other facilities.

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[7]Veterans living greater distances from VA clinics may have a tendency to visit multiple clinics during their outpatient visits, at least partially offsetting the lower number of visits.

Although considerable numbers of veterans have migrated to the western states, VA resources and facilities have shifted little. As a result, facilities in the eastern states are more likely to have adequate resources to treat all veterans seeking care than are facilities in western states, which frequently are forced to ration care to some or all higher-income veterans as well as to many veterans with lower incomes.

Medical centers' varying rationing practices also result in significant inconsistencies in veterans' access to care both among and within the centers. For example, as we reported in 1993, higher-income veterans without service-connected disabilities could receive care at 40 medical centers that did not ration care, while 22 other medical centers rationed care even to veterans with service-connected disabilities. Some centers that rationed care by either medical service or medical condition turned away lower-income veterans who needed certain types of services while caring for higher-income veterans who needed other types of services.[8]

Specialized Services Not Always Available

Veterans' needs for specialized services cannot always be met through other public or private-sector programs. Frequently, such services are either unavailable in the private sector or are not extensively covered under other public and private insurance. Space and resource limits in VA specialized treatment programs can result in unmet needs, as in the following examples:

-- Specialized VA post-traumatic stress disorder programs are operating at or beyond capacity, and waiting lists exist, particularly for inpatient treatment. Although private insurance generally includes mental health benefits, private-sector providers generally lack the expertise in treating war-related stress that exists in the VA system.

-- Inadequate numbers of beds are available in the VA system to care for homeless veterans. For example, VA had only 11 beds available in the San Francisco area to meet the needs of an estimated 2,000 to 3,300 homeless veterans.

-- Public and private health insurance do not include extensive coverage of long-term psychiatric care. Veterans needing such services must therefore rely on state programs or the VA system to meet their needs.

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[8]VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

-- VA is a national leader both in research on and treatment and rehabilitation of people with spinal cord injuries. Similarly, it is a leader in programs to treat and rehabilitate the blind. Although such services are available in the private sector, the costs of such services can be catastrophic.

Veterans Have Unmet Needs for Long-Term Care Services

Finally, veterans frequently have unmet needs for nursing home and other long-term care services. Medicare and most private health insurance cover only short-term, post-acute nursing home and home health care. Although private long-term care insurance is a growing market, the high cost of policies places such coverage out of the reach of many veterans. As a result, most veterans must pay for long-term nursing home and home care services out of pocket until they spend down most of their income and assets and qualify for Medicaid assistance. After qualifying for Medicaid, they are required to apply almost all of their income toward the cost of their care.

Veterans able to obtain nursing home care through VA programs can avoid the spend-down and most of the cost-sharing required to obtain service through Medicaid. VA has long had a goal of meeting the nursing home needs of 16 percent of veterans needing such care. In fiscal year 1995, VA served an estimated 9 percent of veterans needing nursing home care.

OPTIONS FOR RETARGETING RESOURCES TOWARD VETERANS' HEALTH CARE NEEDS

VA could use a number of approaches, within existing resources and legal authorities, to better target resources toward addressing the unmet health care needs of veterans. With limited resources, one approach would be to shift resources from providing services to one group of veterans to paying for expanded services for a different group of veterans. For example, resources spent in providing care for higher-income veterans without service-connected disabilities could be shifted toward improving services for veterans with service-connected disabilities and lower-income veterans whose health care needs are not being met. About 15 percent of the veterans with no service-connected disabilities who use VA medical centers have incomes that place them in the discretionary care category for both inpatient and outpatient care. Another approach could be to narrow the types of services provided--such as the provision of over-the-counter drugs--and use the resources spent on those services to pay for other higher-priority services.

Veterans' equity of access to VA health care services could be improved within existing legislative authority in the following ways:

-- VA could better define the conditions under which the provision of outpatient care would obviate the need for hospitalization. Such action would help promote consistent application of eligibility restrictions, but VA physicians would still be placed in the difficult position of having to deny needed health care services to veterans when treatment of their conditions would not obviate the need for hospitalization. This problem can be addressed only through legislation to (1) make veterans eligible for the full range of outpatient services or (2) authorize VA to sell noncovered services to veterans.

-- VA could reduce inconsistencies in veterans' access to care by better matching the resources of VISNs and individual medical centers with the volume and demographic makeup of eligible veterans requesting services at each center. In effect, VA would be shifting some resources from medical centers that have sufficient resources, and therefore, do not ration care. Such resource shifts could mean, for example, that some higher-income veterans at those medical centers might not obtain care in the future. But the shift would also mean that some veterans with lower incomes who had not received care at the other medical centers might receive care in the future.

-- VA could place greater emphasis on use of the fee-basis program to equalize access for those veterans who do not live near a VA facility or who live near a facility offering limited services. VA has specific statutory authority to contract for medical care when its facilities cannot provide necessary services because they are geographically inaccessible. While this approach would help some veterans, current law severely restricts the use of fee-basis care by veterans with no service-connected disabilities. Such veterans are eligible only for limited diagnostic services and follow-up care after hospitalization.

VA's recent efforts to establish access points will improve accessibility for some veterans, but VA has not applied the outpatient priorities for care or the eligibility requirements for fee-basis care in enrolling patients and providing services. As a result, access points could divert funds that could be used to provide access to VA-supported care for high-priority veterans to pay for services for discretionary-care veterans.

The concept of access points appears sound--to increase competition and therefore reduce costs of contract care. To be equitable, however, care provided through access points could be

made subject to the same limitations that apply to fee-basis care for other veterans.

Increased use of fee-basis care, either through fee-for-service contracting or capitation payments, is not, however, without risks. The capacity of VA's direct delivery system serves as a control over growth in VA appropriations. Without changes in the methods used to set VA appropriations, removing the restrictions on use of fee-basis care could create significant pressure to increase VA appropriations. In other words, the result might be expanding priorities for care covered under the fee-basis program to match the priorities currently covered at VA facilities rather than reordering priorities within available resources. This expansion of priorities could occur because VA's budget request does not provide information on the priority categories of veterans receiving care from VA.

-- Finally, VA could ensure that its facilities use consistent methods to ration care when demand exceeds capacity.

OTHER COUNTRIES INTEGRATED THEIR VETERANS' HOSPITALS INTO THEIR HEALTH CARE SYSTEMS OR SHIFTED THE FOCUS OF THEIR FACILITIES

Faced with aging and declining veteran populations, Australia, Canada, and the United Kingdom closed or converted their veterans' hospitals to other uses. Each country preserved and enhanced veterans' health benefits without maintaining their direct delivery systems. For example, they supplemented services covered under other health programs or gave veterans higher priorities for care or better accommodations under those programs. Veterans' service organizations, originally skeptical about the changes, now generally support them.

In all three countries, falling utilization rates, coupled with (1) the need to treat the effects of an injury rather than the injury itself and (2) the increased chronic care needs of an aging population made maintaining medical expertise increasingly difficult. For example, Australia's veterans' hospitals had trouble retaining skilled staff and maintaining affiliation with medical schools as their patient mix became increasingly geriatric.

The United Kingdom decided in 1953 that transferring its veterans' hospitals to the country's universal care system would both increase utilization of the former veterans' hospitals and allow them to preserve and further develop their specialized medical expertise by expanding their patient mix. Canada, in 1963, and Australia, in 1988, made similar decisions on the basis of continuing decline in acute care use of their veterans' hospitals

and the ability and desire of veterans to obtain care in their communities.

What we learned from our examination of these countries' veterans' health care programs was that health reforms, either nationally or within the veterans' system, that allow veterans to choose between care in VA facilities or community facilities decrease demand for care in VA facilities. In other words, any change in our veterans' health care system--such as the establishment of access points or other contract providers--that gives veterans greater access to community providers will likely decrease demand for that type of care in existing VA facilities.

In contrast to Australia, Canada, and the United Kingdom, Finland continues to operate a direct delivery system. It, like Canada, however, shifted the emphasis of its veterans' health care system from acute to long-term care services to meet the changing needs of an aging veteran population. By 1993, it had converted almost half of the beds in its primary hospital to nursing home care. Both Canada and Finland also developed home care programs to help veterans to maintain their independence as long as possible.

APPROACHES FOR PRESERVING AND ALTERNATIVES TO PRESERVING THE DIRECT DELIVERY SYSTEM

Most of VA's $16.6 billion health care budget goes to maintain its direct delivery infrastructure. It is invested in buildings, staff, land, and equipment. As the Congress deliberates the future of veterans' health care, it will inevitably face the question of whether to act to preserve health care benefits or the direct delivery system or both, as envisioned under VA's planned reorganization.

PRESERVING DIRECT DELIVERY

Three basic approaches might be used, individually or in combination, to preserve the direct delivery system: build demand for hospital care by increasing VA's market share of the veteran population; allow VA to use its excess hospital capacity to serve veterans' dependents and other nonveterans; and convert VA hospitals to other uses, such as meeting the increasing demands for VA-supported nursing home care.

Increase VA's Market Share of Veterans

One approach for preserving the direct delivery system would be for the VA system to increase its market share of the veteran population. About 80 percent of the veteran population has never used VA health care services. Bringing more of those veterans into the VA system could increase demand for VA hospital care.

Decreasing veterans' out-of-pocket costs does not appear to be a viable strategy for attracting new veteran users. All veterans are currently eligible for medically necessary VA hospital care without limits, about 9 to 11 million with no out-of-pocket costs. The remaining veterans would incur some cost-sharing if they sought care from VA facilities, but generally much less than they would incur in seeking care from private hospitals using their Medicare or private insurance.

Strategies that could be successful in attracting new users include the following:

-- Improving customer service. Many veterans have negative perceptions of both VA customer service and quality of care. VA, as part of its response to the Vice President's National Performance Review, has developed plans to improve customer service, including establishing standards for such things as waiting times. Similarly, VA has improved its accreditation scores from the Joint Commission on Accreditation of Healthcare Organizations; its average score is now higher than that of private-sector hospitals. Finally, VA is improving the privacy and amenities in many of its hospitals. For example, bedside telephones are being installed in all hospitals, and the number of private and semiprivate rooms is being increased. As veterans' perceptions change, demand for care is likely to increase.

-- Improving access to outpatient care. Improved access, either through establishment of additional direct delivery clinics or through contract care, could have the secondary effect of increasing demand for hospital care. VA hospitals could, over the next several years, open hundreds of access points and greatly expand market share. There are over 26 million veterans, and 550,000 private physicians could contract to provide care at VA expense. VA's growth potential appears to be limited only by the availability of resources and statutory authority, new veteran users' willingness to be referred to VA hospitals for specialty and inpatient care, and other health care providers' willingness to contract with VA hospitals.

This approach to filling VA hospital beds, however, would require significant budget increases if new access points modestly increase VA's market share of hospital and outpatient users. For example, VA currently serves about 2.6 million of our nation's 26 million veterans in a given year and 4 to 5 million veterans over a 3-year period. About 40 percent of the 5,000 veterans enrolled at VA's 12 new access points had not received VA care in the 3 years before they enrolled. Most of

the new users we interviewed had learned about the access points through conversations with other veterans, friends, and relatives or from television, newspapers, and radio.

-- Expanding eligibility. Expanding eligibility for outpatient care could also attract new users to the VA system. Although such users would be brought into the system through expanded outpatient eligibility, many of the new users would likely use VA hospitals for inpatient care. A 1992 VA eligibility reform task force estimated that making all veterans eligible for comprehensive VA health care services could triple demand for VA hospital care.

Expand Care for Nonveterans

A second approach for increasing the workload of VA hospitals would be to expand VA's authority to provide care to veterans' dependents or other nonveterans. Currently, VA has limited authority to treat nonveterans, primarily providing such services through sharing agreements with military facilities and VA's medical school affiliates.

Allowing VA facilities to treat more nonveterans could increase use of VA hospitals and broaden VA's patient mix, strengthening VA's medical education and research missions. Without better systems for determining the cost of care, however, such an approach could result in funds appropriated for veterans' health care being used to pay for care for nonveterans.

In addition, VA would be expanding the areas in which it is in direct competition with private-sector hospitals in the surrounding communities. Essentially, every nonveteran brought into a VA hospital is a patient taken away from a private-sector hospital. Thus, expanding the government's role in providing care to nonveterans could further jeopardize the fiscal viability of private-sector hospitals. In rural communities without a public or private hospital, however, opening VA hospitals to nonveterans might improve the availability of health care services for the entire community and, at the same time, help preserve the direct delivery system.

Convert VA Hospitals to Nursing Homes or Other Uses

A third approach to preserving the direct delivery system would be to convert VA hospitals to provide nursing home or other types of care. Although converting existing space to provide nursing home care is often cheaper than building a new facility, converting hospital beds to other uses would increase costs. Construction funds would be needed to pay for the conversions, and

medical care funds would be needed to pay for the new nursing home users treated in what had been empty beds.

VA could, however, serve more veterans with available funds if it were authorized to (1) adopt the copayment practices used by state veterans' homes or (2) establish an estate recovery program patterned after those operated by increasing numbers of state Medicaid programs. Unlike Medicaid and most state veterans' homes, the VA nursing home program has no spend-down requirements and minimal cost-sharing. Only higher-income veterans with nonservice-connected disabilities contribute toward the cost of their care, making copayments that average $12 a day.

Alternatives to Preserving the Acute Care Hospitals

Actions taken by Australia, Canada, and the United Kingdom suggest that veterans' benefits can be preserved and even enhanced without preserving the system's acute care hospitals. Alternatives to maintaining the current direct delivery system include (1) establishing a VA-operated health financing system to purchase care from other public and private providers (or expanding an existing program); (2) including veterans under an existing health benefits program, such as Medicare, the Federal Employees Health Benefits Program, or TRICARE; and (3) issuing vouchers to enable veterans to purchase private health insurance. Under any of these approaches, many existing VA facilities might be closed, converted to other uses, or transferred to the community.

Purchase Care From Public and Private Providers

VA already purchases health care services from public and private-sector providers in many ways. For example, it purchases services from its medical school affiliates and other government facilities through sharing agreements; it purchases care for eligible veterans geographically remote from VA facilities directly from private physicians through the fee-basis program; it contracts with groups of public or private-sector providers on a capitation basis to provide primary care services to veterans; and it operates a health financing program, the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), to purchase care for survivors and dependents of certain veterans.

Expanding or combining these programs into a single health financing program could increase VA's purchasing power in the health care marketplace, allowing it to purchase health care services at lower prices. For example, expansion of capitation funding could shift risks for controlling veterans' health care costs from the government to private providers contracting with VA. And increasing the use of private-sector providers within the VA

health care system could retain the focus on veterans' health care needs that might be lost by merging veterans' health care with another program.

Include Veterans Under an Existing Program

On the other hand, additional economies would be likely to be achieved by merging the veterans' health program with one or more of the existing federal health programs. For example, Medicare has many years of experience in negotiating and monitoring contracts with managed care plans and fee-for-service providers to ensure that the interests of both beneficiaries and the government are protected. Although the Health Care Financing Administration continues to face problems in identifying and eliminating fraud and abuse, it nonetheless has more experience than VA in wide-scale contracting.

Similarly, the Department of Defense (DOD) is in the midst of implementing its TRICARE system nationwide. TRICARE, a managed health care program, offers military beneficiaries alternatives to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), a fee-for-service program. TRICARE offers beneficiaries eligible for CHAMPUS two new options for health care in addition to the CHAMPUS program. The options vary in the amount of choice beneficiaries have in selecting their physicians and the amount beneficiaries are required to contribute toward the cost of their care received from civilian providers.

-- TRICARE Standard, or the current fee-for-service CHAMPUS program, gives beneficiaries the greatest freedom in selecting civilian providers but requires the highest beneficiary cost-sharing.

-- TRICARE Extra is a preferred provider option through which beneficiaries receive a 5-percent discount on the TRICARE Standard cost of care when they choose a medical provider from the contractor's network.

-- TRICARE Prime is an HMO-like alternative that provides comprehensive medical care to beneficiaries through an integrated network of military and contracted civilian providers. Beneficiaries selecting this option must enroll annually in the program, agreeing to go through an assigned military or civilian primary care physician for all care. Low enrollment fees and copayment features provide financial incentives for beneficiaries to select this option, the most highly managed of the three options.

Under an agreement between VA and DOD, VA facilities can apply to become providers under TRICARE Prime. To date, no VA facilities

are participating in TRICARE other than as fee-for-service providers. In many respects, VA's restructuring efforts parallel DOD's efforts in establishing TRICARE. Expanding TRICARE to include veterans' health benefits and VA facilities and physicians might further expand health care accessibility and options for beneficiaries of both programs.

Finally, veterans could be allowed to enroll in the Federal Employees Health Benefits program, which provides federal employees and annuitants and their dependents a choice of private health insurance programs, including traditional fee-for-service plans, preferred provider plans, and HMOs. Enrollment costs and cost-sharing vary widely, depending on the plan selected.

Issue Vouchers to Buy Private Insurance

Of the various health care options, offering veterans vouchers to use in purchasing health care services would give veterans the maximum choice. Acting individually to purchase care or insurance, veterans would probably be unable to obtain the same prices on health care services and policies that they could obtain through the volume purchasing advantages of the federal health care programs. For example, individual health insurance policies are generally much more expensive than comparable coverage obtained through a group policy such as those available under the Federal Employees Health Benefits Program.

Any of the options for increasing the use of private-sector providers would address the primary reasons many veterans give for not using VA care: perceptions of poor quality and customer service and limited accessibility. As a result, these options would be likely to generate new demand. Such new demand could be expected to create upward pressure on VA appropriations unless actions were taken under current budget rules to offset new costs. The new options could, however, be structured to supplement, rather than duplicate, veterans' coverage under other health programs. For example, eligibility for veterans with nonservice-connected disabilities might be limited to those without other public or private insurance. Benefits for other veterans might be limited to services not typically well covered under other public and private insurance, such as dental and vision care and long-term care services.

CONCLUSIONS

The VA health care system is at a crossroads--particularly in view of the dramatic changes occurring throughout the nation's health care system. These changes raise many important questions concerning the system.

-- Should VA hospitals be opened to veterans' dependents or other nonveterans as a way of preserving the system?

-- Should veterans be given additional incentives to use VA facilities?

-- Should some of VA's acute care hospitals be closed, converted to other uses, or transferred to states or local communities?

-- Should additional VA hospitals be constructed when use of existing inpatient hospital capacity is declining both in VA and in the private sector?

-- Should VA remain primarily a direct provider of veterans' health care?

-- Should VA become primarily a purchaser of health care from other providers for veterans?

Decisions regarding these and other questions will have far-reaching effects on veterans, taxpayers, and private providers. We believe that attention is needed to position VA to ensure that veterans receive high-quality health care in the most cost-efficient manner, regardless of whether that care is provided through VA facilities or through arrangements with private-sector providers.

The declining veteran population in the United States, in concert with the increased availability of community-based care, makes preserving the current acute care workload of existing VA health care facilities exceedingly difficult. VA will have to attract an ever-increasing proportion of the veteran population if it is to keep its acute care facilities open. Other countries have successfully made the transition from direct providers to financiers of veterans' health care without losing the special status of veterans.

The cost of maintaining VA's direct delivery infrastructure limits VA's ability to ensure similarly situated veterans equal access to VA health care, and funds that could be used to expand the use of fee-basis care are used instead to pay for care provided to veterans in the discretionary care category at VA hospitals and outpatient clinics.

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Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions that you or other Members of the Subcommittee may have.

For more information on this testimony, please call Jim Linz, Assistant Director, at (202) 512-7110 or Paul Reynolds, Assistant Director, at (202) 512-7109.

RELATED GAO PRODUCTS

VA Health Care: Efforts to Improve Veterans' Access to Primary Care Services (GAO/T-HEHS-96-134, Apr. 24, 1996).

VA Health Care: Approaches for Developing Budget-Neutral Eligibility Reform (GAO/T-HEHS-96-107, Mar. 20, 1996).

VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs (GAO/T-HEHS-96-99, Mar. 8, 1996).

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995).

VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs (GAO/HEHS-95-39, Apr. 21, 1995).

VA Health Care: Barriers to VA Managed Care (GAO/HEHS-95-84R, Apr. 20, 1995).

Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Reform (GAO/HEHS-95-14, Dec. 23, 1994).

Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

Veterans' Health Care: Implications of Other Countries' Reforms for the United States (GAO/HEHS-94-210BR, Sept. 27, 1994).

Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

Veterans' Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994).

VA Health Care: A Profile of Veterans Using VA Medical Centers in 1991 (GAO/HEHS-94-113FS, Mar. 29, 1994).

VA Health Care: Restructuring Ambulatory Care System Would Improve Service to Veterans (GAO/HRD-94-4, Oct. 15, 1993).

VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, June 30, 1993).

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STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2450 N STREET, NW WASHINGTON, DC 20037-1127
PHONE 202-828-0400 FAX 202-828-1125
Jordan J. Cohen, M.D., President

ON

FUTURE OF THE VETERANS HEALTH ADMINISTRATION

Presented By

Daniel H Winship, M.D
Dean
Stritch School of Medicine
Loyola University of Chicago

before the

Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
United States House of Representatives
The Honorable Tim Hutchinson, Chairman

334 Cannon House Office Building
Washington, DC
Thursday, June 27, 1996

Good morning, Mr. Chairman and members of the Subcommittee. I am Daniel H. Winship, M.D., dean of the Stritch School of Medicine at Loyola University Chicago. I am pleased to present testimony on behalf of the Association of American Medical Colleges (AAMC) at this hearing on the future direction of the Veterans Health Administration.

As we consider together the future of the VA health system, I want to underscore the AAMC's strong belief that VA is a critically important national asset and worthy of preservation. The VA health system delivers excellent health care to veterans, as demonstrated by the high scores consistently received by VA medical centers from the Joint Commission on the Accreditation of Healthcare Organizations. The VA is recognized as a national leader in many specialized areas of medicine such as geriatrics, mental health, blind and other physical health rehabilitation and spinal cord injury . While these specialized areas are of significant importance to veterans, they are also important to the nation's citizens. In addition to supporting and participating in the education of tens of thousands of medical students and residents every year, the VA health system also contributes significantly to the growing list of advances in medical procedures and treatments attributable to our nation's biomedical research enterprise.

The AAMC represents the 125 accredited United States medical schools; nearly 400 major teaching hospitals, including 74 Department of Veterans Affairs (VA) medical centers; over 90 professional and academic societies; and the nation's medical students and residents. In devoting my professional life to research and academic medicine, I have held appointments at a number of institutions represented by the AAMC, including, in addition to my current position, the Marquette School of Medicine in Milwaukee; the University of Missouri School of Medicine in Columbia, where I served as professor and associate chairman of the department of medicine and associate dean for VA affairs; and the University of Kansas School of Medicine in Kansas City, where I was professor of medicine and associate dean for VA affairs.

I believe I bring a unique viewpoint to this table today. In addition to teaching medical students and residents, conducting health research, and administering a medical school, I have served on the staff of four VA medical centers, including positions as medical service chief and chief of staff at the Harry S Truman Memorial Veterans Hospital in Columbia, Missouri, and as chief of staff at the Kansas City VA Medical Center. I was also medical center director at the Kansas City VA in 1986 and 1987, after which I came to Washington, D.C. to serve as associate deputy chief medical director in charge of programs and operations for medicine and surgery in VA Central Office. In 1990, I left Washington for my current appointment as dean of the Stritch School of Medicine and as an attending physician at both Loyola University Medical Center (Loyola) and the Edward Hines, Jr., VA Hospital (Hines), which are located on adjacent campuses in the near western suburbs of Chicago.

The Hines VA, currently affiliated with Loyola, was the first VA medical center to enter into an affiliation with a medical school. Hines was originally affiliated, in 1946, with both the University of Illinois at Chicago (UIC) and Northwestern University; today, UIC is affiliated primarily with the West Side VA and Northwestern's partner is the Lakeside VA. Today, some 130 VA medical centers have affiliation arrangements of various sizes and scopes with 105 of the nation's 125 medical schools. As we celebrate this year the 50th anniversary of the first affiliation, the AAMC and its member institutions look back with pride upon our decades of service to America's veterans and look forward to continuing our commitment.

The AAMC is pleased to have the opportunity to work with the Congress and the VA to extend into the future the prominence of the Veterans Health Administration as a comprehensive health care delivery system. If our nation expects the VA to provide effective and compassionate care for the bodies and minds of our nation's veterans, the VA should not be forced to limit its scope solely to those areas in which the VA has special expertise. One of the main reasons for the success of VA's unique programs for patients with special needs is the infrastructure provided by comprehensive VA medical centers. This common support system is the necessary foundation upon which VA builds expertise in the specialized areas mentioned above as well as cardiac care, long term care, and substance abuse treatment. Newly created VISNs should rest upon the foundation created

by the joint medical school/VA partnership. This foundation will allow for a more coordinated, integrated and comprehensive health care delivery system for our nation's veterans.

However, the future of VA as a comprehensive health system currently faces serious challenges similar to the ones that medical schools and teaching hospitals are encountering in the emerging environment of health care delivery. The continued success and vibrancy of VA and academic medicine in this health care delivery environment depends greatly upon our responses over the next few crucial years.

Although academic medicine and the VA provide health care of unparalleled quality, both academic and VA medical centers traditionally have been more expensive than those providers that do not share our roles in education and research and our responsibilities for caring for underserved populations. Over the last few years, outside forces have begun pressing both academic and VA medical centers to provide health care more cost-efficiently. For academic medicine, the impetus has been the growth of managed care and the unwillingness of employers and insurers to assume some of the costs associated with health care provided by institutions with additional missions--undergraduate and graduate medical education and research. For the VA health system, the impetus has been stimulated by federal appropriations for medical care that have failed to keep pace with inflation and the needs of its patient population as well as responding to medical progress and innovation.

In response to these transformations, both academic medicine and VA are moving away from the traditional hospital-based model of health care delivery to a structure that emphasizes the delivery of care in ambulatory and outpatient sites. Moreover, academic and VA medical centers are establishing new partnerships with other health care providers to increase efficiency, to rationalize resource distribution, and to manage effectively in the emerging health care marketplace.

For instance, my institution, Loyola University Medical Center, a national leader in many specialized areas of medicine, recently announced a major affiliation with West Suburban Hospital Medical Center, a major provider of primary health care to the citizens of Chicago and its outlying suburbs. Our two facilities, together under one leadership, will complement each other's strengths and provide a comprehensive continuum of health care to the populations we serve. The synergy imbued by partnerships with complementary providers is vitally important to the ability of most academic medical centers to survive in an increasingly cost-conscious and competitive arena.

The VA health system, likewise, is developing a new health care delivery structure that seeks to eliminate inefficiencies and duplication and to maximize its limited health care dollars and resources. Under the leadership of Secretary Jesse Brown and Under Secretary for Health Kenneth Kizer, M.D., the Veterans Health Administration has organized its 171 medical centers into 22 regional systems known as Veterans Integrated Service Networks, or VISNs. Under each VISN umbrella, several VA medical centers and their associated or affiliated partners are expected to work collectively to deliver health care to the veterans in their region both efficiently and effectively. The success of the VISN concept, just like Loyola's partnership with West Suburban Hospital Medical Center, depends upon strong and trusting coordination and collaboration among all partners and affiliates.

For VA to enjoy a successful future, the VA health system must respond directly and efficiently to the needs of its veteran patients. Dr. Kizer's reorganization plan is an important first step toward achieving this objective. The AAMC believes that Congress, the veterans service organizations (VSOs), and the academic community should continue to support the efforts made by Dr. Kizer and his colleagues to restructure and rationalize VA's health resources. Toward this end, the AAMC believes that Congress must tackle the reformation of the arcane and sometime irrational rules governing a veteran's eligibility for care in the VA health system. Eligibility reform, properly crafted, will allow the VA to focus its resources on a well-defined patient population, particularly service-connected veterans

and veterans who rely on the VA as their only source health care. Every eligible patient should be provided with comprehensive health care that runs the gamut from basic preventive care to the specialized services that are the hallmark of VA medicine. The AAMC believes that eligibility reform should be done in tandem with the reformation of the VA from veterans' hospitals to VISNs.

The VA's academic partners, especially the more than 100 medical schools currently affiliated with VA medical centers, also have roles to play in securing a strong future for the VA health system. As each VISN strives to use wisely its human, fiscal, and capital resources, the roles of the various medical centers and other facilities within each network are likely to change. However, most VA medical centers have a close relationship that has evolved over years, if not decades, with a neighboring medical school. At the Hines VA, for instance, virtually all of the service chiefs are Loyola physicians, sometimes medical equipment is jointly purchased and shared, and medical residents and faculty rotate seamlessly between the two medical centers and other affiliated facilities in a truly integrated training program.

Clearly, changes in the roles some VA hospitals may play within their networks would carry major ramifications for the relationship between that hospital and its affiliated medical school. For many medical schools, the affiliated VA hospital is one of the major sites for the clinical education of the school's medical students and residents. At my institution, the Hines VA trails only Loyola's own teaching hospital in importance as an educational resource.

To protect the integrity of the VA's and our own missions in health care, education, and research, medical schools must begin to rethink together how best to use each VISN's research and educational capacities. At the same time, however, if a VISN needs to consolidate services at certain facilities within each network, the VISN director should consult carefully with the VA medical center directors and the deans of affiliated medical schools to devise strategies that enable the VA to allocate its resources more efficiently and the deans to formulate new relationships that preserve the educational and research objectives of their schools. Openness by all parties to new ideas and arrangements for patient care, education and research will bode well for the success of each VISN and, in turn, the VA health system as a whole. At the same time, the AAMC encourages the VA to communicate proposed policy changes in a timely fashion so that all interested parties may engage in discussions and negotiations throughout the process. We are committed to making these changes, but we will need adequate time to move in new directions.

Before closing, I must emphasize that while the VA research program makes major contributions to the nation's research agenda, it is also an important feature in the ability of the VA to recruit and retain highly qualified physicians. The AAMC believes that protecting the quality and size of the research program will allow the VA to maintain its highly qualified physicians, who in turn will provide excellent care to the nation's veterans in a reformed delivery environment.

Academic medicine wishes strongly to ensure the survival of the VA as a comprehensive health system and an important partner in education and research: to that end, medical schools must learn to collaborate with all of the other VA hospitals and medical schools within each VISN. The AAMC will continue to work with VA officials in Washington on national policies that affect the health of veterans and the affiliations between VA hospitals and medical schools. However, the association recognizes that decisions regarding the local administration of VA resources are best made locally. While altering long-standing relationships and forging new collaborations is often a difficult task, we must remember that the primary purpose of affiliations between VA hospitals and medical schools has been and always will be to provide an unsurpassable quality of health care for those who have borne the battle so that we may live free.

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Statement
of
Robert M. Kolodner, M.D.
Deputy Chief Information Officer
Veterans Health Administration
Before
House Committee on Veterans' Affairs
Subcommittee on Hospitals and Health Care
June 27, 1996

Mr. Chairman and Members of the Subcommittee, it is a pleasure for me to represent the Veterans Health Administration, at today's hearing.

I am pleased to have this opportunity to discuss in more specific detail some of the issues raised in broader terms by Dr. Kenneth Kizer, our Under Secretary for Health, at yesterday's hearing before this Committee. Dr. Gregg Pane, our Chief Policy, Planning and Performance Officer, has accompanied me to today's hearing, to join me in responding to any questions you may have.

Mr. Chairman, as Dr. Kizer indicated, we are making a concerted effort to reform and reinvent veterans healthcare. His 1995 *Vision for Change* and the more recent *Prescription for Change* challenge us as practitioners, managers, policy makers and planners to move the VA system as it has never been moved before. The scope and potential of these changes are difficult to explain in the confines of a Congressional hearing--even a two-day session, but let me try to give you a sense of the effort in greater detail, as well as some particular examples from my area of responsibility in telemedicine and information management.

Dr. Kizer explained that we have created 22 new management units in the field, called Veterans Integrated Service Networks. These 22 executive staffs are being empowered to change the very nature of VA healthcare. In a number of ways, they are being urged to be bold; to take reasonable business risks to improve the delivery system; to shift modes of care; to be more focused on providing care in the most accessible and cost-effective ways and less fixed on providing all care in VA facilities; to move the delivery system based on primary care; and to find and manage with new incentives that emulate the best of what we call "managed care," while recognizing that VA is not at its heart a "business." Also, we are implementing a new method of internal resource allocation, using a form of capitation adapted from managed care. This will cause a significant internal financial pressure on the system as we have known it and will begin to shift funds to better match the needs of the veteran population. Finally, we are using an executive-performance incentives system to give key executives strong incentives to create

and manage an environment of change, coupled with system-level performance measures so that we can ensure change is occurring in the "right" direction for veterans.

We are also restructuring VHA Headquarters, Mr. Chairman. Headquarters is now reorganized into logical teams of key offices, led by executives focused on implementing the *Prescription for Change*. Headquarters, in the context of the "new VHA," is not involved in local operations of the healthcare system. We do not intend to micromanage the work of medical centers or VISN staffs, but we do intend to ensure that it results in high quality, compassionate and economical care. We do focus on national coordination of policy, future system direction, economies of scale, consolidations and standardization, in areas where the system as one enterprise can profit from collective, coordinated action. Certainly, as before, we will concentrate on representing VHA interests within government, and will actively participate in government wide activities such as the National Performance Review, various budget processes, as well as major new challenges such as the Government Performance and Results Act and the Chief Financial Officers Act, among other initiatives and clearly national responsibilities.

To give the Subcommittee specific insight into some current Headquarters and field activities, let me discuss a few areas within my own responsibilities within the information-management arena. First, let me discuss the area of Telemedicine. Mr. Chairman, *The Prescription for Change* specifically calls for a ***telemedicine strategic plan.*** Telecommunications, particularly imaging, will enable scarce diagnostic and therapeutic resources to be used network-wide, combining interactive audio, visual, and other ways of transmitting and analyzing diagnostic information. Telemedicine will be used extensively to apply scarce diagnostic and therapeutic resources to rural areas and as a tool for consultative back up to primary care management.

Management of the patient in the home will rely on the patient using simple monitoring systems to transmit periodic information that would be monitored and responded to when control limits were violated. Every home will become a potential access point for care. Non-physician providers will be extensively utilized in the management of chronic conditions utilizing decision support systems that flag situations where physician consultation is mandatory.

VA has been using telemedicine in one form or another for over 13 years. Our current inventory now includes hundreds of applications in every state at every VA medical center, covering the full spectrum of telemedicine, from very simple, inexpensive systems used directly by our veteran patients to new, high technology ones used by VA

staff. These systems help us to provide high quality, cost-effective, convenient care to our veterans.

To illustrate the beneficial impact of our telemedicine activities on the quality of care delivered at the VA, we routinely monitor the ECGs of veterans with cardiac pacemakers in their own homes using standard telephone lines. Pacemaker monitoring not only improves health care quality, but it is also convenient for veterans, since he or she can be in touch with us for immediate monitoring 24 hours a day from any place that has a telephone. We like to say that the VA has made over 386,000 "house calls" since 1982 using this system alone.

Improving the convenience of care for veterans is an important goal of VHA telemedicine activities. Our Interactive Voice Response Systems allow veterans to obtain next- appointment information, and to check on the status of and even order refills of their medications at a VA Pharmacy from their home or from anywhere else they choose. More than 110 VA medical centers are currently using some form of this technology.

Many commercial telemedicine products are used routinely in the VA. These include one system that transmits nuclear medicine images, another that transmits electrocardiograms from multiple remote sites to our VA Centers of Excellence for diagnostic interpretation, and a third that allows pathologists at one VA facility to actually manipulate and interpret pathology slides located at a remote site where there is no staff pathologist using a remote controlled microscope. The telepathology system is the first of its kind in the Western Hemisphere and one of only a few in the world.

Another application that improves our efficiency and quality is a tele-imaging network using a VA-developed imaging system that uses standard, relatively inexpensive hardware components. A variety of medical images such as endoscopies, dermatological, dental, and others, are captured and stored in an electronic patient record which then provides clinicians visual and text information for medical decision making either at the originating VA site or at a remote one where the veteran might receive subsequent care.

It is important to note that the efficiency benefits from this system are not limited just to the VA. In the past, we have worked closely with staff at the Department of Defense to provide them with the VA-developed software that they use to link their MDIS imaging system with their Composite Health Care System, and the Indian Health Service uses a telemedicine system that is based on the VA's imaging system. The Indian Health Service Alaska Native Medical Center in Anchorage reads orthopedic and other radiology films for their remote facility in Bethel, Alaska. In fact, in the first six weeks of operation,

four costly medical evacuations were prevented. Two additional sites in Alaska are in the process of being added.

VA uses telemedicine to provide distance learning opportunities for its staff. With 200 satellite TV sites throughout the Veterans Health Administration, this technology is used for both clinical and administrative continuing education programs

Recently, VA demonstrated the prototype of a very exciting application that may represent the future direction of healthcare automation In partnership with Science Applications International Corporation, we have developed a working model of an Internet "front-end" for the medical record, allowing us to pull data directly from our existing Decentralized Hospital Computer Program system into a Web page using a standard Internet browser, and then to link this data across the Internet to a decision support system at Harvard. This is an exciting new capability becoming available in medicine, and the VA is actively examining how we might best use it to the benefit of our veterans.

The VA telemedicine activities have been able to successfully flourish because we do not have some of the barriers that plague private sector providers. First, VA clinicians can sign medical documents electronically because we are subject to federal laws and not to the morass of state-level pen and quill laws. Second, VA staff licensed in one state are able to practice in any VA facility, so we do not face licensure restrictions when crossing state lines. And third, lack of reimbursement of the telemedicine activity from a third party does not prevent our using telemedicine systems since VA itself is able to fund them because of the benefits they provide to us as a system.

We believe that the use of telemedicine plays an essential role in the transition VHA is making from hospital-based activity to a network-focused system. As extensive as it is, telemedicine is but one small step we are taking in administering Dr. Kizer's *Prescription for Change.*

Mr. Chairman, once again, on behalf of the Department of Veterans Affairs, thank you for the opportunity to testify today. Dr. Pane and I would be pleased to respond to your questions.

THE FUTURE OF THE VETERANS HEALTH ADMINISTRATION (VHA)

Statement of:

Thomas E. Mannle, Jr.
Senior Manager
THE LEWIN GROUP

Before the:

Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
U.S. House of Representatives

June 27, 1996

INTRODUCTION

Good morning, Mr. Chairman and members of the Subcommittee. My name is Tom Mannle, and I am a Senior Manager at the Lewin Group, a health policy research and consulting firm located in Fairfax, Virginia. On behalf of my colleagues at the Lewin Group I am pleased to appear before the Subcommittee this morning as it explores the future of delivering quality, cost-effective health care to the nations veterans, and the implications of changes in current delivery methods for the Veterans Health Administration (VHA).

The Lewin Group, in partnership with the Klemm Analysis Group and Arthur Anderson, LLP, has been working closely with VHA over the past 10 months to study—in response to direction by the Congress—the "feasibility and advisability of alternative organizational structures, such as the establishment of a wholly-owned Government corporation or a Government-sponsored enterprise, for the effective provision of health care services to veterans." (public Law 103-446, Section 1104). Over the course of our work we evaluated alternative organizational structures, conducted a comprehensive review of prior studies and analyses, performed intensive interviews within various levels of VHA, met with representatives of the veterans service organizations, and extensively analyzed the characteristics of the current VHA's health care delivery system using the framework provided by the VHA's *Vision for Change*, i.e., the concept of organizing the VHA as a system of 22 geographically-based integrated service delivery networks called VISNs (Veterans Integrated Service Networks). We included in our analysis a number of dimensions using comparative data from the both the public and private sectors.

My testimony this morning is intended to provide the Subcommittee a broad review of the implications of this analysis for the future of VHA.

BACKGROUND

VHA, like other large health care delivery systems, is under increasing internal and external pressure to change its traditional ways of doing business. The health care marketplace is rapidly moving towards integrated delivery systems that represent partnerships of physicians, hospitals, and other providers. These entities provide care in a coordinated fashion across a continuum from the most basic preventive care to the most complex tertiary care. Increasingly these entities are being paid not in the traditional fee for service mode, but through a set per capita rate. This means providers are now being compensated on the number of people under their care, rather than on the number of services provided. Concurrent with these changes in organizational structure and financing has been a marked shift in how care is delivered. New emphasis has been placed on prevention, primary care, patient outreach and education, and disease management as ways of improving health outcomes while reducing costs. Motivated by pressures to manage costs and supported by changes in technology, the use of inpatient resources has declined substantially, while the use of outpatient resources has increased.

Numerous reports have documented the need for VHA to embrace some aspects of the changes occurring in the marketplace in its delivery of services to the nation's veterans. In summary, all of these reports provide similar recommendations and document the need for VHA to chart a new direction—to reform eligibility, redistribute resources, adopt innovative approaches to improve veterans' access to care, increase emphasis on primary care services, decentralize organizational decision making and authority, and further integrate delivery assets to provide a seamless continuum of care. VHA's ability to implement these recommendations has been limited by concerns on the part of Congress, veterans service organizations, and other important constituencies about the potential for disruption of veterans' care, effects on local employment, and cost impacts of the proposed changes.

The VHA has recently begun implementing many of the changes recommended in these reports, including implementation of the VISN concept and increased development of VHA's outpatient and primary care capabilities. However, VHA's continued existence as a dedicated veterans' health system will likely depend on maintaining patient volume in its facilities sufficient to assure Congress that a separate Federal system is more cost-effective and patient-friendly than private health care facilities. Achieving this goal may require the VHA to move even more rapidly towards improved capabilities to compete successfully with private sector health plans and providers to care for eligible veterans—and potentially their families—who have other forms of

health insurance. Success may also require VHA to meet or exceed the service, quality, and cost performance capabilities of the evolving private sector system. Even if VHA were to focus exclusively on serving service-connected disabled and uninsured veterans, VHA should adopt the best practices of the private sector to maximize quality and cost effectiveness, and to improve access to ensure that no deserving veteran lacks appropriate care.

ANALYSIS OF THE VHA

With this background, our detailed analysis of the mission, capabilities, and strategic options available to VHA was intended to identify the range of possibilities for organizing the VHA health care delivery system in the future. Our analysis included three components (Exhibits 1 and 2 summarize the first two of these components):

Analytic Questions. In our analysis of strategic options, we developed an analytic framework using mission issues and VHA organizational capabilities as the foundation for assessing the strategic options that may be open to the VHA, now and in the future. The following questions represent our approach for conducting the analysis:

- Who is VHA serving? Who could it serve?
- What services is VHA providing? What services could it provide?
- How should VHA approach the service delivery issues it faces?
- What should the new service delivery system look like?
- What capacities and capabilities does the new system need?

Strategy Dimensions. In addressing each of the questions posed above, we found that potential answers aligned with four broad and interdependent dimensions of strategic choice facing VHA. Each dimension can be thought of as representing a spectrum of possibilities for organizing the VHA health care delivery system. Depending on where particular VISNs or VHA as a whole choose to locate themselves on each spectrum, VHA may have one, several, or a multiplicity of delivery system options. The strategy dimensions are:

- **Current or new customers:** Should VHA focus on its current customers (i.e., eligible veterans) or seek new customers? Pursuing a **current customers** approach requires the continued restriction of access to VHA services to only those veterans meeting current eligibility requirements and potential downsizing to match the needs of a shrinking veteran population. Soliciting **new customers,** either within or beyond the veteran population, offers VHA an opportunity to maintain the utilization of its service delivery capacity despite the declining population base of veterans.
- **Full service or specialty care provider:** Should VHA seek to expand its current dual roles as both a full service provider and as a specialty care provider, or place greater emphasis on expanding one or the other? As a **full service provider** VHA would serve a comprehensive range of a veteran's health needs. To pursue this strategy, services would have to be realigned, moved closer in proximity to desired populations, and linked across a broad continuum of care (e.g., integrate outpatient, inpatient, and long-term patient care services). A narrower **specialty care** approach suggests that VHA should concentrate resources on what many consider to be VHA's traditional niche: VHA special programs and the needs of service connected veterans.
- **"Make" or "buy" services:** Should VHA continue to "make" its ability to deliver patient care services—that is, provide services by organizing its internal staff and financial resources and organizational and administrative capacity—or should it purchase services from external sources?
- **Retain or divest capacity:** How much of VHA's current infrastructure and service delivery capacity should be retained, and how much should be divested or converted to non-patient care uses? There are no clear or right answers to these questions; indeed, the

topics of divestiture, conversion or closure have been difficult to raise in policy debate, let alone accomplish. While the stated goal of VHA, recently re-emphasized by implementation of the VISN concept, is "Patients First," observers outside VHA have also concluded that for a variety of reasons, an equally important, implicit institutional goal is the preservation—and expansion in some cases—of VHA's physical assets and facilities. We have noted while conducting the study that this traditional resistance may be changing, and in our analysis we included consideration of under what circumstances it might be appropriate to retain or divest VHA's current capacity to deliver patient care services. Briefly, for any VISN or VHA as a whole, the question should be considered *after* resolving the first three dimensions of strategic choice. In general, decisions to expand VHA's customer base, provide full services, and use VHA's organic delivery capacity will tend to support retention of physical assets and facilities; decisions to concentrate on current customers, provide more limited services, and buy services from external sources will increase pressure to divest or find other uses for VHA's physical assets and facilities.

Data Analysis. To assess VHA's capabilities across the above dimensions, we examined in detail five aspects of the current VHA structure and operations: efficiency, market share, capacity, resource mix, and quality These analyses allowed us to analyze the VISN by VISN feasibility of the various strategic choices, alone and in combination.

In conducting the data analyses, we faced a number of significant analytic limitations. First, we used historic data which may not represent the performance and organization of the new VISN structure In fact, recent data suggest potentially dramatic changes in length of stay, use of outpatient facilities and reduction in the number of inpatient beds which were not taken into account in this analysis. Second, while we completed an extensive review of VHA inpatient costs compared to benchmarks, these data must be interpreted cautiously because of inconsistencies between VHA and benchmarks in how costs are allocated and the uncertain relationship between costs and charges in the private sector. Third, while this study suggests a number of important hypotheses about relationships between cost and market performance in VHA, exploring these questions was not the purpose of this effort. We have used the analyses not to rationalize or defend VHA's current performance, but rather to suggest the direction and focus of a new organizational structure and to outline the range and scope of strategic options that the new structure should accommodate.

FINDINGS

The findings of our qualitative and quantitative work can be summarized in four overall statements:

- VHA does not currently have the resources it needs to invest in making significant changes to its mode of care Funds to invest in new programs, or to make improvements in current programs must come from savings realized through changes to current programs or from the collection (and retention) of revenues from other sources of payment (Medicare, private insurance).

- Interviewees both within and outside VHA expressed the view that any changes in the future strategy of VHA must not dilute its commitment to serving ***the special needs*** of veterans with accessible, high quality programs.

- There is considerable ***homogeneity*** among VISNs in terms of who VHA is serving (which age/sex segments) and what services are strongest (inpatient special programs).

- There is considerable ***heterogeneity*** among VISNs in key performance indicators (cost, Average Length of Stay (ALOS), market share of utilization, market share of veterans, capacity utilization, customer satisfaction, inpatient/outpatient mix).

Given these observations there are several elements of change—together comprising an outline of the objectives of a new service delivery strategy—that VHA should consider. The new system should:

- ***Concentrate on serving the special health care needs of veterans***
- ***Increase the use of contracting for general medical services***
- ***Build capacity to manage across the continuum of care and integrate clinical resources***
- ***Shift services from an inpatient to an outpatient mode***
- ***Create opportunities for each VISN to create a tailored service delivery strategy based on the specific needs of its veteran population and its unique performance capabilities***

In pursuing these objectives, we believe that there are two considerations that must be kept in mind. The first is the continuing importance of the mission questions—Who should be served? With what services? These questions frame the dialogue that the VHA must engage in on an iterative basis with the Congress and its external constituencies. An understanding of how the mission of the VHA should evolve over time must be addressed before the VHA can provide effective attention to the issues of delivery system implementation and strategic management of its service delivery capacity and infrastructure.

Further, a single service delivery strategy will not fit the unique capabilities, client mix and resources of all VISNs. However it is likely that VISNs will cluster around a handful of "prototype" approaches which should all be accommodated in the overall organizational structure. Below we outline three major prototypes which VISNs may choose to pursue. We would expect VISNs to uniquely combine aspects of each approach in developing tailored solutions to meet the specific needs of the veterans in their service areas.

- **VISN Strategy I—Full Service Network.** The full service VISN is one that provides a broad range of inpatient and outpatient services to eligible veterans and potentially other paying customers. In general, pursuit of this strategy would require considerable investment of resources to build outpatient capacity, demonstration that the VISN is or could be the "provider of choice" for a broad group of current and potential customers and, equally, demonstration that the VISN is a leader in high quality and efficient services across a broad range of programs. Under this model the VISN would supply most services directly to veteran clients and would also likely sell many of these services to "paying" clients. The VISN would perform the care management and system integration functions. A variation of this model is one where VHA directly provides all or most inpatient services, and contracts out for a substantial portion of outpatient services.

- **VISN Strategy II—Virtual Network.** Under the virtual network concept VHA combines direct provision of services with considerable contracting. The VISN retains responsibility for managing the care of its patients through case management systems, care plans, and new mechanisms facilitating patient movement across inpatient and outpatient care. The complete system of care, which combines VHA and community-based services under one "care management roof", would be used by eligible veterans and paying veteran clients alike. Pursuit of this strategy would require new tools and mechanisms for managing the continuum of care across VHA and community-based sites. The virtual system could adapt quickly to the emergence of new and evolving health care needs and evolving patterns of demand for VHA services.

- **VISN Strategy III—Centers of Excellence.** This strategy builds on the unique capabilities of VHA in serving the comprehensive needs of special groups of eligible veterans and other paying veteran customers. Pursuing this strategy does require a full set of inpatient and outpatient services—to meet the needs of these groups. This strategy may be most appropriate for VISNs who because of the recognized quality of their programs or documented local demand could position themselves to become national or regional referral centers for special classes of patients from within VHA or from private sources.

To pursue this strategy VISNs would need to build outpatient capacity oriented to VHA special programs. They would also need to devise effective strategies for continuing to serve the needs of priority veterans with more general health care needs.

SUMMARY

Our findings indicate that the speed and direction of the change required for VHA to catch up and then keep pace with the external environment may necessitate more fundamental change than can be achieved by working within the current structure. Restructuring, however, must be done in such a way so as to preserve the unique features of VHA that are valued by the veteran population and society at large, but that might not be supported under a completely market-driven system. These features include VHA's 12 special programs, its unique expertise to serve disabled and mentally ill veterans, and its extensive contributions to teaching and research.

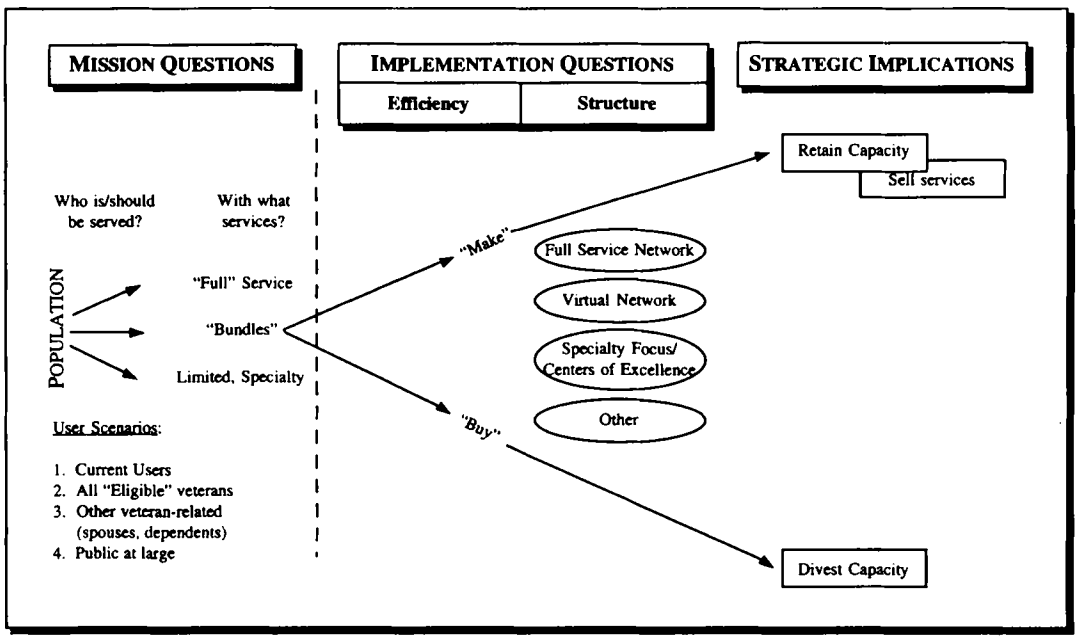
Balancing these two potentially conflicting goals—meeting or exceeding the service requirements of the private sector and preserving what is unique and valuable in the current VHA—will require an organizational structure that retains the accountability of the current structure to Congress and veterans' service organizations but allows for flexibility in operations like that of a private sector delivery system.

EXHIBIT 1
ANALYSIS OF THE VHA

Analytic Questions
◆ Who is VA serving? Who could it serve?
◆ What services is VHA providing? What services could it provide?
◆ How should VHA approach the service delivery issues it faces?
◆ What should the new service delivery system look like?
◆ What capacities and capabilities does the new system need?

Strategy Dimensions
◆ Current vs. new customers
◆ Full service vs. specialty provider
◆ Make or buy services
◆ Retain or divest capacity

EXHIBIT 2
VHA ANALYTIC FRAMEWORK



THE FUTURE OF THE VHA: RECOMMENDATIONS TO CONVERT THE VHA INTO A GOVERNMENT CORPORATION

STATEMENT OF

Mr. Drew Valentine
Senior Manager, Federal
Strategic Services
Arthur Andersen

before the
Subcommittee on Hospitals and Health Care
Committee on Veterans Affairs
US House of Representatives

June 27, 1996

Mr. Chairman and members I'd like to thank you for this opportunity to testify on the future of the VHA. As Mr. Mannle of the Lewin Group has previously indicated, the team of Arthur Andersen, the Lewin Group, and Klemm Analysis has recently completed an important study, commissioned by the Congress, to look at alternative organization structures for the VHA.

We believe that Dr. Kizer has recently developed and pursued some important initiatives at the VHA. We feel strongly that the VISN concept (Veterans Integrated Service Networks) being implemented is the right move, at the right time, for the right reason. Our recommendations are not only consistent with the VISN concept, but, in fact are intended to maximize the impact of the VHA reorganization.

We have attempted to answer the question, "could a new organization structure improve the likelihood that the VISN concept will be a success?" After an exhaustive study and an analysis of VHA's past performance and the early performance of the VISNs we believe that more change is still necessary. Thus we are recommending a restructured VHA.

A restructured VHA will move towards specific improvements in both overall management and performance. On the basis of our analyses of the current characteristics and potential future health care delivery strategies of VHA, we have determined that the new structure should:

- Allow for greater flexibility to create different strategies for each VISN, depending on their current performance and opportunities.

- Remove past barriers to providing a full continuum of care in the most appropriate and efficient setting and allow VISNs the flexibility to use their resources as they see fit to meet the well-defined mission and goals of VHA system.

- Maintain the authority of VHA Headquarters to optimize resource allocation by making certain investments centrally, transferring resources among VISNs, and closing facilities.

- Provide access to new capital funding to make the required shift from inpatient to outpatient services

- Allow VISNs the authority to price and negotiate contracts to "sell" services and the freedom to market those services.

- Give the VISNs freedom from OPM regulations in order to reward good performance

- Provide for structured relationships with the VISN directors to support performance, reinforce "courage" and generate the rewards they will need to make hard and potentially unpopular decisions.

- Facilitate the transfer and application of best practices among VISNs including processes around problem resolution, quality management, customer service, delivery system innovations, operational efficiency , etc.

- Provide more effective management of human resources.

- Ensure a common mission based strategic focus throughout the organization that is tightly tied to VISN and facility level performance objectives and is consistently tracked and rewarded.

In essence, these ten items can be viewed as essential to the future success of the organization. Transformation of VHA will require a structure which accommodates and encourages significant movement towards these goals.

As a result of the great interest exhibited by Congress in alternative structures for VHA, we examined four basic options for possible application to VHA. These were: 1) a government corporate structure; 2) a mixed ownership corporate structure; 3)a government sponsored enterprise; and 4) a performance based organization.

In examining the various organizational options described, we developed an analytic framework of policy presumptions and questions. The assumed goal of such a restructuring is to provide an operating structure that would allow VHA to carry out its functions in the most effective and efficient manner, and in a way that maintains accountability to decision makers while minimizing Federal exposure to loss. In determining the appropriate structure we considered the following questions:

- Is VHA a businesslike enterprise?
- Why not privatize?
- Should VHA become a government corporation?
- What form of organization best allows VHA to meet the ten structural requirements outlined above?

After a careful review of various options and the questions described above we determined two structures to be feasible in the near term; converting VHA into a government corporation (GC), or less dramatically, transitioning VHA to a performance-based organization (PBO).

1. Government Corporation

VHA would be a wholly government owned corporation. The corporation would be directed by a Board of Directors; the following is illustrative of the types of members such a Board might have, according to current practice in other GCs:

- Five directors, appointed by the President with the advice and consent of the Senate. Not more than three of the members of the Board to be of the same political party.

- At least two members of the Board must be selected from representatives of various Veterans Service Organizations (VSOs). Examples of such organizations are Paralyzed Veterans of America, Disabled American Veterans, Veterans of Foreign Wars, Blinded Veterans Association, etc.

- Two ex-officio directors - the Secretary for Veterans Affairs and the Undersecretary for Health. These directors would be voting members.

- A Chairman of the Board to be elected by a majority of the seven person board.

- Terms for Board members to be four years, with appointment to new terms occurring in the first six months of a new President's term.

- Board members may be removed by the President for cause only.

Management of the Corporation

- The Under Secretary for Health would function as both a Chief Executive Officer (CEO) and a Chief Operating Officer (COO), responsible for the day to day operations of the VHA Corporation. The USH would report directly to the Board and indirectly to the Secretary of Veterans Affairs. The exact nature of the relationship between the Board of Directors with the Secretary of Veterans Affairs would be specified in detail in any enabling legislation establishing VHA. Generally, the Board should set long term priorities and develop long term strategies for the new corporation. It should also ensure that the corporation is results and customer oriented in its overall operations

- No change is envisioned when transforming the agency to a government corporation vis-à-vis the VISN structure. Adoption of this corporate form is meant to support the VISN concept and improve the likelihood of its success. Other than the creation of a Board of Directors, and its relationship with the Under Secretary, no major change in reporting relationships within VHA is anticipated under the corporate structure.

Organization/Features

- VHA Corporation will be a Title 31 Executive Agency of the United States. VHA Corporation would remain in some aspects under the purview of the Department of Veterans Affairs to ensure coordination with common programmatic missions and activities (e.g., research, medical education, DOD contingency). VHA Corporation would receive and be responsive to policy instruction from the President and/or agency head, though policy coordination and oversight would not, in general, extend to day-to-day operational control and direction.

- The VHA Corporation would be subject to the provisions of the Government Corporation Control Act (31 USC 91) which provides for specialized budgetary reporting requirements, which are in addition to the reporting required of other Federal entities. Specifically, GCCA requires wholly owned government corporations to prepare and submit business-type budgets to the President each year. The Act also imposes certain audit and reporting requirements on government corporations. Budget requirements for VHA Corporation would require that it be subject to full OMB budget review, modification, approval and apportionment.

- Employees of the VHA Corporation would still be Federal employees and would be subject to the Federal Workforce Restructuring Act and OMB Circular A-76. If VHA Corporation can make a case why its businesslike operations need relief from agency-specific FTE limitations, it can seek adjustments from OMB. Generally, such relief can be considered if the corporation has funds to finance the FTEs and can demonstrate that business conditions demand greater flexibility.

- Most VHA Corporation employees will not be exempt from limitations on employee pay and benefits. An exemption is appropriate and should be sought for VISN directors and other management/medical personnel the Board deems necessary. The justification for these exemptions is that it will be necessary to keep or recruit select personnel with unique technical backgrounds and skills (due to competitive pressures from the private sector).

- VHA Corporation would have a Chief Financial Officer (CFO) and produce an annual audited financial statement pursuant to the CFO's Act. To the extent that VHA may engage in a profitable line of business, the nature and amounts of profit should be revealed in the financial statements.

- The Corporation should be formed with a "charter" that spells out the scope of its activities to assure that VHA Corporation is established and conducts its operations fully accountable for its financial soundness and programmatic activities. The Corporation should be created with strategic goals and defined objectives that will enable the VA Secretary, the Board, and the Congress to judge how well the Corporation is performing.

- VHA Corporation would be subject to reauthorization at periodic intervals (e.g., every five years). It should at that time, make a formal presentation to OMB reviewing its business operations and programmatic performance, particularly in terms of its charter and other requirements.

Authorities

- VHA Corporation would be subject to two major pieces of legislation, namely, the Government Corporation Control Act and the Government Performance and Results Act. Specific legislation is also required to create a new government corporation spelling out its charter, reauthorization time frame, and exemptions requested/required. Most importantly, in the enabling legislation a variety of exemptions and reforms can be addressed and put into place. Specific reform areas could include:
- Financial Resources
  - Provide VHA the authority to seek additional revenue streams
  - Develop a VHA trust fund (modeled on the Medicare trust fund) for deposit of Medicare taxes by active duty personnel
  - Authorize VHA to bill and keep funds from Medicare, Medicaid and other government sources
  - Allow the development of non-profit corporations for fund raising and grants management
  - Allow VHA to sell DHCP software at market prices to support future development
  - Require DOD to pay an up front fee for total-care patients referred to VHA

- Financial Flexibility and Performance
  - Change appropriation law to create multi-year/no year appropriations
  - Eliminate "fenced funds" restrictions
  - Provide VHA authority to establish actual billing rates
  - Authorize VHA to invest non-appropriated funds
  - Reform procurement and contracting practices
- New Customers
  - Incorporate VHA a Federal Employee Health Benefits Plan selection
  - Establish an open enrollment period for newly discharges service members in VHA
  - Reform eligibility to allow for national standard benefits package to enrolled veterans
  - Expand home care services for all veterans
- Better Management
  - Increase flexibility in establishing joint ventures
  - Reform appropriations system to include major and minor construction and MAMOE within the Medical Care Appropriation (NRM), equipment and leasing accounts should remain within the Medical Care Appropriation
  - Expand sharing authority to include agreements with managed care organizations
  - Allow VHA to become part of HMO networks and open HNO enrollment to veterans
  - Allow VHA to switch OWCP claims to private sector insurance
  - Reform human resource management practices for increased flexibility in hiring and firing, compensation, leave, and incentives for providers that are comparable to the private sector

Advantages

Transforming and establishing the VHA as a government corporation offers several distinct advantages. Primary among these is that the VHA Corporation would be more independent and better able to focus on being more efficient and effective in carrying out its mission. Currently, a variety of political and extraneous factors come into play and, on occasion, impact VHA decisions on issues such as 1) the building of new hospitals, 2) the closing of existing hospitals, 3) resource allocations, 4) new programs and initiatives. VHA would benefit from acting more like its private sector counterparts in the health care industry. Change in this industry and the need for more cost effective delivery of health care services will require the VHA in future years to be more innovative, creative, and flexible in how it carries out its mission.

We believe that forming the VHA Corporation (creating a new structure) and getting adequate and complimentary enabling legislation will result in several demonstrable benefits to the Department of Veterans Affairs and the VHA. These benefits would include the following:

- A VHA which is more customer driven - by formally including representatives of the VSOs on the newly created Board of Directors. The needs and views of a primary customer group -- the veterans --will not only be represented but can play a key role in setting the strategic direction of the organization. By participating on the Board, veterans will formally become full partners in determining the best ways of meeting their health care needs.

- A VHA which focuses on strategic as well as short term goals -- a functioning Board can better develop a strategic plan and direction for VHA which will delineate 1) major long term goals and priorities, 2) resources required, 3) strengths and weaknesses, and 4) obstacles to be overcome. The Board will not be caught up in day to day problems, but rather, in defining a strategic direction and strategic priorities.

- A VHA which is more results oriented -- with a more business-like organization the VHA should be able to define outputs and results to be achieved and hold people accountable for these. Enabling legislation to create a government corporation should also provide a VHA Corporation with greater freedom in hiring, rewards and compensation, firing, resource allocation, and experimentation. Results will be tracked and measured as opposed to activity based or process measures.

- A VHA which is more flexible and replicates and develops best practices in health care delivery. A corporate structure would make it easier for the VHA to pursue a variety of significant changes to include 1) expanding its customer base beyond the current veteran population (if that is decided), 2)meeting total health care needs with a major shift to outpatient and primary care, 3) buying services to expand outpatient and primary care capacity, and 4) divesting selected services to the private sector. VHA Corporation's more independent status should make it easier to pursue these changes if that is the direction VHA wants to pursue. A corporate structure allows VHA to respond more effectively and with more flexibility to the changing environment in which it functions.

- Upgraded staff competence and expertise at senior levels in all VISNs. With a corporate structure and a more business-like approach to accomplishing its mission, the VHA potentially could become a more attractive place for senior health care professionals to work. With creative compensation packages, less bureaucracy, and the use of more innovative approaches it should be easier to attract the better people in the field.

Adopting a corporate structure is justified only if the VHA is willing to pursue major or significant change related to its 1) customers, 2) service mix) 3) the making and buying of services, and/or 4) the divesting of selected services. Attachment 1, which follows this page, presents the strategic dimensions and the organizational change required to support a change strategy. Briefly, a government corporation is best suited for accommodating major change in the areas described above. Another option, a Performance Based Organization would be better suited for less significant (but still important) changes. By creating a government corporation VHA would be committing itself to major change and a major reengineering of its structure to accommodate that change.

Many government corporations which exist today were created for a variety of reasons and purposes. Several of these government corporations (or related organizations) have features or qualities which could be replicated to a greater or lesser degree, at VHA. These include but are not limited to the following: 1) greater political independence as is characteristic at the Federal Reserve, 2) innovative ways of compensating senior managers at the Export-Import Bank, 3) greater customer focus as exhibited at Fannie Mae (which is a Government Sponsored Enterprise), and 4) business and results oriented management as seen in the Tennessee Valley Authority. In addition, organization such as a private sector cooperative, Kaiser Permanente, have achieved better leverages of economies of scale in purchasing, facilities management, information systems and clinical best practices.

Just as with the above mentioned organizations, the VHA should replicate their success in responding to their customers and managing their basic functions.

Disadvantages

While we think the advantages of moving VHA to become a government corporation outweigh any disadvantages, there are some difficulties associated with this move. Primary among these is the impact of such a transition coming on top of the recent reorganization and introduction of the VISN concept. Many of the changes we recommend will impact VHA and VISN operations and will require significant changes in outlook and orientation. Nevertheless, we believe such a transition is manageable and will in the long run benefit VHA and its customers.

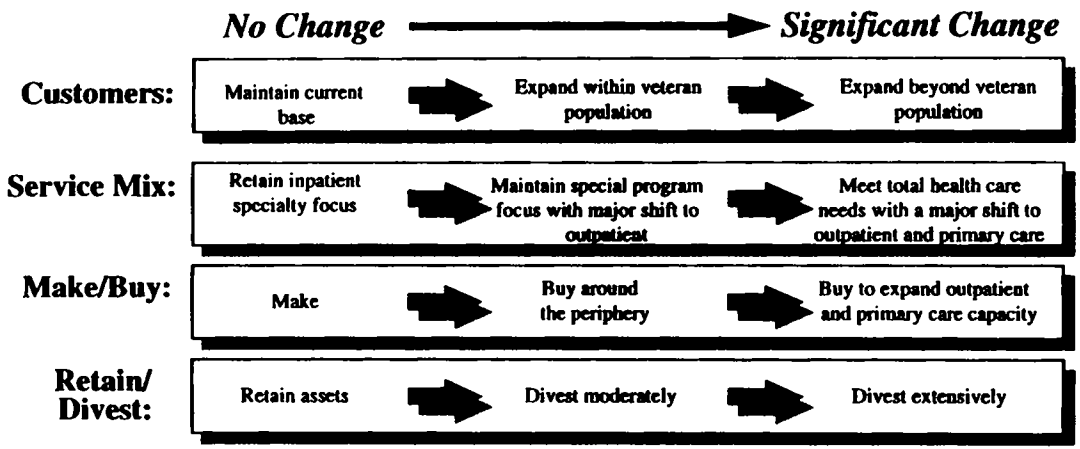
2. Performance Based Organization

- Advantages. Creating contractual relationships through the use of performance contracts sharpens the intended results of VHA program activities and increases accountability for results. By clearly defining results, VHA policy-makers may be less inclined to attempt to control programmatic inputs. Increasing accountability for performance will allow VHA managers to make a case for having greater flexibility in meeting their goals.
- Flexibility can be negotiated between VHA, OMB, and the appropriate congressional oversight authorities. These may include statutory exemptions or regulatory waivers from departmental requirements, or government wide controls in procurement, civil service, budget, or support services from GSA, GPO and UNICOR.
- In the end, an increased focus on results improves public trust and understanding of what VHA does, increases customer (veteran) service, and demonstrates value for tax dollars expended. Faced with ever-increasing demands for higher quality services within finite financial resources, continuing improvement by VHA in performance is essential.

- Disadvantages. Changing the culture at CHA in a move to be more output oriented and performance driven will not come easily or quickly. Changing the culture of VHA will require increased capacity to manage and be held accountable for results.

Making change across any of the strategic dimensions will require a supporting change in organizational structure.

Strategic Dimensions



Organizational Change Required to Support Strategy

At a Minimum:	**Status Quo**	**PBO**	**Gov't Corporation**
Best Support of	**PBO**	**Gov't Corporation**	**Gov't Corporation**

- If VHA moves to become a PBO it must guard against "stovepiping" behavior between it and related agencies in the Federal government ("its not in my contract"), which would run counter to the integrated service delivery approach that the recent implementation of the VISN concept supports. Another possible problem relates to the use of large salaries and performance bonuses for key VHA managers and the possibly negative public perception resulting from these new financial rewards.

Either of these two organization models appears to be feasible and would better position VHA to carry out its basic mission and function within the new dictates of the emerging health care environment. Both a government corporation and a performance based organization, accompanied by exemptions to Federal regulations and requirement in certain areas, would be consistent with and supportive of the recent organization and VISN initiative as well as the ten structural requirements outlined above. The corporate structure, once implemented would offer the greatest degree of independence and flexibility to VHA, but has the disadvantage of taking more time to put in place and involving more politically sensitive issues (such as the creation of the Board of Directors). A PBO would probably be easier to implement and take less time to put in place, but would not give as much flexibility and latitude to VHA managers as the corporate structure.

After reviewing the relative advantages and disadvantages of these two options we believe the government corporation represents the strongest of the two.

STATEMENT OF

GORDON H. MANSFIELD, EXECUTIVE DIRECTOR
PARALYZED VETERANS OF AMERICA

BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
THE FUTURE OF THE VETERANS HEALTH ADMINISTRATION

JUNE 27, 1996

Mr. Chairman and members of the Subcommittee, Paralyzed Veterans of America thanks you for the opportunity to present our vision of the future of the veterans' health care system. Chairman Hutchinson, we also want to take this opportunity to thank you for your service as this Subcommittee's chairman. We know you may have the opportunity to continue demonstrating your commitment to veterans in the Senate and hope that the productive relationship we have begun may continue to flourish there.

I am Gordon Mansfield, the Executive Director of PVA. As you are aware, the future of the Veterans Health Administration (VHA) is a subject Paralyzed Veterans of America has devoted its staff and other resources to addressing. The results of this investment are multiple studies—*Strategy 2000, Strategy 2000, Phase II*, and most recently, *Horizons*, an examination of our own members' future health care needs and how they should be addressed by VA and other health care providers. We also have the *Independent Budget* which we co-author annually with three other veterans service organizations (VSOs). The *Independent Budget* provides a "real-time" analysis of resource and management initiatives the VSOs believe VA requires to be a strong health care provider. This year's Medical Programs section in the *Independent Budget* concentrates on the evolving needs of the specialized programs.

Our commitment to this subject is brought on by our members' reliance on an outstanding health care system that uniquely addresses their health care needs. PVA surveys demonstrate that more than 80 percent of our members use VA health care to meet some or all of their health care needs. Recently, staff conducted teleconferences with some of our members enrolled in private sector managed care organizations. Because managed care is becoming so prevalent, PVA was interested in collecting anecdotal information about the advantages and disadvantages of these plans for our members. Before each of these discussions took place, we told our members that we were mostly interested in their experiences with private health care, not VA. Yet what quickly became apparent to staff is how integral VA's role is in even our insured members' health care delivery. They rely on the VA when they need complicated or acute care services related to their spinal cord condition from a knowledgeable source; they rely on it for access to state-of-the-art durable medical equipment and pharmaceutical drugs; and, when push comes to shove, they rely on VA to give them the skilled care they need for their spinal cord conditions that is, by and large, not available to them in the private sector. This was a surprising and completely unsolicited outcome of these discussions we thought were going to be mostly about managed care. Paralyzed Veterans of America wanted to share this information with you and the Subcommittee so you will understand what a vital stake we hold in the VHA's future.

As your invitation to testify states, VA health care delivery is undergoing a phenomenal transformation. Allow us to briefly suggest some of the possible scenarios we see as possible for the Veterans Health Administration in upcoming years.

- Based on current projections, VHA will have an increasingly limited budget. While we are not prepared to accept this as a *fait accompli,* we are aware that there is going to be more and more pressure on providers to contain costs. This will cause VHA, like other health care providers, to seek the best value for its health care dollar. VHA will probably try to increase its cost-effectiveness by contracting for certain types of care and services; by entering into more sharing arrangements both as a means of enhancing its revenues and as a way to provide its users with better access to care; by seeking new ways of treating patients; and, by "streamlining" its services by eliminating or integrating them.

- VHA will be increasingly influenced by other health care payers and providers. As VA increases its interactions with contractors, sharing partners, and perhaps, a broader patient base, it too will have to respond to changes affecting the environments in which they operate. For example, as the private sector is turning to managed care as a predominant health care delivery and financing system we already see VHA adopting many of these systems' features. VA is adopting primary care, case management, and capitation-based resource allocation already. VHA will no longer operate as an isolated part of the health care community.

- The availability of resources for other health care systems will also affect VHA. Traditional VA partners, such as medical schools, public hospitals, and other federal providers, will be feeling the impact of cuts made in their programs and may be more flexible negotiators. They will look to VA for more residency allocations, more research opportunities, more support on joint ventures, and more help to meet their capital investment needs. Other public payers will look at VA as a potential place to "off load" their beneficiaries. Conversely, VA may also be looking to place veterans in other programs for which they have eligibility: Medicare, Medicaid, the Indian Health Service or the Military Health Services System.

- The practice of medicine will evolve. Treatment protocols and improved information systems will give care providers information about more effective therapies. Gene therapy and other state of the art treatment will become increasingly available and add more cost to the health care. Pharmaceuticals will prevent or ameliorate conditions that are now progressive or incurable. New assistive technologies will develop with improvements in robotics and computers.

- If it responds to its users needs, VA will become more focused on the delivery of long-term care. Specialized services must also evolve to accommodate the chronic care needs of their users. As a group, veterans are aging. Large cohorts of veterans, like the World War II era veterans, are approaching times when they will need long-term care. VA must shift its emphasis to accommodate the population's needs, but it must not make the mistake of abandoning its specialized or acute care programs in the process.

As excited as we are about many of the changes, we also fear some of them. We feel compelled today to focus our comments on how some changes VA plans to implement will affect veterans with special needs, particularly those with spinal cord dysfunction in the near future. We will also share some of our thoughts about the evolving needs of the veteran population and our members. We hope these comments will provide some caveats for the future and identify the best structures and functions VA could adopt to meet its patients' needs. We are confident that VA has the ability to make needed changes if they have the tools they need to do so and *if they do not forget the reason the VA health care system exists—to serve the special needs of veterans.*

We are somewhat concerned that some VA officials are losing sight of this *raison d'etre* as the system undergoes transformation and makes them more "bottom-line" oriented. Please don't misunderstand us, we realize VA, like all health providers, must become more conscious of its spending and become a more cost-effective care provider. We want to help VA make these changes by conveying the need for change to our members and other veterans. Honest, open, and *constant* communication is the only way to ensure that VA can make necessary change. Unfortunately, we are concerned that VA officials in Headquarters and in the field are not always involving consumers in their plans for change. Critical decisions about VA's future, such as how its resources will be allocated, are being made behind closed doors. We are very concerned about this because we realize VA will have to make hard decisions about its future

structure and missions that will affect our members and other veterans. If veterans are not brought into VA's decision-making processes at all levels the consequence may be revolution. We are talking about *real* input into decision-making, not just an obligatory "dog and pony show" to present the results of an important planning process.

Over the next few years, VA will be struggling to adapt to a new care delivery style, with increasingly limited funding. PVA believes many VA facility directors will be sorely tempted to reallocate some funding now provided to VA's special programs. These special programs *are* expensive to operate. Unfortunately, VA directors are coming to the same conclusion as other health care providers and financiers. Their tendency is to exchange "breadth for depth"—that is, to offer basic coverage to more of the veterans in their catchment area rather than offer comprehensive, well-integrated services to fewer. As a consequence some facility directors may be making "penny wise and pound foolish" decisions about health care for veterans with special needs. Good investments in rehabilitation and health today *do* have a payoff for a tomorrow in the future. We have seen the difference.

In an edition last year, *New Mobility*, a magazine for people with disabilities, profiled two individuals in their thirties who were injured at about the same time and at the same level in their spinal cords. The main difference between the two was their drastically different access to therapy and knowledgeable care providers. One individual's physical therapy was provided by a well-known rehabilitation institute until he and his care team believed he could continue to make progress on his own. He now lives independently, works, dates, and plays wheelchair sports. The other individual had limited therapy from a subacute provider lacking significant experience in treating people with spinal cord injury. She lives in a nursing facility and routinely suffers from secondary infections associated with her spinal cord injury. These are two cases, but we could identify many more for whom good initial rehabilitation in the VA or elsewhere has made all the difference. VA must make the decision to continue investing in care that will produce optimally functional people. It is their mission and their responsibility. If they fail to accomplish it to our satisfaction in the future, PVA will be the first to call for Congressional intervention to ensure that veterans continue to receive the best available care.

The philosophy of making sound investments in health care applies to aging veterans as well as veterans with special chronic care needs. While the results of such prudent investments in health may be realized in the long run, VA is a provider that is uniquely well suited to realize the payoffs in properly managing its long-term patients' care needs. Unlike most private-sector providers' patients who may disenroll, most of VA's patients will be theirs for life. VA must be prepared to look at new models for delivering long-term care to its users. This will require VA to augment its capacity in certain types of non-institutional care settings. Again, we feel VA, as one of the very few vertically integrated delivery systems in the nation, is at a significant advantage over other care providers. With these resources, they have the responsibility to provide the rest of the nation with information about how to handle the rising tide of long-term care needs. Some private sector models have shown significant savings and increased quality of outcomes under intensively case-managed long-term care programs. The Program of All-Inclusive Care for the Elderly (PACE) is one model that may be instructive to VA. PACE has demonstrated significant savings over fee-for-service medicine by using its funding in the most cost-effective way, rather then adhering to a fee schedule. It uses a variety of programs, including aggressive care management, primary care, and non-institutional long-term care alternatives to meet the needs of the frail, elderly individuals it serves.

Unfortunately, too often, long-term payoffs for appropriate care management lack the tangibility that immediate results have. In addition, short-sighted managers do not always reward their providers for making these long-term investments. Indeed, managers may have a right to be confused about what is beneficial for their system's patients given the status of research into cost-effectiveness and efficacy. Contradictory research results give them justification for canceling budding programs that have a strong potential for producing results. PVA found one important example of this within VA. VA researchers recently published a study which found that chronically ill patients who were placed in aggressively managed primary care programs for six months were hospitalized more than a control population. As an aside the researchers also noted that these patients' satisfaction with care also increased. We feel that it was irresponsible for these researchers to release this result—one that could seriously deter VA's efforts in implementing primary care—based on only six months' experience. PVA does not suggest that

the research was poor or that the results were wrong. On the contrary, we feel that aggressive primary care management would unearth many diagnoses that would go undetected with episodic treatment. The additional hospitalizations are undoubtedly an artifact of early detection and treatment. These conditions would have gradually manifested at a later stage when VA would have had to treat them more aggressively, and probably at higher expense with poorer patient care outcomes. It is in the interpretation of the data where VA researchers fell short. Rather than extending research results to the next logical conclusion—lengthening the study time or examining the reasons for the increased rate of rehospitalization for the study population—the authors merely suggested that primary care was related to increased rates of hospitalization. The implication is that primary care produces "unnecessary" hospitalization.

Fortunately, there are many other studies that suggest that these researchers' conclusion was faulty. After a year, the Boston Community Alliance which manages care for people with physical disabilities, including spinal cord injuries, and AIDS, showed significant savings over Medicaid program spending for the same individuals in the past and for similar patients in Ohio. A Robert Wood Johnson Foundation Study by the Medicaid Working Group demonstrated that this group was able to shift significant resources into ambulatory care and produce better patient outcomes at a savings to Medicaid. The savings come from providing extensive primary care intervention to avoid extended hospitalizations.

Given the contrary results of the two studies, we would hope that a health care manager would err to the side of the increased quality primary care produced in both studies. Other studies have also demonstrated savings from prevention, screening, early detection and treatment of disease, so hopefully managers will view the results of the VA study with a jaundiced eye. But managers must also be cost conscious. They are looking for ways of cutting their costs. They must have strong justification to make additional investments in care. They must also have economic incentives that are more tangible than long-term savings. VA providers must have adequate incentives to provide good care.

Starting in FY 1998, VA will be working with an allocation system based on the number of individuals it serves. From what we understand Headquarters will identify and reimburse networks for some of their very high cost users and leave it at that. This allocation system will not work well for VA users with spinal cord injury (SCI). Even the high-end capitation rate we are hearing proposed does not meet the costs per bed of many SCI centers.

Historically, VA has been reimbursing providers based on their past cost experience. This gave VA directors an incentive to keep SCI beds, which are expensive, full. As a consequence, some of our members have spent a significant parts of their post-injured lives on VA SCI units. We are not justifying this approach and realize that it must change. Some of our members should be in the community living more active lives for their own benefit. The current trend to outplace long-term spinal cord injured patients in community settings, however, is one that we are carefully monitoring. No VA patients with special needs should be unloaded onto communities ill-equipped to support them. VA has the responsibility to involve patients in planning for their eventual discharges be they to homes, supported living environments or other institutions, including nursing homes. Discharge plans must include strategies for following the patients' care in all settings. PVA is not seeing this systematic approach to discharging patients. We will not accept *dumping* of *any* of our members as an alternative to care on an SCI unit.

The planned allocation system will give hospital directors an incentive to either underserve or transfer these patients to cheaper providers. It will certainly not give directors incentive to create high-quality programs for VA patients. VA providers must be able to "do well by doing good." A fair risk-adjusted capitation rate for people with spinal cord injury and others with special needs as well as performance measures that help us ascertain high quality outcomes from SCI programs and are tied to staff reward systems can ensure that providers are properly motivated.

Funding and demographic issues will make it even more difficult for VA directors to create fair access to special programs in the future. Services must be accessible enough so that patients will use them, but draw from enough of the veterans' community to ensure that staff can practice their skills and, thus, maintain programs' integrity. Complicating matters are the academic affiliations' investment in VA resources and the politics involved in shifting federal resources. A program such as open heart surgery brings prestige to both local administrators and

academicians. Providing some access to these services can also ensure the cooperation of an academic affiliate in placing students and faculty in less glamorous practice settings. Affiliates may be more willing to accept assignments in geriatric and primary care settings, where VA's needs are the greatest, in exchange for access to state-of-the-art programs. Yet continuing the service as demand drops wastes money and threatens lives. As health care resources become increasingly scarce, the tension between access and cost-effectiveness will intensify.

The relationship between access and cost-effective care is a matter PVA is carefully assessing. We feel that the work we are doing in terms of demographic analysis, cost-effectiveness, and developing clinical practice guidelines for spinal cord injury care can be enormously helpful to VA in planning the future needs of people with spinal cord injury and disease. We are working closely with the new SCI chief, Margaret Hammond, M.D. to ensure that we are available to help her with the tremendous task of restructuring the SCI system. Some of the ideas we have already conveyed to her deal with shifting resources to better match patient need. We know, for instance, that many of our members choose to seek care from non-SCI VA centers close to their homes. We know that, like other VA users, their needs are changing and that starting now and in the near future many of our members will need a different mix of programs that meet their long-term as well as acute care needs. Programs we are particularly interested in that VA has yet to develop include assisted living. We feel that assisted living offers our members an opportunity to live as independently as possible, but receive assistance with their activities of daily living when it is required. It is also far more cost-effective than nursing home care. Personal assistance is an option that will become increasingly important to our members as they and their care givers age. VA should have the opportunities and incentives to explore these types of care as options to institutionalization. These are the types of solutions we would like to help VA officials find to help them meet the needs of their patients at less expense than they currently incur.

The development of performance standards should be a high-priority area for VA in all areas. VA must be able to convey information about their services, outcomes, and costs that is comparable with other providers to interact successfully with the rest of the community. Private-sector providers are beginning to collect and report information on immunizations, diagnostic procedures, waiting times, and patient satisfaction, but there is still little work that has been done to objectively assess care for "special populations." VA's standards are even more important because they are being used as a means of objectively assessing network and facility performance. Consistent with its new role, Headquarters is to develop pertinent standards of accountability for the appropriate party. From there, Headquarters staff measure and assess progress toward standards and enforce compliance when necessary. This allows Headquarters to achieve desired ends without dictating the means to achieve them. From what we understand VA will have one important measure, the Functional Impairment Measure (FIM), to assess care and rehabilitation provided to veterans with spinal cord injury. Because this is the only measure directly associated with the quality SCI care, there must be caution used in interpreting the results. VA lacks some experience in applying the FIM assessment to its patients. VA should either use an objective outside party or have the results of their assessment audited by an outside party to establish a baseline for assessing care. An aggregate loss of functionality demonstrated at any one facility may be the consequence of factors other than poor quality health care—treating a disproportionately older or impaired population, for example. Measures will have to be interpreted cautiously and alongside other measures such as access, patient satisfaction, and quality of care that are measured within other patient populations.

PVA is also looking at ways to improve the care process to ensure high quality outcomes. Our project in developing clinical practice guidelines is bringing together providers who are involved in state of the art spinal cord injury and multiple sclerosis care management. Clinical practice guidelines are gradually being created for many types of care and offer a real means of implementing a high-quality programs by creating a "best practice" standard that reflects state-of-the-art care. These are living documents that are transformed by evolving and improving technologies over time. PVA plans to help VA and other care providers implement these guidelines as a means of improving quality of care delivered to our members and others with spinal cord dysfunction.

We were, for the most part, in agreement with the VA's Office of Inspector General's *Review of VA's Spinal Cord Injury Program* released in late March of this year. We are developing a plan to ensure that VA implements the OIG's recommendations. Among them are:

- Evaluate SCI Program access policies with the goal of achieving more consistent admission criteria.
- Review SCI operating policies and guidelines with the goal of providing a more consistent range and depth of services.
- Evaluate the criteria used for distributing SCI resources with the goal of achieving equitable distributions based on program service levels, productivity, efficiency, and patient outcomes.
- Require SCI Centers to develop and maintain program waiting lists.
- Identify all SCI patients who should be offered the opportunity for annual exams.
- Clarify policies addressing SCI interdisciplinary treatment plans.
- Evaluate the coordination and oversight of care provided to SCI patients admitted to non-SCI wards and facilities.

Some of these recommendations we have already discussed in this testimony. We will be developing a plan to actively work with VA to ensure that these recommendations are clarified and implemented. Such implementation will help VA bring more accountability for their care of SCI patients, more balance to the system and thereby higher quality system outcomes for SCI patients. Completion of these activities may also be able to serve as a short-term proxy for outcomes measures that have yet to be developed.

Today, I have attempted to identify the way PVA views VHA's future and how it is proactively working to respond to changes we foresee. Optimistically, we see a system that will work more cooperatively with the communities in which it operates facilities; we see developing opportunities to hold managers accountable for delivering high-quality, cost-effective care; and, we see emerging technologies which will help us determine state-of-the-art treatments for our members and methods for assessing quality of care delivered. In contrast, VA could use the changing environment to abandon some of its high-cost chronic care to States or other providers. PVA will be monitoring VA's referral patterns to ensure that this does not occur.

PVA hopes that VA will use the opportunity that now exists to improve its program management, to explore new areas in cost-effective care delivery, and to develop valid and reliable standards for measuring provider performance. VA's efforts in these areas would improve the national state of health care financing and delivery. We are ready to contribute to these efforts and expect to be called upon to do so. We urge Congress to work with us in monitoring VA's planning processes to ensure adequate consumer participation, supporting fair allocation systems, and enacting legislation, like eligibility reform and gain-sharing, which will allow VA to develop state-of-the art health care delivery systems. It absolutely must ensure that VA adequately supports its "special emphasis" programs as the heart of the Department's health care mission. Only in this manner can VA flourish in its future.

Mr. Chairman, thank you for this opportunity to present PVA's views on the future of the Veterans Health Administration. I will be happy to answer any questions that you, or any of the members of this Subcommittee, might have.

STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
VETERANS HEALTH ADMINISTRATION

JUNE 27, 1996

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to testify on the future of the Department of Veterans Affairs (VA) health care system. We hope this hearing helps establish an appropriate roadmap to lead the Veterans Health Administration (VHA) into the 21st century.

Mr. Chairman, the future role of VA's health care system is, without question, a national policy concern. The VA health care system must be improved, because it will not survive with only minimal reform and the status quo is unacceptable. This subject merits an open and honest discussion, with the development of a strategic plan that we can all support. Where does VA go from here? Every American has a vested interest in the overall outcome.

The current missions and roles of VHA have evolved over the past 50 years. A review of those roles and missions is essential for the efficiency and effectiveness of the system, particularly in light of limited discretionary budgetary resources that may or may not be available in the near future. VHA is currently in the process of reforming certain aspects of its operation, but much more remains to be accomplished.

The American Legion supports the Veterans Integrated Service Network (VISN) concept. Through VISNs, VA is redefining facility service areas and missions. Not everyone will agree with the outcome of this process, but the stakeholders of VA, the veterans of this nation, must have equal input into this process.

The American Legion's vision of the VA health care system in the 21st century is contained in The GI Bill of Health. This proposal will expand VHA's patient base and increase its funding through new revenue sources. For the past 50 years the primary constraints placed on VA health care have been artificial funding limitations. The GI Bill of Health will not only reform current eligibility criteria, but will also improve and reinforce the current annual appropriations process.

Mr. Chairman, in addition to its many inherent problems, the VA health care system has many assets. VA has been described as both "a national asset" and "a second-rate health care system." For too long, VA has not received the resources necessary to carry out its increasing, congressionally imposed, and too often unfunded mandates. Yet, VHA continues to treat more patients, provide high quality medical care, educate and train medical professionals, and pioneer new medical programs and technologies and rehabilitation research techniques, among many other accomplishments.

The VA health care system is confronted by many statutory and financial obstacles that must be surmounted in order for VA to survive and maintain the capability to fulfill the nation's obligations to its veterans. The VA system today must contend with:

- Funding resources almost entirely from federal discretionary appropriations
- Prohibitions against VA billing government health programs for care, such as Medicare
- Confusing and complex eligibility rules that confront veterans and caregivers

- The impact of escalating medical supply and service costs
- Patients who are disproportionately older, sicker and poorer

Today, we look for rationales to promote and defend various perspectives on the future of the VA medical care system. Many agree that improvements can and must be made, but we do not all agree on the optimum means to achieve the necessary changes. Some reform proposals would further extend the present VA system's woes, while others only offer limited relief. The American Legion believes that now is the time to clearly define the future of VA medical care and to correct, improve and preserve the system for years to come.

Mr. Chairman, The American Legion's vision of the future of VA health care is both upbeat and pragmatic. Nearly every discussion of the budget predicament of VHA includes a commentary on the need to balance the federal budget and the difficulty in obtaining scarce discretionary funding. Members of Congress have indicated that discretionary funding will be further decreased in the coming years. Thus, the VA medical care system will continue to face greater patient demands and increased costs, without being able to keep pace with the increased costs exclusively through the federal discretionary appropriations process.

The GI Bill of Health recognizes the necessity of generating additional VA health care funding to complement the current federal appropriations process. Medical inflation continues to increase at approximately six to eight percent per year. VA health care will not survive with its annual funding frozen at current levels through the year 2002, or even with yearly funding increases of a mere two to three percent. For too long, VA has sat on the sideline and watched the private health care industry change from a hospital based system into a health care delivery network. Under the current depressed conditions, and under future dim predictions, VA health care will continue to contract and be less responsive to those it is designed to treat.

The Congress must cost-out and institute demonstration projects to test the viability of new and innovative programs to make more veterans eligible for VA managed care. The answers we are seeking to VHA's future involve a combination of VA and private sector cooperation and enterprise. The GI Bill of Health does not propose enlarging the direct care mission of VHA. Rather the future character of VHA includes a redefinition of the role and mission of the system that allows all eligible veterans, retirees and eligible dependents to choose to invest their health care dollar in VA as their primary health care provider. All new discretionary care patients would bring health care funding with them. Under The GI Bill of Health all veterans will be eligible for a comprehensive medical benefit package through VA. Veterans not included in the *"Shall"* provide category of care will have various payment options.

The single prerequisite to membership in The GI Bill of Health is a veteran's honorable military service. The plan will:

- Reorganize the VHA to improve access, quality and efficiency of the medical care provided to veterans
- Operate VHA based upon the principles of managed care
- Assure all veterans with service-connected illnesses and disabilities access to all services necessary for the treatment of their disabilities at no charge to the veteran
- Assure all special category veterans, indigent veterans and service-connected veterans rated under 50 percent disabled, access to VA health care services at no charge or reduced charge
- Assure the long-term viability of VHA by encouraging veterans who do not utilize VA, and their immediate dependents, to enroll in The GI Bill of Health
- Improve the long-term financial health of VHA by generating new financial resources into the system from other federal health programs, third-party payers and veterans' employer health plans
- Permit VHA facilities to retain the majority of payments made for health care services rendered
- No longer subsidize Medicare and Medicaid

- Eliminate unnecessary, duplicative or contradictory regulations which hamper the ability of the veterans health care system to operate effectively and efficiently
- Federal appropriations for the VA health care system shall be based upon a capitated method using the calculation of fully-allocated costs of care to service-connected and other veterans receiving care at no charge
- Provide an array of health care benefit packages for all veterans and their dependents
- Alleviate VA health care access problems for veterans residing in rural America
- Expand sharing agreements with the Department of Defense and private health care providers
- Enhance specialized health care programs and related research investigations
- Make VHA a patient driven health care network provider

Mr. Chairman, VHA is not a predominately reactive institution. Given the proper incentives and management flexibility, VHA can sufficiently respond to the changes occurring in private sector medicine and provide leadership in many areas. The American Legion is very attentive to VA's ideas on its future direction. With the establishment of VISNs and the potential enactment of the Administration's limited eligibility reform proposal, we are interested in VHA's strategic direction for the next 10 to 15 years and beyond. A good starting point is for VHA to develop and advance an effective strategic plan.

The GI Bill of Health addresses the challenges of shrinking resources, a declining veterans population, and the changes in the practice and delivery of health care services. The VA health care system is at a critical crossroads. The GI Bill of Health incorporates the recommendations of the Commission on the Future Structure of Veterans Health Care that was created and released its findings in 1991. The four themes of the Commission's findings: Improving Access, Financing the Future, Restructuring the System and Enhancing the Quality of Care are included in the proposal.

In the process of reforming VA health care the central issue must be, "What is best for veterans." Recognizably, the task of reforming the VA medical care system is extensive. The American Legion believes that any reform proposal that does not allow VA to retain third-party collections, including Medicare payments, and thereby increase its funding base and reduce its sole reliance upon federal appropriations will be incomplete. Included in this scheme would be a provision that allows veterans' dependents and "Category C" veterans access to VA health care services through a health insurance program, combined with the collection of copayments and premium amounts.

The GI Bill of Health avoids the funding shortage pitfalls of existing law. One of its main features calls for opening VA to all veterans, and includes a plan for financing non-mandatory care and making VA solvent so it can effectively and efficiently serve all veterans for generations to come. The American Legion is currently promoting its plan and hopes to have it introduced as legislation.

Mr. Chairman, that concludes my statement.

STATEMENT OF
JOSEPH A. VIOLANTE
LEGISLATIVE COUNSEL
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
U.S. HOUSE OF REPRESENTATIVES
JUNE 26, 1996

MISTER CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Auxiliary, I am pleased to appear here today to present our views on the future of the Veterans' Health Administration (VHA).

At the outset, Mr. Chairman, we wish to thank you, Ranking Member Chet Edwards, and members of this subcommittee for scheduling today's vitally important hearing on the future of VHA. As noted in your letter of invitation, "VHA is at a key transition point in its history." The direction that VHA takes at this critical transition point, as well as the direction that Congress sets for VHA, will directly impact upon this nation's sick and disabled veterans.

Mr. Chairman, while it is useful to keep in mind how future changes in VHA will impact upon local communities; physicians, nurses, and technicians; researchers, universities, and medical schools; and suppliers, we must never forget that the VA health care system was established and is there for the sole purpose of taking care of the medical needs of our country's sick and disabled veterans.

It is our firm belief, and the bottom line, that the needs of sick and disabled veterans must be paramount when the future of VHA health care delivery system is considered, discussed, and planned for.

Mr. Chairman, hearings over the years regarding the status of the VA health care delivery system and its need for reform, have laid a solid foundation and, in many ways, set the stage for today's hearing. I will not attempt to create a bibliography of the various VA committees, blue ribbon groups, task forces, government and non-government audits and reports, studies and recommendations by groups as diverse as the American Medical Association and the Heritage Foundation, or testimony presented to various Congressional committees and subcommittees over the years, by VA, veterans' service organizations, deans of medical schools, or VA patients and their families.

The DAV offers the opinion that there is virtually no one who would attempt to convincingly argue that VHA need not change. Quite the contrary.

All of us interested in preserving a viable VA health care delivery system acknowledge change is required. Frankly, a radical change is needed. The entire movement screaming for reform of VHA is motivated by the singular recognition it has been an inefficient, inflexible health care delivery system. However, this is not exclusively the fault of VA.

While some of the inefficient and inflexible aspects of the health care delivery system have been eradicated by the reorganization of VHA into 22 Veteran's Integrated Service Networks (VISNs), more needs to be done. As we previously stated in testimony, we believe in and endorse the concept of VISNs. There is no question VHA needs to change if it is to survive in a competitive market-driven health care system now taking shape in our country. Without change, VA will be relegated to a system best described as dysfunctional. Veterans and American taxpayers deserve better.

Mr. Chairman, we are extremely pleased that a tangible effort is underway to produce what we all must recognize as overdue changes to the VA's health care delivery system. We are

optimistic for VISN's success and eager for it to make the necessary changes to bring VHA into the 21st century. Although we have questions and concerns, and will continue to closely monitor VHA's progress, we are hopeful that VISNs will help to bring about needed change in VHA.

As DAV looks to the future, we believe that VA will be faced with a number of unique challenges. It is extremely important that VHA be prepared for these changes. It is of paramount importance that these changes not adversely impact upon the sick and disabled veterans who use the system.

Some of these challenges include:

- Ensuring that a "bottom line" mentality does not take precedence over the health care needs of our nation's sick and disabled veterans;
- The flexibility to provide necessary health care in the most appropriate, efficient, state-of-the-art delivery system available;
- The ability to provide necessary health care to an aging veteran population;
- The continuing ability to provide care to veterans suffering with spinal cord injury, amputations, blindness, Post-Traumatic Stress Disorder and other "special disabilites," as well as related prosthetic items;
- Having adequate facilities available to care for the special needs of female veterans;
- Increased access points with the capabilities to meet the needs of a shifting veteran population;
- The flexibility to enter into agreements for sharing of facilities, resources and administrative functions with other federal or non-federal sources;
- The ability to collect and retain third party payments, including Medicare from certain veterans; and
- Allowing for the treatment of veterans' dependents, as the veteran population declines, provided there is no adverse impact upon veterans.

Mr. Chairman, so that there is no misunderstanding about where the DAV is coming from, I will state that our first duty as an organization is to assist wartime service-connected disabled veterans to ensure they, above all other veterans, receive priority care and the benefits and services that they require and are entitled to.

From that purpose we will not waiver. We will oppose, with all our might and vigor, any and all attempts to deny, diminish, or terminate benefits and services provided by the VA to service-connected disabled veterans. They, after all, became disabled defending our nation and preserving our rights and our freedoms.

It is these men and women who have given and sacrificed so much of themselves for the good of the nation. The very reason for VA being created and the essence for its continuance is to recognize the nation's obligation to care for those disabled as a result of their service. Again, Mr. Chairman, I must reemphasize that any future changes in VHA must be undertaken only after the health care needs of this nation's sick and disabled veterans have been considered and the impact of any change analyzed to ensure that it does not adversely impact upon these veterans.

Unfortunately, Mr. Chairman, we are aware of at least one VA Medical Center where it appears that the "bottom line" mentality has taken precedence over the health care needs of service-connected disabled veterans. As an example, we cite this case of a 100 percent service-connected disabled veteran who has been informed by a VA pharmacy that he will no longer be

furnished diabetic testing kits. At this particular medical center, the Director has decreed that diabetic testing kits are an "over-the-counter" medical supply and, therefore, will not be furnished to service-connected disabled veterans any longer.

Mr. Chairman, from a preventative medicine standpoint it makes no sense to deny a diabetic the very tool needed to prevent severe medical complications. In addition, requiring 100 percent service-connected disabled veterans to pay for their medical care flies in the face of this nation's moral and legal obligation to care for its disabled defenders. Mr. Chairman, this practice must stop!

Mr. Chairman, we believe that there is a viable plan that will assist VHA in caring for veterans in the future. The proposal in the 1996 *Independent Budget* (*IB*) ensures comprehensive medical care for service-connected disabled veterans and allows other Category A veterans, including catastrophically disabled veterans, to be treated in the most appropriate care setting; provides greater access to veterans who are eligible on a discretionary basis; and, would authorize VA to collect and retain third party payments, including Medicare from certain veterans and their dependents. We believe these initiatives are imperative to creating the appropriate balance in the VA's health care delivery system.

Any reform effort must begin with acknowledgment of and support for the concepts embodied in the "Vision for Change" plan proposed by the Under Secretary for Health, Kenneth W. Kizer, M.D., M.P.H. We believe this concept is the appropriate one to initiate the radical changes we all agree are so necessary.

Mr. Chairman, as form follows function, any changes that occur as a result of reform must maintain and support the VHA health care mission which include:

- A complete health care delivery system for service-connected disabled and other eligible veterans;
- A program of education and training of health care personnel;
- A program of medical and rehabilitative research; and
- A backup health care service to the Department of Defense (DoD) in times of war or national emergency.

The VHA mission is carried out by 173 VA hospitals, 391 outpatient clinics, 131 nursing homes, 38 domiciliaries and 201 veterans' outreach centers, employing over 200,000 personnel.

Over the past ten years, the VA has brought about a significant shift in treatment modalities from inpatient to outpatient care and to increase nursing home and domiciliary care. In part, this reflects the medical treatment needs of the aging veteran population and shifting medical treatment strategies from hospital-based to primary and outpatient care models.

The changes we promote complement the VA's ongoing efforts within the boundaries of existing law by supporting: treatment shifts to primary care and outpatient services; increased access points; sharing of facilities, resources and administrative functions; increased contracting authority which supplements but does not supplant the VHA mission; and, importantly, incentives to improve health care delivery efficiencies based on the ability to meet jointly agreed upon standards. Now, more than ever, VA medical facility managers must meet standards or lose resources.

The VA health care system must be given the legal authority to make the necessary changes we all support. Current law contains disincentives to change by restricting treatment options available to certain eligible veterans by requiring they first be hospitalized. In many cases, this is not the most economic or preferred treatment setting. To overcome these treatment disincentives, a number of VA hospitals have initiated plans which move their facilities away from the more expensive, hospital-based model towards the primary care outpatient-based

model. These administrators should be commended for their actions to implement the health care changes we all want -- the changes that must happen for the system to survive. These health care managers must have the flexibility to respond to the veterans' health care needs, in evolving medical treatment, and a local medical community. Mr. Chairman, these law changes cannot occur without the leadership of this subcommittee. The issues addressed by the *Independent Budget* will only be realized through this subcommittee's support and the support of the full committee. As you know, there is remarkable agreement among veterans' service organizations on the direction these changes must take. We also appreciate the subcommittee's leadership on the issue of VA health care eligibility reform. We support, as a good first step, H.R. 3118.

Mr. Chairman, more than a decade of "straight line budgets" have meant no real growth for VA. But no growth actually translates into deep cuts for VA health care when recognizing that medical care costs have skyrocketed, new and costly programs and medical procedures have been added and the veteran population has grown older and sicker.

Access to care is in jeopardy for some and unattainable for many veterans. Today, and for quite some time, discretionary based veteran patients are denied care. More troubling, some non-discretionary veterans -- Category A veterans -- those with the highest priority of care are experiencing difficulty obtaining the care they need. A 1993 GAO report entitled, *VA Health Care: Variables in Outpatient Care Eligibility and Rationing Decisions* (GAO/HRD-93-106, July 16, 1993) indicated that 118 VA medical centers reported rationing some type of care to eligible veterans when the medical centers ran short of resources.

The Historical Tables for the Budget of the United States for Fiscal Year 1996 shows that while the VA health care budget only increased from $1.1 billion in 1960 to an estimated $15.9 billion in the year 2000, in the same time frame, federal outlays for all health programs increased nearly 200 times from $2.3 billion to $443.2 billion.

Mr. Chairman, the DAV believes that eligibility reform and the ongoing and evolving administrative initiatives under current law will provide hospital administrators the tools they need to implement program changes which will improve access to care with existing appropriations. In summary, these changes will result in less rationing without increased appropriations.

In the future, VA health care should be delivered in the most appropriate, efficient, state-of-the-art delivery system available. VA must move from a bed-based system to an ambulatory care system. VA must have the authority to create additional points of access that would allow veterans who are now geographically distant from existing VA facilities to utilize VA care. The authority for VA to contract for care and for the sharing of services must be expanded to include authority allowing VA to be a contractual provider of services. Mr. Chairman, as the veteran population continues to decline, we support the concept that VA should care for dependents of veterans as long as veterans are not denied or displaced from needed care. There are vast opportunities available for VA to create additional funding streams from such arrangements. As long as veterans are not compromised in the process, we believe and encourage VA to move in that direction.

Additionally, although the female veteran population has been relatively small, it continues to increase. In 1986, it represented only 2.5% of the overall veteran population. While in 1992, it had almost doubled to 4.4% of the total veteran population. As of July 1, 1994, the female veteran population of 1.2 million constituted 4.5% of all veterans living in the United States and Puerto Rico. Female veterans as a percentage of all veterans is expected to continue to increase since the number of former military service women continues to increase. By the year 2000, women will represent 5.3% of all veterans, and by 2040, they will make up about 11.0% of the total veteran population.

Mr. Chairman, the DAV has identified specific issues impacting women veterans in their quest to receive timely, quality and compassionate health care from VA. Some of these include: access to care, quality of care, safety issues, privacy issues, sexual trauma intervention, and post-traumatic stress disorder.

The VA health care system of the future must be able to accommodate the health care needs of female veterans. As VHA moves in this direction, it would be better equipped to handle veterans' dependents.

Mr. Chairman, the *IB* is indeed a prescription for change for the VA health care delivery system. Our proposal creates a system that enables VA to be in line with the rest of the medical community. It would allow VA to move from the antiquated, inefficient, costly bed-based model to one of providing care in an ambulatory setting by opening points of access. More veterans would receive quality health care services in an efficient and timely manner. Also, no veteran now eligible for care would be denied care. Rather, their care would be enhanced. This discussion points to a system that would be beneficial for veterans and the VA system. The added ingredient is one of funding.

Importantly, the VA should be allowed the authority to collect and retain certain third-party reimbursements without corresponding appropriation offsets.

The DAV is certainly not wed to the current system. If eligibility reform, as described by the *IB* occurs, and as the VA continues to implement its field reorganization and the veteran population declines as predicted, we believe a close hard look at the VA's physical plant should be undertaken.

The DAV is not automatically opposed to looking at the system with an eye towards major changes. There is little doubt that major mission changes of existing VA facilities need to occur. However, it cannot be done prematurely nor near-sighted.

Mr. Chairman, I believe the committee needs to be aware of the realities surrounding the whole discussion of eligibility reform and its implications for VA and veterans, as well as the American taxpayer. We are still firmly convinced that our proposal would save a considerable amount of money for the VA and the American taxpayer.

As we have stated, VA is not now totally flexible in creating the venues in which health care is delivered. It is this flexibility that is contemplated by the *IB*.

Mr. Chairman, I would conclude my testimony with these major themes:

- VA must remain an independent system and be the responsible federal provider of care to eligible veterans;
- A voucher system that mainstreams VA care must not occur;
- Eligibility reform as proposed by the *IB* must proceed rapidly;
- No service-connected disabled veteran should have their priority to health care benefits diminished or terminated;
- Appropriate changes and alternatives to the existing physical plant of VA must be made but in a reasonable strategic process; and
- A "bottom line" mentality must not be the driving force for reform of VA's health care system.

Mr. Chairman, this concludes my testimony. I would be pleased to respond to any questions you or members of the subcommittee may have.

STATEMENT OF

JAMES N. MAGILL
DIRECTOR, NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS & HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA HEALTH CARE

WASHINGTON, D.C. JUNE 27, 1996

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than two million members of the Veterans of Foreign Wars of the United States, I wish to commend and to thank you for holding this hearing on the future of VA health care. We believe there is no greater issue facing the Department of Veterans Affairs than the reformation of its Veterans Health Administration. By holding this hearing today, you are clearly demonstrating your commitment to our nation's veterans and their health-care system.

The Veterans Health Administration (VHA) has four basic missions: (1) patient care, (2) medical and prosthetic, (3) medical education, and (4) backup to the Department of Defense during time of war or emergency. Probably at no other time has VHA been more challenged in accomplishing these four missions than now. The style of medicine VHS is practicing is clearly outdated. While the private sector is emphasizing primary, patient-centered care in settings that enhance independence, VA is currently relying upon costly inpatient medicine. VA has not kept up with the private sector in replacing inpatient care with ambulatory care, utilizing home and community based care, and adopting the "managed-care" concept.

Critical in opening the VA health-care system to all veterans is the expansion of out-patient care eligibility. Under current law, even veterans who are fortunate enough to access the system are often provided expensive inpatient services rather than the more medically sound and cost-effective out-patient treatment. One study
shows that over 40% of VA's treatment is non-acute and could be more efficiently and compassionately provided in a non-institutional setting. Thus, we strongly contend that as the VA health-care system is made accessible to all veterans, its out-patient care eligibility also be expanded. Then, no longer will a non-service connected veteran have to be admitted as an in-patient in order to receive appropriate out-patient treatment.

An advantage to broader and more fair out-patient care eligibility rules will be that those veterans who already enjoy access to VA health care will be provided with a much expanded variety of health care options as VA, in keeping with modern health care practice, expands its ambulatory and preventive care capabilities. This is an option that just makes plain sense and should be pursued immediately.

The over-reliance on inpatient care can be traced to several factors -- Hospital Directors have an inability, both real and perceived, to shift beds, personnel, and other resources from inpatient to other care settings; VA serves a geographically dispersed population with complex and chronic conditions; and finally VA's current eligibility criteria requires that in many instances it must provide care in an inpatient setting.

To the VFW there is no doubt that reforming VA's eligibility criteria for determining who may receive treatment in VA's medical facilities is the paramount issue facing VA today. Without dramatic and bold changes, the survivability of the VA health-care system will be in jeopardy. First and foremost, VA must change the way it does business while at the same time provide access to all veterans who want treatment in a VA medical facility.

Mr. Chairman, VA recognizes it must change and under the leadership of the Under Secretary for Health, change is occurring. Dr. Kenneth Kizer is in the process of implementing the Veterans Integrated Service Network (VISN), a bold initiative intended to take VA into the 21st Century. The VFW has the highest regard for Dr. Kizer. We believe his dynamic leadership has moved VA away from status quo. However, we also believe the jury is still out on the VISN plan. Without the support of Congress through legislation granting greater management authority and appropriate funding, all Dr. Kizer's plan may amount to is the shuffling of deck chairs on the Titanic. Without support, VA will be accomplishing nothing more than putting VA's health-care system on life support hopefully long enough to find a cure for what can be equated to a terminal illness. Congress must be patient and give Dr. Kizer's plan time to work.

While it is true the veteran population is declining, the veteran patient population is increasing with more veterans turning to VA for their health-care needs. These veterans are coming to VA with more severe and complex illnesses. This is due to the fact that the veteran population is aging much more rapidly than the general population. These older veterans must seek health care more often the care they receive is more expensive than for younger individuals. Due to economic and other factors, many of these veterans in need have nowhere to turn except the VA health-care system. In Fiscal Year '95, the VA discharged 199,727 patients 65 years and older from acute hospital care and 34,290 from long-term care facilities. Approximately 38% of VA's 2.9 million users in FY '95 were over 65 years old and 40 % (10.7 million) of VA's outpatient clinic visits were of this same age group. By the year 2010, the estimated number of VA users who will be 85 years and older will have increased by more than 400%.

VA must prepare itself to provide long-term care to this aging population. This preparation should include increased nursing home care-bed conversions as well as expanding the number of Geriatric Research, Education and Clinical Centers (GRECCs) from the current 16 to the congressionally authorized 25.

Of particular concern is VA's choosing to reduce long-term beds by transferring veterans to community nursing homes on limited contracts or directly on Medicaid programs. We believe this is simply bad medicine.

In closing, Mr. Chairman, the VFW strongly believes the future of VA health care lies in reforming its eligibility criteria and allowing for the retention of third-party reimbursements. As you know, the VFW along with AMVETS, Disabled American Veterans, and Paralyzed Veterans of America have for 10 years co-authored the "*Independent Budget*". This document, just recently released, goes into great depth detailing VA's current health-care status as well as our recommendations and views as to what lies ahead for VA health care as we enter the 21st Century.

This concludes my statement. I will be happy to respond to any questions you have.

Vietnam Veterans of America, Inc.

1224 M Street, NW, Washington, DC 20005-5183 • Telephone (202) 628-2700
Faxes: Main (202) 628-5880 • Advocacy (202) 628-6997 • Communications (202) 783-4942 • Finance (202) 628-5881

A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Statement of

VIETNAM VETERANS OF AMERICA

Presented By

Kelli R. Willard West
Director of Government Relations

Before The

House Veterans' Affairs Subcommittee
on Hospitals & Health Care

Regarding

Future of the VA Health Care System

June 27, 1996

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Introduction

Mr. Chairman and members of the Subcommittee, Vietnam Veterans of America (VVA), appreciates the opportunity to present its views on one of the most complicated and critical issues facing American veterans today. VVA appreciates your sense of urgency, Mr. Chairman, and that of Chairman Stump, in bringing this issue before the 104th Congress.

Veterans health-care reform has long been a matter of deep concern to the veterans community and to Congress. The goals are admirable -- aiming to enhance government efficiency, create less reliance on federal tax dollars, and improve services to our nation's veterans. Certainly the veterans community, as hard-working taxpaying citizens, shares the goals of making the Department of Veterans Affairs (VA) a more efficient, responsive health-care provider. Veterans -- especially service-connected disabled veterans -- deserve high quality care from this nation in return for their sacrifices.

The VA is a national health-care resource that fulfills missions that the private sector is unable to accommodate. VA provides specialized care to service-connected disabled veterans. It also serves as a backup to the Armed Services in times of national emergency or natural disaster. VA research provides for state-of-the-art treatment in many specialty areas and allows VA to recruit and retain highly qualified health professionals. VA also provides a training ground for a significant portion of our nation's health-care professionals. Much of VA's current patient base is indigent and would have no access to health services without VA.

The problems of obscure eligibility rules and inefficient resource allocation continue to be a burden on the veterans this system was designed to serve. The changing dynamics of federal and state health policies and modernized private-sector practices threaten to undermine the VA health-care system. Also, the currently outdated and costly modalities of care make the VA health-care system a huge target for pundits and budget cutters. Significant changes must be implemented both administratively and through legislative remedies.

When asking a broad range of health-care experts and veterans advocates to explain the ideal future veterans health-care system, the responses will likely detail a myriad of visions and prioritizations. VVA is hopeful that there will be some agreement -- just as the VSOs have established through *The Partnership for Veterans Health Care Reform* -- on a set of core principles or goals. Essentially, we need to look not so much at how VA operates today, but how it should do business five to ten years from now -- be prospective rather than reactive. Once these objectives are established, the veterans community must come to agreement on how to achieve that common goal.

VVA feels that much of the necessary and appropriate analysis of these very complicated issues has taken place, and the commonality in principles has been predominantly established -- though perhaps not formalized. The VSOs have demonstrated hard work and cooperation in advocating a set of common objectives, which should make Congressional reform efforts progress relatively smoothly, once the budget details are evaluated completely.

VVA will pursue the goals of ensuring quality care for veterans and their families -- reforming eligibility, streamlining VA bureaucracy, guaranteeing funding, and protecting VA's specialized services and unique missions. We are hesitant to let the process be skewed by nay-sayers who might choose to annul various reform proposals by labeling them as impossible, before looking toward the long-term objectives. Passage prior to adjournment of the 104th Congress of meaningful and realistic eligibility reform, as proposed in H.R. 3118, would carry the VA health-care system a long way toward a better future.

We look forward to working with you, Mr. Chairman, and the committee to achieve the best possible VA reform for our nation's veterans. We wish to underscore the need to expedite the process in order to arrive at a balanced and modernized veterans health-care delivery system which provides the best possible care for America's veterans, and still recognizes the need to also achieve realistic federal budget savings.

VVA's General Position on VA Health Care

We are all aware of the current situation. As some would indicate, VA often appears to be a inefficient, haphazard mess. Veterans using VA health services can get some services at some VA locations, while other similarly-situated veterans get more or less at other sites. There is no continuity and no bottom-line standard of available services. The system must be fixed in order to ensure continuing support from Congress and the nation as a whole -- otherwise veterans stand to loose a great deal more than the bricks-and-mortar of 171 VAMCs.

Eligible veterans who choose to use VA care should be able to receive a comprehensive benefits package, rather than the spotty and inefficient eligibility categorizations currently offered by VA. Veterans must be assured that funding sources will be available to provide those guaranteed, comprehensive health benefits. Service-connected disabled veterans must remain the highest priority for VA, and its unique specialized missions must be maintained and strengthened. The VA must become the provider of choice for veterans by becoming more user friendly and customer service oriented.

As a single-generation organization representing Vietnam era veterans, VVA has a unique perspective on VA health care. This is the "sandwich generation," if you will, caught between the concerns of raising families and contemplating the challenges of aging. Vietnam veterans represent the largest subgroup of the veterans population. The veteran population as a whole is getting smaller as the World War II generation passes on, but the Vietnam generation is only now approaching middle-age. Thus, the rate of reduction in the veterans population will slow somewhat for a period of years, but also grow older. As the Vietnam generation ages, these veterans will become more costly in terms of health-care expenditures.

Many Vietnam veterans have spouses and family members who need improved access to affordable health care. Additionally, many Vietnam veterans have aging parents who face expensive nursing home care. VVA 1995 Convention Resolution P-7-95 calls for organization support for "legislation ensuring that all veterans and their families have access to health-care coverage meeting minimum requirements which is provided at a reasonable cost to both the veteran and his or her family." We favor the concept of caring for veterans' dependents within or through the VHA system with affordable cost sharing and copayments.

Vietnam veterans are critical to the success of VA health-system reform. The large majority of Vietnam veterans have not yet reached retirement age and remain in the workforce. They, like all hard-working tax-paying Americans, have serious concerns about their tax dollars being spent wisely, the effects of our staggering debt, and the deficits that may be passed on to their children and grandchildren. VA's future depends upon its ability to reform, streamline and modernize its health-care service and delivery system. Otherwise VA's efforts to attract high-income, non-service connected veterans who can bring substantial new funding streams to the VA will fail. Without these additional monies, VA will continue to rely solely on federal appropriations.

VVA's membership favors eligibility and health reform plans to create greater VA and private sector health-care efficiency, improve quality, enhance access, provide more choices, and improve responsiveness to meet the unique needs of veterans. These objectives are not mutually exclusive. Many can and should be achieved through meaningful VA eligibility reform.

Eligibility Reform Is Especially Timely in 104th Congress

VVA, like many of our colleagues, hopes that some measure of eligibility reform can be accomplished during the 104th Congress. This would serve as an important complement to Dr. Kizer's reorganization efforts, creating more efficiencies in the system. The private sector is also making radical changes in the way health care is delivered, various state legislatures are moving

forward with local reform initiatives, and federal Medicare and Medicaid health-care programs are experiencing significant budget-driven program changes, all of which will effect the way veterans receive health-care services inside or outside the VA.

Fortunately, one of the best selling points regarding VA health-care reform, and eligibility reform in particular, is that if more cost-effective care could be provided, there would be less reliance on federal spending, and a reformed VA would better serve the veteran population. Veterans organizations have pushed for VA health-care reform for over a decade. It has failed to pass not because of widespread opposition -- in theory there is none. Eligibility reform has failed because of the misconstrued cost implications.

GAO has identified a number of efficiencies which VHA can achieve under current law. Eliminating duplication of services, further coordination of pharmaceutical purchases, enhanced cost accounting, enhanced use of sharing and contract arrangements with community providers, and other management initiatives can do a great deal. The VHA reorganization will likely accomplish many of these administrative reforms. Yet legislative relief is needed to eliminate statutory barriers to more efficient care, and to provide local and regional managers with incentives to create further administrative efficiencies. The latter should come about through at least partial retention of Medical Care Cost Recovery (MCCR) funds.

Basic Components of Eligibility Reform

The objective of eligibility reform is to eliminate the complicated morass of eligibility hoops and hurdles by which Category A veterans can receive a certain range of services, and Category C veterans receive only a patchwork. Furnishing comprehensive care in a holistic manner through a coordinated network of health-care providers has been a highly innovative approach, and is the wave of the future in health-care delivery. Comprehensive coverage and integrated delivery is the best way to ensure cost-effective, high quality care. VVA has long advocated for improvements to VHA programs which enhance efficiency and provide more benefits to more veterans with the same allocation of federal tax dollars.

VA's own estimates indicate that some forty percent of its inpatient episodes of care could be more cost-effectively provided in another setting. Thus, there are very significant cost savings to be achieved by shifting from the outdated acute care emphasis to primary care modalities in an outpatient setting. The efficiencies should logically allow VA to provide more outpatient services because these core group veterans would not necessarily get more care, but simply more efficient care. Even if one assumes a slight-to-moderate influx of core group veterans, the efficiencies should

sustain the system. We wish to underscore the need for a priority focus on this particular area.

VVA favors an incremental approach to veterans health-care eligibility reform for two reasons. In theory, an incremental approach should address inflated Congressional Budget Office (CBO) cost estimates which have thus far inhibited more comprehensive reforms. Also, an incremental approach should provide VHA with time to adjust to these changes -- time that will be critical, as the evolution of a large bureaucracy is not easy. As long as an incremental approach does not jeopardize the end goals, VVA agrees that forward progress in smaller steps is preferable to leaving the VA health system to flounder under its current legal restrictions which force it to function with outdated medical practices. Eligibility reform should be able to eliminate the current barriers to outpatient care for "core" group veterans in a cost-neutral manner, as the Stump bill aims to do.

It would be very difficult and unrealistic for VVA to support proposals to reduce the population of veterans with VHA health-care eligibility. Doing so is a dangerous precedent; it is unfair to those currently eligible veterans who are service-connected disabled or indigent. The system was formed to meet their needs. In addition, cutting back on who is eligible for VA care is bad health-care policy, particularly at a time when access to other federal health-care programs may become more limited. Veterans who might lose access to VA in such proposals -- service-connected disabled under 50 percent or low-income veterans -- are perhaps the most vulnerable to the private-sector insurance market, due to pre-existing conditions exclusions, basic risk-adjustment, and prohibition of portability. High maintenance health-care consumers are expensive to insure. Many of these veterans may have no health-care coverage at all, and are not able to find any affordable health care insurance.

Reducing the pool of eligible veterans who can access VHA care would also be detrimental to VHA efforts to collect third-party reimbursements and copayments, and would thus hamper any VHA reform initiatives that might be undertaken with these funds. To meet the demand for services of this larger eligible veteran population, VA must expand its points of access to care and shift emphasis toward more cost-effective and convenient outpatient modalities of primary and preventive care. VVA has traditionally favored extended use of the fee-for-service program, to allow veterans to utilize whatever providers they choose. VVA remains committed to providing health-care choices to veterans to use providers inside or outside the VA. Various innovations contemplated in the VISN plan may allow greater choices for veterans, as the VA develops localized sharing and contract arrangements with DOD, community providers, and others to provide care in the most cost-effective, medically appropriate, and consumer-friendly manner.

Certainly, we need to be prudent about proposing widespread contracting-out for VA-provided care. There are dangers in losing management and quality controls, as well as potential

liability. GAO has noted many cost increases as various federal government programs are contracted out, and in fact most federal agencies that use high percentages of their budgets to pay outside contracts have experienced higher costs, overruns, scandals and poor financial management controls. VVA recommends strong oversight of such programs within the VA health system to avoid these pitfalls

The emphasis on managed care practices may be a good method of moving the VA health system into more modern practices of medicine. VVA cautions the committee to be careful when defining "managed care" though. In the private sector, some managed care providers attempt to preclude patients from seeking costly specialized care. The veteran population is generally older than mainstream managed-care patients. Veterans, as a rule, also have greater and more severe medical conditions and unique needs for specialized programs Care must be taken to assure that access of service-connected disabled veterans to VHA specialized programs is not restricted or eliminated

In the context of restricted budgets, it is even more critical that VHA be allowed to practice modern medicine with an emphasis on cost-effective care. VHA will be forced to cut programs and turn away seriously ill veteran patients unless efficiencies are realized. Eligibility reform is needed to provide the statutory license and systemic incentives to achieve efficiencies.

VVA's definition of the ideal "comprehensive eligibility reform" would provide federally funded VA access to a continuum of care for service-connected disabled veterans and low-income veterans. Non-service connected, high-income veterans who wish to, should be able to access VA by paying for their care through a third-party reimbursements or copayments. Recognizing that this may not be feasible in this budget climate, an acceptable first step would very simply eliminate barriers between inpatient and outpatient care and thus allow VA to provide comprehensive care to the current pool of eligible veterans in the most cost-effective manner

In essence, VA health-care eligibility reform should not delineate who can and cannot receive services, but rather who should be required to pay for the care and how much.

Core Group -- Mandatory Category Veterans

Service-connected disabled veterans and low-income veterans should always remain VA's highest priority. This principle must be maintained in Title 38. Federal funding must be sustained to meet the nation's obligation to this core group of VA eligibles. VVA firmly believes that services for this population can and must be improved and enhanced through eligibility reform -- allowing access to a continuum of care and increasing quality -- by eliminating barriers to outpatient care.

While some have questioned the role VA plays in providing care to non-service connected, low-income veterans, this is an important mission which should continue into the foreseeable future. We see appallingly high statistics of veterans among the homeless -- one-third of the nation's homeless are veterans. A recent VA study of hospitalized veterans showed that 23% had been homeless at the time of their admission, and an additional 7.4% were at high risk of homelessness after discharge ("FY 1995 End-Of-Year Survey of Homeless Veterans in VA Inpatient and Domiciliary Care Programs," February 7, 1996). We see unemployed and underemployed veterans and their families living in poverty who try every day to find work. It is important that those who have served honorably in our nation's armed services not be allowed to become destitute. Without VA, many indigent veterans would have no access to health-care services at all.

Discretionary Category Veterans

Shifting to more efficient outpatient care, VA will likely have an increased capacity. Just as non-service connected, higher-income veterans can currently access the VA system when resources permit, with eligibility reform the same opportunity should exist for additional veterans who wish to pay for these services. As proposed in *The Independent Budget*, and by *The Partnership for Veterans Health Care Reform*, VHA should be allowed to retain a portion of the monies collected for services to discretionary veterans. These funds should then be reinvested to improve services for all veterans -- mandatory and discretionary. Facility enhancements, equipment purchases, addition of services and access points, and a host of innovations could be accomplished with these new funds, and without additional or new taxpayer-appropriated dollars.

This is the basic premise behind the VSOs' analysis detailing that eligibility reform can increase services and still reduce the VHA's reliance on federal tax dollars. By bringing in new sources of funding and increasing efficiency, VHA could make some of these improvements without tapping into the annual federal appropriation. Again, however, federal appropriations will still be necessary to maintain commitment to care for "core" group veterans.

Closely Monitor VHA Reorganization

VVA and the veterans community have largely endorsed the VHA reorganization plan put forward and currently being implemented by VA Under Secretary for Health Dr. Kenneth Kizer. We look toward full implementation of the VHA reorganization with a great deal of hope, but also some apprehension. Like the veterans community as a whole, VVA is pragmatic about changes that must occur in order to maintain and improve the VA health-care system.

VVA agrees with the goals of shifting to a Veterans Integrated Service Network (VISN)-based system: allocating resources more efficiently, de-centralizing decision-making; increasing points of access to care, eliminating duplication of services, and improving overall customer service. These changes should provide for more effective management by allowing local managers to take into consideration local health-care resources and market, the demographics of the local veteran population, effects of state legislated health reforms, changes in Medicare and Medicaid, and other factors, when determining how best to provide care to the local veteran population.

Veterans at the local level, however, don't completely know how to interpret these changes. Many are afraid services will be eliminated without providing improved alternatives. How these reforms are presented to the local veteran populations will have a great deal to do with their acceptance. VVA will continue to support Dr. Kizer's efforts. We will also work with Congress to monitor the implementation of VHA reorganization to ensure that services for veterans are not disrupted and that the most productive outcome results.

VVA is currently making efforts to identify and appoint our own leaders to serve on the 22 VISN Management Assistance Councils (MAC). These advisory bodies will provide an important information sharing function, and give the veterans community -- VA's consumers -- input into the management of health-care programs. Thus far, we have had mixed feedback about the VISN's progress in establishing these bodies and in their usefulness to participants.

Specialized Programs

One underlying concern we have with the reorganization is the preservation of VA's specialized programs in a system which will likely become increasingly more capitation-cost driven. VA's specialized programs in the areas of PTSD and mental health, spinal cord injury medicine, blind rehabilitation, advanced rehabilitation, prosthetics, long-term care and homeless veterans readjustment are national resources aimed to address veterans' unique needs, while at the same time creating important research and training opportunities for our nation's medical professionals. It is critical that protections are put into place to ensure their ongoing viability.

VVA is very fearful that the specialized programs will be administratively and financially squeezed as the VA begins to operate a capitated, managed-care system along the lines of private sector HMOs. Private sector managed care insurers and providers aim to reduce costs by restricting access to expensive specialized services. The veteran population is unique, however, with a high prevalence of disabilities needing these specialized services. VA's specialized, uniquely veteran programs must be protected, as in most cases, private sector substitutions simply do not exist or the

quality is inferior. The current budget climate for VA medical-care spending presents some distinct challenges, as inflation will eat away ever larger portions of each year's budget. This will undoubtedly put pressures on specialized programs.

A number of recent calls from VVA members around the country have raised concerns that the VHA's well-laid plans are not being wholly embraced by administrators in the field -- particularly with regard to protecting VA's specialized programs, including PTSD and substance abuse programs. The reorganization, it seems, has disrupted the hierarchical chain-of-command somewhat too abruptly. VISN directors and VA Medical Center (VAMC) administrators have been given broad authority to make changes in the way services are provided in an effort to create efficiencies and meet constricted budgets.

Local administrators have begun these well-intentioned changes with little notification to or supervision from Dr. Kizer and VA Central Office. Efforts are now underway to regroup and require VHA field leadership to report to Dr. Kizer what changes are being proposed, how the recommendations were developed, the consultation with stakeholders (VSOs), the alternatives considered, and similar information -- essentially establishing guidelines, criteria and standards for how decisions to close or consolidate services should be made. Dr. Kizer must then sign-off on these changes prior to implementation.

One of the programs that appears to be under the gun is inpatient PTSD and substance abuse units. Citing studies which show that outcomes of inpatient and outpatient treatments for these conditions are comparable, with a significantly lower cost for outpatient care, VHA administrators are contemplating closing or consolidating some of the inpatient programs. In a June 7 letter to Under Secretary for Health Dr. Kenneth W. Kizer, VVA raised concerns about the manner in which these changes seem to be taking place.

The comments VVA is hearing from around the country regarding the sudden and proposed closures of VA inpatient PTSD and substance abuse programs are that:

a) It does not seem that these closures are thoroughly planned out, in terms of making program alternatives, substitutions or accommodations available in order to prevent disruption of service to the local veteran population -- not adhering to the criteria and guidelines stated in the "Prescription for Change"; and

b) Even assuming that the alternatives, substitutions and accommodations are properly addressed in the planning, the public -- and particularly veteran consumer groups -- hasn't been adequately or appropriately informed, thus raising significant, unnecessary misunderstanding

and alarm among veterans

VVA recognizes that some changes in the way hospital-based PTSD and substance abuse treatments are provided are necessary to achieve greater efficiency and improved service -- even in these "specialized services" for which VA is a recognized national health-care leader. I want to be very clear that we are not opposed to making changes, per se. Through greater efficiency, it is hoped that more veterans will have access to these VA services. VVA is simply concerned that these closures -- as currently presented -- might negatively impact patient care.

PTSD and substance abuse treatments are readily identified as part of VA's core mission of caring for the special needs of combat veterans. There are very often no comparable private-sector alternatives for veterans seeking these types of services/care. There are certain PTSD and substance abuse patients for whom acute-care, inpatient medical treatment of this sort is critically important. For some veterans suffering from these conditions, an outpatient program will not meet their clinical needs -- a safe, supervised, therapeutic-setting, overnight accommodation is critical, particularly for veterans on medications, veterans who reside a considerable distance from the VAMC, and homeless/indigent veterans whose day-to-day life circumstance would hinder recovery. An additional factor to consider is the rural versus urban setting -- forcing veterans with these particular conditions to travel from relatively safe rural settings to a VA facility perceived to be in a dangerous urban area can be detrimental to treatment. These clinical needs must be accommodated. It is critical that the unique nature and the clinical integrity of these programs are protected and maintained.

Certainly there are alternatives to the up to $800-a-day acute-care hospital bed that could meet both the objectives of patient care and cost savings. VVA recommended to Dr. Kizer that appropriate alternatives to current inpatient care models be fully evaluated. There are many options. Domiciliary or nursing home-style care could be an appropriate model. Also, VVA has long advocated for community-based organizations, such as the homeless programs in Wisconsin and Connecticut, in which VA establishes sharing or contract relationships with community providers to maximize use of all available resources. We are very concerned, however, that these alternatives be put into place prior to the closure of hospital-based inpatient units.

Additionally, VVA advised Dr. Kizer to ensure that information is disseminated to the local veterans community. Public relations efforts in advance of program chances can help VA to alleviate many fears and defensive posturing of the veterans community. It is very important that the veterans community leadership -- consumers -- be involved in and informed of VA's decisions to change the way care is provided prior to changes taking place. This is particularly true of PTSD programs where the local veterans community takes a very real, personal stake in program quality and continuity. By involving VSO leaders in these discussions of how best to shift inpatient PTSD and substance abuse

care to a more cost-effective setting, VA will be able to educate the public about the purposes and goals of these changes, and will be able to identify additional community resources which may be of use.

Vet Centers as Models

The unique community-based nature of Vet Centers is a distinct asset to the future planning of VA health care. Expanding access points is one of the primary objectives of VHA reorganization and reform. This is critical to VA's ability to provide more cost-effective care and to reach out to those veterans who do not currently access VA services. The geographic distance separating many veterans from the nearest VAMC makes the community-based Vet Centers an important point of contact for veterans in their first attempts to access VA services. The benefit of coordination already being done between Vet Centers and VAMCs around the nation, conducting preliminary health screening and referrals, will be critical to VA's expansion of outpatient and primary care access points. The Vet Centers can serve as a model for VA outpatient expansion.

One of the Vet Centers' greatest strengths has always been that of "help without hassles" -- the customer service perspective which the broader VA health system is working toward. Additionally, the Vet Centers offer an avenue for veterans to get some needed outpatient assistance, while avoiding more expensive inpatient care. These walk-in assistance and referral clinics have proven to provide efficient and cost-effective treatment for veterans seeking help for PTSD, its secondary symptoms of substance abuse and homelessness, as well as more basic VA benefits information and employment and training referrals. VVA continues to advocate that Vet Center services should be opened to all war-time veterans and their families, in order to meet the growing needs and address continuum of care for veterans.

The Senate Veterans' Affairs Committee is due to mark-up Senator Daniel Akaka's legislation S. 403 this week. Representative Lane Evans has introduced a companion bill (H.R. 1429), and Representative Christopher H. Smith has proposed similar legislation (H.R. 2313). Each of these bills aims to provide broader eligibility for Readjustment Counseling Service programs, and provide for enhanced use of these VA facilities for primary care access in VHA's reorganization. VVA has endorsed these proposals and will work diligently toward passage of this legislation. We urge the House Veterans' Affairs Committee to enact this legislation in the 104th Congress. While wholly supported by many legislators and the veterans community, these provisions were a victim of time constraints at the end of the 103rd Congress. This legislation would make health care available and accessible to more veterans, and would better position the VA to provide health care in the future.

The Future of VA's Other Missions

VVA believes that VA's additional missions -- serving as a backup to the Armed Services in times of national emergency or natural disaster; medical research; and training many of our nation's health-care professionals -- do complement VA's primary mission of providing care to our nation's disabled and indigent veterans. In tough budget climates, however, and as VA reevaluates its role and ability to provide care to veterans, Congress may be forced to prioritize these secondary objectives. It may not be possible for VA to continue to be all things to all people. If forced to cut back on VA's role as a national health-care resource, decisions must be made such that veterans' access to quality care is not diminished.

Conclusion

While the legislation and issues surrounding VA health care are very complex, VVA believes the veterans community does have a common end goal -- five to ten years from now, VA should be a provider of choice, accessible to all veterans (and potentially their families) either through their federally funded service-connected and/or low-income VA health care benefits, or through third-party reimbursements and copays. VA should provide comprehensive, high quality and cost-effective care to this beneficiary population. So how do we push VA along the slippery, up-hill slope from Point A (the current VA system) to Point B (the ideal VA of the future)?

There are a few relatively simple and realistic steps which can and should be taken now to move the system toward the 21st Century. In VVA's view, the two must-do elements of VA reform are basic -- 1) eliminate barriers to outpatient care for currently eligible veterans; 2) provide incentives for efficiency by allowing VA to keep a portion of monies collected from insurance and copayments. All the while, VA's primary mission must be the overriding concern.

The VSOs generally supported the eligibility reform provisions introduced by Chairman Stump and passed by the House Veterans' Affairs Committee in H.R. 3118. VVA believes this bill represents a pragmatic and worthwhile initial approach to an uncertain demand for VHA services and volatile budgets. An incremental approach such as this may prove very favorable to the overall goals of system change, as it would provide time for evaluation and to expand access. The bill would ease access to more cost-effective outpatient services and provided incentives for collecting reimbursements and copayments. Though it would not provide increased access for high-income, non-service connected veterans who would pay for care, it would not reduce current benefits for low-income veterans or the majority of service-connected disabled veterans.

VVA understands the concern raised by some that enacting any kind of VA-improvement or eligibility reform may open the system to a new group of eligible veterans, but we do not agree that a significant demand for services is automatically imminent. It is our belief that veterans who need VA care (service-connected disabled or low-income veterans without other health-care options) are already receiving these services -- but in an extremely inefficient and inconvenient manner. Veterans and physicians discover ways to navigate the current eligibility web, and do receive/provide care. Eligibility reform should eliminate barriers to cost-effective modalities of care. There may be some minor influx of patients, but greater efficiencies and incentives for collection of third-party and copayment funds should cover the costs associated with any additional demand for services.

VVA's premise is that opening access to outpatient care is not creating a new or enhanced benefit, but rather providing a more cost-effective benefit to the same "core" pool of eligible veterans. To say that veterans will consume the same quantity of inpatient care and will additionally use more accessible outpatient care under eligibility reform defies logic. Veterans will not automatically become sicker once eligibility reform is legislated and thus use more care; a veteran who would receive cataract surgery as an inpatient under current eligibility rules would not require both an inpatient and an outpatient procedure if the system were reformed to provide more cost-effective ambulatory care. It is our belief that the desired eligibility reforms will, in fact, save federal tax dollars while at the same time improving service and expanding access to care for veterans.

VVA appreciates this opportunity to discuss priorities and general philosophy regarding veterans health care. We look forward to working with you, Mr. Chairman, and the committee to achieve a more efficient, accessible, and enhanced quality health-care system for American veterans. This concludes my prepared statement. I will be pleased to answer any questions you or the committee may have.

Non Commissioned Officers Association of the United States of America
225 N. Washington Street • Alexandria, Virginia 22314 • Telephone (703) 549-0311

STATEMENT OF

LARRY D. RHEA

DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS

AS ENDORSED BY

THE MILITARY AND VETERANS ALLIANCE

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

ON THE

FUTURE OF THE VETERANS HEALTH ADMINISTRATION

JUNE 27, 1996

Chartered by the United States Congress

The Non Commissioned Officers Association of the USA (NCOA) wishes to begin with a word of thanks to the distinguished Chairman for your invitation to appear today at this important hearing. The Association is honored to be included among the diverse group of dignitaries that the Chairman has called to testify. NCOA hopes that our testimony will prove useful as the Subcommittee looks to the future of VA health care.

NCOA is pleased to inform the Subcommittee that our testimony has been endorsed by several Associations of the National Military and Veterans Alliance. Member associations endorsing this testimony are the Air Force Sergeants Association; National Association for Uniformed Services; Korean War Veterans Association; Naval Reserve Association; and, the Naval Enlisted Reserve Association. Collectively, these organizations represent over 500,000 members of the seven uniformed services - officer, enlisted, active duty, reserve, retired and veteran plus their families and survivors.

It is obvious to NCOA that veterans health care, including health care for retired military veterans, is at a critical juncture. Health care and the availability of that care for veterans in DVA and in the DOD and DVA systems for military retirees is the number one issue of concern to the veterans of this Association. Over the last several years, NCOA has testified before Congress on numerous occasions to discuss this issue. Throughout, NCOA has been mindful to offer its best judgement on potential solutions and the Association has strived to ensure that equity is accorded among veterans.

Notwithstanding the restructuring of the Veteran Health Administration (VHA) currently underway, NCOA believes that some basic, fundamental issues surrounding veterans health care need to be addressed in a candid, straightforward manner. It is a task that has proven heretofore difficult. It also clearly is a task that will require courage and leadership if meaningful, long term solutions are to be reached. For your willingness to take on these tough questions, NCOA salutes you Mr. Chairman.

Several areas on which the Subcommittee is receiving testimony during this hearing are, in the opinion of this Association, best left to the experts in those areas. Therefore, NCOA will

confine its testimony to those areas which the Association suspects might not otherwise be covered.

RESTRUCTURING, ELIGIBILITY REFORM AND UNIVERSAL STANDARDS

In stating the Association's support for Vision for Change last year, NCOA indicated a belief that reform of VHA's eligibility rules was essential to the plan's ultimate and complete success. In this Association's view, the success or failure of the VHA reorganization will have a direct relationship to whatever is done or not done about eligibility reform. NCOA also testified last year it is our belief that eligibility reform should run a close parallel with the implementation of the VHA restructuring plan.

Within the context of today's hearing which focuses on the future of the VHA, NCOA wanted to avoid re-plowing the previously tilled ground of eligibility reform. But frankly Mr. Chairman, a discussion regarding the future of veteran health care cannot be undertaken without first dealing with the issue that is the major impediment to any hope for the future. Restructuring VHA was inevitable and probably overdue. It was only a matter of time before it had to occur. The VHA restructuring process is now underway and NCOA suggests that the eventuality of eligibility reform is now at hand. Without it, all the restructuring in the world will have only a minimal effect. Without meaningful eligibility reform, the VHA will only limp along in the future as it does now.

The above paragraph is not intended to be critical of this Subcommittee or the House Veterans Affairs Committee. Conversely, NCOA is deeply grateful for the work done on H.R. 3118. NCOA endorsed and has actively participated in the effort to move this legislation through the House of Representatives. Although that hasn't happened yet, NCOA remains committed to H.R. 3118 for several reasons.

First, NCOA views H.R. 3118 as the initial step on common grounds where agreement could be reached. Secondly, the Association applauded the greater emphasis that the bill placed

on veterans with service connected disabilities. And, no less important, H.R. 3118 permitted the DVA to practice common-sense medicine by giving attending physicians the authority to determine the clinical setting most appropriate to providing the needed medical care.

In many respects, NCOA and other veteran service organizations recognized several years ago that VHA was at a key transition point in its history of providing medical care to veterans. In NCOA's view, eligibility reform is the pivotal point on which a successful transition now rests.

NCOA also wants to restate an issue that the Association believes to be inextricably linked to VHA restructuring and the future. The Association is referring to a set of universal standards. In addition to the element of eligibility reform, NCOA believes that a set of universal standards for individual hospital operations is absolutely essential.

Today, the VA hospital system continues to function without universal standards. Staffing standards, staff to patient ratios, average care costs, duration of stay standards, equipment procurement and tables of equipment standards all seem elusive to the VHA. In NCOA's opinion, there should be guidelines for all medical centers that cover everything from patient care to pharmacy pill counts to supply inventory. Universal standards would enhance efficiency and reduce waste in many areas.

Mr. Chairman, NCOA wants to be entirely clear on this point of universal standards. Micro-management of the hospital system from VA Central Office is not a desirable alternative. The system is just now starting to move away from that malady. Nonetheless, NCOA does believe that universal standards is an issue that must be addressed in a coordinated manner between the Central Office and VISN Directors. Fully relinquishing control over hospitals and medical centers prior to addressing this issue would be unwise in NCOA's opinion.

RECOMMENDATIONS FOR THE FUTURE

Health care has been a topic of national debate for many years. The introduction of the

President's National Health Care Security Act certainly elevated that debate to a higher, more intense level and it continues today. Also, for many years, there has been a growing crisis in military health care that continues to worsen and its impact on military retired veterans and their beneficiaries has been profound.

DOD has made several feeble attempts to overhaul its health care delivery and each time the cost to the individual military retired veteran has increased. DOD has never honored nor does it have plans to honor the promise of lifetime, cost-free health care to military retirees and their beneficiaries. Even under the President's National Health Care Security Act, the promise and premise under which these veterans served would not have been honored. While other segments of society, including illegal immigrants, were to have been guaranteed health care without personal cost, military retired veterans were to have been required to share in the cost of their treatment even within VA.

A few months ago, Mr. Chairman, NCOA hosted an event for a group of young service members that was also attended by several congressional staff members. During that event, a prominent congressional staff member explained to these young people the difference between the Armed Services, National Security and Veterans Affairs Committees of Congress and the issue of health care was raised. On the issue of health care, the staff member explained it this way. The Armed Services and National Security Committees take care of health care for military retirees and their beneficiaries. The staff member went on to explain that the Veterans Affairs Committees of Congress had health care oversight for all veterans who are not military retirees. Although unintentional, the impression left on these young service members was that military retirees are not veterans.

NCOA takes no satisfaction in relating the above instance to the Subcommittee, Mr. Chairman, for it is indeed sad commentary. It illustrates though a certain mind set that not only prevails among some staffers but Members of Congress and within the VA as well. And, frankly, NCOA believes it is a mind set that must change. The sharing agreements that are entered into between the DOD and DVA are a prime example of just how deep this mind set goes.

Under present law, DOD and DVA are authorized to share resources in order to provide the best possible medical care to their respective beneficiaries. The two agencies generally have used this authority wisely benefiting both the recipient of care and the taxpayer. However, recent Memoranda of Understanding between DOD and DVA, which recognize the VA as an authorized care provider for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), require military retired veterans to make co-payments to the VA for treatment received under sharing agreements.

Under current law, DVA routinely waives co-payments from other non-service connected veterans treated in VA facilities even when third-party insurance is involved. Furthermore, there is no other agency of government that requires a beneficiary co-payment for providing medical care to a beneficiary. Even DOD does not charge non-service connected veterans for treatment received in military facilities under sharing agreements between the agencies. Only CHAMPUS beneficiaries must bear such a burden. Plainly stated, NCOA believes that this is fundamentally wrong. As a matter of equity among veterans, the practice of requiring co-payments from military retired veterans for treatment in DVA should be discontinued.

Recently, President Clinton hosted a Media Roundtable for the Chief Executives and National Commanders of military and veteran service organizations. Included in the issues discussed with the President was one dealing with MEDICARE subvention for the Department of Defense. The subvention issue within DOD is identical in nature to that which is confronting DVA. MEDICARE-eligible beneficiaries who have earned lifetime military medical care and have paid by payroll deduction for MEDICARE are not permitted to use their MEDICARE benefit in Military Medical Treatment Facilities.

DOD proposed a joint DOD/Health and Human Services (HHS) demonstration project on June 27, 1995. To date, HHS has delayed moving ahead with the demonstration. Health Care Financing Administration (HCFA) staff representatives believe they do not have statutory authority to conduct the test.

It is important to note that a review by DOD found no statutory evidence that would prohibit

conducting of a DOD/HHS joint MEDICARE demonstration project. Nonetheless, HHS has refused to proceed with the demonstration.

Since the President's June 3, 1996, Media Roundtable referred to above, Administration officials have been actively working to resolve the question of whether the President has authority to order such a demonstration project or if legislation is actually required. The important point in relating this to the Subcommittee is that the President made a commitment to MEDICARE-eligible military beneficiaries that he would seek legislation for a demonstration project if he did not have authority as Chief Executive to do so by Executive Order.

NCOA's purpose in relating the above is simply this. NCOA and every other major veteran organization has been advocating MEDICARE subvention for DVA. Just like the situation with DOD, veteran organizations have been stonewalled by HHS and HCFA. The fact that the President now seems willing to move on this issue should ignite a great deal of interest within this Subcommittee. If by Executive Order or legislation the President moves to establish a demonstration project, NCOA requests that this Subcommittee do everything possible to ensure that DVA is included.

Another recent development that relates to this issue is the fact that on June 19, 1996, the Senate, as a part of the FY 97 Defense Authorization Act, included language for a DoD/MEDICARE demonstration project for MEDICARE-eligible military beneficiaries.

In conclusion, NCOA wants to thank you once again Mr. Chairman for holding this hearing. Your thoughtful consideration of our testimony is greatly appreciated.

Thank you.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

DEPARTMENT OF VETERANS AFFAIRS

RESPONSES TO POST-HEARING QUESTIONS
FOR KENNETH W. KIZER, M.D., M.P.H.
UNDER SECRETARY FOR HEALTH

CONCERNING JUNE 26-27, 1996 HEARING
ON
THE FUTURE OF VA HEALTH CARE

SUBMITTED BY
HON. TIM HUTCHINSON, CHAIRMAN
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS' AFFAIRS COMMITTEE

Question 1: Mr. Coile's vision of the future is one in which the wisest capital investment strategy is most likely one that is asset free. Do you see this as a possibility for the VA?

Answer: In part, yes, but the question overly simplifies the situation. For example, in order to assure that VA's "special emphasis programs" (e.g., blind rehabilitation, spinal cord injury, geriatric and other long term care, prosthetics and sensory aids, etc.) remain available to veterans, VA will always need to maintain a capital infrastructure, since these types of facilities are often not available in the private sector. This will necessitate a continuing capital investment strategy. VA is moving toward more "virtual" service-delivery options, and I foresee major opportunities in that respect in a number of acute-care programs, particularly where we are in partnership with DoD treatment facilities and academic health centers. We anticipate the need for fewer acute-care beds as part of VA's capital plans in the future, and illustrative of this we have closed approximately 7,100 acute care beds in the last 21 months.

Question 2: In 1990, the Commission suggested that one-half of the current short hospital stays could be provided in ambulatory settings by 2010. Do the workload projections which underlie current construction projects -- such as Travis -- reflect this scenario?

Answer: The Commission's views were based on optimal healthcare utilization projections supported in part by VA

Health Services Research and Development studies. I understand that these projections also assumed Congressional action to address the then and still arcane Congressionally mandated eligibility rules. In our eligibility reform proposal, we assume that a more modern view of healthcare will facilitate the provision of a *proper* level of care and will result in fewer inpatient admissions. This assumption is a recognition that VA could provide much more care in outpatient settings if it were empowered to do so.

You mentioned our methods of workload projection and the Travis project in your question. The proposed new facility is a joint venture with the U.S. Air Force that honors the Administration's commitment to Northern California veterans to replace the Martinez Medical Center, which was closed as an earthquake hazard. The project's bed capacity was based on both the current and projected populations of eligible veterans in this area of Northern California. The facility is designed to serve the needs of veterans in Sacramento, Contra Costa and Alameda Counties.

Presently, we are re-evaluating our methods of projecting workloads associated with VHA construction projects, recognizing that such methods must adjust to changing practice patterns and evolving healthcare delivery systems. I am encouraging a number of new approaches in internal planning and finance, and I believe that, over time, a number of incentives will change.

Question 3: The VA has received a Hammer Award for some of its work in the field of telemedicine, specifically telepathology. In general terms, how do you envision this technology impacting the future of healthcare delivery in the VHA?

Answer: Telemedicine is increasingly recognized as being useful in providing more efficient and effective clinical care. As the focus of healthcare delivery within VHA changes from the individual care provider to integrated healthcare delivery networks, I believe that the use of telemedicine will be increasingly important.

I hope that rapid growth of telemedicine is possible within VA because of the existing organizational and technical infrastructure of the system. This should be facilitated by VA not being faced with major barriers such as interstate licensure and reimbursement issues. I expect that VA's future use of telemedicine technology will markedly increase and that it will be shown to be a most effective method of

reducing costs and increasing the quality and timeliness of patient care.

Question 4: In general terms, what role do you see the non-physician caregiver playing in the VHA healthcare delivery system of the future and how far can appropriate "clinical practice guidelines" stretch the autonomy of these providers?

Answer: I expect non-physician caregivers to be increasingly used by VA. Use of clinical practice guidelines are one way to help assure the quality of care provided by these personnel.

Question 5: In "Prescription for Change," you mention that delivery of care will be cafeteria-style. Can you expand upon this concept and its impact on the VHA?

Answer: What I meant by "cafeteria-style" is that VA healthcare providers, especially the primary care practitioners, will have, in their diagnostic and treatment modalities, a wide range of services and programs that can be individualized to meet the specific needs of each patient. These services and programs will range from routine ambulatory care to highly technical services. The delivery of these services will be customer-focused. The availability of these varied services will allow VA providers to select the most appropriate level and site of care for the patient.

Question 6: One of the principles which underlies your goal to "Provide Excellence in Healthcare Value" is strategic alliances. Can you elaborate on this concept?

Answer: The growing quest for providing value in healthcare and the downsizing of the federal workforce present significant challenges. "Strategic alliances" are becoming increasingly common in healthcare. It implies a business relationship that benefits all partners. For VHA, such alliances could allow expansion in needed services in exchange for excess capacity. These relationships could be revenue producing or result in cost avoidance. In some markets, a strategic alliance for VHA could involve a more creative use of excess VHA medical space as the basis of operations shift. VHA could increasingly seek these types of business relationships in the future if it were empowered with more flexible contracting and sharing authorities.

Question 7: In your "Prescription for Change," you conceptualize a future in which the hospital is merely a large ICU. How do you envision the impact of this scenario on the treatment of veterans from future conflicts with injuries resulting from biological and chemical weapons?

Answer: Under the conceptualization cited in the question, the role of the hospital relates to the medical needs of the patient independent of injury/illness etiology and assumes a comprehensive spectrum of services being available in other settings than the acute care hospital. Thus, the specific role of the "ICU hospital" would depend on the specific CB weapon, the stage of illness/injury and other clinical issues.

DEPARTMENT OF VETERANS AFFAIRS

RESPONSES TO POST-HEARING QUESTIONS
FOR KENNETH W. KIZER, M.D., M.P.H.
UNDER SECRETARY FOR HEALTH

CONCERNING JUNE 26-27, 1996 HEARING
ON
THE FUTURE OF VA HEALTH CARE

SUBMITTED BY
HON. CHET EDWARDS, RANKING MEMBER
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS' AFFAIRS COMMITTEE

Question 1: The General Accounting Office will testify, based on experiences in Australia, Canada, and the United Kingdom, that veterans health benefits can be preserved and even enhanced without preserving the systems' acute care hospitals. GAO proposes several alternatives: issuing vouchers to buy health insurance; including veterans under other Federal programs (Medicare, TRICARE, or the Federal Employees program); and having VA purchase care for veterans. Do those options promise to be effective in meeting the needs of severely mentally ill veterans, for example, or others with chronic illnesses?

Answer: It is conceptually possible, although certainly not likely given the current coverage these programs provide for mental illness. Alternatively, why not consider the converse situation? The cost and quality of providing these services under the different systems would be important variables to consider in this regard.

Question 2: Given uncertainty as to the pace of technological and other change in healthcare, do we have any reliable means of gauging just how many acute care hospital beds VA will require 15 years from now?

Answer: While we know that the veteran population will be declining to about 20 million from the current total of 26.4 million, there is no validated forecasting model I am aware of that could reliably project acute care bed needs for VA care in 2010 - 2015. Personally, I expect we might be able to reduce our acute care bed needs by more than 50 percent <u>if</u> we were empowered to provide care in alternative settings

and if no other notable circumstances changed (e.g., no increases in demand from veterans as a result of changes in Medicare or Medicaid).

Question 3: A widely reported recent VA study (published in the New England Journal of Medicine) found that providing previously hospitalized veterans access to primary care resulted in an increased, rather than decreased, rate of re-hospitalization. Does that surprising finding give you pause as regards either the value of early intervention, or a policy of closing thousands of VA hospital beds at the same time as the system is rapidly implementing a primary care delivery model?

Answer: As you might imagine, Congressman Edwards, this article has received a great deal of attention, and it has been variously interpreted by both the lay and professional media. I should point out some findings of this study.

As a preface, it is worth noting that the veterans discharged from VA in this study were severely ill, as measured by clinical indicators of their chronic diseases. In addition, patients reported extremely poor baseline quality of life, much lower than reported in previous studies. Thus, veterans in this study were chronically ill and had serious medical problems.

Further, patients in the primary care study group had increased access to their physician and primary care nurse. This increased access resulted in more readmissions during the study period. It is important to clarify an analysis that the authors report, but which was overlooked in many media reports. Because it is known that prior hospitalization is a predictor of future inpatient use, the authors examined whether the control and intervention groups differed on this important outcome. They found that there was a trend toward more hospital use among intervention patients during the 180 days before randomization. When taking this difference into account, the difference in the number of days of rehospitalization was no longer significant. In other words, there remained an increase in the number of readmissions per month, but there was no significant difference in the number of hospital days between primary care and control patients.

Finally, it is important to measure the impact of the intervention from the patients' perspective. The authors have two major findings in this regard. First, quality of life for this very ill group of patients was sustained.

Second, patient satisfaction was significantly increased, implying that the patients responded positively to their primary care providers. The difference in satisfaction observed in this study exceeds that previously shown to result in patients' changing healthcare systems. This finding is critical for all healthcare systems, given that patients' subjective ratings of their experiences substantially influence where they decide to obtain their care.

The results of this study should not be used to dampen the enthusiasm for increasing primary care within or outside the Department of Veterans Affairs. There are limitations to this study that make it an insufficient referendum on primary care in general or VA primary care in particular. First, patients were only followed for six months. A much longer follow-up is needed to know what the initial findings mean. Second, patients in this study were highly selected and severely ill. How far the results can be extrapolated will be determined by follow-up studies. And third, all of the patients were enrolled during a hospitalization which, for the most part, occurred as a result of late manifestations of their chronic diseases. This means that in many ways the study was skewed from the outset.

Question 4: Panel One: What do current trends tell us about the percentage of veterans who lack or will likely lack private health insurance coverage in the next five, 10, or 15 years?

Answer: While previous surveys of the veteran population suggest that veterans, in general, are more likely to be insured, than non-veteran population cohorts. Future trends in this regard will be determined largely by what happens to Medicare and private health insurance. All veterans, however, are not doing as well as the average veteran, and we know that a large number of veterans are underinsured or uninsured.

Question 5: Panel One: What do current trends, including potential reductions in Medicaid funding, tell us about the potential for veterans to turn in increased numbers to VA for nursing home care?

Answer: There will be dramatically increased needs for long-term care for veterans in the next 10 - 15 years. Any substantial decrease in Medicaid funding will likely exacerbate VA's needs in this regard.

DEPARTMENT OF VETERANS AFFAIRS
RESPONSES TO POST-HEARING QUESTIONS

FOR ROBERT KOLODNER, M.D.
DEPUTY CHIEF INFORMATION OFFICER
VETERANS HEALTH ADMINISTRATION

SUBMITTED BY
HON. CHET EDWARDS, RANKING MEMBER
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS' AFFAIRS COMMITTEE

Question: We've heard a lot about how telemedicine and computer applications will change the practice of medicine. Given the likelihood that most veterans who rely on VA care will not be able to afford to purchase personal computers, as well as the practical limits of VA's own budget, in what realizable ways do you see telemedicine and computer applications changing VA care in the next 5 or 10 years?

Answer: I anticipate that most of the benefit of telemedicine and expanded computer use in healthcare will primarily allow "the system" to provide more efficient and effective care. In the next 5 - 10 years I see only limited benefit to patients as far as the patient directly interfacing with the computer, etc. Conversely, the patient should markedly benefit by these technologies allowing VA providers to make care more accessible, timely and efficient.

INSTITUTE FOR
ALTERNATIVE
FUTURES

July 10, 1996

To: Honorable Congressman Edwards,

The following are my responses to your follow up questions from the June 26th hearing on the Future of VA Health Systems:

1. What do current trends tell us about the percentage of veterans who lack or will likely lack private health insurance coverage in the next five, 10 or 15 years?

Although the Institute for Alternative Futures does not engage in specific demographic research and projections I can tell that it stands to reason that as the general population ages, the number of aging veterans will increase dramatically as well. I will answer this question by referring to our "Business as Usual" scenario developed for the future of VA's Health Systems. This scenario is based on an extrapolation of current trends in health care and the larger American society. Poverty levels will continue to rise over the next 15 years to 15% as technological unemployment (people becoming replaced in the work force by computers and other machines) increases. These people will most likely be unable to afford private health insurance and will need to turn to government assistance. On the positive side we also forecast that by the year 2000, HMOs and other

100 North Pitt Street • Suite 235 • Alexandria • VA 22314-3108 • Tel 703-684-5880 • Fax 703-684-0640 • Futurist@ix.netcom.com

health care providers will have shifted to the forecast, prevent and manage paradigm and this will help to prevent or manage illness better and in turn create a healthier population. This will mean that morbidity will be compressed to the very end stages of life saving on costly medical procedures and measure to keep dying patients alive for a number of years.

What does this mean for VA? The portion of the 15% living in poverty mentioned earlier who are veterans will most likely have to turn to government assistance (in this case VHA) for their medical needs. Hopefully these people will have had the benefit of good preventative medicine and the influence of more healthy lifestyle behaviors so that they are healthier when they enter the VHA system and will not strain the VA's resources as they would before the advent of the forecast, prevent and manage paradigm.

2. What do current trends, including potential reductions in Medicaid funding, tell us about the potential for veterans to turn in increased numbers to VA for nursing home care?

There are two trends that IAF foresees as being the most influential for the future of health care: the move toward more home-based health care and the shift toward the forecast, prevent and manage paradigm. These two trends will lessen the need for older veterans to turn to the VA for nursing home care.

The first trend, home-based health care, will allow people to do health maintenance and preventive care far better than doctors can do today. Increasing amounts of health information will become available over the Internet and more and more people will be able to gain access to the information they need to lead healthier lives. Also, we forecast the use of personal biomonitoring devices (possible in the form of wrist watch devices or chip located in glasses or ear pieces). These devices will be able to perform many medical functions such as measure heart rate, hormone levels, blood levels, or administer drugs through the skin. These devices will be able to rely information to the person's health care provider who will be able to monitor their health remotely. A person will only need to go to a doctor for emergencies, not for routine medical procedures.

The second trend, the shift toward the forecast, prevent and manage paradigm, will help to create healthier people. Disease will be detected early through powerful diagnostic tools (i.e., genetic testing) so that doctors can better manage the disease and hopefully prevent it all together. Health care will be focused on creating health rather than curing illness. Health care providers will realize the value of preventive medicine and the promotion of healthy lifestyles.

In the future less people will need to be in nursing home facilities because they will far healthier and far better able to manage their own health care when they are elderly.

I hope these answers were helpful. Please let me know if you require any information. Thank you.

Sincerely,

Erica Mayer
Associate

Questions for Ms. Marjorie R. Quandt
from the Honorable Tim Hutchinson
for the Hearing on June 26, 1996

Ques. 1 The "Commission" recommended a "self-financed managed care program" as a means of providing higher income veterans better access and to "enhance the use of underutilized capacity." Can this concept be blended with the MSA proposals that have been incorporated in recent Medicare reform legislation.

Answer The Abt Corporation, with consultation from Coopers and Lybrand, prepared a preliminary study of projected costs of a managed care delivery system. Because VA keeps no data on non-users, VA does not provide some social support found in HMOs and the definition of special medical programs were not consistent between the private sector and VA, Coopers and Lybrand could not complete all cost estimates. However, enough was learned that it would be feasible for VA to offer such a policy to higher income veterans. The consultant estimated average annual costs per enrollee to be $4,325.95 based on projected 2010 eligibility. This resulted in a weighted average high end savings of 15 percent and a weighted average low end savings of one percent. The detail of what would be included in the package can be found on pages 2384 - 2397, Part III, **Proceedings of the Commission on the Future Structure of Veterans Health Care.**

To the extent that an unemployed veteran or a retired veteran wished to purchase such care for himself and any dependents, I do not believe the concept fits into the MSA proposals. If the insurance industry and employers are willing to recognize VHA as a quality provider, I believe there is room to fit the proposal into the MSA concept.

Ques. 2 Ms. Quandt, in your prescription for VA, you state that in 14 years it's conceivable that VA will operate less than 19,000 beds. What do you base the number upon and what type of facility do you envision: small hospitals, community hospitals or a few very large specialty hospitals.?

Answer My estimate of 19,000 beds (.93 beds per one thousand veterans) is based on current experience in the private sector, the rate of change in current VHA performance against the major change model of the Commission and known objectives to remove more care from inpatient status. Because some of VA care will be provided in community hospitals, VA can support comprehensive inpatient medical care somewhere in a 400 - 500 bed facility.

My testimony was a plea that Congress guarantee the survival and quality of special medical programs by writing into the definition of VHA in USC 38 that these programs are the core of VA's health service. It is a given that special medical programs require the support and integration with primary care and acute inpatient care where these programs exist. Thus, the hospitals will be complex facilities and function as regional, referral centers. Because of the veteran population in 2005, some states will not be able to support a veterans hospital and routine hospital care will be purchased by VISNs at the most economical, quality rate. Special medical program cases will be referred to the nearest VA comprehensive center.

Assumptions behind .93 beds per one thousand veterans in 2005 are that VA will have outplaced many of its current intermediate care patients to State Veterans

Homes, or assisted living facilities. Much the same will happen with VA nursing home patients. The role of the domiciliary in the medical care program will finally have to be faced. Domiciliaries were only recently defined as part of the medical care continuum. Staffing ratios are questionable for quality care. The total cost to maintain the program for the quality of care given is unmatched elsewhere in the US health care industry. Domiciliaries might better be abolished to divert that funding to better quality, more modern health care programs. At the very least the domiciliaries should be transferred to VBA for management if there is no will to abolish them.

Ques. 3 Ms. Quandt, you have stated that hospitals must be closed to shift resources to primary care. Understanding the political sensitivity of this issue, what in your opinion would be the best way to handle such an action?

Answer The best way to handle the multiple and varying degrees of political sensitivity to closing VA hospitals is use of a BRAC-type commission. This guarantees better than a Presidential commission or advisory type commission that local facility issues, community requirements and concerns, statewide issues, veterans' concerns and real needs, alternate sources of care, graduate education issues, employee displacement requirements and any construction costs for a different level of care are reviewed objectively and weighed against total VA requirements. Without such a statutory commission there is little likelihood that VA resources (money and staff) will move to where veterans live. Nor is there likelihood that VA's policy of equal access to care for veterans can be met without such a commission.

Hospitals must be closed not only to shift funds to primary and community care, but to pay for any anticipated increase in extended care. The government and VA cannot afford to retain fixed assets which do not produce the necessary results. They should be excessed (sold, preferrably) to obtain monies to improve quality and access to care. Unless something cataclysmic occurs within the United States, I do not envision a sudden influx of veterans applying for care. It has not happened since VHA was enacted, nor do I believe it happened during the great depression in the predecessor health service.

Ques. 4 You stated that you supplied the SVAC with a list of 50 hospitals that could be closed. Do you believe your list is accurate and is it your opinion that hospital closures could and should occur?

Answer I have rechecked my list of 50 hospitals against the latest (March 1996) **Summary of Medical Programs** tables. I have traced hospitals over a period of three years, and some trends appear to be established. Furthermore, the recent consolidations have hurried along the demise of some hospitals. I believe my list is accurate, and I could actually add more hospitals. Between September 30, 1995 and March 30, 1996, over 3,000 beds were closed. If this rates continues this will more than twice as fast as bed closures between the end of FY 93 and FY 95.

The VA prides itself, and claims that it operates at 75 per cent occupancy. The system ended FY 95 at 72.9 per cent. What is a more stunning finding is that in the first half of FY 96, at least ten of the tertiary level teaching hospitals are falling into occupancy rates below 65 percent, and some are under 55 per cent. Of all of the more than 3,000 bed closed in the first half of FY 96, half were medical beds and at least half of these were intermediate beds. About 10 per cent of the beds cuts were

in psychiatry. Neurology has never been a large bed service in VHA. It is puzzling, however, with an aging population to see neurology beds cut, and this is happening in some facilities.

Yes, it is my strong opinion that hospitals should be closed and that this should occur as soon as possible in order to husband funds to provide care in a different modality. VHA has had too many intermediate beds, thus, closure of these is a good move. Congress might ask, however, where these patients were sent: to nursing homes, home, or assisted living.

As bed closures are happening now, there appears no rhyme or reason to protect the policies of equal access and moving staff and dollar resources to where populations of veterans exist. Nor does there appear to be any recognition that a VISN including Georgia or Alabama could sell psychiatric services to Florida's VISN. It also seems strange that more bed closures occur in the southern and western states than in New England or the upper middle west.

Some of the individual hospital closings represent as much as one ward to three wards. What has been the net savings in total staff (nursing, building management, pharmacy, supply, laboratory to name a few) and supplies? Not all the staff would be absorbed in ambulatory care.

VHA is right to cut unnecessary beds. It should be done, however, with some recognition of a national goal, while allowing devolution at the VISN level. VHA is also right to move to more ambulatory/community care clinics. These, too, should be sited based on national as well as local need.

As I have stated throughout my testimony, it is also my opinion that many of these VA facilities to be closed should be converted to a combination nursing home/primary care clinic with necessary related community clinics. Any other unused space or land should be made available through the enhanced use program to develop assisted living quarters for veterans who may not have a home or do not wish to maintain one. Veterans in the assisted living quarters would pay their own monthly maintenance fee, but receive care through the VA primary clinic.

Questions for Ms. Marjorie R. Quandt
from the Honorable Chet Edwards, Ranking Member
for the Hearing, June 26, 1996

Ques. 1 **Is the profit motive sufficient to ensure that private sector would do a more efficient and effective job of meeting the nation's obligation to veterans than the VA?**

Answer No, the profit motive is not the sole criterion to ensure that the private sector would do a more efficient and effective job in meeting the nation's obligations to veterans. Neither does the profit motive mean that VA will suddenly change its manner of operation, but it will become more businesslike in spending the tax payers' money. What is necessary are two things: first, where VA can ascertain using comparable data that the private sector is at least equal in quality and cost to VA, VA should be able to use that source for care. Second, it is more important that VA executives adopt more recognition of the profit motive. One reason VHA has been in a financial predicament is the "keeping up with the Jones" philosophy, often fostered by Regional Directors. This has caused unnecessary duplication in some communities and now VISNs. It would have been more cost effective and better quality to support one program. VA has had under utilized dialysis and CT centers because local executives would not operate more hours per week, as does the private sector. Worse yet, not attempting to make the most of assets, VA executives by and large have never tried to market these services to other providers who might need them. One must assume that in its current mind set, and with multiple budget balancing problems, Congress will no longer authorize the full amount of funds requested by VA. Therefore, VISN and local directors must seeks ways to augment funding. One excellent place is to offer any unused capacity in the special programs--long-term psychiatry, spinal cord long-term care, blind rehabilitation--to the private sector.

The profit motive does not mean everything is being moved to the private sector. It merely means VA managers should use it if they are willing to take risks and to use the motive to VA's advantage.

Ques. 2 **The General Accounting Office will testify, based on experiences in Australia, Canada and the United Kingdom, that veterans health benefits can be preserved and even enhanced without preserving the systems' (sic) acute care hospitals. GAO proposes several alternatives: issuing vouchers to buy health insurance; including veterans under other Federal programs (Medicare, TRICARE, or the Federal Employees program); and having VA purchase care for veterans. Do those options promise to be effective in meeting the needs of severely mentally ill veterans, for example, or others with chronic illnesses?**

Answer Were VA to adopt GAO's recommendations for providing veterans care without preserving a portion of the hospital system, those of us familiar with VA's medical programs and its patients would have many anxious moments in the early years of transition. There would probably be horror stories of veterans not receiving care, or delayed care.

Of all the solutions offered by GAO, and even Mr. Coile, none are expert at providing the kind of care VA does through its special medical programs. To put these patients out on vouchers or private insurance, even in TRICARE or FEHP, will take study by actuaries and the Chief Financial Officer, and considerable negotiation with private sector providers as to what VA expects and is buying through vouchers.

To put my concern in a more human context, DVA's 1995 Secretary's Annual Report shows that almost 4400 patients remained in a hospital bed more than two years to more than 20 years on the day of the annual census, September 30, 1995. These were chronic psychiatric and spinal cord injured patients. There are few institutions in the country which offer this type of specialized care. State psychiatric hospitals long ago emptied their institutions. Private psychiatric facilities do not cater to long-term care. The very excellent and prestigious rehabilitation centers, such as the Chicago Rehabilitation Institute, do not provide such care for long-term spinal cord patients.

Assuming that the patients who have been institutionalized for ten or more years can live in society, the only way VA could achieve success with vouchering and other policies, is first to attract a private entrepreneur who would develop a specialized assisted living facility (for which veterans would pay monthly fees) in former hospital buildings or on the grounds. VA then could either offer the care or purchase health insurance for the veteran. From my experience at North Chicago VAMC many of the truly long-term psychiatric patients were not violent, but they were wanderers who needed to be reminded of when to take their medicine, when to eat, when to dress, and to have some type recreation and exercise. These patients became violent only when they missed medication. Many long-term patients are in VA facilities because their families do not want them, they cannot care for them, or the veteran has no family. The solution to some of the long-term care VA provides is social, not medical. The worst thing that can happen is that some VISN decides to outplace these people without proper planning; the outcry from veterans and the community would be horrendous.

To answer your question more directly, there is the promise to be effective, but not necessarily on the immediate horizon.

Ques. 3 **A widely reported recent VA study (published in the New England Journal of Medicine) found that providing previously hospitalized veterans access to primary care resulted in an increased, rather than decreased, rate of re-hospitalization. Does that surprising finding give you pause as regards either the value of early intervention, or a policy of closing thousands of VA hospitals beds at the same time as the system is rapidly implementing a primary care delivery model?**

Answer No, this does not give me pause about early intervention or closing thousands of beds. To be cost effective VA must stop putting people in hospital beds who do not belong there. It must begin to function as Medicare does with prescribed lengths of stay which can be overridden only for very good reason. Operating on Medicare LOS criteria and discharging patients who do not require hospitlization would free up bed days of care for any increased admissions The only way I think VA could find itself in a crush is if Congress suddenly provided a budget for more than 10 percent of the veteran population, its traditional funding. I do not see this happening in the foreseeable future. Last of all preventive care must begin to pay off at some point in time.

Ques. 4 In your statement, you cite as a unique VA weakness the frequent change in Veterans Health Administration leadership and the years of wasted energy you have observed in those changeovers. Why is your only answer to make VHA a quasi-governmental corporation? Isn't that a relatively extreme response? Other Cabinet Departments face such change in leadership; what makes VA's situation so unique as to require this extraordinary solution?

Answer In my opinion the almost 50 year success of the Tennessee Valley Authority is not a relatively extreme solution. It was a solution at the time that fit the product--delivery of cheap electricity. I view it as a solution which allows Congress to continue oversight, but the VHA can function with greater flexibility. In a situational analysis I would deem this solution a maxi/maxi or win/win. Furthermore, the quasi-governmental corporation fits VHA's reason for being and its product.

It is true all Federal agencies probably experience ups and down of political change. There is one major difference, however, VA's product is **DIRECT** provision of health care to a human being (veteran). This is vastly different than all the other agencies, except Defense, who shuffle money or regulations from the Federal government to a state or local government, or industry. If the veteran truly comes first, than a quasi-governmental structure is not extreme. Provision of quality health care should be a steady continuum, not fits and starts or delays.

Ques. 5 Panel One: What do current trends tell us about the percentage of veterans who lack or will likely lack private health insurance coverage in the next five, 10, or 15 years?

Answer With greater numbers of population employed and covered under HMOs, one could assume the percentage of veterans with private insurance will increase. (The Commission found that about 75 per cent of VA inpatient users and 86.4% of outpatients had some type of health insurance. The rate for non-VA users was in the mid-nineties for both types of patients.) There is, however, the frightening economic reality that the US is becoming more and more a two class society: the richer and the poorer, and that the middle class is disappearing. If those labeled poorer are not covered by some government subsidy or Medicaid, the number of veterans without insurance may increase. The bulk of uninsured, however, continue to be women and children not the veteran class.

Ques. 6 Panel One: What do current trends, including potential reductions in Medicaid funding, tell us about the potential for veterans to turn in increased numbers to VA for nursing home care?

Answer If the status quo of nursing home care is maintained, there might be an increase in demand for VA care. Such logic assumes neither Medicaid nor VA will make changes to modernize or to improve quality of how such care is delivered to patients. Many states today pay to keep a nursing home client at home with the help of visiting nurses and other health care workers. This allows them to stretch available dollars. VA should be doing the same thing. Only the most severely disabled should be in a nursing home bed, and then not until absolutely necessary. Current philosophy is that patients are better off cared for in the home.

HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND
HEALTH CARE
HEARING ON: VETERANS HEALTH
ADMINISTRATION
27 JUNE 1996
QUESTION FOR THE RECORD

QUESTION: You have astutely noted the political pressures to maintain the status quo and protect "rice bowls." DOD has been fairly sucessful in overcoming some of these obstacles via the BRAC process: which even incorporated specific hospital closures in the last iteration (BRAC 95). Do you feel that a similar approach to facilitating necessary downsizing within the VHA may be viable?

RADM ROWLEY: Based on my personal observations, I think a similar process may be necessary if political pressures prevent the shift of funding and services to follow the migration of veterans requiring VA health care. It is difficult for a community to give up a facility which provides jobs, possibly supports a teaching institution, and pumps money into the local economy. However, the primary mission of the VHA must be to provide access to quality, cost-effective medical care for needy veterans.

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QUESTION FOR THE RECORD

QUESTION: You mention that MHSS 2020 is training 200 health care futurists. How is DOD training these "futurists?"

RADM ROWLEY: Two hundred interested people were selected from the three military services, other federal agencies and private sector to participate in the MHSS project. The selectees attended a three day conference in February 1996 to "stretch" their minds and learn techniques for inquiry and thinking about the future. They were initially divided into twenty teams to analyze future trends relative to their defined specialties and disciplines via discussions on the Internet. In June, members were reassigned to ten multidisciplinary teams to develop likely scenarios applying to four different potential global futures. The next step will be to develop a preferred future for military medicine to assist decision-makers and planners.

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QUESTION FOR THE RECORD

QUESTION: In "Military Medicine in the 21st Century" you note that medical care will be provided by an integrated system of military, civilian and other governmental components. What role do you envision the VHA playing in the support of the MHSS?

RADM ROWLEY: I envision the VHA and Military Health Services System (MHSS) working together for their mutual benefit while preserving the unique missions and culture of each. For example, the Hampton VA Medical Center and TRICARE Region 2 created a laboratory contract which benefits three VA hospitals and six military hospitals resulting in $4.1 billion savings over five years. This achievement in reinventing government was recognized by the Vice President's Hammer Award. In communities with VA hospitals, and many military beneficiaries but no military medical facilities, there is opportunity for the military to purchase care at VA facilities. Likewise, there are communities where there are no VA facilities, and it makes good business sense for veterans to receive some services in military facilities similar to the arrangement in New Mexico and Nevada, where there are combined Air Force-VA hospitals. There are many opportunities for the military and VA to jointly share expensive technologies and subspecialty care; we already participate in joint research projects and support each other's residency training programs. The best approach is to allow each institution to develop sharing agreements at the local and regional level for their mutual benefit (to achieve both improved access to quality care and cost savings).

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QUESTION FOR THE RECORD

QUESTION: You have suggested that it is possible that most family members and dependents might be treated in the private sector by 2015. The omission of military connotes that they would be treated in "direct care facilities." How would the military maintain the medical competence necessary given the drastic reduction in the spectrum of pathologies presented to military physicians (e.g., thoracic surgeons with no chests to open).

RADM ROWLEY: To ensure continuous training and experience, military medical personnel must be given the opportunity to provide comprehensive care to the full spectrum of medical challenges in military hospitals or through special arrangements within civilian medicine. With the end of the cold war, wartime requirements have shrunk. Small, inefficient military hospitals can be closed in communities with adequate civilian capabilities. There should be enough communities with a continued military medical facility presence to meet ongoing training requirements. Even in those communities with military treatment facilicites, it often makes economic sense to purchase some services or to have a portion of the beneficiary population treated in civilian facilities. It is possible to maintain readiness and still utilize the civilian sector in ways which ensure access, choice and savings.

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QUESTION FOR THE RECORD

QUESTION: You have noted that stand-off weapons will significantly reduce the number of military casualties. One can infer that not only will this reduce the number of future veterans with service connected disabilities but alter the mix of disabilities they have incurred. Is it possible that this mix will include a larger percentage of environmental and psychological injuries and a smaller percentage of traumatic injuries than have experienced in the past?

READM ROWLEY: Yes, it is possible that the majority of future service connected disabilities will be psychological and environmental in nature and could require special treatment best provided by the VHA. However, urban and jungle conflicts may still produce a lot of traumatic injuries.

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QUESTION: Some have criticized the Veterans Health Administration for not having a specific, long-term strategic plan. (Dr. Kizer's Prescription for Change, for example, has a relatively near-term horizon, for example, and does not purport to be a strategic plan.) As a practical matter, though, with the intensity of change likely to occur in medicine, can a health-care system really do effective long-term forecasting and planning? How many years out into the future could you go before you concluded that your assumptions and forecasts were unreliably speculative?

RADM ROWLEY: I do not think accurately predicting the future is possible. But futurists can determine likely key trends and possible futures. The process forces participants to let go of the past, better understand core missions and competencies, develop a preferred future in sync with probable trends, and take steps to move the organization toward that desired future state. Part of the VHA's challenge has been to get the major stakeholders to let go of their old paradigms and see the opportunities awaiting them. It is hard to do detailed strategic planning with political uncertainties and without a clear vision from the American people. Recent acceptance of change by employees and veterans' groups will allow the VHA to participate in the long-term planning process. Assumptions become very speculative beyond ten to fifteen years into the future. The next five - eight years are pretty much locked-in by existing construction projects, major initiatives and the budget cycle.

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QUESTION FOR THE RECORD

QUESTION: With regard to proposals for privatizing VA or vouchering veterans' care, what implications do such proposals have for VA's education and research missions?

RADM ROWLEY: It is appropriate to rightsize and redirect educational and research efforts to meet changing needs for specialists and to fit within financial constraints. It is possible to continue both missions with a governmental corporate structure or in privatized VA medical facilities if requirements are clearly stated in the charter. If the majority of VA facilities were closed and care provided within the private sector, America would have to create another mechanism to assure that medical research and training were adequately supported. Academic medical centers are not sustainable without VA or other outside support. For-profit managed care organizations have, for the most part, avoided medical education and research because of the expense.

Chairman Hutchinson to David P. Baine, Director, Veterans Affairs and Military Health Care, United States General Accounting Office

Response to Follow-up Questions
Submitted for the Record
June 26-27, 1996, Hearing Held By
Subcommittee on Hospitals and Health Care
House Committee on Veterans' Affairs

Question 1: You propose several alternatives to preserving VA acute care hospitals, including vouchering. It's my understanding that perhaps a quarter of VA's hospital patients may be homeless veterans, and that some 40 percent of VA's patients may have chronic psychiatric problems. How practical are your alternatives for meeting the complex health care needs of these kinds of patients?

Answer: Our statement identified a number of alternatives both for preserving and to preserving the direct care system, including vouchers, that have been proposed, but we did not advocate any of the alternatives. Each alternative, including vouchers and maintaining the direct delivery system, has both advantages and disadvantages. For example, a direct delivery system may be effective in reaching homeless veterans in those cities where VA hospitals are located and accessible by public transportation, but are less effective in cities, such as Charlotte and Sacramento, where VA does not operate a hospital. A direct delivery system may result in higher income veterans with no service-connected disabilities obtaining care at direct care facilities while homeless veterans in areas not served by VA facilities receive little or no VA support. In such locations, some sort of contracting arrangement might improve homeless and chronically mentally ill veterans' access to VA-supported care.

The use of vouchers could provide accessibility to VA-supported health care to veterans, including the homeless and chronically mentally ill, in cities and rural areas that do not have VA facilities. In this respect, vouchers could facilitate equity of access for veterans. On the other hand, the homeless and chronically mentally ill are, as you suggest, difficult populations to reach and it would be hard to administer a voucher program directed at their health care needs. It is difficult to predict how insurers would react to such a population. In other words, would they attempt to sell such veterans health plans in anticipation that they would not seek care or would they avoid such veterans because they represent high risk populations. Similarly, a voucher program would need to be structured to prevent veterans from using

the proceeds from the voucher for nonhealth care purposes. Because many homeless veterans have substance abuse problems, actions would be needed to ensure that proceeds from the vouchers are used to treat rather than support their habits.

Question 2: Understanding that the VA is faced with a declining veteran population, could you provide the Subcommittee with an overview of how the problem of a declining veteran population was handled in such countries as Australia, Canada, and the United Kingdom?

Answer: In each of the three countries, decisions were made to close or integrate veterans hospitals into the overall health care system. Such changes were gradual in Australia. Initially, nonveterans were allowed to use excess capacity in veterans hospitals; nonveterans were not allowed to exceed 25 percent of the patients in VA hospitals. At the same time, veterans were given greater latitude to obtain hospital care from public and private hospitals if such hospitals were more convenient. Before these changes were made, veterans hospitals were increasingly becoming geriatric facilities seeing only a limited range of medical problems associated with aging. Actions to increase the number of nonveterans allowed to use veterans hospitals allowed physicians to gain experience in treating a wider range of medical problems, thereby strengthening both the medical education and research missions of Australia's veterans hospitals.

As veterans increasingly shifted to obtaining care in public and private hospitals, Australia decided to transfer its veterans hospitals to the individual states to be operated as public hospitals. Where excess capacity already existed in the states, efforts were made to sell the hospitals.

In the United Kingdom, the decision to merge veterans hospitals into the National Health Service was made shortly after World War II. Although the veteran population was not declining, the number of veterans eligible for veterans health care was decreasing because of more restrictive eligibility.

Finally, in Canada, most veterans hospitals were closed following implementation of universal health insurance. Veterans who previously relied on veterans health care facilities gained access to hospital care closer to their homes. As a result, utilization of veterans hospitals dropped significantly. This,

coupled with the declining veteran population, led to closure of almost all veterans hospitals.

Question 3: Understanding the importance of eligibility reform to the future of VA health care, what strategies would you recommend to control the costs that the Congressional Budget Office have attributed to any change in eligibility?

Answer: Five basic approaches could be used, either individually or in combination, to develop budget neutral eligibility reform. These approaches are (1) set limits on covered benefits, (2) limit the number of veterans eligible for health care benefits, (3) generate increased revenues to pay for expanded benefits, (4) allow VA to "reinvest" savings achieved through efficiency improvements in expanded benefits, and (5) provide a methodology in the law for setting a limit on VA's medical care appropriation. One such potential approach is attached as an example.

PROPOSAL FOR LIMITING POTENTIAL
COST OF ELIGIBILITY REFORM

1) Provide methodology in the bill for setting a limit on VA's medical care appropriation. For example, VA's appropriation could be based on the expected workload of some specified group of veterans such as those

-- with service-connected disabilities rated at 30 percent or higher (approximately 950,000 veterans)

-- who are former prisoners of war (about 36,000 veterans)

-- who are veterans of World War I or the Mexican border period (about 19,000 veterans)

-- who have neither public nor private health insurance and have incomes below the means test threshold or some other level (about 2.6 million veterans)"

(Additional appropriations could continue to be provided for treatment of service-connected disabilities of veterans with disabilities rated at 0 to 20 percent, veterans treated for conditions related to exposure to agent orange, ionizing radiation, or environmental hazards in the Persian Gulf, long term care, and specialized services.)

2) For eligible veterans not covered by the appropriation (those (1) with service-connected disabilities rated at 0 to 20 percent, (2) with no service-connected disabilities who have public or private insurance and (3) with no insurance but incomes above the means test threshold) allow VA to sell available health care service to the veterans.

-- Like private sector providers, Va would be allowed to bill and retain recoveries from private health insurance, Medicare, Medicaid, and CHAMPUS. (VA would continue to collect from private insurance for those veterans covered by the appropriation, but could not retain recoveries beyond the costs of operating the program)

-- Veterans copayments and deductibles would be in accordance with the provision of the insurance coverage. In other words, care for those veterans not covered by the appropriation would be fully funded through insurance recoveries and veterans' cost sharing.

Implications

-- Sets a limit on potential increase in VA appropriations

-- Gives all veterans the opportunity to choose VA as their health care provider

-- Creates an incentive for VA to focus outreach efforts on veterans with the highest priority/greatest need for VA services to maximize appropriation

-- Establishes alternative revenue streams that could eliminate need to ration care

-- Increased veteran cost sharing could be seen as taking benefits away from some veterans

-- Allows government facilities to compete more directly with private sector facilities albeit on a level playing field

-- Could be combined with other approaches such as defined benefits or guaranteed benefits

-- VA would need budgeting and accounting systems capable of handling this new category of receipts and also preventing appropriated and nonappropriated funds from becoming commingled.

-- VA facilities would have a stronger incentive to provide cost effective care because they would be more dependent on recoveries from public and private insurance to offset their operating costs.

Committee on Veterans' Affairs
Subcommittee on Hospitals and Health Care
June 26-27, 1996 Hearing
Response to Follow-up Questions for
Gordon Mansfield
Executive Director
Paralyzed Veterans of America

1. Recently, the VA's Inspector General office released a review of the VA's Spinal Cord Injury Program along with a number of recommendations on how to improve the program. Was PVA satisfied with these recommendations? Is PVA working with the VA in developing a plan to implement these suggestions?

In general, we felt the Office of the Inspector General's (OIG) recommendations were thoughtful and on target. We have attached, for your review, a letter we sent to the Deputy Inspector General of VA, William T. Merriman, with our comments. Like the OIG, we were also assured that the Under Secretary understood the concerns raised by the OIG and was willing to respond to them.

Several PVA projects are working with issues raised in the OIG's report. For example, PVA is in the process of developing a comprehensive plan for monitoring quality in VA health care. Implementation of the OIG's recommendations will be one of the criteria PVA plans to watch carefully. Our plan is to work with VA to establish appropriate systems for surveying, monitoring, correlating and conveying information from the datasets VA now has available or is in the process of developing, namely, the Patient Treatment Files, the Spinal Cord Dysfunction survey, and the Customer Feedback Surveys. PVA hopes that together these systems will provide us with indicators that VA is maintaining a high level of service for veterans with spinal cord dysfunction and disease.

2. In your testimony, you mention the VA's use of the Functional Impairment Measure (FIM) in order to assess care and rehabilitation for spinal cord injured veterans. Do you think this performance standard is adequate? If not, what suggestions would you make to ensure that the VA effectively measures standards of SCI Care?

PVA is working with the Scientific Advisory Panel on the Spinal Cord Dysfunction Registry. Dr. Margaret Hammond, the new VA SCI chief also on this panel, has been a strong advocate of several other indices which provide a far more comprehensive view of functionality in the individual with spinal cord dysfunction. We agree with Dr. Hammond that these other indices are important and should be included in the registry to help us ensure that VA SCI care quality is maintained.

Committee on Veterans' Affairs
Subcommittee on Hospitals and Health Care
June 26-27, 1996 Hearing
Response to Follow-up Questions for
Gordon Mansfield
Executive Director
Paralyzed Veterans of America
from Honorable Chet Edwards, Ranking Member

The testimony presented at this hearing has included proposals to veer sharply from the course VA health care has been on. Russell Coile, for example, called for "privatizing" veterans' medical care over the next 5-7 years. Starting with pilot projects, he would (1) put VA care out to bid (having VA networks compete with private sector HMOs), and (2) consolidate and privatize VA facilities & staff into nonprofit community health organizations, freeing them to merge or affiliate with local health delivery systems. David Baine of the General Accounting Office would have Congress consider eliminating the VA's acute-care system and instead either (1) authorize the issuance of vouchers for veterans to buy health insurance; (2) include veterans under another Federal program (Medicare, TRICARE, or the Federal Employees program); or (3) have VA purchase care for veterans. As I mentioned at the hearing, I would like to ask you to respond to those proposals, in as brief or detailed a manner as you wish.

Mr. Coile's proposals reflect a naïveté about VA that is shared by many health care experts outside of the VA community. He, like others, assume that VA patients are a desirable, and potentially profitable, patient population that private sector providers want to compete for and are able to treat. These are highly debatable assumptions. His first recommendation to allow private sector HMOs to compete with VA to be veterans' health care providers would potentially create more funding obligations for Congress—they would have to continue to support at least some of the costs of maintaining the VA physical plant and staff and throw other dollars to the private sector for other veterans' health care. The likely result would be chaos. Many of VA's costs are "fixed", so, at least in the short run, there would be little opportunity for savings. VA must maintain the costs of its infrastructure if it is to remain open even for a few people. It relies on maintaining economies of scale to keep its costs down (for example, up to a certain point, it is cheaper per person for VA to run an MRI program for many people than it is for fewer).

"Privatizing" VA, that is letting the private-sector manage its services for profit, is another unlikely solution to VA's current problems. VA has, in fact, tried this approach, with limited success through its enhanced-use leasing program. Congress authorized this program to allow VA to offer excess capacity to the private sector. Letting others use extra space in VA facilities in return for a reduced VA rate seemed like a good way to share government assets to the benefit of all. In fact, VA's Loch Raven nursing facility, which was authorized for enhanced-use, was on the market for years without any interest from the private sector. The building was obsolete and the private sector had more than enough health care capacity in more desirable venues. Minneapolis went through the same thought process and decided to raze their old building rather than adding up the expenses of maintaining it for a bidder that was unlikely to surface.

The only benefit to privatization would be freeing VA from the legislative shackles that bind it to inefficient behavior. Many VA managers can do as good a job, or better, than private-sector managers. They are merely compelled to obey laws that sometimes lead to inefficient care delivery. For example, many managers are forced by civil service rules to keep staff on duty that are no longer contributing to the mission of the organization. Congress could empower the same management that works for VA today to make the types of decisions private-sector management is allowed and expected to make to maintain efficient operations.

While Coile might be excused for his lack of understanding of VA health care, Mr. Baine should know better. GAO has worked with PVA on several projects and consulted PVA on numerous other issues. They claim to support VA's mission to meet the needs of service-connected veterans. They also claim to understand that many special emphasis programs which meet the needs of service-connected veterans and others are often unique to VA. The recommendations Baine makes to voucher out the system, to include veterans in other federal medical programs, or to convert VA's mission to one of payer rather than provider, seem incompatible with these two positions. The VA's system of spinal cord injury, for example, is largely unavailable in the private sector. PVA recently did a comprehensive review of how well private-sector managed health care plans (including plans purchased for Medicaid and Medicare beneficiaries) are meeting the needs of our members and others with disabilities. The answer we found was that most private sector managed care plans are *not* adequately addressing these individuals' needs. In recent focus groups, PVA members who had managed care plans revealed that they still relied on VA for expertise in addressing their most serious health care problems. Critics also claim that private sector providers do not respond adequately to blindness and mental illness. There are few, if any, private sector programs which specialize in combat-related Post-Traumatic Stress Disorder.

Congress created a VA to meet the needs of those who served. It seems that maintaining a health care system to meet the special needs of the war-wounded and other veterans should be a priority of the highest order. Throwing veterans into a health care system that is ill-equipped to meet these needs would be tantamount to abandoning this responsibility.

Attachment to Question #1

June 3, 1996

Mr. William T. Merriman (50)
Deputy Inspector General
Department of Veterans Affairs
810 Vermont Avenue N.W.
Washington D.C. 20420

Dear Mr. Merriman:

Paralyzed Veterans of America has reviewed the VA Office of Inspector General March 29, 1996 report, "Review of VA's Spinal Cord Injury Program." On the whole, we find the report a timely, and comprehensive overview of VA's SCI treatment capability. At the same time, we would like to comment on certain gaps, omissions and concerns we observed in the report. Hopefully these observations and recommendations can be used to enhance future IG scrutiny of the SCI system and improve management of these programs by VHA officials.

Recommendation 1:

The first conclusion stated VA needs to examine opportunities to improve the accessibility for spinal cord injury services to veterans, including "reviewing program operations with the goal of achieving more uniform access and more consistent implementation of some national SCI policies and operating criteria among its 200 SCI Centers."

Recommendation 1, however, only called on VA to "evaluate SCI Program access..., review SCI operating policies ... and evaluate the criteria used for distribution SCI resources." These recommendation set goals for action, but do not recommend that VA take specific steps to achieve those goals to correct obvious non-compliance with SCI Program policy and operating criteria. Both the IG and the Under Secretary refer to the Spinal Cord Dysfunction Registry as a tool to analyze patient access and quality problems, but at this stage in its development, the registry does not provide appropriate "yard sticks" to address the problems identified in the report.

The issue of access to care for MS patients was raised in the report and identified as a problem. The IG suggested that VA develop a "consistent policy" reflecting its nature as a "national" care provider to bring some equity of access to system users with spinal cord conditions. The Under Secretary acknowledged that the problem of inequity for MS patients might exist, but suggested that he currently lacks the information and resources he needs to take corrective action. The IG should have suggested that policy to indicate when MS patient admission to SCI wards is indicated and when (and where) it should be referred elsewhere, for example, to neurology.

PARALYZED VETERANS OF AMERICA
801 Eighteenth Street, NW • Washington, DC 20006-3715 • (202) USA-1300 Voice • (202) 416-7622 TDD • (202) 785-4452 FAX

Recommendation 2:

The IG reports that "overall...general compliance with VA policy is good" is not completely supported in the body of the report, nor in the conclusions to this section where the IG "identified opportunities for the Department to enhance the delivery of SCI patient services by more consistent implementation of some national SCI policies and operating criteria."

Items a., b., c., d. under Recommendation 2, recommend specific action to require VA: to maintain program waiting lists; identify all SCI patients who should be offered the opportunity for annual exams; clarify policies addressing SCI interdisciplinary treatment plans; evaluate the coordination and oversight of care provided to SCI patients admitted to non-SCI wards and facilities. These are stronger actions than those listed in Recommendation 1. We concur with the intent of this action.

The lack of adequate documentation of program waiting lists undermines the ability of the system to identify realistic projections of demand and resources needed to support these specialized services. At the same time, the report indicates that some of the facilities that deny care, or are able to maintain waiting lists, maintain fairly extensive waiting lists (sometimes for emergent care) and still operate at a fairly low occupancy. For example, San Antonio reported that it put 81 patients on the waiting list last year - 34 for emergent care - and yet they operate at 60 percent occupancy. In fact, all but one facility are operating at well below 90 percent occupancy . VA should explore why waiting lists exist in the face of apparent available capacity, and whether these delays are due to lack of staff, trouble scheduling specialists, or unavailable resources, such as ventilators. If these beds are actually available and staffed. and needed SCI centers should at least be able to fulfill patients' needs for long-term care.

The care of SCI patients admitted to non-SCI wards and facilities was one of the major subjects PVA discussed with IG personnel during their data and fact-finding phase of operation, just prior to beginning their site visits. The Under Secretary's response that this recommendation (Evaluate the coordination and oversight of care provided to SCI patients admitted to non-SCI wards and facilities) was based on "anecdotal comments" is disturbing. This information is verifiable and has been documented by PVA National Service Officers and Veterans Benefits Department medical staff on an on-going basis.

Of note, the IG did make some attempt to assess referral patterns for SCI patients that receive care outside of centers. The IG cited an example of one SC patient whose conditions became so critical in a non-SCI setting, that when at last he was referred, he required more than a year of rehabilitative care at the center. While the IG suggested that the Under Secretary "evaluate the coordination and oversight of care provided to SCI patients admitted to non-SCI wards and facilities" there was no enforceable follow-up action recommended such as enrolling these individuals and assigning care managers to ensure that their care is periodically reviewed . VA should ensure that there exist guidelines for referral of SCI patients, and training activities VA should pursue to ensure that all patients are treated by a team of knowledgeable SCI providers.

Additional areas of concern:

The IG did not address the following important elements of SCI care in this report:

1 The evaluation of SCI staff physician performance.
The credentialling process was mentioned on pages 33 and 34, however, a review was not conducted to find out if a process exits that could continually assess the quality of care provided by individual physicians, and such an evaluation defines hospital privileges at each of the SCI centers.

2. Site visits were limited to only 5 of the 22 SCI centers. This oversight limits the objectivity and scope of the report, especially since major centers with pivotal patient care problems were not reviewed in depth (i.e., Brockton/West Roxbury, Memphis and Long Beach.

3. Concerning Appendix V: D. Timeliness of consults.
The report states that there is no problem with timeliness of consults. However, 75 percent of the consults were not dated, so timeliness could not be evaluated. Also, the assertion that VA does not routinely employ plastic surgeons is not a true statement and should not used as a reason for a delay in obtaining consults.

Conclusion:

In conclusion, while it was not in the purpose of this report to create strategic policy for VA, many of the findings the IG made suggest the need for re-evaluating resource utilization and clinical guidelines for SCI care delivery. VA should use this report and its findings and recommendations to reinforce efforts at the National Headquarters and VISN level to see that SCD care, a major component of VA's specialized care mission, receives the resources, policy development and oversight it deserves in the process of VHA restructuring.

Sincerely,

Gordon H. Mansfield
Executive Director

cc. Honorable Jesse Brown
Honorable Kenneth W. Kizer, M.D. M.P.H.

The American Legion
For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★
(202) 861-2700 ★

July 15, 1996

Honorable Tim Hutchinson
Chairman
Subcommittee on Hospitals
and Health Care
Committee on Veterans Affairs
335 Cannon House Office Bldg
Washington, DC 20515

Dear Congressman Hutchinson:

The American Legion is pleased to respond to follow-up questions to the June 27, 1996, Subcommittee on Hospitals and Health Care hearing on the Future of the VA Health Care System

Question 1. With regard to the testimony of June 27th, 1996, on the future of the VA health care system, The American Legion believes the expert panel of witnesses offered many sound ideas. In particular, Ms. Marjorie Quant, provided an historic overview of various reform proposals designed to strengthen and improve VA health care services which have never been earnestly pursued. The American Legion thinks that the future of the VA health care system must be determined by experts who understand the system and its myriad intricacies and not by individuals whose primary interest involves private sector, profit motivated health care entities.

Specifically, The American Legion believes the June 27th testimony of Ms. Quant, Mr. Thomas Mannle, Jr. and Mr. Drew Valentine, most closely resembles the recommendations contained in the Legion's GI Bill of Health proposal. We do not believe Mr. Russell Coile or Mr. David Bane truly understand the complexities of the VA health care system, nor does their testimony correspond to the changes required regarding the future of the VA health care system.

The June 27th testimony of Ms. Marjorie Quant, Mr. Thomas Mannle, Jr. and Mr. Drew Valentine offer some interesting perspectives on a restructured Veterans Health Administration (VHA). In conjunction with the GI Bill of Health, their proposals provide support to transforming VHA into a more flexible, managed-care network.

Question 2 The GI Bill of Health is a concept that must be tested in the health care marketplace. The American Legion believes veterans (both Category A and Category C)

and their immediate family members could be attracted to the GI Bill of Health if the plan was cost competitive and provided for a full range of health benefits. Additionally, access to care and the quality of care are important criterion.

Today, the largest of the private sector Health Maintenance Organizations (HMO) has approximately 2.5 million members. With 26 million veterans, plus dependents, excluding mandatory care veterans of which VA today treats approximately 2.5 million veterans annually, the potential pool of veterans and dependents eligible to enroll in the GI Bill of Health numbers approximately 70 million. With a carefully crafted strategy to market the GI Bill of Health, The American Legion is of the opinion that a VA health plan would eventually become the largest single health care insurer in the country.

To date, the GI Bill of Health has been reviewed by one actuarial firm. The initial analysis provided estimated premium costs, with deductibles and without deductibles. The cost of an individual or a family health plan would depend on the type of benefit package selected.

Question 3 The American Legion believes a pilot test program will be required to evaluate the effectiveness of the GI Bill of Health. The test program will identify future legislative initiatives needed to adjust and improve the plan The test and evaluation period will specifically examine the cost of delivering care to the beneficiaries identified in the GI Bill of Health. Such a review can confirm or deny the present cost estimates of the CBO and GAO regarding presently proposed eligibility reform legislation, and confirm the strength of new revenues generated by a VA health care plan provided for all veterans and their dependents. The test program will provide the vehicle to allow the VA the opportunity to enter the competitive medical marketplace and to implement managed care.

The test program will provide the GI Bill of Health with an evaluation mechanism to look dispassionately and non-politically at the effectiveness of the plan and to recommend changes, if any, that would be needed before system wide implementation.

Sincerely,

John Vitikacs
Assistant Director for
Resource Development
National Veterans Affairs and
Rehabilitation Commiission

CC: Honorable Chet Edwards

Committee on Veterans Affairs
Subcommittee on Hospitals and Health Care
June 26-27, 1996 Hearing
Follow-up Questions for
John Vitikacs
Assistant Director for Resource Development
Veterans Affairs and Rehabilitation
The American Legion
from Honorable Chet Edwards, Ranking Member

1. Panel 3: The testimony presented at this hearing has included proposals to veer sharply from the course VA health care has been on. Russell Coile, for example, called for "privatizing" veterans' medical care over the next 5-7 years. Starting with pilot projects, he would (1) put VA care out to bid (having VA networks compete with private sector HMO's), and (2) consolidate and privatize VA facilities & staff into nonprofit community health organizations, freeing them to merge or affiliate with local health delivery systems. David Baine of the General Accounting Office would have Congress consider eliminating the VA's acute-care system and instead either (1) authorize the issuance of vouchers for veterans to buy health insurance; (2) include veterans under another Federal program (Medicare, TRICARE, or the Federal Employees program); or (3)have VA purchase care for veterans. As I mentioned at the hearing, I would like to ask you to respond to those proposals, in as brief or detailed a manner as you wish.

2. The Legion's proposed GI Bill of Health, as I understand it, would allow certain beneficiaries to purchase health care coverage from the VA. How many persons must purchase their care from VA to make the proposal viable? What incentive would veterans who already have health insurance have for leaving their plans and enrolling with VA? What kind of studies or analyses has the Legion done to project demand for care through VA? What kind of actuarial analysis has your plan undergone?

3. Are you proposing any kind of demonstration project or pilot programs to test the elements of your legislation? If so, please describe that pilot proposal, its anticipated scope, and how those models would operate.

RESPONSE TO FOLLOW-UP QUESTIONS
FOR
JOSEPH A. VIOLANTE
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
FROM
COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTHCARE
JUNE 26-27, 1996 HEARING

You rightly point out in your testimony that the Independent Budget does not deny care for veterans who are not eligible. Do you have examples of specific proposals which you feel will diminish care for eligible veterans? If so, in what way?

Under the American Legion's health care proposal entitled "Veterans Health Care Security Act of 1995," some service-connected and combat disabled veterans will be confronted with diminished care and/or increased cost sharing. Further, unlike H.R. 3118, the Legion bill does not contain a provision that anyone receiving care now will continue to receive that same level of care in the future.

Looking at the American Legion proposal and its provisions to include dependents and spouses in the VA health care system, and understanding that service-connected veterans have complained that they are being pushed further and further behind, how do you feel the American Legion proposal would impact service-connected veterans? Do you feel that it would further dilute their priority for care?

In the *Independent Budget*, DAV proposes, along with AMVETS, PVA, and VFW, that the Secretary have the discretion to treat dependents of veterans at their own expense. We do not request that they be entitled to VA medical care. We believe that it would be in the best interest of veterans and VA to allow dependents to use VA medical care at their own expense. Up to a point, treating dependents would help defray overhead costs of underutilized VA services. It would also allow VA practitioners to continue to treat veterans instead of eliminating some services. DAV believes this is a cost-effective policy which is good for veterans and good for taxpayers.

The *Independent Budget* proposal would also authorize VA to provide dependent care when space and resources are available. The DAV supports dependents access to VA health care, so long as it does not limit or delay veterans access to care. We also believe care for veterans will be significantly enhanced from a quality perspective. A prime example would involve the quality of care provided to women veterans.

Under the American Legion proposal, the VA would have to give their enrollee's priority access because the VA would have a contractual relationship with these individuals. It is therefore conceivable that this could limit veterans access to VA health care.

Panel 3: The testimony presented at this hearing has included proposals to veer sharply from the course VA health care has been on. Russell Coile, for example, called for "privatizing" veterans' medical care over the next 5-7 years. Starting with pilot projects, he would (1) put VA care out to bid (having VA networks compete with private sector HMO's), and (2) consolidate and privatize VA facilities & staff into non-profit community health organizations, freeing them to merge or affiliate with local health delivery systems. David Baine of the General Accounting Office would have Congress consider eliminating the VA's acute-care system and instead either (1) authorize the issuance of vouchers for veterans to buy health insurance; (2) include veterans under another Federal program (Medicare, TRICARE, or the Federal Employees program); or (3) have VA purchase care for veterans. As I mentioned at the hearing, I would like to ask you to respond to those proposals, in as brief or detailed a manner as you wish.

The DAV strongly opposes the proposals by both Mr. Russell Coile and David Baine. Neither of these proposals are in the best interest of the veteran population.

The DAV opposes "privatizing" veterans medical care. For the most part, veterans currently using the VA healthcare system are older and more severely disabled than the general population, thereby making them less desirable and less profitable for the private sector. In the short-term,

private HMO's might be willing to "bite the bullet" and provide necessary services to the more costly elderly and severely disabled veterans; however, it is difficult to imagine that any "profit-driven" private sector HMO would be able to continue to provide all necessary services to these veterans for an extended period of time. As profits begin to dwindle, so too will the quality of services to sick and severely disabled veterans. These veterans will have no where to go, because by that time, the VA infrastructure will have been dismantled.

Nor would the DAV support Mr. Coile's proposal to consolidate and privatize VA facilities and staff into nonprofit community health organizations. It is our firm believe that most of the problems surrounding the VA health care system are the result of the antiquated eligibility criteria that forces the VA to behave inefficiently and ineffectively. Congress could effectively transform the VA into an efficient and cost-effective health care provider by enacting health care eligibility reform.

Likewise, the alternatives offered by Mr. Baine of the General Accounting Office would not meet the health care needs of our sick and disabled veterans. On the surface, a voucher system would probably appeal to many veterans. However, it is extremely unlikely that veterans would receive the necessary and, in some cases, special medical care that their disabilities warrant. As we have seen with Medicare and Medicaid, the cost of providing health care has skyrocketed. It is naive to believe that providing care to an older and more severely disabled population through vouchers, other federal programs, or purchased care would not increase at an alarming rate. Within a very short time, the cost of providing medical care under any of these three proposals would certainly outpace the modest increases in health care funding provided to the VA. Nor do these proposals adequately address the specialized programs in VA healthcare, such as those for spinal cord injuries and Post-Traumatic Stress Disorder, to name two. On the surface, these proposals might appeal to some but, in the long run, the level of disatisfaction will increase greatly when increasing costs require services to be cut back.

The proposals made by Mr. Russell Coile and Mr. David Baine were the extremes. Most of those witnesses who testified at the hearing believed that health care eligibility reform was necessary to enable the VA to provide health care in a more efficient and cost-effective manner. The DAV strongly believes that health care eligibility reform, as contained in the *Independent Budget*, would provide the VA with the blueprints to provide for adequate health care in the future. In this regard, we would like to thank the members of this subcommittee, the members of the Committee on Veterans Affairs, and the House of Representatives for passing H.R. 3118. While this legislation does not provide VA with all the necessary tools to ensure adequate health care for sick and disabled veterans in the future, it is a good first step, and very much appreciated.

Committee on Veterans Affairs
Subcommittee on Hospitals and Health Care
June 26-27, 1996 Hearing

Follow-up Questions for
Larry Rhea
Deputy Director of Legislative Affairs
Non Commissioned Officers Association
From The
Honorable Chet Edwards, Ranking Member

QUESTION: The testimony presented at this hearing has included proposals to veer sharply from the course VA health care has been on. Russell Coile, for example, called for "privatizing" veterans' medical care over the next 5-7 years. Starting with pilot projects, he would (1) put VA care out to bid (having VA networks compete with private sector HMO's), and (2) consolidate and privatize VA facilities & staff into nonprofit community health organizations, freeing them to merge or affiliate with local health delivery systems. David Baine of the General Accounting Office would have Congress consider eliminating the VA's acute-care system and instead either (1) authorize the issuance of vouchers for veterans to buy insurance; (2) include veterans under another Federal program (Medicare, TRICARE, or the Federal Employees program); or (3) have VA purchase care for veterans. As I have mentioned at the hearing, I would like to ask you to respond to those proposals, in as brief or detailed a manner as you wish.

NCOA RESPONSE: Contemplating the proposals put forth by Messrs. Coile and Blaine, as well as those from the other witnesses, is intriguing. In NCOA's view though, much of this exercise is moot until Congress addresses and answers <u>two fundamental, difficult questions</u> that bear directly on the various proposals and ultimately the future of VA health care.

<u>First, Congress must make a decision regarding veterans to be served in the future</u>. The bulk of VHA's focus today is non-service connected and low income. The proposals put forth at this hearing and the various reform alternatives introduced in recent months would each carry that same focus into the future. With that in mind, NCOA is probably less optimistic than others about potential benefit to veterans from privatization, vouchers, or rolling veterans into other federal programs, such as TRICARE or Federal Employees Health Benefits Program. Many of the inequities associated with current practices would be magnified under the proposals if the focus of VHA remains unchanged and, very likely, Congress would have no way to control cost.

<u>Second, Congress must make a judgement on the value it places on the Veterans Health Administration as a national resource</u>. Congress is going to have to weigh and decide the trade-offs it is willing to make. What value does Congress place on the VHA as back-up to the Department of Defense? What are the benefits and risks associated with a future VHA

that does not fulfill this role for DOD? Is the relative value of VA's role in federal emergency management and response such that national security and safety needs can be met without VHA involved in these efforts in the future? Similarly, Congress must weigh and judge the overall value of VHA's role in education and research. Is it important to retain the education and research missions within the future VHA? Or, can these missions be better fulfilled in the private sector?

ARTHUR ANDERSEN

ARTHUR ANDERSEN & CO. SC

July 17, 1996

Mr. Tim Hutchinson
Chairman
Subcommittee on Hospitals and Health Care
335 Cannon House Office Bldg.
Washington, DC 20515

Arthur Andersen LLP

Suite 901
1150 17th Street NW
Washington DC 20036-4603
Writer's Direct Dial

(202) 778-4911

Dear Chairman Hutchinson:

I have attached our response to the additional questions raised by Mr. Edwards, the ranking minority member on your subcommittee.

Let me thank you again for the opportunity to testify at your hearings on the future of the VHA. I thought the hearings went exceptionally well and I enjoyed the question and answer period. If we can be helpful in any other way please call me at (202) 778-4911.

Sincerely,

Drew Valentine

Drew Valentine
Senior Manager

BMW

Answers to Follow-up Questions: June 26-27 Hearings on VHA

Question 1

In studying alternative structures for VA, you state that one feasible option is for VA to become a "performance-based organization". Could you explain that term, and how it differs from what Dr. Kizer is already instituting in VA?

Answer: Our recommendation to convert VHA into a Performance Based Organization (PBO) is generally consistent with the recent VHA reorganization and the VISN concept. A PBO would go a bit further than the current VHA structure in linking performance and results to specific employee performance contracts. In a PBO each key manager would have a performance contract which spells out results expected, performance expectations, resources required, and success criteria.

The two major characteristics of the VHA functioning as a PBO would be the extensive use of performance contracts and certain exemptions to Federal personnel and procurement regulations that would allow, among other things, for the VHA to reward key managers for outstanding performance with significant performance payments or bonuses. Compensation and rewards would be determined on the basis of performance.

The PBO would be driven by performance in four basic areas:

- Performance in appropriating financial resources to achieve maximum impact -- VHA as a PBO must develop performance objectives and measure actual results against plan. In turn, management must be flexible enough to abandon ways of delivering services that are not as cost effective as other alternatives.

- Performance in people decisions -- Performance scorecards in the form of individual performance contracts should be used for key managers and staff.

- Peformance in innovation -- VHA must encourage innovation (in service delivery and other areas) to the greatest extent possible.

- Performance in effective strategic planning -- the performance of VHA management should be measured against its business strategies. Was the strategy appropriate? Was the strategy effective?

Question 2

You have concluded that a new organizational structure could improve the likelihood of success of Dr. Kizer's goals for VA. Is a new organizational structure critical to the vitality of the VA health care system? If so, why? What are the most critical limitations of the current structure, as distinct from specific statutory limitations from which VA could conceivably be exempted?

Answer: Several reports on VHA health care in recent years have concluded that structural changes are needed in the system. These reports found that VHA needs to be more flexible, more customer focused, more decentralized, and more cost effective. The move towards the VISN structure is a first step to accomplish these objectives. Several problem areas, however, remain.

Over the long term, we feel that if VISN directors are going to have the freedom to make required decisions, the VHA itself will have to be organized and structured more like its private sector counterparts (HMOs, etc.) The VHA should be more independent and insulated from political considerations and less subject to micro-management. Having a Board of Directors, with customer representation, will provide better strategic direction and focus. It would also better allow the VHA to develop needed private-public partnerships and other innovative approaches.

Question 3

In describing what an alternative structure should be able to accomplish, you say that for one thing it should "provide access to new capital funding." Where might such funding come from, and how might it be financed?

Answer: As stated above, VHA as a government corporation could pursue opportunities to seek efficiencies through private-public partnerships. Clearly, however, VISN will not be able to finance needed investments only from dollars saved by becoming more efficient; they will also need new sources of capital. A potentially viable source is third party payments for Medicaid and Medicare. For this, VHA will need to gain the authority to retain third party payments for services provided to covered veterans. A model is the new gainsharing initiative under the National Performance Review being developed by VHA, HCFA, and OMB.

New and innovative arrangements for a VHA Government Corporation to sell some of its services could also be pursued. Legislation currently under review may expand VHA's opportunities to sell VHA's specialized clinical services. VHA should also be able to open its doors to veterans with health insurance coverage who wish to buy VHA services.

Also a VHA Government Corporation would better be able to pursue joint ventures and cooperative alliances with its private sector health care counterparts.

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