# ROLE OF THE DEPARTMENT OF VETERANS AFFAIRS IN THE NATIONAL HEALTH CARE DELIVERY SYSTEM

## HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

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# ROLE OF THE DEPARTMENT OF VETERANS AFFAIRS IN THE NATIONAL HEALTH CARE DELIVERY SYSTEM

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**WEDNESDAY, APRIL 28, 1993**

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

The subcommittee met, pursuant to call, at 9:37 a.m., in room 334, Cannon House Office Building, Hon. J. Roy Rowland (chairman of the subcommittee), presiding.

Present: Representatives Rowland, Kennedy, Long, Edwards of Texas, Filner, Tejeda, Gutierrez, Baesler, Bishop, Kreidler, Brown, Smith, Bilirakis, Hutchinson, Everett, Buyer, and Linder.

## OPENING STATEMENT OF CHAIRMAN ROWLAND

Mr. ROWLAND. Turning now to the subject of our hearing, all of us, I'm sure, await with great interest submission of the President's proposal for comprehensive health reform.

Certainly our hearings have underscored that proposal that envisions far-reaching change and, with it, both challenges and opportunities for the VA health care system.

At one time there was a concern that the development of this reform proposal might simply ignore the VA health care system. That concern has been allayed.

The First Lady herself has made it clear to Chairmen Rockefeller, Montgomery, and myself that the President's proposal will address VA health care and will assure the independence of the VA health care system. She has given the same assurances to the veterans' service organizations.

I feel that all of us who pressed to have VA play a role in shaping this reform are very pleased that Secretary Brown has been serving on the White House task force, and that more than 30 VA staffers are participating in the supporting work groups.

Notwithstanding the extent of VA's participation, I know that the President will not want to send up this legislation without knowing that there's support for it in the veterans' arena.

So this hearing provides us an important vehicle to identify the principles against which the President can gauge whatever specific proposal for VA emerges from his task force. Similarly, the hearing can provide our committee a basis against which to gauge the President's proposal.

I look forward to gaining several important perspectives this morning: most importantly, from the representatives of those who rely on the VA system; from academicians and experts who have worked in, or in affiliation with, the VA; and, lastly, from among highly experienced, successful managers of VA facilities.

As we proceed on this important course, I'm delighted that the Senate's leading health care expert and leading veterans' advocate, Senator Jay Rockefeller, the chairman of the Senate Veterans' Affairs Committee, I hope will join us as a witness today. And if he comes in during the testimony of other witnesses, we would ask your indulgence that he be allowed to testify at that time.

So I want to welcome all of you here this morning to this hearing, and we'll call our first panel now to the witness table: Mr. John Hanson, who is director of national veterans affairs—one moment before I do that.

Well, I'll go ahead and call the witnesses up to the table: Mr. John Hanson, director of national veterans Affairs and rehabilitation commission from the American Legion; Mr. Gordon Mansfield, executive director of Paralyzed Veterans of America; Mr. Dennis Cullinan, assistant director, national legislative service, Veterans of Foreign Wars; and Mr. David Gorman, assistant national legislative director for medical Affairs of Disabled American Veterans.

Is there anyone here is that making an opening statement at this hearing this morning, any members desire to be heard?

(No response.)

Mr. ROWLAND. If not, then we will proceed with the testimony from the witnesses. We're going to limit, if you will, 5 minutes to statements. So you can submit your statement for the record and try to summarize, if you can, within that period of time.

Mr. Hanson, you're recognized. Proceed as you so desire.

## STATEMENTS OF JOHN HANSON, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; GORDON MANSFIELD, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; DENNIS CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; DAVID GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

### STATEMENT OF JOHN HANSON

Mr. HANSON. Thank you, Mr. Chairman, for the chance to come here this morning to talk about the potential role of the Department of Veterans Affairs in any future national health care reform program.

The American Legion believes that there is a role for the VA health care system in any plan that's proposed by the President. And while we have been assured by members of the task force looking at health care reform that VA will continue to exist as an independent health care delivery network, we're concerned about the shape VA's health care delivery system might be asked to take in the future.

A number of experts have been talking about global budgeting and for health care in general and speculating that global budget-

ing and spending caps would drive the costs of health care down. Well, as you know, VA's Veterans Health Administration has been forced to use global budgeting and spending caps for a number of years.

Those of us who monitor VA health care know that such dollar constraints do force health care systems to be more efficient, but to accomplish this efficiency, sometimes the price is paid.

All the corners must be cut. Sometimes other medical programs are cannibalized. And the ultimate choice in our minds is the prospect that this drive for efficiency and lower cost could lead to a rationing of health care.

As you know, Mr. Chairman, fewer veterans are being treated at VA. The cost of care that's delivered keeps escalating. Because the VA has had so much experience in this environment, a universal global budgeting approach might give VA a slight advantage in delivering health care.

But we feel that it could lead to a rationing of health care for all Americans, and that could further reduce the number of veterans who receive medical care at VA facilities and elsewhere.

As far as managed competition goes, we feel that if the health care playing field were level, VA could perform well and compete for people seeking health care. We know that as the Nation's largest health care deliverer, VA has experience in providing health care to a range of people across the country.

Our lessons learned by VA could be invaluable to planners looking at a national system for all Americans. But for VA to compete, we've got to look at how it operates now and how its current patient load will be handled by the Federal Government.

As each of you knows, the majority of patients at VA receive care because they've fallen into a mandatory service category. A large number of others receive long-term nursing home care, the kind of care that might or might not be addressed by the health care reform task force.

The American Legion is convinced that these categories of veterans must continue to be served by VA, but that a number of our veterans, other veterans, should also be served. I'm speaking, of course, about veterans who use Medicare or other federal health care programs to pay for their health care.

The American Legion is happy to be working with the Disabled American Veterans, the Veterans of Foreign Wars to develop what we consider to be an appropriate role for VA in national health care.

On the Legion's part, our recommendations have been published and circulated to all of you in the form of our gold book on VA health care. Briefly we think that service-connected disabled or medically indigent veterans should continue to receive care, but receive all of their care at VA hospitals.

Furthermore, we recommend that Medicare, Medicaid, and other federally mandated health care funders should be permitted to pay VA for the cost of health care for veterans who are not service-connected disabled and who would be using the federal programs for their medical and pharmaceutical needs anyway.

For veterans without a federal entitlement, we recommend that non-service connected disabled veterans should be able to choose to

go to VA if they want to. These veterans would then pay for their care by using whatever resources they would use for their health care, either their own private insurance or their own funds.

Further, Mr. Chairman, we think that given the chance, VA would be able to compete with other health care providers. We don't deny that some mistakes have been made at some facilities across the country, but we don't know about the mistakes that private hospitals have made. And we don't want to overlook the tremendous medical discoveries and procedures that the VA has pioneered that have benefitted all Americans.

Mr. Chairman, VA has shown an uncanny ability to keep costs low while delivering a good health care product. We're certain that VA's experience can lead a number of hospitals to use the lessons learned and other ideas to cut their costs where possible.

What we feel most, though, is the notion that the VA should somehow revert to a narrowly specialized service deliverer, there would be very few veterans who could use those services.

The way VA in pioneering prosthetic research, blind rehabilitation, and long-term nursing home care can't be overstated, but neither can we jump to the conclusion that those functions will be all the VA has to offer in the future.

We want to use this opportunity to commend Secretary Brown for insisting that VA be an active player in the health care task force that is wrapping up its work, we hope, in the next few weeks. And we want to thank the First Lady for her commitment to a continued and strong role for VA in health care across this Nation.

That concludes our statement, Mr. Chairman. Thanks for your time.

[The prepared statement of Mr. Hanson appears on p. 69.]

Mr. ROWLAND. Thank you very much.

Mr. Mansfield.

## STATEMENT OF GORDON MANSFIELD

Mr. MANSFIELD. Thank you, Mr. Chairman. The Paralyzed Veterans of America would like to thank you for your continuing advocacy for a viable VA health care system.

Perhaps the best place to start is to outline my understanding of what Mrs. Clinton said at the White House meeting, which was that the VA would continue to be a national independent system, that there would be a basic package of benefits provided, there would be portability, the system would have to be economic, and there would be some competition involved.

I think we ought to realize that the VA system currently and probably in the future will continue to have a responsibility of being the DOD backup. It is a research asset that should be continued.

There's a health care education factor that has to be factored into the overall plan; i.e., the VA has educated approximately 50 percent of the medical care professionals in this country. And the VA has the only national specialized medicine system, for example, in spinal cord injury.

I would refer the committee to the full testimony, which outlines PVA's Strategy 2000, directed by Dr. Custis and presented previously.

I think we have to understand that as we move into this new system, PVA believes that there are some elements that need to be considered and are priorities. The first is entitlement reform, and that includes a core entitlement group, which should include the service-connected and other currently statutorily entitled veterans, catastrophically disabled non-service connected veterans, and the non-service connected veterans who are poor. The VA also should be required to provide a full continuum of care, and there should be a capitated funding mechanism.

The role of the VA in the new environment would include it being in competition with AHPs. To do that, we believe there should be a level playing field. This requires that there should be adequate fiscal support, as a congressional obligation to provide the veterans a capitation budget based on obligation to the system users, that we should remember that the VA is not a for-profit provider nor the beneficiary of charitable or community support.

We should ensure that the infrastructure of the VA is taken care of in that it must be perceived as a comparable provider to be competitive. This requires contemporary equipment, facilities that are up to date, adequate clinic space, good maintenance, and patient amenities. The staffing needs to be adequate in both numbers and skills to be competitive in timeliness and quality of service.

There should be a maintenance of affiliations which requires a balance of programs which attract a range of patients in order to support a range of residency programs and try to maintain top quality health manpower.

In addition, we believe there should be operational streamlining, which would reduce the waiting time, both in clinics and for appointments. We should attempt to minimize administrative requirements and procedures. We need an ability to meet accounting and reporting requirements that exist in the AHP environment.

In addition, there are parts of the system that are going to have to be put in place that don't currently exist. For example, in addition to being able to account for the cost for each veteran client, we may need to look at a marketing capability.

Based on this, we believe that the incentives that are needed to make the VA a player in the new national system demand that the entitlement for the core group have unrestricted access to VA health care so that the VA can provide medicine as other providers do, that the full continuum of care be provided, and that access to specialized services; i.e., for those veterans in the non-core group or others, be provided.

Mr. Chairman, I think that the basic line here, as we all recognize, we're moving into a new environment. We want to see the VA continue to be a major player in this environment. And we want to see the VA be able to carry out the commitment this country has to its veterans.

Thank you.

[The prepared statement of Mr. Mansfield appears on p. 73.]

Mr. ROWLAND. Thank you, Mr. Mansfield.

Mr. Cullinan.

## STATEMENT OF DENNIS CULLINAN

Mr. CULLINAN. Thank you very much, Mr. Chairman. Before I begin, I'd like to extend the special appreciation of our entire membership of the VFW to you and all the members of this committee for conducting today's hearings. It's an extremely important forum in our view, and we're honored to play a role.

Mr. ROWLAND. Thank you.

Mr. CULLINAN. As you know, the VFW's commitment to the preservation and enhancement of the VA health care system, carrying out this Nation's obligations to care for the military veterans in their time of need, the VA health care system has proven to be of immeasurable value to all Americans.

We are approaching today's hearing with a view that national health care reform will eventually become a reality. While we are, of course, supportive of providing the comprehensive health care benefits package to all Americans, we remain firm in our position that the VA health care system remain dedicated to America's veterans.

The VFW believes that within the context of national health care reform, the VA should remain a separate, independent, and exclusive health care option for veterans.

The VFW acknowledges that the VA system may well have to be modified in order to better serve veterans and fulfill its role within the context of national health care reform.

Our position in this regard may be best encapsulated be stating that the VFW is committed to the VA's providing the best possible care to veterans in accordance with state-of-the-art medical practices and procedures. We are not tied to a particular physical configuration.

It would now appear that national health care reform will be structured along the lines of the managed competition model. We believe, given certain resources, that the VA will be able to compete very effectively within this framework. However, we must now reaffirm our conviction that the VA has always been and should continue to be something far more than just another business-oriented health care provider.

The VFW holds that there should be no change in the overall mission of the VA health care system since its continued operation is not only vital for veterans and veterans' health care. It's also beneficial for all Americans.

Further, it is also unique and irreplaceable with respect to the areas of education, research, and DOD backup. The benefits from these areas of endeavor flow to all Americans, not just veterans.

We believe VA should become the primary provider of health care to America's veterans. Toward this end, reform of eligibility standards for VA health care must be brought about to open up the system for all veterans.

VA must be allowed to retain its third party collections from third party insurers as well as other federal entities, such as Medicare and Medicaid. This will allow for the proper enhancement and development of the system with the eventful diminishment of the required appropriation support. Core inter-transfers of Governmental funds must be provided for under law to allow for this to happen.

It is our view that regardless of the forum the national health care system assumes, VA must retain its exclusive appropriation support. VA has always been and should always be far more than just another health care provider. Regardless of how successful it may become as the provider of choice to America's veterans, a certain amount of federal support will always be required.

With respect to competing within the managed competition model, VA needs to improve its operation immensely. The fact of the matter is at this point in time, VA is suffering from a serious image problem.

This is especially true among the middle class veterans with insurance and perhaps a bit of money in their pockets whom VA will need to attract into the system if it is to capture their funding and eventually reduce its appropriation burden.

So VA is going to have to start truly concentrating on its image, on public relations work. As we all know, this is becoming increasingly important in the health care field in general, and we think this is something VA is going to have to take a careful look at.

In conclusion, the VFW believes that the VA health care system should serve as a contributing partner and model for the future. Through sustaining and improving the VA health care system, all Americans will benefit.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Cullinan appears on p. 82.]

Mr. ROWLAND. Thank you very much, Mr. Cullinan.

Mr. Gorman.

## STATEMENT OF DAVID GORMAN

Mr. GORMAN. Thank you, Mr. Chairman.

I think that the hearing today is timely, Mr. Chairman, in that it serves, in our view anyway, as a continuation of the eligibility reform hearings this subcommittee conducted last year about this same time and also timely in the sense that Senator Rockefeller in the Senate Veterans' Affairs Committee is conducting a series of similar hearings. I think all of that information together is going to produce a firm direction for the way that the VA should proceed in this issue as we debate national health care.

As we are also keenly aware, Mr. Chairman, the VA health care system is in the throes of crisis with similar issues as being faced by the country's health care system as a whole. Principally, such crisis results, in our view, from years of inadequate funding and a patchwork approach to addressing the health care needs of veterans.

During last year's presidential campaign, it was heartening to hear President Clinton profess his support for the maintenance of the VA health care system. More recently, the First Lady met with leaders of the major veterans' service organizations as well as Chairman Montgomery and Senator Rockefeller and Secretary of Veterans Affairs, Jesse Brown, and again asserted the President's support.

We believe it is a view that is shared by most others, Mr. Chairman, that the issue of eligibility reform is the single most pressing issue facing VA health care today.

Eligibility needs to be clarified to define who is eligible for VA health care services and the scope of services that will be provided. With eligibility reform, veterans would know what they were entitled to and, thus, be enabled to plan for their health care needs.

By removing the antiquated, both economically and clinically, rules for care, veterans' health care needs on an inpatient, outpatient, and long-term care basis would be better met. And the VA's ability to strategically plan would be available. Perhaps for the first time VA would be required and able to plan based on veterans' needs, rather than simply on budgetary feasibility and restraints.

Mr. Chairman, on February 20 of 1992, legislation was introduced, the American Veterans Health Care Reform Act of 1992, that embodied in bill form the DAV's vision and plan for a restructured VA health care delivery system.

In general, our plan has three main components, consisting of access to care, scope of care, and funding of care. The centerpiece of our proposal establishes a group of core-entitled veterans, consisting primarily of service-connected veterans and low-income veterans.

Secondly, our proposal calls for the focus of VA moving from a sick care system of a traditional acute bed-based model to a disability-based model. This continuum of care, Mr. Chairman, would focus on health promotion and disability as well as disease prevention and treatment.

Nontraditional means of treatment, such as adult day health care, home health, and maintenance services, would be provided as would other necessary health care collateral services. In other words, we envision a continuum of care to comprise of services ranging from preventive care to hospice care for veterans.

Finally, our proposal calls for an entitlement to be created, a non-discretionary congressional appropriation to be made for the cost of care provided to the core-eligible group.

We advocate the VA's ability to collect and retain funds from secondary payers; Medicare, for example, as being applicable only to eligible veterans outside of the core-entitled group. Our proposal, therefore, clearly does no harm to the Medicare Trust Fund.

Mr. Chairman, the DAV is indeed pleased the decision was made to include VA as an active participant, not only in the debate regarding health care policy, but also as an active participant in the task force.

In our view, VA has nothing to fear as a result of scrutiny. Rather, the VA can hold and should be recognized for what it really is, and that is a system that can help realize the stated goals of national health care reform.

Mr. Chairman, the DAV is convinced that the VA stands alone as a competent, quality-innovative, cost-effective provider of health care services to a special, albeit complicated, population of patients.

Further, we remain confident that given the opportunity to compete in the national health care arena and when allowed to do so on an even playing field, VA is extremely well-positioned and able to do so.

We are not, however, so parochial, Mr. Chairman, to recognize that the traditional role and structure of the VA can continue.

Rather, we recognize change needs to occur with a vision towards the future of how we best provide care, not only to eligible veterans, but also to the entire citizenry of our country.

I'll stop there, Mr. Chairman, and be pleased to try to respond to any questions you may have.

[The prepared statement of Mr. Gorman appears on p. 90.]

Mr. ROWLAND. Thank you very much. Thank all of you for your testimony. We will limit our additional questions to 5 minutes each. And then if we can't get them completed during that period of time, we'll come back for a second round.

I've got a couple of questions I want to ask you. Several of you called for a level playing field if the VA is to complete in the national health care reform. Would you agree that, those who say that, under that principle, the VA should generally be subject to the same standards and requirements that would apply to other competing health plans?

Mr. GORMAN. I think if I can start, Mr. Chairman, I think, number one, the VA is in a position to not only adhere to the same standards, but perhaps in many ways, if not all ways, set the standards for what health care should be in this country.

Certainly—and I remember there has been an issue that this subcommittee addressed some time ago about the regulatory authority that may be imposed on VA should other federal agencies have interests such as Medicare reimbursement or the clear regulations with VA.

And I think at that time it was clear that the standards the VA does set and the oversight the VA is subjected to, both from other accrediting agencies, groups, Congress, the veteran service organizations, clearly, in our view anyway, would have the VA at a threshold where the rest of the country should.

And then for the rest of the country to compete under national health care reform, they would maybe have to catch up with the VA and do the things that the VA is doing.

Mr. ROWLAND. There are certainly some specialized things that the VA does that may not have been done in other areas of our health care system. So I think you make a good point in that respect.

Mr. CULLINAN. Mr. Chairman, it's the VFW's view that the VA should always be something more than just another health care provider. We think that it will enable them to compete very effectively for the non-service connected middle class veteran who now simply doesn't have access to the system.

Part of the problem today is that these veterans can't get in for what they need. They're looking for things like outpatient care, health care maintenance, these sorts of things, and they're not eligible for it. So one of the first things that's going to have to happen is to revise the eligibility standards to get these veterans in.

Now, with respect to subjecting VA to outside standards, to regulations from other federal entities, we believe that the VA, for one thing, is the health care system, as opposed to HHS, which is simply a federal payer.

VA is a health care system. It has outside oversight. It has interior oversight. And it has congressional oversight in connection to

the role of the VSOs. So we think that, indeed, some of the other federal entities may have to catch up with VA's standards.

Mr. HANSON. I agree, Mr. Chairman. The American Legion doesn't have any problem at all with VA having to adhere to any standards anyone else would have to adhere to.

I think some of us would like to see other hospitals have to be subjected to the scrutiny VA hospitals are subjected to, not just by the federal regulators, but by the media and by its own constituency.

There is certainly no problem on our part of VA having another set of eyes looking at how it does its job.

Mr. MANSFIELD. Mr. Chairman, the answer is yes on one hand and no on the other hand. As far as quality of care goes, as far as the outcome of care goes, as far as meeting the standard, yes.

As I indicated in my testimony, though, however, what we have to take into consideration are the examples of: Is the VA going to continue to be a DOD backup? And is it going to have to have resources set aside to deal with that, which would put it in a noncompetitive position vis-a-vis other systems which may not have to do that?

Is the VA going to continue to be a national asset in specialized areas of research? Is the VA going to continue to be a major player in the health care education field? And is the VA going to continue to provide specialized medical care in areas such as spinal cord injury?

And the point I was trying to make there is if that's the fact and we're going to carry that over, then we have to recognize that. And when we say a level playing field, PVA is saying you have to take those factors in consideration as you measure the VA's competitiveness.

Mr. ROWLAND. If the VA is to compete against other health plans that offer, say, consumers family plan options, would it make sense for a national health care reform plan to authorize but not require VA to offer veterans a family option as well with provisions for the VA to contract out some of those services?

Mr. GORMAN. It would seem, Mr. Chairman, that, first of all, I think the VA in some limited cases now does, in fact, offer that family plan in the form of CHAMPVA benefits.

And the VA now has gotten out of the traditional role of treating. CHAMPVA beneficiaries are paying for the care in the private sector. And now is made an effort to bring that population into the VA hospitals, but purely not only for economical reasons, but clinical reasons also. And it's going to save money.

It seems, to me anyway, that if the VA is going to hold itself out as a competitor on this level playing field that we have been talking about, they need to make the same kinds of provisions that the rest of the community is providing. And they can't operate within a vacuum of care.

The contracting out of care goes on now. I think that's going to have to be enhanced a little bit, not only to meet veterans' needs, but some of these other beneficiary needs. So we're certainly open to that kind of consideration.

Mr. ROWLAND. Let me interrupt right here, and then we can take up. As I indicated earlier, Senator Jay Rockefeller was to join us

this morning. And if we could just sort of move our chairs aside there?

And, Senator, if you would be so kind as to come down? We want to tell you how pleased we are that you're here this morning. Thank you very much, and we look forward to hearing your testimony.

We know you're on a very tight schedule this morning.

Senator ROCKEFELLER. Mr. Chairman, I apologize to my colleagues here at the table for what I think is a very rude thing that I have just done, which is to interrupt them.

Mr. ROWLAND. I accept responsibility for that.

Senator ROCKEFELLER. You can't be rude, and you never are.

## STATEMENT OF HON. JOHN D. ROCKEFELLER IV, CHAIRMAN, COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE

Senator ROCKEFELLER. I'm incredibly grateful to you, Dr. Rowland, as indeed I am to our mutual Chairman, Sonny Montgomery. You're one of two doctors in the House. We have none in the Senate.

I look at you, and I'm filled with awe. I would give my eyeteeth to freeze my Senate position so that nobody could touch it for 2 years, and I could disappear off to a school of health care policy to do some graduate work for 2 years and learn half as much as you know.

Mr. ROWLAND. Well, you don't need to go to school. You already know a great deal about health care. You've made great contributions to our country in that respect as well as many other respects.

Senator ROCKEFELLER. Well, now that we've said good things about each other, let' proceed.

You're going to be receiving testimony today, Mr. Chairman, on the future of the VA health care system under national health care reform, an incredibly important, intricate subject.

And, as you know, my committee is also studying this very critical issue. In fact, we have held three hearings on the VA system and national health care reform already. And we're having one more on long-term care as it affects the VA system now and health care reform generally in the country.

Yesterday we heard from those who have obviously the biggest stake in the VA's future, that is, our Nation's veterans. And we also heard from providers, all different kinds of providers within the VA health care system, who are working as hard as they can, and expert witnesses at previous meetings have discussed VA's contribution to the overall U.S. health care system. And it is an extraordinary story, an extraordinary story.

Most veterans I know all across America worry right now. They worry that somehow we're going to make the wrong decision, that somehow the VA system is going to disappear, that somehow inadvertently we're going to do or allow to happen what happened in Canada.

You and I and Chairman Montgomery know that's not going to happen, that that will never happen. The President has promised that's not going to happen. The First Lady has promised that's not going to happen. Sonny and myself and you have all promised it isn't going to happen, but people are concerned about it.

I very much believe, indeed, that we have to preserve and strengthen a separate VA health care system focused on veterans' needs. And, as I indicated, I know that the President and the First Lady share that conviction. Of course, Secretary Brown does.

In fact, I would say that veterans have two really good friends in the President and the First Lady at the White House. I don't say that politically, I really don't. I mean, these people are very, very concerned about our veterans.

However, preserving VA should not mean preserving the status quo, and herein comes our difficult part. The VA health care system is in crisis. That is the fact. It cannot continue.

Great change is coming to our overall health care system. That can't be changed. The VA in some way is going to be changed. How is that going to happen? How can we best be sure that that's to the benefit of veterans?

We may never again, in fact, have as great an opportunity as we do now to, in a sense, reinvent the VA health care system in a positive way for veterans, away that will enable it to respond quickly and effectively to veterans' changing health care needs.

I believe that we can best achieve that goal by allowing the VA to compete with non-VA providers through health alliances on the basis of quality and cost.

Under this scenario, all veterans would be able to enroll in the VA health care system on an annual basis. VA would receive premium payments from the health alliance for veteran enrollees.

Some veterans, most likely those not otherwise entitled to VA care under the current situation, will be charged copayments and deductibles to cover part of the costs of their care should they choose to go to VA facilities.

Now, this is going to be a very big change, a monumental change, but one which I believe the VA can achieve and one which can improve veterans' health care.

Studies have shown that VA costs are comparable to those of non-VA facilities and providers. And even as I read that statement, I'm thinking of a lot of things that say that we can provide comparable care at less cost—indeed, up to 30 percent less in some cases.

Outcomes research indicates that the quality of care furnished to veterans is equal as well. Recently enacted legislation has improved VA's ability to recruit and to retain highly qualified physicians, nurses, and other health care professionals, although I will say that unless we get some of that research money restored, we're going to lose some of our top positions and researchers in the VA system.

The way VA appears to this Senator to fall short is in providing that care in as timely and as sophisticated a manner as could be done. I'm sure you all have heard from veterans in your district about long waiting times for appointments at outpatient clinics, admissions to inpatient PTSD treatment programs, hip replacements, and all kinds of procedures.

In fact, I would make the case that we could do so much if we could just make the VA system's waiting rooms more receptive and welcoming to veterans and if we could speed up attention to processing benefit claims.

You also know that many VA managers cannot afford to replace worn medical equipment or repair aging facilities. In an interesting way, therefore, an infusion of premium payments from health alliances would provide VA with the resources necessary to make these improvements, which we as a Federal Government have not been able or have not chosen to do.

It's a fascinating concept that the private sector, so to speak, allows the Government sector to compete better against the private sector. It's an interesting thought.

Moreover, competition would compel VA to manage its resources much more efficiently, and we're for that. The whole VA system would have to be reorganized to ensure that veteran enrollees can obtain all services to which they are entitled.

Moreover, managers would have to market their services. We discussed that at a hearing yesterday. The VA would have to market themselves. They haven't done that up to this point. They're going to have to market themselves to veteran patients and streamline their operations to provide services efficiently and cost effectively.

In addition, VA employees would have to become more customer-oriented. I am for that. Although most VA employees are talented and dedicated individuals, too often we hear about the few who don't appear to feel the obligation to treat veterans with the dignity and the compassion that they particularly deserve.

Many veterans tolerate such treatment now because they have nowhere else to go. If they could obtain high quality services from non-VA providers with minimal out-of-pocket costs, they're likely to choose those providers unless we can make VA customer-friendly and provide everything that veterans want and deserve.

Obviously, many difficult questions remain regarding the specific details as to how VA and non-VA providers should compete. Questions relating to enrollment are especially critical: How much flexibility would veterans and other Americans have to use facilities and providers not affiliated with the health plans in which they have enrolled? Should any veteran who satisfies VA's entitlement criteria be entitled to use VA facilities at any time, whether or not the veteran has enrolled in the VA system? All of these questions would have to be answered.

Other important questions concern whether VA would provide care to veterans' spouses and children, either in VA facilities or on a contract basis—contracted by the VA in some other facility—and whether VA would have to provide contraceptives, obstetrics, and other services to which very few veterans are presently entitled.

I do not raise these issues to cast aspersions about competition. Rather, in fact, I ask them because I very much want to see health care reform that builds upon market-based competition succeed and succeed for veterans. We cannot do that unless we come to a consensus on precisely what competition will actually mean, what it will entail.

The road to victory will not be easy, and we must form a united front against those who would prefer to dismantle the VA system, and we know they are out there, or just watch it wither away.

I challenge everybody in this room to join all of us together to make sure that we protect and improve that system. We don't have a minute to waste.

I'm one of those who believes that we cannot wait until 1994 to pass health care reform. We've got to pass it this year, by December 22, 1993. That gives us 2 days for Christmas shopping. If we wait until 1994, the 750 health care lobbyists—separate trade associations—will tear this thing apart.

The President wants it now. The First Lady wants it now. We want it now. We can get it done now. The American people definitely want health care reform done. Veterans have an incredible opportunity to gain through all of this. I want to see it happen, and I know the chairman does, too.

I thank the chairman again for inviting me to share my thoughts with you today.

Mr. ROWLAND. I thank you very much, Senator Rockefeller. And thank you for a most insightful statement, too. I want to associate myself with the remarks that you made relative to how the VA is going to have to fit into any new system that is put in place.

I agree that national health care reform can help the VA get where it needs to be. It can become even more user-friendly than it is now. I hear so often that the VA seems to be cold, and it's not the professional people. It is usually entry-level people that project that image. I've heard that since I've been here in the Congress, and that's something that we're going to need to really work on.

I look forward to hearing from all of the veterans' organizations that we've been hearing here this morning. You all have already had three hearings about how they think we ought to be doing this.

I'm very grateful for everything that you do. I know that you're on a real tight schedule. I wonder if you have any time for questions from any members here.

Senator ROCKEFELLER. Mr. Chairman, I'll try to take one or two, but I'm fighting for my life for 800 jobs, really good jobs, for West Virginia, and I've got a 10:30 meeting that may make that possible.

One question. No—two or three, but I don't want to miss those 800 jobs, Mr. Chairman.

Mr. ROWLAND. Does anyone have a question that they wish to ask?

## OPENING STATEMENT OF HON. CHRISTOPHER H. SMITH

Mr. SMITH. Senator, I would just like to make a very brief point. You know, many of us on the minority side, Republican side, have been very concerned about this process. We are concerned that there have not been sufficient numbers of seats for Republicans at the table as national health reform has progressed at the White House.

I know the most recent demise of the so-called stimulus package hopefully was a wake-up call that bipartisanship is necessary. Even though, particularly in the House, there's a commanding Democrat majority, Republicans remain a very viable and potent force and with a large number of ideas that I think the American people will find of interest.

You know, there is a consensus in generalities for national health reform, but as the polls would indicate and as seven town meetings of my own district have very loudly indicated to me, as soon as you get the details and start delineating exactly what the cost would

be and what it may mean to the individual who needs health care, there is a very wide discrepancy.

A number of people are profoundly concerned. And it seems the more they find out about what might be contemplated, the less likely they are to embrace it.

It seems to me that we need on this side, in particular, and I would suggest on the Senate side as well, a dual track that yes, there may be sweeping reform in the cards.

As Mr. Cullinan mentioned a moment ago, he believes that eventually we will have national health reform, but I think there's also the very real prospect of substantial tests. And we need to be looking at how we can make the VA system operate that much better in case we don't have this sweeping reform, as some would suggest.

And, again, a closed process locks certain people out, as you know, Senator. I know you work very well with your Republican colleagues, so my comments are more directed to the White House.

It will lead, I think, to a continued stalemate on certain issues that need and demand reform. So I would hope that you would consider that.

Senator ROCKEFELLER. Yes. And I certainly agree with you that we can do none of this for the Nation or for our veterans, much less both, unless we do it on a bipartisan basis.

One of the things that's hard about all of this is that there has never been a process of creating a Government bill like the one which is going on now at the White House. I've heard a lot of talk about people being excluded.

The American Medical Association was talking about that. I asked the President of the American Medical Association how many times he had met with Ira Magaziner. He said four times. I said, "Look, I'm right in the middle of the whole thing, and I work with the White House very closely. I met him five times, never within a room of less than 50 or 100 people."

The First Lady has made an enormous effort to come to the Hill, to reach out to Republicans and Democrats on the Hill. I sat in the Finance Committee meeting of the Senate, with just the Republican and the Democratic Senate Finance members.

And it was remarkable to me, Representative Smith, to see how Republicans would be skeptical because of exactly what you're saying, because of the word that's going around that it's a closed process.

The process doesn't in some ways begin until the bill is submitted. It's just that this has never happened before. Nobody has ever done this before in preparation for a bill.

But as they listened to Mrs. Clinton, it was amazing to see people open up to her as they realized there wasn't an exclusionary policy or this wasn't some diabolical plan. And one of them—I won't mention who, but he is a very, very good friend of mine—walked up to her afterward and said, "You know, I think we can do this thing together."

So I think the thing is to focus on what's in the bill. There are really three people: Hilary Clinton, Ira Magaziner, and Judy Feder. Everyone is trying to see those three people, and if they don't see those three people, they consider they haven't been talked to. I wish we could clone dozens of them, but we can't.

I think bipartisanship is our only hope. We can't do it in the Senate, where we operate under more constrictive processes than you do in some ways, without bipartisanship. So I agree with you.

Mr. SMITH. Good. Thank you.

Mr. KREIDLER. Mr. Chairman, I would like to ask a question of the Senator about who would be the eligible enrollees. I've worked for the United States Army as a health care provider, and worked for a staff model HMO for well over 20 years.

The concept that you have described here as something close to my personal experience in health care delivery, where I have been in a salaried position, either for the Army or for a consumer-owned nonprofit HMO.

I asked a question of the Department, and their response was that if we had comprehensive health care reform, as many as 50 percent of the current recipients of VA medical services would no longer be there because of——

Senator ROCKEFELLER. Would go elsewhere?

Mr. KREIDLER. Would go elsewhere largely because they would have health insurance coverage to go elsewhere. My assumption here is what you're describing would potentially then open up the VA system to all veterans or they would be eligible for joining the staff model HMO, be they VA hospital system or medical system——

Senator ROCKEFELLER. Or potentially veterans who are not eligible under all circumstances.

Mr. KREIDLER. Exactly, just all veterans, going well beyond those who are eligible today.

Senator ROCKEFELLER. Taking the funding stream of those veterans who have been going to other non-VA hospitals, bringing that into the VA system, would mean veterans using the VA system and bringing other moneys with them.

It wouldn't cost the Government anything because they would be bringing third party payment—Blue Cross/Blue Shield or whatever—money with them. And we could use that money to make the VA system itself more competitive by upgrading its facilities.

Mr. KREIDLER. Well, I can tell you from my own personal experience in working for Group Health Cooperative, Puget Sound in that particular type of delivery system, I'm confident that the VA could step up to that kind of a challenge and continue to provide medical services, particularly in urban areas, where they can really deliver the services. I would imagine that some of the veterans facilities may be in geographic locations where that may not be feasible; whereas, others do exist and may need to be augmented to develop that full range of services and have the capabilities of delivering the services.

Senator ROCKEFELLER. Yes. And I don't think it's going to be easy.

Mr. KREIDLER. No.

Senator ROCKEFELLER. You know, we've never done this before in the history of this country; we've never reformed the health care system. We can certainly sit around here glibly and make it sound nice and smooth, but it isn't going to be smooth.

But we can make it work, and I believe we can make it work for veterans very well.

Mr. KREIDLER. Great. Thank you.

Mr. ROWLAND. Do you have time for one more?

Senator ROCKEFELLER. Sure do.

Mr. ROWLAND. Mr Buyer.

Mr. BUYER. Thank you, Mr. Chairman.

Senator Rockefeller, I have to ask a question because my ears perked up when you talked about the VA hospital being not only more user-friendly, but also being able to get into the marketplace and compete for services, and when you mentioned the word "contraceptives."

Let's take it one step further. Are you saying that you would be advocating to use VA hospitals for abortions?

Senator ROCKEFELLER. No.

Mr. BUYER. I mean, we've got a President who is on a tremendous social agenda.

Senator ROCKEFELLER. Yes.

Mr. BUYER. And say we've got a means test out there for a veteran. It's a legitimate question; right?

Senator ROCKEFELLER. Of course it's a legitimate question. And I knew when I put that word in there, I would get a question.

Mr. BUYER. Because if we're going to have abortions on an overseas basis—and I am just curious——

Senator ROCKEFELLER. Yes. I think it's one of the things that has to be on the table. My approach on these things is you don't avoid them because they're difficult or controversial. You get everything out on the table and talk about it.

Mr. BUYER. What is your position, Senator?

Senator ROCKEFELLER. I don't know yet. I mean, if we open up different other kinds of services—let me tell you this. I'm pro choice, so that——

Mr. BUYER. I don't want to get into an abortion debate with you. I'm just curious. In the entire health care——

Senator ROCKEFELLER. It could be. It could very well be.

Mr. BUYER. We know we have a President now who has also discussed using Medicaid to pay for abortions. If we're going to talk about keeping the VA separate and we've got someone out there that's going to say, "Well, geez, I could either go have Medicaid pay for it," or perhaps, "Can I go to a veterans hospital if I'm a veteran or if I'm an eligible veteran to have those services?"

That's one of those questions that needs to be discussed.

Senator ROCKEFELLER. Sure.

Mr. BUYER. I ask that we discuss that question.

Senator ROCKEFELLER. Just as it is one of the questions, I also want to try to raise the very large question of whether we're going to do veterans the favor they deserve, as with this once-in-a-lifetime chance we have to make veterans hospitals competitive with nonveterans hospitals. They have got to be competitive in every respect.

Now, that doesn't mean that every hospital does everything, as, indeed, every commercial hospital or non-VA hospital doesn't do every service. If we're going to have to start doing that in this country, everybody can't have an MRI.

Mr. BUYER. Right.

Senator ROCKEFELLER. But I just raise all questions, all possibilities. That question is asked about VA hospitals, and will be asked about Medicaid or other areas for non-VA hospitals.

Mr. BUYER. A wide range of services——

Mr. SMITH. Will the gentleman yield?

Mr. BUYER. Yes, I will.

Mr. SMITH. Thank you for yielding.

I just think, very briefly, that an under-emphasis on competitive advantage could very quickly lead to an elimination or at least a downgrading of the mandate of veterans hospitals. I think we need to proceed with caution on that regard.

And, too, when you said other services, my ears perked up. You know, there was a New York Times poll that was done—and the New York Times has been no friend to the right-to-life movement over the years—that said that 23 percent of the American people, according to their survey, wanted abortion services, which I happen to feel takes the life of an unborn baby, included in a national health plan. And, in the alternative, 72 percent wanted it out.

So it seems to me that if we want sweeping reform, and I think there needs to be some real genuine reform, we heavily weigh the prospects of success at the end of the day, if we go with undue taxes, and changing mandates of the VA health care system, which I think could be dangerous. Then we factor in abortions, as Mr. Buyer pointed out the DOD hospitals.

I have been very proud, very proud, of our overseas medical doctors, who have maintained their focus on healing, rather than destroying, life. Only one in the entire Western Europe front, in Europe, is willing to engage in abortion and none in Japan. That suggests to me that——

Mr. ROWLAND. Senator Rockefeller, I know that you're on a very tight schedule here.

Mr. SMITH. Mr. Chairman, this is an important point because it was brought up by the distinguished Senator.

Mr. BUYER. If I can recapture my time, I think that the point here is, Senator, that we ought to make the VA system marketable, like you said, but when you—yes?

Mr. ROWLAND. Senator Rockefeller, what is your time schedule right now?

Senator ROCKEFELLER. I'd be perfectly happy to complete what I hope this will be, a short polemic exchange.

Mr. BUYER. Is it, Senator, that yes, we can keep the VA marketplace but within a certain range of services? And that's the point that I wanted to make to you, and I'm anxious to hear what your response is, sir.

Senator ROCKEFELLER. And the point that I want to make to you, sir, is that I hope that both of you gentlemen put the same enthusiasm as you fashioned on one word in my testimony to all of the other words in my testimony, which have a great deal to do with very difficult decisionmaking and being willing to make those hard decisions, and whether it means that we are afraid or not afraid to make the VA systems competitive with non-VA hospitals.

The gentleman on my right here indicated that some studies showed that a lot of veterans would be leaving the VA system to go to non-VA hospitals. I don't want to see that happen.

That's what happened in Canada. And I'm sure the two gentlemen on this side of the aisle don't want to see that happen. Now, the only way that's not going to happen is if we make sure that VA hospitals have the services, the broad array of services, and have the atmosphere and the ambience that veterans can find in other forums.

If they're going to go to other forums, we will replicate Canada. And I'm quite sure the two gentlemen don't want to see that happen. I know the veterans don't want to see that happen.

Mr. BUYER. Good point.

Mr. SMITH. What services are you talking about? It's my view that the VA system, while not absolutely efficient in providing everything that everybody wants, has been fulfilling the mandate, particularly of our service-connected disabled veterans.

Senator ROCKEFELLER. Well, I suggest to the good gentleman that there are a lot more women now in the military. And women get out of the military when they're still at childbearing age. We don't have much ability to provide prenatal care in the VA system.

Women can have babies up until—I don't know what the age is now, Doctor. You do.

Mr. ROWLAND. Around 40, something along that——

Senator ROCKEFELLER. Something of that sort. So somebody who goes in at the age of 18, would be out by the age of 38, let's say.

These are all things that can be worked out and which have to be discussed. I just want to make sure that the VA system doesn't collapse and doesn't go the way that it did in Canada.

Mr. SMITH. That's precisely our problem, sir.

Senator ROCKEFELLER. And that's what the gentlemen in the Army are worried about, too.

Mr. ROWLAND. Senator, I want to thank you very much for being here this morning and for the very insightful testimony that you gave. You certainly took a lot of time to come here. We appreciate it very much.

Senator ROCKEFELLER. Mr. Chairman, I'm honored to appear before your committee. And as we go forward in this, I look forward to working with you. And I would repeat what has been said, that we should do so on a bipartisan basis.

One of the things that I feel good about is that my instincts in carrying out legislation are bipartisan, and I know that Chairman Montgomery's instincts are that way. So I feel pretty good about the future.

Mr. ROWLAND. Thank you very much.

Mr. ROWLAND. Members will be recognized in order of seniority if they were here at the time of the gavel, then as they appeared. Chris?

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

I'd like to ask our panel if they could comment on the concern that I think we all have, and that last exchange probably highlighted it a bit, that some of the veterans might exit the VA health care system. How can we proactively prevent that from happening as we go through this process?

Mr. CULLINAN. Mr. Chairman, I'll start with that. We believe—I'll just start with a general assertion. We believe that the VA should be able to compete very effectively. Given certain changes

in law, VA will be a highly competitive health care resource, especially in its earliest manifestations.

As I now understand it, the managed health care model will be a long time coming before it could even care for indigent veterans. A report was issued this morning, I believe, out of the White House that it will be 7 years before indigent people, period, will be properly accommodated under this new model.

That means even if managed health care, national health care reform, becomes a reality tomorrow, VA is still going to be caring for the same indigent veterans that it is today.

Additionally, we see an evolution taking place in VA health care. As VA is opened up to all veterans, we see a natural tendency, a natural evolution, as it were, toward bringing other individuals, the family of veterans.

This is almost an inevitability, of course, if VA is to become the provider of choice for America's veterans that eventually once all veterans are accommodated, their families have to be accommodated as well. When you subscribe to an insurance, health care insurance, program, you don't do it just for yourself. In most cases it's your family.

So we think that VA should have certain advantages if properly managed in the early stage to attract veterans and that the indigent veterans that it now cares for will tend to stay with VA as it becomes a better and better quality health care provider.

Mr. GORMAN. If I may, Mr. Smith, I think, number one, the VA is right now really what national health care envisions. And that is the kind of patients the VA treats, the quality they treat them with, and the cost-effective manner in which they're treated, and the continuum of care they're provided in certain instances once eligibility is made. So, with that said, the VA really serves as a model in that respect.

Another thing that is the way veterans think when they go to a VA hospital, for many, many veterans, the only thing remaining as a reminder to them of their military service is the VA, and specifically a VA medical facility.

They get a check from the VA, but that's not really tangible to a lot of veterans. A VA hospital that they can see and visit and go to and mingle and interact with their comrades is. A lot of veterans, I think, for that very reason, continue to go back to VA facilities.

Also within the VA there's this concern, I think, in national health care that if you leave your job and you become uninsured, you can't get insured somewhere else, the portability that I think Mr. Mansfield mentioned.

With veterans, once you get into the VA system, you can certainly be portable and partake of those services throughout the system. If you enroll in Boston and are moved to California, you're still within that system. You should be entitled to benefits.

The last point I would make as far as why veterans would stay, if you open the system up and once you're in, you provide the kind of care and services that are medically indicated, then that package of benefits ranging really from A to Z is, in my opinion, going to far outstrip the package of benefits that any national health care reform is going to be able to offer.

So, for that reason, I think that there's an incentive for veterans to stay in the system and to come to the system.

Mr. HANSON. Congressman, the American Legion thinks people will stay in the system, too, although there may be some people leaving the system, especially if getting to a VA hospital is hard to do. If they live in a remote area, it's difficult to get to a VA hospital.

We're convinced that if VA is permitted to compete and deliver services that we're confident that it can deliver, that veterans will stay and more veterans will come.

Our concern, obviously, is that veterans are served as the primary audience and that attention is paid to the quality of care that's delivered. If it's there, we think that the veterans will continue to call on VA.

Mr. MANSFIELD. I think the answer is partly recognizing what we have now that will be carried over into whatever we're going to carry it over in. And part of that is the VA actually operates now as a quasi-HMO.

The other factor is that it has traditionally for a number of years operated under budget constraints. The VA is operating with some of the features that are going to be necessary in whatever the new system is.

I think the items we indicated in our testimony: entitlement reform, which will lead to a more modern practice of medicine; the full continuum of care, preventative, acute, sustaining, long-term, being provided; and then adequate budget resources with direct appropriations or third party fees remaining for use in the system, combined with the fact that the VA has specialized medicine that many veterans need; i.e., spinal cord injury, blind rehab, provision of prosthetics and orthotics, geriatric care, or psychological care, indicates that the VA can be a player.

One factor that has to be recognized—and this came up at the White House meeting—was with the recognition that the VA is and will be a national system, we also have to recognize it is not and will not be a universal system; i.e., it will not be able to directly provide every veteran in every place in this country direct care in a VA facility because there aren't enough of them and there are more veterans. There are other methods of doing that; i.e., fee basis or sharing agreements, that need to be pursued.

So PVA looks at some loss, perhaps some gains. But the VA we believe is poised to be competitive in whatever new system we get.

Mr. SMITH. Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you, Mr. Smith.

Mr. Hutchinson.

Mr. HUTCHINSON. Thank you, Mr. Chairman. And thank you, the panel, for your presentation today.

Let me preface my question by saying I very much want the VA system to survive. And I am fully committed to that. I am much more skeptical than you gentlemen have been today concerning its ability to compete with the private sector health care system if a private health care system survives the reform.

Even if you market, as the Senator suggested, even if you expand services, as the Senator suggested, you cannot legislate user-friendliness. You cannot legislate ambience.

And I'm wondering if there is any historic example that any of you could give me of where a Government-operated system competed with a private system and the public chose the Government-operated system.

Mr. GORMAN. Let me try to respond to that. No, I can't answer that question because I don't think, number one, the Government, for a lot of different reasons, actually and literally competes with the private sector.

Mr. HUTCHINSON. Isn't that what's envisioned? Isn't that exactly what we're talking about in the concern about many people leaving the VA system?

Mr. GORMAN. I think what you may be talking about in the future is that's correct. But I think to answer your question of a known instance of where that has happened, my answer to your question is I don't know of one, but I would like to respond to what I do know about.

That is just last month I visited the Baltimore VA medical facility, new, opened probably to patients in January of this year. I would challenge anyone to find a medical facility in this country and perhaps in the world that's as well-equipped to take care of patients as that facility is.

When a veteran walks through the door of that facility, he or she is greeted by a veterans' greeter. It's an employee of that facility that tries to do what you talk about to be user-friendly, steers them to where they have to go and directs them to where they have to go for the services they need.

When that facility opened and moved from the location in the outskirts of the city limits, the borders of the city limits downtown, their veteran patient workload has increased beyond their expectations.

Why is that? Why? Because the facility is where veterans are. It's a new facility. It's equipped. It's staffed, as it should be staffed, to take care of veterans.

It's not fighting for dollars. It's not scraping for dollars. It's not having to make decisions, "We either provide this, this, or this, but we can't provide two of those three things."

So if you use Baltimore as an example—and that's the example I'm using—plus the fact that it has a concrete bridge that links it to the University of Maryland Medical School, the exchange with that affiliation is rich.

It benefits both the affiliation and the veteran patients, more importantly. So I would challenge anybody to find a facility that provides better care to veterans than that Baltimore facility, principally because it doesn't operate under those kinds of restraints that we all know the VA system operates under and has been for years.

So that's the level playing field, I think, that I refer to anyway when I discuss this issue.

Mr. HUTCHINSON. Because I'm running short on time, let me kind of add to that to follow up. We're talking about the level playing field. What services do the VA hospitals have to provide in order to compete?

I mean, the Senator was talking about prenatal care. Where do you see it?

Mr. CULLINAN. At this point in time in order to compete we're competing for universal coverage. We're going to have to provide everything that's required by the veteran patients, albeit at this point in time there aren't many women in the system. But the women are coming.

As we see it, the VA health care system is going to evolve into something more, into a comprehensive system that has to deal not only with the veteran patient, but with the family of the veteran patient and so on.

Therefore, they're going to have to provide every service which is provided by other HMOs in addition to those specialized services that they're now providing.

I'd like to add one other thing here. I think with respect to competition, I think in the sense that you mean, you would have to say that VA is already in competition with the private sector, albeit for groups of people who are really very well accommodated by the private sector; the indigent veteran, for example.

Mr. HUTCHINSON. But you don't have universal coverage now. So it's not——

Mr. CULLINAN. No. I'm just saying that there is a form of competition going on right now. It's lopsided because there's nobody else to fill the vacuum that's in the private sector side as far as the indigent veteran is concerned, medically indigent veteran.

Mr. HUTCHINSON. One last question, Mr. Cullinan or Mr. Gorman. I think you both referred to the need for eligibility reform, the urgent need for that. Secretary Brown has stated that eligibility reform should only proceed after the unveiling of the Clinton health plan.

Assuming that the legislative course for such sweeping reformation is going to be long and arduous,—if there's one thing I've seen up here, it is a long legislative process—do you believe it's wise to delay VA eligibility reform while we wait on the overall health care reform?

Mr. GORMAN. I think that if you refer to the release of the plan, which should be coming in early May or maybe late May, I don't see it necessarily a problem.

I would make the point, though, that absent national health care reform, the VA still has a problem. They're in crisis. They need to move forward. I think the purpose of this hearing is to gain further information toward that end.

The VA can't, I believe, wait for the national health care reform to click in and to take hold. Rather, we need to see where that's coming out, where veterans are affected.

But the VA has to move forward with reform in and of itself and can't wait, can't just sit back and as a reason for not doing something wait for health care reform in general to occur.

Mr. HUTCHINSON. Thank you. Thank you, Mr. Chairman.

Mr. ROWLAND. If you have additional questions, we'll have another round.

Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

I would preface my question by saying that I think there are some people who probably don't realize the inevitability of health care reform, that there is going to be a bold and comprehensive

change of the American health care system. It's not a matter of if it's going to happen. It's when and how it's going to happen.

And, as it happens, I think the uninsured over 7 years are likely to be phased in for coverage in the universal system. And if we wait 7 years before we decide to change the VA medical system, the VA medical system will probably represent about half of what it does today. A number of hospitals will have been closed and many other facilities eliminated if we indeed wait that long.

If we're ever going to balance this federal budget, if we're ever going to make this country competitive, we will need comprehensive medical reform.

As we see this reform take place, and in order to make sure that we have that kind of competitive VA system, that enables veterans and their dependents to enroll into the VA system for coverage as a part of a comprehensive system—and I'm presuming that we're talking about all veterans being eligible for enrollment in this particular plan—that I would like to hear a response as to how you would envision these plans as they develop.

Would you envision that they would be essentially a staff model HMO in the concept that exists presently in this country, as defined in statute even, as to what do HMO services have to represent, the benefits that would be part of a comprehensive reformed American health care system?

Would you see the VA system, then, evolving into an HMO and offering comprehensive services along those lines in order to essentially be able to continue?

I might add, too, that if we are going to keep the VA system alive and well, particularly for those services that are particularly unique to veterans, it is absolutely paramount that they be able to attract patients and be able to continue to operate and have those facilities providing comprehensive care.

Otherwise they're down to just those critical services, rehabilitative and orthopedic, and so forth, that are very unique to military and veteran-type needs.

How would you respond in seeing that comprehensive system? Would it be along those lines of a staff model HMO that would be soliciting, as Senator Rockefeller said, enrollment of veterans, all veterans, as we see the uninsured being rolled into a national system?

Mr. MANSFIELD. If I could respond, I think part of the problem we're dealing with here is we're talking about what, in effect, are unknowns and we're making assumptions.

So the answer would be in my mind yes if the basic package of benefits is what we think it might be and defined in the testimony and then in the competitive model we're placing the VA in competition with what are 50 or more AHPs, if the VA model then has, in addition to whatever the basic package is across the board for everybody, again the emphasis on the special needs for veterans; i.e., in my case spinal cord injury care, blind rehab, prosthetics, geriatrics, those areas where it specializes.

So I think generally it's based upon the idea that we are making a lot of assumptions here. Yes. And, as I say, it, in effect, operates that way right now.

Mr. KREIDLER. Would you see it perhaps as the health maintenance organization, but augmented by these special services, spinal cord or rehabilitative services and others, where VA has been identified as services are unique; in fact, in the leadership, that those would be augmentations that would be available to make sure that veterans would still have those services, but then, in addition to that, there would be this health maintenance organization that would take care of what would be considered the usual and customary type of medical services?

Mr. MANSFIELD. I think that's what I was trying to say in the concept of defining a level playing field for a VA system. That part of the definition is the basic package, whatever that gets defined as, and then those special unique features that are currently a part of the VA system and are needed services for veterans. I answer with that as a given.

Mr. HANSON. I would like to make a point here, and I don't know that any of us is going to get to making this point yet, but we're not new to these thoughts.

The PVA Strategy 2000 is a piece of work that didn't just happen overnight. The Legion, the VFW, and the DAV had been working on this general question for almost 2 or 4 years now.

And we did it because we saw a continuing constriction of care offered to veterans within the VA system. And on top of that, we saw moves preceding this administration to move toward some sort of national health care plan.

We don't know what plan that would take, but we were concerned that if things didn't change inside VA, that the presence of a national health care plan, regardless of whether it addressed VA or not,—and most of them did fairly negatively—we knew the VA would suffer.

So we tried to come up in our own way, and everybody can speak to their own ways. We tried to come up in our own way with a scheme that would return VA to a primary deliverer of health care to veterans, recognizing that the population of veterans has changed in this country, and to take the shackles off of VA in its attempt to try to deliver health care.

And those shackles are substantial. They have been for the last 6 or 7 years. Rather than seeing VA expand its care, we've seen what happens when health care and health care management are driven by money, rather than need.

So that is really what drove, I think, most of our concerns here. We want to make absolutely sure that the VA system flourishes. That's clear from our statements there today, I think, but we also think that it can't flourish, it can't succeed, and it can't survive unless a full continuum of care, whatever that happens to mean, is offered to veterans who go to VA for care and not just say "If you're 30 percent service-connected, we will treat that service-connected disability, but you'll pay us for this or you'll pay us for that."

We've made VA health care a near impossibility to deliver for the people responsible for doing it. That is something that we have to get away from or we're going to have to give the system up.

Mr. ROWLAND. Thank you.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

I suppose my question is a follow-up to the gentleman's last couple of questions. It's really a generic one. Mr. Hanson, you have addressed it somewhat.

I am clearly for keeping veterans' health care separate, no question about that. I think all are in this room. But I think we support it because we also have reasons for it, not because this is what we prefer, not because it might justify our existence.

It certainly would justify the existence, continuing existence, of this particular subcommittee, which is a Hospitals and Health Care Subcommittee. And if a veteran's health care is no longer independent and separate and becomes a part of the overall picture, I'm not sure of the role of this subcommittee, Mr. Chairman. You're liable to have a very short chairmanship.

Obviously we don't want to oppose that taking place for all of the reasons I mentioned. We want to oppose it for good reasons, for the right reasons. And maybe the response is too detailed to be done here in the 2 or 3 minutes that might be left after I ask my very long-winded question.

Really, the concern is and should be what will happen to the quality of veterans' health care, if you will, if, in fact, we lose our independence and the VA becomes a part of the overall picture.

It's critical, and I hope that has been conveyed to the Administration. I hope it's been conveyed to the various task forces and groups up here. I don't know that you've been given your day in court to explain that among a lot of these task forces and groups.

Dennis, you look like you're chomping at the bit there. And I might add that, again, in the limited period of time, you may not be able to answer it adequately, but I think it's critical. And personally I think you ought to be submitting anything to the record that might supplement any oral remarks you might make here today. Yes, sir?

Mr. CULLINAN. Thank you, Mr. Bilirakis. I didn't mean to quite chomp, but it is a very important question. The VFW would not want to see the VA health care system evolve into just another HMO. Its primary concern has to remain health care for America's veterans with a special emphasis on the service-connected, indigent, and so forth.

VA has a very special mission, and it should remain so. But in its capacity as it grows into a more comprehensive health care provider, it will be providing other services to individuals outside of the direct veteran community that are equivalent to what are provided by an HMO.

We think most certainly in the earliest stages, the benefit package the health care package that VA should be able to offer will far surpass what any other HMO out there can offer at this point in time, but, first of all, the mission has to remain veterans; secondly, in accommodating the family of veterans, but we would never want to see the VA, so to speak, HMO mission subordinate its primary concern, caring for veterans.

Mr. GORMAN. If I could, Mr. Bilirakis?

Mr. BILIRAKIS. Sure, Mr. Gorman.

Mr. GORMAN. I know I wouldn't want to sit before this subcommittee or anybody else and try to defend a system that I don't truly believe is defensible, nor would I try to defend a system that

doesn't provide quality health care to its patients. I believe the VA does that.

I'm not exactly sure what a staff model HMO is. I receive all my care at the VA medical facility, and I can talk to that. But I think what we're all talking about, together with the Legion, VFW, and DAV—and we all have our plans, and the PVA has done theirs. The independent budget has done theirs. The Mission Commission has met and reported to the Secretary.

I think what we're all talking about is a change to the VA from the traditional way we've always viewed it. If they continue down the same path they always have and if people advocate that they do that, then the system will wither on the vine and die, I believe. It's got to change, and it's got to change in all VA hospitals.

For example, the Tampa facility can't continue to try to do all things for all veterans. They're going to have to network within maybe the State of Florida, with Gainesville, with St. Petersburg, where each of them will have defined specific missions and resources, both human and otherwise, to carry out those missions.

That is maybe parallel to an HMO model within the VA, but the VA, from what I understand, has functioned from an HMO model.

Mr. BILIRAKIS. Yes, certainly.

Mr. GORMAN. And they can provide all services, but they can't provide them in all places to all veterans. But they can do what they're challenged to do very, very well once they are challenged to do that and given the guidance and the resources to do it.

Mr. BILIRAKIS. My time is just about up, but I guess what I am really saying here, is that if I were on a panel having to make these decisions and was concerned, of course, with the problems of efficiency and quality and all of these things and if I weren't already biased towards retaining an independent veteran system, but if I were completely open-minded, I would want to hear reasons why VA should not be a part of the overall picture.

Are there people on that panel who might be thinking that way now? I don't know. The chairman may know. But I guess what I'm saying is that, if I were in your position I would have that in mind.

That should be your pitch, I think, more than anything else, and especially other than "Well, it's always been separate, and we want it to remain separate." Do you see my point?

Mr. GORMAN. Yes.

Mr. MANSFIELD. I think as a response, maybe I can make this point as—and I thought I did it before. Our understanding and where we're coming from as the base for testifying is that VA is going to remain a national independent system with a mission for caring for veterans.

Mr. BILIRAKIS. Yes, sir. And we're holding this hearing on that premise. And we're talking about eligibility reform on that premise. And we're talking about all of the other things that are needed to help veterans on that premise.

But, darn it, if it doesn't come to pass, if these promises and assurances that we hear, for some reason or another, don't come to pass, all of this will have been almost work down the drain, I suppose, Mr. Chairman.

I don't want to belabor this, although I think it's generically a very, very significant point. Frankly, I think that's the way we ought to approach it.

Mr. ROWLAND. It is a very significant point. I appreciate your addressing that particular point.

Mr. Gutierrez.

Mr. GUTIERREZ. Thank you, Mr. Chairman. I want to thank you for drawing attention to the urgent matter at hand today and to tell you that thousands of veterans every day count on the VA hospitals and at Hines and Lakeside becomes part of their daily schedule for many of them. And so the work we have here today has a huge impact on them.

I want to tell you that I'm delighted to hear that there are going to be some changes in the facilities at San Juan, Puerto Rico as we all know that veterans there have been under-served and that there are great deficiencies in that facility I'm happy to see that there are steps being taken to rectify.

I would like to say that I appreciate the opportunity to serve on this committee with you precisely because we're going to be going through this process of health care reform.

And I'm happy to hear that the veterans hospitals are looking and that people are talking about ways to look at how veterans hospitals grow and develop and look at how they're going to begin to accommodate the families, understanding that the primary concern of any veteran hospital would be veterans.

Let me suggest that in today and probably in the past as more and more women join the military and, indeed, leave the military, it is women who make, by and large, the primary decisions of who in their families and where in their families they're going to receive health care.

So if the VA is to compete in the future, women are going to want to send their children there if it's going to expand to the children of veterans and women are leaving the military and are going to make decisions as veterans of the military, it had better be user-friendly and it had better accommodate the needs of families if that's what we're going to do and make it competitive.

I don't know where we're going. We know we want to guarantee a system that makes sure that veterans hospitals are competitive and continue to primarily live up to the concerns of veterans.

I want to ask just one question, and it's to Mr. Mansfield. There is one passage that I found particularly interesting in the written testimony that you gave. You speak about the need for entitlement reform and refer to the convoluted and limiting modalities.

You call them statutory constraints that restrict what types and levels of care a doctor can give to a veteran. You say that a physician is denied the opportunity to practice contemporary medicine in an ethical manner.

I found the reference to ethics very powerful. Would you care to expand on that point? And should we use ethics more often when we're talking about health care reform in more general? And in reference to the VA, would a discussion of ethics help us in our effort to convince others of the need for entitlement reform?

Mr. MANSFIELD. To attempt to answer what I think is a three-part question, first of all, the reference is to the mandated system

that says the person going in the door is qualified for certain care, depending on, for example, a service connection for a specific medical condition in a situation where that patient comes in the door.

And in the VA system, the doctor will probably figure out what is the basis for treating this person and what part of this person's treatment can we actually provide under the laws that we have.

In other words, to simplify it, they can't treat the whole person. What we're saying is to get into modern medicine and the provision of modern medicine, you have to move toward the treatment of the whole person.

The other part of that, too, is with the convoluted system we have, one might be treated on an outpatient basis in another facility, may have to be treated on an inpatient basis in a VA facility.

It's evolved over a long period of time and based on the statutory requirements and the regulatory follow-up. We're saying if you're moving into a new world, then let's move into the real world. That's one part.

The second part is what we've outlined here. The answer to that is what we've all said, which is provide entitlement to service-connected veterans, to poor veterans, and catastrophically disabled veterans, and then, say, provide those individuals the opportunity to have the full continuum of care, preventative care, acute care, prosthetic care, long-term care.

If you do that, I think you have solved the third part, and I think the answer should be obvious that there has to be an ethical consideration given to this. We feel that if you do that, if you make those changes, then the ethical considerations will follow.

I hope that answers the question.

Mr. GUTIERREZ. Thank you.

Mr. ROWLAND. Thank you very much. I want to thank the panel. There will be some additional questions, but we will submit them for the record. Thank you very much for being here this morning.

Mr. ROWLAND. Our second panel is Mr. Michael Brinck, who is accompanied. He's director of the veteran service/legislation, AMVETS, accompanied by Mr. Noel Woosley, national service director; Mr. Paul Egan, who is the Executive Director of Vietnam Veterans of America; Mr. Tom Miller, director of governmental and community relations of Blinded Veterans Association; and Mr. Charles Williams, executive director, American Ex-Prisoners of War.

Mr. GUTIERREZ (presiding). Thank you very much for being here this morning with us. Mr. Brinck, if you would care to begin?

## STATEMENTS OF MICHAEL BRINCK, DIRECTOR OF VETERANS SERVICE/LEGISLATION, AMVETS, ACCOMPANIED BY NOEL WOOSLEY, NATIONAL SERVICE DIRECTOR; PAUL EGAN, EXECUTIVE DIRECTOR, VIETNAM VETERANS OF AMERICA; TOM MILLER, DIRECTOR, GOVERNMENTAL AND COMMUNITY RELATIONS, BLINDED VETERANS ASSOCIATION; AND CHARLES WILLIAMS, EXECUTIVE DIRECTOR, AMERICAN EX-PRISONERS OF WAR

### STATEMENT OF MICHAEL BRINCK

Mr. BRINCK. Thank you very much, Mr. Chairman, members of the committee. AMVETS very much would like to thank you for holding what we feel is a hearing on the keystone of VA benefits.

Today we would like to discuss some broad policy implications for veterans' health care in the coming national health care reform. Obviously, the details of the interface between VA and the national health system will depend largely on the final design of the larger national system, but there are certain principles upon which veterans' health care must be founded.

The first is that of fairness. Those now entitled to receive free health care, formerly known as the Category A veterans, should continue to receive free health care at no cost. Under the entitlement reform, the Fiscal Year 1994 independent budget for VA details expanded the core group of entitled veterans as those currently in Category A, the veterans who are uninsurable, and catastrophically injured.

The second principle is that of priority and/or preferential access to health care. This can be defined as direct access to a veteran-unique treatment system, such as partially accomplished by the current VA health care system, or favorable tax or premium rates available only to veterans.

President Clinton has stated on many occasions that he favors a national system based on managed competition. Therefore, we would like to discuss how VA might play a part in a nominal national managed competition system.

One option would be to offer all veterans an opportunity to join a veterans-only group, for whom the Federal Government would be the contractor for coverage.

Those who now receive free care would be covered at no charge. The balance of the veterans community, generally the non-service connected veterans, would pay rates subsidized by the Government to offer low-cost premiums for those choosing to participate.

To comply with the first two principles, the basic package of benefits for all veterans should exceed that offered to the general public and should include long-term care.

We do not see the VA system as static. There is no magic in the number 171. Maybe the right number at some point is 200, maybe 135. As the veterans population changes, we support mission changes at existing facilities, regional centers of excellence, relocation of existing facilities, or acquisition of new units, and increased sharing of resources.

The efficiencies of the regional system should, in turn, provide savings that will enable VA to service a larger number of veterans, but to make the regional concept work, each medical center, sat-

ellite clinics, and private sector providers should coordinate referrals within the VA system.

VA should also expand the role of vet centers as independent community-based centers for preventive medicine and basic outreach services. And it is time to revitalize the vet centers to serve a larger portion of the veteran population.

Change has many implications. VA must provide a full continuum of care on a regional basis and locally where appropriate. For their part, veterans must be willing to access acute care at facilities that may not be near their homes, assuming the VA picks up the transportation costs. Congress must resist the political pressures to retain home district facilities when the facts do not support continuation of the status quo.

The medical establishment, for its part, must adapt to the change by refocusing its teaching hospitals towards preventive care, gerontology, and other areas that will be in high demand.

The third principle is that of quality. Quality medical care is that which provides timely access, competent treatment, and reasonable surroundings at an acceptable cost.

Today VA falls short in timely access in two categories: the excruciatingly long adjudication process and the often long waits for appointments. But AMVETS wants to go on record that, on the whole, we consider VA treatment at least on a par with that available in the private sector. And in many specialties, VA sets the standard of excellence for the rest of the medical community throughout the country.

Are there instances of mistreatment and neglect? Sure. But the compassion and technically excellent treatment given to the vast majority of veterans is absolutely undeniable.

Obviously, the policies adopted under national health care will impact on construction requirements. But assuming an integrated national network composed of private, local public, and federal health facilities that is needs-based in its implementation, some new facilities will undoubtedly be needed.

AMVETS totally supports the policies of enhanced use and short-term leasing as viable alternatives to new major construction where appropriate. At a time when change may become the order of the day, such policies will enable VA to continue to offer an expanding range of services through sharing with the community and region while retaining its independence as a veterans' asset.

Mr. Chairman, that concludes the statement.

[The prepared statement of Mr. Brinck appears on p. 104.]

Mr. GUTIERREZ (presiding). Thank you very much, Mr. Brinck.

Mr. Egan.

## STATEMENT OF PAUL EGAN

Mr. EGAN. Thank you very much. I'd like to begin, Mr. Gutierrez, members of the committee, by saying how really very excited we are about the challenges, about the opportunities posed by a debate on national health because the opportunities permit a cleaning of the slate, wiping away of the dust, removing of the blinders, an opportunity to look at VA health care realistically.

My organization has said for years that the most important element of the VA health care system is the veteran user, more so than the brick and the mortar that constitute the system.

And here we are on the brink, poised to debate national health insurance. And, sure enough, the biggest challenge to VA health care is: What decision will veteran users of the system today make in tomorrow's national health environment?

The GAO says that as many as 50 percent of the current users will decide not to use VA. The Paralyzed Veterans of America in their outstanding work, "Strategy 2000," comes in with an estimate a bit lower than that.

But the fact is that for the very first time, veteran users are the engine that has to pull the system. And if we don't address ourselves to the importance of what decisions those users are going to make, whoever they may be, whether they're current users or future populations of veterans of varying degree or different kinds of disability, it's what those veterans decide that will determine the outcome of this entire debate on VA health care.

As we see it, there are five fundamental themes that are emergent in this debate. They all need to be carefully weighed, and they all need to be accurately addressed.

The first of those is finding—and these are not necessarily in order of importance. The first is to find a way to address the health care needs of rural Americans, veterans and nonveterans alike—and I'm not suggesting that nonveterans ought to be able to access the VA, but certainly rural veterans and nonveterans are currently under-served and need to be served; if they're going to get the benefit of modern medicine that is primary in preventive care, they've got to be served by both VA and a national health system—and what role VA might play in meeting those rural health needs is important to consider.

The second theme is finding a definition of quality that equally balances the biases and preferences of all those entities that have a stake in VA health care.

We bandy around the word "quality" pretty easily and perhaps too easily, but the fact is quality means something different to teaching affiliations than it does to veterans, just as it means something different for researchers than it does for teaching affiliations. It means something different for hospital administrators.

With the decisions of the veterans being so important in this debate, we need to arrive at a definition of quality that VA can meet that finds its basis in the preferences of users.

That's not currently the case today. Outcomes as a measure of quality are certainly important, but what comes from the point of contact with the institution to getting out of that institution with ultimately a successful remedy to whatever the medical episode was is just as important as the outcome, at least as important in the decisions that these veterans are going to make.

The third theme is identifying the most likely factors governing who will elect to use the VA in a national health environment in order to avoid wasting scarce resources on VA's health infrastructure based on erroneous assumptions of who will use this system.

We say that this is going to be an independent system, continue to be an independent system, providing care for veterans. But it's

important to understand which veterans this system is going to take care of.

Maybe it's going to be all veterans. If that's the case, it's going to have to be a competitive system. It's going to have to be able to provide the same quality that veterans believe is available from non-VA providers. It means that accessibility is going to have to be addressed in some fashion or other.

The fourth theme is identifying the specific investments that must be made in VA in order to make it attractive to current and new populations of users if it is decided that VA can or even should compete with non-VA providers for clients in a national health environment.

And finally, and certainly not least in importance,—and this has been a serious problem over many years—is reaching a long-term consensus in the Congress that can be relied upon to yield the resources necessary to maintain VA's viability as a health provider equal to its mission, whatever that mission you decide it to be.

We have said in the past that veterans, certainly the service-disabled veterans, ought to be permitted to exercise choice in whether to use the VA or the private sector for their health care.

And I think that the importance of this debate now in the emergence of national health has created an environment where that suddenly is, first and foremost, something that has to be dealt with because veterans, at least as I see it, are going to be given just that choice.

And how we prepare the VA to make itself attractive to these veterans is probably the most important consideration that you as the board of directors of VA health care can possibly make.

[The prepared statement of Mr. Egan appears on p. 109.]

Mr. ROWLAND. Thank you very much, Mr. Egan.

Mr. Williams.

## STATEMENT OF CHARLES WILLIAMS

Mr. WILLIAMS. Thank you, Mr. Chairman, members of the subcommittee. Thank you for the opportunity to present the views of the American Ex-Prisoners of War on the role the VA health care plan should play as part of the current efforts to improve health care services for all Americans.

First and foremost, we want to make clear that we are pleased with the interest being shown in this subject. The American Ex-Prisoners of War believe strongly that some form of national health care is a must for our Nation and that the Department of Veterans Affairs has a longstanding obligation for health care to the veterans of this country.

We believe the Department of Veterans Affairs is the vehicle that must continue to provide health care for all veterans. The Department of Veterans Affairs must be a separate but official part of any health care system.

We recognize the disastrous consequences a major or prolonged health problem can have on any family lacking the personal resources or insurance required to provide proper care, and we recognize that too many American families are in this vulnerable position. We applaud the determination of Congress and the White

House to develop a solution to more effectively serve all Americans in this vital role.

We affirm our Nation's promise to provide priority services to veterans who became disabled while serving their country and have individually been determined to have such disabilities. Yet, we believe Congress has erred in assigning former prisoners of war a lower priority.

The starvation and inhumane treatment accorded POWs, wherever they were held, has resulted in a significant disease burden in later life for this small but unique group of veterans.

The absence of adequate records concerning the capture or interment, together with the lack of medical knowledge as to the specific causal relationship of the extreme depredation to specific medical conditions, has limited VA's ability to formally service-connect them. Assuring POWs full access to the health care system is a reasonable and proper way to at least partially correct the deficiency.

The bottom line in the VA health care system is a crucial and effective part of our Nation's total health care services. It does not deserve the image of an insulated system that is outside the mainstream of American medicine. Instead, it has played a leadership role as a model of an effective health care delivery system and can continue to fulfill its essential mission.

We understand the expanding budget deficit that Congress continues to struggle with is the root cause. Nevertheless, it would be wholly counterproductive to the present efforts to improve the quality and accessibility of a national health care system and continue to under-fund the VA health care system. It is essential to strengthen it before further erosion occurs.

The concept of core-entitled veterans who would have full access to the VA health care system has our support. Yet, the proposed Americans' Veterans' Health Care Act of 1992 makes no mention of combat veterans who risked their lives for their country and have earned a greater right to VA health care than other eligible non-core veterans. Some provision according them a higher priority is fully warranted.

It is critical to recognize that VA's potential scope of responsibility extends to nearly one-seventh of the total population. It is and should be considered a major player in the overall health care services of this Nation.

Although the primary burden of the VA health care system has been to serve veterans disabled as a consequence of their military service, that responsibility has also extended to provide needed services to other veterans, including the homeless, who are unable to defer the cost of that care.

On doing so, the VA has traditionally lessened the burden that would otherwise have fallen on community, state, or other federal resources. It also provides services to active military personnel in accordance with cooperative policies developed with the Army, Navy, and Air Force.

It is important to recognize that VA has contributed generously to the availability of well-qualified health care professionals in its role as the foremost trainer of the professionals since World War II.

Included in this significant training mission has been physicians, dentists, nurses, psychologists, social workers, and virtually all categories of health care personnel.

This commitment has involved not only developing large numbers of health care providers for services outside the VA, but also developed proper standards for many of those providers.

Long-term care is an item where our country has always been deficient and must now be addressed. It is not proper for a veteran to become destitute in his final days and die without proper care. All veterans should be allowed to die with dignity.

We believe that as our veterans age, alternatives must be explored. Needs change as we move into the nursing home age. Proposed legislation should be expanded to include proposed alternatives to nursing home care be used as a guide.

Mr. ROWLAND. Mr. Williams, are you near the end of your statement?

Mr. WILLIAMS. No. I have some more, but we'll——

Mr. ROWLAND. Could I ask you to summarize, if you will?

Mr. WILLIAMS. Sure. I think what we're saying is that the VA must relate very closely with any national health care plan. Yet, it must be a separate entity into itself with the purpose of serving the veterans of this country and only the veterans of this country. I believe that's a necessity.

One of the gentlemen spoke a while ago of some of the problems in the VA, and I will tell you that one of the things that we have noticed most around the country is what the VA refers to as a problem of sensitivity. They've developed two films that they use for sensitizing the members of their organization.

This sensitivity problem is not prevalent within the professional staffs, but it is within the nonprofessional support that the VA have. I think if we have people leaving the VA, as has been suggested, it's going to be because of a result of being turned off by the nonprofessional members of the VA staff and the inability to treat people like human beings.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Williams appears on p. 128.]

Mr. ROWLAND. We've heard that over and over again.

Let me just ask you one question here. Several of you have expressed the belief that the VA can operate successfully in this era of competition, of managed competition, however you want to phrase it. And if you do, are there any specific points of caution that you would want to make about doing that, participating in this kind of a system?

Mr. BRINCK. The country has the duty to take care of the veterans, whether the VA is able to compete on a strictly commercial basis, cost basis, whatever you want to call it, with the private system or whether they can't compete strictly on a cost basis. There is that built-in cost that the country has to be willing to bear, regardless of what the final design of the VA is going to look like.

So I would caution against being counterproductive to the idea of competition by saying that the VA is not treating a broad spectrum as cheaply because a lot of the built-in overhead that the VA has—it was mentioned before, I think, by the PVA representative, the VA does a lot of things that the private systems do not address.

And we have to understand that that's part of the cost of going to war and creating a veterans population and all of the things associated with it.

Mr. EGAN. Mr. Chairman, we spent considerable time in our testimony, in fact, cautioning against competition directly with the VA. And we offer that caution because we know from what the GAO has said and what the Paralyzed Veterans of America have said in Strategy 2000. We know from our own anecdotal experience with our own members. That veterans given a choice will leave the VA for the private sector.

I did a lot of traveling last year. I've gone through this exercise. Everywhere I went, I asked, "All of those of you who are members who are service-disabled veterans, raise your hands." Several would raise their hands.

"Of those of you who are service-disabled, how many use the VA for health care?" A few less raised their hands. "How many of you would opt for another option outside of the VA if you could?" And then everybody raised their hand.

So it's a question of understanding that today the VA can't compete. Something has to be done if it is to be fashioned in a way that it can.

Just a hypothetical example: Let's take two individuals, one in the private sector and one in the VA. Both of them need the same, let's say, nonelective surgical procedure.

The one that's a nonveteran sees his doctor. The doctor makes an appointment for him to be admitted to the hospital in the private sector. That's done, let's say, 2 or 3 days, maybe a week, later.

The individual is admitted to the hospital, immediately, to the room. Whatever testing has to be done is done. He gets into the room, and he uses the phone to call his wife or his family to let them know how things are and settles back and—let's say it's a semi-private room—turns on the TV and waits for things to happen.

In VA the individual is going to see—maybe he's going to see the doc at the VA hospital on time, maybe not. He's probably going to wait for quite a while. As often as not, the doctor is going to say, "Well, you know, we need you to get this surgery, but we'll give you a call in about 6 months, when we've got the room."

Six months later the individual is admitted to the hospital, checked into a room. There is no phone. So he can't call his family. There is no TV. So he can't bide his time.

The tests that are done preliminarily are probably tests that were already done, the same battery of tests, 6 months earlier by a different medical resident that's attending the case.

Those are the differences in quality that the veteran perceives in the difference from what the nonveteran sees. As I said in my oral testimony, it's what happens between the first contact with the institution and the discharge. It's not just the outcome of the medical procedure.

Whether real or imagined, veterans believe that the VA is providing a substandard quality health care product, and there is nothing imagined about the fact that for veterans across this country, access to the VA is inconvenient.

These are serious issues that the VA has got to grapple with. If we are going to have a system in which VA will compete, we have to attend to making sure that the VA gives the veteran just what the individual in the non-VA provider system can expect.

Mr. ROWLAND. We heard the term "user-friendly" here this morning. Now, I didn't hear you say that these veterans did not get the kind of outcome with their procedure that they expected, but what I was hearing you saying is from the time they make the first contact until they finally get that procedure done is where the problem really lies.

Mr. EGAN. There are some of our members whom I've talked to who use the VA regularly because they're depending upon it. And any time they go in for an exam or they need to be reevaluated because of a rating decision where they maintain the same level of disability, they go through the same and sometimes very invasive diagnostic testing procedures every 6 to 12 months. It's as if the previous record never existed. That is inconvenient, and it's not necessary.

Mr. ROWLAND. Thank you very much. I appreciate that.

Mr. Smith.

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

Much of what we've been talking about—and I do appreciate your testimonies very, very much—has been concept. Again, we're dealing with some concepts that nobody knows where or what actual form they're going to take.

We fight for every dollar of funding in this committee and on this full committee every year, and we know that there is an anticipated cost-cutting due to management efficiency reforms or something that will save about a billion dollars, which none of us—I think there is a bipartisan sense—think that we're going to squeeze that money out of.

When we're talking about, on the other hand, in this hearing about competition and enhancing the VA's ability to attract health consumers, has anyone flushed out what the cost might be over the next year, say, if this were to be enacted this year for the next fiscal year or, say, more generally over a 5-year period? What kind of surveillance has been done to ascertain bottom line costs?

Mr. BRINCK. Do you mean under the new eligibility rules that were——

Mr. SMITH. Well, I know you admonished us not to get too much into the competition mode, but if this national health insurance reform is really on a fast track, I, too, believe that, if for no other reason than proximity, some of the veterans who look at a 2-mile distance to their local hospital or a 50-mile trek to their VA hospital might choose the former, rather than the latter.

So how does the VA really enhance its appeal? And what kind of money are we talking about or are we looking at a well-intentioned effort that will ultimately lead to the demise of the VA health care system?

Mr. BRINCK. I couldn't address the cost. We at AMVETS have never developed that. But there will certainly be a natural leveling process under whatever new rules are adopted in conjunction with national health care.

And I'm speaking of health reform, reform within the VA, that will possibly create an entitlement group plus make it easier for those who are not entitled to care to get in.

And I suspect that while VA and GAO have found that people will leave, there will be people who will now show up. Can we predict exactly what that will be? I don't think we——

Mr. SMITH. Mr. Brinck, could you come up with what form that might take—because you did testify that the package would exceed the general public's offering?

Mr. BRINCK. Well, what we were trying to imply there was that the range of services, I think, within the nominal health national plan. For instance, long-term care was not included. We are absolutely convinced that that should be a part of any VA program for the entitled set of veterans, at least.

We could pick nits and grits out of there also, but it comes back to the preferential access. What the bottom line here becomes is that as veterans' organizations, we believe that our constituents deserve and have earned something beyond the ordinary.

And if that is cheaper treatment, if it is free treatment, if it is an expanded range of services in the basic package beyond what nonveterans get, that's appropriate, we believe. And that's what I was trying to get at there.

Mr. SMITH. I appreciate that.

Mr. Egan.

Mr. EGAN. Yes, Mr. Smith. I don't think any of us have a crystal ball to be able to pinpoint the dollars and cents to the nickel. The national health——

Mr. SMITH. How about to the billion?

Mr. EGAN. From our perspective, however, I think it's important to note that if national health reform comes and if, indeed, it genuinely harnesses competitive market forces, there are going to be some rather watershed changes in the way health care is done, both in the public as well as the private sector.

We know that over the last couple of decades there has been a significant increase in the number of doctors per capita in this country. Yet, that has not resulted in any downward pressure on cost. It just means a greater volume of procedures being done.

I think we're going to see a greater reliance on things like the HMOs Mr. Kreidler has discussed. We're going to see a greater reliance on other kinds of providers, like physicians' assistants as well as nurse-practitioners. We're going to see different ways in which hospital units are staffed.

We give an excellent example of one of those operating in a hospital in Baltimore that is a brand new Baltimore hospital in which if you extrapolate the savings in that one unit across 2,000 other hospitals across the country, you would save $5 billion just from the number of reduced days in recovery room.

We're going to see the kind of revolution in health care that we have seen in the economy with a transition from a heavy industrial, manufacturing sector to a service economy if, indeed, competitive forces are harnessed in this program.

Mr. WILLIAMS. I think the original question that started this whole thing off was: Can the VA compete? It's my contention that there is more to competition than dollars and cents.

There's a technical capability, and there is an attitude or a treatment part that goes along with the dollars and cents. If the VA fails to compete from my observations at the moment, it's the problem that I brought up a few minutes ago of attitude within the VA.

We were told nationwide by our people around the country that the technical capabilities appear to be good within the VA. There's no complaint in that particular area.

If, in fact, they do learn to do this on a cost-effective basis—and I have no doubt that they can; I don't think that there's a problem in that basis—we're back to the attitude problem.

And I think that's a major quirk in your competition, not just the dollars and cents. But I think they can compete dollars and centswise. Technically I have no question about it. The other problem is the only area where I see that they have a difficulty.

And I'm not quite sure why that exists. I don't understand them, but they don't seem to have it in the civilian hospitals.

Mr. SMITH. One final brief question. I have others, but I'll submit those for the record. Would placing a health team in the VA's 201 vet centers help facilitate a VA shift to ambulatory care in your view?

Mr. BRINCK. Absolutely.

Mr. EGAN. It might very well. In fact, it kind of raises a question asked the earlier panel by Mr. Hutchinson about providing at least one example where quality is satisfactory in the VA and preferable in the VA to the non-VA providers. And that is the vet center program.

Mr. SMITH. Thank you.

Mr. WILLIAMS. I'm sorry, sir. My hearing is not good enough. I did not get your question.

Mr. SMITH. Putting a health team in the VA's 201 vet centers. Will it help facilitate the shift towards ambulatory care having a health team at a vet center so that certain work can be done prior to going to the VA hospital so that admissions are made much quicker and care is provided on a more expedited basis?

Mr. WILLIAMS. I think your vet centers are a necessary part, and I think that they need to be expanded. The limitation that has been imposed upon them in their use I think is unfair to a large segment of the veteran population. I'm sure that they assist in the areas where they do practice.

Mr. BRINCK. One more thing. The success of the vet centers has been to a great extent due to not only the services that are offered to the Vietnam veterans, but the locations of the centers.

And I think AMVETS would feel that it would be a mistake if the VA tried to draw the vet centers into the locales of the medical centers. That would re-create the problems that they've had in the past that the vet centers were established to cure; that is, to attract those who normally don't like dealing with the Government and providing a small town type of a setting.

Mr. SMITH. I would just say parenthetically I'm working in my own district in the City of Trenton, where there's a very viable vet center with space immediately adjacent to it which would be a turnkey operation for such a health team to come in and help process veterans so that they can again move up to the VA health centers on a more expedited basis. So I thank you for your answers.

Mr. EGAN. The very motto guiding the vet center program goes directly, in summary, to the issue of quality as defined by the veteran, and that motto is "Help Without Hassles."

Mr. ROWLAND. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

This exchange is a perfect illustration, I think, of how we talk about competition. You know, the word "competition" boggles me, I suppose, in the sense that we talk about competing with the private sector.

We should be concerned about having high technology equipment and competing for better quality. And we should also be concerned about competition in those regards, but personally I'm not concerned about competition from the standpoint of convincing a veteran that he should have to drive 50 miles, or whatever the case may be, when, in fact, he may ordinarily choose to go to another hospital.

This is a perfect illustration of us competing in the right way. It's quality. It's accessibility. I know at the Haley Hospital in Tampa, the SCI Center there, Dr. Bernard has a system in place where he has teams set up. Just different colors I believe is the way he reflects them, blue team, et cetera.

And these teams are assigned to certain SCI patients, not only the doctor, but the entire team, the nurses and all of the other supportive personnel. And so they see the same personnel every time they need treatment.

So that takes care of, I think, to a large degree, the one particular program that you mentioned. And I would like to think that maybe that's something that can be expanded in the VA system to some degree.

There are a lot of things that we can do to compete in terms of quality of care, I think, more so than trying to compete for patients, for example trying to get veterans to come to the VA when, in fact, they have been accustomed to going to the private facilities.

I really don't have any questions. It's a great learning experience, Mr. Chairman. I know the hearings sort of drag, but it's a great learning experience hearing from these people. We're gaining an awful lot.

I hope we're not doing it all for naught. I just hope that the VA is going to remain independent, and separate.

And hopefully a lot of these things that we are learning in this process, we'll be able to put into place, rather than be rolled in along with every other man, woman, and child in America.

Thank you, sir.

Mr. ROWLAND. Thank you. It is a learning process——

Mr. BILIRAKIS. It sure is.

Mr. ROWLAND (continuing). And very enlightening, what we have heard here this morning.

Mr. Kreidler.

Mr. KREIDLER. I think there is a concern right now, that has certainly been stated, as to what changes might evolve in health care funding. I would certainly argue that there is in all probability going to be a reallocation of money.

And if we can't do it within the 14 percent of the gross domestic product which goes to health care right now, when our major eco-

nomic competitors in the world are spending something around 8 or 9 percent, something is terribly wrong.

But the VA system would obviously have to have some of the dollars that right now aren't flowing to the VA medical system—Medicaid, Medicare, or some of the other types of reimbursement that might become part of a national health care system.

If, however, that were not to be the case, let's say the VA medical system were not eligible to receive those monies, and if the GAO's numbers proved accurate, and 50 percent of the current recipients of VA medical care were no longer there, what would be left in the way of a VA system, if 50 percent of their funding also went away with half of their patient population at the current time? What kind of threat do you see that then representing to the veterans?

Mr. EGAN. Mr. Kreidler, I think what you've just described is probably an identical scenario to the one that probably took place in Canada when their veteran system completely disappeared.

That is why in our testimony we stress the importance of a floor level of service in health care to veterans, we have got to get serious about identifying the populations of veterans who will be served. Who can be served by the VA better than they can be served in the private sector.

And I'm talking about the spinal cord-injured. I'm talking about the people who need prosthetic research and prosthetics. I'm talking about blinded care programs, geriatric programs, inpatient and outpatient, long-term mental health and substance abuse programs. These are things the VA does better than anybody in the private sector.

And last, but certainly not least, if in the national health program long-term care for the aging is too expensive, VA is going to be a very popular option. These are populations of individuals that can save the system and keep it stable.

We can continue to debate about HMOs and competition and all of the rest, allocations of resources, but if we fail to identify those core populations that guarantee the survival of this system, then we risk the potential of losing the system, in my opinion.

Mr. BRINCK. I'd agree with the remarks about identifying the core population. I think what it boils down to is there's no real argument about the special areas of care.

So we're talking about what we term general medicine, I guess. Are we going to attract those folks who could get their standard general type medical treatment someplace else?

It would seem to me that if the long-term health policy in the United States is to decrease costs and increase the numbers of people who can access treatment, that you're spreading a relatively fixed amount of dollars over more people.

And I don't know how we're going to gain enough efficiencies to make Cadillac kind of treatment available to everybody. So I think that under the coming national health care system, we're probably going to see less quality at high cost.

In terms of competition, the ability of the VA to compete with the private sector will be increased because I suspect that the private sector is going to make a move towards a much more VA-like system and that you're going to have longer waits because there are more people that are going to get treated.

You may not have the fancy waiting rooms and everything that you would normally get in other places because I suspect that things like that may not be financed. I'm talking off the top of my head here, but I think that the VA will be able to compete with the private sector successfully once we understand and once the veteran population understands what the implication of national health care is going to be on the private sector.

We keep focusing on the VA. But let's look at what they're going to be competing with.

Mr. KREIDLER. I take it that no one here is concerned about the Government offering health care services—obviously, the VA system has represented the largest Government-operated health care system in this country today.

Some people would call that socialized medicine, but, in fact, it's been around for a very long time. And I think we all would agree that we want to see that it continues to operate, that having a Government-run health maintenance organization, as it might be called, isn't something that causes anybody from the veterans' organizations anxiety. Are you saying we should see it continue as a viable alternative for those veterans who want to choose between private health care or going through the VA medical system, as their choice of where they receive their care? Is that an accurate statement?

Mr. EGAN. Yes.

Mr. BRINCK. I would agree with that.

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

Mr. ROWLAND. Thank you very much. And I want to thank all of you very much for your testimony here this morning.

Mr. ROWLAND. Our third panel is: Dr. Gerard Burrow, who is dean of the Yale University School of Medicine; Dr. Itamar Abrass, who is professor of medicine and head, Division of Gerontology and Geriatric Medicine at University of Washington; Dr. Kenneth Shine, who is president of the National Institute of Medicine; and Dr. Earl Brown of ABT Associates and former associate deputy chief medical director, Department of Veterans Affairs.

I want to thank you very much for your patience this morning. I'm grateful to be in such distinguished company here. We're very pleased that you're here and look forward with anticipation to your testimony.

Dr. Burrow, if you would proceed first?

## STATEMENTS OF GERARD N. BURROW M.D., ASSOCIATION OF AMERICAN MEDICAL COLLEGES AND DEAN, YALE UNIVERSITY SCHOOL OF MEDICINE; ITAMAR B. ABRASS, M.D., CHAIR, VA GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE AND PROFESSOR OF MEDICINE AND HEAD, DIVISION OF GERONTOLOGY AND GERIATRIC MEDICINE, UNIVERSITY OF WASHINGTON; KENNETH I. SHINE, M.D., PRESIDENT, NATIONAL INSTITUTE OF MEDICINE; AND D. EARL BROWN, JR., M.D., ABT ASSOCIATES AND FORMER ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, DEPARTMENT OF VETERANS AFFAIRS

### STATEMENT OF GERARD N. BURROW, M.D.

Dr. BURROW. Good morning, Mr. Chairman. I am Gerard Burrow, a physician who is Dean of the Yale University School of Medicine. On behalf of the Association of American Medical Colleges, I appreciate the opportunity this morning to testify on the role of the Department of Veterans Affairs in reform of the national health care delivery system. I do this from 35 years of personal experience in the VA system.

I examined my very first patient as a second year medical student at the West Haven VA Hospital. I was in the first group of Yale interns that went to the VA hospital. And during residency training, I literally lived at the VA hospital for significant periods of time.

At the other end of my spectrum, I chaired the Dean's Committee at the San Diego VA Hospital from 1988 to 1992 and currently chair the Dean's Committee at the West Haven VA Hospital, also served on the Department of Veterans Affairs Advisory Committee for Health Research Policy in 1990.

Based on this experience, I'm absolutely convinced that this has been an outstanding marriage between the VA and the medical schools, in which both partners have benefitted immeasurably.

In looking at the issue of national health care delivery, the Veterans Administration hospitals relate in two areas. First, in the education of this Nation's physicians, each year more than 30,000 medical residents and 22,000 medical students receive a portion of their education at VA hospitals.

Secondly, the Veterans Administration contributes significantly to the exciting advances in U.S. medicine through a research program which has an impressive record of innovation and success. In return, half of the investigators who receive VA research support remain as outstanding clinicians in the VA system.

Any discussion of health care reform in the United States must consider both the strengths and the responsibilities of the VA system. The patient population served by the VA is older, sicker, and poorer than the general population with very specific problems, like Post Traumatic Stress Disorder and major rehabilitation issues, like spinal cord injury.

The VA Advisory Committee on Health Research Policy, on which I served, was convinced that the research program of the VA was entirely appropriate to its clinical mission. The research primarily supported physician investigators involved directly with pa-

tient care oriented to problems, like Post Traumatic Stress Disorder.

Parenthetically, the 11 percent cut in the VA research budget in the administration's fiscal year 1994 budget proposal is harmful and potentially disastrous in this area.

The Veterans Administration, as you are well aware, is approaching a crucial period for decision making. In a period of increasing fiscal constraint, the patient population at the VA is becoming older and sicker at the same time that that very population is declining.

There are several options. Elimination of the VA as a discrete health care system would ignore the great and unique strengths of this system that have been so well discussed this morning.

The other options, it seems to me, depend on the range of medical services to be offered and the extent of the patient population to be served. The options could range from a small population of eligible veterans given complete medical services to a large population including all veterans with limited services or anything in between.

The academic medical community would welcome the opportunity to participate in the deliberations. These options represent dramatic implications for veterans' access to health care and the continued success of VA medical school affiliations.

In addition to my experience in VA hospitals, I spent 12 years as an academic physician in the Canadian health care system between 1976 and 1988. Specifically I'm talking about the system as a health care system and not the VA part of it in Canada.

The United States VA health care system represents an outstanding example of the single payer health system with global budgeting. As the United States seeks to improve the delivery of health care, we could learn much from this experience and use the VA as an important experimental model.

Thank you for the opportunity to share my views and those of the Association of American Medical Colleges.

[The prepared statement of Dr. Burrow appears on p. 134.]

Mr. ROWLAND. Thank you very much, Dr. Burrow.

Dr. Abrass.

## STATEMENT OF ITAMAR B. ABRASS, M.D.

Dr. ABRASS. Thank you. Thank you, Mr. Chairman, for giving me this opportunity to meet with you today.

I think the climate of health care reform presents both challenges and opportunities for the VA health care system. I believe that to best serve veterans under a national health care plan, the VA health care system needs to be operated under two major principles: one, the delivery of a continuum of care; and, secondly, participation within, rather than outside, managed competition.

One obstacle to the cost-effective and efficient delivery of health care in our present system is fragmentation of both the system and its financing. To some extent, this is also true in the VA health care system.

Therefore, the VA health care system should establish a continuum of care for eligible veterans. This will lead not only to a sys-

tem that serves the needs of veterans, but will also allow the system to be competitive in the era of managed competition.

Such a plan will require eligibility reform such that veterans eligible for care will be eligible for the full continuum of care, from health promotion and disease prevention to long-term care.

Approximately 50 percent of veterans are now 55 years of age or older. The health care needs and utilization of these individuals' needs will not only be in long-term care, but also in ambulatory care and acute care.

The VA health care system should not become only a long-term care system, for this would only perpetuate the present costly, inefficient system. A system in which the complete health—and I emphasize health—of an individual is its responsibility will develop the most appropriate levels of care for that individual.

For example, up-front increased costs for health promotion and disease prevention are cost-effective if they lead to decreased costs at another level of care.

However, there is no incentive to a component of a health care system responsible for health promotion to improve care at increased costs that is not responsible for care in another component where it can recoup those costs because the health promotion intervention reduced the overall resource utilization.

Assuming that the President's national health care reform relies on a system of so-called managed competition, an independent VA health care system would probably best serve its veteran constituency within that system of managed competition.

Why would a veteran then choose the VA program over others? First, if the VA system offers a continuum of care to its eligible veterans, it will offer equivalent or superior care to its enrollees.

Secondly, with a continuum of care, the VA system will be cost-competitive and, thus, be able to offer that continuum without copayment. However, to remain competitive, the VA system must also have economy of size in the number of its enrollees.

Eligible veterans who choose the VA system must have priority for care, but the system should be open to all veterans who select the program. Again, other veterans would preferentially select the VA system for its continuum of care.

To remain competitive, the VA health care system must also maintain its research and development program. Caution must be taken to preserve the research program as cost savings are approached in a managed care system.

The VA system needs to continually assess how to best deliver care to its constituency, including the delivery system, services, technology, and treatment.

The best care today was research 10 years ago. To maintain an excellent system in the future and to remain competitive, the VA health care system must invest in research and development now and must be careful not to lose sight of its importance to excellence of care.

The challenges and opportunities are there. I believe the VA health care system can meet them and develop a model for others to emulate.

Since I have a moment, I might deviate from my actual testimony and maybe mention two things. People have talked here to

you about the issue of family and delivering care to other family members of the veterans.

I'm a geriatrician who takes care of older individuals, and I think you're probably aware that a lot of the care that's delivered to any individual is in that more informal network. The care-givers are the individuals who deliver a lot of health care.

It's clear to me that I don't only take care of the patient when they come to see me. I take care of that family, not only for the care of that family, but, in fact, for the best care of that individual. So if one thinks about a comprehensive continuum of care for the veterans, one also must think about the care-givers as part of that system.

Thank you.

[The prepared statement of Dr. Abrass appears on p. 140.]

Mr. ROWLAND. Thank you very much, Dr. Abrass.

Dr. Shine.

## STATEMENT OF KENNETH I. SHINE, M.D.

Dr. SHINE. Thank you, Mr. Chairman. Rather than to review my testimony as I've submitted, I'd like to make some comments trying to relate what I think is likely to happen in health care reform to what we should be thinking about with regard to the VA.

I do so on the basis of my background both as a physician practitioner and as someone who has worked closely with a number of VA facilities in Los Angeles.

Health care reform will develop over time, as we have heard. Whether it's 5 years, 7 years, 10 years, although legislation may be passed in some relatively short time, there's going to be an evolutionary process.

That's both an opportunity and presents problems. I strongly support the notion that to prepare the VA for the future, eligibility reform has to take place now, cannot wait during that evolutionary period.

On the other hand, during that period there will be a substantial amount of innovation, particularly at the state level. States have already moved in this way, and we're going to see a whole variety of approaches. Health care, in fact, is a local phenomenon.

In that regard, we don't know what the best way is to organize health care of Americans at the present time. There is no system that we can point to to say this is the obvious system that we ought to be using.

If that's the case, in my view, the VA has an opportunity to do a series of experiments to innovate in a variety of ways, some of which we have referred to, which will allow us to learn how veterans can be cared for better and, as a matter of fact, can be a model for the rest of the country.

It's clear that there will be some kind of a benefits package that will have to be employed around the country. The VA will have to match that benefits package. It does not do so at the present time.

The VA cannot provide continuity of care. The VA does not have the kinds of systems to provide ambulatory care, or enough primary care physicians, to do a lot of the things that have to be done.

And, as Dr. Itamar has pointed out, to do that appropriately will require an investment of resources. Prevention or ambulatory care

is a more cost-effective way to provide care, but it isn't going to happen until or unless you create those facilities or those networks and those ways to do it. And we need to figure out ways to do it so that we don't have a two-class system, which is what health care reform is about.

Outcomes assessment will be a key part of whatever happens. And part of that will be an assessment on the part of the consumer as to what he or she thinks about the health care. And, again, in view of the testimony you have heard this morning, ask yourself how a veteran will, in fact, rate the health care in that particular facility and what that means in a so-called competitive environment.

The VA is not a perfect system. It has a long way to go, but it does provide an opportunity for innovation. And I have described in my written testimony some of the activities at Sepulveda VA Medical Center.

You heard Mr. Bilirakis describe a spinal cord injury program in Florida, where continuity of care for those kinds of veterans is identified. There are lots of ways that we can do this, but we've got to get about it.

The benefits package clearly has to be expanded. There are certain things the VA does superbly well: geriatric care, substance abuse, mental health, spinal cord injury care. They are very expensive. And they will not be something that the community AHP is going to be anxious to produce.

On the other hand, if you're going to have a, quote, "competitive" environment, you have to have a large enough population so that there are some of the low-cost things in the package. And that means being able to enroll a wide variety of veterans so that you, in fact, have a way of balancing those costs.

I don't think it will be simply a staff HMO system in every place. You're going to have to create mixed systems because there's no way that one's going to want the VA to suddenly come up with a comprehensive benefits package within its own doors.

And here the university affiliations are extraordinarily valuable. There's an opportunity here. The universities need the VA for education. They need a relationship for teaching. They need to be able to figure out ways to capitate care in terms of populations they see.

The possibility for alliances between those institutions and groups of providers is an extraordinary opportunity. And I hope neither the academic institutions nor the VA lose that possibility.

There have to be systems of care, and those systems of care have to include rural and urban connections. The VA has a wonderful opportunity by using a system in which there is a central hospital, an ambulatory facility locally, an ambulatory facility of the kind that I've described in Bakersfield, California, ambulatory facilities in other areas using video technology for communications and a variety of other things in order to provide systems of care which would make it attractive to veterans.

Let me conclude by saying that there is going to be a difficult transition time, during which time there's going to be a lot happening at the state level. VA is going to have to monitor that very carefully. It's going to have to understand how the local markets are going to have to deal with it.

VA is going to have to figure out how to do effectiveness research and technology transfer in a timely way which will help the efficiency of the VA and again instruct the national activity.

And, finally, I have to say that I was stunned by the decrease in VA research support, which Senator Rockefeller made reference to. That is the most unreasonable way to try to save a few dollars that I've heard of in a long time.

At a time when the overall system is so fragile, where morale is difficult, where people, veterans and others, don't know what's going to happen, the idea of cutting back on research as a way of saving money I believe is exactly the wrong message you want to say to a community which says it wants to preserve the VA system.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Shine appears on p. 142.]

Mr. ROWLAND. Thank you, Dr. Shine.

Dr. Brown, nice to see you again.

## STATEMENT OF D. EARL BROWN, JR., M.D.

Dr. BROWN. Good to see you again, sir.

Mr. Chairman, I appreciate the opportunity to address this committee, and I will summarize my statement. First, it is important for the delivery of health care in the VA to be consistent with that of the rest of the Nation.

I'll discuss six areas in which I think the VA needs to make some changes in order to be a successful player in a managed competition environment. First is comprehensive care.

In order to provide the services necessary in a managed care environment, the VA must expand the provision of primary care, including preventive care. And by "preventive care," I mean such diverse services as provider rapport and attention, which increase patience compliance, case management, case continuity, and counseling regarding smoking, hypertension, diet, exercise, et cetera.

The ability to offer a full continuum of care to eligible veterans is currently a major strength of the VA. It is important for the veterans who rely upon the VA for care.

As has been mentioned before, the rules of entitlement must be simplified and standardized. With simplification of entitlement, the VA can provide better than basic coverage for veterans.

Veterans are likely to have health care needs that are quite different from what may evolve in the President's plan as a basic benefits package for the general public. An example might be more extensive mental health benefit.

If included in the basic package, it probably will be limited to a specific number of outpatient days and hospital days. The VA's experience would indicate that that is insufficient for veterans.

The VA alone has the experience and expertise to determine what benefits veterans require. The VA alone also has the expertise to provide for the special needs of veterans, such as spinal cord injury and PTSD, as has been mentioned.

The VA has the capability to become competitive in the new environment by providing a benefits package that might include an expansion of benefits, free care for veterans currently in the system, no coinsurance, no deductible, and lower premiums.

It will be necessary to require enrollment of veterans. Only thereby can the VA know how to plan and budget. Knowing your population base is a significant part of managed competition and will position the VA favorably in the new health care environment.

Next is standard outcomes reporting. In order to level the playing field of health care delivery, managed competition proposes to evaluate health care organizations according to standard criteria, such as outcomes reporting. This is a most difficult challenge for any health care delivery system.

The VA in its cooperative studies program has demonstrated the ability to collect data and report outcomes according to a standard protocol. Landmark studies performed in the VA have repeated such results for American medicine as defining the current standard treatment for hypertension, discovering and developing today's effective treatment for tuberculosis, defining the most effective treatment for congestive heart failure, and developing psychoactive drugs for the treatment of mental illness. These are but a few of the examples wherein studies conducted in the VA have improved medical care for all U.S. citizens.

This capacity should not be lost. Indeed, it should be expanded through the continued development of a national database available for clinical practice, research, and management within the VA. The VA should lead the Nation in conducting outcome studies, developing data that will result in standards of care.

Next, information management. The VA has in operation the best integrated health care information system in the Nation. In order to implement managed care techniques effectively, the VA must have an expanded and responsive information system. However, budget limitations make it difficult to implement such techniques as concurrent review, for example.

In order to be competitive, the VA requires a significant expansion of the current information management resources in order to support the techniques of managed care.

In summary, as the manner in which medical care is delivered in the U.S. changes, the VA should respond with changes that enhance the strengths of health care delivery in the VA.

The VA has the capacity and capability to become an active participant in the President's health care plan. I would urge the members of this committee, Mr. Chairman, to support providing the VA with the resources to thrive in the environment. We should not lose this important national resource.

And I thank you for permitting me to testify.

[The prepared statement of Dr. Brown appears on p. 148.]

Mr. ROWLAND. Thank you, Dr. Brown. I want to thank all of you.

I will have to say that I believe that the deletion of $26 million in research funds for the VA is myopia to the extreme. Apparently whoever made that decision or whatever group made the decision is not sensitive to the contributions that research makes, not only to the welfare of the VA, but to the population in general. And we're certainly going to do everything that we can to see that that is changed.

Dr. Shine, I was really pleased to hear you say that health care is a local phenomenon. I believe it really is. And I noticed in the New York Times this morning that you're listed as one of the indi-

viduals that would be looking at what has been,—I don't want to use the word "concocted"—let me say, put together at the White House.

My perception has been, be it right or wrong, that what has been done there has been done to the exclusion of many entities in our health care delivery system that should have been involved. So I'm pleased to hear you say what you did and that you're going to be involved in reviewing what has taken place there.

As you review this plan as it relates to the VA health care system, for example, by what principles or criteria will you evaluate it? Would you view it to be within your role to advise the President or his assistants on the VA system's funding needs?

Dr. SHINE. Mr. Chairman, I don't want to be coy. I made a commitment in the process of becoming active in that to not discuss that particular activity until the plan is formulated, and I want to respect that commitment.

Everything I've said to you this morning are things that I believe in and that I've commented on in other environments. And, as you know, as early as 1989, I gave testimony in both the Senate and the House, indicating that the VA system is grossly under-funded, that the funding has been short unmercifully during that time.

Someone used the term "cannibalization" this morning with regard to plant and others, and I've used that same term. So I have great concerns in this regard and have for a long time with regard to the overall funding levels.

I would indicate to you that one of the areas that we didn't have time to discuss but which I think is particularly important and relevant to the VA and its needs as well as those of the Nation are that there is now a goal—and Gerry Burrow can speak to this for the AAMC—at 50 percent of physicians who had trained and graduated being primary care physicians because we desperately need them in the local community.

The VA is uniquely positioned, given the number of residents that it trains, to very quickly adjust the balance of residents. I don't mean overnight, but over a period of several years.

And if they did that, they would have an enormous impact not only on the VA system, but locally because if you can produce a stream of primary care doctors,—and most primary care doctors practice where they've been educated—including all of the outreach activities of the VA and others, then I think that there is a very interesting opportunity for the VA to have a major local impact as a confluence of that educational mission and the requirement for more primary care physicians.

Mr. ROWLAND. I think so, too. The VA medical center in my home town of Dublin, Georgia now has an affiliation with the Mercer Medical School. This is like a rural setting that we are in now, and this is almost like a local phenomenon that's taking place just as you've pointed out. They understand what the needs are. The school understands the needs that the VA has and vice versa. It's working extremely well.

Dr. Burrow, I was listening to what you were saying about training in the VA. I got part of my training in the VA. A number of physicians that are around our country—what is the number? It's more than half that must have gotten——

Dr. BURROW. Somewhere over half of the physicians in the United States at the present time have received at least a portion of their training at the VA hospital.

And to comment on Ken's comment, university hospitals, which are really now becoming more and more intensive care units with very short stays, very sick patients, it becomes increasingly more difficult to educate medical students to be general physicians.

And the broader scope of patients at the VA hospital and that it's possible to have those patients for a longer period of time and they haven't been completely worked up represents an ideal place to train general physicians.

Mr. ROWLAND. As a rule of thumb, I think that we see in our country we produce about 75 percent specialists and 25 percent generalists. And we ought to be doing just the opposite of that, maybe 75 percent in primary care.

I see my time is up. Let me turn to Mr. Smith.

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

I noted that, Dr. Shine, you said you were stunned. Dr. Burrow, you said you noted with alarm the $26 million cut, which is an 11 percent cut, as you pointed out, and that doesn't even take into effect inflation, which means we would need even more than a current level to continue the kinds of programs we have had.

I was wondering if you could tell us, Dr. Burrow, perhaps Dr. Shine as well, what effect, in your view, will reducing the VA's research budget have on affiliations with medical schools and the attempts to recruit and retain physicians, particularly in the research area.

Dr. BURROW. I think there are two parts to this. As the chairman has commented, the research that has been done in the VA—and the example of hypertension and the benefit of treatment is enormously important to this country as a whole.

The absolutely important statistic is that the young individual who goes into academic medicine—and many of these go to the VA, do clinical research, and 50 percent of those individuals remain within the VA system.

I'm sure that's higher than the percentage of individuals who start at Yale University and remain in academic medicine. Those are the individuals who provide the care to veterans and also provide the role models for the students to go on.

This has enormous implications. This 11 percent cut is on the background of several years of dwindling resources. So that there are no available scholarships and traineeships for these individuals. It has enormous impact exactly in the area where I think this country cannot afford it.

Dr. SHINE. Dr. Burrow has stated it very well. I would just make two additional points. Dr. Abrass will tell you that the first significant study showing the cost-effectiveness of a geriatric assessment in the United States was done in the VA hospital. In fact, he was affiliated with that hospital. That was research that would show how to save money.

Similarly, the kinds of effectiveness and outcomes research that we've made reference to that are critical for the VA are applicable to the country as a whole. And the guidelines that can be developed within the VA can be used throughout the health care system.

One of the big problems we have is that the rate of development of new clinical guidelines and new ways to measure outcomes and effectiveness has been too slow. It's lagging behind the desire to reform the system. If you're going to rely on that to reform the system, you need that information.

The VA can be of enormous value in the biomedical research area, in the prosthetic research area, in the effective outcomes research area, in the health care area.

Mr. SMITH. Dr. Brown.

Dr. BROWN. May I comment on that?

Mr. SMITH. Of course.

Dr. BROWN. My experience with the VA was this, that if in a given year there's a reduction in the budget for research, what happens is you lose key personnel who are performing research.

And then if the funding is restored 2 years later, you don't catch up. It takes several years in order to assemble those teams and get them back working on research projects.

The priority system within the VA of selection of research is so careful that they really are doing only the most productive research in the first place. And with the funding cut this year, my understanding is that a lot of the things that they regard as high priority within the VA will simply not be funded. And you will lose those people and the key personnel who are there to do the research.

Dr. BURROW. There's also research being done that can't be done anywhere else. The West Haven VA Hospital has a research program on Post Traumatic Stress Disorder. It's clear that a number of these individuals—there's a co-morbidity between this and substance abuse. It's an enormously difficult and dangerous group with which to work.

If this research were to stop, I don't think it would be—it would not be possible for us to do this within the university. So we have research going on that simply can't be done anywhere else.

Mr. SMITH. Do any of you have any sense where the figure ought to be since, as you pointed out, there's been a dwindling over many years or wholesale cuts? Where should we be in terms of this research effort?

Dr. ABRASS. Well, the VA did have a specific task force to look at just that issue. And it was, I believe, at the $320 million level; right? Somewhere. But there is a specific task force that reviewed just that for you. So that I think, rather than our giving you a figure, there are some specific recommendations done on that.

And I want to reinforce what's been said here for several reasons. One is you have the issue related to the academic affiliation. That's certainly an issue. I think part of the bottom line is the whole issue of good patient care as well.

I'm sorry I took a lot of your time.

Mr. SMITH. No.

Dr. ABRASS. But I think it is very important. I think the issue of our having done the study at Sepulveda of setting up a geriatric evaluation unit and demonstrating that it can be cost-effective could have only been done in the VA system.

And it's also demonstrated that it can save the VA system money and also, on top of it, deliver better care. That's sort of the bottom line.

Dr. SHINE. NASA got a 6.7 percent increase in its research budget. I can't understand why you would use a negative number in the VA.

Mr. SMITH. Maybe, Dr. Brown, you might want to touch on this one. There are costs, including the VA itself or including all veterans, although there would be a prioritization of who gets our services.

But, according to a VA document on alternative veteran health care eligibility proposals, if the number is boosted from 2.5 million veterans to 5.3 million veterans, without offsets it jumps to $53 billion, with offsets to $27 million.

When I look at cuts of $26 million here, a billion out of the aggregate over the next several years in the budget submission several months ago, it would seem to be going in the wrong direction. And then we're talking, on the other hand, further inclusiveness and bringing more people into the system.

It seems to me that out of the block, at least, the administration is de-prioritizing veterans' health care, just based on the numbers that they propound for our consideration.

But you, having your very long tenure with the VA, how much additional cost do you think is necessary? Do you agree, as I do, that there is a wrong trending line here with some of these submissions? And, secondly, how much do you think ought to be——

Dr. BROWN. I certainly agree that this requests the wrong trend line. I don't have an idea at this point of what the figure should be, but, as I mentioned in my testimony, if, indeed, in accordance with the changes that are supposed to happen in the private sector, the VA changes in order to be competitive, it's going to require some up-front money.

Just the data analysis alone is exceedingly important. And that's up-front money. And I think that would require an infusion of dollars in order to prepare the VA.

I think there will be a payoff ultimately because I think the VA does, and has demonstrated very clearly that it can provide care at a lesser cost. Also, I think if the VA is permitted to retain some of the reimbursements, that can offset ultimately.

Mr. ROWLAND. Let me follow up on that question, if I can, with Dr. Brown. There are some people that would say that restructuring the VA system from its emphasis on acute care to a greater reliance on primary care in the ambulatory setting would free up some resources that would help in the problem that we have been having with funding.

Do you perceive that to be true? Are there any flaws in that thinking, that type of thinking?

Dr. BROWN. I think that's true. Again, if you expect a payoff in a very short period of time, it's not going to happen. And my experience in the VA was, of course, that if we expected to save some money by doing something, OMB took that money up front. It doesn't work that way. I think ultimately more emphasis on primary care and preventive care will save dollars.

I think also attracting additional veterans so that you get a different mix of veterans, a "normal" mix, then the cost per patient per care episode would reduce as well.

So I would expect that ultimately there would be a payoff, but not immediately.

Dr. BURROW. I think it would depend how they looked at primary care. I think Itamar can probably answer it. At an HMO one expects four times more visits from an individual in the geriatric age group, rather than usual people. And in the VA, the veterans are aging 10 years ahead of the general population.

So this isn't just a population out there but a very specific population that is older, sicker, and poorer with more health problems.

Dr. ABRASS. But, again, the VA because its population is aging about 10 years ahead of the rest of the population again can be a specific model. And Ken Shine sort of raised that issue for you.

We may not at this moment know what the best health care model should be in the sense of what should be delivered and how to do that in the most cost-effective way, but, in fact, the VA, both for its own health care system and for the Nation as a whole, has a real opportunity to do just that. And that is: How do you care for an aging population?

There's no question we're going to have to do it. There's no question it's expensive. But how do you do it in the most cost-effective and efficient way so you're delivering the kind of health care that these individuals need.

Dr. SHINE. There are some real opportunities, I think, also to think about some joint ventures here. The health care system as a whole, whether you're talking about HCFA or a variety, are going to need management information system. They're going to need electronic patient records. They're going to need to deal with confidentiality of records. There's a whole host of those kinds of issues out there.

VA has some interesting material. They have some interesting background. They've got some pilots in which they're doing some of this. It would seem to me that it would make a certain amount of sense to think hard about putting together components of the Government who are concerned about these kinds of issues and saying "Are there some of these areas where we could joint venture the development so that, in fact, a number of agencies would benefit from the use of an important patient management system?"

Mr. ROWLAND. Several of you suggest and you keep talking about the fact that as we move toward some reform in our health care system, there's a lot that can be learned from the VA. You keep talking about that this morning.

But one of the things that really distresses me is that the VA doesn't often get the recognition that it needs to get the successes. We hear so much criticism, and we don't hear about the successes.

What can be done to overcome that kind of perception that seems to be out there?

Dr. BROWN. May I comment on that? When I was with the VA, I was concerned about the very same thing. How can we increase the publicity, all of these fantastic medical discoveries that are good for all the population? How can you tell the public that?

I explored the possibility of: How can we let the public know? What I was told—and I think maybe the gentleman on your left was one of them who told me this—is you can't spend appropriated dollars to advertise what a federal agency is doing.

So it certainly needs to be told, but what the legal vehicle is I'm not sure.

Dr. BURROW. One of the things that does happen is often that one has these advances in research and they come out from a university and one does not include the VA.

We've tried very hard, both when I was in San Diego and I know that Ken did it, to make sure that when that research comes out, that the VA is mentioned in conjunction with the university.

I think that part of this alliance—and it is a marriage because it's more than simply people getting together—is that the university can market. And it's such an important part that we need to do it, and we need to do more of it.

Dr. SHINE. And the press conference when you announce the research result after it's been published should be with the VA, not at the university. But I would suggest to you, again, that there's an opportunity developing. Either the medical schools and the VA will seize it or we're all going to lose.

The opportunity is how to create networks of care because the VA can't do all the things that we were talking about before; the families of veterans, for example. I mean, it has to develop capacities to do certain things involved with other providers.

And the logical way to do that is to try to connect the medical school faculties, create those kinds of provider opportunities, trying to tie it in in a bunch of different ways.

I would bet you dollars to doughnuts that once the private sector physicians in the community are part of the VA health care system, that the kinds of press that they'll get in terms of what's happening would change very dramatically. It's just human nature. People tend to focus on the positive aspects of something that they're associated to.

I just hope we take advantage of the opportunity in here because the medical schools are going to need the VA and the VA is going to need the medical schools. And this is a nice opportunity to try to marry those.

If you've got that kind of a network, there's nothing that says you can't use medical schools or faculty planned money to advertise. It may be that you can't do it using federal money, but, again, joint venturing it can, I think, do a lot of interesting things.

Mr. ROWLAND. I think the experience that the VA has had and the contribution that it has made is generally known in medical circles, but is not known outside medical circles.

I again will mention the community that I come from, where the private physicians in town and the VA physicians four times a year, every quarter, had one day of CME. And we had visiting speakers that came. It was a real good close working relationship, and the community in general knew that in that area. It seemed to work extremely well.

Were you going to say something else, Dr. Shine?

Dr. BURROW. No, but just let me follow up. Whatever happens, it looks as those HMOs are going to be there more and more. And we're talking about covered lives.

We estimated that in order to educate neurosurgeons, we may need access to as many as 400,000 lives. There's no way the university is going to do this with a practice plan and the kinds of net-

works that Ken is talking about that we are talking about doing right now. It would make every sense for VA to be an integral part of that.

Dr. SHINE. Could I also make one other point in this regard? It's one of the things that's bothering me a lot about the VA system, and I don't know how to deal with it, but I think you have to get a handle on it.

If someone puts together a network or puts together a program or consolidates some services in the VA system in a way that provides more effective service at less cost, they lose the money.

That is, there is no incentive for the people at a particular VA facility or a group of facilities to figure out a way—and I don't mean we should put it in their pockets, but there ought to be a way that when they are creative and they save resources, that the resources are available to them to do more with it.

I'm very concerned about that aspect because if you want competitive facilities, people have to get some reward for doing a very good job which can be invested into other activities.

Mr. SMITH. If the chairman will yield, that was part of the theory, I think, behind the DRGs. And, unfortunately, as with every agency of Government, if they don't spend it in that given year, and there's usually a rush to spend it in the final weeks, they lose it the following year.

So you're absolutely right. I appreciate that comment.

Dr. SHINE. We certainly can figure out a way to do that.

Mr. SMITH. I know.

Dr. SHINE. I mean, somehow we've got to get over that mentality because otherwise there is not the incentive to innovate. People tell you "Why consolidate services? Because we'll lose the resources, and no one will be the better for that."

Mr. ROWLAND. This conversation is interesting, and we could spend a lot more time. But I know that you've been here a long time. We do appreciate so very much your coming this morning.

Dr. ABRASS. Thank you.

Mr. ROWLAND. The next panel is Mr. Malcom Randall, director of the VA Medical Center in Gainesville; Mr. Fred Malphurs, who is director of the VA Medical Center in Albany, NY; and Mr. Al Zamberlan, director of the Central Region, Veterans Health Administration, Department of Veterans Affairs.

I want to thank you for your patience here this morning. It's been a long morning. There have been some outstanding managers from around the country, and we look forward to hearing your perspective on these issues that we are thinking about here this morning.

Mr. Randall, it's nice to see you again. I think the last time I saw you was going through the airport in Atlanta sometime back.

Mr. RANDALL. That's right, Mr. Chairman, it is also good seeing you again.

Mr. ROWLAND. It's been some while. It's sure nice to see you again.

Mr. ROWLAND. Well, if you will begin, we will be interested in hearing your testimony.

## STATEMENTS OF MALCOM RANDALL, DIRECTOR, VA MEDICAL CENTER, GAINESVILLE, FL; FRED MALPHURS, DIRECTOR, VA MEDICAL CENTER, ALBANY, NY; AND AL ZAMBERLAN, DIRECTOR, CENTRAL REGION, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

### STATEMENT OF MALCOM RANDALL

Mr. RANDALL. Thank you, Mr. Chairman.

We've been engaged in a medical arms race in this country. And I think it has finally driven the cost of health care so high that the President has decided that we need health care policy reform and, thus, the task force.

And as that task force has been set up, there have been people who have raised questions about the role of the VA: If we have health care reform, what should happen to VA?

I happen to believe that VA should remain in place as a continuing entity. It's one of the most valuable resources that this country has. And this follows up on something you said, Mr. Chairman. It's also one of the country's best kept secrets. The VA's $14.5 billion budget is only 1.6 percent of the money spent on health care in this country.

And if we recaptured the entire budget, it would fund less than 6 days of health care for the rest of the country. And, yet, out of that very small, out of that less than 6 days of, health care coverage for everyone in this country, we return to the people of this country a tremendous return.

We've heard a lot of talk about quality. And that's very difficult to measure, but I would point out that in the last go-round of surveys by the Joint Commission on Accreditation of Health Care Organizations, VA has outscored all hospitals in the private sector. The average score for VA hospitals has been 85. The average score for hospitals in the private sector has been 80. Now, that's just one measure.

One of the things, again, Mr. Chairman, a question that you raised, we don't get credit for the job that we do. For some reason or other, we are held to a higher standard than anybody else in the world.

When you look at the VA system, across this system there are hundreds of thousands of individual interactions that are going on every single day, resident to patient, attending physician to patient, nurse to family member, food service worker to patient.

And depending on how any one of these hundreds of thousands of interactions happens to fall, it could blow up into a cause celebre. And then it's in the news media for the next 6 months.

And in this very complex, very critical health care environment, we are expected that in 100 percent of these hundreds of thousands of individual interactions, there's going to be a 100 percent perfect outcome 100 percent of the time.

Life is not that perfect. So we are being held to a standard that is more perfect than life. So we find ourselves in the media constantly with issues that never surface at all in the private sector.

I think that we will have enough veterans to compete. There are some estimates that say no, that we'll lose half our people. And I respect those people who made those estimates, but I also would

like to point out that when Medicare was passed, the conventional wisdom at the time was that VA would soon go out of business because we'd lose all patients over age 65.

Today over one-third of our patients are Medicare-eligible. And, yet, they still prefer to come to the VA. So I suspect that some of those people will not leave the VA.

I agree with everyone who spoke about eligibility reform. I know that the Secretary of Veterans Affairs is seeking eligibility reform, and we need to do something to reform the Byzantine eligibility rules that we have so that we can do some of the things that would make us more competitive.

For example, we could set up low-cost health stations around the country, which would be satellite to a parent VA medical center, manned by either a nurse, or a physician's assistant. That could be the point of entry into the VA health care system. Those would be inexpensively operated, needing only an examining room and an office.

They would answer to a physician in the parent hospital for consults. And that could be the point of entry. That low-cost health station could then, based on consults with the parent physician in the medical center, determine what was needed for that veteran. These health stations would provide access to veterans close to home and increase the number of veterans using that VA system. And that would avoid many long trips to a VA emergency room when all of the patient needs is simple examination and counseling and perhaps a medication.

Can we compete in managed competition? You bet we can. We can compete on cost. We can compete on price. We can compete on quality. If we wish to, we can compete for those veterans who are not eligible for whatever package that the VA eligibility reform determines is our primary responsibility.

We could even become an accountable health plan and compete for discretionary veterans on cost and on quality. I think that we could beat any other accountable health plan in the community.

I've spent a lot of time talking with staff of the Agency for Health Care Administration in Florida. The State just passed a bill establishing a new health system that is going to look a lot like, according to the director of the Florida agency, the health care plan that is likely to come out of the national health care reform task force.

I've talked to the Director of the Florida Agency for Health Care Administration. He says yes, he thinks we can compete, and Florida would be glad to have us compete for veterans against other accountable health plans.

I think I'll stop there, Mr. Chairman. I had several, four or five, options about how we could be accountable health plans, but I'll save that for later.

Mr. ROWLAND. Maybe we can bring those out during the questioning.

Mr. Malphurs.

## STATEMENT OF FRED MALPHURS

Mr. MALPHURS. Thank you, Dr. Rowland.

I'd just like to simply say that I'm proud to have the opportunity to participate here today. I believe in the effectiveness and the value of the veterans' health care system.

I am and intend to be an advocate for this system that should be enabled through health care reform to provide more services to more veterans, financially with the same or similar requirements imposed on all other health care providers, with whom the VA cannot only compete, but should be able to add to our abilities and assets for serving veterans and our communities.

Thank you.

Mr. ROWLAND. Thank you.

Mr. Zamberlan.

## STATEMENT OF AL ZAMBERLAN

Mr. ZAMBERLAN. Thank you, Mr. Chairman.

I, too, am pleased to be here to have the opportunity to make a few comments. I'm not going to read my formal remarks, but just make a few comments and hopefully be able to be more productive in the question and answer series.

Let me just talk about why I think the VA can be very competitive. I think we have a lot of strengths that deal with a form of managed care. We have a long history of providing a continuum of health services.

One of the things I'm concerned about is that continuum is not available for all people. As Malcom mentioned earlier, I think one of the big issues we do have is eligibility reform. I think that would resolve that issue.

I think our federal budgeting process is the kind I think that's going to be accommodated by a managed care system. I think, too, that we have a lot of programs, as was mentioned by the previous panel and also by the veterans' advocates, the service organizations, about the various programs that we do have, that I think we would not only be competitive, but we're the leader in that arena.

I think, too, because of our networking that we have in the system, where we have hospitals that relate to one another, that feed one another, that actually provide for effective utilization of services, I think we are a leader in that regard.

Let me give you an example that we're not waiting for it. Somebody said here this morning we shouldn't wait for this national health care reform to happen for the VA to be more productive: to look at what we think should happen in the system: to have less hospital beds and perhaps look at noninstitutional alternatives.

Part of my region is the Chicago area. In the Chicago area, I have four acute VA facilities in close proximity to one another. We're looking at the possibility of reducing the number of acute hospital beds there and looking at having a VA, a VA, health delivery system and not four individual hospitals out there delivering health care.

We're in the process right now of proposing it to our Central Office. I know they like the idea. We're going to reduce construction costs. We're going to be able to redirect costs. And this is going to be budget-neutral and treating more veterans.

We're going to be able to actually treat more veterans and using what we call a gate-keeping environment there so that we will

make sure that the veteran goes and receives the care that he or she needs with regard to going to an acute facility or other alternatives.

Some of the things are barriers to the VA, the one that is more important in our system today is eligibility. I think we need to do something about that.

One other one is that we're kind of ambiguous in some of how we read our regulations and how we implement our regulations in the VA. Let me give you an example. The authorizing committee permitted us to devote 15 percent of our community nursing home dollars so that we could use it for other community resource alternatives.

With that regard, it limited us to two alternatives. One was that we could use home health services for those with a 50 percent or greater disability, and it had to be for that disability. And the other was for adult day care. That's not always that easy to achieve in some of our areas.

I would suggest that we could be a lot more successful if our hands weren't tied to that regard, that if you had permitted the medical centers like Gainesville and Albany to let them take that 15 percent and spend it for any alternative, care-givers or homemakers or whatever, we could have been a lot more successful.

I think the success for us in managed care is to give a lot more accountability and less restrictions on our medical centers. I think as we exit the 1990s and get into the Twenty-First Century, we need to make sure where the action is. And that's where we ought to put the dollars and hold them accountable, but I think we ought to have less oversight from the Central Office, and even from my perspective, for those people to be effective.

Let me just suggest some ways I think that we can be better. That is, we have to have eligibility reform. In order for people to see us and view us in a managed care environment and to ask you and provide you with information, we need to have information that's going to be comparable to the private sector.

We have excellent data systems, but we do not compare ourselves to the private sector on a regular basis. We could compare ourselves only within the VA system. We need to make sure that in order for us to be competitive, we have to compare to the community and demonstrate that to you.

As I said earlier, we need to have less oversight. I think the medical centers have to have a lot more flexibility for them to function. The criterion that I would use for me to review the 43 facilities that I'm responsible for is the bottom line. Whatever we actually allocate to them in the budget, that's what they ought to achieve. As long as they don't exceed that and I'm comfortable with what's happening within that bottom line, that's all I should expect.

With that, I'll stop and then answer any questions that you have. Thank you very much, Mr. Chairman.

Mr. ROWLAND. Thank you very much. There's little doubt in my mind that the VA can be very competitive in any health care reform system. I think we can do that insofar as providing quality of care is concerned.

But you were in the room this morning earlier, I think, when Mr. Egan was testifying and we were talking about user-friendly serv-

ices that are available. I was a little distressed to hear him say that a group of veterans were asked whether or not if they had the choice they would continue to get their care in the VA or else move out to another system. And almost every one, I believe he said, indicated they would get their care outside of the system.

So you heard some of the things that he said, I suppose, about the way that an individual would be treated if they were in the private sector versus if they were in the VA.

I've heard over the years complaints, not about the quality of care, but about those very things. It seems to me that if we're going to be able to compete in the VA, that we have to address that because people are not going to go to a place where they're not treated with some warmth and some sensitivity.

I would like for you all to comment on that, if you will.

Mr. RANDALL. Well, I agree with you, Mr. Chairman. And I was distressed when I heard those comments also. They don't track with my experience. I have in our file at Gainesville hundreds of letters praising the "concerned" and "compassionate" case.

One of the interesting things is when you get letters that make statements such as "the most outstanding hospital I've ever been in," "outstanding surgeon," almost in the same breath, same sentence, they use terms such as "Everyone was so concerned about me as a person" or "Everyone was so compassionate" or "Everyone made me feel that they cared about me."

They're not qualified professionally to judge whether or not that's the best hospital they've ever been in or whether the surgeon was superb. What they are judging is how they were treated as a person.

I think our hospitals really do a good job of treating people as human beings. And I don't know of any director in the system who would willingly tolerate people who were rude and less than compassionate in working with veterans.

You heard testimony this morning. I think the system has been vastly under-funded, and understaffed. We are trying to take care of hundreds of thousands of outpatients in space that was not designed for outpatient space.

And so in a busy hospital, when you have 150 "walk-ins" that you don't know, but you know you're going to have about 150 patients walk in unscheduled, and you don't know what kind of care they're going to need.

So I can understand the occasional time when a harried employee might be less than courteous to a harried patient waiting 3 hours to be seen, but that doesn't mean we're going to tolerate it. If we know about it, we're going to come down hard on the employee that does that.

In fact, that's the most distressing thing that I heard in the testimony today, Mr. Chairman, because I just don't believe that any of our people will tolerate that kind of behavior. If we can do anything about it, we're going to.

Mr. ZAMBERLAN. Let me just make a comment. I do have 43 facilities that I visit. I have urban facilities, and I have rural facilities.

I just came back from South Dakota and Illinois. I stopped by, and I actually visited the wards. I selected patients and asked

them about care and how they're treated, specifically how they're treated personally. This was in Chicago or it could be in Fort Meade, SD. I don't hear that.

Now, at my level I have to respond to some of those complaints, and we do get some. I mean, it's not at the level that was started. I was real surprised, too, to hear that they felt it was at all levels.

I don't see that out there. I think you have a significant high number of dedicated VA employees out there. And I can tell you this: I have not worked with a better bunch of people. They're just very dedicated.

There are a few out there at times who do get out of sorts. And when that does happen, I agree with Malcom that I think locally that medical center director would not tolerate that.

Mr. MALPHURS. Dr. Rowland, I'd like to respond to that as well. I think that veterans are choosing the VA currently. At my own medical center last year, we collected $7.2 million in third party cost collections. We did over a million and a half in sharing. All of those people clearly had the choice to go anywhere they wanted and came to the VA as their preferred provider.

We routinely do the VA patient satisfaction surveys. And at least speaking for my own, it shows routinely a very high level of patient satisfaction, pretty much uniformly across the board: physician interaction, food service, what have you. Our experience in Albany is running about 15 or 20 to one, 15 or 20 positive letters, cards to every written complaint.

I think part of the phenomenon where veterans complain about that interaction comes from a sense of ownership that they have for the VA because we are clearly a public entity. And I believe where those incidents occur, they believe that we should provide a higher standard. And, clearly, I believe that, too.

And, lastly, many of us in the VA have embarked on converting our work processes to the principles and processes of continuous quality improvement. And I believe the philosophies embodied behind there, that concept, as it gets ingrained with all of our staff will raise the level of our performance in that area as well as others.

Mr. ROWLAND. Do you center directors in any way feel restrained in dealing with employees who may not be performing as they should in the respect that we're talking about by any rules or regulations that are in place?

Mr. RANDALL. No, sir. No, sir. I think that if we have evidence of someone who has been less than courteous to a patient, that we can take action and we do.

Mr. ROWLAND. Thank you very much.

Mr. SMITH. Thank you very much, Mr. Chairman. I want to welcome our panel.

Dr. Shine in his testimony has suggested as one type of reform that a managed health care system would identify each patient with a primary care provider.

And he points out in the written portion of his testimony that in Sepulveda, CA, a series of health care teams were constituted, as you probably know, which included physicians, nurses, dieticians, social workers, nutritionists, occupational therapists, and so on.

Each veteran would be assigned to each one of these, like the blue team or the red team, although I'm sure you can give it numbers, with the point being that it is a pilot program and it seems to have some merits, especially when we're talking about how to make the VA more competitive.

One of the complaints that I have heard over the last 13 years has been "I never see the same doctor" or "I never see the same health care personnel." So there's a sense of re-explaining the whole file, if you will, of what their problem is. And there is a certain trust that's built up when you have that same face to face with the same basic team.

In your view, collectively, or individually if you would speak to it, does this offer some hope of a model that ought to be replicated throughout the system? Will it cost more/less in your view and, again, perhaps provide an added degree of competitiveness because it is an attractive option?

Mr. MALPHURS. We in Albany are in the process of converting ambulatory care to primary care. Probably about 20-25-30 percent of all of our patients now have primary providers. We have a managed care pilot. From our experience, there are probably at least 30 or 40 other VAs who have embarked on doing this as well.

We think it's something that we have to do anyway to cover some of the imbalances in the system that Dr. Rowland referred to, such as the availability of primary care providers, general internists, physicians' assistants, et cetera. Having additional resources would certainly help that conversion, but I firmly believe it's something that we need to do anyway.

We have set up a primary care clinic for all of our former POWs who wish to avail themselves of this primary care clinic. And I think that goes a long way to addressing some of the patient/customer concerns that have been expressed in the past as well as providing better continuity.

Mr. SMITH. Thank you.

Mr. RANDALL. I think that it would cost more money, but in the long run it might be cost-effective. I think that we would just have to see.

The idea of health stations that I talked about is akin to this idea. Through these health stations, we need case managers so that every patient has a case manager that's going to track that patient, no matter at what level of care he is in the VA system, whether it's primary care, whether it's tertiary care, nursing home care, or whatever level he is, so that they are completely familiar with his case and they are the one individual responsible for keeping track of that patient.

Now, that would cost us some money to set up these health stations with case managers, but I think if we compete under managed competition, we can pick up some of that money.

For example, people will quarrel about whether or not VA is cost-effective. In 1991 a Department of Commerce publication indicated that care in the VA during that year was $6,000 per inpatient.

During the same period of time, a Health and Human Services study showed that Medicare costs to inpatients in the private sector were $10,000. Now, that's about a 40 percent differential.

Another study that was done by the Inspector General of the VA matched 15 university hospitals with 15 VA hospitals in the teaching setting. And, strangely enough, the figure was 62 percent. VA's costs were 62 percent of the costs in the university-owned hospital. Here again, this 40 percent differential popped up.

So we can recover some of it. We can compete, if need be, in managed competition. The VA should retain some of the money. If there is a standard package for that particular health area and VA is the choice for the discretionary veteran, then we ought to be able to keep some of the money from that patient.

And then we could pay for the kind of thing that Fred is talking about, increased costs of primary care, setting up these health stations to provide more ready access to the system for veterans and at a lower cost, and also to provide better case management.

So VA can be a win-win situation if permitted to under health care reform.

Mr. ZAMBERLAN. As Fred said, there are probably 30 or 40 that are doing that in hospitals. But, actually, at satellite clinics and our community-based clinics, that happens today. The patient who returns back to Michigan, one of my facilities, sees the same doctor. So it does happen. All we have to do is just enhance the rest of the system.

And it will probably cost a few dollars more up front, but I think that would be what I would call seed money, but also that money, I think, would be restored and retained for some other use there.

Mr. SMITH. I have several questions, but I'll reduce most of them to the written form and ask them that way. I do have one final question I would like to ask, really two if you don't mind answering both at the same time.

Mr. Zamberlan, I seemed to hear you say earlier that you want less oversight from central VA.

Mr. ZAMBERLAN. Yes. I ran some medical centers in the VA. And I think that micro management is not part of my bag, and I think these two gentlemen agree with that.

Mr. SMITH. Then looking at that and the fact that there is a tremendous amount of oversight from Central Office, will that be an inhibitor or—and I think you have already spoken to this—a facilitator to managed competition?

Mr. ZAMBERLAN. It would inhibit it because I think in managed competition, they need all the flexibility they possibly can have out in the field.

Mr. SMITH. Yes?

Mr. MALPHURS. We have by our last count in Albany 47 external reviewing agencies who accredit, certify, or audit us. We spend a disproportionate share of our resources responding to these agencies. I think that's a part of the complex of micro management.

Mr. SMITH. With all due respect to the chain of command, how do you feel about the consequence of a $26 million cut in the research budget as contemplated in the budget?

Mr. ZAMBERLAN. I think it's disastrous. One of the things that Dr. Shine didn't say is that, in addition to—he had mentioned about recruitment retention.

Mr. SMITH. Right.

Mr. ZAMBERLAN. We certainly won't recruit. We'll lose them. As Dr. Brown said, we'll lose them. But, just as important, there aren't going to be any new medical funded programs at all this year, in 1994. And that means that that's the recruitment potential is in jeopardy.

And even some of the programs that we have in place right now are going to probably have to be curtailed because we don't have the money to do it. I think it's terrible.

Mr. RANDALL. I think also we need to recognize that the clinicians who are doing research are not in a buried laboratory someplace. They're taking care of patients. The opportunity to do research is one of the things that has attracted them to the VA.

So the average physician, in at least the settings I'm familiar with, will put in a 60 to 70 to 80-hour week. If we lose that person from the VA because he no longer has the opportunity to do research, we're losing 60 to 70 hours of patient care time a week from a very highly qualified, very dedicated, motivated individual.

Mr. SMITH. The patient care time we lose to competitors, I assume, as well?

Mr. RANDALL. Yes.

Mr. SMITH. And we also lose that person from the system. Even if the money is restored 4 or 5 years down the line, it's still somebody out of the loop——

Mr. ZAMBERLAN. That's right.

Mr. SMITH (continuing). Plus the benefits to the research itself.

Mr. ZAMBERLAN. They'll look elsewhere.

Mr. MALPHURS. In addition to those things that have already been discussed this morning in relation to this research question in the VA, I would like to add that a lot of that money goes to hire research technicians, people who are Bachelor's, Master's, and sometimes Ph.D.'s prepared in basic science in this country.

A lot of those people are having a great deal of difficulty finding jobs, and the country has a tremendous investment in them. There's greater difficulty in getting into graduate school.

So in a real sense, it's an interruption of careers and maybe a stifling of careers in areas that are really important to all of us.

Mr. SMITH. Just my final comment. I can assure you—and I'm sure we will do this in a bipartisan way—that we will fight to restore those funds because all we've heard today are the words "disastrous," "alarmed," "stunned." There's nobody for whom it is a good thing.

When you're talking dollars and scarce dollars, how do you allocate those and prioritize? I think this money would be extremely well-spent if we could restore it. So I will certainly work in that regard.

Mr. ZAMBERLAN. I think Malcom's point is well-taken. You cannot divorce research from clinical care. There's no way you can do that because that same clinician is involved in both.

Mr. SMITH. Thank you very much.

Mr. ROWLAND. I was interested in your comments on cost-effectiveness of VA. This is something that I've been trying to prove for a long time with the numbers, and it's not easy to do that.

I know when Vic Raymond was here in a position on this subcommittee, that we worked a long time trying to prove that. I think

we finally did get enough information together to prove that that is, in fact, the truth.

I was speaking to the president's advisory board at the Medical College of Georgia about 4 weeks ago and made the comment about the cost-effectiveness of the VA and mentioned the number of veterans that get the care and the amount of the budget.

One of the people there just simply took the amount of money and divided by the number of veterans and came up with a figure like "Well, it costs $45,000 a year." It's not that simple. And trying to point that out to him, it wasn't easy to get him to understand that it wasn't that simple either.

But I think that's the perception that's out there. I think maybe that will put them out of some of the problems that we have in trying to get the public at large to understand about the VA and the contributions that it makes.

It's long past the noon hour now, and I know everyone has gotten tired. We do have some more questions. We would like to submit those questions to you. I do appreciate your patience very much here this morning and the testimony that you have given.

We stand adjourned.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

# APPENDIX

## PREPARED STATEMENT OF CONGRESSWOMAN BROWN

Thank you, Mr. Chairman for holding this hearing on the VA's role in National Health Care Reform. We are here today because with new leadership in the White House, Congress will finally be addressing this nation's health care crisis. By the end of May, President Clinton is expected to present his health care reform proposal to Congress. Before his work is complete, this Subcommittee needs to send its point of view to the White House Task Force. I would urge Chairman Rowland to send a letter to the President which reflects the main issues and concerns of the members of this Subcommittee.

I believe that whatever form our health care system takes, it should include an independent VA health system. However, I hope that the VA is ready and willing to adjust to a new environment and make the changes that might be necessary to compete with the private sector. But if the VA has to compete, we, Congress and the Clinton Administration must provide eligibility reform and a level playing field.

As we consider all the options, we must not forget the unique role that VA plays in our society, its special expertise in the treatment of war-related conditions, its contribution to health professional education, its back-up to the Department of Defense and the National Emergency Medical System, its unique setting for large scale clinical trials that transfer newly developed medical technology to the marketplace, and the exceptional quality of its geriatric training, treatment, and research programs.

I would like to extend a special welcome to Mr. Malcolm Randall, the Florida Representative and Director of the VA Medical Center in Gainesville. Thank you for coming today.

STATEMENT OF JOSEPH P. KENNEDY II
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
APRIL 28, 1993

Good Morning, Chairman Rowland, and thank you for calling today's markup and hearing. I commend you and the Ranking Member, Rep. Chris Smith, for your foresight in taking important steps to ready the Department of Veterans Affairs for the implications of national health care reform. The advent of major health care reform and the changing demographics of our aging veteran population warrant careful attention to current VA health care programs and needs.

I am pleased that provisions of the draft bill, "Veterans' Health Programs Amendments of 1993" will ensure that the VA follows procedures to impart efficiency and mission direction for facilities appropriate to our veterans' needs. Provisions of this bill will require the VA to update and build facilities in keeping with what tomorrow's veterans will require -- even under a national health care reform. In this way, the VA can better plan for future construction projects -- reflective of veterans priority needs for long-term, mental health, and outpatient care.

Increasing efficiency while providing enhanced, targeted services based on veterans' needs has always been a priority to me. I support provisions of the draft bill which call on the VA to review the missions and clinical programs of each of its health care facilities to provide better services without duplication. In addition, I am pleased to see provisions which encourage the sharing of health care resources whenever feasible between the VA and State homes.

Mr. Chairman, I support this legislation as a first step to further evaluation of our veterans' health care needs. It is clear that the VA medical care system is in a crisis. The VA's ability to provide quality patient care has been critically compromised by shrinking federal support. While the FY 1994 request for VA health care funding has increased $1 billion over last year's enacted level to $15.6 billion, this represents a nominal boost to programs that have been chronically underfunded for the last decade. Not only does this put in jeopardy the health care services provided to the brave men and women who served our country in World War II and Vietnam, but it also puts at risk our ability to care for the special needs of Persian Gulf veterans -- at a time when numerous Gulf war illnesses are being reported.

We must take steps to ensure that the VA health care system is part and parcel to the overall national health care reform proposal which is due at the end of May. Our hearing today is an important forum in constructing the framework for meeting the growing needs of our nation's veterans.

In this health care picture, we must consider every way to embrace eligibility reform in tandem with health reform and continue to search for ways to provide a full continuum of coverage from outpatient care to long-term care for those eligible.

For these reasons, I look forward to the testimony brought before us today by our distinguished witnesses. Thank you, Mr. Chairman.

**TESTIMONY OF**
**JOHN HANSON, DIRECTOR**
**NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION**
**THE AMERICAN LEGION**
**BEFORE THE**
**SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE**
**COMMITTEE ON VETERANS AFFAIRS**
**U.S. HOUSE OF REPRESENTATIVES**

**April 28, 1993**

Good Morning Mr. Chairman and Members of the Subcommittee:

It is a pleasure to appear before you to offer the position of The American Legion on the subject of the Department of Veterans Affairs (DVA) medical care delivery system's role in national health care reform.

Mr. Chairman, the Legion firmly believes that the Department of Veterans Affairs health care delivery system can and must continue to exist in any future national health care environment. Events regarding national health care reform are rapidly unfolding, the issue of eligibility for VA care is being studied, appropriations negotiations are in progress and VA's National Health Care Plan is about to be unveiled. Each of these important changes could be pivotal to definition of the role of VA in health care in this country, but none will deter the steadfast resolve in this nation to care for our sick and disabled veteran patients.

There is presently a great deal of discussion regarding the impact of global budgeting and spending caps on health care costs. There are those who would say that such caps on spending would drive aggregate health care costs down and reduce the percentage of the Gross Domestic Product which is devoted to health care. Mr. Chairman, the Veterans Health Administration has operated under a global budgeting scenario for years. Such dollar constraints do force the system to become more efficient and create increased accountability for those who fiscally plan for veteran patient care. But, to accomplish this , corners must be cut and funds from other medical programs are cannibalized. The ultimate result is

that which would occur in the private sector as well.....rationing of care. Fewer and fewer veterans are being treated in the VA while, for a variety of reasons, the costs of that care continue to escalate. Any health care reform package which would encompass global budgeting and price caps would allow the VA to operate at something of an advantage but, unfortunately, would perpetuate the rationing of care and reduction of the population of veterans served if quality is not to suffer.

The role of the Veterans Health Administration under a managed competition scenario of national health care reform is less clearly defined because of our inability to determine the final form such a plan would take. Be that as it may, Mr. Chairman, we believe that VA, given free rein as far as their internal reform is concerned, could fare well under managed competition. Several mitigating factors must be clearly understood. First, a major portion of the costs of VA health care are based upon care mandated by law to certain groups of veterans such as those with service-connected disabilities, those exposed to herbicides and ionizing radiation, those too poor to pay for their care and others. Since the care for these deserving veterans is mandated by law, it must remain available and those costs can not be factored into a competitive package cost. Secondly, some of the cost of care in the VA is that created by the delivery of long-term care. Since it appears that long-term care may not be a portion of the basic benefits package which will be the basis for competition, the VA must separate out those costs as well. If the health care playing field is level, there is no doubt that VA could create a package of benefits which would allow it to be a strong competitor for veteran patients at the local level. It must also be understood that the playing field would not be level if the restrictions of convoluted eligibility and the existing prohibition against the collection of Medicare reimbursement were allowed to limit the VA's ability to compete.

Mr. Chairman, The American Legion believes that a plan to afford universal access to health care under reform would impact upon the VA in several ways. If health care consumers were to have their health care vouchered under a universal access plan, some veterans might move to the private sector for their care. These moves could be counter-productive for several reasons. In regard to keeping costs down, the private sector has never been proven to be able to deliver quality care at a cost equal to or lower than that delivered by VA. Thus, any mass move could increase rather than decrease costs nation wide.

On the other side of the coin, many veteran beneficiaries who had not previously taken advantage of VA health care, might move to the VA for their care simply because the idea of getting quality care at less cost may be an attractive option. The unknown in the voucher equation is the number of veterans who would, taking advantage of their opportunity for choice, pick one or the other option.

As a word of caution, however, one could look to the Canadian experience in regard to veteran health care under universal access, and the presumption that veterans, service-connected disabled or not, did not deserve or require a dedicated care system allowed the complete dissolution of Canada's veterans health care system.

Mr. Chairman, under an insurance based reform, the VA could optimize their services if all insurers, public and private, were mandated to reimburse the VA on a negotiated or a usual and customary charge basis. This would include such programs as Medicare and would apply to care rendered to the discretionary group of veteran patients.

Regardless of what form a new national health care delivery mechanism takes, it is important, we think, to remember that the Department of Veterans Affairs has over 60 years of experience in delivering health care nationally. In that time, VA has learned some important lessons.

The doctors and hospitals in the VA system have made some serious mistakes, to be sure, but they have also made some remarkable scientific discoveries which have benefited all Americans. VA's experience has shown us the difference between delivering health care based on need, and bringing that care that is based on resources. We will tell you that health care that is driven by money can be very poor health care. If VA has taught us anything, it is that fact.

Given a chance to compete for health care dollars from all veterans, VA can flourish. And, with VA healthy, we are certain that the rest of the medical community will be healthy, too.

Mr. Chairman, we believe that the Department of Veterans Affairs' health care system could act as a model for national health care reform, in particular, after eligibility reform is achieved. The VA has a proven track record in the ability to deliver quality health care at a cost well below that of the private sector. Recent studies have demonstrated that health care of equal quality can be delivered by the VA at costs which are 20 to 40 percent lower than that delivered by affiliated university hospitals. Any plan to reform the nation's health care delivery system should utilize the cost-containment experience of the Veterans Health Administration.

Mr. Chairman, that concludes our statement.

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF
GORDON H. MANSFIELD, ACTING EXECUTIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
REGARDING
IMPLICATIONS OF NATIONAL HEALTH CARE REFORM
FOR THE DEPARTMENT OF VETERANS AFFAIRS
APRIL 28, 1993

Mr. Chairman, I am pleased to have this opportunity to participate in this morning's hearing. I wish first to express the appreciation of the *Paralyzed Veterans of America* for this committee's steadfast advocacy of the VA health care system.

We of PVA are acutely concerned that national health care reform, by placing VA in direct competition with the private medical sector, presents a daunting challenge for Veterans Health Administration (VHA). Our organization has some specific recommendations on how the coming impact from health care reform can be converted from a negative threat to a positive opportunity for enhancement of VA provided health care. PVA sincerely believes the VA health care system has an excellent potential to compete with other provider organizations. The playing field, however, must be sufficiently leveled by appropriate incentives to encourage veterans and other qualified beneficiaries to consider the selection of VHA as their health care provider of choice.

As you know PVA has for some time been involved in the *Strategy 2000* study titled *"The VA Responsibility in Tomorrow's National Health Care System"*. The Advisory Panel of nationally prominent consultants for that study designed what they called their "consensus scenario", a description of what they thought would constitute the nation's health care operational environment by the year 2000. It now seems that their projection may prove to be prophetic.

Although deliberations of the President's task force on health care reform are closely held and, reportedly, still fluid, enough information has found its way into the press and the health care literature that our considerations today can be based on certain assumptions. It is quite likely that the administration's reform proposal will feature some meld of managed competition and budget controls, that the basic package of benefits will be considerably more than "bare bones", and that government subsidies will help assure universal coverage.

**Managed Competition and the Consensus Scenario**

It was the consensus scenario upon which all *Strategy 2000* analysis was based. Even allowing for the flexibility claimed for managed competition, with budget constraints from above, its operational structure for the delivery of health care closely resembles the consensus scenario. The main difference lies in the method of financing and in the requirement that all consumers are expected to enroll in one of several *Accountable Health Partnerships (AHP)*

offered by a given *Health Insurance Purchasing Cooperative (HIPC)*, more recently called *Health Alliances*.

**Projecting Workload**

*Strategy 2000* includes an analytical attempt to quantify the reduction of demand for VA health care from the influence of universal health care coverage. Because of the many variables, it is not an easy thing to do. The effects of national health care reform and veterans' entitlement reform on VHA workload and case mix, the aging and migration of the veteran population, VHA restructuring, the prospects for future VHA budgets, and VHA's role in a managed competition environment must be considered together. The complex and interconnected problems VA faces cannot be definitively solved by analyzing them independently. All influences are not at this time definable.

PVA recognizes that its models are not perfect predictors of future VHA workload. Uncertain interactions not withstanding, however, PVA believes that its models give a reliable picture of the direction and order of magnitude of the changes to come, but specific facility and program resource requirement cannot be determined until new policies are implemented and data on veterans' patterns of health care utilization are collected.

It should be understood that the *Strategy 2000* prediction of a 50 percent VA loss of acute medical/surgical inpatient care and a 25 percent reduction in acute outpatient care occurs only under the circumstances of the worst case variant of the consensus scenario-that is, very generous basic medical benefits, no significant out-of-pocket costs and a VA system which has continued to deteriorate under inadequate funding.

The first step in our methodology attempted to identify the veteran population and a subset of VA hospital users by age, service-connection and income level. We reduced treatment rates for acute care services only. Treatments for psychiatric and specialized care workload would be held at the FY 1992 level. This methodology takes into account many of the assumptions previously documented.

One should not underestimate the consequence of continued underfunding. It would compromise VA's ability to buy equipment, make repairs to the physical plant, recruit and retain talented clinical staff, and implement new programs which could adapt system resources to users' needs. These continued problems would alienate affiliations with medical and other professional schools and limit opportunities to enter into sharing agreements. Veterans would begin to discern the difference in the quality of care they received.

With these factors in mind, we began to assess the veteran population and VA medical system users. We examined FY 1991 (which have been updated to FY 1992) treatment rates for age, service-connected and income stratified veteran populations. Strategy 2000 staff relied on VA data sets including its estimates and projections of the veteran population 1980-2040, automated management information system (AMIS) files, patient treatment files (PTF), the 1987 Survey of Veterans, and the Survey of Medical System Users for its meta-analysis.

The FY 1992 treatment rates were applied to the year 2000 population to determine a "baseline" rate of utilization. Given the FY 1992 treatment rate with no entitlement reform which would allow the system to provide better access to veterans and to furnish care in the most appropriate setting, VA could assume a decrease in both its hospital inpatient and outpatient workloads. The aging of the veteran population alone will necessitate a significant increase in nursing home workload just to maintain the FY 1992 treatment rate. However, we believe that the current

inadequate budget with which VA operates will prohibit VA from accommodating this level of workload. The net effect on workload would be no change from the FY 1988 service level.

We then adjusted FY 1992 treatment rates for the effects of national health care reform. We assumed that inefficient care practices would continue to exist due to restrictive entitlement criteria and limited funding. While we assumed a fairly "rich" benefits program, we agreed that the standard package would be geared to a "mainstream" population who primarily require acute health care services. This would leave "gaps" in coverage for specialized and long-term care services which VA could assumably continue to provide to eligible veterans.

Using these guidelines and VA data sources, staff identified a set of factors which would affect a veteran user's decision to either stay or leave the system. Because greater rates of system utilization are associated with service connection, adjustments in service-connected veteran workloads were considered separately from those for nonservice-connected veterans.

Survey of veterans (SOV) identified "provided needed service" as the primary reason for 36% of the veteran users' last selection of VA over other hospital services. We assumed that most of the "needed services" would be for service-connected veterans. Because VA does provide quality services that are not duplicated in the private-sector and are not likely to be covered by a standard benefits package, we anticipated that most service-connected veterans will stay in the system. We allowed treatment rates for the poorest of these veterans to drop by 5%. We decreased the rate slightly more (10%) for the service-connected with incomes between $10 and $40 thousand because these veterans might be more willing and able to afford a small copayment which might be associated with private-sector benefits. We assumed that service-connected veterans whose income is at least $40 thousand are likely to already have financial access to other care providers.

Much like other health care users, we believed that cost and access would be the guiding determinants in the non-service-connected veteran's choice to use VA health care. The existence of convenient cost-competitive care providers would have the greatest impact on system exodus. Thirty-eight percent of SOV respondents identified cost as their primary reason for choosing a VA hospital for their last stay. Staff assumed that given another choice of provider these veterans would leave the system. Distance and time from a VA facility would also influence a veteran's decision to leave the system—even if a veteran likes VA services, if there are comparable services closer to home the veteran is likely to choose them. Staff assumed that the geographic distribution of the disabled veteran (found in the survey of disabled veterans) was similar for able-bodied veterans and made a conservative reduction in caseload for veterans that lived over 100 miles from a VA medical center (6%). We allowed these two factors to account for a 45% reduction in treatment rates for the poorest nonservice-connected veterans. We decreased the rates by 50% for those that had more disposable income. For those with incomes over $40,000 we made no adjustment because these veterans probably already have financial access to other care providers and choose to use VA.

Outpatient care was reduced in a similar manner, but also assumed that the veteran population's aging would force VA to accommodate more long-term care on an ambulatory basis. We allowed a five-percent reduction from the service-connected treatment rate and a forty-percent reduction for non-service-connected treatment rates for those with incomes less than $40,000. We made no adjustment for those with higher incomes.

It is beyond coincidence that the PVA study and that of the government accounting office (GAO), using different methodologies,

arrived at very similar estimates regarding the expected reduction in VA health care utilization. Parenthetically we are in general agreement with the content of the June 1992 GAO report *"Alternative Health Insurance Reduces Demand for VA Care"* and especially commend the GAO for the historical role it has played in the successful promotion of VA sharing programs.

**VA Revitalization**

Based on the *Strategy 2000* findings, PVA is convinced that VA is a valued national resource that has a continued role to play as a component part of the nation's coming health care reformation. However, to deserve such assignment, it must be ready to conform to tomorrow's environment, focusing especially on those medical services not likely to be adequately covered in any universally available basic benefit package. Shifts in veteran demographics, the distortion of VA medical center health care missions, the wasteful duplication of medical services, and the protracted federal budget austerity all combine to necessitate a thorough review and reassignment of missions, the restructuring of VA facilities and the realignment of their roles and services. VA rejuvenation is essential, and must be done with a sharp eye to the future.

There are some VHA features which will facilitate adjustment to an environment of managed competition constrained from above. The VA health care system has always operated under prospective global budgets and it is by nature a quasi-HMO with a managed care mode of health care delivery. There is little reason for any defensive practice of medicine. And, although the system is inefficient, perennial shortfalls have certainly made its managers cost conscious.

The inefficiency stems from a VA environment that is antiquated and a practice style that is obsolete. This environment has the effect of increasing the cost of VA delivered care and impeding its delivery. Efforts to change the mission of its hospitals, to accommodate the changing health care needs of veterans, have at best been dilatory. There is a remaining need to eliminate unnecessarily duplicated programs and to regionalize certain services. Resource allocation mechanisms should not provide facility directors with perverse incentives. The need for change is further aggravated by the unwillingness of some VAMC directors, supported by some members of Congress, to accept recommended mission changes that would be in the best interest of the VA health care system and the veterans it serves. This often perpetuates inefficiencies and
marginal quality care.

**Entitlement Reform: The First Priority**

The greatest impediment to efficient delivery of health care is the current morass of veterans' entitlement to that care. The fragmented and confounding entitlement rules have created a system of care within the VA that is comparable to no other. VA physicians cannot deliver care to veterans in the same way it is delivered in the private sector. They must use the modalities of care for a given veteran that are tied to his level of entitlement.

Whereas outpatient care might be the appropriate modality for treatment of a given condition, costly inpatient care is often substituted. A single outpatient visit, with denial of any follow-up appointment, is the result for many nonservice-connected veterans seeking VA care for which they are unknowingly only partially entitled. Not only do these statutory constraints on patient management deny the needy veteran the most appropriate care, they deny his physician the opportunity to practice

contemporary medicine in an ethical manner. Finally such barriers to proper medical practice cost the VA more than is necessary to treat its population of veteran users.

In today's environment of national health care reform with the imperative for cost constraint, VA must be allowed to participate with the nation's health care industry on an even playing field. VA system should not be criticized for inefficient and questionable medical practices if the rules by which it must deliver care generate those very problems, along with the provision of care at higher costs than should be expected within this diverse system.

Entitlement reform is of top priority. It is the critical component of any meaningful strategy for system recovery and the necessary precursor of any valid strategic planning. The VA health professionals must be allowed to practice contemporary medicine. In the past the rationale for not pursuing meaningful entitlement reform has been the anticipation of consequent demand that could not be met with the resources available. However, VA finds itself in a precarious position at this time. With the enactment of some form of national health care reform on the horizon, VA is not in a position to provide the same continuity of care for a given condition as an individual can expect to receive in the private sector. The situation is such that if a veteran is given the option for care in the private sector, with little or no out-of-pocket cost, many medically indigent nonservice- connected veterans will likely opt for care in the private sector where they will expect high quality, continuous care to be provided in the most appropriate setting. This inequity must be corrected.

Veterans must clearly understand they are entitled to comparable opportunity for service within the VA system. Entitlement clarification would stem some of the VA losses PVA anticipates as a consequence of national health care reform enactment. It would also lower the cost of VA care, allowing VA providers to practice a higher level of managed care. Reference is often made that fairness in competition calls for a level playing field. Under the expected environment of universal health care coverage, there needs to be VA based incentives to balance those enticing the veteran into the private sector for his health care.

The health policy statement of the *Paralyzed Veterans of America* has for some time included this resolution:

> *"Congress should reconfirm its historic commitment to veterans' health care and mandate entitlement to the full continuum of care to all veterans fulfilling the criteria of category a classification. It should, furthermore, acknowledge responsibility to provide, now and under any future health care reform legislation, funds to assure legally entitled veterans all necessary and authorized medical services, including preventive, acute, restorative and long term care. To obviate poverty spend-down, all permanently and catastrophically disabled veterans should be classified under Category A. These veterans should be considered part of the "core entitled" group."*

The General Accounting Office, in its December 1992 transition papers, phrases this recommendation more succinctly: "Remove differences in veterans entitlement for inpatient, outpatient, and long-term care and provide service-connected and poor veterans with a full range of needed health care services."

The need cannot be overstated. Entitlement reform is the essential first step to revitalizing the veterans health care system.

**Workload and Cost Control Under Entitlement Reform**

The correlated issue in addressing entitlement is how to control

costs resulting from anticipated workload expansion of certain services. Ignoring, for this purpose, the impact of national health care reform, consider the effect on workload of giving the core entitled group of veterans access to the full range of VA services and at the same time restructuring and modernizing the modalities of VA delivery of health care. Since an entitlement already exists for inpatient hospital care there would be no pressure placed on this modality of care except from some of whom do not have access to VA, and some increase for elective procedures that are now delayed. As PVA sees it, the inpatient hospital workload could decrease since as much as 40 % of current hospital workload may be under inappropriate venue. Admittedly, much of this is due to the lack of space appropriate for ambulatory surgery or even outpatient clinics. There is also the problem of veterans traveling long distances to VA hospitals without having provision for local domiciliary arrangements.

Outpatient care would experience substantial increase due to several factors: 1) workload that would be shifted to outpatient care that is now done on an inpatient basis, 2) workload that would result from monitoring chronic conditions, care for acute illness that should not require hospitalization and some chronic psychiatric care, 3) the establishment of preventive programs, and 4) the creation of long term care programs to maintain individuals outside of the institutional setting.

Nursing home care: Since there is no current entitlement to nursing home care, a considerable demand could be expected from entitlement reform alone. The real issue becomes how to control the workload for nursing home care in an unconstrained environment since savings from inpatient hospital care would be required to offset the increased outpatient workload. The answer lies in controlling cost which can be accomplished in a number of ways.

Before addressing the issue of controlling cost of nursing home care it is important to return to a consideration of entitlement reform in the context of national health care reform. If national health care reform provides, as we assume it will, some limited long term and nursing home care, this would have a dampening effect on demand for care in the VA system, which might well be offset by surfacing of suppressed demand. Further, if the conditions under which the nonservice-connected veteran could obtain long term care in the private sector were to be as generous as that provided him in the VA, the effect would be an extensive lessening of demand for VA long term care.

However, in Strategy 2000 PVA stated that by the year 2000 acute medical and surgical inpatient workload would decrease by as much as 50%, that outpatient medical surgical workload would decrease by 25% and that the level of nursing home care would remain essentially the same as today. The conditions under which this forecast would occur were specified as 1) a continuing inadequate VA budget through the year 2000, 2) entitlement to VA care unchanged from the present, 3) a generous benefit package under national health care reform that included some long term care, and 4) little or no out-of-pocket costs for our user veterans (i.E. 90% Of the nsc users of the VA system have incomes of $10,000 or less).

With continued limitation on VA nursing home care access under these conditions:

- There would be no change in the VA nursing home program.
- Those veterans opting for the benefit under national health care reform would be replaced by other veterans requiring nursing home care.
- The census is capped by the number of VA beds and funds to purchase such care in the private sector.

There would be a net loss in inpatient hospital care. Since some of this inappropriate workload would shift to outpatient care, with some loosening of resources, the net loss in the outpatient program would be limited to approximate 25% – all of the psychiatric programs being unaffected. Some of the resultant shift in resources could be used to support the specialized services the VA will provide that are not adequately covered in the private sector under national health care reform.

**Workload and Cost Control Revisited:**
**With National Health Care Reform and VA Entitlement Reform**

Now let us examine the affect of national health care reform on a VA health care system already committed to veterans' entitlement reform. Because of the system flexibility predicted by the authors of the managed competition concept, preliminary consideration must also be given to various configurations of VA structure and services within that framework. In any design for VA/private sector interface, however, there must be assurance of complete health care access for all needy, service connected and catastrophically disabled veterans, with special focus on the specialized programs referenced below.

Workload mix can be controlled in each VA medical center through sharing agreements with hospitals and clinical facilities of affiliated medical schools, the department of defense and private communities. Long term care access would be controlled by the number of VA operated beds authorized by Congress for nursing home care and the funds appropriated by Congress for nursing home care outside the VA utilizing both the state and community programs. All nursing home care would be provided on a cost sharing formula related to the income of the veteran. Priority would be given to those veterans enrolled as VA users and who use VA as the their primary care giver. Capacity could be expanded to meet demand and to control case mix – based on the ability of VA to recover the cost of care from what ever payors might be defined by national health care reform legislation including medicare and sharing agreements.

With entitlement reform and national health care reform, rural hospitals in the VA system could be expected to provide a central role in health care. They could meet more of the health care needs of veterans and, through sharing agreements, meet some of the needs of the community of which they are a part. Sharing agreements could be used to offset VA's cost of expanding its service delivery capabilities in these rural settings.
In the non-rural areas, especially the cities, the VA program should be structured to fit the environment. For example there should be an agreed upon relationship between the number of psychiatric beds – both acute and long-term in the private sector and the VA – sufficient to meet the veteran need and in accordance with community agreements regarding VA's market share responsibility. The same approach could be used for acute medicine and surgery beds. Such planning could help VA fit into the reformed system in an optimal way through planning between the community and the VA to assure veteran health care needs are met. This would be especially important for VA as it expands its capacity to meet the needs of its veterans who require specialized and long term care programs.

**Specialized Programs**

A word about *Strategy 2000* and specialized programs. The outcome of the PVA study calls for significant changes in VA hospital missions, based on service areas and hierarchial relationships among realigned component programs. The objective is to strengthen the system while anticipating reformation of U.S. health care in the near future. VA should complement and supplement the basic

benefits to be provided under tomorrow's universal health care to assure veteran health care needs are met. It is highly unlikely that the universal health care benefit package would include any significant coverage for such high cost specialized care as spinal cord medicine, blind rehabilitation, prosthetic rehabilitation and research, mental illness, war related post traumatic stress disorder, substance abuse, geriatrics and long term care. They are the very same programs in which VA excels. Tomorrow's VA should place special emphasis on the direct provision of all otherwise inadequately provided specialized medical programs. These specialized services, however must be accompanied by the provision of all the necessary multi-disciplinary clinical support. Spinal cord injury medicine is a typical example of such a complex multi-specialty service in which treatment cannot be fragmented, isolated, nor segregated. It does not end with acute care, but involves a comprehensive continuity of life-long medical and social and economic support. Catastrophically disabled veterans deserve no less.

**And Then There is Financing**

The statement was made earlier that analytical attempts at predicting future VA health care workloads must consider multiple factors, both quantitative and intangible. But when multi-factored models are programmed into computers and their results analyzed, it becomes apparent that the influence of funding assumptions determines the output. All the data analysis, trend identification and guesstimates about veteran's behavior are "dampened" to insignificance by the overwhelming power of funding to determine workloads.

The amount of the annual appropriation determines VHA workload and will continue to do so in the future. The effects of other influential factors – veteran demographics, entitlement reform, the effect of national health care reform – cannot be accurately estimated without specifying some assumed level of appropriations. Reflection on the past twelve years' VA appropriations and expectations for the remainder of the decade should make it apparent that funding is not determined by demand.

For some years now VA has attempted to keep pace with the ever increasing demand for health care in the face of ever decreasing level of resources – by cannibalizing the system. However, had VHA effectively realigned its programs and facilities, consolidated its redundant services and modernized its modalities of care, budget shortfalls would probably have still been there. VA restructuring can yield savings that could be used to improve access and quality were they not to be lost through budget decrements penalizing increased efficiency.

Utilization of the VA system has changed significantly in the past five years and will continue to change. National health care reform legislation is imminent. The President's plan or something like it will probably get through Congress. It will change VHA's casemix of patients. Entitlement reform will change veterans' access to care and the VA's modalities of providing that care. Restructuring will change the way it distributes resources. However, restructuring will require a significant investment in VHA, which will not be available unless there is a consensus that VHA has a future as a part of the nation's reformed system of health care delivery and financing. Then, finally, it is the level of funding requested by the administration and appropriated by Congress that will ultimately determine tomorrow's VA workload.

**Back to the Level Playing Field**

It is especially disconcerting that the VA health care system is

deteriorating at the very time the nation's entire pluralistic health care industry is caught in such crisis. VHA must be challenged to eliminate the negative forces compromising its productivity and reputation. Assuming a revitalized VA health care system, the assurance of adequate financing through appropriations and extramural reimbursements, and legislated entitlement reform as outlined above – additional incentives will still be required to accomplish a level terrain for VHA competition with more conveniently placed private health care providers. These incentives could take the form of exemptions from cost sharing, provision of specialized services beyond the nation's basic medical benefit package, opt out provisions, a full continuity of high quality health care, and socio-economic support.

As Congress settles into final debate on the nature of health care reform it must be able to reaffirm the VA system's value for its special expertise in the treatment of war-related conditions, its contribution to health professional education, its back-up to the Department of Defense and the National Emergency Medical System, its service to difficult and un-wanted drug and alcohol abusers and psychiatric patients, its unique setting for large scale clinical trials that transfer newly developed medical technology to the marketplace, and the exceptional quality of its prescient geriatric training, treatment, and research programs. Congress should affirm the continued presence of the VA system and define its role as a valued component of tomorrow's system of universal health care coverage.

This concludes my statement, Mr. Chairman.

STATEMENT OF

DENNIS M. CULLINAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

PRESENT AND FUTURE ROLES OF VA HEALTH CARE

WASHINGTON, D.C. APRIL 28, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million members of the Veterans of Foreign Wars of the United Sates I wish to thank you for inviting us to participate in today's most important hearing. Through the years the VA health care system has been of profound importance to veterans throughout the nation. In carrying out this nation's obligation to care for her military veterans in their time of need, the VA health care system has also proven to be of great service to all Americans. VA contributions in the areas of medical research and education have been instrumental in making overall American health care and science the best in the world. Further, in caring for medically indigent veterans in a highly cost effective manner, VA has reduced the burden which would have been placed on Medicaid as well as other federally funded social services. The savings accrue to benefit the American taxpayer. In our view, there can be no doubt that the VA health care system should be a critical and integral part of any national health care delivery system. The VFW is highly gratified in being provided this opportunity to help to more precisely delineate the role of the VA health care system in this regard.

It is now acknowledged by many that the problems associated with skyrocketing health care costs and the consequent lack of accessibility for individuals throughout the nation have reached crisis proportions. Health care reform is viewed by many as being both an urgent human priority and an economic necessity. By 1994 there will be 40 million uninsured in the United States

with another 22 million underinsured. Millions of Americans throughout the country are now demanding increased access to what is clearly the finest health care in the world.

While the VFW is, of course, supportive of a national health care system which would provide a comprehensive benefits package for all Americans, we are adamant that the VA health care system remain dedicated to America's veterans. The VFW believes that within the context of national health reform the VA should remain a separate, independent and exclusive health care option for veterans. Rather than trying to assimilate the VA system into a national health care configuration, we believe that it is best to build upon VA's strengths and construct a national health care system around VA. In this way VA would serve as the anchor of a national health care system and, in fact, constitute it's crown jewel.

The VFW acknowledges that in certain aspects the VA system as we know it today may have to be modified somewhat in order to better serve veterans and to better fit the parameters of a national health care system. The VFW recognizes that the present configuration of VA medical assets do not take fully into account the current demographical picture of the nation in terms of where the majority of its potential veteran patients are located. We are confident, however, that through the modification of how and where VA operates and of the health care modalities it provides, VA will be better able to meet the demands of a growing universe of veteran patients. The VFW is committed to the concept and the reality of VA providing the best possible care to veterans in accordance with state of the art medical practices and procedures, and we are certainly not tied to a particular physical configuration. VA should be allowed and encouraged to reconfigure itself into a viable health care delivery system which is more available to its patients through such things as more mobile clinics, smaller hospitals, more out-patient clinics, and screening units. In this way the veterans' health care system will be better able to care for those to whom it is dedicated and serve

as the guiding star by which the voyage to effective national health care reform may be accomplished.

It is now apparent that national health care reform in this country is to be pursued in accordance with the "managed competition" model, and the VFW is confident that, given certain resources, the VA health care system will be able to compete very effectively within this environment. We point to studies which show that VA already provides quality health care at less cost than is currently available in the nation's community hospitals. Provided with the proper resources, and allowed to build upon its already considerable strengths, the VA health care system will certainly become the "HMO" of choice for America's veterans.

But having likened the veterans' health care system to a for-profit HMO, we must reaffirm our conviction that the VA has always been and should continue to be something far more than just another business oriented health care provider. The mission of the VA health care system is basically four fold: First and foremost is medical care for veterans; Second, is education; Third, is research, and Fourth is back-up of the DOD health care system during time of war or national emergency. There must be no change in the mission of the VA health care system since its continued operation is not only vital for veterans and beneficial to all Americans, but also unique and irreplaceable with respect to the areas of education, research and DOD back-up.

Just to briefly illustrate this case, it must be remembered that over half of the physicians in this nation have received some or all of their training/education through the VA medical system. Further, VA research and development in such areas as those affecting the blind or deaf, spinal cord-disabled, and individuals needing prosthetics and/or suffering from traumatic injuries is without equal. These advancements would never have occurred within the private sector. Finally, the VA health care system provides a physical plant as well as reservoir of trained health care professionals in its capacity of backing-up the DOD system while serving veterans that would simply not be otherwise available. The VA is a vital national resource which must be both strengthened and preserved. Whether national health care

reform is achieved or not, there is no adequate replacement for VA.

We believe that in order for VA to continue to be able to serve America's veterans as well as serving as the guide and focal point of national health care reform certain criteria must be met. We believe foremost that VA should be established as the primary provider of health care for America's veterans. Critical to this end is reforming VA's current eligibility standards for health care--they must be changed so that all service-connected and indigent veterans are mandated care by VA and all other veterans are mandated access to care. Within this framework, as more and more veterans are drawn into the VA health care system--their provider of choice--it is essential that VA be allowed to retain at least a portion of its third-party collections (be they federal dollars such as Medicaid or from private insurers) without offset from its annual appropriations. Of course, the transfer of funds from other federal agencies and departments to VA must still be provided for under law. This will allow VA to provide for the needs of an increasing number of veteran patients and properly fulfill its role as a component of a national health care system.

With respect to the issue of funding for VA, it is our position that regardless of the form any national health care system assumes, VA must retain its exclusive appropriations support. As was indicated earlier, VA has always been, and should always be, far more than just another health care provider. In meeting this nation's moral and legal obligation to care for those who have often sacrificed so much on behalf of the national good, VA is providing service and knowledge to the nation of incalculable value, going far beyond what may described in dollars and cents alone. This value, this good which flows to veterans and non-veterans alike, may only by sustained by providing VA with a sufficient annual appropriation.

It is the belief of the Veterans of Foreign Wars that the VA health care system should serve as a contributing partner and model for the future. Through sustaining and improving the VA health care system, all Americans will benefit.

Mr. Chairman, this concludes my statement. Once again, I wish to thank you on behalf of the entire membership of the Veterans of Foreign Wars and its Ladies Auxiliary for including us in today's most important hearing. Germane resolutions are appended to this statement and I would be pleased to respond to any questions you may have.

Resolution No. 624

FULL APPROPRIATION SUPPORT FOR VA MEDICAL CARE

WHEREAS, a succession of laws enacted by the Congress have stipulated specific types and levels of medical care for certain classes of veterans; for example, those who are service connected; and

WHEREAS, there is no binding language placing the government in the position of obligor in terms of precise levels of funding for this medical care that it directs to be provided; and

WHEREAS, this circumstance places the Department of Veterans Affairs, as the agent for the veterans it serves, in the position of perpetual supplicant in the matter of obtaining funds to carry out its moral and statutory mandates; and

WHEREAS, this situation impacts adversely upon veterans seeking medical care under programs established by the Congress; now, therefore

BE IT RESOLVED, by the 93rd National Convention of the Veterans of Foreign Wars of the United States, that the obligation and requirement to adequately fund veterans health care shall be acknowledged and properly met through appropriations actions which provide requisite funding to support all veterans medical services and programs authorized by the Congress.

Adopted by the 93rd National Convention of the Veterans of Foreign Wars of the United States, held in Indianapolis, Indiana, August 14-21, 1992.

Resolution No. 651

OPPOSE NON-VETERAN ACCESS TO VA HEALTH CARE

WHEREAS, from time to time the health care delivery system of the Department of Veterans Affairs is subject to both internal and external review in an effort to determine the best mix of physical plant and staffing needed to meet the needs of those of our veterans entitled to VA health care; and

WHEREAS, as consumer advocates for veterans, we have a proprietary interest in the continuation of VA as a cabinet entity devoted to the administration of entitlements exclusively for veterans, who have been designated as a unique class of citizens based upon service to the nation; and

WHEREAS, the continued need for a specific health care system designed to accommodate veterans of past and regretfully future wars; and

WHEREAS, there seems to be a never ending supply of suggestions that VA health care delivery be significantly altered by the inclusion of non-veterans in the ostensible hope that this would generate an infusion of outside funding for the VA; now, therefore

BE IT RESOLVED, by the 93rd National Convention of the Veterans of Foreign Wars of the United States, that we urge the Congress to reject any proposals to dilute or change the historical mission of the VA by accepting non-veterans into its' care; and

BE IT FURTHER RESOLVED, that we remind both the Congress and the Administration of their collective commitment these many years to fund programs providing high quality medical care to veterans entitled to same by reason of their prior service to the nation.

Adopted by the 93rd National Convention of the Veterans of Foreign Wars of the United States, held in Indianapolis, Indiana, August 14-21, 1992.

Resolution No. 651

Resolution No. 650

NATIONAL HEALTH CARE IMPACT ON VA

WHEREAS, the Department of Veterans Affairs is responsible for the health care of veterans of the Armed Forces of the United States; and

WHEREAS, the VA hospitals and medical care facilities have been providing this health care for sixty years; and

WHEREAS, the veterans of this country deserve to be treated as special cases with special treatment for the entitlements that they have earned through their military service; and

WHEREAS, there is an increasing demand by the electorate of the United States that some sort of federal health care be provided for all residents of the United States; and

WHEREAS, there has been introduced in the 102nd Congress national health care proposals which would eliminate the veterans health care system; and

WHEREAS, we believe that all Americans should have access to health care, and we are not opposed to a universal health care proposal that would provide this service, if it in no way undermines or diminishes the VA health care system's historical role of caring for veterans; now, therefore

BE IT RESOLVED, by the 93rd National Convention of the Veterans of Foreign Wars of the United States, that we oppose any national health care bill that would reduce or abolish the VA health care system.

Adopted by the 93rd National Convention of the Veterans of Foreign Wars of the United States, held in Indianapolis, Indiana, August 14-21, 1992.

Resolution No. 650

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
APRIL 28, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.4 million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, I want to first extend DAV's appreciation for the opportunity to appear before you today and offer our thoughts regarding the issue of health care reform.

Your letter of invitation solicited our views on the principles which should govern consideration of the way the Department of Veterans Affairs (VA's) is positioned vis-a-vis national health care reform.

Mr. Chairman, you and members of the Subcommittee deserve special recognition for the concentrated efforts being made to garner as much information as possible on this most important subject.

The DAV acknowledges and applauds these efforts.

As we contemplated the approach our testimony should assume for today's hearing, many thoughts came to mind. Initially, we tried to recall all that has been said about the state of our national health care system. That was immediately followed by thoughts of attempting to recall all that has been offered in hopes of fixing the system; and, the seemingly unending plans, proposals and legislation offered toward that end.

In view of the magnitude of such a challenge, what we have decided to do is attempt to offer a perspective that sometimes has become lost in debates as large, multifaceted and complex as the one regarding national health care reform: the perspective of a consumer of, and an advocate for, VA health care.

Mr. Chairman, few know as well as you the imminent crisis facing this nation and its citizenry as the result of a broken health care delivery system. Broken predominantly in terms of:

* Some 100,000 people per month losing their health care insurance coverage and joining the swelling ranks of uninsured and underinsured Americans;

* Unrelenting escalation of health care costs that consume 14 percent of our gross domestic product today and will rise to 18 percent in the year 2000, an unthinkable bill of $14,000 per family; and

* Lack of security and the threat that individuals will not have adequate access and coverage to meet their basic health care needs.

As we are all so keenly aware, the VA health care system is also in the throws of crisis. Principally, such crisis results from years of inadequate funding and a "patchwork" approach to addressing the health care needs of veterans.

Today, as in the past, VA is faced with funding shortfalls that produce numerous adverse effects on the delivery of health care, the most common of which include:

* Bed closures;

* Staff reductions;

* Delayed physical plant maintenance;

* Delayed equipment purchases/repairs; and

* Rationing of care to extreme proportions.

Mr. Chairman, I would add at this juncture that were it not for the House Veterans Affairs Committee, your counterpart in the Senate and, I believe, principally the thousands of dedicated, committed VA health care professionals throughout the system, we would be in far worse shape.

It seems logical at this point to state what I am sure is the obvious: the VA health care system, as an independent system, must be maintained and, once the philosophical commitment to do so is realized, appropriate action and attention must be exerted to foster VA's evolution as a provider of health care services to a very special segment of our population ... a system that meets the test of quality and cost effectiveness.

During last year's Presidential campaign, it was indeed heartening to hear President Clinton profess his support for the maintenance of the VA health care system. Most recently -- April 15th -- the First Lady, Hillary Rodham Clinton, met with leaders of the major veterans' service organizations (VSOs), as well as Veterans Affairs Committee Chairmen Montgomery and Rockefeller, Secretary of Veterans Affairs Jesse Brown, and again asserted the President's support for an independent VA health care system.

Mr. Chairman, simply stated, the VA health care delivery system is one that is nationally dispersed and provides comprehensive care to a specifically defined population. The Veterans Health Administration (VHA) operates and maintains the system and has as its mission to provide:

* A complete health care delivery service for 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.

Currently, the VA system is comprised of 171 VA hospitals, 371 outpatient clinics, 131 nursing homes, 36 domiciliaries and 201 veterans' outreach centers. VA employs some 209,000 individuals.

During 1992, the VA treated approximately 2.7 million different veterans as patients, approximately 600,000 of whom received inpatient care and nearly all received outpatient care. This workload represents somewhat more than 10 percent of the total veteran population. On average, however, VA patients are older, have lower incomes and need more comprehensive care than their counterparts in the general patient population. The VA medical care program is designed to meet the special needs of

the veteran population and has created an associated health care delivery mechanism designed to meet those needs. In VA, inpatient health care is linked with outpatient care and specialized care modalities to provide an integrated, comprehensive system of health care delivery for eligible veterans.

It is significant to note that the care for the typical veteran patient differs significantly from health care delivery in the private sector. In a private hospital, the typical patient receives medical care preceding the hospital episode and is then sent to the hospital for treatment of a specific condition. Upon completion of treatment, the patient typically returns to home and job with necessary medical care follow-up being rendered in the private doctor's office within the community.

However, Mr. Chairman, many VA patients do not or are not able to follow those steps. Often they arrive at VA as self-referrals. Their diagnostic and inpatient treatment proceed, usually for several medical problems. When specific treatment is completed, the need for post hospital care must be addressed. Often times additional days of non-acute inpatient care may be provided as being found preferable to having patients travel long distances to their homes from the hospital only to return shortly thereafter for follow-up care. This may produce extended length of stays in some instances, however, it is certainly preferable to ensure that veterans receive adequate follow-up care.

Mr. Chairman, the system I have described and what we know as the VA, is a good system. Veterans are a proud, patriotic and heroic group of men and women who have repeatedly answered their country's call to service. For veterans, many memories and lingering thoughts of our military service will always be with us. Most are good memories of past friendships, acquaintances and adventures. Still others are the thoughts and memories of less pleasant times, of bodies and minds ravaged by the instruments of war. Through it all, to many of us the last tangible reminder of what service to our country means is the VA hospital sitting there atop a hill.

Countless millions of people -- veterans and nonveterans alike, have had contact, if only visually, with a VA hospital and realize what sacrifices have been made that make such a facility necessary. These facilities serve as constant reminders to all who witness them what the price of freedom really means.

## REFORM OF THE VA HEALTH CARE SYSTEM

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 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 veteran patients are denied care. More troubling, some non-discretionary veterans -- Category A veterans -- those with the highest priority of care, are experiencing greater difficulty receiving the care they need. And, in certain instances, the care that is available and provided is of suspect quality.

Mr. Chairman, the DAV does not view today's hearing as a forum to list in detail the myriad of things that many view as

being wrong with the VA system. Neither, are we here to assume the role of VA bashers. Rather, we hope to offer viable suggestions and remedies for a system that we feel is one deserving to be maintained. A system that, given a fair chance, possesses the potential in both human resources and commitment to deliver health care to veteran patients in a manner second to none.

Likewise, the complexities, magnitude and sheer vastness of the VA system and, therefore, the number of issues involved do not lend themselves to easy discussion on an issue by issue basis. As would be expected, a more global view is necessary.

Mr. Chairman, clearly, in our view, the factors which have led to the current crisis in VA health care are many. However, none is more telling than the constant decremental budgeting that has occurred within the VA health care system. This has occurred at a time when veterans have been placing more and more demands on the system and VA has been required to implement many new programs and methods of delivering health care, often without accompanying resources.

The percentage of the total federal budget spent on veterans' programs has been cut in half from 4.4 percent in 1977 to 2.2 percent in 1991. I am appending to my statement a chart showing federal outlays for social welfare programs in constant 1991 dollars. The chart, from the Congressional Research Service, clearly shows that starting in 1965 and continuing through 1991, federal dollars devoted to veterans' benefits have remained constant while spending in other programs, such as Social Security and Medicare, as well as other health programs have shown dramatic and constant increases.

In our view, Mr. Chairman, and we believe it is a view shared by most others, the issue of eligibility reform is the single most pressing issue facing VA health care today. Eligibility needs to be clarified to define who is eligible for VA health care services and the scope of services that will be provided.

Mr. Chairman, we believe such an effort would assist not only veterans seeking care but, would be of immense benefit to the VA itself. With eligibility reform, veterans would know what they are entitled to and thus be enabled to plan for their health care needs. By removing the antiquated -- both economically and clinically -- rules for care, veterans' health care needs on an inpatient, outpatient and long-term care basis would be better met. With eligibility reform, VA's ability to strategically plan would be available. Perhaps for the first time VA would be required and able to plan based on veterans' needs rather than simply on budgetary feasibility and restraints. Also, simplification of eligibility criteria would result in a more efficiently administered system.

Mr. Chairman, on February 20, 1992, legislation was introduced -- the "American Veterans' Health Care Reform Act of 1992" -- that embodied, in bill form, the DAV's vision and plan for a restructured VA health care delivery system.

At the time the bill was introduced, the DAV had not witnessed any positive response on the part of VA to the Mission Commission's recommendations. Additionally, the VA's own health care eligibility reform package that was being developed appeared to be shelved. As the initiatives called for by the Commission appeared to be in limbo, we felt it imperative to continue the dialogue initiated by the Commission's recommendations.

We believed the bill served as one vehicle to initiate the debate on what direction the VA health care system should and must take in order to survive and flourish. Also, we believed it represented a responsible plan of action to ensure that an independent VA will exist to serve the health care needs of veterans well into the 21st century.

Mr. Chairman, similar to the DAV's proposal of some three and a half years ago calling for increased VA/Department of Defense (DOD) health care sharing, we believe our proposal represents a plan that promotes responsible, realistic proposals for initiating reform of VA health care.

In developing our proposal, we considered the recommendations of the Commission. Also, we met and had numerous discussions with members of the Commission, other health care professionals, Congressional staff and VHA personnel, as well as other veterans' service organizations.

In general, our plan has three main components consisting of:

* Access to care, including a core-entitled group and a general eligibility group;

* Scope of care, that is a description of the services provided; and

* Funding of care.

Mr. Chairman, the centerpiece of our proposal establishes a group of core-entitled veterans. This group consists of service-connected veterans, low income veterans, POWs, and other veterans currently defined by "Category A." All other honorably discharged veterans outside of the basic core group would be eligible for care. However, their eligibility would be contingent upon the ability to offset costs through reimbursements by federal or other third party payors, direct payments or purchased, managed care packages.

Secondly, our proposal calls for the focus of VA moving from a "sick care system" of a traditional acute bed based model to a disability based model. This "continuum of care" would focus on health promotion and disability and disease prevention and treatment. Eligibility to core-entitled veterans would flow on an inpatient, outpatient and long-term care basis. Non-traditional means of treatment such as adult day health care, home health and maintenance services, etc. would be provided as would other, necessary collateral health care services.

Finally, our proposal calls for an entitlement to be created and nondiscretionary Congressional appropriations to be made for the cost of care provided to the core-eligible group. Appropriations would be dependent upon how many veterans meet the core group eligibility requirements and the necessary cost of care to be provided.

Funding for the non-core, general eligibility group of veterans' care would be discretionary and could be determined in consideration of reasonably expected collections of reimbursements from other sources.

Mr. Chairman, we propose VA be granted authority to be reimbursed for care provided to veterans <u>outside the core-entitlement category</u> who are covered by Medicare, Medicaid, CHAMPUS and other private or third party health insurance carriers under the various provisions governing those programs.

It is important at this point, Mr. Chairman, to clarify our intent as to who the principal beneficiaries of the VA system should be. Certainly, service-connected disabled veterans should receive their care from the VA through Congressionally appropriated funds to the VA system.

We advocate the VA's ability to collect and retain funds from secondary payors -- Medicare, for example -- as being applicable only to eligible veterans outside the core-entitled group.

With that stipulation, Mr. Chairman, it should be clear that we do not believe the VA should continue to "subsidize" the Medicare system by treating Medicare eligible veterans who have basic eligibility but no priority for VA care. Therefore, our proposal clearly does no harm to the Medicare Trust Fund as Medicare should be responsible for the primary health care needs of those individuals. We happen to believe VA is able to provide care more economically than the private sector. Therefore, the added benefits of economies of scale should prove very cost efficient.

I believe, Mr. Chairman, you will find a consensus agreement among all the VSOs, as well, to a degree, among the VA and Congress that the system needs reform. Additionally, and in no way attempting to speak for the other VSOs, I believe we are in almost universal agreement about what needs to be done in the process of reform.

More surprisingly, perhaps, is our belief that VA's thoughts concerning entitlement reform closely mirror those of the VSOs.

On April 2, 1993, Secretary of Veterans Affairs Jesse Brown, setting forth his vision for VA, stated, in part,

> "We will be an active participant in national health care reform to ensure that a comprehensive medical care system for veterans is developed and maintained. Moreover, we will move to make our system available to all veterans who choose to use it. Further, we will explore whether access can be expanded to include veterans who would be willing to pay for care through their insurance coverage, Medicare benefits, or personal funds. And without exception, we would guarantee top quality service in top quality facilities.
>
> We will aggressively respond to the changing needs of our veterans. This will include emphasizing improved delivery of services to veterans with special needs, such as AIDS, PTSD, spinal cord injury, prosthetics, and exposure to environmental hazards, and to homeless, older, and female veterans. We will be the leader and share our innovative approaches and experiences in these and new areas, such as national service, with the rest of the nation."

The document, "The Independent Budget for Veterans Affairs, Fiscal Year 1994," jointly produced by AMVETS, DAV, PVA and the VFW sets forth a strategy -- pages 70-72 -- for entitlement reform.

Appended to my statement is a position paper endorsed by the American Legion, DAV and VFW setting forth our collective views regarding how health care should be delivered by the VA.

Mr. Chairman, the striking characteristics of all the VSO proposals and plans are they all speak similarly not only to the point reform is needed, but how it should actually occur.

The salient point, Mr. Chairman, is that a true consensus has been achieved by the VSOs as to the need for and the method in which entitlement reform should proceed.

Mr. Chairman, when looking at a reformed VA system, configured in the manner I have described, and while recognizing the population VA treats, together with the concepts VA operates within (global budgeting, managed care, and access to care), one can see how VA would mirror the outcomes being strived for by the National Task Force on Health Care Reform.

While we have all had some limited access, via the media, to what Mrs. Clinton and the Task Force are considering, the specifics of the proposal are not yet known. We envision, however, some main components to be:

* Universal access to care;

* Global budgeting;

* Freedom of choice;

* A basic benefits package of services; and

* Controls on greed, waste and abuse relating to medical resources.

There were and remain some who would say that the veterans' health care system -- as a direct provider of health care -- will be "damned if it does and damned if it doesn't" become an active, acknowledged participant in the national debate over health care reform. If VA does enter the debate and seeks to be factored into any national health care delivery and/or financing considerations, it lays itself open to considerable scrutiny by many who may be less interested in maintaining an independent system for veterans. Conversely, there are those who fear such scrutiny would lead to changes that move VA out of the traditional role it has played in American medicine.

Mr. Chairman, the DAV is indeed pleased the decision was made to include the VA as an active participant, not only in the debate regarding health care policy but, also as an active participant in the Task Force and their 34 working groups.

In our view, VA has nothing to fear as a result of scrutiny. Rather, VA can and should be recognized for what it really is: a system that can help realize the stated goals of national health care reform.

VA is important for the many significant roles it plays and contributions made to health care in instances such as:

* Provision of general and specialized services to veterans;

* Safety net for low income veterans;

* Education of health care personnel;

* Major contributor to medical research; and

* The major backup to DOD in the time of war, as well as an integral factor when our nation is besieged by natural disasters, such as Hurricane Andrew.

Mr. Chairman, it is no secret that the driving factor in VA's inability to provide appropriate care to all eligible veterans stems from a deficient funding mechanism.

Notwithstanding the funding issue, VA does in fact operate under the same principles envisioned by the Task Force. They have always operated under a "global budget" and have provided "universal access," at least to the highest priority veteran.

Likewise, they provide not only a "basic benefits package" but, within the framework of the system, provide every conceivable form of medical care ranging from the most basic preventive measures and extending to multiple organ transplants and everything in between. This, coupled with a comprehensive rehabilitative program for the catastrophically disabled, cannot be matched anywhere else.

VA health care has operated within the framework of a "global budget" since its establishment. VA managers both at Central Office and in the field have become not only accustomed to, but adept at devising innovative and visionary methods of coping with an ever eroding fiscal base and ever increasing demand for services.

Mr. Chairman, the DAV is convinced the VA stands alone as a competent, quality, innovative, cost effective provider of health care services to a special, albeit, complicated population of patients. Further, we remain confident that given the opportunity to compete, and when allowed to do so on an even playing field, VA is extremely well positioned and able to do so.

The role VA has assumed over the years which takes account of its long-standing missions, as well as multiple health care roles, sets it apart as a model that the country should emulate.

VA should be looked to as an opportunity. The VA has not denied care to individuals simply by virtue of the nature of their disabilities as the private sector often does. Rather, VA has learned how to treat, in a cost effective manner, the whole person. VA does not cancel veterans "coverage" or "charge" veterans exorbitant rates based on the nature of their disabilities.

VA is a recognized leader in geriatric medicine and provides the flexibility needed to care for older veterans through inpatient, ambulatory and community based programs such as adult day health care and hospital based home care services.

VA has been successful in controlling the cost of prescription drugs which, as we all know, represents one of the most uncontrollable and disgraceful factors in the rising health care costs to this country.

In addition to comprehensive medical and rehabilitative programs, VA assists the severe and catastrophically disabled with comprehensive services including such necessities as driving education for spinal cord injured or amputee veterans and adaptations to veterans homes so a degree of independence may be obtained and the need for costly medical care lessened.

The VA has established itself in the foundation of American medicine. In many respects it is but a microcosm of the entire medical care community. At a certain point, however, it breaks away and assumes a vitality all its own.

It is that vitality, Mr. Chairman, that needs to be exposed and released to all of medicine. It needs to be allowed to grow and flourish. VA presents a unique opportunity to lend its decades of experience and innovations to the national debate. A lesson can be taken from its employees who work not under the best of circumstances or earn the highest of salaries ... a lesson of dedication, commitment and caring to the well-being of patients.

Clearly there is a role for VA in the national health care reform movement. We have but skimmed the surface today. Suffice it to say, VA must be permitted to continue to be a provider of care, the primary provider of care, to this nation's disabled veterans.

We are not so parochial, however, Mr. Chairman, to recognize that the traditional role and structure of the VA can continue. Rather, we recognize change needs to occur with a vision toward the future of how we best provide care not only to eligible veterans but to the entire citizenry of our country.

In our view, Mr. Chairman, we are citizens first and veterans second. Therefore, we are eager to continue the discussions of VA health care and look forward to working with your Subcommittee and your counterparts in the Senate regarding this issue.

This concludes my statement, Mr. Chairman, and I would be pleased to respond to any questions you or members of the Subcommittee may have.

## POSITION OF MAJOR VETERANS SERVICE ORGANIZATIONS ON THE DELIVERY OF VETERANS HEALTH CARE

Major veterans service organizations have chosen to speak with a unified voice regarding veterans health care as delivered by the Department of Veterans Affairs - Veterans Health Administration. We find major problems concerning access because of laws governing access to care; the inability of the VHA to deliver the continuum of care mandated by sound medical practice; and the rationing of care because of inadequate fiscal appropriations. The following statements reflect the positions taken by The American Legion, Disabled American Veterans and the Veterans of Foreign Wars as building blocks to achieve our vision of an efficient, fair and quality VA health care delivery system:

- The Department of Veterans Affairs health care system must continue to exist as a system dedicated to the care of veterans with primary missions of delivery of quality health care, healthcare-related research, medical education and the contingent care of those wounded or ill as a result of a national disaster or involvement in existing military conflict.

- Eligibility and entitlement reform must be undertaken immediately. Such reform must precede any other reconfiguration of the system in order to define the populations of veterans to be served by VHA. No mission changes, re-allocation of resources or expansion or contraction of services can be undertaken without first defining those

veterans to be served.

- The VA shall offer a full range (continuum) of medical care services, as an entitlement in law, to all honorably discharged veterans. Eligibility to exercise that entitlement is satisfied by any veteran who is adjudicated to have a service-connected illness or disability rated at 0% to 100%, or any veteran who is ill and/or disabled and falls within the guidelines as prescribed in Section 1710, Title 38, USC. In addition , the VA shall provide necessary care to any veteran who suffers a catastrophic illness or disability not covered by insurance and the cost of such care would render the veteran indigent. Any veteran who is considered "uninsurable" because of pre-existing medical condition as well as those in receipt of VA pension should also have access to medical care. These veterans should be considered the "core entitled" groups for receipt of medical care.

- The cost of rendering care to the "core entitled" group shall be funded by congressional appropriations at a level determined by their treatment needs at the required services level. Care for the expanded universe of veterans beyond the "core entitled" group will be financed by contributions from those veterans receiving care by some form of payment option such as private health insurance reimbursement, reimbursement from state/federal programs such as Medicare, CHAMPVA, CHAMPUS or the Indian Health Service or by premiums paid into any managed care program administered by the VA. Any moneys received as reimbursement for care from <u>any</u> third-party payer must be permitted to be retained within the Department with no budget offset.

- The Department of Veterans Affairs health care delivery system shall offer, based upon medical need, a full continuum of care. VHA serves as case manager for that care which includes, but is not limited to, preventive care services, acute care, outpatient care, specialized care such as blind rehabilitation, spinal cord injury treatment and rehabilitation, post-traumatic stress disorder and prosthetics services, intermediate care, dental care, respite care, hospice care and long term care. Long term care shall include institutional care where required. Non-institutional care such as home health and maintenance services which would preclude or defer institutionalization, would be one of the methods which could minimize long-term institutionalization.

- The VA must assure availability and accessibility of care for eligible veterans by allocating resources and assigning and reassigning missions to facilities in areas wherein the optimum number of veterans will be served. Contract care should be provided when necessary.

- The Department of Veterans Affairs - Veterans Health Administration must be allowed to share medical services, equipment, facilities and procurement services with other medical care delivery systems, in the federal and private sectors, with a goal of enhancement of medical care for veterans. Resources of the VA must be directed exclusively to the care of veterans until any expanded universe of veterans, provided by eligibility or entitlement reform, has been offered needed medical care. Then, and only then, should the VA considering services to non-veterans.

"I agree that the above 'Position of Major Veterans Organizations on the Delivery of Veterans Health Care' is the position of the organization for which I affix my signature":

March 25, 1993 — 3/10/93

John F. Sommer, Jr. (date) — Charles E. Joeckel, Jr. (date)
The American Legion — Disabled American Veterans

25 March 93

Larry W. Rivers (date)
Veterans of Foreign Wars

The Washington Post

WEDNESDAY, MAY 6, 1992 A27

# SOCIAL WELFARE PROGRAMS

FEDERAL OUTLAYS IN BILLIONS OF CONSTANT 1991 DOLLARS

*The programs created in the broadly defined Great Society era, spanning the presidency of Lyndon B. Johnson and the early White House years of Richard M. Nixon, represented the greatest expansion of welfare and social services since the 1935 Social Security Act.*

One of the first major Great Society bills was the Economic Opportunity Act of 1964, the cornerstone of Johnson's so-called War on Poverty. The act had 10 major components. Among them, it authorized creation of the Job Corps to help train young people for work in both rural and urban training centers; work-study programs for students from low-income families; VISTA (Volunteers in Service to America, a sort of domestic Peace Corps); additional work training programs; and the community action program, which funded community organizations and nonprofit groups' local development programs.

Total spending on these initial War on Poverty programs was not very great—about $1 billion was authorized the first year. Funding for these programs was then dwarfed by funding for housing, medical and Social Security programs that usually are considered part of the Great Society legacy.

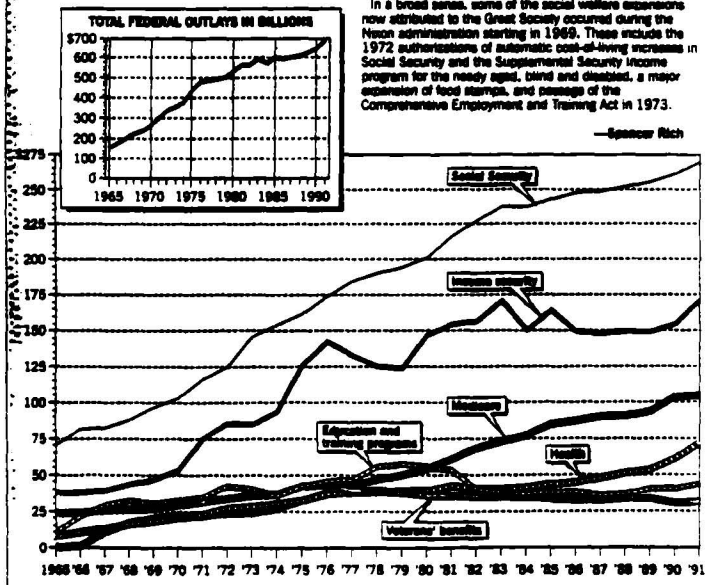
Ironically, the program often most sharply criticized as harming the poor by discouraging them from working—welfare for low-income families with children (Aid to Families with Dependent Children)—was created in the 1935 Social Security Act. Its expansion was not radically broadened by federal legislation.

The Johnson era also saw the expansion of the pilot food stamp program (1964) into a general benefit program. It was enlarged substantially during the Nixon presidency. Other Johnson initiatives included a 1965 housing program that provided rent supplements for the poor and two 1965 education programs: aid to elementary and secondary schools targeted at improving instruction for disadvantaged children, now called Chapter 1; and the Higher Education Act, which provided federal scholarships for needy children and authorized low-interest guaranteed loans for middle-income college students.

Fiscally, the most significant social welfare expansion involved Social Security and the creation of Medicare and Medicaid in 1965. There were seven Social Security raises between 1965 and 1975, plus the addition of an automatic cost-of-living feature in 1972. Of the $689 billion in total social welfare spending shown below for 1991, Medicare for the elderly accounts for $104.4 billion, federal Medicaid outlays for the poor (most of which are matched by the states) total $52.5 billion and Social Security as a whole is $269 billion.

In a broad sense, some of the social welfare expansions now attributed to the Great Society occurred during the Nixon administration starting in 1969. These include the 1972 authorizations of automatic cost-of-living increases in Social Security and the Supplemental Security Income program for the needy aged, blind and disabled, a major expansion of food stamps, and passage of the Comprehensive Employment and Training Act in 1973.

—Spencer Rich

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Statement

of

Michael F. Brinck
AMVETS National Legislative Director

before the

House Committee on Veterans Affairs

on

The Department of Veterans Affairs Role

in the

Future National Healthcare System

April 28, 1993

Mr. Chairman, thank you for inviting AMVETS to testify on what we consider the keystone of VA benefits.

Today, we will discuss the broad policy options available for veterans healthcare in the coming national reform. Obviously, detailed discussions of the interface between VA and the national health system will depend largely on the final design of the larger national system. But there are certain principles upon which veterans healthcare must be founded.

The first principle is that of fairness; those who now receive free healthcare (the Category A veteran) should continue to receive healthcare at no cost. The FY 94 Independent Budget for the Department of Veterans Affairs detail what the endorsers recommend as the core group of entitled veterans under entitlement reform. Briefly, it is the current Category A veterans plus those who are or become uninsurable and finally, catastrophically injured veterans.

The second principle is that of priority/preference. AMVETS believes that veterans should receive preferential access to healthcare. Preferential access can be defined as direct access to a veteran-unique treatment system (as partially accomplished by the current VA healthcare eligibility system), or favorable tax or premium rates available only to veterans. President Clinton has stated on many occasions that he favors a national system based on managed competition. Therefore, we would like to discuss how VA would play a part in a nominal national system of managed care.

The managed care model features healthcare coverage buying groups, a national health board that would define a basic benefits package and certify qualifying providers, qualified insurance companies that would compete for buying group business, possible tax incentives to those participating in the program and increased emphasis on preventive care, education and research.

This model offers several ways for veterans to obtain preferential access to care. One option would be to offer all veterans the opportunity to join a veterans-only buyer's group for whom the federal government would contract for care. Those who now receive "free" care would be covered at no charge when care is obtained through the VA or a VA-contracted provider. The range of care would include long-term care. To encourage entitled veterans to use VA facilities, co-payments could be required for those seeking care at non-contract private

providers.

The balance of the veterans community - generally non service-connected veterans would pay rates subsidized by the government to offer low cost premiums for those choosing to participate. To comply with the first two principles, the basic package of benefits for all veterans would exceed that offered to the general public and would include long-term care.

To help fund the VA medical system, a portion of all premiums paid by veterans should be rebated by the insurers and earmarked for the VA medical system. VA should be reimbursed by the insurers for services rendered within the VA system.

Mr. Chairman, as you know, the demographics for the veteran population show several trends; the advancing age of the veteran population, a decline in total numbers - assuming no future need for large forces due to conflict, a shift in the population to the sunbelt, and finally the large increase in the percentage of elderly veterans living in sunbelt states.

AMVETS' national resolutions support retaining the VA system as a standalone healthcare asset dedicated solely to the treatment of veterans. With some exceptions, such as sharing agreements and treatment of the blind and those with spinal chord injuries, AMVETS opposes opening the system to non-veterans until all veterans have preferential access to treatment.

That does not mean that we see the VA system as static. Quite the contrary. There is no magic in the number 171 - maybe the right number at some point will be 200, maybe 135. As the veterans population changes, we support mission changes at existing facilities, regional centers of excellence, relocation of existing facilities or acquisition of new units to serve the greatest number of veterans and increased sharing of resources. The system must be dynamic - because it is the very static nature of the system that has brought the VA to the present crisis. Change will be the order of the day and veterans, the VA and the Congress must face up to the fact that business as usual is the surest ticket to losing this most precious healthcare asset.

VA healthcare facilities can no longer afford to be all things to all veterans. Mission changes that, while reducing the scope of services at some facilities, will offer increased quality within the regional system. The efficiencies of the regional system should in turn provide savings that will enable VA to service a larger number of veterans than are now seen in the system. Regional healthcare networks appear to offer the greatest bang for the buck. But to

make the regional concept work, each VAMC, its satellite clinics and private sector healthcare providers should coordinate referrals within the VA system. VA should also expand the role of the Vet Centers as independent, community-based centers for preventive medicine and basic outreach services. It is time to revitalize the Vet Centers to serve a larger portion of the veteran population. Key to making the regional system work, will be flexibility at the primary care level - the private sector must be able to participate in referral.

This has many implications. VA must provide a full continuum of care on a regional basis and locally where appropriate. For their part, veterans must be willing to access acute care at facilities that may not be near their home -assuming VA picks up the transportation costs. Congress must resist the political pressures to retain home district facilities when the facts do not support continuation of the status quo. The medical establishment must adapt to the change by refocusing its teaching hospitals towards preventive care, gerontology and other areas that will be in high demand.

The third principle is that of quality. AMVETS defines quality medical care as that which provides timely access, competent treatment, and reasonable surroundings at a cost that is reasonable.

Today, VA falls short in timely access in two categories; the excruciatingly long adjudication process to gain initial access and the often long waits for appointments.

Lack of competent treatment in VA facilities borders on the apocryphal, but AMVETS wants to go on record that on the whole, we consider VA treatment on a par with that available in the private sector, and in many specialties VA sets a standard of excellence for the rest of the medical community. Are there instances of mistreatment and neglect? Of course - but the compassion and technically excellent treatment given to the vast majority of veterans is undeniable.

There is no doubt that VA's physical plant is aging at least as fast as its patients. AMVETS commends the president for requesting stimulus funds that would eliminate about a quarter of VA's non-recurring maintenance backlog. While it is possible to point to a few projects that may seem inappropriate, the package taken as a whole will improve the safety and habitability of VA facilities. If given the scheduling flexibility to commit these extra resources, AMVETS is confident Secretary Brown will spend the money wisely.

VA's construction program begs the question of whether it will be necessary to build new facilities following implementation of national healthcare reform. Obviously, the policies adopted under national healthcare will impact on construction requirements. But assuming an integrated national network composed of private, local public and federal health facilities that is needs-based in its implementation, some new facilities will undoubtedly be needed. AMVETS totally supports the policies of enhanced use and short-term leasing as viable alternatives to major new construction where appropriate. At a time when change may become the order of the day, such policies will enable VA to continue to offer an expanding range of services through sharing with the community and region, while retaining its independence as a veterans asset.

Keep in mind the demographic changes mentioned earlier. Are local communities able to absorb the largest numbers of older veterans? Is it fair to expect the taxpayers of a few states to bear this portion of the cost of national defense? Of course not.

Therefore AMVETS recommends that veterans healthcare be financed on a federal basis and implemented locally in the most cost effective manner with veterans participating as mentioned earlier. That will mean a mix of public and private providers and facilities. That means that VA facilities may need to be built to accommodate care entitlements. Most importantly, it means that everyone involved in VA healthcare must be willing to keep those three basic principles in mind as we work out the details of VA's place in the national system.

Mr. Chairman, that concludes our statement.

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***STATEMENT OF***

## *VIETNAM VETERANS OF AMERICA*

***Presented By***

***Paul S. Egan***
***Executive Director***

## *BEFORE THE*

## *HOUSE VETERANS AFFAIRS SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE*

***On***

***The Role of VA Health Care in a National Health System; Challenges and Opportunities***

***April 28, 1993***

## *DISCUSSION*

Mr. Chairman and members of the Committee, Vietnam Veterans of America (VVA) is pleased to have the opportunity to present its views on the critically important topic of how Veterans Administration health care can coexist in a national health environment in which health care options outside VA become available to veterans currently dependent upon the VA. As the committee well knows, the concomitant question is what the VA might be capable of doing to attract veterans or even others in a national health environment who currently use the private sector for meeting their health care needs.

To its credit, the Senate Committee on Veterans Affairs has already held two hearings on these general topics in which expert academics, researchers and policy analysts have provided their views. In the first Senate hearing on March 5, 1993, witnesses discussed or defended VA's relationship to rural health providers as well as to teaching institutions, and made recommendations for improvements in these relationships. To some extent the topic of health care quality was also discussed.

The second hearing held on March 31, 1993, used two panels of experts to take up the twin topics of what influences national health will have on demand for care in the VA and whether VA can offer a health care product of equal quality at comparable cost to that available from non-VA providers. For purposes of our testimony at today's hearing, we begin with a discussion of the themes emerging from testimony by the experts at each of the Senate Committee's two previous hearings. Having reviewed the statements of these earlier witnesses, a variety of insights occurring to us are appropriate to share today in order to help the committee sort through the relevant issues at stake from the standpoint of the veteran user--both current and future--of VA health care. Five themes emerge from the previous hearings. These include:

* Finding a way to address the health needs of rural Americans, veterans and non-veterans alike, and what role VA might play in meeting rural health needs.

* Finding a definition of quality that equally balances the biases and preferences of all entities having a stake in VA health care.

* Identifying the most likely factors governing who will elect to use VA in a national health environment, in order to avoid wasting scarce federal resources on VA's health infrastructure based on erroneous assumptions.

* Identifying the specific investments that must be made in VA in order to make it attractive to current and new populations of users if it is decided that VA can or should compete with non-VA providers for clients in a national health environment.

* And finally, but not least in importance, reaching a long term consensus in the Congress that can be relied upon to yield the resources necessary to maintain VA's viability as a health provider equal to its mission--whatever that mission is determined to be in the coming months.

## RURAL HEALTH CARE

In testimony offered on March 5, before the Senate Committee, Mr. Bruce Behringer of the National Rural Health Association offered a variety of suggestions designed to strengthen relationships between VA and rural providers. Perhaps most importantly Behringer challenged the committee to find a way to

avoid rural veterans losing "the availability to their existing benefits while finding ways to improve their access to services closer to home."

A specific model for developing a relationship between VA as a parent facility with rural or remote providers is cited in the March 5, testimony of Dr. Kenneth Shine, M.D. of the National Academy of Sciences. Dr. Shine refers to the establishment of an outpatient facility in Bakersfield, California which is located between 50-60 miles north of the Sepulveda VA Medical Center (VAMC). In Dr. Shine's model, referrals from the primary provider at the Bakersfield clinic are made to what Shine refers to as a "global health team" consisting of an interdisciplinary group of health specialists.

Both of these witnesses offer a hint of what is ultimately going to have to be created in VA--a general decentralization not of management controls, but of provider networks. Rural health care delivery, if it is to benefit equally from trends toward primary and preventive care, must be planned, managed and coordinated in a way that casts the widest geographic net possible. For VA this would constitute a major shift in emphasis from its currently well-established and highly centralized tertiary hospital operations.

We suggest moving forward with a legislated shift in emphasis in order to assure VA's ability to sustain its relevance to modern trends in primary and preventive care and its ability to play a meaningful role as health care provider for rural America. As part of this shift, VA should borrow from and expand upon Dr. Shine's model by assembling what he refers to as "global health teams" which he notes are met with a "high degree of enthusiasm... among students, interns and residents." These teams might be used to further enhance the availability of health care providers in rural or remote communities by requiring a rotation of these students into these communities.

Another suggestion we offer toward enlarging the geographic net of accessible care in rural areas is to require VA to invest much more of its resources in development of mobile medical clinics either based from VA's own outpatient clinics or from existing rural clinics through sharing and contract provider arrangements.

## DEFINING QUALITY

As used in different circles of those with a stake in VA health care, the term quality has different definitions. Teaching institutions affiliated with VA define quality as the availability of a wide variety of medical conditions suitable for training students. Managers of VA health care, who dread having a highly publicized medical "misadventure," see quality as medical outcomes comparable to similarly-sized non-VA health institutions. Researchers think of quality as the availability of medical institutions sufficiently cooperative and with a patient population sufficiently in need to undergo experimentation. For the veteran user of the VA health system, however, quality is best defined as being seen at appointments on time by courteous and compitent professionals, being subject to a minimum of invasive procedures designed to satisfy teaching needs and by being reasonably assured of a successful medical outcome in any medical episode. It is worth noting that D.C. General Hospital is affiliated with at least two fine medical schools but no one lately has been heard to characterize the quality of care at that institution as anything but poor, at least as quality is understood by the general public.

At the March 5, Senate Committee hearing, Jonathan T. Lord, M.D. stated that "health care quality has been traditionally measured by looking at the technical outcomes of care. In fact, usually by measuring the bad outcomes of care.... I do not believe

that VHA provides a high quality product as defined by efficiency, effectiveness, accessibility, satisfaction, appropriateness and other outcomes measures. Applying a contemporary perspective to 'quality', VHA does not have data that reflects the value of services provided or improvement in the health status of veterans served by VHA" (emphasis added).

The consensus of veteran users of VA health care--right or wrong--is that quality is deficient. If VA expects to improve its reputation and to make itself attractive to veterans, it must seriously address the issue of quality from the perspective of its consumers. The VA can ill afford to ignore any longer the fact that the advent of national health care offers veterans currently dependent upon VA the first hope of exercising choice in deciding where to secure health care. Like other consumers veterans will go for care where they can most conveniently be treated in a manner meeting their expectations of quality.

In VVA's view it has always been the veteran user that is the most important player in VA health care. The expected availability of the freedom to exercise choice gives veteran users of the system the keys to VA's future. Should their preferences as consumers be misjudged or insufficiently weighed in the policy decisions made in the coming months, the VA's viability as a permanent part of the overall health care landscape will become doubtful.

As a step toward assuring quality in VA health care, we propose a legislated mandate requiring VA to begin measuring quality using different criteria than it has in the past. A scale must be developed using equally weighted indices such as those referred to by Dr. Lord in his March 5, testimony.

## WHO WILL USE VA?

Later in this testimony we detail our recommendations for who should be served by VA in order to allow the system to remain viable in a national health environment. Here we review some of the factors we believe will influence health choices veterans will make. Our desire is to see the system survive and flourish. Our fear is that the wrong assumptions may be used in assessing VA's prospects for success in a competitive setting in which consumers will decide the fate of a moribund system insufficiently willing to accept inevitable change. VA need not be less, but it most assuredly must be different in the future.

In order to assure an orderly transition, steps must be taken immediately to legislatively foster VA's acceptance of the inevitable. One such step is House Hospitals and Health Care Subcommittee Chairman J. Roy Rowland's draft health legislation, requiring development of a general mission review of all VA Medical Centers (VAMC). Other steps, however, must be resisted. On this matter we refer to the ever-tempting inclination in Congress to legislate major and minor construction projects without the benefit of an overall health mission review. We urge, instead, that such projects be placed on hold and that these resources be used to fund at least that part of VA's infrastructure that all or most can agree will be needed in the future. A rural health care network of some design is one such example.

### *Entitlement Reform*

In testimony presented before the Senate Committee on March 31, Dr. Donald L. Custis of the Paralyzed Veterans of America (PVA) made a stunning yet obvious point. In discussing the burdensome complexities of eligibility for care, complexities that even differentiate between outpatient and inpatient care eligibility for the service-disabled, Dr. Custis forcefully argues for eligibility reform, noting that this can now be safely accomplished in an emergent national health environment. His point is that

"entitlement clarification would stem some of the VA patient losses PVA anticipates as a consequence of national health care reform enactment...Under the expected environment of universal health care coverage, VA-based incentives should balance those enticing the veteran into the private sector for his health care". This, Custis notes, is possible and achievable now while it was not politically feasible in the past because "in the past, the rationale for not pursuing meaningful entitlement reform has been the anticipation of consequent demand that could not be met with resources available".

If VA is to compete with non-VA providers as a matter of policy, we must agree with PVA's Dr. Custis and urge entitlement reform as a way of offering VA a level playing field in the competition for pools of potentially eligible consumers. While we caution the committee against policy decisions placing VA in the unenviable position of directly competiting with non-VA providers thought to offer better quality, we still maintain at a minimum that reform making eligibility uncomplicated will be needed in the process of attracting those populations of veterans the VA can most successfully serve.

***Medical Staffing Must be Carefully Weighed***

On March 31, the Senate Committee heard from Kerry E. Kilpatrick, Ph.D., of the University of North Carolina's School of Public Health on the topic of comparisons of VA and non-VA staffing patterns. His point was that "for patients with similar diagnoses the demands of care in the VA are likely to be higher than in the private sector, across all patients the acuity level for private sector institutions would typically be higher than in the VA because of the chronic nature of the problems presented by many VA patients. If this is true, lower staffing levels in the VA would be expected and would be consistent with efficient allocations of personnel resources."

As the committee proceeds to make decisions on the future of VA health care, we caution against the temptation to justify short term savings by pointing to such a rationale. Even if he were correct in suggesting that staffing levels in VA today are appropriate -- we disagree -- the staffing needs of VA in the future will have to be decided based on those consumers the VA will serve. Future populations of VA users may have different levels of need than those VA users dependent upon the system today. If, for example, a decision is made to position VA in a competition for consumers in a national health environment, VA will most assuredly need to be prepared as a matter of competitive fairness to handle a patient population equal in acuity levels to those discussed by Kilpatricks on and found today in the private sector. VA is unprepared for this at the present time, as even Kilpatrick would have to agree.

## MEDICAL STAFFING THAT PROMOTES QUALITY, JOBS FOR VETERANS AND BUDGETARY SAVINGS

Harnessing the power of consumer choice in the health care marketplace in a managed competition setting can be expected to revolutionize medical practice as it is known today. This type of change is perhaps best anticipated by comparing what is expected in health care to what has happened to the American economy over the course of the last 15-20 years. The watershed transformation from a heavy industrial and manufacturing economy to a service and information age economy has forced enterprises big and small to compete or perish. The same will probably be true for some of our most well-known and generally accepted tenets of medical practice. The ways in which medical facilities are staffed today and some of the licensure requirements that have been put in place have acted to escalate costs and artificially shrink the pool of available medical professionals. Many of these medical staffing practices

must change in the interest of quality, job availability and cost savings.

***An Operational Model in Baltimore***

We offer to the committee the example of a program currently operating at the University of Maryland Medical System (UMMS) hospital in Baltimore, Maryland, that can serve as a model not only for VA but for the entire nation. The program we refer to involves just one department in this Baltimore hospital, but its application to other departments and medical disciplines is obvious.

This program is a veterans hiring program that has continued to develop and has proven to be a sound mechanism for employing veterans and building upon their military training not only to provide the veteran with a career path, but also to provide the hospital with an upwardly mobile employee base at considerable savings.

The pilot program is statutorily protected in Maryland by an Internship Amendment to the Maryland Respiratory Care Practitioner Licensure Law and also enjoys the support of the American Association for Respiratory Care (AARC). VVA is currently constructing a national format for the program and working with the AARC to provide statutory inclusion in a State Respiratory Care Practitioner Licensure bill for programs modeled after the pilot program at UMMS in states across the nations.

The primary architect of the program also constructed internal educational, training and procedural formats geared toward upgrading the skills of veterans in the program, as well as of individuals who are graduates of traditional schools. Utilizing concepts fostered by the AARC, the Joint Commission for the Accreditation of Health Care Organizations, Peat-Marwick, and his own internally-developed concepts, this individual was able to increase the efficient delivery of respiratory care services to the patients at UMMS, reduce misallocation of resources, cut costs and achieve improved patient outcomes.

Reducing the average number of days that critically ill patients spent on mechanical ventilatory support in Intensive Care from a monthly average of 1,450 days to 900 days accounts for a cost savings to the hospital of 5 million dollars a year and quite a bit more than that to third party payers. If two thousand other facilities realized only half of this cost containment, the figure on a national basis would be 5 billion dollars and, again, significantly more for third party payers. From a standpoint of budget constraint, VA hospitals would also be well advised to consider implementing similar training and upgrading formats for a variety of care disciplines.

While this program, in and of itself, should be receiving developmental support from the Congress, DOD, VA and DOL based on its proven ability to provide employment, training and career opportunities to veterans, both HHS and the President's Task Force on National Health Care Reform should also be investigating other clinically engineered outgrowths of the program.

***Better Use of Physicians Assistants and Nurse Practitioners***

Another step that should be taken in the rethinking of medical care staffing involves the better use of physician's assistants and nurse practitioners. These are highly-skilled, salaried professionals who are far less expensive than physicians. Greater use of these professionals and better acceptance of them as key health care providers must be seen as inevitable. These providers have an obvious potential role to play in rural health networks and the importance of their role in more traditional

institutions, though less obvious, can constitute significant savings.

As we have seen in the medical marketplace, the increase in the number of doctors graduating from medical schools has had no appreciable effect on the price of services. Competitive market forces have been absent in health care. There can be no other explanation for an absence of downward pressure on costs. The only obvious result of greater numbers of medical professionals is greater volume of care delivered typically on a proprietary basis. Under the circumstances, greater reliance on intermediate less costly care providers must become one of the new realities in the provision of health care services.

## CONSISTENCY OF CONGRESSIONAL SUPPORT

Not least in importance in any serious discussion of VA's future in a national health environment is the reliability of Congress in allocating resources consistently, and the ability of Congress to carry out its health care agenda in a way that offers consistent policy for all the populations benefitting from federal health care support.

Annual budget cycles have proven unreliable. The Congressional budgetary exigencies of the day are the enemy of long-term public policy planning for individual health care programs. We strongly recommend a multi-year budget cycle for all federally-supported health programs. Only in this way can a measure of long-term planning be brought to bear on fragile health programs that tend to be resource and personnel intensive.

The process of allocating resources in Congress is a topic of discussion by members of the Joint Committee on Congressional Reform. Without knowing what will emerge from the deliberations of the Joint Committee, we hope a more reliable process can be devised and adopted. Even apart from health care provided by VA and the methods used to allocate resources for VA health care, congressional processes must be developed that permit a closer relationship between policies approved by Congress and the appropriations actually made available to put these policies in place.

## VVA'S GENERAL POSTURE

Perhaps the most challenging issue facing the organized veterans community this year is the shape VA health care will take once some form of national health program is adopted. The two leading health reform designs are "managed competition" and "single payer" programs. Of these, "managed competition" is the design President Clinton has embraced.

In either case, however, it is clear enough to us that many veterans currently dependent upon the VA for health care would opt out of VA if a more accessible option with perceived higher quality were available. Using the "single payer" assumptions contained last year in former Representative Marty Russo's (D-IL) national health bill, the GAO has estimated that 50 percent of VA's acute care patient load would be quickly lost to the contemplated new health system. The Paralyzed Veterans of America (PVA) has estimated the loss of VA's acute care load to be a bit less. Even though GAO used "single payer" assumptions, it seems likely that the estimated losses by VA would be the same even if "managed competition" assumptions were used, because access to and perceived quality of care in the private sector would be preferable to veterans in either model.

As nearly as we can ascertain, VA's inpatient census on any given day consists of about 33 percent who are service-disabled veterans. About half of these are being treated for non-service-

related medical problems. The point is that while there are sufficient numbers of service-disabled veterans to fill all of VA's 171 hospitals, those with jobs and employer-supplied health insurance have already opted against VA-provided health care. Those still using the VA do so because they are either so catastrophically disabled that employability is unlikely or their characteristics parallel those of the 66 percent of VA's inpatients who are non-service-disabled. These characteristics are as follows: single, male, elderly, poor, unemployed/underemployed, uninsured or underinsured. We strongly believe many of those veterans currently with no choice other than VA would opt for a private sector national health provider due to easier access and perceptions of superior care quality.

## RISKY FUTURE FOR VA'S ACUTE HEALTH CARE MISSION

As we see it, the upcoming debate of national health and the ensuing policy outcomes are fraught with danger for the VA health care system as it is known today. On the other hand, if the inevitability of a national health system is accepted by the VA and the organized veterans community with a minimum of "turf protection" resistance, the choices that can be made for the future of VA health care are both positive and consistent with VA's original mission.

Many of the available realistic choices for VA have already been articulated by PVA in their recent report, "Strategy 2000," which represents the most progressive and realistic thinking on VA health care seen from the organized veterans community in recent memory. Many of PVA's proposals should be embraced legislatively in order to codify the future role of VA health care in a national health environment.

In essence, little if anything can be done to prevent VA in its current configuration from instantly becoming a dinosaur once a national health program is in place. Today, most of VA's hospitals and clinics are designed to provide acute and tertiary medical care. In order to prevent the VA from becoming an expensive "ghost town" of a health system as veterans opt for the national option, the VA itself must be forced to accept the fact that its current primary mission of providing this type of care is no longer tenable. In saying this, we harbor no desire to see the VA health system dismantled. Instead, we strongly suggest a new set of missions for VA.

## FUTURE VA HEALTH CARE SHOULD BE DIFFERENT, NOT LESS

Though quality and access problems make VA's continued principal mission as acute care provider unsustainable, there are a variety of things the VA does as well or better than the private sector. Just a few of these include specialized spinal cord injury units, blinded care units, research and provision of specially adaptive equipment and prosthetics, long term mental health care, substance abuse treatment, outpatient treatment of PTSD through Vet Centers and even inpatient PTSD treatment when hospitals are serious about treating PTSD. All of these programs should be expanded through bed conversion. Legislation mandating bed conversions using a phase-in mechanism should be developed and enacted once the specific shape of a national health program becomes clear.

Perhaps the most important service VA provides, the one on which its future as a sprawling nation-wide system depends, is its continuing work in providing a full range of treatment modalities for aging veterans. Most of the innovations in geriatrics treatment seen throughout the nation found their genesis in VA research conducted by Geriatric Research and Evaluation Centers (GREC). A burgeoning population of aging veterans combined with

the fact that escalating nursing home care costs in the private sector are not covered by Medicare (intermediate and unskilled nursing care as well as a variety of assisted living and in-home options) make VA's future as an aged care provider ideal. That future will become all the more ideal if long term care of the aging is omitted from the national health system design because of cost.

Another proposed new mission for VA health care is provision of care for the birth defected children of veterans exposed to Agent Orange or other toxics. Although chronic care will be involved here, so will pediatrics and help with learning disabilities, new fields for VA. Justification for this mission expansion is not difficult: These are Americans with service-connected disabilities if the term has any meaning, and the anguish their veteran parents suffer can best be treated by VA accepting responsibility for the treatment of the children.

Yet another new mission VA could and should assume as discussed earlier is that of rural health provider. A community-based infrastructure should be designed out of which mobile health clinics should operate. This model would also be useful in providing care in heavily populated but under-served areas such as exist throughout the Commonwealth of Puerto Rico.

Agreement must be reached on those populations of veterans the VA can realistically serve in a national health environment. The most appropriate posture to assume is not that VA will be less in the future but simply different than it is today. To some extent even the VA itself is wrestling with these issues. Proposals being developed within the VA on eligibility reform, though yet to be finalized, are an indication that realistic thinking is taking place. Whether these proposals will still be realistic by the time they have been through the meat grinder of entrenched Central Office health bureaucrats remains to be seen. In this connection, it will become critically important to prevent VA from shaping the debate if its eligibility reform proposals simply obscure the key topic of mission reform.

Assuming some agreement is possible on the populations VA will serve, the full continuum of health services must be provided for these populations. This can be done by maintaining fewer, but enough, acute-care beds while bed conversions to other purposes are carried forward. Sharing arrangements and contract provider arrangements with the private sector for provision of expensive surgeries or diagnostic procedures should dovetail easily with a national health program.

## CHANGED HEALTH CARE MISSIONS

In raising the topic of population selection, what is really at stake is mission selection. The term "eligibility reform", is somewhat imprecise. As used properly, this term should refer to population or mission selection. What ought the VA to do, given its abilities and potentials?

Mission selection also entails deciding which missions currently undertaken by VA are less tenable as primary activities for the future. The sharply diminished extent to which VA can maintain an acute care network of hospitals and clinics as its primary mission has already been discussed. The extent to which VA can realistically maintain its role as trainer of medical students through its network of teaching affiliations must also be discussed.

It is unclear what the value of VA to medical training institutions will be if acute care and all the associated diagnostics and surgeries are limited to the proposed target populations selected for VA service. Along with its acute care

mission, VA's mission of training some 50 percent of the nation's physicians will also have to be adjusted as options that are more accessible and believed to have higher quality become available to veterans, drawing them to the private sector in a national health environment.

## VA AS BACK-UP TO DoD

Another of VA's health missions has gone untested. This is the role VA is mandated to play as a medical back-up to DoD in time of war or national emergency. How this mission can be sustained deserves careful consideration. Surely a medical back-up for DoD is needed, especially since so many of DoD's hospitals have already been closed. During preparations for anticipated casualties resulting from military action in 1990 from Desert Storm, the VA readied between 60 and 65 of its medical centers. Careful planning and coordination of its medical services were undertaken along with preparations for psychological treatment, resupply of medical equipment and availability of needed medical personnel. Fortunately, these preparations were never tested. Had they been tested, the full range of hospital services--including emergency medical--would have been needed and heavily taxed.

Assuming, as we do, that VA should retain its mission as a back-up to the military, the question is how VA can do so once a period of market-driven mission transformation in a national health environment has taken place. In order to meet the need of VA to continue its role in training physicians, supporting important medical research, as well as providing the full range of care to those veterans who do choose to utilize the VA, we propose the use of 60-100 VA hospitals as a back-up to the military. These hospitals, whatever their identification might be in a carefully developed VA-DoD emergency plan, should be maintained as full-service tertiary care facilities sheltered from the modifications, bed conversion and medical service realignments that must inevitably take place elsewhere in VA's medical infrastructure.

## VA HEALTH CARE SHOULD COMPLEMENT NATIONAL HEALTH, NOT COMPETE

Last February, Senate Majority Leader George Mitchell (D-ME) addressed the National Governors Association on the topic of health care. His remarks, featured on C-SPAN, outlined a five pillar program for national health reform. These include cost control, universal access, primary/preventive care, consumer choice and state control/flexibility. It is well to bear each of these in mind as VA's future in considered. Importantly, VA's future health care operations and missions must complement these basic national health system pillars rather than compete with them.

On the issue of cost control, many point to VA as a cheaper provider of care, one capable of offering the same quality as that found in the private sector but at significantly less cost. According to Chairman Montgomery in his article submitted last December to the national magazine of AMVETS, the VA Office of Inspector General is conducting a study that will show VA's health costs to be as much as 40 percent less than the same services provided in the private sector without any appreciable difference in quality. Given strapped health funding for VA over several years and accompanying severe staffing shortages, the IG finding on quality comparability is a bit difficult to swallow.

Nevertheless, this argument often is marshalled to support VA access to Medicare payments as well as Medicaid and Indian Health reimbursements to VA for services provided to veterans and non-veterans eligible for other federally-funded health programs. Since VA care is cheaper, the argument goes, taxpayers will save money by having as many of these other federal health program beneficiaries as possible treated at the VA. In essence, the

government saves money overall, the VA gets a new pipeline of needed funds and, less obviously but perhaps most importantly, the VA's beds stay filled without fundamental changes in mission.

Keeping VA's beds filled takes on added meaning in a national health environment. In order to subscribe to this argument, one must accept as truth that VA's costs are and always will be less expensive than the private sector. Similarly one must also accept as truth that VA's care quality is and always will remain comparable to the private sector. Finally, to subscribe to this argument, it must be further assumed that VA can and always will serve a legitimate primary role as an acute care provider.

The first of these assumptions may be true for some period but if Senator Mitchell, the Clinton Administration and Congress are serious about health care cost control in the private sector, the differences in cost between the VA and the private sector may narrow significantly over the course of time it takes to fully implement a national health system. The assumption about VA quality comparability fails as a practical matter, with veterans expected to opt out of VA just as soon as a more accessible and believed better-quality option becomes available. The assumption concerning VA's continued primary role as acute-care provider fails for the same reason. Moreover, VA's mission as a continuing provider of acute care may not conflict with Senator Mitchell's cost control pillar, but such a continuation would constitute an expensive gamble that veterans somehow will change their minds and stay with VA.

The universal access pillar Senator Mitchell described to the governors contemplates health care as a right rather than as a privilege. The specific population Senator Mitchell alluded to having little to no access to health care have essentially the same profile as that population of veterans currently relying on VA for health care: poor, aged, unemployed or underemployed and uninsured. If Senator Mitchell's pillar of universal access becomes a reality in either a "single payer" or "managed competition" system, there is no good reason to believe veterans currently using VA will necessarily continue to do so. In this instance an unreformed VA health system would face daunting risks by standing in direct competition with a national health system.

Primary and preventive care constitutes Senator Mitchell's third pillar. He properly notes that preventive health care is less expensive than care provided to rectify medical conditions that have been allowed to develop fully. What is true of uninsured, poor, aged and unemployed non-veterans is certainly true of similarly-situated veterans. Both populations tend to wait too long before getting needed primary and preventive care. For veterans, however, the inaccessibility of VA--both geographically and because of excessively complicated eligibility criteria--has constituted an important reason why VA-dependent veterans tend to wait too long to get care, so the care provided is often on an emergency basis. Here again, ease of access to a national health program will draw many current VA users to the private sector. As with universal access, the availability of primary and preventive care in a national health system places the VA in an unenviable competitive conflict.

Consumer choice in a national health program, for reasons already discussed, makes VA a likely loser in the competition for acute care patients. VA should avoid this competition in order to retain its credibility as a complementary player in an overall health care delivery apparatus.

State control and flexibility might be the one pillar in Senator Mitchell's scenario constituting a possible, though unlikely, diamond in the rough for VA. If states regulate health operations and eligibility in a manner similar to recent VA trends

such that access becomes complicated by eligibility rules, state resource shortages or co-payment criteria, VA may become comparatively easier and cheaper to use. Whether or not this becomes the case, VA would still be well advised to shore up its attractiveness by going forward with its own version of complexity-abatement eligibility reform.

Moreover, VA's most appropriate place in the debate of national health care is one in which its proponents articulate a comprehensive set of missions that complement the private sector in a national health environment. Resistance will undoubtedly be great, but change is inevitable whether embraced and controlled by VA and the organized veterans community, or forced by changing health care market realities.

## TIMING OF CHANGE IN VA HEALTH CARE

The President's Task Force on National Health Care is well into its work. The President has indicated an intention to release his proposals in late May. Meanwhile there is great value in having VA Secretary Jesse Brown on the President's Task Force. However, just as it would be inappropriate for a national health plan to be devised without considering the successes and failures of VA health operations, so too would it be inappropriate for a VA health reform plan to be devised without certainty on the direction of overall reform in the private sector.

For VA and the veterans community, too much is at stake to act precipitously on changing VA's health missions without first being certain of the shape of overall national health reform. In the legislative arena, the Veterans Affairs Committees would be well advised to await final action on the main reform program before taking irreversible action on VA reform. This "wait-and-see" posture makes sense in assuring the veterans community that appropriate change in VA's health care role can be trusted to make sense and that the VA system's basic structural integrity will be sheltered.

Between now and late May, it is recommended that tentative legislation be prepared to codify the most appropriate new missions of VA, stipulating what populations will be served, and how and what fiscal resources will be required to get the job done properly. On this latter issue, as stated before, multiple-year budgeting must be seriously considered -- perhaps in the context of those issues under review by the Joint Committee on the Organization of Congress.

## COMPENSABLY SERVICE-DISABLED VETERANS HEALTH

Much of what VA is currently undertaking as "eligibility reform" is designed to determine who will receive the full range of health care at VA facilities. Instead of simply reshuffling the deck to arrive at a new definition of "category A" veterans, it is much more realistic to consider legislating who among service-disabled veterans should be afforded totally free health care in the private sector and for what medical problems under a national health program. Since most of these veterans already use the private sector and will likely continue to do so, legislation is needed to codify what rights veterans will have to private sector care at VA expense.

We propose that all 30 percent or more compensably service-disabled veterans be authorized free health care in the private sector national health system for all service related and non-service related medical conditions. This authority would extend to inpatient and outpatient care and include to all prescription drugs. Naturally, those veterans with specialized needs consistent with one or another of VA's reformed missions would have the option of obtaining care in the VA. For veterans being provided

disability compensation at a rate of less than 30 percent, free care would be available in the private sector for any service-related condition. Here again, inpatient and outpatient care as well as prescription drugs should be free. For private sector care of non-service-related medical conditions, the rules governing general participation in the national health program should apply. If, however, these veterans are among those for which VA's mission was reformed, the full continuum of care should be provided by VA at no cost to the veteran.

## WOMEN VETERANS HEALTH CARE

Section I of the Veterans Health Care Act of 1992 was a landmark victory in the long struggle by women veterans to assure continued recognition and support for their specific health care needs. VVA is proud of the leadership role we have taken in the legislation, which calls for the development of well women health care programs, broadening the context of service-connected Post Traumatic Stress Disorder to include the aftermath of sexual trauma and authorization of funding for a Women Veteran's Health Study are only initial steps in adequately addressing the needs expressed by women eligible for VA health care.

We have noted, at hearings in Congress, in the media and within our own membership, that women veterans consistently call upon the VA to address these issues. More often than not, complaints or reports of inadequacies in the system are treated as if they were anecdotal rather than the symptoms of system-wide deficiencies. Increased numbers of women serving in the Armed Forces will and are becoming eligible for VA programs. If we are to really address the needs of women veterans in VA, there has to be a more conscious effort on the part of the VA to assure that women receive quality care defined as providing at least what is usual and customary in the private sector.

With the new authorizations for health care programs, funding for women veterans coordinators and research for women veterans, there is need for more accountability than can be assured by the present staff and their access to the Secretary. VVA suggests that the time has come to establish a more formalized process to assist women veterans by developing a section within the VA much like the Department of Labor's Women's Bureau. We believe the recurring problems of outreach, privacy, adequate physicals and any other gender-related issues would be best addressed if there was some structured oversight within the VA.

Not only could a Women's Bureau serve as a clearing house for present programs designed specifically for women veterans, there is the additional potential for program evaluation and planning based on research and hard facts instead of relying on the traditional tools of rhetoric and conjecture. The establishment of a permanent office of women veterans programs in the VA with a director having direct access to the Secretary would reflect the Department's commitment to rectifying the mistakes of the past and its resolve to maintain the standard of care these veterans deserve. More importantly, it would be a major step in instituting a method to assure the maximum utilization of resources designated to assist women veterans.

## POST TRAUMATIC STRESS DISORDER TREATMENT AND RESEARCH

The importance of enacting legislation to broaden VA treatment of PTSD is that so little has been done by the VA of its own accord to address the magnitude of the PTSD epidemic. Similarly, it is critically important that veterans with PTSD who are treated in VA general psychology or psychiatry inpatient, outpatient or other clinics lacking expertise in PTSD be treated for the proper disorder. Today no such guarantee of proper treatment exists.

VVA endorses an updated version of the legislation introduced in the 101st and 102nd Congresses by former Representative Jim Jontz. Such a bill would recognize the research already done on this issue and embrace improvements in access to service and modalities of treatment. Passage of such legislation would move the VA closer to acceptance of a medical mission to provide the range and type of PTSD care that is presently lacking in both the VA and private sectors.

Although actual numbers vary by study and source, it is blatantly apparent that the VA is treating only about 10% of those veterans thus affected by their military service, whether this service occurred during or before the Vietnam War, in Operation Desert Storm, or in the day-to-day routine of military operations. Not only has the demand for program services been ignored by VA in the past, but the success of those existing programs have often been threatened by "departmental reorganization" efforts and funding cuts. The most recent example is that of the Vet Center program. In addition, specialized PTSD services, like that of VA health care in general, are sparse and may be located at an inaccessible distance from the veteran.

Even when the veteran is able to access VA care, PTSD is often misdiagnosed. VA needs to recognize and implement procedures to ensure that veterans needing PTSD care are recognized properly and treated appropriately.

The proposed legislation would increase access for all wartime veterans to appropriate care within the VA by expanding and improving current specialized PTSD treatment units, and by providing additional research into modalities of treatment. It has been suggested that the expertise of the National Institutes of Mental Health and the Center for Mental Health Services be integrated. Furthermore, this bill would encourage health professional specialization in PTSD under the VA Health Professionals Scholarship Program and allow VA provision of counseling services to veterans' families through the Vet Center program.

The legislation we advocate would phase in an expansion of the store-front "Vet Center" program by 40 "Vet Centers" over the course of four years; there are currently 201 sites. Authorization should also be included to provide for 76 additional staff at the currently existing Vet Centers, to meet the demand for service more adequately. Inpatient PTSD units operated by the VA, of which there are only 20 system-wide at present, would be increased in number by 30 such units over the same period. In addition to this, so as to assure proper treatment of PTSD in VA facilities lacking inpatient PTSD units or nearby "Vet Centers", the number of PTSD clinical teams (PCTs) would be increased by 50 over four years; there are currently 57 PCTs.

In addition to the increase in Specialized Inpatient PTSD Units (SIPUs) by 30 units over the next four years, the bill should provide authorization for an additional number of the smaller inpatient units that VA has designed to provide care for those awaiting openings in SIPUs (Evaluation and Brief Treatment Units; currently, there are 8-9 units) and post-SIPU adjustment (Residential Rehabilitation program; currently there are 10 units). The number of these units should be tripled with incremental steps stipulated over the same four year period.

Finally, the importance of creating statutory authorization for the Advisory Committee on Readjustment of Veterans has become vital just this year. The Committee is a viable sounding board for consumer recommendations on the VA PTSD and readjustment programs. As a result of President Clinton's recent Executive Order terminating all non-statutory advisory committees, this program is

on the chopping block, and needs the language included in this bill to preserve its functionality.

Chronic PTSD is widespread and has associated disorders such as depression and substance abuse. Dual-diagnosis also complicates the treatment process. Awareness needs to be raised throughout the Veterans Health Administration of the symptoms and proper modalities of treatment for PTSD. Ranging levels of treatment are necessary to provide a continuum of care for individual veterans at varying levels of recovery. These program levels are and should continue to be mutually supportive, so that care and counseling are provided at whatever level is appropriate and accessible.

## REDUCING MEDICAL LIABILITY INSURANCE

One way to reduce the cost of medical malpractice insurance is to deny coverage for criminal conduct. Today the health industry is essentially exempt from criminal liability for medical "misadventures" resulting from disregard for human life and safety. In order to successfully prosecute a practitioner under criminal statutes, intent to harm must be proven. The recent case involving a Navy surgeon who was practicing at Bethesda Naval Hospital while nearly blind demonstrates the futility of current law. His conviction in lower court was overturned on appeal in the absence of proof of intent to injure his patients.

In most industries and in most circumstances where responsibility for public safety is assumed, statutory definitions of criminal conduct apply. Medical practitioners and administrators escape accountability except under tort liability. We recommend legislation to define criminality in medicine such that the definition would apply to health practitioners as well as health administrators. Our proposed definition would allow criminal prosecution of a "pattern of activity disregarding human life and safety".

In addition to providing a needed safeguard, such legislation would contribute to efforts aimed to diminish liability insurance costs. Physicians, practitioners and medical administrators could be expected to be far more careful if personally accountable for their actions or inactions, and criminally dangerous practioners and administrators could be removed from the health system more effectively than at present.

## CONCLUSION

The advent of a cohesive nation health environment is an exciting development to which the VA can offer as much as it will receive in return. The system's strengths -- its many skilled and caring health care workers, its network of facilities and its decades of experience -- are those of a national health system that is already in place, one that provides a wealth of examples of how to proceed and how <u>not</u> to. The system's weaknesses can best be addressed in a broader discussion of providing health care rationally, rather than confining evaluations of the VA to considerations of the unusual needs of a "separate" population. Vietnam Veterans of America welcomes the discussion that is now under way.

Mr. Chairman, this concludes our testimony.

BLINDED VETERANS ASSOCIATION
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TESTIMONY

FOR THE RECORD

PRESENTED BY

THOMAS H. MILLER

OF THE

BLINDED VETERANS ASSOCIATION

BEFORE THE

HOSPITAL AND HEALTH CARE SUBCOMMITTEE

OF THE

HOUSE COMMITTEE ON VETERANS AFFAIRS

FOR THE HEARING OF APRIL 28, 1993

MAY 14, 1993

CHARTERED BY THE CONGRESS OF THE UNITED STATES

Mr. Chairman, on behalf of the Blinded Veterans Association (BVA), I want to express our appreciation for the opportunity to present our views on the principles that should govern VA role in National Health Care Reform. I had planned on testifying in person at the hearing when it was originally scheduled for April 10 but was unable to be present for the April 28 rescheduled hearing date.

BVA has an extremely strong interest in the VA health care delivery system and the special programs and services it offers for blinded veterans. For over 48 years wi have been a strong advocate for these programs and the availability of the VA health care delivery system. Clearly we have a vested interest in this system and it future and are grateful for the opportunity to participate in the debate surrounding the future of this system. Our constituents, along with those of Paralyzed Veterans of America, are probably more dependent on the VA health care delivery system than most veterans and stand to loose the most should this system be dismantled or otherwise eliminated in any national health care reform.

The principles BVA believes should be adhered to regarding VA's role in national health care reform are as follows:

**1.** Without question, an independent VA health care delivery system should be preserved for addressing the medical and psychological needs of our nation's veterans. Our nation has been committed to "caring for those who shall have born the battle and their survivors" nearly since our inception; we should never shrink from that commitment. VA is truly a national asset and has contributed greatly to the quality of life, not only for our veterans, but for all Americans. VA has acquired very special knowledge, experience and expertise related to treating the medical and psychological needs of our veterans and cannot be replaced by reforming the civilian health care delivery system. The sacrifice of the men and women who have served and will serve in the armed forces certainly is deserving of a separate independent health care system capable of delivering high quality services.

**2.** As mentioned above, VA is a national asset and as such, successfully carries out several missions, in addition to health care, that are indispensable from a national perspective. The education of health care professionals to manage the health care needs in this country would be severely compromised without the VA system. Over 50% of our physicians receive at least part of their training in the VA health care delivery system and percentages are equally high for the other health care professionals so vital to the delivery of quality comprehensive services. The VA has no equal in terms of providing high quality learning environments in such areas as Geriatrics and Extended Care, Rehabilitative Medicine, Spinal Chord Injury, Blind Rehabilitation, Post Traumatic Stress Disorder, Substance Abuse and many other services. The educational opportunities provided by the VA significantly impact the availability of quality health care for all Americans.

VA research is another mission that has been absolutely invaluable to our nation's quality of health care and should not be eliminated or even substantially reduced; as will happen if the current FY-94 budget request for VA is enacted. VA sponsored research has made enormous contributions in health care and offers a unique environment to directly transfer basic research

to clinical practice. VA can and should be the leader in the research arena.

The final mission performed by VA is back-up to Department of Defense (DoD) medical care system in the event of war or a national emergency. This is absolutely essential and no other system exists to carry out this mission. Had we experienced the numbers and types of casualties predicted in the Persian Gulf War, DoD would certainly have been overwhelmed and VA would have been heavily involved in treating those casualties. The private sector could not have responded adequately to that kind of demand.

3. Above we advocate preserving an independent VA health care delivery system. This is not to say, however, that the system as it currently exists should be preserved without change. Absolutely essential to this entire process is Entitlement Reform for VA health care. We have maintained for years that before VA can, and we believe it must, restructure its system, it must first clearly define who it is the system will treat and what services it will provide for those mandated veterans. Until these questions are answered, any effort to change the system will be futile. BVA strongly supports eligibility reform that defines a core group of veterans who will be entitled to a full range of health care services. This core group of veterans entitled to mandate care should include those veterans already classified as Category A for inpatient services as well as all severely or catastrophically disabled veterans regardless of Service Connected status or income level. We also believe veterans whose income levels or non-service connected status currently precludes them from services should have access to the system through third party reimbursement to include Medicare, Medicaid, CHAMPUS, CHAMPVA and private insurance. A buy-in potential should also be explored.

Regarding the full range of services mentioned above, this should include preventive, out-patient, acute and long-term care to include nursing home care. Every possible modality of non-institutional care or extended care should be available. Understandably, because of fiscal constraints, a package of benefits or services may have to be developed containing as many of the previous elements as possible.

The most essential ingredient of all is that the comprehensive package of mandated care outlined be funded through the normal appropriation process. This is the commitment our nation must live up to. Clearly, if VA defines the group of veterans it will treat and the kind of care, as described above, it will enter the 21st century with a modern progressive health care delivery system.

4. Business cannot continue as usual in terms of health care delivery within VA. The current delivery system is dictated by the eligibility system and a structure emphasizing acute care. It is essential for VA to move swiftly to a managed care delivery model to be more cost effective as well as providing better care. To a large extent, VA already provides managed care to some veterans, depending on eligibility and has been highly successful in doing so. Blinded veterans, for example, who are service connected participate in a managed care delivery model and have benefited tremendously. We have often testified regarding the Visual Impairment Services Team (VIST) program and how effective it is addressing the special needs of blinded veterans. Unfortunately, we usually testify regarding the need for additional resources for this essential program and perhaps do not highlight strongly enough what an excellent program it is. BVA endorses all veterans having access to such an effective delivery system.

As VA restructures to position itself to deliver managed care for eligible veterans, there is no question, it can position itself to compete nationally to provide services for veterans. Veterans can and should have a choice in a national health care system. VA certainly can compete given appropriate entitlement reform and appropriate levels of appropriated funding for mandated care.

**5.** Implicit in all BVA principles outlined above is that VA must be assured the opportunity to provide a full continuum of care that is needs-based not budget driven. VA must be allowed to treat the whole person, not just certain parts as required under the current system. With appropriate eligibility funding levels, VA offers tremendous potential in a managed competition market for health care delivery. Our nation's veterans deserve no less.

**6.** Finally, Mr. Chairman, BVA does not endorse the continuation of VA only for the purpose of conducting special disability programs. The disabled veterans currently, and into the foreseeable future who will be served by these programs, require the full range of services during the rehabilitation process. Blinded veterans, for example, usually have multiple medical problems that must be effectively managed during residential blind rehabilitation and for this reason would be unacceptable to the few private or state programs. Blind rehabilitation services comparable to VA are just not available in the community and the same can be said for spinal chord injury, Post Traumatic Stress Disorder and many other special programs. They cannot stand alone, however, but must remain an integral component of the full range of health care services provided by VA. This is what makes VA so special; the capability of providing an interdisciplinary team approach to treating the whole veteran. No other system can bring the high level of expertise to care in such an effective comprehensive manner. VA can, with changes in its focus, from acute care to ambulatory and extended care, be the model by which all health care should be delivered in the country and be the leader in the field. We cannot afford to waste such a valuable resource.

Again, Mr. Chairman, I want to thank you for this opportunity to express the views of BVA for the hearing record and regret I was not able to appear in person at the hearing to answer any questions. As always however, we are available should you have any questions and look forward to working with you on this crucial issue.

Thomas H. Miller
Director of Governmental Relations
Blinded Veterans Association
May 14, 1993

TESTIMONY

OF THE

AMERICAN EX-PRISONERS OF WAR

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE OF VETERANS AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

PRESENTED BY

CHARLES M. WILLIAMS
EXECUTIVE DIRECTOR

WASHINGTON, DC APRIL 28, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUB-COMMITTEE

Thank you for the opportunity to present the views of the American Ex-POWs on the role the VA health care plan should play as part of current efforts to improve health care services for all Americans. First and foremost, we want to make clear that we are pleased with the interest being shown in this subject. The American Ex-Prisoners of war believe strongly that some form of National Health Care is a must for our Nation, and that the Department of Veterans Affairs has a long standing obligation for Health Care to the Veterans of this Country. We believe the Department of Veterans Affairs is the vehicle that must continue to provide Health Care for all veterans. . The Department of Veterans Affairs must be a seperate but official part of any health care system.

We recognize the disasterous consequences a major or prolonged health problem can have on any family lacking the personal resources or insurances required to provide proper care--and we recognize that too many American families are in this vulnerable position. We applaud the determination of Congress and the White House to develop a solution to more effectively serve all Americans in this vital area.

We affirm our Nation's promise to provide priority services to veterans who became disabled while serving their Country and have individually been determined to have such disabilities. Yet we believe Congress has erred in assigning former POWs a lower priority. The starvation and inhumaine treatment accorded POWs, wherever they were held, has resulted in a significant desease burden in later life for this small but unique group of veterans. The absence of adequate records concerning the capture or internment ,together with the lack of medical knowledge as to the specific causal relationship of the extreme depredation to

specific medical conditions, has limited VA's ability to formally service-connect them. Assuring POWs full access to the health care system is a reasonable and proper way to at least partially correct the deficiency.

The bottom line in the VA health care system is a crucial and effective part of our Nation's total health care services. It doe not deserve the image of an insulated system that is outside the mainstream of American medicine. Instead, it has played a leadership role as a model of an effective health care delivery system and can continue to fulfill its essential mission. We understand the expanding budget deficit that Congress continues to struggle with is the root cause. Never the less it would be wholly counter-productive to the present effort to improve the quality and accessibility of a national health care system and continue to under fund the VA health care system. It is essential to strengthen it before further erosion occurs.

The concept of Core-entitled veterans who would have full access to the VA health care system has our support. Yet the proposed "Americas' Veterans' Health Care Act of 1992" makes no mention of Combat Veterans who risked their lives for their country and have earned a greater right to VA health care than "other eligible, non-core veterans". Some provision according them a higher priority is fully warranted.

It is critical to recognize that VA's potential scope of responsibility extends to nearly one-seventh of the total population. It is and should be considered a major player in the over all health care services of this nation. Although, the primary burden of the VA health care system has been to serve veterans disabled as a consequence of their military service; that responsibility has also extended to provide needed

services to other veterans, including the homeless who are unable to defer the cost of that care. On doing so, the VA has traditionally lessened the burden that would otherwise have fallen on Community, State, or other federal resources. It also provides services to active military personnel in accordance with cooperative policies developed with the Army, Navy and Air Force. It is important to recognize that VA has contributed generously to the availability of well-qualified health care professionals in its role as the formost trainer of the professionals since World War 11. Included in this significant training mission has been physicians, dentists, nurses, psychologists, social workers, and vertually all categories of health care personnel. This committment has involved not only developing large numbers of health care providers for services outside the VA, but also developed proper standards for many of those providers that were accepted by American medicine and the professions involved.

The VA health care system has played a leadership role in research that has major impact on the understanding and treatment of many health problems and it continues to do so.

Long term care is an item where our Country has always been deficient, and must now be addressed. It is not proper for a veteran to become destitute in his final days, and die without proper care. All veterans should be allowed to die with dignity. We believe that as our veterans age alternatives must be explored. Needs change as we move into the ""Nursing Home" age. Proposed legislation should be expanded to include proposed alternatives to Nursing Home Care be used as a guide.

Americans are loving and caring people who tend to care more during periods of war than they do in peace time. Commitments made are meant to be kept. Military pay has always been low, with the understanding that things such as health care, commissary, and post exchange privaleges, continue during retirement. Health care for those not retiring continues to be provided through the VA.

Funds reimbursed to the Government, should be returned to the Department of Veterans Affairs, but we have problems in requiring their return to the facility that furnished the resource. This, in effect ties the VA hands. We believe Central Office should not lose control. As a practical matter, we believe that a seperate budget committee for the VA is a mandate. We do not believe that VA can maintain its commitment to the Veterans of this Country who have fought and died to protect the way of life that we hold dear, when it must compete for dollars with "Space Stations" and other glamour projects.

We believe the only valid reason to support the construction or operation of child care centers, or expend funds for associated services is to recruit and retain qualified health care providers. We believe this area must be closely monitored, as it lends itself to frequent abuse if it is not.

In major Metropolitan areas, VA health care facilities are overburdened with demand from all categories of eligible veterans. It is unrealistic to assume that those facilities could be utilized by other veterans who are non-service connected and like some other Americans, have health insurance or sufficient financial resourses to pay for their own care. However, VA health care facilities that are not fully utilized could be utilized by these veterans. As the proposed legislation indicates,

these veterans could be extended the opportunity of receiving their their treatment in the VA system with reimbursement to that facility on the same cost bases as the other health care facilities. The cohesiveness and integrety of the VA health care system to serve veterans would be retained while operating in a more economically effective manner.

In closing, we believe it is essential to recognize and support the role the VA health care system has and is playing as a significant part of our National health care efforts. Methods for VA to recover costs from non-priority veterans, having the means to pay for their care should be developed as far as possible, but opening the doors of VA medical centers to non-veterans is unrealistic in terms of current demands for treatment from veterans and would needlessly damage the integrity of the VA system as an effective part of a National Health Care system. Finally, VA has consistently modified treatment programs in the past to serve the evident need of its patients and will continue to take the initative to do so without mandated changes from legislative bodies.

THANK YOU

# STATEMENT

*OF THE*

AAMC ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Robert G. Petersdorf, M.D., President

**ROLE OF THE DEPARTMENT OF VETERANS AFFAIRS IN THE NATIONAL HEALTH CARE DELIVERY SYSTEM**

Presented by:

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before the:

Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
United States House of Representatives
Representative J. Roy Rowland, M.D., Chairman

334 Cannon House Office Building
Wednesday, April 28, 1993
9:15 AM

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Good morning, Mr. Chairman and Members of the Subcommittee. I am Gerard Burrow, M.D., Dean of Yale University School of Medicine. On behalf of the Association of American Medical Colleges (AAMC), I appreciate the opportunity to testify this morning on the role of the Department of Veterans Affairs (VA) in reform of the national health care delivery system.

The AAMC serves as the national voice for the country's 126 accredited medical schools, over 90 professional and academic societies, and 400 major teaching hospitals, including over 70 VA medical centers. Currently, over 130 of the 171 VA medical centers (VAMC) are affiliated with 102 medical schools. Each year, more than 30,000 medical residents and 22,000 medical students receive a portion of their education in the VA. Overall, half of the practicing physicians in the U.S. have spent some time training in the VA. The VA also participates in training a variety of other health care professionals, including nurses, dentists, and pharmacists.

In my own case, the first patient I ever examined was as a second-year medical student at the West Haven Veterans Hospital. I was in the first group of medical interns at Yale who rotated through the West Haven VA, and I spent significant amounts of time there during two years of my residency. At the other end of the spectrum, I chaired the Dean's Committee at the San Diego Veterans Hospital from 1988 to 1992 and I currently chair the Dean's Committee at the West Haven VA. I also served on the Department of Veterans Affairs Advisory Committee for Health Research Policy in 1990. From the vantage point of 35 years of experience at all levels of the VA system, I believe it has been an outstanding marriage between the VA and medical schools in which both partners have benefitted immeasurably.

In a critical, but subtle way, the VA and national health care system intersect at two points, brought together primarily through the academic affiliations. First, as the statistics I mentioned earlier indicate, the VA plays a critical role in the education and training of future U.S. health care professionals. Secondly, the VA contributes significantly to advances in medicine through a research program which has an impressive history of success and innovation. Whereas training and research issues are of primary interest to academic medical centers, manpower and staffing issues are central to the VA's success in meeting its primary mission of delivering health care to veterans. The intersection of these two goals brought medical schools and the VA together officially in 1946 and continues to bring mutual benefit to both partners and to the nation. Changes instituted as part of health care reform need to consider the VA's special strengths and training responsibilities.

The VA delivers quality health care to a unique, and from a clinical perspective, a very complicated patient population. Previous hearings of the Subcommittee have addressed the analysis completed by the "Mission Commission" which documents that veterans treated by the VA tend to be older, sicker, and poorer than the general population. The Commission highlighted the aging of the veteran population as the most dramatic phenomenon facing the VA health care system. Similarly, the Commission data tell us that patients enter the VA system with a greater number of diagnoses than patients entering non-VA health care facilities. The VA plays an absolutely critical role in offering access to care for a special group of Americans who would be unlikely to be as well served outside the VA.

To address the health care needs of veterans, the VA has developed nationally-recognized expertise in several areas, including geriatric medicine, mental health services, long-term care, and rehabilitation for spinal cord injuries and loss of limbs. For example, at the New Haven Veterans Hospital, the Post Traumatic Stress Disorder (PTSD) Center is working in a high risk area that probably cannot be done outside of the VA. In San Diego, the Spinal Cord Injury Center, a major center for spinal cord injury treatment and research, would be hard to duplicate elsewhere.

To advance and complement the VA's clinical care mission, the VA supports an impressive research program. I note with alarm that the Administration's FY-94 budget proposal recommends an eleven percent cut in the VA research budget, from $232 million in FY-93 to a proposed $206 million in FY-94. Research dollars can be thought of as a leveraged fund that involves substantial return on the initial outlay.

The VA Advisory Committee for Health Research Policy strongly believed that the research program of the VA was entirely appropriate to its clinical mission. The research primarily supports physician investigators who are involved directly in patient care with orientation toward solving problems, such as PTSD, of special import to veterans. National health care reform requires data on outcome assessment and clinical trial follow-up; this type of research is much easier to accomplish in the VA system, as the VA is ideally suited for clinical and health services research. Multi-center trials and cooperative research also work well in the VA system.

The areas of specialization developed by the VA and supported by VA research can be divided into two categories -- those which will remain particularly important to veterans and those which will become increasingly important to the general population. The veteran population has a

unique demand for rehabilitation and mental health services, in many cases related directly to military experience. The extent and breadth of care in these areas is unlikely to be as relevant for the general population as for the veteran population. On the other hand, in areas related to aging, the VA has developed an expertise because of patient demographics, but this type of medicine will become more critical to the entire health care delivery system as the general population ages.

The Mission Commission demographic data make it clear that the VA is approaching an important crossroad. The VA patient population will quickly begin to decline in this decade. To avoid addressing this phenomenon would be fiscally unsound, but more importantly, avoiding the issue will jeopardize the quality of care in the VA. Achieving an optimum workload in a health care setting is a delicate balance; under-utilization can be as injurious as overload. The reality of a declining patient base and the threat it presents to quality of care leaves policy makers with important decisions about the future of the system. Current and projected fiscal constraints on VA appropriations make the timeliness of such decisions even more dramatic.

From the AAMC's perspective, there are several options for reforming the VA health care delivery system. The first, but least likely, option would be to eliminate the VA as a discrete system and integrate veterans into the national health care delivery system with no differentiation between veterans and the general population. This option ignores the value of the VA and the special role it plays in the national health care delivery system, as it relates to care for veterans and to medical education. Options which would acknowledge these features of the VA revolve around two concepts -- range of services and patient population.

At the outset of considering options for retaining and reforming the VA, two main features must be defined: (1) a set of services to be provided; and (2) the population to be offered services. Numerous combinations or elements of these two essential decisions could be adopted for a final VA scenario.

In other words, a future VA system could be categorized as follows, but conceptualized in a variety of formats, electing elements of each category, to design an ultimate policy course:

1. **Adjust the size of the VA system** as the eligible veteran patient population declines. The range from this category could involve reducing the whole system, with all of its current services, to reflect diminishing patient demand. Or, decisions about the size of the system

could address elimination of certain services (i.e. tertiary care) which veterans could receive outside the VA system. An option of the latter nature would direct the VA to focus on services of special import to veterans, or areas in which the VA has developed an expertise, including mental health, geriatric medicine, long-term care, and rehabilitation.

2. **Revise eligibility** for entering the VA system. In the short-term, this could involve opening the VA to veterans other than those currently entitled to mandatory care. In the longer-term, the VA could develop means to provide services to veterans who are not "entitled" to care, or to other patients, such as veterans' spouses and dependents.

Examples of scenarios involving options from each of these categories could also be summarized as follows:

- The VA should be a system that provides complete coverage, in the sense of a comprehensive insurance policy and care deliverer, to a relatively small cohort of individuals, likely to include veterans exclusively.

- The VA should be reoriented as a system that offers access to certain, limited services to a cohort of patients, giving priority to veterans, but to include other individuals also. In a sense, this scenario can be characterized as a health care boutique, focused on a set of buildings staffed by health professionals who provide specialized services that are not as accessible in the general health care delivery system.

Each of these options has a series of costs and benefits in health policy, financial, and political terms. I anticipate future hearings will consider discrete options carefully and weigh the relevant advantages and disadvantages. The academic medical community would welcome the opportunity to participate in deliberation of these issues as they present dramatic implications for veterans' access to quality health care and for the continued success of VA-medical school affiliations.

In a separate vein, the experience of the VA can be analyzed from a variety of perspectives that may be helpful in informing the debate on reform of the national health care delivery system. The following outline presents examples of issues that could provide a framework for considering the VA as a model in which many important lessons can be learned.

1. The VA is the largest global budget for health care in the U.S. currently. What can the nation learn from the VA experience in areas such as:

   a. centralized management of resource allocation

   b. incentives and disincentives to control costs locally

   c. means of introducing new technology

   d. conversion of outdated facilities and replacement of equipment

   e. data collection for planning efforts

   f. quality assurance activities and measures

   g. the role of health services and outcomes research

2. The VA is ideally positioned to and striving toward providing a full continuum of services (primary through long-term care) to a discrete patient population. Is this a paradigm worth considering as a model for managed care?

3. How will the VA fit into a managed competition environment? Could the VA be organized as one national, or several regional, HIPCs?

4. To address its clinical care mission, the VA has developed an emphasis in specialized areas of health care that are of more predominant importance to the VA patient population than to the general population, namely mental health and rehabilitation for spinal cord injuries and loss of limbs. Because the veteran population is aging at a rate approximately ten years ahead of the general population, the VA has also developed an expertise in geriatrics and long-term care. A relevant question for health care reform would be to consider how the nation can capitalize on these strengths of the VA.

5. The location of many VA facilities, particularly certain rural and inner-city medical centers, provide a valuable resource to that community. These VA facilities create exceptional opportunities for building partnerships or networks to offer access to health care to under-served populations.

From a personal perspective, I spent twelve years as an academic physician in the Canadian health care system. The global budgeting system for hospitals was similar to the experience in the VA system. The VA system is a model that could provide useful information that would help shape a national health care delivery system. I will be happy to expand on this subject or to answer any other questions.

Thank you for the opportunity to share my views and those of the AAMC this morning.

# The VA Health Care System and Health Care Reform

Testimony to the Subcommittee on Hospitals and Health Care
US House of Representatives Committee on Veteran's Affairs

April 28, 1993

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&
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# The VA Health Care System and Health Care Reform

The climate of health care reform presents both challenges and opportunities for the VA health care system. I believe that to best serve veterans under a national health care plan, the VA health care system needs to operate under two major principles: delivery of a continuum of care, and participation within rather than outside managed competition.

One obstacle to the cost-effective and efficient delivery of health care in our present system is fragmentation of both the system and its financing. To some extent this is also true in the VA health care system. Therefore, the VA health care system should establish a continuum of care for eligible veterans. This will lead not only to a system that serves the needs of veterans but will also allow the system to be competitive in the era of managed competition.

Such a plan will require eligibility reform, such that veterans eligible for care will be eligible for the full continuum of care from health promotion and disease prevention to long-term care. Approximately 50% of veterans are now 55 years of age or older. The health care needs and utilization of these individuals' needs will not only be in long-term care, but also in ambulatory care and acute care. The VA health care system should not become only a long-term care system, for this will only perpetuate the present costly, inefficient system. A system in which the complete health, and health is emphasized, of an individual is its responsibility will develop the most appropriate levels of care for that individual. For example, upfront increased costs for health promotion and disease prevention are cost-effective if they lead to decreased costs at another level of care. However, there is no incentive to a component of the health care system responsible for health promotion to improve care at increased costs, if it is not responsible for care in another component where it can recoup those costs because the health promotion intervention reduced overall resource utilization.

Assuming that the President's national health care reform relies on a system of so-called "managed competition," an independent VA health care system would probably best serve its veteran constituency within that system of managed competition. Why would a veteran then choose the VA program over others? First, if the VA system offers a continuum of care to its eligible veterans, it will offer equivalent or superior care to its enrollees. Secondly, with a continuum of care, the VA system will be cost competitive, and, thus, be able to offer that continuum without copayment. However, to remain competitive the VA system must also have economy of size in the number of its enrollees. Eligible veterans who choose the VA system must have priority for care, but the system should be open to all veterans who select the program. Again, other veterans would preferentially select the VA system for its continuum of care.

To remain competitive, the VA health care system must also maintain its research and development program. Caution must be taken to preserve the research program as cost savings are approached in a managed care system. The VA system needs to continually assess how to best deliver care to its constituency including the delivery system, services, technology and treatment. The best care today was research ten years ago. To maintain an excellent system in the future and to remain competitive, the VA health care system must invest in research and development now and must be careful not lose sight of its importance to excellence of care.

The challenges and opportunities are there. I believe the VA health care system can meet them and develop a model for others to emulate.

# TESTIMONY

BY

KENNETH I. SHINE, M.D.

PRESIDENT

INSTITUTE OF MEDICINE

NATIONAL ACADEMY OF SCIENCES

TO THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

APRIL 28, 1993

My name is Kenneth I. Shine. I am physician/cardiologist who currently serves as President of the Institute of Medicine of the National Academy of Sciences. While the Institute has carried out a significant number of important studies for and about the Veterans Affairs health care system, my comments today represent my own perspective on this system acquired from over twenty years of experience as a physician who has cared for patients in the VA hospitals affiliated with the UCLA School of Medicine. I also served as Chairman of the Department of Medicine, and as the Dean and Provost for Medical Sciences at UCLA. In this latter capacity, I had the special privilege of participating in a number of planning activities, not only for the three hospitals associated with UCLA, but also in the western region and on a national basis. In all of these capacities, as well as in my current role, I have been deeply committed to reform of the American health care system, including the imperatives for universal access, maintenance of quality, and control of costs.

I previously had the opportunity to share my view with the Committee on Veterans' Affairs in the United States Senate. At that time, I indicated that, with all of its limitations and problems, the Veterans Affairs health facilities represent an opportunity for creating a functioning health care system that can serve veterans, their families, as well as military dependents. I believe that the Veterans Affairs health care system provides an opportunity for innovation which can not only improve the health of veterans, but also can intelligently and significantly inform the debate as health care reform progresses. In this regard it could create model systems for policy makers and for providers. I believe that a properly preserved and developed veterans health care system can continue to make critically important contributions to the education of health professionals and to health sciences research. In this regard it can produce a larger number of primary care physicians, which our country desperately needs, in addition to producing a number of other types of physicians.

Much has been made of the decisions which veterans might make when they have a choice of health care through some other system. Several observers have attempted to determine the proportion of veterans who would choose to receive their care in the VA system if they had alternatives. The aging of the veterans population will certainly decrease the pressure for services from the existing group of veterans who use the system, but changes in eligibility, expansion of opportunities for families and military dependents will clearly influence the size of the population served. Whether the system would be used will depend critically upon the cost of such care in a competitive, managed competition environment, and it will critically depend upon the quality of the service. Although the data is still not well developed, the budget of the VA system has produced a program in which a considerable amount of cost-effective care is being provided. Properly organized and built on some of the experiments currently under way in the system, methods for health care delivery could be organized and evaluated in a manner that would be very useful to veterans and to the rest of society.

I would emphasize that, regardless of the timing of a federal health care reform package, the implementation of such a package will require a number of years. During that time, an important series of innovations will be carried out in states such as Oregon, Maryland, Florida, Washington, to name a few. Each of these experiences will be helpful in informing other states and the federal government on ways to improve access and control costs in health care. For the veterans system not to participate in these innovative activities would be very shortsighted.

I do not come to these conclusions without recognizing the extraordinary obstacles to their successful accomplishment. However, I believe that the current climate provides a unique opportunity to move the agenda, which may never again be available to us.

The Veterans Affairs health care system, like every system, has important strengths and weaknesses. Let me begin with the weaknesses. First, the system as a whole has been seriously underfunded for over a decade. The underfunding has resulted in the use of resources that otherwise would have supported plant and equipment, but were instead diverted to operations. If not properly addressed, some of these deficiencies will limit the capacity of the system to maintain care as well as the opportunity for innovation. Second, the political environment and management style has impeded the capacity to consolidate reorganized services in ways that would improve cost-effectiveness while maintaining quality. These limitations have ranged from difficulties in closing or converting particular facilities and has created a mentality, at times, that increasing efficiency will cause hospitals or clinics to lose resources. It is difficult for health providers and managers to achieve such savings if the monies will be withdrawn. Third, the focus of the health care system has historically been on inpatient facilities and inpatient beds. While the maintenance of a finite number of beds is more myth than reality, the creation of proper ambulatory services is still impeded by issues of reimbursement, eligibility, and inappropriate facilities. This includes not only the quality, but the location of these ambulatory facilities. Although the Veterans Agency system has begun to move in this direction, it still lags dramatically behind the rest of the health care system in providing ambulatory services. Fourth, the VA system has suffered remarkably from the attempts to micromanage it centrally. It is simply too large and complicated for this to be successfully accomplished. Delegation of authority and responsibility, proper recognition of accomplishment, and prompt action in response to ineffectiveness in the context of well-articulated, programmatic goals and objectives are the only ways such a large and complex system can be efficiently and effectively managed. Finally, one of the most important challenges to this system is the remarkably heavy and diverse disease burden carried by the veterans it serves, including chronic illness such as lung and heart disease, substance abuse, and mental illness. This burden will continue to increase as the veterans population ages.

But the system also has great strengths. Included among these strengths are: first, its mission to provide health care to this nation's veterans; second, the remarkable dedication of the professional and administrative staff of the VA health care facilities to that mission and to the veterans whom they serve. I am constantly inspirited that, even under their

adverse circumstances over the last several years, that dedication and commitment remains remarkably strong. Third is the high quality of patient care provided under most circumstances by the system. Although in many of our facilities nursing care is stretched to the very limits, if not beyond, particularly by staffing patterns, the quality of care remains amazingly high. Fourth is the leadership that the system has provided in certain specific areas, including the care given to paralyzed veterans, geriatric research and education centers, and special programs in such areas as substance abuse, physical medicine rehabilitation, and AIDS. Fifth is the tradition of medical school affiliation, which has allowed the recruitment of very high caliber physicians and other health professionals. Sixth is the high quality of VA research, which has not only led to Nobel Prizes and memberships in the National Academy of Sciences, but more importantly to regular improvements to the quality of health care, not only for veterans, but also for non-veterans. Seventh is the importance of the VA system in educating a substantial fraction of all of the interns and residents trained in the United States.

For purposes of our discussion, however, the key strength of the system is the opportunity to innovate in health care delivery in ways that will not only improve the health of veterans, but also provide a model system for the rest of the country.

Our health care system is challenged to rationalize four conflicting forces: control of costs, universal access, maintenance of quality, and the desire on the part of our citizens that each patient has access to the latest and most effective technologies available. Rationalizing these forces and maximizing health, which is, after all, our real objective, will require several key components to a health care system. I would like to identify each of these components and the capacity for the VA health care system to address each element. First is a global budget, defining in a sensible way what is a reasonable rate of rise in overall health care expenditures. To a large extent, by virtue of the budgeting process for the VA health care system, it already has its annual global budget. Second is a system of managed care in which each patient is identified with a primary care provider who can, in consultation with the patient and the patient's family, make rational decisions as to the appropriateness of care. In such a system, continuity of care is required in order that the patient's history and background is known and a proper long-term, as well as short-term, health plan be made. The primary care provider in such a managed care system should have incentives for preventive care and for maintaining the patient in a healthy state as well as for providing the most effective and efficient care when illness occurs. This is not a feature of current care in the VA health system nor for the vast majority of Americans at the present time. However, the VA system could innovate in managed care in very exciting ways. Because of my personal experience with the pilot ambulatory care and education center at the Sepulveda VA Medical Center in Sepulveda, California, let me just briefly describe how that system works. Under Dr. Alan Robbins, a series of health care teams have been created at that facility, which includes physicians, nurses, dietitians and social workers, nutritionists and occupational therapists, and a variety of other health care providers. Each veteran is assigned to a particular global health care team and is provided with a primary physician as well as a backup physician, should the primary physician not be available. Each team also

has a nurse clinical practitioner, who participates in the global team activity and who is available for night calls and other times that the physicians might not be rapidly available. Each global health care team is responsible for comprehensive care of the patient, including educational programs using a wide variety of audio\visual strategies, preventive interventions, and rehabilitative services after an acute illness. When subspecialty consultation is required, the nature and extent of such consultation is determined by the primary care provider. The global health care team, therefore, provides comprehensive care with a strong preventive, educational, and rehabilitative component. The patient deals with a limited number of physicians who come to know the patient well, and the use of high technology is subspecialty services is carefully monitored by the primary care providers. Two other features of this type of managed care experiment are worthy of comment. First, the Sepulveda VA Medical Center has established an outpatient facility in Bakersfield, California, some fifty or sixty miles to the north. Patients in that community can be seen by a primary care provider at the Bakersfield clinic. If it is necessary to refer the patient to the Sepulveda VA Hospital, a specific referral is made to one of the global health care teams, so that a primary care provider at Sepulveda becomes responsible for following up on the patient and referral from Bakersfield. This is another one in which continuity of care is provided from a distant site. Secondly, it is worth noting the high degree of enthusiasm which this approach has engendered among students, interns, and residents. The Sepulveda VA Medical Center has been able to recruit a full complement of general internists to staff its global health care team and has no difficulty in attracting a very high quality of intern and resident to its educational programs. I mention the Sepulveda experience only because it is one that I know reasonably well. There are a variety of other potential experiments in managed care within the system, which could be attempted and evaluated. Third, control of costs is a critical element in a successful health care plan. The VA medical centers now provide care that is significantly less costly than that obtained in the private sector. In some cases, this has been the result of an unfortunate degree of underfunding, but, on balance, the VA health care system is increasingly cost-effective and therefore could be very competitive in a managed care environment. Fourth, the rational use of technology in health care requires careful assessment of the true incremental value of new technology. At the present time, I know of no other system in which the opportunities for careful assessment of the value of new technology could be carried out that would be more appropriate than the VA health care system. Fifth, controlling costs and limiting the application of technology will put substantial pressure on the system to demonstrate the maintenance of high quality. The use of outcomes and effectiveness research becomes critical in order to monitor any decrease in effectiveness or any increase in bad outcomes. The VA system is highly suited for developing techniques for assessing both outcomes and effectiveness.

The VA health care system would therefore provide an environment in which extensive innovative use of managed care might be implemented with improved assessment of technology transfer and measurement of outcomes and effectiveness. Managed care with continuity of care would require a significant shift in the capacity of the system to provide long-term ambulatory care. In this latter regard, the interest of the affiliated medical schools and the VA health care system are becoming increasingly concordant. Medical educators

have increasingly recognized in the last several years the critical importance of the ambulatory environment for educating medical students, interns, and residents. The VA health care system provides an opportunity to expand the ambulatory programs at the same time that the system itself is attempting to adjust to the challenges it will confront in a changing health care environment. I believe that the pressures upon America's medical schools and the VA health care system will find a number of very common interests to which both can mutually contribute.

Finally, I would comment upon the necessity for health care systems within the larger VA medical system. The availability of care to veterans who are at a distance from major VA health care centers will require systems of care covering large geographical areas. These can be provided to a series of satellite clinics attached to a principal facility. With the use of audio\visual equipment, and careful rotation of personnel, a common patient record, and a commitment to primary care of the managed care variety, current VA health care facilities can serve as the focus for systems of care extending large distances. Free standing ambulatory facilities should, in my opinion, be merged into these geographical systems of care.

Thank you for allowing me to comment on the future of the VA health care system. As I have suggested, it is a system with strengths and weaknesses in which the strengths far outweigh the weaknesses. In an era of health care reform, I believe it also offers opportunities which we should grasp and to which we should respond aggressively.

STATEMENT OF

D. EARL BROWN, JR., M.D.

MANAGING VICE PRESIDENT
HEALTH POLICY RESEARCH AREA
ABT ASSOCIATES, INC.

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERAN'S AFFAIRS

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

CONCERNING THE

ROLE OF THE VA IN MEETING THE NEEDS OF VETERANS
UNDER A NATIONAL HEALTH CARE PLAN

APRIL 28, 1993

Mr. Chairman:

I appreciate the opportunity to address this committee and consider it a privilege to be invited. As you know, Mr. Chairman, I served the VA for about eight years, the last six as Associate Deputy Chief Medical Director. I continue to have allegiance to the VA and to the veterans they serve. If I come to this hearing with a bias, it is that veterans deserve the best medical care we can provide and that those who work for the VA are some of the most devoted personnel I have encountered. As you expressed in your letter of invitation to this hearing, I, too, am interested in how veterans can best be served under a national health care plan.

My primary concern in my current position is health policy. My focus is on the policies required to ensure equity of access to health care that is of high quality and delivered in an efficient and effective manner. To that end, my colleagues and I have defined a managed care model for CHAMPUS for mental health and substance abuse care. We have also worked for the Commission on the Future Structure of Veterans Health Care, producing a Projection of Cost of a Managed Health Care Delivery System for the Department of Veterans Affairs. We are following closely the developments of the President's task force on health care reform. Even though developments in the deliberations are not public, it seems clear that the proposal will include managed competition as a model with a set of basic benefits, some method to promote universal access to care, and budget limitations. Our question today is how should the VA respond to the changes in health care initiated by the President's plan.

First and foremost, the VA should respond to changes in health care by also changing. It would be a mistake for the VA to either remain on the same path or proceed in a direction different from the majority of health care providers in the country. Therefore, change is a necessity and in many ways the VA is well positioned to respond to a system of managed competition. To evaluate this, let's look at the major tenets of managed competition,[1] [2] including:

- Integration of financing and delivery of health care,
- Standardization of coverage,
- Economies of scale,
- Procompetitive regulatory framework, and
- Universal coverage.

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[1] Professor Alain Enthoven and Representative Jim Cooper (D-TN), Breakfast Briefing sponsored by the National Health Council, April 13, 1993.

[2] Multiple articles, Managed Competition: Health Reform American Style?, Health Affairs, Supplement 1993, Volume 12.

Integration of financing and delivery

Managed competition proposes to reward low cost and high quality in health care delivery. It has been shown that the VA delivers medical care at low cost, and the quality assessments performed by the VA show that overall quality is good. A change the VA needs to make is to integrate financing of health care with measurements of quality. This is what is proposed in managed competition, and is one of the greatest challenges for all health care delivery systems, public and private. Until quality is measured by outcomes of health care, only proxies for quality can be used, and they will not provide measures to accurately differentiate between health care delivery organizations or providers.

In order to integrate the financing and the delivery of health care, the VA requires more patient specific and cost accounting data, including, as examples, an automated clinical record, enhanced patient data exchange, patient specific cost accounting, case management tracking, and development of a national database for clinical care and operations management.

Standardized coverage

With standardization and simplification of entitlement, the VA can provide better than standard coverage for veterans. Currently, VA providers cannot deliver care to veterans in the same manner as provided in the private sector. For example, if a veteran requires care that can be provided on an outpatient basis, but is only entitled to inpatient care, the VA physician will admit the patient. Further, the rules of entitlement are so complex that they must be redefined and simplified. Only then can the VA offer a benefit package that is standard across the board.

Veterans are likely to have health care needs that are different from what may evolve in the President's plan as a basic benefits package for the general public. An example might be a more extensive mental health benefit. It is likely that the basic package will limit the mental health benefit to a specific number of outpatient visits and hospital days. The VA's experience would indicate that is insufficient for veterans. The VA alone has the experience and expertise to determine what benefits veterans require. The VA alone also has the expertise to provide for the special needs of veterans, such as for spinal cord injury and post-traumatic stress syndrome.

Economies of scale

The VA has the benefit of large scale both in terms of facilities and numbers of beneficiaries, and is already saving money through major purchases of equipment and pharmaceuticals.

Pro-competitive regulatory framework

Two aspects of the regulatory framework are required in order to make the competitive system work. Health Insurance Purchasing Cooperatives and patients must have adequate information in order to differentiate between health care delivery programs. Secondly, in order to reduce the costs of health care the threat of malpractice suits must be reduced.

Standard outcome reporting is the key to the first aspect of the required regulatory framework. This is the most difficult challenge in any health care delivery system. The VA has demonstrated the capability of measuring and reporting outcomes in their cooperative studies program. The VA's cooperative studies are unique in that multiple medical centers collaborate in a given research protocol, making it possible to collect data on a large number of cases in a relatively short period of time. This program has been successful largely because of the capability to capture outcomes data. However, to make this a standard reporting framework, the VA needs increased capacity in the area of information resource management.

The other aspect of the regulatory framework in managed competition has to do with the practice of defensive medicine to avoid law suits. Managed competition would mitigate the practice of defensive medicine through utilization of a credible "supreme court" of medical technical evaluation that bases decisions on science. In this manner the number cases that would require the judicial system would be markedly reduced. The VA does not have a problem in this area because of the checks and balances provided by internal and external oversight systems.

Universal coverage

Category A, with highest priority for VA care, includes veterans who cannot afford care, and the VA can continue to offer care to those who cannot pay. However, if offered a standard benefits package in the private sector, some veterans may elect to go elsewhere, especially if access to a VA medical center is difficult because of transportation or other problems. In order to attract veterans to remain in the VA medical system and attract others who can pay, the VA can offer an expansion of benefits, cost free care for veterans currently in the system, no co-insurance, no deductible, and lower premiums. This would also shift the VA's case mix from the predominantly severely ill to a more normal distribution which will increase volume without a comparable increase in utilization of expensive services, thereby reducing the per patient costs.

In a managed competition mode of health care delivery, individuals identify a single source of health care. The VA should continue to have responsibility for the care of service connected disabled veterans. Service connected veterans have greater requirements for health care and are likely to be underserved by other health plans. Currently HMOs generally exclude individuals with service connected disabilities. In order to assume responsibility for total care of service connected veterans, the VA needs to expand the availability of primary care. Also, in managed care, families generally are cared for by the same provider network. Is the VA to compete to the extent that responsibility is assumed for the entire family? The VA could team with other medical facilities for the provision of full family services, in order to become more fully competitive.

The above are what I understand as the major tenets of managed competition, and the relation of each to the VA. Now, I would like to discuss some aspects of managed care that will have an effect on the VA, how I believe the VA should respond, and finally some words of caution as the Committee considers the VA's role in the President's health care plan.

Managed care techniques

Managed health care is an approach to health care delivery and financing that incorporates cost containment while promoting the use of medically necessary and efficient health care resources. Whether the approach includes health maintenance organizations (HMOs), managed fee-for-service (FFS), or preferred provider organizations (PPOs), all rely on a set of techniques to manage costs through case-by-case assessments of the clinical justification for proposed medical services. These techniques include preadmission review, admission review, concurrent or continued stay review, discharge planning, second opinion, retrospective utilization review, provider feed-back, and case management. The purposes of the techniques are to curb unnecessary use of health services and to direct patients to appropriate treatments and settings.

Many of these techniques are used currently by the VA. The VA has in operation the best integrated health care information system in the nation. In order to implement managed care techniques effectively, the VA must have an expanded and responsive information system. However, budget limitations make it difficult to implement such techniques as concurrent review, for example. In order to be competitive, the VA requires a significant expansion of the current information management resources in order to support the techniques of managed care.

An important strategy in managed care is the provision of preventive services and wellness care. These include many services: provider rapport; discussion and explanation to increase patient compliance; case managers; care continuity; and counseling regarding smoking, hypertension, diet, exercise, recreation, social activities, sexual adjustment, and work habits, to name a few. These services have the potential to prevent more serious and costly care, and should be made available to veterans.

Another important factor in the provision of cost effective, high quality care is a system of incentives for providers to prescribe the most appropriate services. The most effective cost reducing incentives used by managed care firms to effect the behavior of providers is to have providers share the financial risk of caring for patients. However, these incentives are worrisome because of the potential for reward by compromising quality. There is no satisfactory answer to the issue of effective incentives. I am confidant that some VAMCs as a part of total quality management, have implemented techniques for rewarding providers for good performance. The VA is an excellent laboratory for evaluating schemes for provider incentives. I suggest that authority be granted for the design and evaluation of various means of influencing provider behavior to deliver high quality, cost effective care.

In order to be a player in managed competition, the VA will require a full range of services, especially alternatives to institutional care, such as ambulatory care, partial hospitalization, and social support. A refinement of entitlement will assist in the provision of such services, and authority to provide additional alternatives will be necessary. The VA provides limited case management at present, but would need resources to provide case management for all high cost and/or high risk patients. The additional funding required for the VA to make necessary changes required might be offset by permitting the VA to retain reimbursements.

I realize that enrollment is controversial. However, in order for the VA to compete in managed competition, I believe that it will be necessary to require enrollment of veterans. Only thereby can the VA know how to plan and budget. The additional incentives cited above (cost free, no co-insurance or deductible, guaranteed entitlement, etc.), could serve to entice veterans to enroll. Knowing your population base is a significant part of managed competition. In order to be competitive, it is imperative that the VA know its population base.

Important suggestions

Primary care must be expanded in the VA, and must include preventive care, as described above. One major strength of the VA is the ability to offer a full continuum of care to eligible veterans. This is important for veterans who rely on the VA for needed care. It is also important because the VA is an essential resource for medical education. A teaching hospital generally provides higher quality care, and the VA is no exception. The affiliations with medical educational institutions enhance the quality of care for veterans throughout the system.

I mentioned early in my testimony that the VA is in the unique position of having the capability of measuring outcomes of medical intervention. I refer to the cooperative studies program. Unfortunately, the public does not know what a tremendous resource for advancement of medical science the VA is. The landmark studies performed in the VA have reaped such results for American medicine as defining the standard treatment for hypertension today, discovering and developing the effective treatment for tuberculosis (streptomycin), defining the most effective treatment for congestive heart failure (the use of vasodilators produced a 50 percent reduction in mortality), and developing psychoactive drugs for the treatment of mental illness. These are but a few of the examples wherein studies conducted in the VA have improved medical care for all U.S. citizens. This capacity should not be lost--indeed it should be expanded through the continued development of a national database available for clinical practice, research, and management within the VA. The VA should lead the nation in conducting outcome studies, developing data that will result in standards of care.

Summary

As the manner in which medical care is delivered in the U.S. changes, the VA should respond with changes that enhance the strengths of health care delivery in the VA. The VA has the capacity and capability to become an active participant in the President's health care plan. I would urge the members of this Committee, Mr. Chairman, to provide the VA with the resources to thrive in the new medical environment. We should not lose this important national resource. Thank you for permitting me to testify. I will be pleased to respond to any questions.

STATEMENT

BY

CHIEF MASTER SERGEANT BOB MILLER, USAF RETIRED

LEGISLATIVE AFFAIRS MANAGER

AIR FORCE SERGEANTS ASSOCIATION

BEFORE THE SUBCOMMITTEE ON HOSPITALS

AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ON

PRESENT AND FUTURE ROLE OF VA HEALTH CARE

APRIL 28, 1993

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Air Force Sergeants Association
International Headquarters, Post Office Box 50, Temple Hills, MD 20757

Mister Chairman and distinguished members of this committee. Thank you for the opportunity to present our views on behalf of the 167,000 members of the Air Force Sergeants Association (AFSA) regarding the present and future role of VA Health Care. Our members, active duty, retired and veteran enlisted personnel of the Air Force, Air National Guard and Air Force Reserve are increasingly concerned about the quality and access to health care for our current and future veterans. In this testimony I will bypass the tendency to reiterate the reasons for our government's obligation to provide quality health care and the current problems and budget deficiencies that plague the VA health care system, because you are already knowledgeable of those facts. Neither will I address the specific effects that the yet unknown National health care reform package may have upon the VA health care system. However, I will express our major concerns and offer several specific recommendations that may assist you in the arduous task of ensuring the accomplishment of the VA health care mission within the framework of the national system.

Our foremost concern is that as the Clinton administration and Congress address Health Care reform, the Veterans Affairs Health Care System may be degraded or lost in the process. It is absolutely imperative that the VA health care system remain in tact and independent to meet its permanent mission which includes:

(1) Medical care for veterans

(2) Education and training for national health care professionals and physicians

(3) Medical research; and

(4) Back up for the DOD health care system during war or other national emergency.

This mission must not be changed -- there is no other provider, public or private that can satisfactorily meet these national requirements.

We are also concerned about access to quality care for our veterans. Many veterans must travel long distances and may contend with long waiting periods and delays to receive care which often is perceived of being of questionable quality.

Another major concern is that eligibility requirements are in dire need of revision so that all veterans may access the system based upon their needs and abilities. The current system is complex and confusing to VA health care providers and to veterans; and in many instances appears to produce inequitable treatment and services.

Regardless of the impact that national health care reform will have on the VA health care system we urge you to seriously consider the following recommended actions to strengthen the VA health care system as we prepare to enter the 21st century.

- The VA health care system should be an integral part of any National health care delivery system, but must remain dedicated to America's veterans. The strengths of the VA system may provide good examples for use in the development of a reformed national health care system. To illustrate, VA has proven its ability to deliver health care at a cost well below that of the private sector. Recent studies show that health care of equal quality can be delivered by the VA at costs which are 20 to 40 percent lower than that delivered by affiliated university hospitals. National health care reform should use the cost-containment examples provided by the Veterans Health Administration.

Additional excellent examples include specialized spinal cord injury units, blinded care units, research and use of specially adaptive equipment and prosthetics, long term mental health care, substance abuse treatment, and last, but certainly not least, is the VA's work in providing a full range of treatment for the aging. Most innovations in geriatrics treatment in the nation had its beginning in VA research.

- Make improvements that will make its services more readily available to its patients by establishing more mobile clinics, smaller hospitals at more locations, more out-patient clinics and screening units. VA

will be better able to meet the future demands by taking into account the demographical factors in terms of where the majority of its potential patients are located.

- The VA must make a serious effort to raise the level of quality as defined by the factors that are important to the veteran users. More specifically, the quality of health care and services are judged by efficiency, effectiveness, accessibility, satisfaction and suitability.

- AFSA strongly urges the committee to ensure that eligibility and entitlement reform is accomplished immediately, as well as provisions for reimbursement from all 3rd party payers for care provided by the VA. More specifically, we support the position of the American Legion, DAV and VFW as expressed in their joint position paper, dated 3/8/93, which is attached to our written statement for convenient reference.

With your support of these recommendations, the VA Health Care System could do a better job of providing access to quality health care for our nation's veterans. Also, the VA could play a valuable role in the national health care reform. Thank you for allowing us to present AFSA's views. We are prepared to answer any questions you may have.

## POSITION OF MAJOR VETERANS SERVICE ORGANIZATIONS ON THE DELIVERY OF VETERANS HEALTH CARE

Major veterans service organizations have chosen to speak with a unified voice regarding veterans health care as delivered by the Department of Veterans Affairs - Veterans Health Administration. We find major problems concerning access because of laws governing access to care; the inability of the VHA to deliver the continuum of care mandated by sound medical practice; and the rationing of care because of inadequate fiscal appropriations. The following statements reflect the positions taken by The American Legion, Disabled American Veterans and the Veterans of Foreign Wars as building blocks to achieve our vision of an efficient, fair and quality VA health care delivery system:

- The Department of Veterans Affairs health care system must continue to exist as a system dedicated to the care of veterans with primary missions of delivery of quality health care, healthcare-related research, medical education and the contingent care of those wounded or ill as a result of a national disaster or involvement in existing military conflict.

- Eligibility and entitlement reform must be undertaken immediately. Such reform must precede any other reconfiguration of the system in order to define the populations of veterans to be served by VHA. No mission changes, re-allocation of resources or expansion or contraction of services can be undertaken without first defining those

veterans to be served.

- The VA shall offer a full range (continuum) of medical care services, as an entitlement in law, to all honorably discharged veterans. Eligibility to exercise that entitlement is satisfied by any veteran who is adjudicated to have a service-connected illness or disability rated at 0% to 100%, or any veteran who is ill and/or disabled and falls within the guidelines as prescribed in Section 1710, Title 38, USC. In addition , the VA shall provide necessary care to any veteran who suffers a catastrophic illness or disability not covered by insurance and the cost of such care would render the veteran indigent. Any veteran who is considered "uninsurable" because of pre-existing medical condition as well as those in receipt of VA pension should also have access to medical care. These veterans should be considered the "core entitled" groups for receipt of medical care.

- The cost of rendering care to the "core entitled" group shall be funded by congressional appropriations at a level determined by their treatment needs at the required services level. Care for the expanded universe of veterans beyond the "core entitled" group will be financed by contributions from those veterans receiving care by some form of payment option such as private health insurance reimbursement, reimbursement from state/federal programs such as Medicare, CHAMPVA, CHAMPUS or the Indian Health Service or by premiums paid into any managed care program administered by the VA. Any moneys received as reimbursement for care from <u>any</u> third-party payer must be permitted to be retained within the Department with no budget offset.

- The Department of Veterans Affairs health care delivery system shall offer, based upon medical need, a full continuum of care. VHA serves as case manager for that care which includes, but is not limited to, preventive care services, acute care, outpatient care, specialized care such as blind rehabilitation, spinal cord injury treatment and rehabilitation, post-traumatic stress disorder and prosthetics services, intermediate care, dental care, respite care, hospice care and long term care. Long term care shall include institutional care where required. Non-institutional care such as home health and maintenance services which would preclude or defer institutionalization, would be one of the methods which could minimize long-term institutionalization.

- The VA must assure availability and accessibility of care for eligible veterans by allocating resources and assigning and reassigning missions to facilities in areas wherein the optimum number of veterans will be served. Contract care should be provided when necessary.

- The Department of Veterans Affairs - Veterans Health Administration must be allowed to share medical services, equipment, facilities and procurement services with other medical care delivery systems, in the federal and private sectors, with a goal of enhancement of medical care for veterans. Resources of the VA must be directed exclusively to the care of veterans until any expanded universe of veterans, provided by eligibility or entitlement reform, has been offered needed medical care. Then, and only then, should the VA considering services to non-veterans.

"I agree that the above 'Position of Major Veterans Organizations on the Delivery of Veterans Health Care' is the position of the organization for which I affix my signature":

March 25, 1993 — 3/10/93

John F. Sommer, Jr. (date) — Charles E. Joeckel, Jr. (date)
The American Legion — Disabled American Veterans

25 March 93

Larry W. Rivers (date)
Veterans of Foreign Wars

## WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

Responses To Questions For The Record
Submitted By
The Honorable Chris Smith
to:
Gordon Mansfield
Executive Director, Paralyzed Veterans of America
For Hearing Record Of
Subcommittee on Hospitals and Health Care
April 28, 1993

1) WHAT DOES THE TERM "MANAGED COMPETITION" MEAN IF IT WERE APPLIED TO VA?

Managed competition describes a health care system where large groups of insurees can promote competition among providers to promote lower cost and enhanced quality in the provision of health care. The concept also incorporates such features as managed care and the use of "gate keepers" and quality control.

While there is enough latitude in the concept to allow some alternatives for operating the VA health care system in a managed competition environment, the basic concept would require that VA function as an Accountable Health Provider (AHP) in competition with other AHP's. VA would have to have the tools both to attract veterans to utilize the system and to provide quality care at a cost that would allow it to compete successfully with the private sector. Currently, VA as a federal health care system, presently supported by appropriated dollars, does not have the flexibility to provide sufficient innovation to compete on this level.

VA will have to be given the management flexibility to be able to adapt rapidly to changes at disparate local levels. VA will have to provide a standard health benefit package beyond the basic benefits package required of all AHPs that includes specialized care that matches the needs of the veteran population.

Core eligible veterans (currently service connected, low income, special category and the catastrophically disabled) must be offered clear entitlement to these services, including the full range of outpatient care and long term care.

VA will have to develop a more efficient use of resources and distribution of resources among facilities and regions of the country.

VA will have to restructure the provision of services to avoid duplication, particularly in the provision of expensive specialized services.

VA will have to improve its budget and service base through improved collections and reimbursements from third parties and enhanced sharing agreements with other public and private health care providers.

VA will have to improve its information and cost accounting systems and be able to market itself to attract and retain a steady clientele of veteran patients.

2) WHAT ARE THE VIEWS OF YOUR ORGANIZATION WITH REGARD TO VA FACILITIES PROVIDING ABORTIONS AND BECOMING ABORTION MILLS?

PVA has no official policy on the use of federal funds or federal facilities to provide abortion services.

3) THE VA IS ESSENTIALLY A VERTICALLY-INTEGRATED SYSTEM CONSISTING OF, FOR THE MOST PART, MAJOR MEDICAL CENTERS AND RELATIVELY FEW FREE-STANDING AMBULATORY CLINICS. WHAT IMPACT DOES VA'S FACILITY STRUCTURE HAVE ON THE PROVISION OF HEALTH SERVICES TO VETERANS?

VA's shift to more cost-effective outpatient services has been compromised by archaic and confusing eligibility requirements that authorize outpatient services to some veterans and not others. Under health care reform, eligibility for outpatient services will have to be standardized and improved if VA is to compete successfully and efficiently with other health care systems providing comparable benefits under a revised health care system. At the same time, VA's shift to ambulatory care has been hindered by a lack of adequate funding for conversion of plant facilities to clinic space and adequate staff to support those new facilitates. VA, as well, will have to increase its investment in smaller community based outreach clinics and mobile health care vans to serve remote rural areas.

4) ASSUMING THAT UNIVERSAL ACCESS WOULD BE PROVIDED THROUGH SOME TYPE OF INSURANCE, DO YOU BELIEVE THAT VA SHOULD BE AUTHORIZED TO COLLECT REIMBURSEMENT FROM SUCH INSURANCE FOR CARE DELIVERED TO VETERANS?

The Congress should ensure that the historic integrity of the VA is maintained by requiring that care for service connected disabled veterans is provided for through appropriated funding. However, VA should be authorized to collect and utilize third party reimbursements as just one other method to help support the system.

5) WHAT IMPACT DOES THE CURRENT FUNDING PROCESS HAVE ON VA'S ABILITY TO COMPETE IN A LARGER HEALTH CARE SYSTEM?

Over a decade of VA budget shortfalls has eroded the resource base of its health care system, encouraged cannibalization and neglect of plant maintenance. There is also a consequential backlog of obsolete equipment, rationing of medical services and loss of productivity.

However, in the context of the VA's ability to compete successfully in a larger health care system, the historic lack of sufficient resources will be as much a hinderance as the process through which VA has receive those funds. Unlike its potential private sector competitors, VA is totally supported by appropriated funds. In nearly all instances it is prohibited from accepting or generating revenues from non-appropriated sources. Because of fear of Office of Management budget offsets, VA has to return the bulk of its third party reimbursement collections to the federal treasury. At the same time, even if VA is able under the new plan to accept certain reimbursement and premiums, the system, under current eligibility requirements, would only be able to compete for plan users among the veteran population. Other plans would have a much broader spectrum of the American population from which to draw on or recruit potential users.

6) WOULD PLACING A HEALTH TEAM IN THE VA'S VET CENTERS HELP FACILITATE VA'S SHIFT TO AMBULATORY CARE?

PVA, for some time, has touted the Vet Center Program for the services it provides to Vietnam veterans but also for its future facility as an outpatient, community-based resource for the

entire VA health care system. Undeniably as time passes, Vet Centers should experience a slackening of demand. As that happens, this valuable outpatient infrastructure strategically located in communities across the country should not be lost to the VA effort to bring a wide variety of cost-effective care to the entire veteran population. PVA is aware that some Vet Centers on a very limited basis are already providing certain clinical services. We believe this function could be expanded in the Vet Center system but only if: (1) independent resources were made available and, (2) these additional activities did not detract from the mission or the ability of the individual Vet Center to perform its mandated function.

7) DO YOU SUPPORT PLACING THE VET CENTERS UNDER THE CONTROL OF MEDICAL CENTER DIRECTORS?

As the scenario described in the previous answer unfolds we would anticipate that medical center directors should have greater control over the non-readjustment counseling functions in Vet Centers. The medical center in that respect should also provide an increasing level of support for the community-based facility. If a Vet Center was to be actually converted to serve as mini-outpatient clinic to meet the general health care purposes of the medical center, PVA would support total conversion to the control of the medical center director as well. These decisions should be made on a careful review of the demand for services. Where viable readjustment counseling services are still needed within Vet Center service areas we would support maintaining the existing independent management and funding structure of the Readjustment Counseling Service.

KENNETH I. SHINE, M.D.
PRESIDENT
INSTITUTE OF MEDICINE

**Responses to Honorable J. Roy Rowland**
**Questions Submitted for the Record**
**Subcommittee on Hospitals and Health Care**
**Committee on Veterans' Affairs**
**April 28, 1993**

*1. Do you see risks to VA if its health care system operates outside the national health reform umbrella? If so, what are they?*

Some veterans with service-connected disabilities will always require special services provided through a VA health care system. Spinal cord injury veterans is one example. Care for these veterans is costly, highly specialized, and unlikely to be provided in a satisfactory manner in a fully integrated private sector for health care. To provide these services outside the national health reform umbrella will work to the detriment of such veterans. Progressively shrinking services to a shrinking cadre of aging veterans with special health needs will make it increasingly difficult to maintain the physical infrastructure, the breadth of professional experience and expertise, and the quality of broad-based care that is required in the care of patients. The potential for the VA health care system to revert to an antiquated, old soldiers home outside the mainstream of American health care will be substantial. The overall quality of services will deteriorate.

Operating within the health care reform umbrella provides real opportunities to challenge the professionals and staff within the VA to further strengthen and improve services. Many of them are anxious to compete with other elements in the health care system. Moreover, the VA system represents a splendid opportunity for innovation in health care reform which can inform the rest of the system. The innovations may range from computerized record keeping and facilities and equipment planning, to outcomes research and technology assessment.

*2. Assuming that health care reform will take some years to implement, would you recommend that VA initiate any pilot programs or studies to position itself for the changes ahead? If so, could you offer any specific recommendations?*

The opportunity for innovation mentioned above implies that the answer to Question 2 would be to encourage the VA to initiate pilot project and studies to position itself for the changes ahead. These would include a) efforts to develop continuity of care models, with a strong emphasis on primary care and prevention; 2) the development of geographical systems of care, which would include both urban and rural underserved areas, as well as possible inclusion of families of active duty military personnel; and 3) continued development of computerized information systems and patient records for expanded activities in the assessment of outcomes of health care and of technology transfer.

Substantial autonomy ought to be given to the leadership of multiple facilities on a geographical basis, with efforts to locate relevant services rationally and consolidate redundant services and technology, but develop regional systems of care. Some significant portion of resource savings in an area, as well as in a facility, ought to be available to those facilities for additional program development. In this way, innovation would be rewarded.

These experiments should include opportunities for broadened eligibility for care up to and including care of all veterans and their families. Such experiments would include systems of care closely linked to academic medical centers or to other health care

providers in the private sector in order that networks of care be available for children, women, and for services that are not necessarily to be located at the veterans health care facility itself. Rapid efforts to shift the residency mix in the direction of primary care residencies will be useful to the veterans health agencies, their affiliated institutions, and the personpower needs of the country. In all of these areas and in many others, there are opportunities for pilot programs or studies.

KENNETH I. SHINE, M.D.
PRESIDENT
INSTITUTE OF MEDICINE

**Responses to Honorable Chris Smith**
**Questions Submitted for the Record**
**Subcommittee on Hospitals and Health Care**
**Committee on Veterans' Affairs**
**April 28, 1993**

*1) Can VA compete under a managed competition scenario? What factors inhibit competition?*

Under proper circumstances, the VA can compete under a managed competition scenario. However, the current organization of the VA does not allow for effective continuity of care or comprehensive services required under a standard benefits package. Moreover, most families will wish to have all of their care provided by the same organization. This will require the VA to create systems of care including their affiliated institutions with rural and center city outreach.

*2) How would global budgeting and cost-containment measures included in the National Health Care Plan affect VA?*

The VA will always require some direct budgetary support in order to provide for special needs that are service-connected, such as spinal cord injuries. However, the system has operated as a global budget by virtue of its organization, and has the capacity for significant cost-containment.

*3) If VA's ability to recruit and retain physicians is reduced, is VA's competitiveness diminished?*

Absolutely! It is essential that VA's facilities continue to have a close relationship to academic institution and that the research budget of the VA be maintained. In a environment in which an increasing proportion of physicians will be salaried, the combination of academic affiliation, teaching, and research opportunities will allow the recruitment and retention of outstanding physicians.

*4) In your estimation, should medical center directors be responsible for defining the mission of their own facilities? If so, won't most directors want to maintain full services with an acute care mission?*

On the one hand, the VA health care system cannot be micromanaged from Washington. There needs to be flexibility and opportunities for innovation that rewards directors and leaders. This will require geographical responsibility for a population of veterans within a substantial catchment area, an opportunity for planning between institutions in order to consolidate services, and an opportunity to build both primary care and continuity environments. This will be successful only if there is an incentive to succeed. I believe the incentive ought to be the capacity of facilities in a geographical area to retain a substantial portion of any cost savings, which can be invested into new programs or activities. This would require capitated care for a population of veterans with measurable and demonstrable rewards to facilities that maintain high quality while containing costs.

*5) The VA is essentially a vertically-integrated system consisting of, for the most part, major medical centers and relatively few free-standing ambulatory clinics. What impact does VA's facility structure have on the provision of health care services to veterans?*

It is essential that networks of care which are comprehensive and geographically distributed are created. This includes ambulatory facilities and some secondary care facilities in rural and center city locations. In this regard, the VA would have some very substantial advantages. It would be possible to use interactive video for communications between the various sites. It would be possible to rotate both primary care and subspecialty staff among the facilities. The development of a consistent electronic data system and patient record would allow the VA to provide services close to veterans and their families as part of this type of system.

*6) Is the current system of centralized VA management an inhibitor or a facilitator to managed competition?*

Health care is largely local. Health care reform nationally will almost certainly be implemented on a state by state basis. There is no way that a centrally managed organization will be able to compete in this environment. There must be decentralization of responsibility, authority, and accountability.

*7) Do you agree with the premise that universal access would lead to veterans "abandoning" the system in favor of the National Health Plan? If so, how could such exodus be prevented?*

There is no question that, unless VA services are patient-friendly, responsive, and convenient, veterans will choose alternatives if these are available. On the other hand, there is a substantial loyalty to this system which can be built upon if user friendly and effective services were available. I believe that we have a maximum of five or six years in which to make the evolution to these kinds of systems.

*8) Assuming that universal access would be provided through some type of insurance, do you believe that VA should be authorized to collect reimbursement from such insurance for care delivered to veterans?*

Absolutely. Moreover, a significant portion of such collections should be maintained within the local facility or area providing care as an incentive both to collect funds and to attract such payers.

*9) Do you believe the current restrictions on VA's ability to contract for health care services should be revised? If so, should contract services in a national system of universal access be more flexible or more restrictive?*

Contract services must be far more flexible. There is no way to provide a standard benefits package which would include adequate services for males, females and in some cases for children, without the creation of networks, extensive contract arrangements, and for the enhanced potential to consolidate services, in some cases in collaboration with community hospitals and/or academic medical centers.

*10) Secretary Brown has stated that eligibility reform will proceed after the unveiling of the Clinton Health Plan. Assuming that the legislative course for such sweeping reformation could be quite lengthy, do you believe eligibility reform for VA health care should wait?*

Eligibility reform needs to move forward promptly and vigorously. It will not be a simple matter and ought to be pursued now.

*11) If eligibility reform is not enacted prior to implementation of National Health Reform, how will VA's ability to compete for patients be affected?*

A failure to introduce eligibility reform will deprive the VA of the opportunity to do meaningful experiments for a broader sample of veterans, particularly those who are less ill and those who have choices. By widening eligibility, there is an opportunity to test approaches to determine whether in fact VA programs can attract significant numbers of patients beyond those who will use the systems because of either complexity of their illness or a lack of resources.

*12) Would placing a health team in the 201 vet centers help facilitate VA's shift to ambulatory care?*

The vet centers need to be part of an integrated system of health care with clear geographical responsibility for a population of veterans. The methodologies by which these centers would be linked as part of the system ought to be flexible and subject to the imagination and energy or local leadership.

*13) Do you support placing vet centers under the management of medical center directors?*

Regional geographic catchment areas for a defined population of veterans will require modification of the roles of medical center directors. In an area with multiple medical centers, a coordinating committee chaired by a knowledgeable and thoughtful senior individual would be required in order to carry out this type of planning. In less densely organized areas, this may occur under the responsibility of a medical center director. Reward to such directors, however, should be based upon their capacity to provide comprehensive care to veterans in their geographical area rather than upon the performance only of their tertiary hospital.

*14) What effect will National Health Reform have on VA's research program?*

If the VA research program is supported at some kind of reasonable level, the combination of facilities and modest research support could give the VA a substantial advantage over the rest of the health care system. There still is great uncertainty as to how clinical research will be compensated for patients in the overall health care plan. There continues to be great anxiety about whether health care research in the biomedical arena creates a pressure to increase cost. Expanded outcomes and effectiveness research within the VA, with a strong emphasis on technology assessment, would not only allow the VA system to be particularly effective in evaluating its own performance, but also instruct the rest of the health care system in the course of health care reform.

Honorable J. Roy Rowland
Questions Submitted for the Record
Gerard H. Burrow, M.D.
Subcommittee on Hospitals and Health Care
April 28, 1993

1. Do you see risks to VA if its health care system operates outside the national health reform umbrella? If so, what are they?

The VA would not be well served to be considered or to operate outside of the national health care system, and, as such, must be a part of the national reform debate. The success of the VA is assisted by coordination with, as opposed to separation from, the overall national health care delivery system. For example, the VA has established productive, synergistic relationships with academic medical centers and with Department of Defense health care facilities. Similar affiliations should be promoted in the future. A coordinated approach helps the VA ensure that it is able to deliver high quality health care to veterans. It also brings the VA into the national health reform debate from a variety of important perspectives, many of which were addressed at this hearing. I would, however, recommend approaching reform of the VA with caution.

The overall national health reform debate seems to be focused more on competition as a means of controlling costs. I hear less about how factors related to quality of care will fit into a competitive structure. For the VA there are a special set of quality of care issues that must be addressed which relate to some of the special health care needs of the veteran population. For example, veterans use of medical services is greater than that of the general population in areas including prosthetics and mental health. As such, the VA has developed model programs in these areas, many of which are quite costly. It is critical that these types of services and programs within the VA are protected during health reform. First, veterans, in part related to their military service, will continue to have disproportionate need for certain specialized services that will not be as readily available outside the VA. Second, the VA is currently well positioned to offer such services, but the cost of continuing to do so could put the system at a competitive disadvantage, with unfortunate consequences if cost is the primary factor in a competitive model.

2. Assuming that health care reform would take some years to implement, would you recommend that VA initiate any pilot programs or studies to position itself for the changes ahead? If so, could you offer any specific recommendations?

As I mentioned, the VA has already established model programs in areas of special relevance to veterans health status. As such, the VA has become identified as a national leader in many such areas, for example, geriatrics, long term care, rehabilitation, prosthetics, and mental health. Veterans and non-veterans would be well-served by the VA continuing to develop prototypes in these areas. In the future, the VA could play a similar role in developing pilot programs in areas of special importance to veterans that also have broad applicability. Examples of clinical and professional development programs that would fit into this category would include primary care services, AIDS treatment, geriatric psychiatry, and a variety of medical opportunities becoming possible as a result scientific advancements in neuroscience.

Honorable Chris Smith
Questions Submitted for the Record
Gerard N. Burrow, M.D.
Yale University School of Medicine
Subcommittee on Hospitals and Health Care
April 28, 1993

1. Can VA compete under a managed competition scenario? What factors inhibit competition?

The VA can compete effectively under a managed competition scenario. Existing major factors that inhibit the VA's ability to compete include insufficient resources, limited local flexibility, and an ill-defined patient population. To enable the VA to compete more effectively, I would recommend promoting local decision making, designing a means to enable the VA to offer a full continuum of services to an identified population, and establishing a method for adjusting for the relatively high costs of certain specialized services, such as spinal cord injury or substance abuse programs, that the VA provides to meet some of the health care needs of the veteran population.

2. How would global budgeting and cost-containment measures included in the national health care plan effect VA?

The VA could offer a model for consideration in many of the concepts that are part of the national health care reform debate, including the experience of operating within a global budget and incorporating externally-established cost containment measures into planning activities. It could be argued that the VA will fare better than many other delivery systems precisely because of the system's experience and adaptability in these areas.

3. If VA's ability to recruit and retain physicians is reduced, is VA's competitiveness diminished?

Undeniably yes. The answer would be the same for any single or set of health care facilities. High quality professional staff is the single most important component of delivering high quality care. Quality will be jeopardized in an environment where concerns exist related to physician recruitment and retention.

4. In your estimation, should medical center directors be responsible for defining the mission of their own facilities? If so, won't most directors want to maintain full services with an acute care mission?

As I suggested earlier, I would attempt to promote greater local flexibility, although I understand the need for some centralized planning activities. With respect to allowing each director to define the mission of that facility, I do not agree that each director would seek to structure an acute care facility. Good health care administrators understand that providing high quality care to fit the needs of the patient population must be the mission of any hospital, clinic, or other facility. Quality standards would quickly decline in a facility where the mission did not meet the needs of the patient population, probably more quickly in an acute care setting than in others. If local accountability were matched with autonomy in defining a mission, facility directors would have overwhelming incentives to strive to establish an appropriate mission, to concentrate on attracting appropriate staff and other resources to advance that mission, and to maintain high quality standards. To support such a concept, the VA would need to develop a system of resource allocation that does not penalize facility administrators for increased efficiency or for expanding workloads.

5. The VA is essentially a vertically-integrated system consisting of, for the most part, major medical centers and relatively few free-standing ambulatory clinics. What impact does VA's facility structure have on the provision of health care services to veterans?

My personal experience and conversations with colleagues indicates that within the national VA system there is geographic disparity in availability of some services, including ambulatory care access. Eligibility rules exacerbate the problem, as some veterans are only permitted to be treated on an in-patient basis.

In part due to resource constraints, the VA has not been able to move as quickly as the private sector in developing ambulatory care capabilities. For many procedures, ambulatory settings have become a preferred modality because it maximizes patient comfort, eliminates the some of the risks, such as infection, associated with hospitalization, and reduces the costs of care. The VA should continue to develop more broadly based ambulatory care capabilities and build referral networks between ambulatory clinics and other facilities. In general, planning should focus on providing appropriate range of services to the veteran population and equitable distribution of resources, based on patient demographics.

6. Is the current system of centralized VA management an inhibitor or a facilitator to managed competition?

As addressed in question 4, a mix of central planning and local autonomy and accountability would facilitate management decisions that reflect national standards and community needs within the VA health care system.

7. Do you agree with the premise that universal access would lead to veterans "abandoning" the system in favor of the national health plan? If so, how could such exodus be prevented?

To answer this question in the abstract is difficult. The parameters of "universal access" and the construct of the VA system would make a tremendous difference in veterans' choices. However, even in the abstract, I would not agree entirely that veterans would "abandon" the VA system. The VA offers an environment designed for veterans, making it the facility of choice for some veterans. Geographic location of VA facilities and other facilities would also be a dominant factor in individual choices.

In the context of my understanding of what the Clinton health care plan may involve, I would disagree more strongly with the premise that veterans will "abandon" the VA.. Reports of the plan being developed seem to indicate that the VA may currently offer a wider range of services than a basic benefits package will include. Moreover, I would project that many veterans will continue to come to the VA for specialized services in which the VA excels, such as geriatric medicine, rehabilitation, and mental health services. Maintaining high quality, insuring availability of key services, and improving the VA's public image would help prevent veterans electing to receive care outside the VA system.

8. Assuming that universal access would be provided through some type of insurance, do you believe that VA should be authorized to collect reimbursement from such insurance for care delivered to veterans?

If veterans not currently "entitled" to care from the VA were permitted access to the system, it could only be with the proviso that the VA be permitted to collect from outside payers. The system and local facilities could not afford to support the costs of expanding services without increased appropriations or reimbursement from insurance coverage.

9. Do you believe the current restrictions on VA's ability to contract for health care services should be revised? If so, should contract services in a national system of universal access be more flexible or more restrictive?

The premise behind the VA's use of contract services is based on both cost and quality concerns. In other words, an individual facility may not have sufficient patient demand for certain services. To attempt to maintain such services for a limited number of patients would be medically and financially unwise. In some cases, a veteran requiring that service could be referred to another VA medical center. It other cases, it makes more sense for the VA to negotiate with an outside provider for that service. As medicine has become more sophisticated and more specialized, contracting has become a more important tool in health services access. From inside the system, I hear of increasing restrictions on the VA's ability to contract for services. From the perspective of someone outside the system, I see increasing regulatory burdens in negotiating contracts. With that overlay, it seems clear that revisions involving greater flexibility are necessary.

The VA's ability to make appropriate use of contracts will increase as it is included in the national move toward universal access. For example, to remain competitive, the VA will be challenged to offer a broader range of services to care for women veterans. Depending on patient demand, the VA would need to build linkages with other community providers to offer services such as management of a high risk pregnancy.

10. Secretary Brown has stated that eligibility reform will proceed after the unveiling of the Clinton health plan. Assuming that the legislative course for such sweeping reformation could be quite lengthy, do you believe eligibility reform for VA health care should wait?

Eligibility reform fits best in the context of overall system reform. To maximize effective policy and planning, the VA must have a clear understanding of the population it will be expected to serve. However, I am concerned that eligibility reform not be delayed too much longer. As you are aware, the current system of coverage is ill-defined, inconsistent, and from a clinical perspective, can distort provision of appropriate, high quality health care delivery.

11. If eligibility reform is not enacted prior to implementation of national health reform how will VA's ability to compete for patients be affected?

The VA's ability to conduct rational planning will be seriously jeopardized if eligibility reform does not accompany reform of the delivery system. Before competing for new patients, the VA must ensure that it has the rudimentary foundation, including the appropriate infrastructure, staff, and equipment, to care for the discrete cohort of veterans who should maintain priority in receiving care.

12. Would placing a health team in the 201 vet centers help facilitate VA's shift to ambulatory care?

While I support efforts to facilitate expanding the ambulatory care capabilities of the VA, I am not familiar enough with vet centers to comment on this proposal. In general, I would suggest that the costs of conversion be carefully considered. Moreover, consideration must be given to providing appropriate support and to establishing appropriate referral centers for all ambulatory care settings.

13. Do you support placing vet centers under the management of medical center directors?

I am not familiar enough with this issue to comment.

14. What effect will national health reform have on VA's research program?

It is unclear at this time how health research will be treated in general in national health reform. Research could become a critical element for successful implementation of features of health reform and as a means of analyzing the success of a new system. I am concerned, however, that in a price sensitive environment, research could easily be targeted for cuts to reduce costs. In my view such an approach would be enormously short-sighted. It will be critical to maintain the quality of the VA system so that the benefits of VA research, as supported by Members of this Subcommittee and the full Committee, be recognized and that the program would be sustained.

**Honorable J. Roy Rowland**
**Questions Submitted for the Record**

**D. Earl Brown, Jr., M.D.**

**Subcommittee on Hospitals and Health Care**
**April 28, 1993**

*1. Do you see the risks to VA if its health care system operates outside the national health reform umbrella? If so, what are they?*

The greatest risk would be that the delivery of health care in the VA would not be in step with that in the private sector. For example, if the private sector implements most of the techniques of managed care and the VA does not, care in the VA would not be subjected to the same criteria for ensuring quality and cost effectiveness. Having to be responsive to different criteria would ultimately result in different standards of care. The private sector will implement systems to monitor and associate quality and costs of care. It is unlikely that the VA will have the resources to stay abreast of such developments in the private sector if the VA is not a part of national health reform. Even if the VA implemented techniques to ensure quality and cost effectiveness, comparison of care within and outside the VA would not be possible. Affiliation with medical schools has forced the VA to stay abreast of medical practice in the private sector, which has ensured that health care in the VA is comparable and of good quality. Thus, just being in step with private health care helps maintain quality.

Another risk is that the private sector health care plans may see an opportunity to off-load veterans to VA care in order to save money. This would be less likely if the VA were a full participant, with enrollment and capitation.

*2. Assuming that health care reform would take some years to implement, would you recommend that VA initiate any pilot programs or studies to position itself for the changes ahead? If so, could you offer any specific recommendations?*

I appreciate the opportunity to offer suggestions. I recommend three studies/pilot programs for consideration:

1) In my testimony, I recommended that the VA's Cooperative Studies Program be expanded to perform standards of care studies based upon outcomes of illness. I believe this would be an excellent investment for our country, and would produce data upon which standards of care for the nation would be based. The VA currently has the medical information system which, with enhancement, could perform the data collection, and standard research protocols developed in accord with the Cooperative Studies Program would ensure excellence of design.

The VA has already established a VA Outcomes Group at the VAMC, White River Junction, VT. The group's mission is to foster research which examines endpoints that are relevant to patients and society through clinical research, health services research, and dissemination. Projects currently in progress focus on improving outcomes and cost effectiveness, studying patient preferences, and the use of administrative databases for health care research. Current research includes a study of variations in treatment and outcomes of acute myocardial infarction, decision analysis of screening mammography, the impact of substituting telephone calls for routine ambulatory visits, and decision analysis of displaced femoral neck fractures, among others. The establishment and operation of the VA Outcomes Group demonstrates the progressive thinking of the VA and the capability of the VA to lead the nation in this type of landmark research.

2) I also believe that the VA offers an excellent opportunity to evaluate and compare the effect of implementing managed care in one or more medical centers. The VAMC would have to be given the flexibility to provide the most appropriate care for the veteran, without regard for current eligibility rules. Veterans who are eligible for care would be provided whatever care they needed, but based upon the usual set of techniques to manage costs through case-by-case assessments of the clinical justification for proposed medical services. The managed care

techniques could be administered by a contract firm or a unique organization set up within the VA. Techniques would include preadmission review, concurrent or continued stay review, discharge planning, retrospective utilization review, provider feed-back, and case management. Guidelines would have to be provided the contractor or in-house organization that would ensure the flexibility to make exceptions for veterans with unusual problems (no one at home to provide support following discharge, for example). The intent would be to evaluate the delivery of health care to veterans in a managed care environment designed to curb unnecessary use of health services and direct patients to the most appropriate treatment, compared with another VAMC conducting business as usual. Comparison should be made on quality, including patient satisfaction, and costs.

3) A step short of fully implementing managed care, but a step that would better position the VA for managed competition, would be to implement a demonstration project to help restructure the delivery of health care to achieve best practices of care for illnesses. We know that health care providers learn and improve the quality of practice through feed-back regarding optimal care. Through the use of specialized computer programs (e.g., MedisQual, MedisGroup, and Clinical Financial Incentive System), practice patterns of providers are compared, and adjusted for severity. The information is furnished to the providers, who learn from others, and change accordingly. The result is lowering of costs and improvement of quality. An example of this proposed demonstration project is described in an article, "Physicians, hospitals unite to meet reform head-on," on page one of the June 14, 1993 edition of American Medical News.

*3. If the Congress were to attempt to assure veterans access to care by mandating that VA pay for needed treatment in the community under circumstances where it lacks the capacity to provide reasonably timely care or treatment in its own facilities, what specific mechanisms could Va employ to contain costs of outpatient treatment and assure the appropriateness of proposed treatment? Are similar mechanisms needed or desirable with respect to VA-provided care and treatment? How might VA best mobilize or implement such "care-management"?*

The primary strategy of managed care programs is to introduce an independent professional review of the decisions made by clinicians concerning proposed courses of treatment before treatment is actually delivered.[1] The objective is to reduce the cost of health benefits without reducing quality. Most approaches to managed care incorporate some form of utilization review (UR) and some form of quality assurance (QA). These two components may be thought of as "checks and balances" to assure that care is simultaneously necessary and delivered appropriately. These two aspects, when combined, are intended to achieve a proper balance between cost effectiveness and quality.

The core processes of a managed care system -- utilization review and quality assurance -- should be supported by three additional processes:

- provider and beneficiary education,
- an appeals process, and
- a claims processing and management reporting system.

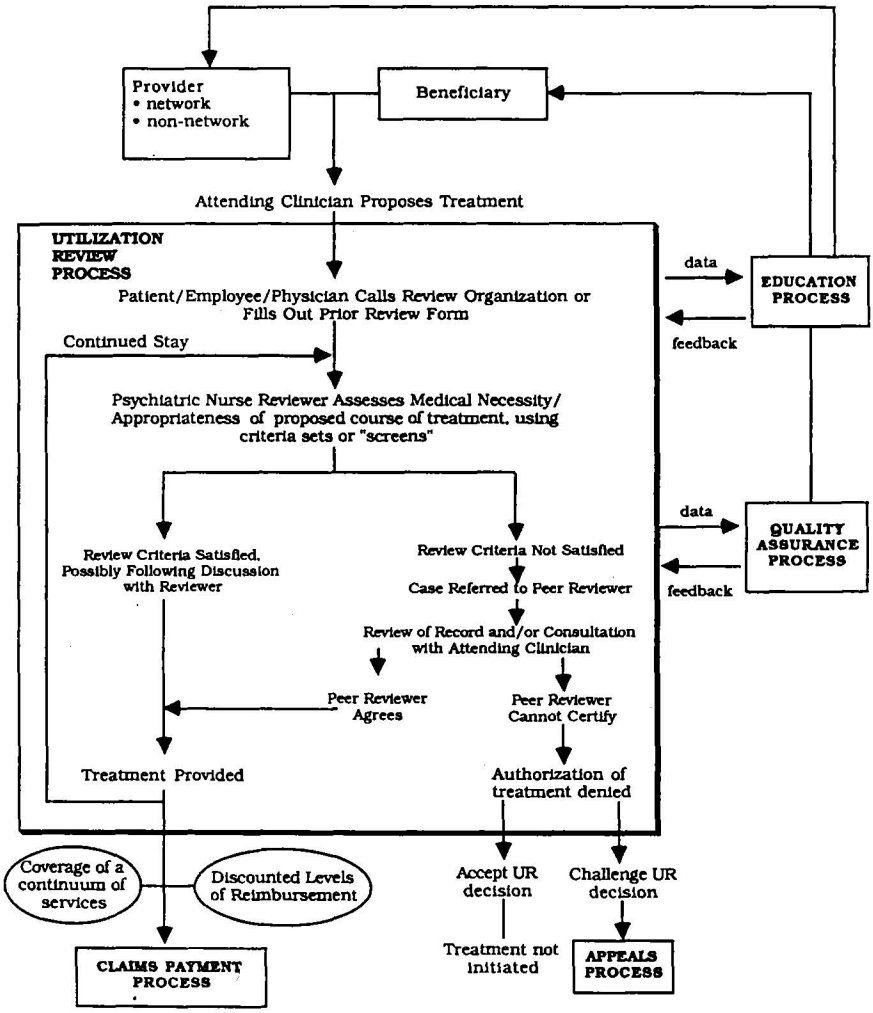
A complete managed care system thus includes a set of carefully interrelated components. The relationship among these different components are illustrated in Exhibit 1 and discussed briefly below.

Utilization review. Utilization review is the core process of managed care, as it enables the managed care system to influence the delivery of services to beneficiaries. With a typical UR process as shown in Exhibit 1, attending clinicians are expected to present proposed courses of treatment to independent, professional reviewers. These reviewers assess the medical necessity and appropriateness of the proposed courses of treatment, using criteria or "screens"

[1] While the strategy of managed care plans is initiate review prior to the commencement of services, emergency care generally requires initiation of treatment before an independent review can be performed. Typically, emergency care is subject to review on a retrospective basis.

Exhibit 1

## Typical Steps and Components in Managed Care




Source: Adapted from Institute of Medicine, Controlling Costs and Changing Patient Care? The Role of Utilization Management (Washington, D.C: National Academy Press, 1989), Figure 3-2.

that suggest clinically appropriate treatments given the condition of the patients. When the reviewer verifies that the proposed course of treatment is appropriate and medically necessary, that treatment is authorized. Particularly lengthy or costly treatments typically require periodic reassessment during the course of treatment as part of the UR process. The determination being rendered by the reviewers is whether the care is appropriate and should be authorized. The implication of this decision is that unauthorized care will not be reimbursed (unless the review decision is appealed and overturned). The ultimate decision to provide services remains the responsibility of the clinician.

In general, UR consists of three sequential phases of review, distinguished primarily by the timing of the review in relation to the point where services are rendered:

- Prior authorization, which occurs *before* a proposed course of treatment is initiated;
- Concurrent review, which occurs *during* a course of treatment; and
- Retrospective review, which occurs *after* a course of treatment has concluded.

In addition to these three phases of review, some managed care programs more closely manage their highest cost patients *throughout* the course of treatment, through the application of proactive *case management*.

To implement UR, managed care firms use a set of similar approaches:

- Professional reviewers -- Initial review for treatment plans is performed by several types of professionals including nurses and social workers. When initial reviewers are unable to authorize care, the case is referred to professional peers. As a result, no ultimate denial of authorization occurs before a professional peer has reviewed the case.
- Consistent, professional criteria -- Reviewers are guided by clinical criteria, or "screens," that establish preliminary decision rules about the need for care, the appropriate level of care, and the appropriate intensity of care. The screens are generally developed by committees of experts based on their knowledge of the literature and their professional experience. Screens are periodically updated by a systematic process of feedback from reviewers and from advances reported in the literature.

The goal of UR is to ensure that appropriate care is authorized and that unnecessarily expensive modes of treatment are avoided. The approach outlined above helps ensure that the process responds to concerns for cost control within the bounds of sound professional judgement.

Quality assurance. While managed care firms generally do not systematically appraise quality outcomes, they seek to maintain quality of care by establishing criteria that reflect appropriate professional practices and by establishing review processes to ensure that the criteria are properly applied. For example, managed care firms seek to ensure that reviewers correctly interpret screens; that appropriate cases are referred to higher level review; that waivers are carefully tracked; and that criteria are modified when appropriate.

UR may be thought of as a process to avoid overutilization, and QA as a complementary review process to avoid underutilization. The nature of the review is typically different for each function. For example:

- When interacting with a typical UR process, a clinician proposing to hospitalize a patient will be expected to set a target length of stay (LOS) for the admission as part of the proposed treatment plan. The clinician may anticipate an inpatient stay of 14 days, based on the principal diagnosis. An initial UR screen may indicate that, based on the diagnosis and other clinical data, a target LOS of 7 days should be established. If the clinician agrees that the UR screen is appropriate, the admission will

be authorized for 7 days. If the clinician is adamant that 7 days will not be adequate, he or she must present additional justification for a longer LOS. If this justification convinces the reviewer of the appropriateness of a longer LOS, it will be authorized. If agreement cannot be reached, a second level of review will be initiated.

- In contrast, the QA process has a different orientation. QA screens focus on different types of data. QA screens examine issues such as the accuracy of clinical interpretation of lab tests, the comprehensiveness of progress notes in the medical record, or the appropriateness of a discharge plan. QA reviews also examine some of the same data considered in the UR process, but with a different perspective. If a provider consistently discharges patients with a particular diagnosis in half the time of a UR target, a QA screen can suggest focused review of the particular provider. If early discharges for a specific diagnosis are found to be consistently correlated with subsequent readmissions at a later date, QA screens can help identify whether a provider is consistently discharging patients before they are ready or whether appropriate treatment has been provided.

Beneficiary and Provider Education. Providers and beneficiaries need to be educated in how to access and use any health benefit program. But more than a basic educational effort is required for managed care. With managed care, UR and other processes are introduced into treatment decisions that in the past were reached more or less autonomously by the provider and the patient. There is a clear potential for misunderstandings, rather than productive and educational negotiations over courses of treatment. The managed care system must be explained to providers and beneficiaries, and the justifications for UR decisoins must be carefully communicated--the justifications for those decisions will not be self-evident. Accordingly, an active educational program for beneficiaries and providers is vital.

Appeals Process. As a check on the decisions of the reviewers, there should be a formal process for providers or beneficiaries to appeal denials of authorization.

Claims processing and management reporting system. Management of care requires effective, automated information systems to track patients, periodically reassess treatment plans, ensure claims payment consistent with authorizations, and monitor the performance of managed care reviewers.

The complexity and interrelatedness of the components of managed care, and the sensitivity among providers of implementing such a system, make it important that it be initiated in a complete and sophisticated manner. Therefore, I recommend that the VA be authorized to conduct a demonstration program in which several VAMCs contract with established managed care firms to implement the components of managed care. This should be accompanied by adequate data collection to provide evaluation and comparison between VAMCs to assess impact and effectiveness.

**Honorable Chris Smith**
**Questions Submitted for the Record**

**D. Earl Brown, Jr., M.D.**

**Subcommittee on Hospitals and Health Care**
**April 28, 1993**

*1. You state in your testimony that "Veterans are likely to have health care needs that are different from what may evolve in the President's plan as a basic benefit package for the general public." You give as an example the need for more extensive mental health benefits. What other special needs do veterans have and what should be included in a veteran's package?*

I would recommend that veterans with service connected disabilities (perhaps more than 50 percent) be provided total care available through the VA. As the entitlement rules are redefined, I recommend that veterans determined to be eligible be provided all care available.

The VA is best equipped with knowledge and understanding to care for these veterans. Disabled veterans were injured in line of duty for which the nation has obligation. They should not be required to incur costs, such as copayments or premium shares because of the service connected condition. In addition, most insurance plans currently exclude from coverage any care related to a service connected disability, probably because coverage would increase the cost of the plan to others. The VA should be funded for such care, and the VA can best provide the care.

Other special needs include care for emotional trauma related to combat (such as post-traumatic stress disorder); prosthetic devices of all types; amputations and other severe injuries; rehabilitation services; and spinal cord injury. In addition, we really do not know the emotional and mental residua of combat. We do know that veterans who come to the VA for care require a great amount of care for psychiatric and substance abuse problems. In all of these problems of veterans, the VA provides a therapeutic milieu that is difficult to quantify, but relates to having health care providers who know what veterans have endured and understand their special needs; and being with other patients who have had similar experiences. These factors are very important to rehabilitation from war related injuries and trauma, but are also an important aspect of care for other medical conditions.

*2. Can VA compete under a managed competition scenario? What factors inhibit competition?*

I believe that the VA can compete in a managed care scenario. I also believe that careful design will compensate for the factors that might inhibit successful competition. Inhibiting factors that need to be dealt with include:

- Enhancement of DHCP because the demand for data under managed competition will be much greater.
- Improvement of the appearance and functionality of VA Medical Centers.
- Reduction of waiting times for appointments and queuing for services.
- Increase in provision of preventive services and wellness care.
- Enrollment of veterans for whom a given medical center or veterans geographic area has responsibility.
- Increase in the ability to provide primary care.
- Capability and requirement to associate the costs with measurements of quality of health care.
- Standardization and simplification of entitlement which is currently very complex. Veterans will need standardized coverage that competes well with that offered to the public.
- Ability to offer complete care to veterans deemed eligible, and to their families.
- Implementation of the various techniques of managed care.

*3. How would global budgeting and cost-containment measures included in the National Health Care Plan effect VA?*

From what I understand of global budgeting, the VA has been subject to it all along. Also, if the system of payment for care is changed so that the VA will receive an amount per head for whom they are responsible, this should not be a problem because VA already provides less costly care. Therefore, the VA should not have a problem with such changes. If the issues cited in the prior question are dealt with, the VA should also have no difficulty with cost-containment measures.

*4. If VA's ability to recruit and retain physicians is reduced, is VA's competitiveness diminished?*

The VA 's ability to recruit and retain excellent physicians is crucial to the survival of the agency's health care system, particularly under managed competition.

*5. In your estimation, should Medical Center Directors be responsible for defining the mission of their own facilities? If so, won't most Directors want to maintain full services with an acute care mission?*

Medical Center Directors should participate in the definition of their facilities' mission. However, the decision should be made by the Under Secretary for Health. The reason for this is that every director desires to manage a tertiary care facility capable of performing every medical service. That motivation is good and serves veterans well. But only a responsible executive knowledgeable concerning the future direction of the VHA and capable of placing each center in the perspective of the overall mission of the VHA can objectively determine the mission of each facility. Only by centralizing decisions about missions of VAMCs, can there be established centers of excellence for providing high cost, low volume procedures, as an example.

*6. The VA is essentially a vertically-integrated system consisting of, for the most part, major medical centers and relatively few free-standing ambulatory clinics. What impact does VA's facility structure have on the provision of health care services to veterans?*

The facilities of the VHA are designed to provide the care to which veterans are entitled under current laws and regulations. Thus, they are designed primarily for in-patients, both acute and long term. With a redefinition of entitlement that makes veterans eligible for care at a level most appropriate for the condition from which they suffer, the VA will need to change to provide alternatives to in-patient care. This includes an increase in ambulatory clinics as well as other alternatives such as home health care, partial hospitalization, day care, respite care, attending nurse care, etc. Alterations of current facilities will permit the provision of most of these alternatives, including ambulatory clinics. The problem may be that the facilities may not be in the best geographic locations for easy access, especially if the VA is competing for patients with the private sector because of a standard benefit package available outside the VA.

*7. Is the current system of Centralized VA Management an inhibitor or a facilitator to managed competition?*

The current system of centralized VA management facilitates participation in a managed competition model of health care. The components of managed competition that have been discussed require central direction and management. Policies and procedures must be established and enforced. It should be noted also that with improved information systems, VA management will be better able to monitor performance of VAMCs, which obviates the need for many restrictions. With valid information, the CMD can permit more flexibility for facilities that are functioning well. However, in order to compete successfully, the VA will have to be given considerably more latitude in operations than exists today. Budget line item and contracting flexibility, and authorization to retain and utilize reimbursement come to mind.

*8. Do you agree with the premise that universal access would lead to Veterans "Abandoning" the system in favor of the National Health Plan? If so, how could such exodus be prevented?*

I don't agree that veterans will abandon the system for standard benefits packages available in the private sector. Some will, but most will stick with the VA because of familiarity and collegiality. They "know the VA system and the VA people" and that means a lot. Still, in the long term, the VA will have to be more than competitive. This can be done by standardization and simplification of entitlement, and by offering an expansion of benefits, cost

free care for veterans currently in the system, no co-insurance, no deductible and lower premiums.

*9. Assuming that universal access would be provided through some type of insurance, do you believe that VA should be authorized to collect reimbursement from such insurance for care delivered to veterans?*

Yes, I believe the VA should be authorized to collect reimbursement from indemnity plans of insurance companies. Also, if a VAMC participates in an HMO or other managed care plan, it would be appropriate for the VAMC to be reimbursed for providing care just as other participants. Funds collected should be retained for use by individual facilities, and, of course, must be accounted for.

*10. Do you believe the current restrictions on VA's ability to contract for health care services should be revised? If so, should contract services in a national system of universal access be more flexible or more restrictive?*

In order for the VA to compete satisfactorily, it will be necessary for some current restrictions on the VA's ability to contract for health services to be lifted. The VA will need more flexibility.

*11. Secretary Brown has stated that eligibility reform will proceed after the unveiling of the Clinton Health Plan. Assuming that legislative course for such sweeping reformation could be quite lengthy, do you believe eligibility reform for VA Health Care should wait?*

I believe that both efforts should proceed simultaneously. Eligibility (entitlement) reform will be a lengthy and difficult process. However, eligibility reform is sorely needed and I believe the nature of the reformation will not depend much on the particulars of the Clinton Plan. I would recommend the process begin sooner rather than later.

*12. If eligibility reform is not enacted prior to implementation of National Health Reform, how will VA's ability to compete for patients be affected?*

The changes that I have said need to be made in order for the VA to compete for patients will take considerable time. Just identifying what the VA has the authority to do and what requires changes in legislation will take time. I am concerned that the VA's ability to compete will be compromised if it is considerably behind the power curve of change.

*13. Would placing a Health Team in the 201 Vet Centers help facilitate VA's shift to Ambulatory Care?*

The logistics of placing health teams in vet centers is complex. If the health team is simply to conduct screening exams, such as blood pressure or visual acuity, it would be simple to implement. However, even then I would have concerns about follow-up and continuity of care. Any services beyond routine screening would require laboratory and other support that would necessitate establishment of a free-standing ambulatory clinic. The next question is how extensive the service beyond primary care is to be provided -- ambulatory surgery, specialty consultation or care, etc? These decisions will make considerable difference in the support services required, equipment, etc.

On the other hand, the VA needs to establish sources of care more convenient to veterans if the VA is to compete in the new health care plan. The vet centers are located convenient to veterans.

I would recommend that the VA lease space adjacent to or nearby vet centers to establish ambulatory clinics. This is working very well in Hawaii. This places clinics in strategic geographic locations, available to veterans, and it also maintains the integrity of the vet centers.

This latter point is important because the mission and operation of the vet centers are different, and that difference needs to be maintained in order to continue to provide the type of care required for veterans suffering from post-traumatic stress disorder and other residual effects of combat. The reasons for the establishment of the vet centers as separate and distinct facilities has not abated, even today. Therefore, it would be a mistake to make major changes in the manner in which the vet centers operate until the need for them diminishes markedly.

In conclusion, I recommend that the VA, following redefinition of eligibility, establish clinics in centers of population of veterans, which will likely be near vet centers in many instances. And I recommend that the vet centers modus operandi remain essentially unchanged.

*14. Do you support placing Vet Centers under the management of Medical Center Directors?*

I do not support placing vet centers under the management of VAMC directors at this time. When the need for the type of care provided in vet centers diminishes markedly, placing them under the management of the line VA will make sense. Currently, the vet centers are functioning well and serving an important need. The current management structure is effective, providing close oversight, training, supervision of outreach activities, and accountability of fund utilization. In spite of many potentially volatile situations over the years since the establishment of the program, to my knowledge there has still not been one major adverse incident. It isn't broken and therefore does not need fixing.

*15. What effect will National Health Reform have on VA's research program?*

I am hoping that the Congress and the Clinton administration will protect the VA's research program, regardless of how it is determined the VA will participate in the new health reform plan. Medical research is always at risk when there is increased competition for dollars. It is an area to cut expenditures when more resources are needed for the provision of health care. The VA's medical research is so important to the nation, that the dollars to support it must be protected. I believe that if the Congress does not protect the VA research program, it will not survive.

**Mr. Al Zamberlan**
**Responses to Questions Submitted for the Record**
**Honorable J. Roy Rowland**
**Subcommittee on Hospitals and Health Care**
**April 28, 1993**

Question 1: Many references have been made this morning to the importance of a level playing field. Do you have any concern about VA being subject to the same rules and standards that would govern HMO's or other health plans when those rules and standards may be developed without the unique circumstances of a federal provider in mind?

Answer: As a federal health care system, the VA has always operated under very stringent rules and regulations as mandated by professional organizations as well as federal law. Our policies and procedures for meeting credentialing and privileging standards, JCAHO standards and external peer review criteria are well established. Performance under JCAHO as measured by accreditation scores over the past few years, demonstrates a level of performance/compliance well above the national average score for private sector hospitals.

Question 2: Amvets makes the point that timely access to VA care - both in terms of initial adjudication and long waits for appointments - must be addressed to make VA an attractive health care choice for veterans. How would you achieve those kinds of changes?

Answer: On an ongoing basis VA monitors timeliness of service. Efforts are continuously made to achieve timeliness standards and may include revision in information flow, adding staff in a particular clinical service to manage overflow or referring patients to a nearby VA facility or community provider. Revisions to eligibility requirements will also provide powerful incentives for prevention and wellness and perhaps reducing the need for a number of acute services which create back-log. Incentives such as retaining third party collections would also facilitate improvements in timeliness.

Question 3: Would you agree with Senator Rockefeller that allowing VA to operative competitively as an accountable health plan under national health care reform would provide added incentives for VA staff to become more customer-oriented? What other effects would you foresee from competition?

Answer: VA staff have long been committed to providing the highest quality health care services to our veteran patients. Of course, as in any organization, improvements are a continuous process. Operating competitively as an accountable health plan would be one of many incentives our facility executives, managers, and professional staff would have in order to maintain a "customer-first" environment.

Question 4: Would you agree with the view that participation within national health reform provides a unique opportunity to "reinvent" or reform VA health care delivery?

Answer: National health reform initiatives will provide unique opportunities for society in general and health care organizations in particular, to "reinvent" how business is conducted. For those of us in the federal health care system, those opportunities go beyond the delivery of specific services to more general operating principles which have guided us for more than 40 years. The opportunity to place accountability for action and outcome where it belongs, on the chief executive officer of each facility, is one eagerly anticipated.

Question 5: As you contemplate a transition with VA toward full participation under national health reform, have you any thoughts on the magnitude of the changes ahead, the challenges you might face, and the period of time it might take to realize these changes?

Answer: As mentioned in the above, placing accountability at the lowest organizational level possible, in the case of VHA, with the Medical Center Director and the Regional Directors, is imperative. This will require a change not only in how we conduct business, but in our strategic thinking and planning as well. The degree to which we achieve that objective is largely dependent on the willingness to take risk and manage change initiatives. In an environment of continuous quality improvement, these objectives will be sought on an ongoing basis. The most important thing to keep in mind is not so much when we complete all actions, as it is when we get started on initiating change.

Question 6: Would you agree with those who suggest that for VA to compete on the basis of cost and quality of service, it needs more sophisticated information systems, to include a cost accounting system?

Answer: Yes, cost accounting is definitely one improvement the system needs to achieve, not only to measure competitiveness, but for budget formulation and performance indicators. We must have information systems which demonstrate cost comparability with public and private health care providers in order to be a serious participant in health reform. This comparability should be institutionally-specific as well as provider-specific, thus allowing comparison within and between providers, VA facilities and community groups. The VA does have in place many excellent information systems. Our focus needs to include discerning what data is collected, avoiding duplications in data collection, using the data in various systems and streamlining collection and use.

**Mr. Al Zamberlan**
**Responses to Questions Submitted for the Record**
**Honorable Chris Smith**
**Subcommittee on Hospitals and Health Care**
**April 28, 1993**

Question 1: If eligibility reform is not enacted prior to implementation of national health reform how will VA's ability to compete for patients be affected?

Answer: The most significant impact of lack of action on eligibility reform will be that most veterans will not have available the full range of choice of providers. Many of these individuals will be locked into a particular provider individual/organization without the benefit of evaluating what the VA can provide and the high quality of that service.

Question 2: Would placing a health team in the 201 Vet Centers help facilitate VA's shift to ambulatory care?

Answer: Most national health care reform initiatives have one element in common, that is the focus of customer contact will be the ambulatory care setting. The VA has been expanding it's provision of ambulatory services for a number of years through community-based satellite clinics, expansion of medical center ambulatory care space and providers and the use of mobile clinics.

A unique initiative being pursued in the Detroit metropolitan area is for the VA to place a health care team in a community based clinic which is contiguous to residential space for homeless veterans being implemented by the Michigan Veterans Foundation. Similarly, health care teams located in or near Vet Centers, could expand our capability to provide point-of-service contact. In fact, a model for future provision of service in the Chicago area specifically identifies the use of Vet Centers as initial patient access points.

Question 3: Do you support placing Vet Centers under the management of Medical Center Directors?

Answer: The Vet Center Team Leaders and Medical Center Directors have established effective working relationships to achieve the objective of providing needed service to Vietnam-era veterans. A number of improvements in providing a continuum of service may be achieved through such an organizational change. Oversight from VACO program officials would continue, with day-to-day operating decisions made at the local level.

Question 4: Is VA prepared to furnish itemized billing to insurance carriers? Why or why not?

Answer: The VA has proven to be most effective in collecting fees for service from third party insurance carriers. In the Central Region alone we collected $113,189,585 in FY92 and have collected $72,200,026 through April of this fiscal year. Medical center staffs have established effective systems for providing the information required by most major carriers, as reflected in our collection performance. At present, our cost accounting systems do not provide patient-specific, service-specific, cost breakdowns. Our information systems do provide detailed diagnostic and procedure data, ancillary service profiles, length of stay information, et cetera, although specific unit cost information is not available.

We must have information systems which demonstrate cost comparability with public and private health care providers in order to be a serious participant in health reform. This comparability should be institutionally-specific as well as provider-specific, thus allowing comparison within and between providers, VA facilities and community groups.

Question 5: Do you believe VA's current medical model is based on illness and disease or is it based on a wellness model? Should this change? If so, how?

Answer: VA's medical model at this time is largely driven by eligibility requirements resulting in clinical decisions being made for to comply with legislaton rather than for patient need. Except for the 50%+ service-cornected veteran, these requirements mandate a "disease" focus rather than prevention and wellness. The VA has the professional expertise and systems in place to move toward prevention and wellness.

Question 6: How would global budgeting and cost-containment measures included in the national health care plan effect VA?

Answer: The VA has always operated under a global budget process. In addition, cost-containment efforts are well documented by the National Center for Cost Containment at VAMC Milwaukee, Wisconsin. Any new measures delineated in a nation health care plan would be complementary to current systems, not be replacements.

Question 7: If VA's ability to recruit and retain physicians is reduced, is VA's competitiveness diminished?

Answer: The VA takes great pride in hiring and retaining the most qualified staff at all organizational levels. The extent to which we can present ourselves as an attractive employer to physicians is a cornerstone of our personnel objectives. This ability ranges from salary, attractiveness and adequacy of physical plant, research, to continuing education opportunities. Significant reductions in any of these areas, or a lack of ability to maintain a competitive edge with other physician employers will have a significant and direct negative impact on recruitment and retention.

Question 8: The VA is essentially a vertically-integrated system consisting of, for the most part, major medical centers and relatively few free-standing ambulatory clinics. What impact does VA's facility structure have on the provision of health care services to veterans?

Answer: Over the past few years, VA has expanded it's ambulatory care capabilities through the addition of more community based clinics, such as those in Youngstown, Ohio and the Quad Cities area in Iowa. In addition, a number of mobile clinics have been introduced and health care teams are being placed in community settings. These initiatives are in addition to the renovation of medical center space for ambulatory care activities. As more ambulatory care physical plant needs are identified, the system is well able to respond in a number of ways which best meet veteran needs. A comprehensive review and analysis of the provision of care in Chicago provides a model of future care which is typical of the HMO ambulatory care point-of-service.

Question 9: What impact does the current funding process have on VA's ability to compete in a larger health care system?

Answer: The current funding process provides few, if any, competitive incentives. The inability to implement high cost, high technology equipment procurement and construction projects in a timely fashion precludes responding to patient need in a timely manner. Reductions in operating budgets has required medical centers to use replacement equipment and non-recurring maintenance program funds for day-to-day operations. These processes are not conducive to being an active player in a competitive environment. Increase delegation of responsibility for resource management at the medical center level. In addition to placing accountability in the field, multi-year budgeting initiative should be considered to facilitate planning.

Question 10: Do you agree with the premise that universal access would lead to veterans "abandoning" the system in favor of the national health plan? If so, how could such exodus be prevented?

Answer: To the contrary, if VA is allowed to be a true "player" in national health care reform - meaning eligibility reform is enacted as soon as possible - I believe you will see increasing numbers of veterans attracted to VA facilities. Just looking at the number of veterans who continue to use VA facilities even though they have excellent third party insurance benefits and could go to any number of community providers, but freely choose the VA, demonstrates the quality of service provided. Veterans are acutely aware of the many unique services and professional expertise of VA staff in areas such as prosthetics research, PTSD and geriatric care.

Question 11: Assuming that universal access would be provided through some type of insurance, do you believe that VA should be authorized to collect reimbursement from such insurance for care delivered to veterans?

Answer: Not only is such collection imperative if we are to be a part of national health care reform, monies so collected should be retained by the medical center, or at least a major portion of such dollars collected. Competition is the key in health care reform and providing competitive incentives such as retaining insurance dollars collected is very powerful.

Question 12: Do you believe the current restrictions on VA's ability to contract for health care services should be revised? If so, should contract services in a national system of universal access be more flexible or more restrictive?

Answer: Yes, achieving organizational goals and objectives occurs when those executives and managers responsible for implementation are also held accountable. Medical center staff should be held accountable for evaluating patient needs and identifying providers with high quality at competitive costs. The provider of choice may be an individual or group in the community or may be the VA - local dynamics and patient need should be the only controlling variables. For example, the alternative uses of community nursing home dollars should not be limited. The patients needs must be matched with services available, through VA or private sector, to meet those needs.

Question 13: Secretary Brown has stated that eligibility reform will proceed after the unveiling of the Clinton health plan. Assuming that the legislative course for such sweeping reformation could be quite lengthy, do you believe eligibility reform for VA health care should wait?

Answer: Secretary Brown is leading efforts to examine many components of eligibility reform. Work is ongoing to evaluate the impact on the system given various reform scenarios. This type of evaluation is imperative before any recommendations on eligibility reform can and should be presented to Congress and our veteran constituents.

Question 14: What initiatives are available to health care providers to promote preventive care and helping the patient to maintain optimum health?

Answer: Enabling legislation has been passed to facilitate the provision of preventive health care services, but concomitant resources to fund those services has not been forthcoming. Initiatives have been recognized as needed and programs are available at least conceptually, but have not been funded for implementation.

Medical centers do have well established patient education programs which include a number of prevention and wellness initiatives such as Smoking Cessation classes and dietary instruction. In addition to 1:1 counseling or small group sessions, a variety of written materials are distributed throughout medical centers. Staff also participate in many community events such as Health Fairs which provide educational material, blood pressure screening, et cetera.

Question 15: In your estimation, should Medical Center Directors be responsible for defining the mission of their own facilities? If so, won't most Directors want to maintain full services with an acute care mission?

Answer: The mission of the VA system must continue to be defined in terms of a "system". Some operating missions may be national in scope, such as research initiatives, while others have a more local perspective such as the purchase of a particular piece of equipment. However, the "system" must always be kept in mind in making these mission decisions.

RESPONSE TO:
HONORABLE J. ROY ROWLAND
QUESTIONS SUBMITTED FOR THE RECORD
MR. MALCOM RANDALL
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
April 28, 1993

Question 1: Many references have been made this morning to the importance of a level playing field. Do you have any concern about VA being subject to the same rules and standards that would govern HMO's or other health plans when those rules and standards may be developed without the unique circumstances of a federal provider in mind?

Answer: No, however we must be given maximum flexibility in order to respond to the needs in the areas served by each VA medical center. We need to be more responsive in terms of waiting times and clinic backlogs. This could be accomplished with additional funding, either appropriated funds or funds collected for "discretionary veterans" who would chose a VA "accountable health plan."

Question 2: Amvets makes the point that timely access to VA care -- Both in terms of initial adjudication and long waits for appointments -- must be addressed to make VA an attractive health care choice for veterans. How would you achieve those kinds of changes?

Answer: Timely access to VA care can be addressed through making more professional people available to staff our primary care medical clinics, our specialty clinics and the establishment of "health stations" as the point of entry into the VA system. I would visualize that a number of these "health stations" could be established in the primary service area of each VA medical center staffed by a nurse clinician, a nurse practitioner or a physicians assistant. This would provide easy access to veterans throughout the primary service area close to their home. Many veterans need only the kind of primary care that could be provided by a single provider in these health stations. After the provider takes a medical history and does a physical examination, this individual would arrive at a tentative diagnosis. They would then pick up the phone and be connected with a physician at the parent VA medical center. They would discuss the case and the supervising physician would either agree with the tentative diagnosis or ask that the patient be referred to either a satellite outpatient clinic or the parent VA medical center. It is anticipated that many of these patients can be taken care of by the single provider at the "health station." This would include continuing follow-up care. In addition, medication could be prescribed for the patient. Thus a number of patients could not only have ready access to their home, but they could be cared for with much reduced waiting time and at a lower cost than if the patient were seen in a very busy outpatient department of a VA medical center. In caring for these patients at a level appropriate to their medical needs would also free up space in the parent VA medical center's outpatient departments. Many VA medical centers in the system have from 100 to 150 unscheduled "walk-ins" who come to the evaluation area of the medical center every day. By having a large number of these "walk-ins" seen in health stations it would free up space and permit patients to be seen much more quickly in the outpatient department of the medical center. It would also free up space and time for additional patients who might be attracted to the VA under an accountable health plan. To be seen at the VA medical center, many of these patients would have been referred from one of the health stations as needing more in depth evaluation by a physician for laboratory or diagnostic radiology tests.

Question 3: Would you agree with Senator Rockefeller that allowing VA to operate competitively as an accountable health plan under national health care reform would provide added incentives for VA staff to become more customer-oriented? What other effects would you foresee from competition?

Answer: I would agree that if VA is to compete as an accountable health plan under national health care reform, that we would need to become more customer-oriented. I believe that VA employees would welcome this. Our limited staffing means that in many settings too few employees are attempting to take care of too

many patients. This does not permit employees to spend the time with patients as they would wish. If our medical centers could add staff so that our employees could spend more time with patients and so that patients could be processed more quickly and in a more orderly fashion, then I think we would see even increased emphasis on customer service and increased job satisfaction on the part of VA employees.

Question 4: Would you agree with the view that participation within national health reform provides a unique opportunity to "reinvent" or reform VA health care delivery?

Answer: I not only agree that participation within national health reform provides a unique opportunity to "reinvent" VA health care delivery, but I believe it is necessity if VA is to continue to be in the mainstream of American medicine and continue to have quality patient health care. As a first step, we need a change in VA eligibility requirements that make no sense from a medical point of view. We need to be able to provide a full range of service within our vertically integrated capability for an identified group of veterans. These eligibility changes need to be made quickly since they would be central to our competing for discretionary veterans under health care reform. VA is the best organized health care system in the country. However, there are serious gaps in service which participation as an accountable health plan could well give us an opportunity to plug. If we compete successfully for discretionary veterans and if the insurance funds for those veterans are returned to the local VAMC, there would be an opportunity to expand staff and more appropriately and expeditiously care for patients at the VA medical center. In addition many veterans are long distances from a VA medical center. The establishment of a number of "health centers" would provide easy access to veterans across the entire primary service area of the VA medical center and could serve as a point of entry into the VA system so that we could ensure that the veteran is taken care of at a medically appropriate level of care. This would mean that veterans could have access to the VA health care system, without traveling long distances. It would reduce the costs of providing health care, it would free-up VA medical center evaluation areas and outpatient areas to take care of those patients who really need to be seen in a hospital setting, and it would provide a new frame work for effectively placing veterans at the appropriate level of care in a consistently managed vertically integrated health care system.

Question 5: As you contemplate a transition within VA toward full participation under national reform, have you any thoughts on the magnitude of the changes ahead, the challenges you might face, and the period of time it might take to realize these changes?

Answer: This is a thought provoking question. I would think that the changes ahead are of the magnitude that was involved when General Bradley as Administrator and General Hawley as Chief Medical Director and Dr. Magnusom as Associate Chief Medical Director for Education completely revolutionized the VA health care system in 1946. They turned it from a health care system that was characterized by many experts as a back water of American medicine providing shoddy care, to a system characterized as providing first rate medicine with the affiliations with the medical schools of the country providing a guarantor of the quality of the care. Those who are no longer alive who were with the VA in its pre 1946 days would not recognize the VA health care system today. Similarly, I think that many who have been involved in the VA health care system post WWII would not recognize the VA health care system of tomorrow. We have the opportunity to hold on to the tremendous gains that have been made since 1946, to improve on the level of care that we now have, to provide care for more veterans, and to enhance and enrich the care that is being provided. We must think anew as we prepare to participate in health care reform and we must develop a new health care delivery system structure in order to take advantage of the opportunities that will exist for us. One such frame work that I have suggested under previous questions would provide increased access to all veterans, and would provide care at the medically appropriate level of care and provide a structured frame work for moving patients up and down the vertically integrated system as their medical needs dictated. It would provide care to more veterans and provide them in a less crowded less pressured atmosphere. The magnitude of the changes that I envision loom large and the challenges that we might face are many. I do not feel that we can afford to stand on the sidelines as the rest of the health care system in this country goes

through change. The first requirement would be the overhaul of the current eligibility rules for care so that veterans could be provided whatever level of care and whatever kind of care they need based on medical necessity and not on administrative fiat. This is essential to moving patients up and down the vertically integrated system I have spoken about. We then need to develop accountable health plans to present to the health care alliances for approval. These accountable health plans would have to provide the core package of care prescribed by a national health board or some similar central body and would have to offer that care at a cost which would be competitive with other accountable health plans in the alliance area. In developing accountable health plans each VA medical center may have to include community and university hospitals, medical schools, other organizations found in communities such as day treatment centers, hospices, and other organizations needed to provide the range of services that would conceivably be required by a central health board for all accountable health plans. On the other hand, we may be in a position to provide care and services beyond the prescribed core package and this could be an additional incentive for veterans to use the VA system. Health care reform may also give us the opportunity, for the first time since the early days in 1946, to have our health care system adequately staffed and adequately funded. This could be a new day for VA so that we would not be forced to yield to anyone in terms of quality of our care and in terms of our responsiveness and in terms of our attractiveness to the health care professionals to make a career of VA service. We will, however, need to make some changes not previously mentioned. The VA medical center directors need to be given maximum flexibility in developing accountable health plans and to entering into relationships with health care organizations in the community. We need to staff our facilities adequately so that we can provide a responsive and more timely service to our patients. We need to provide the kind of remuneration for our physicians that is truly competitive. Despite the great step forward by the latest physician bonus bill which was passed, we still are not competitive in many specialties including primary care. In a large number of our affiliated hospitals, we could not hope to have the caliber physicians that we have unless the medical schools supplemented their salaries. We need to worry less about the conflict of interest and worry more about adequately remunerating our physicians. We need to recognize that contracting for scarce medical services, although it must be guarded from conflict of interest, is somewhat different than contracting for commodities in the open market. If we can bring about these changes, I think that the VA of tomorrow will be a remarkable health care system that will contribute immeasurably not only to the care of veterans but to health care at large in this country. An additional challenge to be faced will be the negotiations that need to be carried out in order to bring other health care providers into VA accountable health plans so that we might provide a full range of services in the accountable health plan that we would present to the health care coalition. This area also is new ground and is going to require venturing into new fields. Even with the magnitude of the changes VA will have to make and even with the challenges involved, I am convinced that we can reform the VA health care system and reform it in a positive way. As to the time that it might take to place a new VA health care structure in place, I can only make my best guess. Given eligibility reform, I think that it might take 2-3 years to put a new VA health care delivery system in place which would enable VA to compete successfully for the "discretionary" veterans.

Question 6: Would you agree with those who suggest that for VA to compete on the basis of cost and quality of service, it needs more sophisticated information systems, to include a cost accounting system?

Answer: No. One of the greatest efficiencies in the VA is the relatively small portion of our resources devoted to cost accounting systems. A detailed cost accounting system should not be necessary for any capitation type of prospective reimbursement.

RESPONSE TO:
HONORABLE CHRIS SMITH
QUESTIONS SUBMITTED FOR THE RECORD
MALCOM RANDALL
DIRECTOR VA MEDICAL CENTER
GAINESVILLE, FLORIDA
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
April 28, 1993

Question 1: If eligibility reform is not enacted prior to implementation of national health reform, how will VA's ability to compete for patients be affected?

Answer: As a first step, we need a change in VA eligibility requirements that make no sense from a medical point of view. We need to be able to provide a full range of service within our vertically integrated capability for an identified group of veterans. These eligibility changes need to be made quickly since they would be central to our competing for discretionary veterans under health care reform.

Question 2: Would placing a health team in the 201 Vet Centers help facilitate VA's shift to ambulatory care?

Answer: No. The Vet Centers serve a unique need and should remain as they are.

Question 3: Do you support placing Vet Centers under the management of medical center directors?

Answer: The current organizational structure is appropriate.

Question 4: Is VA prepared to furnish itemized billing to insurance carriers? Why or why not?

Answer: I do not believe that this should be an issue. With health care reform we see reimbursement moving toward a capitation system for which detailed billing is not necessary. I would hope that it would not be necessary to develop a detailed system of billing since the cost would be exceedingly high.

Question 5: Do you believe VA's current medical model is based on illness and disease or is it based on a wellness model? Should this change? If so, how?

Answer: The medical model is one of illness. I would hope that by restructuring our health care delivery system and using "health stations" ran by a nurse practitioner or a physicians assistant as the point of entry into the VA system, we can improve on this. Each VA medical center could establish a number of "health stations" in its primary service area. This not only would give veterans access to the VA system at a setting closer to their home. This should also enable the physician extender in the "health stations" to spend time on patient education and on prevention measures. This approach should also reduce the number of unscheduled "walk-ins" in the parent VA medical center and thus enable the staff in the ambulatory care area of the VA medical center to spend more time on patient education and on prevention activities. The inference of the congressman's question is right on target. We should be spending more time on maintaining wellness among our veterans rather than concentrating the major portion of our effort on illness and disease.

Question 6: How would global budgeting and cost-containment measures included in the national health care plan effect VA?

Answer: The VA is currently a working model of global budgeting and has had an ever strengthening cost-containment program since decremental budgeting began in FY 1976.

Question 7: If VA's ability to recruit and retain physicians is reduced, is VA's competitiveness diminished?

Answer: Not only will the VA's competitiveness be diminished but the quality health care

program that we now have will be destroyed.

Question 8: The VA is essentially a vertically-integrated system consisting of, for the most part, major medical centers and relatively few free-standing ambulatory clinics. What impact does VA's facility structure have on the provision of health care services to veterans?

Answer: Geographic accessibility is currently poor in most areas and additional small clinics should be established. These small, low cost clinics, or health stations, which would be satellites of a parent VA medical center would dramatically improve access and our ability to compete. Timely access to VA care can be addressed through making more professional people available to staff our primary care medical clinics, our specialty clinics and the establishment of "health stations" as the point of entry into the VA system. I would visualize that a number of these "health stations" could be established in the primary service area of each VA medical center staffed by a nurse clinician, a nurse practitioner or a physicians assistant. This would provide easy access to veterans throughout the primary service area close to their home. Many veterans need only the kind of primary care that could be provided by a single provider in these health stations. After the provider takes a medical history and does a physical examination, this individual would arrive at a tentative diagnosis. They would then pick up the phone and be connected with a physician at the parent VA medical center. They would discuss the case and the supervising physician would either agree with the tentative diagnosis or ask that the patient be referred to either a satellite outpatient clinic or the parent VA medical center. It is anticipated that many of these patients can be taken care of by the single provider at the "health station." This would include continuing follow-up care. In addition, medication could be prescribed for the patient. Thus a number of patients could not only have ready access to their home, but they could be cared for with much reduced waiting time and at a lower cost than if the patient were seen in a very busy outpatient department of a VA medical center. Caring for these patients at a level appropriate to their medical needs would also free up space in the parent VA medical center's outpatient departments. Many VA medical centers in the system have from 100 to 150 unscheduled "walk-ins" who come to the evaluation area of the medical center every day. By having a large number of these "walk-ins" seen in health stations it would free up space and permit patients to be seen much more quickly in the outpatient department of the medical center. It would also free up space and time for additional patients who might be attracted to the VA under an accountable health plan. To be seen at the VA medical center, many of these patients would have been referred from one of the health stations as needing more in depth evaluation by a physician for laboratory or diagnostic radiology tests.

Question 9: What impact does the current funding process have on VA's ability to compete in a larger health care system?

Answer: The current funding structure has forced the VA to be cost conscious in the extreme. Although this constant pressure to reduce costs can be counter-productive at times, it has resulted in a system that would be very competitive on a purely cost basis. We simply do not have sufficient appropriated funds to enable us to compete under health care reform. We must develop accountable health plans and compete for discretionary veterans so that the funds each VA medical center would recover from insurance would make us better funded and staffed, and thus enable us to be competitive. Funding from appropriated funds to cover the core veterans and to provide for capital investments should be continued.

Question 10: Do you agree with the premise that universal access would lead to veterans "abandoning" the system in favor of the national health plan? If so, how could such exodus be prevented?

Answer: No. Today, over one-third of our patients are Medicare-eligible. Clearly this demonstrates that many patients who have a choice choose the VA. Timely access to VA care can be addressed through making more professional people available to staff our primary care medical clinics, our specialty clinics and by the establishment of "health stations" as the point of entry into the VA system. I would visualize that a number of these "health stations" could be established in the primary service area of each VA medical center staffed by a nurse clinician, a

nurse practitioner or a physicians assistant. This would provide easy access to veterans throughout the primary service area close to their home. Many veterans need only the kind of primary care that could be provided by a single provider in these health stations. After the provider takes a medical history and does a physical examination, this individual would arrive at a tentative diagnosis. They would then pick up the phone and be connected with a physician at the parent VA medical center. They would discuss the case and the supervising physician would either agree with the tentative diagnosis or ask that the patient be referred to either a satellite outpatient clinic or the parent VA medical center. It is anticipated that many of these patients can be taken care of by the single provider at the "health station." This would include continuing follow-up care. In addition, medication could be prescribed for the patient. Thus a number of patients could not only have ready access to their home, but they could be cared for with much reduced waiting time and at a lower cost than if the patient were seen in a very busy outpatient department of a VA medical center. Caring for these patients at a level appropriate to their medical needs would also free up space in the parent VA medical center's outpatient departments. Many VA medical centers in the system have from 100 to 150 unscheduled "walk-ins" who come to the evaluation area of the medical center every day. By having a large number of these "walk-ins" seen in health stations it would free up space and permit patients to be seen much more quickly in the outpatient department of the medical center. It would also free up space and time for additional patients who might be attracted to the VA under an accountable health plan. To be seen at the VA medical center, many of these patients would have been referred from one of the health stations as needing more in depth evaluation by a physician for laboratory or diagnostic radiology tests.

Question 11: Assuming that universal access would be provided through some type of insurance, do you believe that VA should be authorized to collect reimbursement from such insurance for care delivered to veterans?

Answer: Yes. These additional funds collected from insurance sources will be important in developing and re-focusing programs that will further enhance our competitive position.

Question 12: Do you believe the current restrictions on VA's ability to contract for health care services should be revised? If so, should contract services in a national system of universal access be more flexible of more restrictive?

Answer: Yes. Less restrictive contracting policies will permit greater flexibility in obtaining necessary services in the most cost effective way.

Question 13: Secretary Brown has stated that eligibility reform will proceed after the unveiling of the Clinton Health Plan. Assuming that the legislation course for such sweeping reformation could be quite lengthy, do you believe eligibility reform for VA health care should wait?

Answer: We believe that eligibility reform should be implemented as soon as possible.

Question 14: What initiatives are available to health care providers to promote preventive care and helping the patient to maintain optimum health?

Answer: The medical model is one of illness. I would hope that by restructuring our health care delivery system and using "health stations" ran by a nurse practitioner or a physicians assistant as the point of entry into the VA system, we can improve on this. Each VA medical center could establish a number of "health stations" in its primary service area. This not only would give veterans access to the VA system at a setting closer to their home. This should enable the physician extender in the "health stations" to spend time on patient education and on prevention measures. This approach should also reduce the number of unscheduled "walk-ins" in the parent VA medical center and thus enable the staff in the ambulatory care area of the VA medical center to spend more time on patient education and on prevention activities. The inference of the congressman's question is right on target. We should be spending more time on maintaining wellness among our veterans rather than concentrating the major portion of our effort on illness and disease.

Question 15: In your estimation, should medical center directors be responsible for defining the mission of their own facilities? If so, won't most directors want to maintain full services with an acute care mission?

Answer: No. Each medical center is a part of a national system which is one of our greatest strengths.

MR. FRED MALPHURS
QUESTIONS SUBMITTED BY HONORABLE J. ROY ROWLAND
HEARINGS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
APRIL 28, 1993

Question 1: Many references have been made this morning to the importance of a level playing field. Do you have any concerns about VA being subject to the same rules and standards that would govern HMO's or other health plans when those rules and standards may be developed without the unique circumstances of a federal provider in mind?

Answer: Not really. A law that was part of health care reform that simply stated each state would have to treat VAMC's in the same way as all other hospitals and health care providers in the state are treated would be a start. Congressional mandates, for example the House passed budget bill that would eliminate incentive awards for 5 years, would be devastating for the VA in health care reform. The recent OMB decision that all leases for more than 1 year for equipment, e.g., photocopiers, must be capitalized in entirety the first year is another example. It effectively eliminates cost benefits of leasing (and ignores the dilemma of the huge replacement equipment backlog). Inability to pay market rates for certain scarce category physicians is another. We must be given delegated authority to contract locally for space and equipment without CO approval. We must also be given the ability to market and finance DHCP, consulting expertise in CQI, waste management, etc., without dependency on VACO or other Washington-based approvals.

Question 2: AMVETS makes the point that timely access to VA care -- both in terms of initial adjudication and long waits for appointments -- must be addressed to make VA an attractive health care choice for veterans. How would you achieve those kinds of changes?

Answer: The flexibilities inherent in having a truly level playing field and CQI environment will create necessary change. We believe that we are already an attractive health care choice, but improvements can and will be made. We have all of the desired features being discussed for health care reform in place.

Question 3: Would you agree with Senator Rockefeller that allowing VA to operate competitively as an accountable health plan under national health care reform would provide added incentives for VA staff to become more customer-oriented? What other effects would you foresee from competition?

Answer: We agree. It is an opportunity for us to demonstrate through data and real performance, not existing perceptions, how good we are. We have an older, sicker patient with fewer social supports and probably more than our share of total care patients, patients with severe psychiatric or substance dependent background. We don't envision much competition for these kinds of patients. AIDS, TBI and SCI are other categories where we have real strengths. In cardiac rehabilitation, we are already a designated preferred provider. We believe we can achieve such status in other

specialty areas as well while increasing our ability to serve veterans. We also believe that we could compete effectively for our own employees and FEHBA should permit us to do so. Finally, we should be enabled to become a gate keeper for patients who refer themselves out to the community for services that we cannot offer like cardiac surgery, and where other VA's have waiting lists or are at great distances.

Question 4: Would you agree with the view that participation within national health reform provides a unique opportunity to "reinvent" or reform VA Health Care delivery?

Answer: Health care in this country needs reinventing. The VHA has a real leadership opportunity since it is a proven cost effective deliverer of care. We in VHA need to get better at primary care, improve geographic access and increase our software development, but we truly believe it is a unique opportunity to help national health care reform through example of a non-fragmented, systematic delivery of coordinated care over the life span of the patient. We need the flexibility within that participation to treat DOD beneficiaries, veteran families and other Federal beneficiaries wherever possible.

Question 5: As you contemplate a transition within VA toward full participation under national reform, have you any thoughts on the magnitude of the changes ahead, the challenges you might face, and the period of time it might take to realize these changes?

Answer: Coordination, communication and local flexibility are the keys to the local VAMC being responsible to these changes. Without knowing the requirements that a state health care purchasing board might establish, we are not able to state with accuracy how long making required changes would take. If VAMC's could become hybrids organizationally, able to sit down and reach agreement at the local level in the short run with DOD, Indian Health, Federal Bureau of Prisons, FEHBA and the state boards, clearly we could negotiate changes and probably drive the change process.

Question 6: Would you agree with those who suggest that for VA to compete on the basis of cost and quality of service, it needs more sophisticated information systems, to include a cost accounting system?

Answer: Not really. While comprehensive cost accounting systems are nice and important to have, there is other information that's more necessary, for example more computerization of clinical and provider information. Automating manual interfaces such as patient clinic registration, point of care entry of information, etc. are more important than improved cost accounting.

MR. FRED MALPHURS
QUESTIONS SUBMITTED BY HONORABLE CHRIS SMITH
HEARINGS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
APRIL 28, 1993

Question 1: If eligibility reform is not enacted prior to implementation of national health reform how will VA's ability to compete for patients be affected?

Answer: It will be handicapped. We might be obligated to treat a veteran's knee but would have to "bid" for the rest of his care in the case of the less than 50% service connected. We don't need complete eligibility reform, we do need eligibility simplification that would permit us to place patients in the appropriate level and/or point of care without patient hospitalization first.

Question 2: Would placing a health team in the 201 Vet Centers help facilitate VA's shift to ambulatory care?

Answer: Only in some cases. Primary care clinics (ambulatory care) in rural areas should be placed in community hospitals or DOD health care facilities first if they are available because of the potential need for x-rays, lab work-ups or emergency response or backup. In our case, the Vet Center is only 2-3 miles away and placing health services there would be duplicative.

Question 3: Do you support placing Vet Centers under the management of Medical Center Directors?

Answer: I do not see the need at this time.

Question 4: Is VA prepared to furnish itemized billing to insurance carriers? Why or why not?

Answer: No. The VA has no integrated system in place to capture all services and supplies provided at each patient encounter and pass on to a centralized billing package. Software development that would facilitate itemized accounts for patients is an example of software development that is a higher priority than cost accounting. Additionally, under a managed care concept, the emphasis should be on keeping persons healthy and payment based on some sort of a capitated system. This would eliminate the necessity for itemized billings.

Question 5: Do you believe VA's current medical model is based on illness and disease or is it based on a wellness model? Should this change? If so, how?

Answer: There is little question in my mind that operationally our patient care is largely based on illness and disease. Another way to say this is that it is based on immediate need, and not on anticipated need, as far as the individual patient is concerned. The VA health care system is still in many ways proscribed from providing long term comprehensive outpatient care. Preventive medicine and anticipatory care is done on a very limited basis in many facilities, but with very little support in the form of resources, and only for the small number of patients who are lucky enough to get matched up with a provider willing to give these services. The bulk of the patient population continues to wait until they have symptomatic disease and become "applicants for care".

Should this situation change? In my opinion the answer is absolutely yes. To make the change will require a review and undoubtedly some changes in eligibility requirements, a recognition and clear mandate that this should take place, and there absolutely needs to be provision of resources. The number of primary care physicians and physician extenders in VHA is entirely too small. Can resources be shifted from subspeciality care to primary care? The answer is unclear, but probably only to a small extent. As an example, to what degree would attempts to make the veteran population quit smoking reduce the number of pulmonary subspecialists needed and how long before that would take place?

To what degree can the site of care be changed from inhospital to outpatient clinic, with concomitant shift of resources? There is little doubt that this is possible to a degree, but many of the admissions to VAMC's are likely to be indicated for socio-economic reasons. The population served by VA tends to be older, sicker, poorer and therefore more likely to be rural or live a long distance from the Medical Center, frequently lacks family to provide care at home, and frequently is referred from a nursing home, group home or shelter. Lastly, the distribution of resources within VA has not rewarded facilities for ambulatory care, and has actually encouraged the use of inpatient resources. This must change.

Question 6: How would global budgeting and cost-containment measures included in the national health care plan effect VA?

Answer: Global budgeting and cost containment are the system VA has operated on for a number of years. We are completely accustomed to operating with an approved formulary and similar cost containment incentives.

Question 7: If VA's ability to recruit and retain physicians is reduced, is VA's competitiveness diminished?

Answer: YES.

Question 8: The VA is essentially a vertically-integrated system consisting of, for the most part, major medical centers and relatively few free-standing ambulatory clinics. What impact does VA's facility structure have on the provision of health care services to veterans?

Answer: I do not agree with the premise. There are over 300 ambulatory care facilities in the VA. We should triple this number by the end of the decade as a goal. Treating more patients on an ambulatory basis will yield more subspeciality care, more surgery and should fully justify existing facilities and in some areas such as ICU and other monitored beds, and acute psychiatry will have to be increased.

Question 9: What impact does the current funding process have on VA's ability to compete in a larger health care system?

Answer: It wouldn't have a big impact <u>if</u> it didn't have mandated floors, ceilings, and line items. We should be able to retain all funding sources (currently can't bill Medicare, can't retain 3rd

party). We should be enabled to retain funds, maintain reserves for equipment replacement and market other services (such as DHCP) as well. We also believe that a two year budget process should be tried.

Question 10: Do you agree with the premise that universal access would lead to veterans "abandoning" the system in favor of the national health plan? If so, how could such exodus be prevented?

Answer: No. There has been very little competition for veteran patients by the private sector and VA is the caregiver of choice of a large part of our veteran population. This can be supported at this Medical Center by: (1) the large number of VA patients with dual eligibility for Medicare coverage; (2) the number of veterans with private third-party insurance who elect to use VA services (as indicated by MCCR collections); and (3) the number of Category C veterans willing to absorb an out-of-pocket copayment to use VA medical services. Given a level playing field (which currently does not exist), we should be able to attract more veterans. Right now, the situation is typified by the remark made by one of our ex-POW volunteers who when asked why he didn't use the VA said "I have insurance so am able to go anywhere and if I came to the VA I'd be taking a spot from someone who had no alternatives." In addition, many of our patients are demanding, need comprehensive health care, are multiply diagnosed, etc. In health care reform, the competition will be fiercest for healthy 25 year olds who don't utilize much health care, yet the provider would presumably get the same fixed capitation payment as for an older and sicker patient.

Question 11: Assuming that universal access would be provided through some type of insurance, do you believe that VA should be authorized to collect reimbursement from such insurance for care delivered to veterans?

Answer: Yes. For example, in the case of a totally disabled veteran paid for through the medical appropriation, we should be able to bill insurance carriers if there is coverage from his employment or spouse's. To do otherwise would fragment the financing mechanism and would discriminate against veterans and their freedom of choice.

Question 12: Do you believe the current restrictions on VA's ability to contract for health care services should be revised? If so, should contract services in a national system of universal access be more flexible or more restrictive?

Answer: If other restrictions were removed, i.e., physician pay ceilings, we would not need to contract. Contract services in a national system should be more flexible, especially in terms of our being able to increase quickly the number of outpatient points of care (by real estate purchase or lease, construction, contracting with community hospitals for spouse and overload, etc.).

Question 13: Secretary Brown has stated that eligibility reform will proceed after the unveiling of the Clinton health plan. Assuming that the legislative course for such sweeping reformation could be quite

lengthy, do you believe eligibility reform for VA health care should wait?

Answer: VHA's ability to respond to health care reform will be handicapped if eligibility reform does not take place. We might be obligated to treat a veteran's knee but would have to "bid" for the rest of his care in the case of the less than 50% service connected. While we don't need complete eligibility reform, we do need eligibility simplification that would permit us to place patients in the appropriate level and/or point of care without hospitalization.

Question 14: What initiatives are available to health care providers to promote preventive care and help the patient to maintain optimum health?

Answer: VHA health care emphasis must shift from episodic treatment of illness and disease to preventive medicine and anticipatory care. This can be accomplished by the provision of long term comprehensive outpatient care, the development of a wide range of prevention/wellness programs, such as flu shots, smoking cessation, patient education on basic health issues, and the use of innovative technologies (telephone triage/follow-up, closed circuit cable programs, VCR, etc.).

Question 15: In your estimation, should medical center directors be responsible for defining the mission of their own facilities? If so, won't most directors want to maintain full services with an acute care mission?

Answer: Within certain broad limits. Directors should not only be responsible for defining the Medical Center's mission, but should be held accountable to do so. Depending on how acute care is defined, most VAMC's should almost certainly be required to maintain certain acute care services. Having some services typically defined as acute in a long term care facility is probably appropriate: oncology, urology, ophthalmology, and basic diagnostic capability.

**THE HONORABLE CHRIS SMITH**
**QUESTIONS SUBMITTED FOR THE RECORD**
**PAUL EGAN**
**VIETNAM VETERANS OF AMERICA**
**SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE**
**APRIL 28, 1993**

*1. Do you agree with the premise that universal access would lead to veterans "abandoning" the system in favor of the national health plan? If so, how could such exodus be prevented?*

The VA was not designed to, has never been, and should not attempt to be all things to all veterans. Those veterans who have sacrificed the most in their military service are entitled to have related medical concerns taken care of by this country, within a VA facility or from outside providers of the veteran's choice. Other veterans should have the option of utilizing VA health care as a secondary agency priority, and at their own expense or with their national health benefit package. Given the poor performance evaluation the VA has from its current consumers, it is illogical to presume veterans will line up outside the door when eligibility reform allows open access.

The VA, in order to fulfill its mission as backup to the DoD medical facilities in a national emergency, will need to maintain approximately 60 to 100 tertiary care hospitals. Veterans should be able to receive the full continuum of care at these facilities. The remaining facilities should focus on those specialized populations of veterans that the VA has proven service superior to the private sector, such as spinal cord injuries, prosthetics, substance abuse, blinded care, etc. In areas where the VA is incapable of providing the full range of health care to service-connected disabled veterans, these individuals should be provided comparable care in local non-VA facilities of the veteran's choice at the VA's expense.

Unless the VA makes certain adaptations to become a more consumer-friendly system, VVA does contend that patients will leave the VA to utilize the national system which will likely be easier to access, and of higher quality by the veteran's definition. In order to prevent such an effusion, the VA needs to be competitive with the private sector on such standards as the veteran consumer determines are important. This means he or she must be able to obtain the full range of care from a single VA provider on an outpatient or inpatient basis as is medically appropriate; be able to consistently see a regular physician at scheduled appointments without long waiting periods; and the veteran should be able to expect a favorable health outcome without excessive and repetitive testing and invasive procedures aimed to teach students.

As several testified at the hearing, in many cases it is not that the treatment outcome is substandard, but that the veterans' perception is that the VA treats patients less professionally, less courteously, more invasively, less comfortably, less conveniently, with less privacy and discreetness and in a less timely manner. If the VA health system is to be saved by veterans who will in many cases be choosing to use the VA at their own expense, these critical consumer considerations in choosing a provider can no longer be ignored.

Given the GAO and PVA predictions of VA's patient loss with the advent of national health reform, it is questionable how many veterans would choose the VA as their provider unless financial incentives are also put into place. The VA system should be placed into competition wherever it fits into the national health reform scenario, whether this is health alliances or another structure. In order to be competitive for provision of health services to veterans, a better standard benefits package should be offered at no cost to eligible service-connected veterans who utilize the VA, with the option to buy into this package for all remaining veterans and perhaps dependents.

*2. What does the term "managed competition" mean if it were applied to VA?*

If in fact some form of managed competition is the health reform plan passed by the Congress and implemented by the Administration, the same standards of cost-effectiveness, health outcomes, and most importantly patient satisfaction should be applied to the VA as are to be used for evaluating and reporting on other health provider alliances. VA health care should be an optional choice for all veterans to buy-in-to to the extent it is reasonably available. Certainly, eligible veterans would choose to receive care at the VA for such treatments that the VA provides better than other providers--spinal cord injury care, blinded care, substance abuse, prosthetics, etc., and would therefore purchase the VA benefit package.

The benefits package offered by the VA system should be as accessible and of equal quality as that offered to the general public, yet should cost the veteran no more than packages purchased from other provider networks. Eligible service-connected disabled veterans should receive free health care from the VA, or care from another provider of the veteran's choice at VA expense. It may be necessary to control costs by establishing a baseline disability percentage for eligibility for "totally free" health benefits.

We believe the VA can and should compete with non-VA providers for some services--those which it does best as has already been noted. Those services which it doesn't do best, and thus in which VA is likely not going to be competitive, should be contracted with non-VA providers, or be performed on a fee-for-service basis. It is illogical to pour huge influxes of funds into attempts to bring the VA up to competitive

standards when these services can be performed more cost-effectively elsewhere.

For instance, there is an ongoing debate within our membership as to whether the VA should go to great expense to comprehensively provide female specific health services to women veterans, or whether this care should be contracted with non-VA providers already equipped to provide these services. If the VA will indeed be providing medical care to the dependents of veterans under the health alliance scenario, these as well as pediatrics care and others will definitely need to be accommodated by the VA through contract providers, or fee-for-service arrangements.

It would certainly be a disincentive for veterans to join the VA health provider alliance if required to obtain care for family members using a separate health alliance, or if required to use only VA service providers when in fact they feel some services are inferior to the private sector. VVA would support allowing all veterans' families to enroll in the VA system provided that service-disabled veterans receive priority, and provided that there is a clearly spelled out portability option to receive care under VA contracts with non-VA facilities and providers, or on a fee-for-service basis.

There has also been long overdue discussion recently of the VA participating in rural health care networks providing primary and preventive care in underserved areas. VA facilities may be an appropriate medium for the federal government to ensure accessibility to health care services for populations in medically underserved rural areas. In these areas, the VA may provide the gamut of services to veterans because no private sector alternative exists. Sharing arrangements could be established for equipment, personnel and space with non-VA health provider alliances. While non-veterans would not be allowed to purchase the superior VA benefit plan, these individuals may receive care from a non-VA benefit plan whose providers are co-located with the VA, or these services may be purchased from the VA. This would bring additional private funds and/or resources to VA for service provision to veterans.

3. ***Is the current system of centralized VA management an inhibitor or a facilitator to managed competition?***

Both. Centralized budgeting and regulations can be an asset in providing continuity of quality and a standard of services provided, and in prioritizing budgets and services nationwide. It is the feeling of our members that the VAMCs must be required to adhere to central office oversight, reporting and inspection standards. Allowing too much local decision-making tends to create discrepancies in eligibility policy, service availability and even the quality of care, etcetera from one center to another.

There are conditions and instances, however, in which centralized management has placed undue burdens on the local facilities to provide extensive paperwork, services not locally in demand, etc. VA Central Office often does not have a clear perspective on the challenges faced in the field to fulfill required services, or the demands and/or assets of the local community. As universal health care and the resulting competition with the private sector for veteran patients become a reality, it will be necessary for the VA to capitalize on the strengths of the centrally-managed system, while still allowing local facilities the decision-making authority to adjust to specific resources and needs of the local veteran community. A balance between central oversight and local authority should be achieved in order to ensure accountability.

4. ***Assuming that universal access would be provided through some type of insurance, do you believe that VA should be authorized to collect reimbursement from such insurance for care delivered to veterans?***

VA should cover all costs for service-connected health problems of disabled veterans, whether this care is provided at the VA or elsewhere. If the VA is providing care for non-service connected conditions of veterans who have not purchased the VA benefits package, the VA should be able to bill private insurance. Private insurance or provider networks should likewise be able to bill the VA for non-VA care provided for service-connected conditions. For example, a woman veteran receiving non-VA reproductive health care for service-connected conditions resulting from Agent Orange exposure, should have these services paid for by the VA.

5. ***Do you believe the current restrictions on VA's ability to contract for health care services should be revised? If so, should contract services in a national system of universal access be more flexible or more restrictive?***

It is our position that the VA should utilize more contract providers and/or fee-for-service arrangements in order to provide veteran users with as much flexibility as possible. This is particularly the case in areas where VA care is remote or inaccessible due to geographic conditions. Many disabled veterans wishing to use the VA, for instance, may not be able to endure several hours of travel to the nearest VA facility. In some areas, the local VA doesn't provide the needed services, as is often the case for women veterans.

It makes no sense, from a cost-effectiveness perspective, to pour huge influxes of funds into the VA to achieve the ability to provide particular services if these types of care when they are readily available and may be obtained more cheaply in the private sector. If in fact the VA begins providing services to dependents of veterans in order to induce participation in the VA competitive health benefits package, it will be more cost-effective for the VA to purchase pediatrics and reproductive health care, than to invest huge sums into obtaining such equipment, facilities and qualified staff.

Again, the services provided directly or under contracts or fee-for-service arrangements will depend upon

demand for specific services and private-sector availability in any given locale. VA facilities in rural areas which have shortages of private sector medical personnel will likely provide the gamut of treatment modalities in-house.

*6. Secretary Brown has stated that eligibility reform will proceed after the unveiling of the Clinton health plan. Assuming that the legislative course for such sweeping reformation could be quite lengthy, do you believe eligibility reform for VA health care should wait?*

Both the Clinton health reform plan and VA eligibility reform could be quite complicated and completion of legislative consideration, as indicated, could be lengthy. We recommend that VA eligibility reform should not wait. There are system-wide adaptations that will require advance preparation to be completely ready for implementation, such as staffing and equipment adjustments, paperwork adaptations, etc. We would recommend passing eligibility reform in advance of the Clinton health package, with the effective date coinciding with implementation of national health reform.

*7. If eligibility reform is not enacted prior to implementation of national health reform how will VA's ability to compete for patients be affected?*

Open access to the full continuum of care at the VA needs to be in place from day one of national health reform implementation. Otherwise, veterans and their families will use health service providers that are close to home, easiest to access, where they can receive care for any condition on a medically appropriate inpatient or outpatient basis. Veterans will then become comfortable with their private sector providers and won't wish to change to the VA once eligibility is opened.

AMERICAN EX-PRISONERS OF WAR

1) Do you agree with the premise that universal access would lead to Veterans "Abandoning" the system in favor of the National Health Plan? If so, how could such exodus be prevented?

No. This "NO" to your question is contingent upon the VA providing quality care that is reasonably accessible. Veterans perceive VA care as being more sensitive and responsive to their needs and this perception must continue.

2) What does the term "Managed Competition" mean if it were applied to VA?

Managed Competition is a term that includes quality and breadth of service offered. Not Cost Alone.

3) Is the current system of centralized VA management an inhibitor or a facilitator to managed competition?

I believe it is a facilitator to managed competition. Centralized management can improve effectiveness and substantially reduce duplication of effort. Through centralized management makes VA leadership in many areas possible.

4) Assuming that Universal Access would be provided through some type of insurance, do you believe that VA should be authorized to collect reimbursement from such insurance for care delivered to Veterans?

No. The more claims filed with an insurance carrier, the higher the cost for that insurance to the Veteran. If the decision is made to go this way, then the proceeds should stay with the VA.

5) Do you believe the current restrictions on VA's ability to contract for Health Care Services should be revised? If so, should contract services in a National System of Universal access be more flexible or more restrictive?

If the VA is to control their own future, then the restrictions should not be made more flexible. Quality of service becomes a major problem with contract services. The VA, to maintain their lead, must be funded adequately to reduce the need to use contract services.

6) Secretary Brown has stated that eligibility reform will proceed after the unveiling of the Clinton Health Plan. Assuming that the Legislative course for such sweeping reformation could be quite lengthy, do you believe eligibility reform for VA Health Care should wait?

Eligibility Reform must move forward without delay. It is wrong to hold up changes that the VA can do in house until the National Health Care works its way through the Congress. If eligibility needs to be changed, then it should be done now.

7) If Eligibility Reform is not enacted prior to implementation of National Health Reform how will VA's ability to compete for patients be affected?

If National Health Reform is implemented prior to eligibility Reform, it is likely that many Veterans would flock to the new National Health System, creating a major problem for a VA system that requires a large and diverse patient population. Trying to woo them back would be much more difficult than holding them now.

Question and Response from John A Talbott, M. D.

Would you amplify on your proposal that VA design "models" for treating special populations?

What I meant was that the VA, because it has a higher concentration of mentally ill veterans with specific co-morbid problems such as PTSD, alcohol and drug abuse and physical trauma, could issue an RFP for VA medical centers to propose different models of care for these populations and then measure outcome and economic differences between and among them. Thus, as it did with its multi-site cooperative Day Hospital and Psychopharmacology studies, the VA could establish successful models for the nation in areas where they have strength and patient concentrations.