FUTURE ROLE OF THE VA HEALTH CARE SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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WEDNESDAY, JUNE 17, 1998

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

The subcommittee met, pursuant to call, at 10:10 a.m., in room 334, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Cooksey, Gutierrez, and Peterson.

Also Present: Representative Evans.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. The Subcommittee on Health will come to order.

The subcommittee has from time to time stepped back and attempted to look into the future and to assess whether the VA health care system is moving in the right direction.

In examining the future role of the VA health care system, we have certainly understood that that future will be closely tied to changes in medicine and the medical marketplace. Research breakthroughs in the development of technology which we cannot even foresee may markedly alter medical practice, yet uncertainty about the future and the need for VA to be flexible and adapt to change should not diminish the need for strategic planning.

Likewise, it is critical that we explore and pursue avenues to gain consensus on key policy questions that will confront us in the years ahead.

Should the VA open its door to veterans' dependents? What should be VA's role in meeting the long-term care needs of aging veterans? How should VA best deploy its vast capital infrastructure?

We have discussed some of these questions in the past. I have found it interesting to review those discussions in the record of prior hearings on the future of VA health care. In that review I detected, for example, a growing consensus over the last decade that the VA health care system needed to change.

Just 2 years ago one of the major veterans' organizations testified in this hearing room on the future of VA as follows:

"All of us interested in preserving a viable VA health care delivery system acknowledge change is required. Frankly, a radical change is needed. The entire movement, screaming for reform of

VA, is motivated by the singular recognition it has been an inefficient, inflexible health care delivery system."

A review of the testimony being presented this morning would suggest that we may no longer have the degree of consensus that we had even a few years ago. But despite some substantial differences in views among those testifying today, we need to foster and focus this dialogue. I hope this morning's hearing takes us at least that far.

The issues we face in VA health care are not easy ones, but as diverse views are expressed this morning, we should remember that we are all united by a common concern: providing for the well-being of veterans. Maintaining that focus should help illuminate our inquiry and ease the task ahead.

With that, I will yield to my ranking member, Mr. Gutierrez.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Mr. Chairman, I ask that my complete statement be included in the record, and I would like to make one last point, and that is, the veterans of America are solely responsible for the world in which we have fewer veterans. The peace we enjoy today is their peace. Our veterans' sacrifices have reduced the threats to our Nation. If there are fewer veterans of war in the future, it is because of the victories won by the veterans of today; and we should keep that in mind as we change our health care system, to make sure that we provide service for them all.

I would like the complete text of my opening statement included in the record so we can hear from the panelists.

[The prepared statement of Congressman Gutierrez appears on p. 38.]

Mr. STEARNS. Without objection.

At this point we will move to the first panel, Mr. Steve Robertson, Mr. Robert Carbonneau and Mr. William Warfield.

STATEMENTS OF STEVE A. ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION; ROBERT P. CARBONNEAU, CHAIRMAN, FISCAL YEAR 1999 INDEPENDENT BUDGET POLICY COUNCIL, ACCOMPANIED BY RICHARD A. WANNEMACHER, JR., ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS, AND RICHARD B. FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND WILLIAM WARFIELD, DEPUTY DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

Mr. STEARNS. And we will start with Mr. Robertson.

STATEMENT OF STEVE A. ROBERTSON

Mr. ROBERTSON. Thank you, Mr. Chairman. I would like my full text to be submitted for the record.

Mr. STEARNS. Without objection.

Mr. ROBERTSON. Mr. Chairman and members of the subcommittee, the American Legion appreciates the opportunity to share its vision for the future of the Veterans Health Administration. Today, for about 3 million veterans, especially those with severe service-connected disabilities, VA serves as their life support system. Mil-

lions more would like to have access, but limited resources preclude access.

Thanks to the work of this committee and VA's progressive leadership, positive changes have occurred. The American Legion believes it is important to have a clear vision for VHA beyond the strategic planning period.

For most of its existence, VA medical care has been entirely dependent upon Congress for funding through the appropriations process. The results of placing VA on a strict budget are rapidly becoming apparent. Each division seeks every opportunity to save resources, collect third-party reimbursements and develop new resources. The current paradigm is that reducing costs will make the system work much better while trying to serve more veterans. Unfortunately, in many cases VA has no reliable long-term treatment outcome data to support the drastic reductions in inpatient care.

VHA's reliance on the medical care cost recovery leaves the system in a precarious position. If recovery projections are inaccurate, VHA will be forced to seek supplemental appropriations or ration care.

The American Legion supports VA's reform efforts as long as the quality, timeliness and accessibility to care are not compromised. VHA must continue to lead in specialized services.

Mr. Chairman, what is Congress's long-term view for the VHA. What kind of system does Congress think would work best for VA and veterans? The American Legion has offered the GI Bill of Health as a blueprint to prepare VA health care for the 21st century. The first goal is to open VA to all veterans. Public Law 104–262 was a valiant attempt towards that goal, but the term "within existing appropriations" forced VA to further prioritize veterans into seven subcategories. Obviously not every veteran will have access.

The American Legion believes that it is possible for all veterans to have equal access in VHA by the following simple principle. If a veteran qualifies for care, access to the VA is at no cost to the veteran. Otherwise the veteran is responsible for reimbursing VA for his medical care treatment.

Using that same philosophy, the GI Bill sees an opportunity to expand access to the VA health care to all dependents of veterans. Adding family members to the VA health care system will strengthen the system and enhance the patient mix to meet the health care needs of all veterans.

The second goal is to allow VA to collect and retain all third-party reimbursements, copayments, deductibles and premiums. The GI Bill of Health calls for subvention from Federal health care insurance programs. This proposal offers greater opportunity for coordination and cooperation among the Federal health care programs. Congress wisely decided to allow VA to retain third-party reimbursements, but reduced the annual discretionary appropriations by an arbitrary collection goal.

The discretionary appropriations are designed to fund health care for priority veterans. Third-party reimbursements comes from treatment of nonservice-connected veterans. Third-party reimbursement should be used to supplement the discretionary appropriation rather than be calculated as an offset.

The GI Bill of Health calls for an annual open enrollment system. When the veteran enrolls, he identifies his or her funding source.

The third goal is to increase the access points to VA medical care. Public Law 104–262 granted VA this authority, and the American Legion strongly supported that provision. The American Legion envisions VA as the world's largest integrated health care network. VA's network would include Federal and private sector health care providers.

This coordinated approach would move access to health care physically closer to a veteran's residence. This would help strengthen the rural hospitals and health care clinics.

The fourth goal is to strengthen, improve and preserve all of VA's specialized services by offering them to veterans who currently may not have access to these programs.

The GI Bill of Health offers the opportunity to meet the veterans' needs in these disciplines and generate new revenue sources.

Mr. Chairman, it is time for comprehensive legislation to develop a long-term strategic plan for the VA health care system. The plan must develop a financially viable means to meet the health care needs of the entire veteran community rather than the 10 percent that it currently serves.

All government health care systems are in jeopardy and face economical problems that require creative and visionary solutions. The GI Bill of Health is designed to provide a workable, fiscally responsible solution for the VA.

Mr. Chairman, that brings us to the final question. If we build such a network, will veterans choose VA? The American Legion believes the answer is a resounding yes. The American Legion believes it is too important to the future of VHA not to conduct a pilot demonstration program of the GI Bill of Health.

That concludes my remarks, and I am prepared to answer questions.

[The prepared statement of Mr. Robertson appears on p. 41.]

Mr. STEARNS. Thank you. Mr. Carbonneau.

STATEMENT OF ROBERT P. CARBONNEAU

Mr. CARBONNEAU. Mr. Chairman and members of the subcommittee, I am Bob Carbonneau, Executive Director of AMVETS. I am pleased to be here today as chairman of the Fiscal Year 1999 Independent Budget Policy Council representing the Office of Independent Budget.

Also supporting me at this hearing today is Dick Wannemacher of the Disabled American Veterans, Richard Fuller of the Paralyzed Veterans of America, and Dennis Cullen of the Veterans of Foreign Wars should be joining us shortly.

For the past 12 years our organizations have published a yearly in-depth analysis of the budget needs of veterans' programs, benefits and services. Through this collaboration, we also present updates and policy recommendations on a wide range of issues affecting the present and future course of veterans' programs.

"The Future of the VA Health Care System": As you know, this is an issue of intense interest for our organizations. Hundreds of pages have been dedicated in previous independent budgets at-

tempting to map the future of VA health care. The Federal Government and VA have spent tens of millions of dollars on studies and commissions. The results have been a lack of implementation, or worse, only partial implementation or being eclipsed by rapidly changing political or budgetary forces. In fact, it is the politics surrounding the operation of the VA health care system coming from either the administration, the Congress or the VA itself that steers the course of where VA is from one year to the next. From this standpoint, strategic planning is regularly overtaken by tactical events.

Third-party reimbursement: Allowing VA to keep third-party reimbursement was finally approved 2 years ago, but the original proposal designed to give VA a much-needed alternative funding mechanism was short-circuited. Some saw the proposal as a way not to enhance VA funding as we had intended, but to offset needed routine increases in the Federal appropriation to support VA health care.

Even worse, with the VA health care appropriation frozen under the terms of last year's balanced budget agreement, VA is also failing to meet what we feel is its overly optimistic third-party collection totals. This is a classic example of what started out as a grand idea having been twisted and only partially implemented as intended.

Health care eligibility: In the same vein, for years we had called on the Congress to reform and standardize VA health care eligibility. The old eligibility rules designating which veteran got what care, and when and why, were both inefficient and embarrassing in light of the reform sweeping the rest of the Nation's health infrastructure.

Eligibility reform came our way, too, but again only partly as originally intended. Again, the appropriation was capped third-party reimbursement falling short, and the newest wrinkle arose, enrollment.

Enrollment was never part of our recommendations for eligibility reform, but became the political trade-off to enforce the policy that only so many veterans could get into a VA hospital as there were dollars to provide that care. This was done because of what we feel were grossly inaccurate cost projections by the CBO. In these instances, what started out as a major plan for reform was greatly influenced by changing political winds and budget trends.

The lesson learned from these two policy changes alone is that both the veteran service organizations and the Congress should be very careful in promoting any more major changes in the system.

At a minimum, we need to see where the changes we have already made bring us over the next few years before we take additional steps to reform. In other words, let's take time to evaluate these major changes and use this period to tweak and fine-tune.

What does the future look like for VA health care? We don't even know what the present has in store on many fronts. Dr. Kizer's plan for a decentralized VA with 22 VISNs is still in its growing stages. Dr. Kizer recently said that without additional funding sources, the VA soon would, quote, "hit the wall."

As that happens or if it begins to happen, a VISN could respond differently to shrinking resources affecting quality or quantity of health care.

The biggest question mark facing the short term is the impact on enrollment. Scheduled for completion in just 3 months, the enrollment process places an entirely new dynamic in the provision of veterans' health care. Capped budgets and limited enrollment certainly bring enormous pressures to find solutions. While billions of dollars are being made available for other Federal programs, the Congress has greatly restricted additional appropriated dollars to support the VA.

Third-party reimbursement has reached its limits. Medicare reimbursement, if enacted in its present form, would not bring substantial additional resources into the system, at least for the time being. In response, VA managers have been told to seek efficiencies wherever they can through contracting, downsizing and shifting resources.

We have long supported the drive to efficiencies; however, we never envisioned shifting of services being done in such a severe budget climate and certainly would not envision what impact this would actually have on the VA's traditional mission in caring for the specialized needs of the veteran population.

This process is producing disturbing trends, showing degradation of the VA inpatient mission and specialized services such as spinal cord injury and long-term care to name just a few.

It seems my time is at the end, and I will just wrap it up if I could.

We are concerned that fiscal priorities may drive managers to enter into sharing agreements with their eye on the dollars generated and not the benefit of the veteran patient. This can be dangerous.

Mr. Chairman, innovation is not wrong, but innovation for the wrong reasons, sheerly to shore up flagging budgets that replace the Federal Government's responsibility to provide health care for veterans is unacceptable. From the track record we have seen, good ideas and good intentions in designing innovation in VA health care funding and services have not always turned out the way that they were originally intended.

There are still 26 million veterans in the United States today. Despite the dwindling number, the majority are still in need of health care and are at the peak of use of the system. Over the years, even with its faults, the VA health care system was designed to meet the specialized needs of this patient population. It was not designed to be all things for all veterans and all things for all nonveterans at the same time.

The system is in serious transition. The solution, based on past history, is to be patient and to monitor changes already made. The VA must stay focused on its primary mission. You, the members of the committee, and we, the veteran service organizations, must continue to be flexible in the efficient delivery of services but adamant that the quality of care is always paramount. We must also keep in mind that from a budget standpoint, veterans' health care is a Federal Government responsibility. The cost of war, military

readiness, veterans' health care must not be programmed to failure.

Let's work through the major reforms already implemented and see where it takes us. As most of you know, the independent budget members are not at all pleased with recent developments in the Congress that seem to send the message, particularly in an election year, that transportation issues are far more important than the commitment to America's veterans.

Mr. Chairman, that completes my statement.

[The prepared statement of Mr. Carbonneau appears on p. 47.]

Mr. STEARNS. Mr. Carbonneau, your entire statement will be part of the record if there are portions that you didn't include in your oral testimony.

Mr. Warfield.

STATEMENT OF WILLIAM WARFIELD

Mr. WARFIELD. Thank you. The VVA is pleased to present testimony regarding our vision for the future of VA health care. I would like to just give you an overview and summary of our testimony on the reform measures.

Eligibility reform: VVA considers this legislation a landmark in creating much-needed reform and flexibility to the VHA. It has helped to modernize and improve efficiency by removing arcane and unworkable statutory barriers to outpatient care. The enrollment requirements for each veteran who uses or intends to use the VA health system are reasonable. We are still working in close cooperation as part of the VHA and VA, as a working group, to make sure that initial misinformation and erroneous information has been corrected and clarified. We feel that it has.

We have some serious problems and concerns with the draft enrollment regulations which have been submitted to the Department that are now under review. Those concerns deal mostly with clearing up specific, defined priorities within the seven eligibility categories.

We have expressed our recommendations to VHA on the need to expand some of the basic medical benefits in the package, for instance, the need for emergency room care. Prescription and medication coverage needs to be defined better.

Second, decentralization for VISNs: While these revolutionary changes in putting into place 22 stand-alone VISNs have created several important advantages and efficiencies in the delivery of Medicare, they are a double-edged sword in terms of ensuring consumer input and accountability. Our experience with VISN Management Assistance Councils, or MACs, has been inconsistent and often fragmented.

Additionally, and most importantly, VHA has so far not been able to develop a workable and effective management information and data processing system. Under these adverse circumstances, VA's top management, Congress, this subcommittee and veterans, as well as taxpayers, may not have any way of knowing how well or how poorly each VISN and the facilities within it are functioning.

Funding problems: VA's long-range goals may not be realistic or attainable, especially due to the shortfall in VA discretionary ap-

propriated dollars. The budget for health care is frozen over the next 5 years by the budget agreement, at about $17 billion.

We have serious reservations about VA's capacity and ability to officially collect third-party payments from private health insurance providers. The VA goal to increase collections by 10 percent through MCCF is overly ambitious since the cost of collection rates are higher than normal, and again VA is having difficulty in shifting from a no-charge-for-service policy to a complex new cost-of-recovery.

During this vital transition period, which we believe will take much longer than originally programmed, our question will be: Will Congress and the administration be willing and able to protect the critical levels of funds required through the appropriated dollars to maintain our minimal care?

For the future aspect of VA, our future patient base, we believe if current demographic trends continue, 60 percent of community hospitals and over 80 percent of the VA hospital beds may not be needed in the next 15 years. The veteran population has been on the decline since 1980, and by year 2010, it is expected to total 20 million, roughly one-third less than 1980.

In addition to fewer veterans seeking treatment, VA medical care may further decline due to the expansion in Medicare use by older veterans. In an April GAO study, elderly veterans', age 65 and above, usage of VA hospitals dropped by 50 percent between 1975 and 1996. This change in demographics of the veteran population will dictate a change in the menu for care and services offered.

By the year 2010, 42 percent of the veteran population, some 9 million people, will reach 65 and older. Therefore, VA should be moving in the right direction, which they are, to expand adult daycare and other senior services. Also by 2010, 6.4 percent, about 1.3 million veterans will be females. They must become more efficient and attractive in meeting the needs of women veterans.

The fifth point I would like to make is more emphasis on prevention and wellness. As medical technologies have advanced, the burden of disease has shifted from acute episodes of illness to chronic diseases which are now the leading cause of long-term disabilities.

This year alone an estimated 35 million Americans will suffer some form of chronic disability. Fifty-two percent of severely and chronically disabled people are over the age of 65; an even higher percent are also veterans. The VA of the future should increase life-style intervention to lower risk factors for disabilities among the elderly and near-elderly. Examples are depression and mental health screening, exercise therapy, good nutrition, smoking and alcohol use cessation and reduction. The main goal should be that of disability prevention so as to maximize a person's well-being, independent living and overall quality of life.

VA should also be moving toward the treatment of chronic disease. In the past, VA's biggest concern for health care was on acute care directed towards curing the disease or fixing the injury, then moving on to the next problem. Today, the biggest concern facing health care providers is chronic care management.

Our conclusion: On the whole, VVA feels that health care is evolving in the right collection. We are anxious how and if the commitments will be met, especially the downsizing trend and the

severe cuts and transfers of VA dollars for other purposes made by Congress this year, and the even greater reduction contemplated in the President's budget and by the House and Senate budget resolution.

This concludes my statement. I will be pleased to answer any questions. Thank you, Mr. Chairman.

[The prepared statement of Mr. Warfield appears on p. 53.]

Mr. STEARNS. Thank you, Mr. Warfield.

Just for the record, I would like it to be known that Dick Wannemacher of Disabled American Veterans is here with us to help answer questions; and Richard Fuller, Paralyzed Veterans of America, is also here; and I want to thank them also for their time and for participating.

I thought I would go to this area concerning tobacco funds for the VA, and I think Mr. Carbonneau just indirectly referred to it.

The VA estimates that it spent about $3.6 billion in fiscal year 1997 to treat tobacco-related illnesses and will spend $20 billion on that care over the next 5 years; and this is a question for all three of you.

In your view, should the tobacco settlement, if it ever comes before Congress and gets passed, be used in part to help the VAs and in what way? Research? Direct benefits? Lump sum? What would be your position on this, and what do you think that the committee should be recommending?

Mr. ROBERTSON. Mr. Chairman, I think the question is whether or not veterans should be service connected for tobacco-related illnesses because of their service in the military. If that is the case, they are entitled to medical care for their service-connected condition. That is the issue.

The tobacco settlement is an entirely different subject. How that money is used, I don't care. What I do care about is that the veterans that serve this country, that developed a medical condition—a medical condition—are compensated and treated for that condition. That is the promise that was made to the veterans in title 38, U.S.C. That is the promise that was made.

Now, I know that we have broken our promise to military retirees, but this is one that The American Legion is absolutely going to hold you to.

Mr. STEARNS. So you are saying, forget the tobacco settlement, forget there is anything involved here? You are just saying, the veterans are committed under that title, if it is service connected, to take care of the veterans; and so this is divorced from the tobacco settlement in your opinion?

Mr. ROBERTSON. Yes, sir, I think it is. The American Legion has a position that the VA should pursue part of that tobacco settlement to assist in the treatment of these veterans. We don't object to that part. What we are objecting to is turning our backs on the veterans who have tobacco-related conditions as a result of their addiction to nicotine while on active duty.

This rhetoric, just because you started smoking in basic training and now 40 years later you are entitled to the benefit, is false. You have to prove that you were addicted to nicotine during the time of active duty.

Mr. STEARNS. This is a health subcommittee, it is not a benefits subcommittee.

I think what you are not saying that the tobacco settlement is irrelevant; you indicated that the tobacco settlement is something that should be pursued. Is that yes or no?

Mr. ROBERTSON. Yes, that is true.

Mr. CARBONNEAU. I agree. It should be pursued, but if memory serves me correctly, the biggest customer, if you will, of the tobacco companies for years was the Federal Government. And it is the Federal Government's responsibility on health care issues. If we can go over to—in the tobacco settlement and get money for health care, that is fine, but we still view it as a Federal Government responsibility.

Mr. STEARNS. You are saying that the Federal Government is the largest purchaser of tobacco products?

Mr. CARBONNEAU. From some of the figures that I have seen over the last several months, the tobacco industry, the largest customer was the Federal Government in purchasing and supporting the tobacco industry.

Mr. STEARNS. What was the Government doing with the product? Were they then reselling it or giving it away?

Mr. CARBONNEAU. You have to remember they were in C rations. They were provided at low cost to the veterans serving. They were in commissaries. They were provided at lower prices throughout the world for years and years and years. The Federal Government was a major player in that.

Mr. STEARNS. Mr. Warfield?

Mr. WARFIELD. Yes, Mr. Chairman. I would like to refocus the question on the impact on health care.

A veteran—it does have an effect on veterans' health care. If the present language was signed into law, it declares that a veteran's willful misconduct makes the veteran ineligible for not only benefits but could be declared ineligible for health care because he or she were a smoker, we have a concern regarding that, and I would like to commend Dr. Kizer's visionary fairness.

In today's *Washington Post*, Dr. Kizer makes note of his concerns over—in a memo saying that he does not believe that it is willful misconduct and that VA will have a great deal of problems in denying health care on that basis. I think he is absolutely right.

And finally, I don't think the issue is the debate over tobacco versus—smoking versus nonsmoking. I think the internal congressional debate should be to permit taking money that belongs in the veteran baseline away from this committee and granting it to another committee that doesn't have anything to do with veterans' funding, the Transportation Committee, to use the money inappropriately.

I think this subcommittee could appropriately use the money for health care benefits.

Mr. STEARNS. When you say "benefits," what do you mean?

Mr. WARFIELD. Improving the quality of health care from smoking. Agent Orange could be classified in certain conditions, and being denied as a smoker a benefit for Agent Orange.

Mr. STEARNS. I would like to ask Mr. Wannemacher or Mr. Fuller if you have any comments that you would like to make.

Mr. WANNEMACHER. I would concur with all three presenters with regard to the settlement. And after reading the memo from—in the *Washington Post* extract, we agree that willful misconduct would lead to denial of health care benefits for veterans, and this is something that is appalling; and that's why we fully support the technical corrections amendment with the proper language, and we also support Senator Rockefeller in his move to remove the VA's money from the transportation bill.

Mr. STEARNS. Mr. Fuller?

Mr. FULLER. Yes, Mr. Chairman. I would like to add and underscore that it is obvious, as the debate over the tobacco settlement goes forward, that there are lots of entities both in the Federal Government and State government and even the private sector who are trying to get their hands on part of this money.

The Independent Budget is very clear that the VA should receive a part of this tobacco settlement for health care purposes, health care purposes only.

As you probably know, Senator McCain on the Senate side has already offered a successful amendment to the legislation that is going forward over there which would provide $3 billion of the settlement to go to veterans' health care. He has used a very general rubric on what health care is in order to give flexibility to use it for health care research or other purposes. I would like to add that for the record.

Mr. ROBERTSON. Even if this money were received from the settlement, unless the veteran is service connected for that condition, he or she may not have access to the system to receive the treatment.

With the priority system, 1 through 7, if I was a smoker while I was in the military and now I am discharged and I have no service-connected disability, I am in priority group 7. I don't have access to that money. But the way—under the current enrollment system, I may never step foot in a VA hospital. That is where people have lost in this debate. The "hook" that gets this tobacco-related illness into the VA system for treatment is the service connection; and I believe there is a logical way to approach determining who can file the claims and who can't.

Mr. STEARNS. Let me ask each of you to answer, yes or no: Does your organization support the Rockefeller amendment, Mr. Warfield?

Mr. WARFIELD. Yes, sir.

Mr. STEARNS. So you understand what it is?

Mr. WARFIELD. Yes.

Mr. STEARNS. Mr. Wannemacher?

Mr. WANNEMACHER. Yes.

Mr. STEARNS. Mr. Robertson?

Mr. ROBERTSON. Absolutely.

Mr. STEARNS. Mr. Fuller?

Mr. FULLER. Absolutely.

Mr. STEARNS. Mr. Carbonneau?

Mr. CARBONNEAU. Yes.

Mr. STEARNS. So there is unanimous agreement here about the Rockefeller amendment. We have looked at it, staff and I; in fact we have drafted legislative language and we are just trying to be

sure we understand it and be sure that you folks understand it before we go forward. But it is interesting, and I appreciate your comments.

Is there any reason to limit settlement payments to a 5-year period?

Mr. ROBERTSON. No.

Mr. WARFIELD. No, sir. I see no reason to limit.

Mr. WANNEMACHER. No.

Mr. STEARNS. Mr. Fuller?

Mr. FULLER. No.

Mr. CARBONNEAU. No.

Mr. STEARNS. Before I yield to the distinguished ranking member, let me just move to the American Legion's GI Bill. I would like each of you to indicate whether you support the bill, and if not, whether there are specific elements which you can or cannot endorse.

It is nice to have folks from so many organizations here, VSOs, and I would like to hear just briefly on this.

Mr. Robertson, why don't you start?

Mr. ROBERTSON. Yes, sir, I would support the American Legion's GI Bill 100 percent. I think it is the best plan going. It is the only plan going.

Mr. STEARNS. We give you the lead-off.

Mr. Warfield?

Mr. WARFIELD. Yes. If I had unlimited, omnipotent powers and I were czar, I would support it. But we have to work within the system. If we could, somewhere in the future, move toward an ideal system, that would be fine; but right now I don't think that it is necessarily realistic.

Mr. STEARNS. Some of our research indicates, Mr. Robertson, that some of your colleagues don't support it. There is some hesitation, and that is what I am trying to find, if there are any portions that not all groups agree with.

Mr. Wannemacher?

Mr. WANNEMACHER. As the independent budget in the testimony stated, with enactment of 104–262 and the reengineering being made by VHA and Dr. Kizer is progressing. We have to give VHA an opportunity to work things out. The third-party collections (MCCF) is currently collecting 31 percent of the billed amounts. Because of as unacceptable billing, VHA must be able to have proper accounting systems and collections tools. By putting in the core groups that are in the GI Bill of Health, and offering insurance policies to nonveterans and dependents, how can we expect the Veterans Administration to bill, collect and spend those monies efficiently? We have concerns over that aspect of the proposal. And, for those reasons we are withholding endorsement of the American Legion's GI Bill of Health.

Mr. STEARNS. Mr. Carbonneau, what about the cost in this——

Mr. CARBONNEAU. I am going to let Mr. Fuller answer that.

Mr. FULLER. Thank you, Mr. Carbonneau.

I think that the cost is unknown at this point; I think that there are many things in the GI Bill of Health which are similar or identical to things that the Independent Budget has recommended for quite some time.

I think the scope of it, going back to what the Independent Budget testimony was today, is somewhat troublesome in light of the fact that VA is still trying to cope with the changes that it has right now, rather than imposing more monumental structure on the system at the present time.

Mr. STEARNS. That is the problem we face up here. If the thing has a very high cost, there is a possibility that there would be cost shifting here, and the cost that will go for one program will hurt another program; and with limited dollars, we are all trying to find ways to make sure that there is not this problem.

Mr. Carbonneau, go ahead. Do you want to answer anything?

Mr. CARBONNEAU. No.

Mr. ROBERTSON. Mr. Chairman, I would like to point out one thing about the GI Bill. Almost every element of the GI Bill has already been implemented in some phase or another. We have an enrollment system. We are treating VA dependents in VA facilities currently. We do collect and retain third-party reimbursements.

The only thing that we have not done is offer a defined benefit package that could be purchased by somebody who has no insurance coverage at all, and I understand that because the ultimate reform bill, that VA is now developing a defined benefit package for the people in various categories as to what they are going to have. A lot of elements of the GI Bill are already being tested, but not to the full magnitude of our proposal.

Secondly, I think TRICARE is exactly a classic example of what has happened—of what we are trying to do. DOD ran into a problem similar to what VA was doing, but they broke their promise to their veterans and said, we are going to create this separate health care system to take care of you. The American Legion wants to make sure that the promise made to the veterans is not broken.

Mr. STEARNS. In your demonstration project, you might think about testing your plan at 20 to 40 VA medical centers. You might consider in some way to move that into a focused pilot program. That is just a thought.

What we need is some evidence that this is not going to be costly, because I think most people like the program and want to implement the program. We just get worried about the cost, and so it is just a thought.

Mr. ROBERTSON. Yes, sir. We are worried about the cost, too, and that is why we came up with the concept of veterans actually paying for their health care. If they are not completely covered under some Federal health care coverage program, we have TRICARE, Medicare, Medicaid, whatever, if they have no coverage at all, we expect them to pay for it out of their pockets. And if their dependents are coming into the system, their dependents have to pay for it.

It is just like any health care industry out there in the private sector. The only difference is, we are not trying to make a profit. We are not going to have to have a golden parachute for Dr. Kizer when he leaves.

Mr. STEARNS. How much is that parachute?

Mr. ROBERTSON. It is a hell of a lot more than I am making.

Mr. STEARNS. Let me go to the distinguished ranking member for questions.

Mr. GUTIERREZ. I thank this opening panel and I suggest that we spend some time, Mr. Chairman, just dealing with the tobacco-related illnesses of veterans. We must get to the core of the issues and we need to invite some people in to provide testimony. Clearly we are hearing a lot of debate and concern.

We obviously have to look at it, in all seriousness, because the Government handed tobacco out free to members of the armed services with enlisted men and women. And I don't know if they did the same in the private sector, but they said you could have 10 minutes off to smoke cigarettes. They even gave them a break so they could smoke. We gave them the cigarettes and gave them time off, and it was part of the regimen of military service.

And I know we must also talk about disabilities in terms of compensation, as well as the need for medical treatment for those tobacco-related disabilities. I don't know of any major health care insurance plan that denies anybody health care coverage because people smoke.

They may deny you a life insurance policy or charge you more money for one, but every Member of Congress who smokes and contracts cancer or some other disease, will be covered for this problem and so is everyone else with insurance coverage in the work force.

So I don't know how you can distinguish between veterans and the rest of the American population. As far as I know nobody gave us free cigarettes and time off to smoke them. I think it might be a good idea to debate this complicated issue. It is an area the American public needs a lot of information about.

Having said that, I would like to ask Mr. Robertson: The GI Bill of Health would expand access to VA health care to nonpriority veterans and their dependents. Is there any concern that drastically expanding the system in this fashion would compromise the VA's ability to focus care towards veterans who are most in need?

And, in addition, the VA possesses virtually no experience at treating young people. How will the VA be able to offer them proper care, given their lack of experience? Could you just examine these couple of questions for us?

Mr. ROBERTSON. I would like to address the most important aspect of that question, and that is our service-connected veterans. They will always be the number one concern of The American Legion and should always be the concern of the VA.

The concept that we have is expanding, based upon supply and demand. As you increase your enrollment base and more people are in the system, the health care needs have to be expanded through contracting of services, through sharing agreements, whatever mechanisms the VA is using to expand its network so that there should be minimum waiting time, the quality of care should be maintained, and the timeliness of service should be comparable to that of the private sector. That is how you attract people to your system, if you are better than the other guys.

We would hope that with the expanded base, we will be able to expand the network to where the veterans will be able to go and receive their care in a timely manner, quality care.

As far as taking care of children, when you contract out services, that is what you do. You are contracting because there may be

services that you are not able to provide. So contracting pediatric care or OB/GYN care should not create a problem. For years the VA contracted out OB/GYN services because they didn't perform them within their facilities. So I think it could be done quite easily.

As a matter of fact, I think it would complement the problems being faced by TRICARE right now with veterans that are in areas where there is no TRICARE provider close to their physical location. Right now I think it would be complementing DOD's health care programs. I think it would be complementing Medicare. HHS, they have been trying to get people into managed care programs. I think that would solve that problem.

I think it would help the rural health care problem. I think there are a lot of good ideas in this package. It is just a matter of being willing to change your thinking from inside the small box that VA currently operates in and go out into the rest of the world, like the rest of the health care industry.

Mr. GUTIERREZ. Thank you, Mr. Robertson.

Mr. Carbonneau, it has been our general contention that the Government, Congress and the administration, are currently failing our Nation's veterans. We are making policy to meet short-term budget restraints and not in the interest of providing the best-quality care. I think this is dangerous, and I feel it will lead to serious problems in coming years. We seem to have forgotten the VA's mission as we rush to create a new VA in the image of the private health care industry.

Mr. Carbonneau, I know that you have examined the effects of recent reforms. Nevertheless, I fear if the supporters of veterans' programs cannot develop a vision that preserves the VA and its mission of caring for veterans in need, privatizers, downsizers and government accountants will pursue the dismantling of the VA system.

In your view, what can I and other supporters of a strong VA health care system do to preserve the VA in the long term?

Mr. CARBONNEAU. As I mentioned, for 12 years we have been putting out the Independent Budget, and in that document, in the executive summary, it just outlines where we are going and what we think the vision is.

Dr. Kizer brought with him many—when he came, brought many new innovative ideas, thinking outside of the box, doing things that we had wanted to see for a long time. With that come adjustments that need to be made.

The system is a very large system, and it takes a longer time to turn around the system or to get it focused and to provide services in a more efficient setting and to turn the system around.

I think, as our statement says, the politics is what has been the problem. We have had good intentions. We have had compromise on eligibility reform that we didn't like from a veteran service perspective. And in those compromises have been some of the problems that have developed. They need to be tweaked and overcome.

But we need to, I guess, use our Independent Budget as a blueprint—it is a good one—for the future of the VA and in what we view as the four service organizations that make that up and the 50-some-odd that endorse it, what we view as a good blueprint for the future.

Mr. GUTIERREZ. In Chicago, my hometown, the VA inpatient substance abuse programs have been eviscerated because of the budget constraints. If you can, describe the problems that members of AMVETS have perceived in specialized services and what you have seen or heard around the Nation in different service networks, describing specialized services and their degradation or improvement as you see it.

Mr. CARBONNEAU. I am going to refer that to Richard Fuller.

Mr. FULLER. Indeed, Congressman, that has been one of our concerns through the recommendations of the Independent Budget regarding the future of the VA working with Dr. Kizer and his particular reforms.

The core of the VA health care system is specialized services. The VA was established to take care of the specialized needs of disabled veterans. Out of that history has grown a remarkable record in such areas as blind rehabilitation, long-term care, mental health and substance abuse.

Unfortunately, a lot of these types of services are very expensive, and when you get into this private sector model of do more with less and take care of more people with less money, you get down to the level of what is known as "bottom-dollar medicine."

At this particular time, if you look at the private sector models, the first things that they go after are the expensive outliers, your expensive specialized services.

We have had good dialogue with this committee in recognizing the importance of these programs and putting actual language in the eligibility reform legislation requiring VA to maintain its capacity to provide these services. Likewise, we have had a very good dialogue with Dr. Kizer on this issue, as have the blinded veterans and others who have a stake in these specialized programs.

Where we have to remain constantly vigilant, however, is with 22 VISNs and the different policymakers at that particular level, we need to watch very carefully. As the dollars shrink, so does the potential commitment to this specialized mission of the VA and these services begin to erode and disappear. I can assure you that Paralyzed Veterans of America and the Independent Budget are very concerned about this and will work with you to address your problems, too.

Mr. GUTIERREZ. My time is up. I just wanted to thank the rest of the members of the panel.

Mr. Warfield, good to see you again.

I would like to apologize to the second panel and to the members of this committee. I have a meeting with Mr. Gephardt in—well, a minute ago. I am going to have to ask to be excused from the rest of this hearing. I will try to get back as quickly as possible.

Mr. STEARNS. Mr. Peterson.

OPENING STATEMENT OF HON. COLLIN C. PETERSON

Mr. PETERSON. Thank you, Mr. Chairman. I want to commend all of our witnesses and I think that they, the issues that they brought forward are very relevant, and I agree with most everything that they have put forward.

I would like to ask any of you that want to respond, one of our witnesses on the next panel Marjorie Quandt, from the Commission

on the Future of Health Care, I don't know if you have looked at this, but they have this chart here which says that most of my district and a good part of the country will not have enough veterans to support a VA hospital in the year 2010, 2015.

I don't know if you have looked at this or not. I think that all of the discussion we are having about the short term is relevant, but in my district I am already having a lot of problems with the distances. It takes 7 hours for people to drive from one end of my district to the other.

To be honest with you, in this day and age, the way this whole system works, it is not a particularly conducive situation to have to drive that far and then sit there for 5 hours to get in; and if you have a certain kind of condition, what are you going to do? You have to keep coming back time and again.

I guess what I have been kind of struggling with is thinking about where we are going with this situation? We are moving; they are going to open up an outpatient clinic in one of our towns, which will help; but as we move through this whole thing, are we going to get into a fight between people that want to keep the bricks and mortar and keep the business in their town versus moving to outpatient? And how are we going to manage all of that?

I am concerned that as we move through this thing that those of us that are in the sparsely populated parts of the country are going to get left out somehow or another. I am sure everybody is going to say that will not be the case, but they told us that with deregulation we would not get left out, and we did. We have been down this road with a lot of different issues.

I am concerned that as the resources are limited and as we try to move through this thing, those of us that are out in the rural areas are going to get the short end of the stick; and the political clout that is in California and Chicago and Florida and places where they have larger populations is going to overwhelm us.

My question is, are you folks concerned about that and are you talking about that within your organizations?

Mr. ROBERTSON. Absolutely. Having spent 7½ years in Minot, ND, I can identify with your problem. That is part of the idea of our health care network. A network can be expanded or contracted, based upon your need, not necessarily requiring bricks and mortar where you are delivering the health care. So if you have a rural part of the State that has a health clinic, the VA can assist in getting the veteran into that facility. If he needs more major—the veteran needs more major medical care, they will keep moving him closer to where that service can be provided.

One thing I want to caution you about, this projection of what the veterans' community is going to be like in 2010, if you would have asked a Congressman in 1919 what the veterans' population would be like, he would have probably told you, we just fought the war to end all wars.

Right now I think that the national threat, the proliferation of nuclear weapons, and as many places as we have troops stationed right now maintaining the peace, the chances of a war to break out, much like Desert Storm, is realistic. And had Saddam Hussein used weapons of mass destruction, chemical-biological warfare weapons on a large scale, you could immediately have hundreds of

thousands of service-connected veterans pounding on your doors asking for health care.

So when you are trying to develop a health care plan for the future of the VA, you can't just look at the existing population. You have to look at it in the global picture of what we are doing national security-wise, foreign relation-wise right now.

I tell you that I am not—I would love for the membership of the American Legion to go to zero because our membership requires wartime veterans. That is what our membership requires. I would love to go out of business because there are no more wartime veterans. That is our goal. But we have to be realistic. You can't do your strategic planning in a little bitty picture.

You have to look at what is happening around you. And Desert Storm is a classic example of why we need something like the GI Bill of Health, because of the health care problems that the veterans had coming back. Had the GI Bill been in place, every one of those veterans could have walked up to a VA hospital and said, I want to be treated today. They could have enrolled. They could have been enrolled before they deployed. And instead of having their health care coverage canceled by their businesses while they were on active duty, rather than having their families have to travel hundreds of miles to go to a DOD medical facility, those problems would have been resolved.

I think that we need to look exactly like you are saying well ahead into the future. And how we are going to be able to adjust this, we think that the GI Bill is the right approach.

Mr. WANNEMACHER. In enactment of 104–262, when Congress gave the Veterans' Administration the ability to enhance sharing agreements and enhance leases and reaching out and bringing the Veterans' Administration to the veteran, that was a global vision to better care for veterans' health care needs. It does not take bricks and mortar. It takes a commitment of the U.S. Government to say, Veterans, when you become disabled, there is going to be a system in place for you. It may not be the stereotype VA-provided doctor or full-time employee physician, but it is someone whom the Veterans' Administration has contracted with to provide your health care. And that is what the veterans' organizations asked for when 104–262 became law, and that is what we continue to support also.

Mr. PETERSON. Thank you, Mr. Chairman.

Mr. STEARNS. Let me just follow up on Mr. Peterson.

Ms. Quandt, who is on the second panel, former Executive Director of the Commission on Future Structure of VA Health Care, Department of Veterans Affairs, believes that the VA should at some point—I am asking your opinion on this—sell highly unused hospitals, which are very costly to maintain, and reinvest in new, modern outpatient facilities. Are there circumstances that would make this idea acceptable?

I would like to go from the right to the left.

Mr. Warfield, yes or no?

Mr. WARFIELD. I do partially agree. I think that is incrementally what the Dr. Kizer plan is for integration. For instance, there have been 4,200 beds that have been closed in the mental health and substance abuse treatment. Then there is a transition program for

intermediate or domicilic care. I think that that is what is already happening, by attrition and by the change in need and demand for services.

Mr. PETERSON. Mr. Chairman, before the rest of them answer, that is part of my question.

You say that that is the way we are going to go. We are going to have a hell of a fight if you are going to try to close Fargo and Rapid City and all these other places that are on this chart. And I guess my question is, along with what the Chairman is asking, how is it going to work?

I think the people in Fargo are—I understand what you are saying, but they are going to fight like crazy to keep that hospital. The same thing in Rapid City. How is this going to work? If we in fact have this fight and if we are going to move this way, how is this going to play out?

Mr. ROBERTSON. From the GI Bill of Health standpoint, I will tell you, because of the military retirement community that is in the Fargo, ND, area, I think that the patient population, since it will be more than just service-connected veterans, will justify the facility staying open for many years. Would there be a decision somewhere——

Mr. PETERSON. You don't agree with the chart?

Mr. ROBERTSON. No, sir, I don't.

Mr. FULLER. I would like to add that Marjorie Quandt was the chair of one of those commissions that we talked about in our testimony that cost millions of dollars. And at this point, even though she is a very articulate spokesperson for the view—for her own views and the views of commission, the results of the commission really didn't go anywhere.

I would also like to state that it is a great idea to go out and sell your assets. But once you sell your assets, they are gone. Then what do you have for it? Potentially, in light of what OMB has done to us over the past several years, if all of a sudden VA comes up with money in one pot, they are going to offset our appropriation in the other. So I think you are being penny wise and pound foolish.

Putting all of the money into outpatient care is cost-effective for people who are ambulatory. What will happen when a veteran needs specialized inpatient care, which has been allowed to degrade. You don't have a whole system there anymore?

Mr. STEARNS. Would anyone else like to comment on Ms. Quandt's statement to sell unused hospitals because they are costly?

Mr. ROBERTSON. Mr. Stearns, under our GI Bill of Health proposal, the VA would become a business, for lack of a better comparison. So if that is a business decision that would have to be made that the veterans would be better served by selling one facility and maybe increasing the contract agreements with another health care facility, that may be the most business-sound decision to make rather than plowing money back into bricks and mortar.

But I think that it would—that the American Legion would want to thoroughly investigate whether that facility should be closed. Right now the only procedure we use is earthquakes.

Mr. WARFIELD. Our experience in the Federal Government with the sale of assets, whether loan assets or tangible assets, has been catastrophic. We have lost hundreds of billions of dollars in selling those assets and not, as my colleague said, I agree with that, and not getting any beneficial return for it. I would say that is a very bad recommendation.

Mr. STEARNS. Well, gentlemen, I thank all of you for your participation. Without any further comment, we will move to the second panel.

Ms. Chenoweth was here and wanted to ask questions, but she could not stay because she was managing a bill on another committee. We are offering her the opportunity to ask questions, and we will put them in as part of the record and get replies for her. Without objection, so ordered.

[The prepared statement of Congresswoman Chenoweth appears on p. 40.]

Mr. STEARNS. We appreciate the patience of the second panel: Dr. Kizer, Under Secretary of Health, Department of Veterans Affairs; Mr. Stephen Backhus, Director of VA Affairs and Military Health Care Issues; Richard Krugman, a doctor, Dean of the University of Colorado School of Medicine, representing the Association of American Medical Colleges; and Marjorie Quandt, former Executive Director, Commission on Future Structure of VA Health Care.

STATEMENTS OF KENNETH W. KIZER, M.D., M.P.H., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; STEPHEN P. BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE; RICHARD KRUGMAN, M.D., DEAN, UNIVERSITY OF COLORADO SCHOOL OF MEDICINE, REPRESENTING THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES; AND MARJORIE R. QUANDT, FORMER EXECUTIVE DIRECTOR, COMMISSION ON FUTURE STRUCTURE OF VETERANS HEALTH CARE, DEPARTMENT OF VETERANS AFFAIRS

Mr. STEARNS. I want to welcome the second panel, and at this point, let me open up for your opening statements. We will start with Dr. Kizer. I want to thank you again for coming, and his energy and perseverance in trying to help veterans with the administration; and all of us are very respectful and interested in your opening comments.

STATEMENT OF KENNETH W. KIZER, M.D., M.P.H.

Dr. KIZER. Thank you, Mr. Chairman.

I am pleased to be here this morning to continue the dialogue that we have been having over the past several years regarding the future of the veterans' health care system. Indeed, I think it is probably a very opportune time to again focus on this, since it was done 2 years ago when Mr. Hutchinson chaired the subcommittee, and so much has changed in veterans' health care over the past 2 years. Indeed, I think I can say without reservation that there is no other health care system in the country that can match the ex-

tent of change that has occurred in veterans' health care since we launched our reengineering effort in late 1995.

My written testimony includes considerable detail to exemplify that point. I trust that my full statement will be included for the record.

Mr. STEARNS. Without objection, it will be made part of the Record.

Dr. KIZER. I would summarize by emphasizing that the VA continues to be in rapid evolution, just as American health care everywhere is in rapid evolution or rapid transition. There is not yet anywhere in this country, indeed anywhere in the world, a health care system that fully satisfies all of the needs or demands for access, quality, user service or user friendliness, and cost.

I think VA is wrestling with many of the same problems that everyone else in health care is wrestling with. The difference, though, is that the size of the VA sometimes magnifies the problems that everyone is having.

In this regard, I would also note that in addition to being the largest fully integrated health care system in the United States, the VA is also the most complex health care system in the world because of our multiple missions. These are missions which are, at the same time, complementary to each other, but they also do compete with each other at times and set the stage to be conflictive with each other as well.

I would make one other point in this regard, it is so often not appreciated how much the public at large benefits from the VA, whether it is in the training of health professionals, or the research that is done, or caring for the homeless, or responding to national disasters, or pioneering better ways of managing chronic illness. While those things all certainly benefit veterans, they also benefit the public at large in many ways.

Let me turn my focus, in the time that remains here, to some comments about the future. As I look at the future, I believe that the veterans' health care system will continue to evolve along the lines that we have been pursuing for the past 3 years. I also believe that we are very well positioned to expand services, should policy decisions so dictate, as well as funding sources be made available to support any increases.

The issue that we will continue to have to address, as will the rest of health care today, is providing good health care value. As we have discussed before, VA has operationalized or defined health care value as being the composite of achieving easy access, high technical quality, good service satisfaction and optimal patient functionality at a reasonable cost. With that in mind, I see the VA health care system evolving in three general directions.

First, I see the VA getting better at what it now does; that is, getting better at taking care of service-connected and poor veterans in a system that not only provides current state-of-the-art medical care, but also that trains tomorrow's health care providers, and one that researches and pioneers tomorrow's health care solutions. Finding better ways of caring for VA's population of chronically ill, older and poorer veterans will ultimately result in better care for all Americans.

In pursuing this direction, I think that I would also underscore, and I think that we have been consistent in the direction given, that we have to pursue five key principles as we pursue this direction.

First, I would echo some of the comments that were made earlier this morning by the first panel that we have to be constant in our focus on providing for the special needs of veterans, whether this is providing for spinal cord injured veterans or providing prostheses or blind rehabilitation or treating PTSD or environmentally related conditions; whatever, we have to maintain that constant focus on providing services for the veterans and services that often are not readily available in the private sector.

I think in that regard it is also worth noting that over the past couple of years, while we have increased our performance in a number of ways, we also are treating more patients in our specialized programs. Last year we treated 19 percent more homeless than we did 2 years before, 8 percent more substance abuse or psychiatric patients, 20 percent more blind rehabilitation patients, so we actually are maintaining that focus and indeed expanding care in these areas.

One other point I would make in this regard is that we have to concentrate on managing care and not cost. I think we have to especially concentrate on managing care for complex chronic conditions that are so prevalent in VA's population, but are increasingly prevalent in the public at large.

I think that as we look at the resurgence of double-digit inflation in the health care sector, it is becoming increasingly clear that the biggest failure of managed care has so far been that it has focused too much attention on managing cost and not actually improving care. Too often managed care companies, in their efforts, have addressed only the symptoms of the ills that afflict private health care. They have not addressed the basic pathology of fragmented care, provider-focused and user-unfriendly services, redundant and excess capacity, and other things. Managed care has not done enough to make care more coordinated, more convenient and more coherent, i.e., actually managing care in a way that it improves outcomes.

I will forgo some of the other comments I was going to make in that regard and just conclude by commenting on the two other directions I see the VA moving in.

The second of the three directions is that I see VA taking in or taking care of more or a larger number, an increasing number of the military-related family, whether it is higher-income veterans or more active duty personnel or more military dependents and retirees in contrast to the past. However, I see this occurring largely because of the service that is provided. I think these new users of the system will have options, but they are increasingly choosing the VA because they see the VA as providing superior service.

The foundation has been laid for much of this already in agreements and arrangements that are ongoing with DOD and TRICARE.

Finally, a third direction that I see VA health care going is having an expanding role in providing for the public's good by using the VA's existing infrastructure and our unique array of assets to

address more general public needs. I think this will take a variety of forms in the future, whether it is preparing—at the one end of the spectrum, preparing a local public service agency to better respond to the threat of terrorist actions involving weapons of mass destruction or, on the other end, of providing services to other publicly funded health care beneficiaries.

In contrast to some who might see this as a threat to the future of the VA, I see it really as helping to ensure the future of the VA by the relationships that would be established, and increasingly making a population that has not had as much exposure to or who is less familiar with the military and veterans' issues appreciate the strengths and the value and the benefits of maintaining a publicly funded health care system that has as its primary mission providing care for the men and women who have served this country in the military.

With that, let me stop.

Mr. STEARNS. Mr. Backhus.

STATEMENT OF STEPHEN P. BACKHUS

Mr. BACKHUS. Good morning, Mr. Chairman. Good morning to you, Mr. Evans and Mr. Cooksey. I am pleased to be here today to discuss the future health care role of VA. My comments this morning will focus on how VA's system transformation is progressing and what challenges VA faces as its role evolves.

The information we are presenting is based on the series of studies we have conducted over the past several years to identify ways to improve the efficiency and the effectiveness of VA's health care system. During the course of our work, we have visited dozens of VA medical facilities, spoke with hundreds of administrative and medical staff, many veterans and, of course, the veterans' service organizations.

In summary, VA has made substantial progress in transforming its health care system to compete more effectively with other health care providers in order to become the veterans' provider of choice. For example, VA's 22 service delivery networks have made hundreds of restructuring decisions, including consolidating administrative and clinical services, shifting care from inpatient to outpatient or residential settings, and purchasing care from other providers.

These initiatives have enabled VA to avoid over $1 billion in unnecessary expenses, savings that have provided critical financing needed to further improve the system's overall accessibility and quality of care.

In addition, the networks are planning to develop and implement additional efficiency initiatives over the next 5 years. But VA faces several challenges before completing its transformation. Of these, VA's decisions regarding existing infrastructure may be the most significant and contentious.

For example, VA has spent hundreds of millions of dollars over the last decade constructing and renovating inpatient capacity. Some of this capacity is no longer needed because of its decreasing reliance on inpatient service. Meanwhile, VA continues to serve veterans in other locations using aged and deteriorating buildings

that will require billions of additional dollars to renovate or replace.

VA's decision to consolidate inpatient medical care at fewer locations is complicated by such challenges as VA's longstanding relationships with medical schools for education and research and with the DOD for contingency medical support.

In our view, VA's future success in fulfilling its health care role, as envisioned by recent eligibility reforms, depends in large part on its ability to transform its current delivery infrastructure into an integrated system of VA and private sector providers, which may be more attractive to new users, especially those already insured, who could provide VA with an additional source of revenue.

VA's strategy also suggests to us that it will ultimately purchase much more health care from the private sector providers than it does now and deliver care using its existing infrastructure predominantly in those areas where private sector alternatives are not available or where VA is an acknowledged leader.

VA's success will also depend on its ability to overcome several other management and implementation challenges. These challenges include designing an enrollment system, establishing new provider networks, developing and awarding potentially complex health care service contracts, improving collections from other health insurance that veterans and others have, and developing a system sufficient to capture critical cost access and quality information for managing and evaluating system performance.

If, as some have suggested, VA's competitive role is expanded to include not only the current veteran population but also veterans' spouses and dependents, the challenges facing VA will be even greater. For example, VA will have to either provide or arrange care for populations and medical conditions that it has little experience dealing with, such as pediatric or maternity care.

In conclusion, Mr. Chairman, we are encouraged by VA's progress to date and support its efforts. However, it is essential that VA address its infrastructure and other management challenges. If VA is ultimately unable to overcome these challenges, it is conceivable that VA could have to limit enrollment among lower-income veterans, and this could include those with the greatest need, because many of them have no other health care alternatives.

Mr. Chairman, this concludes my statement. I will be glad to answer any questions you or any other members of the subcommittee may have.

[The prepared statement of Mr. Backhus appears on p. 65.]

Mr. COOKSEY (presiding). Thank you, Mr. Backhus.

Dr. Krugman, you are next.

STATEMENT OF RICHARD KRUGMAN, M.D.

Mr. KRUGMAN. Good morning. I am Richard Krugman. I am Dean of the University of Colorado's School of Medicine, and I am here today to present testimony on behalf of the Association of American Medical Colleges. I would like to use this time to extend my written remarks, Mr. Chairman, which could be put into the Record, with your permission.

Mr. COOKSEY. Without objection.

Dr. KRUGMAN. The points I think I would like to make are that the health care system in the United States is under significant change. As others have testified to here and as the GAO report testifies to, throughout the United States, as care is more and more managed, populations of patients who are basically well or who are basically young or who basically have less complex disease are being gathered into groups to be cared for by entities that are happy to take their insurance coverage and provide an overview of care to them that is not very complicated.

On the other hand, the Veterans' Administration and many of America's medical schools and public hospitals find themselves caring for, historically, populations of patients who are older, who are sicker and who have much more complicated conditions. So in that environment, where competition is occurring and the populations of patients that we are historically dealing with are more and more isolated, it is even more critical that America's medical schools work with the Veterans' Administration and the VISNs' systems to be sure that these historic populations will get the care that they deserve.

In that regard, our situation in Colorado and in many other parts of the country may provide some examples of things we can do together that are relatively easy and also provide some examples, as my written remarks have, of some things that are hard to do because of regulation or because of bureaucratic difficulties on both sides of the street. This is not just a VA problem.

For this to work and for us to be able to work together, we think that we need to engage in intensive and frequent communication. That is not just between the medical schools, the university hospitals and the Veterans' Administration hospitals in our communities, but the entire VISN network and the MACs. In our area, we are participating in that regard.

We need to develop an agenda of problems and mutual goals and objectives. We need to work collaboratively to see if there are opportunities we could share. We have examples of our brokering a relationship between the Cheyenne VA and an affiliated family medicine residency in Greeley, Colorado, for example, both of whom were looking for a place to provide primary care to their populations. Neither of them had a big enough population to be able to support the overhead for the populations they were serving, but combined, they could do that.

We have the same in Denver where we have put a primary care clinic at the former Fitzsimmons Army Medical Center in place where the Veterans' Administration and University Hospital and University Physicians, which is our practice plan, provide care to the populations that we are serving, sharing the overhead and sharing the costs of that environment.

Those types of collaborations, I think, are ways that we can move forward together and assure that our health care missions will be successfully completed.

In education and research, we have the same opportunities to collaborate. Dr. Kizer has already alluded to the link we have had in education through the years. A substantial portion of our medical student, nursing student, dental student and resident education takes place at not only the Veterans' Administration facility in

Denver but throughout our VISN network. Medical education is increasingly community oriented, and we find a partnership between the facilities in our VISNs and our area health care education center system, which helps the veterans' facilities recruit and retain physicians to their system, provide them continuing education. And the best continuing education is actually to have a medical student or resident working with you for a month or two and then keep that educational focus in the community which, from our point of view, in our medical school, is where most education is going to go. As hospitals gradually shrink, the population base in hospitals is no longer an adequate supply of educational material, if you will, for our students and residents.

Finally, in the research arena, we have the same opportunity as we have in the clinical arena to collaborate. Research equipment is very expensive. We have the opportunity to share with our VA colleagues this research equipment. We share populations of patients for studies on health care outcomes, which are increasingly important if we are going to be sure that we are providing quality of care.

In all of these arenas, I think, the opportunity for medical schools and Veterans' Administration hospitals and VISNs to work together is there. Our goal should be to work together and to do this in a way that assures that we don't either step on each other's toes or trip over each other. And in the future I think if we pay attention to some of the regulatory difficulties that keep us from doing pretty obvious things out in the community, we will continue to provide the best possible care for veterans and the best possible education and research for our system.

In the spirit of moving toward problem-oriented learning rather than lectures, I will conclude my remarks at this time and wait for the questions.

[The prepared statement of Dr. Krugman appears on p. 73.]

Mr. COOKSEY. Thank you.

Miss Quandt, is that the correct pronunciation?

Ms. QUANDT. Yes, sir.

STATEMENT OF MARJORIE R. QUANDT

Ms. QUANDT. Mr. Chairman, you have invited me to discuss my vision of the future of the VA health care system.

First, let me say my vision is not the vision of the Commission on Future Structure of Veterans Health Care. It is based on my experience in the VA, looking at what is happening in the private sector and in other countries with health care.

Also, I would say this about that commission report: It made it much easier for Dr. Kizer to start the major changes he has brought about in the veterans' health care system.

I prefer to emphasize my vision of the electoral branch of the Government's commitment to veterans and DOD beneficiaries. By that, I mean sustained support, not the yo-yo effect one sees during periods of military conflict followed by dwindling resources until another conflict occurs. It has been all too easy to ignore the fact that the injuries and illnesses from war require treatment for more than half a century.

The statement about veterans' benefits in the 1999 budget is a staggering admission. The budget does not report the full size of these obligations and, in my opinion, it shirks the duty of putting veteran care elsewhere than in discretionary funding.

It is even more amazing to me that while this discussion of the budget listed veterans' requirements for comp, pension, education and loans, it completely ignored health care. There is a time coming when VA work load will eventually force the VA into the position of being what I call a bill-payer, rather than a direct provider. This should also be a concern for DOD. Forcing large work loads to the private sector will leave it without necessary medical manpower in time of war. If the dissatisfaction with 5-to-9-month tours of duty for those in the medical reserves is true, causing them to resign, DOD is doubly at risk.

On January 15, I appeared before the Congressional Commission on Servicemember and Veterans Transition Assistance to discuss forecasts for the 21st century. Participants were to answer the question: Will the benefit programs in place today meet the needs for tomorrow's veterans? My conclusion was that if both VHA and DOD continue on their present paths, that servicemembers and veterans will be ill served by their country.

I concluded that the two systems must be aligned much more intimately than they are now and that, by 2015, the VHA program will be subsumed in DOD because of the small veteran population. I based that on the fact that military casualties transferred to VA from the Gulf War were totally unlike those that came from the Vietnam conflict. In fact, when you look back now at Gulf War syndrome, it is a series of what are conditions or symptoms which can largely be treated as outpatient, not as inpatient.

Further, if you look at the current conflicts in this world of ours, we may well have a nuclear war and there may be no veterans returning or very small numbers. So there are certain what-ifs that one can look at.

It is often difficult to obtain accurate figures about the two health systems. One set leads me to believe there are 20 million beneficiaries between DOD and VA. Twenty million potential enrollees is as large as Oxford Health and Kaiser-Permanente together. They are the two largest HMOs in the United States. Even if I take the lesser figure of 6 million, this is still, by U.S. standards, a large health program. The beauty of DOD and VHA is, it represents the only full spectrum of care.

Between the two programs, there are at least 331,000 full-time equivalent employees, representing the full gamut of health care. My working arrangement would permit DOD to take over all your emergency-urgent, acute and some primary care in both systems. VHA, in return, would take over primary care, certain specialty care, especially rehabilitation and sustained care. Staffs from both systems would be assigned where needed. Thus DOD physicians or nurses will be staff in VA facilities, and VA staff would serve in DOD hospitals and clinics.

If you look at the map attached to my report, which has already been discussed, you will note 19 States where VHA will not have enough work load to support hospitals in 2010–2015. It is preferable that in these States there be additions to outreach clinics,

community-based clinics and the use of contracting for or purchasing hospital space. VHA-DOD professional staffs would seek privileges at local hospitals to keep control of care within the federal health system. In the other States, the VHA and DOD medical staffs would move back and forth and provide a full range of care.

I need to tell you what my vision does not involve. It does not involve attracting more category A veterans and their dependents. It does not involve category C, rich veterans. It does not involve subvention of Medicare or reliance on MCCR. My vision adheres to the amount of coverage VHA has received. Historically, back 20 years, it was never funded to cover more than 10 percent of the total veteran population. MCCR is drying up and Medicare will continue to ratchet down its payments. A Clinton lite plan to enroll all veterans and their dependents is an idea whose time has disappeared.

Furthermore, all the plans to attract category A and C veterans and obtain Medicare funds pit a wonderful Federal health care program against a gigantic private sector market. Nor do I know of any tenet in law which generally allows the Government to compete with private industry.

GAO, in its study, would allow private practice physicians to treat veterans in VA facilities. This also flies in the face of the market system locally, and I think in very small communities would not be accepted.

I am not concerned about displaced VHA employees. Health economists say that for every $2.1 billion saved, 22,000 health care workers lose their jobs. However, the great majority are picked up by contractors or other programs in the community.

I am very concerned that VA does not have the authority to sell unneeded, unused physical plants. If it had the proper authority from Congress, it could sell those, invest the capital funds received and use those funds for whatever level of care was needed.

My vision is not to save bricks and mortar, but to combine the two Federal programs to have a modern, efficient, managed care program which will fulfill the goals of readiness, patient care in war and peace, education and research.

Thank you.

[The prepared statement of Miss Quandt, with attachment, appears on p. 100.]

Mr. COOKSEY. That was a wonderful statement, very direct, very candid, without political considerations. We need more of that. It is very refreshing.

Ms. QUANDT. Thank you.

Mr. COOKSEY. I would note that it was from a woman and maybe we need more women up here testifying. Very good. Thank you.

I don't necessarily agree with all of it, but it was a good statement. I agree with a lot of it, though—most of it.

Dr. Kizer, you have looked at the costs that VA incurs in smoking-related illnesses, I understand. What do you project these costs to be for the Veterans' Administration?

Dr. KIZER. A lot.

Mr. COOKSEY. A lot, I agree. Any numbers, ballpark figures?

Dr. KIZER. I think that the staff have provided previous estimates of the potential exposure depending on the number of veter-

ans affected. I have not been involved in developing the methodology for doing that. I would only say that depending on how many are treated and exactly what they are treated for, it is likely to cost billions of dollars.

Mr. COOKSEY. Five, 10, 50, 100?

Dr. KIZER. I think the lower end there is certainly consistent with current projections.

Mr. COOKSEY. Okay. There has been some discussion about the tobacco manufacturers bearing some of the cost of the VA care for veterans. Is there not also a case made for that industry's providing money for research to the Veterans' Administration, and do you think this is a good option or a viable option?

Dr. KIZER. I think there are many viable options where any funds that accrued from that settlement could be wisely used to support veterans' care and which, in turn, would benefit the public at large.

Mr. COOKSEY. Okay. Do you think that the VA is in a position to carry out some of this research, for example, with your population? Do you think your population in the VA hospital and your current staffing would allow you to carry out this research that would shed some light on methods of—well, what tobacco does and, of course, quite frankly, you and I know that we have known a lot of what tobacco will do since 1962 and beyond that, but methods of getting people to stop smoking, discourage people from starting, and so forth.

Dr. KIZER. As you know, there is a plethora of information about the untoward effects of smoking. Certainly one of the—one of many potential research opportunities that exist in the VA would be how you control this addiction or curtail this addiction in a population that is very severely addicted.

There is no question that nicotine is every bit as addictive, if not more so, as cocaine and heroin and other drugs of that type, and that this is an addictive disorder. We have many veterans who are addicted and continue to support their unhealthy habit. And certainly, if funds were made available to research ways of curtailing or dealing with that addictive behavior, we have a population that will provide many opportunities to investigate it.

Mr. COOKSEY. Do you consider it a physiological addiction or a psychological addition, tobacco?

Dr. KIZER. I think that pushes the definitions or the distinctions between those two. There is unequivocal evidence that it is both physiological as well as psychological. At some point it becomes hard to distinguish, when you are dealing with neurochemistry, what is the difference.

Mr. COOKSEY. Dr. Krugman, what about you, do you think it is a physiological——

Dr. KRUGMAN. I concur with Dr. Kizer's statement. I think it is both.

Mr. COOKSEY. Veterans' Administration, VA hospitals have made some quantum leaps in this transition from inpatient to outpatient care. The period when we were all in medical school, Dr. Kizer pointed out in our earlier meetings that he was in the first grade when I was in medical school. So Dr. Krugman, maybe your hair

is not quite the right color, but it is getting there. I assume you were in medical school in the 1970s.

Dr. KRUGMAN. Actually the 1960s.

Mr. COOKSEY. Good, those were my years. Anyway the VA hospital has made some major changes in moving from inpatient to outpatient. Some of the veterans' service organizations are concerned that the move is being done too fast and going too far too fast and that maybe the cost-cutting is taking precedence over quality of care.

I liked your statement, Dr. Kizer, that we really should put the emphasis on quality of care and not just cost of care, because that has been one of the shortcomings of managed care, these CEOs, the bean counters, the CPAs that run these organizations have in most cases not been involved in taking care of patients. They take care of financial statements. That is coming back to haunt them now.

But do you think that this perception by the VSOs that you are moving too far too fast is a proper perception, or do you think it is just a PR problem that the Veterans' Administration has?

Dr. KIZER. I would respond several ways. One, the VA has all kinds of PR problems, so I am sure there is an element of that. The VA is universally unsuccessful at PR.

Second, I think that in many ways the rapidity of the change—and it has been very rapid, and I think it is certainly unprecedented in the history of the VA and is even unparalleled by private sector standards, but I think that it is only a warm-up for the type of change that is going to have to occur in the future.

When we look at the sort of technological interventions, gene therapy, and other things that are in the pipeline and that are going to be reality in a very short period of time, I think what we all have to get used to in health care is continuous, very rapid and, in fact, tumultuous change. That is just the world that we live in.

VA was pretty quiescent for a long period of time. We have catch up to do—I think we have done that; we are moving in the right direction. But change is just part of the future scenario, not only for the VA but all of health care.

The last thing I would note in that regard, though, is that too often overlooked, when we talk about changing the VA, is how quality of care has changed in the VA. If you look at any of the standard indices that are used to track quality of care in the private sector, what you see is that the VA is now superior on all of those measures and that we have made incredible progress in improving quality of care in VA in a short period of time that certainly rivals others' performance, and now have a very good record to speak to in that regard.

It is of interest that increasingly we are being contacted by other entities to assess what we have done in that regard to benefit other large organizations on how they can pursue quality management.

Mr. COOKSEY. And I would support your statement. I know that I have one VA hospital in our area and it is, the administrator there is really an outstanding administrator. They did a good job. Of course, I am an eye surgeon, but I have been into their eye clinic. They have some equipment there, some instrumentation that I wish we could have in our clinic and could afford in our clinic. It is really state of the art.

Dr. Krugman, what is your response to that, to the question? Do you think that the VA hospital is making these changes in an expeditious manner and what, how can those changes work to the advantage of the medical schools and the medical schools work to the advantage of the veterans, not the Veterans' Administration but to the veterans? I am a veteran, and someone has to speak up for the veterans.

Dr. KRUGMAN. Well, I think what we are learning in the health care system, and certainly schools of medicine have learned this, is that the whole focus of what we need to concentrate on now are populations of patients in addition to just taking care of the individual patient. That is still a very important part of what we do. So the bedside teaching and the bedside care of veterans in the VA hospitals will always be important.

But as those numbers decrease—an increasing proportion of what we are going to do is in the community, in places such as ours; VISN 19 is Colorado, Wyoming, Montana, places with very few people and a lot of miles in between them and lots of miles between situations, between facilities—we have felt the need to work together to create networks of care focusing on those populations, linking physicians in those in the VA system. And many of them are our clinical faculty in the medical schools as well.

And we really do this, we really do this together because we, with our small population, with our great distance and with the increasing cost of caring for fewer people within the hospital settings, it really is critical for the VA and the medical schools to work together to be sure that the care is met. Key to that is the development and access to primary care in the communities where the veterans are, as well as primary care for the populations that we care for.

I should tell you, sir, that our strategy to survive in Colorado has been to focus on caring for populations of patients that we have been historically linked to. We actually are the health plan, part of the health plan for TRICARE and we take—we are the network manager, our medical school and university hospital, for the TRICARE program in Colorado.

We also operate a Medicaid HMO to care for the Medicaid patients in our area, and many of those Medicaid patients in our statewide system are linked to veterans or dependents of veterans and many are in the veterans' system.

So I think we need to provide the best care for veterans. Those of us, as I said at the beginning in my statement, who have historically cared for these underserved populations and these very complicated populations need to work together so we can do it most efficiently.

Mr. COOKSEY. Miss Quandt, commenting on his statement, referring to your map——

Dr. KRUGMAN. We are the white State in the midst of all of that.

Mr. COOKSEY. That is what I was referring to. How would you take his medical school and his unique position and take care of these veterans in these surrounding States that are x-ed out basically?

Ms. QUANDT. In all the surrounding States x-ed out, where there are some military hospitals there would be a VA-DOD presence.

Where there is no DOD hospital, there would be a joint VA-DOD community clinic. Dr. Krugman's medical school could be affiliated with those clinics.

Since the affiliation currently does go up to Wyoming, this map does not stop that. In fact, I can see that this plan, which uses clinics, then going out and purchasing service at very strictly negotiated rates in the private sector, could allow medical schools to move out and away from their traditional university hospital. It would not be unlike what WAMI did.

Mr. COOKSEY. What who did?

Ms. QUANDT. WAMI, Washington, Alaska, Montana, Idaho, in which they moved residency out in rural areas.

The same thing could apply in these States, whether it is Colorado, whether it is a medical school that survives in South Dakota or some other State.

Dr. KRUGMAN. We have affiliated residencies serving both in Caspar and Cheyenne, Wyoming, in addition to 10 community residencies in Colorado.

Mr. COOKSEY. Good. Well, my personal comments, I am concerned about the tobacco issue. I think that the tobacco issue, once it was brought up, once the lawyers became involved, it has been—everybody has been piling on and everyone sees this big potential pile of money. And it seems like everyone is trying to get money out of it; it is almost as if it is an unlimited supply of money that is going to solve all the problems.

I think that some of the groups that hope to benefit from this really need to look—stop and look at it and know that it is not an unlimited supply of money and that the money may never materialize.

The money is not, the money is not just going to come down like manna from heaven. It is going to come from additional taxes. It is not going to come from the reserves of the tobacco companies, because some of those would probably bankrupt some of these plaintiff attorney plans that are actually implemented.

But it has almost become distorted to a certain extent.

I am pleased with the changes that you, Dr. Kizer, are leading in Veterans' Administration. They are good changes, and they ultimately will work to the benefit of the veterans. I feel very strongly that the veterans, that the veterans that have combat-related injuries or diseases should have whatever it takes to take care of them forever and ever.

In my particular congressional office, 35 percent of my staff's time in the district—and I have really three offices—is spent with veterans' issues; 35 percent is spent with Social Security disability issues, so 70 percent of the time is spent with disability issues. And for those people that come in with combat-related injuries, I have personally taken care of them over the years—blinded veterans with war injuries, and most of them, really all of them pro bono treatment, and I think we should continue to do that.

On the other hand, there are people that come to our office with great expectations that were maybe injured when they fell off the back of a pickup truck at Fort Polk between the Korean war and the Vietnam war and between the Vietnam war and the Persian Gulf war, and those are legitimate injuries.

But then there are those that have problems not related to their time in the service or any injury or disease that they acquired in the service, but because they are a veteran, they have great expectations, and they have to understand that the first obligation is to those injured in war and have diseases that they acquired during that time period.

I am also concerned that we have a lot of duplication of health care services in this country and that there is duplication in the urban areas, and yet we don't have adequate treatment in the inner city urban areas. There are a lot of low-income people that don't get health care when they should, and some of those are veterans, and some of the rural areas are deprived of health care.

So it is a complicated problem with no simple answers. Managed care is not the total answer. Tobacco is certainly not the total answer, the tobacco settlement.

It will require a lot more time and thought and creative thinking and candid statements like all of you have given this morning, and particularly you, Miss Quandt.

I have no other comments or questions. Do any of you have any last comments?

We appreciate you being here today. The testimony was outstanding.

The committee is adjourned.

[Whereupon, at 12:05 p.m., the subcommittee was adjourned.]

APPENDIX

LANE EVANS
HEARING ON THE
FUTURE OF THE VA HEALTH CARE SYSTEM
JUNE 17, 1998
10:00 AM

Thank you, Mr. Chairman. Today's hearing will feature testimony on the future of the VA health care system. VA has undergone a number of important changes over the last five years. It has restructured system management to give more autonomy to field managers, giving those managers more control over their resources, and, in turn, making them more accountable for their performance. This Committee also initiated and eventually enacted eligibility reform legislation which allowed VA to make decisions about patient care that were more consistent with modern health care. In so doing, we gave VA the opportunity to make more cost-effective care delivery choices that we hoped would also be more responsive to patients' preferences.

Health care practice, in general, has changed dramatically since the VA health care system proliferated in the middle of the century. Back then we associated health care with hospital care. Very few medical procedures took place outside of the hospital. Almost all surgeries were performed in hospitals and required hospital admissions. Physicians were the undisputed authorities on virtually all aspects of patient care. Most doctors had long-term associations with their patients and had a clear idea of their medical histories. Prescription drugs and prevention did not allow clinicians to manage their patients chronic or acute illnesses as effectively as they can today.

Things have certainly changed in medical care—in VA and elsewhere. To add to the challenges of transforming to changes in medicine, VA must also respond to the changing needs of its veteran patients. The median age of the veteran population is now 57 years old. The largest conflict era group is now comprised of me and my peers from the Vietnam Era followed by the World War II cohort of veterans. Most veterans do not need the acute rehabilitation for war injuries some relied upon when service members first returned home—now those veterans need good continuing care and rehabilitation to ensure that these conditions do not deteriorate or contribute to other problems with veterans' health. I am certainly not advocating that VA abandon the services upon which it built its reputation—its spinal cord injury centers, blind rehabilitation centers, post-traumatic stress treatment and mental health programs, and care for amputees. On the contrary, I believe these programs form the heart of the system and should continue to evolve to meet the needs of the veterans they serve. I believe VA should use these programs to reach out to the rest of the health care community and promote itself to those unfamiliar with the level of excellence in services it can provide. Without them VA will become indistinguishable from other health care providers. I have been disturbed by recent reports that indicate that these programs have received less attention from VA managers as the system has restructured. Frankly, I believe that if VA's managers allow the special programs to wither on the vine, America will rightly begin to question the need for a unique hospital system for veterans.

Veterans who are frail and elderly or who have chronic disabling conditions need reliable sources of long-term care. They should have care providers who "manage" their conditions in the best sense of the word—not by restricting their choices, but by monitoring their health and intervening at the earliest opportunity if a problem arises. VA should be a leader in defining

America's strategy for dealing with a graying society in a humane and cost-effective way. We must begin to respond to this important challenge today.

With care more accessible elsewhere, many veterans will no longer accept the long drives to hospitals for routine care. They need and expect care to be more accessible to them. Older veterans need more accessible care because of transportation problems—younger veterans need more convenient care options so they do not have to decide between working and seeking necessary health care. VA is wisely developing the process of putting more of its care out in the community in outpatient centers. This is working well for veterans and allowing VA to develop its patient base to meet its lower per-patient cost goal.

Because VA has evolved to a decentralized management system, VA must increasingly rely on a sound information infrastructure to tell us about the patients it treats, the quality of health care services it provides, the resources it uses and the types of care veterans seek. This information allows Congress and VA's Headquarters to create policy that is responsive to veterans' needs. Assuring quality health care is essential to justify an adequate appropriation. If Congress had better information about the cost of health care services for veterans, it is possible we would be more effective in attaining adequate funding for VA and ensuring that the funds Congress seeks to authorize VA to collect are sufficient to cover VA's costs. This has been a major problem in attaining authority for VA Medicare Subvention. Congress is now considering a bill that may seriously affect where and for whom the VA spends money—if the bill is enacted, VA is going to have find even more money to offset the potential new spending the Congressional Budget Office projects will occur. I cannot help but feel if VA had had its operational information infrastructure intact we could have had far more leverage in negotiating with the Ways and Means Committee and the Health Care Financing Administration. It may have also relieved my concern that VA would not bankrupt itself trying to honor contractual managed care obligations to veterans who would enter the system as Medicare beneficiaries. Management information systems will undoubtedly play an even larger role in "real world" decision-making and helping VA managers and other stakeholders choose the best course for VA in the future.

I am deeply concerned about the future of funding for the VA health care system. We'll hear the same theme from many of our witnesses today—American Legion says that "VHA's reliance on medical Care Cost Fund recoveries leaves the system in a precarious position". Ms. Quandt's testimony will allude to the risks of retaining insurance from higher-income veterans and deem VA-Medicare Subvention a "specious effort". PVA has gone so far as to ask with regard to the recent budget resolution, "Why does the House of Representatives hate veterans?" I believe these views are increasingly representative of the cynicism that now abounds in the veterans' community because of Congress's failure to appropriate an adequate budget for VA health care. And there is just cause for such cynicism.

Time since a conflict period with massive casualties and dwindling numbers of veterans in the Congress have made it easier to turn our backs on the veterans that risked their lives for the freedoms we now take for granted. Veterans are now viewing efforts to obtain funding from non-appropriated sources as a diversionary tactic. They see that far from bolstering VA, these devices are being used to let us off the hook for finding the dollars to fund the system adequately with appropriated dollars. I supported legislation to retain medical care recoveries and I have supported Medicare Subvention but I now believe VA may be paying dearly for our support of such schemes. The Ranking Member of the Ways and Means Committee, Charles Rangel, acknowledged his reason for reporting Mr. Thomas and Mr. Stump's Medicare Subvention

proposal favorably out of Committee. **He said, "...so I will reluctantly support this measure today, but I think it's sad that we have to play musical chairs to find the funding for the VA medical care system instead of just appropriating the funds the system needs" (confirm or delete).** The Congressional Budget Office estimates the Thomas plan that is now on the table may cost VA $450 million in direct funding. Over the same period of time, the Republican Budget Resolution will require a $10 billion reduction in VA's mandatory spending. Where VA will find cuts of this magnitude that do not significantly affect benefits is anyone's guess. I believe we need to do what we can to stem the damage. Staking an extra half-billion on a Medicare revenue stream that is so uncertain is more than I care to gamble for the opportunity to give the Health Care Financing Administration discounts for Medicare beneficiaries—even if they are veterans.

While I believe it was a laudable effort, I now believe we may be headed in the wrong direction embracing VA's 30-20-10 plan. Recruiting new veteran enrollees when we cannot meet many of our current patients' needs for mental health, long-term care, other types of chronic care, or emergency care may be wrongheaded. Even with the added benefit of new community outpatient centers, current users may not be receiving the care they need. There is already some evidence that our most vulnerable populations may have been affected as VA scrapes to find efficiencies in its already lean system. Psychiatric beds have been decimated and there are few outcome measures in place to assure us that their needs are being cared for in alternative settings. The Prosthetics and Special Disabilities Task Force has identified significant problems in maintaining the infrastructure of some of the special programs VA operates—including those to which the Congress gave special legislative protection. Facilities are beginning to limit the long-term care they will provide or sponsor for their veteran patients. These are indicators that the system may be sacrificing its most difficult and expensive care for the sake of the "greater good". Unfortunately, too often in making health care choices, policymakers and managers feel they must exchange breadth for depth and our most vulnerable citizens are the first to feel the effect of the squeeze. If this indeed is the case in VA, I am seriously concerned about the system's future.

I think as policymakers, we must begin to seriously question the 30-20-10 plan and its effect on current users. We must begin to ask hard questions about maintaining infrastructure—maybe we can do without some hospitals if long-term care facilities and community outpatient centers will better respond to veterans' needs. We must look at what makes VA special and different from other health care providers and work on enhancing and promoting these services. VA must maximize our opportunities for partnering to ensure that veterans VA enrolls receive a full continuum of care that is high quality and cost-effective. We must not turn our backs on our most vulnerable veterans. VA must ensure that it has the tools to provide this level of care to its users—it needs to exploit the technologies that are available from telemedicine to make care more accessible; it needs to use reliable and valid information systems to drive their decisions regarding health care. We need our research programs to look at new models for delivering care to meet veterans' special needs. Once costs are known, VA may decide it has some services it must maintain ***for the sake of its current users*** that it could sell to other health care providers. I believe that there is a role for VA in the future but it is not a role as another faceless managed care provider—VA is different. It is only in capitalizing on these differences that VA can show its strengths and find a niche in the future of American health care.

Thank you, Mr. Chairman. This concludes my statement.

Statement by Rep. Luis V. Gutierrez
Committee on Veterans' Affairs
Subcommittee on Health
June 17, 1998

Thank you Chairman.

Discussing the future of the veterans health care system is vitally important at this crucial juncture in the VA's history.

Refashioning the VA to ensure that veterans receive the best treatment and medical attention available is a greater challenge today, in this era of fiscal constraint, than at any time since the veterans health system began.

Unfortunately, this morning I was unable to bring my crystal ball.

Hypothetically though, if I had brought my crystal ball to this hearing, I would hope to gaze into the future and observe a veterans health care system providing better quality medical services to all veterans who require it.

And better medical care for veterans is a goal we all share.

Fortunately for us today, we have been joined by veterans, medical practioners, health care experts and other VA stakeholders who have brought their collective wisdom and views on the future of the VA to this chamber.

Today, we can start the process of planning that is so important to the long-term health of the VA system.

We must all be aware of a number of facts as we begin this process.

In politics, a key rule of success is knowing your constituency.

For the VA to succeed this rule holds true as well.

Demographically, the veterans population is aging with that of the nation.

But while overall population in America continues to rise, the percentage of veterans in our nation declines.

The VA's constituency of the future may be reduced in number but greater in need.

The greying of the veterans community will require the VA to adapt its care and research toward the needs of older Americans while ensuring that younger veterans continue to receive adequate services.

Long-term care may become a greater priority for veterans in their later years of life. And preventive medicine that can help deter the most prevalent medical ailments, such as heart disease and cancer, will similarly be of an enhanced necessity for our veterans community.

As the VA continues to transform itself from a hospital-based system to a more flexible and accessible care provider, we who are charged with maintaining our nation's obligation to our veterans must remain in touch with this constituency.

There is one last point I would like to make before I conclude.

The veterans of America are solely responsible for a world in which we have fewer veterans.

The peace we enjoy today is their peace. Our veterans' sacrifices and courage have reduced the threats to our nation.

If there are less veterans of war in the future it is because of the victories won by the veterans of today.

Thank you Mr. Chairman.

Representative Helen Chenoweth

Statement to the Veterans' Affairs Health Subcommittee

June 17, 1998

Thank you, Mr. Chairman, for holding this hearing today. I look forward to hearing from today's witnesses on how we might work to improve the quality of health care for our nation's veterans.

The VA has been a valuable tool for providing health care to the heroes of our nation, the men and women who served in her defense. I am hopeful that today's hearing will help give those of us on the Veterans Committee some insight as to how we might be able to help the VA to provide better care for our veterans.

As our veterans population ages, the issue of health care grows more and more important. It is important that we in Congress as well as the Department of Veterans Affairs continue to explore all available options regarding new methods of providing health care.

At the same time, we must continue the efforts that we have made to maintain high standards for care. Our veterans deserve the best that we have to offer, as they offered the best years of their lives for our country. Let us keep that in mind as we listen to the testimony today.

I would like to thank Dr. Kizer for his appearance and testimony today, and I would also like to welcome Mr. Robertson of The American Legion and Mr. Warfield of the Vietnam Veterans of America. Your organizations provide invaluable service to our nation's veterans, and I am anxious to hear your insights on the future of health care in the VA.

Again, thank you Mr. Chairman, and I look forward to the testimony today.

STATEMENT OF STEVE A. ROBERTSON, DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE FUTURE OF VA's VETERANS HEALTH ADMINISTRATION AND THE GI BILL OF HEALTH

JUNE 17, 1998

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to share its vision for the future of the Department of Veterans Affairs (VA) -- Veterans Health Administration (VHA). For several years, The American Legion has offered the GI Bill of Health as a blueprint to prepare VA health care for the twenty-first century.

Mr. Chairman, the VA health care system is important to veterans, their families and to the nation. Several generations of veterans continue to receive quality medical care through VHA facilities. To many of these veterans, especially those with severe service-connected disabilities, VA serves as their life-support system.

Families greatly appreciate the quality of treatment and services offered by VA to meet the demanding health care needs of their loved ones, especially those veterans with debilitating conditions that require inpatient care and/or extensive rehabilitation.

Today about three million veterans rely on the system to meet their health care needs. The American Legion sincerely believes that millions more would like to have access, but limited resources still preclude unimpeded access. For some veterans, the medical care is directly related to disabilities incurred or aggravated as a result of active military service, but for many more veterans, VA serves as a health care safety net provided by a grateful nation. Most veterans and the vast majority of Americans perceive VA as a health care system for those who served in the armed forces, both in peace as well as in war.

Mr. Chairman, thanks to the work of this committee and VA's progressive leadership, many positive changes have occurred within VHA in recent years. Congress has facilitated certain improvements by enacting major legislation to improve efficiency within the VA health care system. A new culture exists within VA that provides both opportunity and heightened anxiety among veterans. Many of the changes occurring today within VHA are both difficult and necessary. What is uncertain, however, is " What will be the constant characteristics of the VA health care system in the twenty-first century" ? The American Legion believes it is important to have a clear vision of VHA beyond the current strategic planning period of Fiscal Years (FY) 1998-2002.

For most of its existence, the VA medical care system has been entirely dependent upon the United States Congress for its funding through the appropriations process. Today, VA has the authority to retain third-party reimbursements. With the Balanced Budget Act of 1997 freezing VA health care appropriations at $17 billion for the period FY 1998-2002, there is an increased incentive to develop new non-appropriated funding sources. In addition to absorbing annual medical care inflation, the Balanced Budget Act requires VHA to effect clinical savings of two to three percent per year to compensate for a flat-line budget.

The results of placing VHA on a strict budgetary regimen are rapidly becoming apparent. VHA's flat-line budget provides more consolidation than growth. The 22 Veterans Integrated Service Networks (VISNs) seek every opportunity to save resources, collect third-party reimbursements and develop new revenues. A resource distribution methodology, although imperfect, is changing how medical centers are funded. The paradigm today is that reducing costs will make the system work much better, while trying to serve more veterans. Unfortunately, many theoretical patient care models are being promoted to reduce costs. In many cases, VA has no reliable long-term treatment outcome data to support a drastic reduction of inpatient care.

Through discussions with many VA administrators, clinicians and support staff, the consensus view is that budgetary factors have forced too much change too soon. A review of VISN business plans suggests that bed closures and the emphasis on outpatient primary care are part of an overall plan to reduce expenditures. Certain VISNs have not adequately reinvested a reasonable portion of savings accrued from downsizing inpatient programs because inflation and other cost increases have absorbed the savings. Inpatient mental health programs have been critically reduced , and proven PTSD and substance abuse treatment methods have been realigned to increase efficiencies, not simply to enhance or improve treatment.

VHA's reliance on Medical Care Cost Fund (MCCF) recoveries leaves the system in a precarious position. If the MCCF recovery projections are inaccurate, VHA will be in a more difficult position and forced to seek supplemental appropriations. The 30-20-10 plan promoted by VHA requires a recovery of $1.7 billion in reimbursements by FY 2002 to meet the non-appropriated funding projection. Even at that level, whether that amount will compensate for a five-year flat-line budget is doubtful.

The American Legion supports VA's efforts in cost containment and cost reduction within VHA and for other federal health care programs through sharing and other arrangements, as long as the quality of care and accessibility to care are not compromised. However, VHA must adjust its programs and services to meet the needs of increased elderly patients who will need care in the next 20 years. The American Legion believes VHA must continue to lead in other specialized fields such as spinal cord injury, blind rehabilitation, serious mentally ill veterans, substance abuse services, PTSD, women veterans health programs, homeless veterans treatment and assistance programs, and other specialized treatment services.

One of the primary concerns of The American Legion is that VHA is placing itself in a budgetary dilemma through its strict adherence to the mandates of the Office of Management and Budget (OMB). At the beginning of its " Journey for Change," VA was tasked by OMB to accomplish its 5-year objectives within the boundary of a no growth budget. A greater period of time is needed to determine the legitimacy of VHA's 30-20-10 plan. VHA's " Journey for Change" is a skillful plan, but it may also be overly optimistic.

Mr. Chairman, in early 1995, a VA physician wrote an article that appeared in US Medicine News entitled: VISN: Prelude to Dismantling VA Care. In the article, the author speculated about (at that time) the proposed Veterans Integrated Service Networks. He wrote: " If VHA continues to follow the structure and the philosophy that govern Health Maintenance Organizations -- incentives of downsizing, underutilizing, competing, rationing and cost savings -- it will have cemented all the basic ingredients needed to dismantle the VA health care system."

Mr. Chairman, it is possible that VHA is on a path to being seriously downsized or dismantled. With each passing month, all 22 VISNs are under increasing budgetary pressures. VA has closed approximately 25,000 hospital beds within the past three years. Certain medical centers have contracted out, in whole or in part, inpatient operations, and others are in the process of reviewing whether to follow course. Several VA nursing homes have closed. All 22 VISNs are responding in different means to VHA's budgetary realities.

The American Legion must ask to what degree, if any, as a result of downsizing, has VHA's capacity to provide back-up medical emergency services to the Department of Defense and to the National Disaster Medical System been compromised?

Mr. Chairman, many of the changes occurring within VHA over the past few years are the result of a need to transform a system that was essentially unchanged since its inception. The American Legion commends Dr. Ken Kizer for his vision and his determination to reform VHA. Nevertheless, we must ask, what is Congress' long-term vision of VHA? What kind of system does Congress think will work best for VA and for veterans in the twenty-first century?

Numerous congressional hearings have focused on how to transform VHA to reflect the best practices of private medicine and also to retain its unique characteristics. In 1991, The American Legion analyzed the major problems within VHA and devised a plan to transform and improve the VA health care system. The result of this exercise is the GI Bill of Health. Many of the recommendations proposed in the GI Bill of Health are shared by other members of the veterans community.

THE GI BILL OF HEALTH:
A VISION FOR EXCELLENCE IN VETERANS HEALTH CARE

Mr. Chairman, the **FIRST GOAL** of the GI Bill of Health is to open VA to **all** veterans, service-connected and nonservice-connected. Public Law 104-262 was a valiant attempt towards that goal, but the term " within existing appropriations" forced VA to further prioritize veterans into 7 subcategories. Obviously, not every veteran will get into the system since the annual discretionary appropriation for VA medical care is funded to provide care for only a portion of the eligible veteran population.

The American Legion believes it is possible for all veterans to have equal access to VHA by following a simple principle: If a veteran qualifies for care, under title 38, United States Code, access to VHA is at no cost to the veteran. Otherwise, the veteran is responsible for reimbursing VA for the medical care received, either directly or through third-party health insurance. Using this formula, VA medical care funding would come from two sources: the United States Treasury and from the private health insurance sector.

Using this same philosophy, the GI Bill of Health sees an opportunity to expand access to VA health care to **all** dependents of veterans. We all know that the most important part of a veteran's life is the family. Most health care decisions are made by the family, not just the head of the household. Family members also experience the sacrifices and hardships associated with military service. Family members must also help heal the physical and mental scars of war. They must maintain the home and family unit during the nation's call to arms. Adding family members to the VA health care system will strengthen the system and enhances the patient mix to meet the health care needs of all veterans. The GI Bill of Health is one step closer to achieving President Lincoln's goal: " To care for him who shall have borne the battle, and for his widow, and his orphan."

The **SECOND GOAL** of the GI Bill of Health is to allow VA to collect and retain **all** third-party reimbursement, co-payments, deductibles and premiums. These revenue sources would go into a secure, interest-bearing trust fund to pay for health care services and treatment. Using a capitated formula, VA would receive payments from the United States Treasury for those veterans eligible for federal health care coverage. VA would offer various health care benefit packages on a premium basis. VA would establish a billing system based on actual costs of services, rather than the average cost of care.

The GI Bill of Health calls for subvention from federal health insurance programs. This budgetary approach is logical. A veteran could be eligible for multiple federal health care coverages. By identifying with one (in this case VA) would help minimize duplication of limited federal resources. For an example, a 50 percent

service-connected veteran could be eligible for VA health care and coverage from other federal health care programs. Should that veteran choose one of these health care systems as his primary health care provider, the United States Treasury would calculate funding only one system for that veteran. This approach provides greater opportunity for coordination and cooperation among all federal health care systems.

Congress wisely decided to allow VA to retain third-party reimbursements, but reduced the annual discretionary appropriations by an arbitrary " collection goal," which may or may not be realistic. The discretionary appropriations are designed to fund health care for " priority" veterans. Third-party reimbursements come from treatment of nonservice-connected treatments. This is counter-productive. Third-party reimbursements should be used to supplement the annual discretionary appropriations rather than be calculated as an offset.

The GI Bill of Health calls for an annual open enrollment system. When a veteran enrolls choosing VA as the primary care provider, the veteran would identify his or her funding source. The veteran would identify a federal health care program, a private insurance company, employer or others providing the coverage. VA would also develop optional health benefit packages that the veteran could purchase directly from VA on a premium basis. Since VA is a non-profit federal agency, the absence of a profit margin should result in lower premium rates.

The **THIRD GOAL** of the GI Bill of Health is to increase the access points of VA medical care. Public Law 104-262 granted VA this authority and The American Legion strongly supported that provision. The American Legion envisions VA as the world's largest integrated health care network. VA's network would include federal and private sector health care providers. Through sharing agreements with other federal health care programs, veterans and their families would have expanded access to care. The GI Bill of Health does not require VA to be the primary provider of care but, rather, envisions a greater partnership with the private health sector. The GI Bill of Health would provide greater leverage in negotiating contracts with private health care providers.

This coordinated care approach would adequately address the current rural health care problem. VA would be capable of moving access to health care physically closer to veterans' residences, without the burden of " bricks and mortar." This could very well help strengthen rural hospitals and health care clinics.

The **FOURTH GOAL** of the GI Bill of Health is to strengthen, improve and preserve **all** of VA's specialized services by offering them to veterans who currently may not be capable of accessing these programs. The American Legion believes that long-term care and mental health services are not being adequately addressed by VA. Under the GI Bill of Health, these issues can be meet head on. The GI Bill of Health offers an opportunity to meet veterans' needs in these disciplines and generate new revenue sources. All of us are aware of the problems faced by families obligated to care for those suffering from aging related conditions. There has to be a better way to assure that the true defenders of democracy have appropriate health care choices in their retirement years.

Mr. Chairman, it is time for comprehensive legislation to develop a long-term strategic plan for the VA health care system. Veterans want a health care system that meets the needs of older and younger veterans, while preserving VA health care for the America of the twenty-first century. The plan must develop a financially viable means to meet the health care needs of the entire veterans community rather than the 10 percent that it currently serves. All government health care systems are in jeopardy and face economic problems that require creative and visionary solutions. The American Legion sees no logical reason why VA and DoD cannot achieve the corresponding goal of caring for the health care needs of the military retirees and their families.

The GI Bill of Health is designed to provide a workable, fiscally responsible solution for VA. The fundamental principle is that the government pays for the health care of those veterans and dependents entitled to federal funded health care coverage and everyone else pays for the health care coverage they desire.

For years, The American Legion has held that the VA health care system can only be improved through coordinated program changes in the way medical care is delivered, to whom it is delivered and how it is financed. The GI Bill of Health will enable VA to tap into public, private and corporate revenue streams that strengthen, improve and preserve a quality national health care network available to all veterans and their families. Economies of scale would allow VA to do so with lower costs. These savings will be passed on to taxpayers.

The GI Bill of Health permits all service-connected veterans to receive the quality of care they currently receive. There will be no reduction in benefits to any veteran being treated by VA. In fact, many service-connected veterans will receive greater benefits than they currently receive. The GI Bill of Health assures the long-term availability of the benefits by encouraging full utilization of medical services and facilities. The GI Bill of Health would be able to provide comparable quality of care, timeliness of service, accessibility to care and a reduced cost for both the federal government and nonservice-connected veterans who purchase their health care directly from VA on a premium basis.

Once empowered by the GI Bill of Health, VA would operate like the private sector, but health care decisions would be driven by medical rather than budgetary needs. Today's reality is that most veterans are still restricted in their use of VA. Under the terms of the GI Bill of Health, every veteran would have the option of choosing VHA to meet their family's medical needs.

Obviously, the GI Bill of Health could not be fully implemented overnight. The American Legion recommends phasing in the GI Bill of Health by pilot testing the program in a number of VISNs before the concepts are implemented system wide. Representative Gerald Solomon (NY) introduced H.R. 335 creating a Commission on the Future of America's Veterans to develop and implement changes in the current system based on proposals, such as recommended by the GI Bill of Health. No actions can be implemented by the Commission without the final approval of Congress. In effect, the GI Bill of Health asks Congress to let VA help itself through visionary leadership.

The final question: If we build such a network, will veterans choose VA? The American Legion believes the answer is a resounding **YES**!

A study presented by several physicians at the VA medical center in San Francisco, CA, to the Society of General Internal Medicine in May 1996, compared reported preventive health care services received by male veterans and their spouses and measured whether spouses would choose to receive their medical care through VA.

The study surveyed 230 randomly selected married male veterans and mailed self-administered questionnaires to be completed by them and their spouses. 170 (74%) of eligible subjects completed the questionnaire. The mean age of the veterans and spouses was 74 and 67 years, respectively. Veterans reported significantly higher rates of receipt of recommended preventive services than their spouses in all five areas assessed, including blood pressure measurement; influenza, pneumococcal, and tetanus vaccination; and serum cholesterol measurement. Veterans were significantly more satisfied with their current health care than their spouses. Finally, 83% of spouses reported that they would choose to receive their medical care at VA if allowed to do so. These findings suggest that spouses of male veterans represent a sizable group that could be incorporated into the VA system, especially given their strong desire to do so.

The authors of the study concluded, "Our data suggests that wives of male veterans may represent a population with somewhat less access to care and lower rates of screening than their veteran husbands. Given the VA system's need to integrate itself more fully into the American health care system, these spouses may represent a sizable group that could be incorporated into this system, especially given the population's strong willingness to do so. As the largest health care provider in the United States adapts to the rapidly changing health care environment, further studies are needed to better define the optimal role of the VA in providing care to veterans and their dependents."

Mr. Chairman, this study supports the recommendation of the GI Bill of Health to create a premium-based VA health plan for certain eligible veterans and their qualified dependents. The American Legion believes it is too important to the future of the VHA not to conduct a pilot demonstration of the GI Bill of Health.

The current VA health care system is inaccessible to over twenty million veterans, who equally served this nation, but by the grace of God were not injured or wounded. The assertion that "some gave all and all gave some" is justification enough to create a national veterans health care network.

Mr. Chairman, that concludes this statement.

STATEMENT OF

ROBERT CARBONNEAU, EXECUTIVE DIRECTOR, AMVETS

CHAIRMAN OF THE FISCAL YEAR 1999

INDEPENDENT BUDGET POLICY COUNCIL

BEFORE THE

SUBCOMMITTEE ON HEALTH

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE FUTURE OF THE VA HEALTH CARE SYSTEM

JUNE 17, 1998

Mr. Chairman and members of the Subcommittee, I am Robert Carbonneau, Executive Director of AMVETS. I am pleased to be here today as Chairman of the fiscal year (FY) 1999 Independent Budget (IB) Policy Council representing the authors of the Independent Budget: AMVETS, Disabled American Veterans, Paralyzed Veterans of American and Veterans of Foreign Wars. For the past 12 years, our organizations have published yearly in-depth analysis of the budget needs of veterans programs, benefits and services. Through this collaboration, we also present updates and policy recommendations on a wide range of issues affecting the present and future course of veterans programs.

The subject of this hearing is the "Future of the Department of Veterans Affairs' (VA) Health Care System." This is an issue of intense interest for our organizations. Hundreds of pages have been dedicated in previous Independent Budgets attempting to foresee the future of VA health care. Along with our proposing and prognosticating, the federal government and VA, itself have spent tens of millions of dollars on studies and

commissions. The product of this process, designing a blueprint for the future, has suffered from a lack of implementation, or worse, only partial implementation, or been eclipsed by rapidly changing political or budgetary forces. In fact, it is the politics surrounding the operation of the VA health care system, coming from either the Administration, the Congress, or the VA itself that steers the course of where VA is from one year to the next. From this standpoint, strategic planning is regularly overtaken by tactical events.

For instance, the Independent Budget, in practically every year of publication, has endorsed the concept of giving VA the authority to collect and retain third party reimbursement from veterans' insurance companies to cover the cost of care for non-service connected disabilities. Allowing VA to keep third party reimbursement was finally approved two years ago. But the original proposal, designed to give VA a much-needed "alternative funding mechanism" was short-circuited. The Office of Management and Budget, along with congressional budget and appropriations policy makers saw the proposal as a way, not to enhance VA funding as we had intended, but to offset needed routine increases in the federal appropriation to support VA health care. Even worse, with the VA health care appropriation frozen under the terms of last-year's balance budget agreement, VA is also failing to meet its overly optimistic third-party collection totals, falling ever shorter of needed funding. This is a classic example of what started out as a grand idea having been twisted and only partially implemented as intended. In the end, the third-party reimbursement concept acts not so much with the best interest of the veteran patient in mind, as to meet some otherwise overreaching political or budgetary goal completely irrelevant to the needs of veterans.

In the same vein, the Independent Budget, for years, had called on the Congress to reform and standardize VA health care eligibility. The old "balkanized" eligibility rules designating which veteran got what care, and when, and why, were both inefficient and embarrassing in light of the reforms sweeping the rest of the nation's health infrastructure. Eligibility reform, came our way too, but again, only partly as originally intended. There was a price to pay here as well. The political incentive was clear: to

limit the number of people who could receive VA health care by promising full services to those who could get into the VA. Then, as a trade off, drawing a line in the sand showing who could not. Again, the appropriation was capped, third party reimbursement falling short, and the newest wrinkle arose, "enrollment." Enrollment was never part of our recommendations for eligibility reform. But it came as the political trade-off to enforce the policy that only so many veterans could get into a VA hospital as there were dollars to provide that care.

In these instances, what started out as a grand plan for reform, was greatly influenced by changing political winds and budget trends. They have not ended up exactly where we thought they would. The lesson learned from these two policy changes alone is that both the veterans service organizations and the Congress should be very careful in promoting any new grand schemes for change within the system. At a minimum, we need to see where the changes we have already made bring us over the next few years before we take additional steps to reform.

Seeing the future of the VA health care system is nearly impossible. We don't even know what the present has in store on many different fronts. Dr. Kizer's plan for a decentralized VA with 22 Veterans Integrated Service Networks (VISNs) is still in its growing stages. Instead of one VA health care system, VA, with the individual authority given VISN directors, is on the road to devising 22 different systems. Dr. Kizer has said that without additional funding sources, the VA soon would "hit the wall." As that happens, or if it begins to happen, different VISNs could respond differently to shrinking resources with different impact of the quality or quantity of health care provided in their service areas. These reactions could bring on great variation in where and how and to whom VA health care is provided.

The biggest question mark facing the short term is the unknown impact of enrollment. Scheduled for completion in just three months (October 1, 1998) the enrollment process places an entirely new dynamic in the provision of veterans health care. Facing the continuing budget crunch, no one is really quite certain how many veterans will be

enrolled and how far down the enrollment hierarchy ladder individual medical facilities will be able to go before veterans are literally turned away from the system. Likewise facing the crunch, no one is sure what reaction this will bring from the veterans community and what potential action this will bring on the part of the VA.

Capped budgets and limited enrollment certainly bring enormous pressures to find solutions. The Congress unfortunately has spoken. While billions of dollars are being made available for other federal programs, the Congress has greatly restricted additional appropriated dollars to support the VA health care system. Third-party reimbursement has reached its limits, Medicare reimbursement, if enacted in its present forms would not bring substantial additional resources into the system, at least for the time being. In response, VA managers have been told to seek efficiencies wherever they can, through contracting, downsizing, and shifting services from expensive inpatient specialty services to more cost-effective outpatient and primary care venues. The Independent Budget has long-supported this drive to efficiencies. However, we never envisioned such shifting of services being done in such a severe budget climate, and certainly could not envision what impact this would actually have on the VA's traditional mission in caring for the specialized needs of the veteran population. This process is producing disturbing trends showing degradation of VA inpatient mission in its specialized services such as spinal cord injury and long term care to name just two.

Likewise, in response, VA managers have been given the authority to go and seek their own sources of income, parlaying existing resources and assets through contracts or sharing agreements to acquire additional sources of income. Certainly, the Independent Budget has supported innovation through contracting, where necessary, and sharing agreements that can be proved beneficial to both sharing partners, whether the partner is in the private sector, such as an affiliated medical school, or a federal partnership such as the Department of Defense. Linkages with private and public sector entities enhance quality of care in VA by tapping a broader pool of physician and staff expertise, optimizing the use of medical resources and fostering communication among entities with similar missions. But we have supported sharing with the strong proviso that in all

instances the care of the veteran patient always comes first. Sharing agreements, particularly involving VA care for non-veterans must in no way displace veterans seeking care. The sharing agreement must also be of clear financial benefit to the VA health care system.

We are concerned that fiscal priorities are driving managers to enter into sharing agreements solely for the dollars generated and not the benefit to the veteran patient can be dangerous. Such a situation, without adequate means of monitoring and accountability could very well lead to abuse, whereby the VA admits and treats the 'reimbursable" non-veteran at the expense of the veteran whose cost of care is covered by an ever-shrinking capitated dollar. In many instance, particularly with regard to the specialized services, VA does not have the data or monitoring ability to identify what capacity they have now to treat veteran patients – let alone, what excess capacity they might have to share.

The main point of this statement, Mr. Chairman, is that innovation is not wrong. But innovation for the wrong reasons, simply to shore up flagging budgets or replace the federal government's responsibility to provide health care for veterans can be dangerous. From the track record we have seen in recent years, good ideas and good intentions in designing innovation in VA health care funding and services have not always turned out the way they were originally intended. The best-laid plans designed to solve one problem, without careful intentions and persistent monitoring, can easily turn out to create two or three more unintended problems.

There are still 26 million veterans in the United States today. Despite what some say that the needs of the population are declining as veterans' numbers dwindle, the majority of that population is just now reaching their lifetime highpoint need of health care utilization. Over the years, even with all its faults, the VA health care system was designed to meet the specialized needs of this patient population. It was not designed to be all things for all veterans and all things for all non-veterans at the same time. The system is in a serious period of transition. It is impossible at this point to judge what the

future holds when we aren't even certain of the impact of changes in policy that will happen tomorrow or three months from now. The solution, based on past history, is to be as judicious in the changes we allow to happen which could steer VA away from its primary mission, and to be as vigilant as possible to see that the system stays on course.

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Statement of

VIETNAM VETERANS OF AMERICA

Presented by

William Warfield
Deputy Director of Government Relations

To the

House Veterans' Affairs Subcommittee on Health

Regarding

The Future of VA Health Care

June 17, 1998

Introduction

Chairman Stearns, Ranking Member Gutierrez, and members of the subcommittee, Vietnam Veterans of America (VVA) is pleased to have an opportunity to present testimony regarding our vision for the future of VA health care. It is appropriate and timely for the Subcommittee to hold this oversight hearing. This subcommittee has historically made great contributions to the improvement in the overall delivery and accessibility of health care for veterans. Your ongoing work to preserve this vital service is particularly important during this period time of frozen discretionary budget resources for VA.

The evolution of the VA health care system is one of the most pressing issues facing American veterans today. This is a critical time for the system designed to serve our nation's service connected disabled and lower income veterans because of the myriad of very dramatic and even revolutionary reforms underway concurrently.

VA Reforms Underway

Eligibility Reform

One of the most progressive forces for change in the right direction was the efforts made by this Subcommittee and its leadership in passage of the Veterans Health Care Eligibility Reform Act of 1996. This legislation, long supported by the veterans community, allowed VA to modernize it's medical practices by eliminating the arcane statutory barriers to outpatient care. By increasing efficiency with the shift in emphasis away from expensive inpatient modalities of care, it is hoped that VA will be able to serve more veterans.

In addition, the eligibility reform legislation contained an enrollment element designed to assist VA's new capitated budgeting processes by estimating annual workload. While there has been considerable confusion among veterans in the field about what enrollment means (as evidenced by Internet veterans forum communications), the enrollment system by and large seems to be implemented systematically and logically.

VISNs

The restructuring of VA health care from one of highly centralized command and control to a more streamlined, decentralized model has been accomplished in record time. We now have 22 separate and autonomous Veterans Integrated Service Networks (VISNs) in operation. While these changes create some advantages and efficiencies for medical care delivery, they are a double-edged sword in terms of creating quality management tools and accountability. We will address more specific concerns with the networks later in the testimony.

VERA

Another innovation, put in place with the close cooperation of Dr. Kizer and this Subcommittee, was the development of the Veterans Equitable Resource Allocation (VERA) system. The VERA method provides for a formula allocation of scarce appropriated dollar resources based upon actual workload and capacity for each network and the facilities within the network. As is true for any change of this magnitude, there has been some need to adjust and make some of the allocations more flexible.

Funding Issues

Part of the underlying premise of each of these reform measures is the principle that VA must attract more veterans to use health care facilities as "paying customers" -- bringing their insurance and copayment dollars to the VA. Fewer than ten percent of those eligible now actually utilize VA health care services. Ideally, VA would be the provider of choice for veterans who do not fit the traditional mold of VA patients; VA is attempting to attract higher income, non-service connected veterans. By design, then, the new revenue brought in by these new patients would help VA be more self-sufficient and less dependent upon the annual federal appropriation. The new revenue will supplement this base funding and improve care and services for all veterans.

VVA has concerns, however about VA's capacity and ability to efficiently collect third party payments from private health-insurance providers. The VA's goal of having as much as 10 percent of the annual medical budget collected through MCCF seems very ambitious. When VA's retention of third-party collections was included in eligibility reform, the veterans community was cautiously optimistic. We remain concerned that there will be efforts to substitute these collections for appropriated dollars, as proposed in the President's budget, and we urge this Committee to be vigilant on this point.

VA's budgetary priories are, in theory, reasonable. Setting a goal to lower overall medical costs by 30 percent, expand new patients by 20 percent, and achieve an increase in non-appropriated funding of ten percent looks great on paper. However, tracking and monitoring by the GAO and congressional committee staff, reveal some serious deficiencies in quality of care, and patient satisfaction measurements. This is especially true in some areas of the "special needs" or uniquely veteran treatment programs such as PTSD, serious mental illness, homeless and substance abuse programs.

In general terms, we agree with the policy sea change that has shifted VA from being a hospital bed system to a managed health-care system, with emphasis on primary and outpatient treatments. However, we need to strongly express our concern that there must be a viable transition before most if not all inpatient services are eliminated that address special needs populations. The ultimate and historic responsibility of providing heath-care for veterans who served America must not be substituted for the private- or state-run health insurance system, but shall remain a federal VA responsibility.

Medicare Subvention

Another funding issue which is particularly timely is that of Medicare Subvention proposals. VVA remains a strong advocate for the enactment of realistic and effective legislation which will permit VA to accept Medicare-eligible veterans for treatment and to receive reimbursement payments. We are supportive of legislation which was approved last year by this Subcommittee (H.R. 1362), as well as legislation pending in the Senate.

Knowing that the Committee has worked very hard with your counterparts on the Ways & Means Committee to pass legislation on this very subject, VVA commends the members and staff of this Committee for your tenacity. While VVA continues to have some concerns about the compromise provisions that were adopted by the Ways & Means Committee, we agree that this is a very important issue which must be pursued. We are hopeful that a workable bill will be adopted by Congress yet in this session.

Upon passage of Medicare Subvention legislation, VVA does insist that protections be incorporated into the authorizing legislation to ensure that Congress does not subsequently reduce the veterans discretionary health-care budget with any collection offsets. This is certainly not the objective of Medicare Subvention legislation and the Veterans' Affairs Committees and the entire veterans community will need to be vigilant in ensuring an ongoing commitment to adequate VA baseline funding.

Consumer Input & Accountability

Consumer input and oversight must be available to VSOs and veterans in the local communities. The experience of VVA members across the country with the VISN Management Assistance Councils (MACs) has been inconsistent and often less than satisfactory. The MACs are designed to be a management tool, incorporating the advice and counsel of primary stakeholders into VISN and facility-level decision making. The broad VSO support for original VISN reorganization plan and as well for Dr. Kizer`s policy guidelines set forth "Vision for Change" and "Journey of Change" was based in part on the expectation of real input into the process through the MACs. Unfortunately the actual MAC process has become fragmented and piecemeal.

It is important that VA central office provide better policy guidance to each network manger on how the MACs should be made to work better. We agree with Dr. Kizer that the Washington headquarters should not micro-manage the day to day operations of VISNs. However, it is not a good management practice to delegate all operations without having a valid system of maintaining accountability.

Additionally, there seems to be no workable management information system in place at the national level which can provide even basic information on services, policies or changes in each VISN at any given point in time. Under these adverse circumstances, both VA`s top management and

Congress -- who has the ultimate responsibility to the taxpayers -- are left in the dark.

VVA very much agrees with the observation made by the Assistant Inspector for Health Care Inspections during the March 19 oversight hearing before this Subcommittee. It bears repeating that, "VHA's decentralized management structure has, in some cases, resulted in a fragmentation of knowledge. This appears to have inhibited senior field managers' ability to apply lessons learned and best practices gained in areas other than their own. Furthermore there is no single entity or database that can provide information about all quality-related issues or data. VHA may need to benchmark itself in this area with other large health-care delivery systems."

Absent such critical information management, Congress and stakeholders responsible for oversight of the VHA will experience ongoing and severe quality and service problems of a recurring nature. VVA will continue to work closely with Dr. Kizer and with this Subcommittee to assure that VISNs are adhering to necessary standards of quality and concern for patients under the laws established by Congress.

Care for Tobacco-Related Illnesses

As you know, VVA was adamantly opposed to the provision in the recently passed transportation bill which diverted $15.4 billion in savings from abolishing tobacco-related illnesses compensation. While the legislative language did not deal specifically with health care benefits, it will have the very real effect of denying VA health care services to veterans who do not otherwise have a service-connected disability.

There are at least two bills pending in the House which would restore the VA health care access to veterans who are effected by this new law. VVA agrees with the intent of this legislation to ensure that no veteran falls through the cracks and is denied health care benefits for conditions which we continue to believe are service-connected. However, care should be exercised in the consideration of these bills to ensure that no other veterans are adversely effected. For example, giving veterans with tobacco-related illnesses higher priority for health care without a corresponding increase in VHA funding will have the adverse consequence of squeezing more currently eligible veterans out of the system.

VA's Future Veterans Patientbase

According to a recent GAO report, "VA Hospitals Issues and Challenges for the Future," (April, 1998), if current trends continue, 60 percent or more of community hospitals and over 80 percent of VA hospital beds may not be needed in the next 15 years. VA's strategic planning to adjust to the demographic changes in the veteran patient population is based upon attracting new users and establishing more community-based outpatient clinics mainly at sites remote from VA hospitals. GAO further noted some reservations about whether this plan may or may not work,

indicating that VA may also be forced to consider opening medical treatment services to non-veteran patients.

Of course this prophecy is predicated on the shaky assumption that the U.S. will not become engaged in a war with combat conditions creating significant numbers of wounded troops in need of longer term hospital-based care. Is there any VA or Congressional contingency plan in place for such emergencies? Or will we only react again after the next Pearl Harbor hits us?

VVA believes that the approach which uses over simplified data to explain the reduced demand for VA hospitals misses some of the key factors contributing to VA usage trends. Yes, the veteran population has been declining since 1980, and by 2010 is expected to total about 20 million veterans -- roughly one-third less than in 1980. But another factor contributing to reduced VA patientbase is the expansion of Medicare, which has led older veterans (age 65 and older) to use VA less. According to GAO, elderly veterans use of VA hospitals dropped by 50 percent between 1975 and 1996.

One important way for VA to grow was granted when Congress passed the Veterans Health Care Eligibility Reform Act of 1996. This important modernization tool removed most of the archaic restrictions on VA's ability to buy and sell services to the private sector. This has permitted VA's health-care networks to expand sharing among facilities, the Department of Defense and other community health-care providers. VA needs to market what it does best and eliminate unused capacity and duplication and waste.

Geriatrics and extended care services, for example, is one area where VA excels. By 2010, more than 42 percent of the veteran population -- some 9 million veterans -- will be age 65 or older and require assistance for everyday living activities. This is an important opportunity for VA to expand adult day care and other senior services. Also, the number and percent of female veterans are increasing; by the year 2010, 6.4 percent of all veterans (about 1.3 million) will be female. VA must become more efficient and adept at providing effective health care to female veterans.

Certainly changing demographics of the veteran population will dictate a changed menu of services VA should be providing. But to assume, as some have, that VA will simply cease to be needed as the veteran population dwindles is a far cry from what VVA believes is appropriate and effective public policy. Veterans with special health care needs are and will continue to be a federal responsibility. At the risk of sounding melodramatic, we are adamant in the belief that to shirk this federal commitment would undermine the very premise of our nation's all-volunteer national defense.

Other Challenges

National Prescription Formulary

VVA continues to hear numerous complaints from veteran-patients and medical practitioners

about problems with the VA prescription formulary. The issue is the medical determination, versus a budgetary determination, of what prescription medications are best for the individual patient. In some cases, it has been reported that for cost savings purposes the doctor's judgment is being second guessed and even ignored by druggists through the VA National Formulary process. Pharmacists sometimes change the patient's medication to a formulary-approved prescription without any consultation with the physician.

The most recent examples brought to our attention are cases where Hepatitis C virus was confirmed as a diagnosis, but the drugs of choice as prescribed by the treating physician (Alpha Interferon and/or Respirol) were denied by the formulary. These and many other cases are far too numerous to mention in detail, but an investigative and oversight hearing by this subcommittee are very much needed.

VA has developed its formulary based upon its own therapeutic categories, lumping medicines into groups based upon its own assessment of which drugs offer similar options for treating a condition. It does not take into account the standard for determining which drugs may be safely interchanged and ignores the Food and Drug Administration's therapeutic equivalence rating.

VVA recommends support a moratorium on the VA National Formulary pending the completion of an independent assessment; we understand language is included in the FY 1999 Senate VA/HUD Appropriations bill prohibiting funding for the formulary. We recognize that these type of problems exist in the private sector, as well, as evidenced by similar reports and complaints directed at managed care institutions and insurance companies. This is a very complex issue and we urge this Subcommittee to collaborate with your colleagues on other committees with jurisdiction over health care matters to investigate this situation.

Hepatitis C

New information indicates that large and disproportionate numbers of veterans are carriers of the Hepatitis C virus, particularly Vietnam veterans. This is because veterans were exposed to the disease in the combat theater (it is indigenous to the Southeast Asia region), and because veterans were exposed to contaminated blood and blood products at higher rates than civilians as a result of war time wounds and other risks in combat.

Until the early 1990s, the U.S. blood supply was not screened or tested for the Hepatitis C virus. This condition, which is treatable but not curable at this time, often has a latency period of 20 years or longer, and is life threatening when left untreated. VVA strongly advocates that VA should be required to routinely conduct blood screening for Hepatitis C of all veteran patients. VA does not perform this simple and inexpensive blood test at present. Screening and early treatment is far less expensive than providing care for the full-blown condition.

VVA recommends that the subcommittee investigate this infectious condition which may have as many as one million veterans now asymptomatic and undiagnosed. Furthermore, the Armed

Services Committees should be involved or apprised of the issue because DOD also does not currently screen for the condition during veterans' exit physicals. We appreciate the Subcommittee's commitment to hold hearing on this subject this summer.

Prostate Cancer

VA does not presently do any routine blood screening of male veterans for prostrate cancer, though this condition is on the presumptive service-connection list for Vietnam veterans exposed to Agent Orange/Dioxin. Early detection of this disease has proven to be the most effective and least costly way to treat it. We believe that VA should be required, similar to the position we advocate regarding Hepatitis C screening, to implement a routine Prostate Cancer screening program without delay.

Emphasis on Prevention and Wellness

VA needs to expand and put greater emphasis on "prevention and wellness" programs. Certainly this is one of the stated objectives in many of the reform efforts currently underway. But it should be more aggressively pursued, both in the interest of improved quality of life for VA's veteran patients and as a cost-efficiency goal.

As medical technologies have advanced, the burden of disease has shifted from acute episodes of illness, such as infections, to chronic diseases like arthritis, heart disease, and diabetes. Chronic disease is now the leading cause of disability. An estimated 35 million Americans suffer from some chronic disability. Arthritis, for example is the nation's most common disabling condition and costs the United States more than $54 billion per year. Fifty-two percent of severely and chronically disabled people are over age 65.

The benefits of lifestyle interventions in modifying risk factors in the elderly and near elderly, such as depression screening, exercise, good nutrition, and smoking and alcohol use cessation programs, are familiar to VA. These have demonstrated an opportunity to improve quality of life, reduce treatment costs, and lower rates of chronic disabilities. The contemporary VA is recognized for medical expertise in research and treatment for gerontological conditions. Because of its uniquely aging and disabled patient population, VA must be a leader in implementing this prevention/wellness philosophy of medical care. A main goal for the direction or redirection of the VA should be that of disability prevention in order to maximize an individual's functioning, well-being and quality of life, while achieving optimum care and cost outcomes.

We find it ironic that VA, with so much potential for wellness and prevention medical practice, frequently must be almost forced to take the lead in advancing its research capacity in these and many other areas. We recommend that the Subcommittee help to guide VA in taking action in these life saving and least costly wellness and prevention measures.

Chronic Care Management

VA is also moving forward in recognition that the effective treatment of chronic diseases is largely shifting from interventions aimed at cures, to providing care with the goal of limiting disease progression. This too, is an area where VA can be a leader within the medical community because of its expertise and research initiatives which spawn from the unique characteristics of its patient population.

Health care in the United States is changing , and VA health care is no different. In the past the biggest concern for most patients and providers was acute care focused on curing the disease or fixing this injury then moving on to the next problem. Today the biggest concern facing health care patients and providers is chronic care.

Individuals often have more than one chronic condition. For example, of the 20 million people aged 65 and over who have arthritis, 16 percent also have heart disease, 48 percent also have hypertension, 11 percent have cancer, and 11 percent have diabetes. Chronic diseases account for approximately 80% of all deaths and 90% of all morbidity (Goldsmith, 1990); thirty-five million are affected. An estimated 11.3 million people in the U.S. over age 21 have a severe and chronic physical and or mental impairment that limits their ability to live independently (Center for Vulnerable Populations, 1994). The seven most prevalent chronic conditions in the non-institutionalized civilian population are: chronic sinusitis -- 32.2 million; deformities or orthopedic impairments -- 31.8 million; arthritis -- 31.2 million; high blood pressure -- 28.9 million; hay fever or allergic rhinitis without asthma -- 22.3 million; deafness -- 21.2 million; heart disease -- 19.5 million (Collins 1993).

Dramatic growth in the number of persons with chronic illness is expected. More than four of five people aged 65 and older have at least one chronic condition. Between 1990 and 2030, the number of older people is projected to rise from 31.6 million (about 13% of the total U.S. population) to over 65 million (about 23% of the population). But people of all ages experience high rates of chronic illness as well: asthma and chronic bronchitis, as well as dermatitis for those under age 18; high blood pressure and migraine headaches in the age 18 to 24 group; deafness and orthopedic impairments in the 45 to 64 age groups.

Research is increasingly showing the benefits of a disability prevention focus. For instance, in a recent study of 100 frail elderly nursing home residents who participated in exercise training over a ten week period, even among the very frail elderly, "high intensity resistance exercise (including cardiovascular and weight training) is a feasible and effective means of counteracting muscle weakness and physical frailty" (Fiatrone, 1994).

VA is making some changes and adjustments to accommodate to the changes in health care needs, through research and treatment applications. Even greater changes are needed in the way chronic care services are organized, delivered and funded.

Vet Center Program

VVA would be derelict in our responsibilities to our members if we did not use this opportunity to detail our commitment to the Vet Center program and how these services fit into the VA health care system. We believe that one of the best models for the design of user-friendly VA health-care services is the 206 vet centers. Nationwide, vet centers are expanding their patient workload as a result of changes in the provision of inpatient and other hospital-based PTSD and substance abuse treatments. From 1997 to 1998, patient visits nationwide increased from 728,958 to 767,000. In 1999 VA forecasts at least a growth rate to 774,000.

This community-based program has proven to be effective in treatment and outreach for PTSD and many other illness at a very low cost per patient. VVA advocates increased coordination between the Vet Centers and mainstream VA health-care programs to create additional points of VA outpatient access, with the caveat that the Vet Centers mission, clinical integrity, and line authority should remain separate and autonomous from the VISNs.

The Vet Centers are important tools for VHA to use in the improvement and parity treatment for mental health, particularly as inpatient programs continue to be reduced. This is particularly true for the homeless veteran population, which faces even more difficult challenges in accessing appropriate comprehensive care for their very complicated medical, mental health and socialization problems. The vet centers are no less important than are the expanded VA community-based outreach clinics for physical health of veterans. In general, vet centers are under funded and under staffed by any objective measurement criteria. And, like most other VA programs, annual appropriated funds are in reality in decline in an environment of flat-line budgets.

Conclusion

The VA health care system, for several years now, has been in a significant state of flux. This Subcommittee has done a great deal of work in assessing usage trends and demographic information about the veterans population. And certainly the ebb and flow of budgetary constraints are a major influencing factor. Representatives of the VSOs probably sound like broken records in noting repeatedly over the last few years that the evolution of the VA health-care system continues to be one of the foremost concerns of average veterans, and one of the most critical issues facing the veterans community.

One thing VVA always attempts to keep in mind is the fact that these often revolutionary changes are not operating in a vacuum. In addition, the broader health care environment in which the VA system operates is an incredibly complex and ever changing dynamic. Many of the "managed care" oriented reforms and challenges we have discussed above are ongoing challenges to private sector health care providers and insurers too. And VA is largely behind the curve in implementing many of these reform initiatives. Being behind the curve is not necessarily a disadvantage for VA, though. VA can and should use the lag-time to learn from and avoid the strategic planning mistakes and implementation pitfalls made by the private sector in attempting to implement "managed care" reforms.

We should be clear in noting that VVA is not opposed in any fashion to "managed care" modalities and techniques. We simply believe that the VA should be perhaps even more careful than the private sector in implementing these reforms, because of the very unique mission VA carries out on behalf of our federal government in caring for disabled and needy veterans. And also, VA faces a more delicate situation of public scrutiny than does any other medical care provider in this country.

Eligibility reform and the shift toward outpatient care, the enrollment system and more aggressive third-party collections, decentralizing of decision-making to the Veterans Integrated Service Networks (VISNs), and budget allocations through the Veterans Equitable Resource Allocation (VERA) program are each mammoth reforms. Taken together, this transition is very rapid and widespread and does pose dangers of service disruption -- or, at the very least, there is the danger of perceived service disruption and quality disintegration.

On the whole, VVA feels that VA health care is evolving in an appropriate direction. We understand that facility missions may be realigned or even abolished as the system evolves to a more outpatient emphasis. Care may be provided more and more in a larger number of small clinics, rather than large medical centers, or even through contract or sharing arrangements with DOD or private-sector providers. The infrastructure is less important than the actual services provided. So long as services -- especially specialized services for service-connected disabled and lower-income veterans -- are maintained and protected, there should be minimal complaints. In fact, it seems to be elected officials who have more difficulty with reductions in identifiable infrastructure than those within the veterans community.

VVA firmly believes that the challenges of reform and the problems of quality that currently exist are not unique to the VA. But the unique mission and the federal commitment to ensure the best possible health care to VA's patientbase is unique. In planning for the future of the VA health care system, Congress, the VA and the veterans community have distinctive responsibilities in deliberating these issues and evaluating the status quo and all reform options. VVA looks forward to continuing to work with this Subcommittee and the larger Veterans' Affairs Committees on the multitude of concerns surrounding the transitions in the provision of veterans health care.

This concludes our formal statement. We would be pleased to respond to any questions the Subcommittee may have regarding VVA's positions on these issues.

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Bill Warfield received his B.S. degree in Economics from the University of Maryland. And served honorably for four years in the United States Air Force . He resides in Rockville, Maryland , with his wife Ellen . The Warfield`s have two daughters Abbie and Amy and six grand children.

United States General Accounting Office

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Testimony

Before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

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VETERANS' HEALTH CARE

Challenges Facing VA's Evolving Role in Serving Veterans

Statement of Stephen P. Backhus, Director
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Health, Education, and Human Services Division

GAO/T-HEHS-98-194

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the future health care role of the Department of Veterans Affairs (VA). VA operates one of our nation's largest health care systems, including 400 service delivery locations, 3,000 buildings, and 183,000 employees. This year, VA will serve about 2.7 million of the nation's 26 million veterans, at a cost of $19 billion.

The United States has a long tradition of providing health care to veterans injured in military service. Over the last 75 years, however, this health care role has evolved from rehabilitating disabled wartime veterans to also providing a health care safety net for peacetime veterans. Today VA is positioning itself as a competitive health care alternative for all veterans. More specifically, 3 years ago, VA began to transform its health care system, in response to market changes and budgetary pressures, to make it more competitive with other health care providers. To aid this transformation, the Congress provided new revenue sources and reformed veterans' eligibility for care and VA's ability to purchase services from other providers.

My comments this morning will focus on how VA's system transformation is progressing and what challenges VA faces as its role evolves. The information we are providing is based on a series of studies we conducted over the past several years to identify ways to improve the efficiency and effectiveness of VA's health care system. We have also examined the relationships between VA's health care role and that of other public and private health benefits programs, including the effects changes in those programs could have on VA health care. During the course of our work, we visited dozens of VA medical facilities, spoke with hundreds of administrative and medical staff, and spoke with many veterans and veterans service organizations. (See Related GAO Products listed at the end of this statement.)

In summary, VA has made progress in transforming its health care system to compete more effectively with other health care providers in order to become veterans' provider of choice. For example, VA has created 22 service delivery networks, which have made hundreds of restructuring decisions, including consolidating administrative and clinical services, shifting care from inpatient to outpatient or residential settings, and purchasing care from other providers. These initiatives have enabled VA to avoid over $1 billion in unnecessary expenses–savings that have provided critical financing needed to further improve the system's overall accessibility and quality of care. In addition, the networks are planning to develop and implement additional efficiency initiatives over the next 5 years.

But VA faces several challenges before completing its transformation. Of these, VA's decisions concerning existing infrastructure may be the most significant and contentious. For example, VA has spent hundreds of millions of dollars over the last decade constructing and renovating inpatient capacity. Some of this capacity is no longer needed because of its decreasing reliance on inpatient services. Meanwhile, VA continues to serve veterans in other locations, using aged and deteriorating buildings that will require billions of additional dollars to renovate or replace. VA's decisions to consolidate inpatient medical care at fewer locations are complicated by such challenges as VA's long-standing relationships with universities' medical schools for education and research, and with the Department of Defense (DOD) for contingency medical support.

In our view, VA's future success in fulfilling its health care role, as envisioned by recent eligibility reforms, depends in large part on its ability to transform its current delivery infrastructure into an integrated system of VA and private sector providers, which may be more attractive to new users, especially those already insured, who could provide VA with an additional source of revenue. VA's strategy also suggests that it will ultimately purchase much more health care from private sector providers than it does now and deliver care using its existing infrastructure only in those geographic areas

where a private sector alternative is not reasonably available or where VA is the acknowledged leader.

VA's success also will depend on its ability to overcome several management and implementation challenges. These challenges include designing an enrollment system, establishing new provider networks, developing and awarding potentially complex health care service contracts, improving collections from other health insurance that veterans and others have, and developing systems sufficient to capture critical cost, access, and quality information for managing and evaluating system performance. If, as some have suggested, VA's competitive role is expanded to include not only the current veteran population but also veterans' spouses and dependents, the challenges facing VA will be even greater. For example, VA would have to either provide or arrange care for populations and medical conditions that it has little experience dealing with, such as pediatric or maternity care.

It is essential that VA address these infrastructure and other management challenges. If VA is ultimately unable to overcome these challenges, it is conceivable that VA could have to limit enrollment among lower-income veterans.[1] This could include those with the greatest need, because they have no other health care alternatives.

BACKGROUND

At end of the first world war, the federal role of providing health care to veterans was to treat war-related injuries and help rehabilitate veterans with service-connected disabilities. Over time, VA became a national leader in rehabilitative medicine, including treatment of the lingering effects of war-related injuries. Today, of the 2.2 million veterans who have service-connected disabilities, less than half--about 1 million--use VA's health care system.

VA's federal role was expanded in 1924 to include a safety net function partly because of declining use by veterans with service-connected disabilities and limited public and private insurance coverage available to veterans with lower incomes. VA provided hospital care for the nonservice-connected conditions of wartime veterans who lacked the resources to pay for their care. In 1973, this safety net function was expanded to include hospital care for peacetime veterans unable to defray the cost of care. Today, an estimated 7 million veterans have lower incomes, including about 1.4 million who use VA's system.

In 1986, the federal role expanded once again to offer a competitive health care alternative for higher-income veterans. These veterans, however, are required to make copayments for their health care, which over time has come to include a comprehensive array of inpatient and outpatient services to address veterans' overall health care needs. VA currently serves approximately 140,000 of approximately 16 million higher-income veterans.

Overall, VA serves 10 percent of the total veteran population of 26 million, with the other 90 percent receiving their health care through private or employer health plans or other public programs. The nation's veteran population is expected to decline significantly in the future. VA estimates that the veteran population will drop to 16 million in 2020.

VA's health care system has grown from 54 locations to about 400 locations as its role evolved. By 1990, VA operated over 150 full-service medical centers that included one or more hospitals, nursing homes, domiciliaries, and outpatient clinics. VA also

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[1]Lower-income veterans are those whose incomes fall below a statutory threshold, for example, a veteran with no dependents with an income less than $21,611. Income thresholds are higher for veterans with dependents.

operated numerous freestanding outpatient facilities, including some that provide primary and specialty care and others (the majority) that provide primary care only.

In the early 1990s, VA recognized that its system was not adequately responding to a changing health care market, which was implementing managed care principles to avoid unnecessary inpatient services and emphasizing primary care. VA began to shift its focus from primarily inpatient hospital care to outpatient care in order to provide a more flexible, accessible, and efficient delivery of health care to veterans. In 1995, VA accelerated this transformation by realigning its facilities into 22 service delivery networks and empowering these networks to restructure the delivery of services of its medical centers.

This year, VA expects to receive over $19 billion from several sources to operate its health care system. About $18 billion represents appropriated funds for medical care, construction, administration, education, and research. VA also estimates that it will receive over $680 million from third-party insurance and earn over $100 million from the sale of excess services such as lithotripsy or CT scans to beneficiaries of DOD, medical school hospitals, or other providers.

VA'S ONGOING SYSTEMWIDE TRANSFORMATION

VA has made progress in transforming its health care delivery system away from its previous focus on inpatient care to an emphasis on outpatient care. VA's networks have implemented hundreds of restructuring initiatives involving acute-care medicine. For example, networks have integrated the management of 46 facilities in 22 locations, consolidating clinical and administrative services within or among hospitals. As a result of these and other changes, over a 4-year span VA reduced its hospital admissions by 23 percent, eliminated almost 18,000 operating beds, and reduced staffing by over 16,000 employees systemwide.

At the same time, VA has used savings from its efficiencies to finance improvements in veterans' access to and quality of care. For example, VA served an additional 80,000 veterans last year, opened or plans to open nearly 200 new community-based clinics, and created about 1,000 primary care teams. In addition, VA's indicators suggest that quality of care is improving overall, as indicated by a rise in the quality rating of ambulatory services and a drop in the number of problems reported by veterans.

VA's service delivery networks have also significantly transformed the delivery of long-term care, including nursing home and psychiatric care. For example, VA evaluates and stabilizes nursing home patients and, when appropriate, transitions them to community environments, including their own homes. Similarly, VA is shifting much of its psychiatric care from inpatient to residential settings. As a result, some VA facilities have significantly reduced the average length of stay of long-term-care patients.

CHALLENGES VA FACES AS ITS ROLE EVOLVES

With its transformation to a more competitive health care system, VA faces difficult decisions concerning its existing infrastructure, as well as other management and implementation challenges. How well VA deals with these challenges will in large part determine how successful it will be in maintaining or increasing the number of veterans served.

VA's Infrastructure Dilemma and Options

Of primary importance is VA's decision about its medical centers that encompass the largest number of buildings in its system. The condition of these buildings varies greatly. Some buildings have been recently constructed or renovated, some require major

renovation, and others are no longer needed. Ironically, some of the hospitals, which VA has recently spent millions of dollars to construct or renovate, are underutilized, while many other hospitals need expensive renovations in order to serve veterans in a manner comparable to private sector providers. In deciding what to do with its infrastructure, VA faces a fundamental question: Are the interests of veterans better served by repairing and maintaining the infrastructure through which care is provided or by spending these resources directly on patient care?

VA has several options for addressing this dilemma: These include but are not limited to (1) continuing to renovate hospitals if they will be used for another 20 years or more, (2) replacing hospitals with more efficient outpatient clinics, (3) consolidating facilities, (4) negotiating enhanced-use leases, or (5) disposing of or selling unneeded facilities.

VA has implemented such options in a limited number of locations. For example, VA closed hospitals in Sepulveda and Martinez, California, and replaced them with modern, full-service outpatient clinics that perform ambulatory surgeries as well as provide primary and specialty care. Despite initial misgivings, veterans now seem satisfied with this change. In Long Beach, VA has proposed to renovate excess inpatient space in one building in order to transfer clinical and administrative services from an older, deteriorated building and then demolish that building, thereby saving maintenance and future renovation costs.

At most locations, however, VA appears reluctant to aggressively address this infrastructure dilemma–to the detriment of veterans. For example, in Chicago, where VA has four major hospitals, we recommended that VA close one and meet veterans' needs using the other three. VA has chosen instead to have a consultant study the issue further. As a result, VA is forgoing (1) savings of about $20 million per year in maintenance and operating costs and (2) better services for veterans by not closing one of the four hospitals. VA appears to be experiencing a similar situation with hospitals in several other locations, such as Boston.

Challenges Complicating
Infrastructure Decisions

VA's decisions regarding its infrastructure are complicated by several other challenges, including ongoing transformations of VA's affiliations with medical schools, medical research activities, and DOD medical contingency activities.

Since 1946, 130 VA facilities have affiliated with 105 medical schools to provide educational opportunities for 55,000 individuals and research or employment opportunities for over 3,000 faculty and others. Currently, most VA facilities are affiliated with a single nearby medical school, making it easy for residents, students, faculty, and researchers to fulfill their obligations at both locations. VA's inpatient population provides an important focus for educational and research activities.

VA's transformation of its care from an inpatient to an outpatient focus along with its consolidation of such services in fewer hospitals is causing VA and medical schools to rethink their affiliation arrangements. It seems inevitable that a medical school will need to share inpatient educational and research opportunities with other schools at a single VA facility. Medical schools, however, seem reluctant to share at this time, which constrains VA's ability to effectively address its infrastructure dilemma.

Since 1982, VA has served as the primary medical system backup to DOD during war and to other federal organizations such as the Federal Emergency Management Agency and the National Disaster Medical System during national emergencies. During this time, however, DOD and others have made limited use of VA facilities. Currently, VA has agreed to make about 28 percent of its operating beds available to DOD within 72 hours

of notification. As with the medical school affiliations, VA's transformation is also causing VA and DOD to rethink their medical contingency arrangements, which they plan to do in earnest in the near future. Continuing a predominately bed-based (as opposed to a specialty-based) approach to fulfilling the contingency requirement may contribute to VA's infrastructure dilemma.

Many Management Challenges Lie Ahead

While VA has made progress to date in transforming its health care system, it still faces a number of difficult management challenges critical to its success in competing for increased market share. These include (1) designing a strategy, including marketing materials, for informing veterans of VA's newly transformed system, (2) establishing a system for enrolling new users, and (3) creating integrated networks of VA and non-VA providers to serve veterans.

Of these, VA's efforts to create integrated networks on a large scale appear especially challenging. These challenges include (1) deciding when, where, and what health care services to purchase; (2) developing contract specifications for health care purchases that include not only the types of care to be provided but also administrative requirements such as periodic reporting, utilization management, eligibility verification, and care coordination with VA's direct care providers; and (3) administering contracts and monitoring contractor performance.

In addition, our past work has also highlighted significant shortfalls in other areas, which VA is currently addressing. These include improving its system to recover from veterans' other health insurance plans and developing systems sufficient to capture critical cost, access, and quality information for managing and evaluating system performance.

It remains to be seen whether VA has the resident technical expertise necessary to design, build, and manage such sweeping reforms. Our evaluations and observations of DOD's experience in implementing its nationwide managed health care program, TRICARE, suggests that a significant amount of the planning, implementation, management, and evaluation tasks that VA still faces will need to be contracted out. In many respects, VA's management and oversight role will be transformed just as its provision of health care is being transformed.

As difficult as VA's currently envisioned transformation will be, the challenges will be even greater if, as some have suggested, VA's patient base is expanded to further enhance its competitiveness by including veterans' spouses and dependents and active duty military members and their spouses and dependents. Not only would the challenges associated with VA's current efforts be compounded by potentially doubling the number of eligible beneficiaries, but additional challenges would be created, such as having to either provide or arrange for care for populations and services that VA has little or no experience serving, like pediatric or maternity care.

Expanding VA's competitive role may also pose significant risks to veterans and other health care providers. For example, veterans' access may be adversely affected if VA cannot provide care to nonveteran enrollees within the revenues earned or if VA must shift appropriated funds from patient care to renovating or maintaining infrastructure needed to serve a significantly expanded patient workload. Other providers, including DOD, could also be adversely affected if VA continues to deliver care directly because new customers for VA mean fewer customers for other providers, resulting in lost revenues that could jeopardize their financial viability.

CONCLUDING OBSERVATIONS

In conclusion, Mr. Chairman, while we are encouraged by VA's progress to date and support its efforts, we realize that many uncertainties remain as to how successful VA

will ultimately be in addressing its infrastructure and other management challenges. It seems certain, however, that veterans and others will be best served by resolving these challenges sooner rather than later.

- - - - -

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Subcommittee may have.

RELATED GAO PRODUCTS

VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 1998).

VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998).

VA Health Care: Status of Efforts to Improve Efficiency and Access (GAO/HEHS-98-48, Feb. 6, 1998).

VA Medical Care: Increasing Recoveries From Private Health Insurers Will Prove Difficult (GAO/HEHS-98-4, Oct. 17, 1997).

Department of Veterans Affairs: Programmatic and Management Challenges Facing the Department (GAO/T-HEHS-97-97, Mar. 18, 1997).

VA Health Care: Issues Affecting Eligibility Reform Efforts (GAO/HEHS-96-160, Sept. 11, 1996).

Veterans' Health Care: Challenges for the Future (GAO/T-HEHS-96-172, June 27, 1996).

VA Health Care: Improving Veterans' Access Poses Financial and Mission Related Challenges (GAO/HEHS-97-7, Oct. 25, 1996).

VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs (GAO/T-HEHS-96-99, Mar. 8, 1996).

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995).

VA Health Care: Retargeting Needed to Better Meet Veterans" Changing Needs (GAO/HEHS-95-39, Apr. 21, 1995).

Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

Veterans' Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994).

(406154)

STATEMENT

OF THE

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Jordan J. Cohen, M.D., President

on

The Future of Veterans Health Care, Education, and Research

presented to the

Committee on Veterans Affairs Subcommittee on Health
United States House of Representatives
The Honorable Cliff Stearns, Chairman

334 Cannon House Office Building
Washington, DC 20515

by
Richard D. Krugman, M.D.
Dean
University of Colorado School of Medicine

Wednesday, June 17, 1998

Good morning, I am Dr. Richard D. Krugman, Dean at the University of Colorado School of Medicine. I am here today to present testimony on behalf of the Association of American Medical Colleges (AAMC). The AAMC serves as the national voice for the country's 125 medical schools, 86 professional academic societies, and nearly 400 major teaching hospitals, including over 70 Department of Veterans Affairs (VA) medical centers. Currently, 139 Veterans Health Administration (VHA) medical centers are affiliated with 107 medical schools. Each year more than 30,000 medical residents and 22,000 medical students receive a portion of their training in the VHA.

Your invitation for my testimony today asked for a vision of the future role of the VA health care mission and VA's education and research missions. As you well know, the VA's "vision for change" developed an exciting new administrative structure for responding to the industry-wide shift in the way health care is provided. Under the leadership of former Secretary Jesse Brown and Under Secretary for Health Kenneth Kizer, M.D., M.P.H., the VHA has organized its 171 medical centers into 22 regional systems known as Veterans Integrated Service Networks, or VISNs. Under each VISN umbrella, several VHA medical centers and their associated or affiliated partners work collectively to deliver health care to veterans in their region. This new structure was developed to eliminate inefficiencies and duplication of services, and to maximize the effectiveness of limited health care dollars and resources.

The VHA has a rich history and tradition of contributing to the nation's research effort and medical, nursing and other health professions education programs. The VHA's education and research missions add substantially both to the quality and accessibility of its health care mission. At the same time, both of these missions deeply involve VHA's medical school partners. The VHA plays a critical role in the education and training of health care professionals who are destined to serve the entire nation. These training opportunities make VHA the nation's single largest health workforce producer, providing financial support for ten percent of the nation's graduate medical education. In addition, the VHA's medical research initiatives have an impressive history of success and innovation and have provided major advances in medicine. For example, Dr. Tom Starzl performed the first liver transplant at the Denver, Colorado VA medical center over twenty years ago, and within the last five years the Denver VHA medical center was

instrumental in research that identified and determined that the gene responsible for filtering information in people with schizophrenia can be stimulated by nicotine.

However, the first priority of the VHA must be to provide quality health care to our nation's veterans. During the past ten years, changes in the environment of providing hospital, physician, and health care services have been occurring at breath taking speed. I believe it is fair to say that prior to the inception of the "vision for change," the VHA had not been keeping pace with major changes that were occurring in other health care provider systems. With the implementation of the "vision for change," substantial energy has been devoted to engaging all VHA facilities and programs in meeting the demands of the new environment.

In this new environment there are some VISNs where VHA leaders and their colleagues in medical schools are working relatively well together, while in others, for a variety of reasons, there has been substantial tension among those that need to work collaboratively. With change necessarily occurring so rapidly, this tension is certainly to be expected.

I believe the VHA's academic partners, especially the more than 100 medical schools currently affiliated with VHA medical centers, can play a vital role in securing a strong future for the VA health system. In capitalizing on this potential, we need to recognize the rapidity and magnitude of the changes required to implement the VISN structure successfully, and the number of new individuals recently recruited to leadership positions from outside the VA. Given these facts, it seems clear that some special care must be taken to ensure that the inevitable stresses on the long-standing and successful partnership with its medical school affiliates do not hamper achievement of either partner's missions.

During this continued transition, I cannot emphasize enough the importance of communication. I think all of us need constantly to be alert to the fact that communication is the key to clear understanding, and that if we are going to have a debate on the future role of VA's health care, education and research missions, we should debate real issues. We have worked hard in my home setting to achieve excellent communication and a collaborative approach to ensuring our

respective futures.

At the University of Colorado we have taken steps to integrate the programs and services of the VHA medical center and the University of Colorado medical center. For example, the Denver VHA medical center and the University of Colorado Hospital jointly purchased a linear accelerator. The machine was installed at the University Hospital and serves VHA patients. The resulting collaboration has avoided duplication of services, reduced costs for both institutions, and provided first class service to patients. In addition, we have taken joint tenancy of new VHA and University Hospital primary care clinics sharing a common site at the former Fitzsimmons Army Medical Center. We were experiencing a common need and found an opportunity to satisfy this need in a mutually beneficial fashion. Once again, this has been a sound financial decision for both institutions, and met the needs of the patient populations we serve. We also have been able to broker a collaboration between the Cheyenne VHA medical center and our affiliated family medicine residency program and the Area Health Education Center in Greenly, Colorado.

We have been unsuccessful thus far in one attempt to consolidate laboratories and also in an effort to complete a VHA contract with University Hospital (UH) for utilization of UH primary care clinics throughout Colorado under a capitation arrangement. These initiatives were much more complex, and there are a variety of reasons why they have not come to fruition. In the case of the primary care clinics, there were at least four major reasons for the failure that are worth noting:

- a lack of understanding by each institution of the other's requirements/restrictions;
- UH's perception that Veterans Service Organizations were concerned that veterans were being "abandoned";
- UH's perception that VHA funding would be not available beyond one year; and
- VA's prohibition from contracting with a "middle-man."

The experience purchasing equipment jointly and combining clinics, as well as the difficulties in contracting afford VHA and the University of Colorado the opportunity to evaluate the successes and problems of these joint efforts. Consequently, these efforts should prepare us well for the day

when veteran patients can use the services of the University of Colorado Health Sciences Center and non-veteran patients can use the services of the VHA medical centers

Let me return for a moment to the missions of education and research. The implications of service efficiency, cost control, and competitive prices are all challenges to these missions. While we all understand and participate in the need to change the incentives and conserve resources, we also have a responsibility to provide an environment in which research and education can flourish. In the VHA, there is a specific budget for research: $272 million in the current fiscal year. However, in the new price competitive environment, the dollars devoted to research and education in the "medical care" budget are more important than ever.

Whether the research and education missions are sustained and will flourish will be determined by the availability of time and money. This is a problem not just for the VHA; it is a problem for medical schools and all teaching settings. The VHA has an opportunity to be very specific in doing something to address the need for these resources. To attract educators and researchers, the VHA needs to maintain its reputation as an integrated service system that highly values these missions. The AAMC urges the members of this Subcommittee to be supportive of VHA leadership efforts to do so.

Before closing, let me reiterate the characteristics of the VHA medical partnerships necessary for us to achieve our respective missions. We must:

- engage in intensive, frequent and clear communication;
- develop an agenda of problems and mutual goals and objectives;
- work collaboratively to determine if there are sharing opportunities;
- be assured adequate lead time if major changes in relationships are required; and
- be assured the education and research missions are highly valued at the same time every effort is made to achieve efficiency.

The nation's medical schools will work to ensure the survival of the VHA as a comprehensive health system and an important partner in education and research: to that end, medical schools

must learn to collaborate with all other VHA hospitals and medical schools within each VISN. The AAMC will continue to work with VHA officials in Washington on national policies that affect the health of veterans and the affiliations between VHA hospitals and medical schools. Through the AAMC's VA-Deans Liaison Committee, VA leaders and AAMC leaders meet twice a year to discuss national issues that are of particular concern to the VA- medical school relationship. However, the association recognizes that decisions regarding the local administration of VHA resources are best made locally. While altering long-standing relationships and forging new collaborations is often a difficult task, we must remember that the primary purpose of affiliations between VHA hospitals and medical schools has been and always will be to provide an unsurpassable quality of health care for those who have served our country in the name of freedom.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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Jordan J. Cohen, M.D., President

June 12, 1998

Mr. John Roerty
United State House of Representatives
Committee on Veterans Affairs
338 Cannon House Office Building
Washington, DC 20515

Dear Mr. Roerty:

On behalf of the Association of American Medical Colleges (AAMC), please find the enclosed 150 copies of the AAMC's written testimony for the Wednesday, June 17, hearing on the future role of VA health care, education and research. You also will find the testimony on a 3 1/2" diskette in Microsoft Word.

Pursuant to the "truth in testimony" rule that requires all non-governmental witnesses to disclose the amount and source of any Federal grant or contract, for fiscal years 1995-97, the AAMC received $1,956,359 in Federal funding from the Agency for Health Care Policy and Research ($809,304), National Institutes of Health ($641,063), and the Health Resources and Services Administration ($505,982). Additionally, please find the enclosed curriculum vitae for the AAMC's witness, Richard D. Krugman, M.D.

Sincerely,

Jordan J. Cohen

Jordan J. Cohen, M.D.

enclosures

6/97

CURRICULUM VITAE

BIOGRAPHICAL SKETCH

Name	Richard David Krugman, M.D.
Date & Place of Birth	November 28, 1942 New York, New York
Present Position	Professor of Pediatrics University of Colorado School of Medicine
	Dean, University of Colorado School of Medicine
Present Address	237 Lead King Drive Castle Rock, Colorado 80104
Citizenship	U.S., SS# 134-34-7958
Marital Status	Married, 4 Children

EDUCATION

June 1963 B.A. Princeton University
June 1968 M.D. New York University School of Medicine

Licensure	1969 Colorado (#16768)
Board Certification	1973 American Board of Pediatrics
Military Service	Senior Surgeon 1971-1973 U.S. Public Health Service 1982-1989 Major, U.S. Army (Reserve)

ACADEMIC APPOINTMENTS

July 1968 - June 1969	Intern in Pediatrics University of Colorado School of Medicine
July 1969-July 1970	Resident in Pediatrics University of Colorado School of Medicine Denver, Colorado
July 1970-June 1971	Chief Resident Department of Pediatrics University of Colorado School of Medicine Denver. Colorado
July 1971-June 1973	Staff Associate Bureau of Biologics Food and Drug Administration U.S. Public Health Service Bethesda, Maryland
July 1971-June 1973	Clinical Instructor of Pediatrics Georgetown University Washington, D.C.
July 1973-Dec. 1977	Assistant Professor of Pediatrics University of Colorado School of Medicine Denver, Colorado
July 1973-June 1974	Program Director Pediatric Housestaff Program University of Colorado School of Medicine Denver, Colorado
July 1973-Present	Pediatric Consultant Child Protection Team Colorado General/University/ Children's Hospitals, Denver, Colorado

Aug. 1974-Dec. 1977	Director, Pediatric Group Practice University of Colorado School of Medicine Denver, Colorado
July 1975-June 1978	Director of Admissions Child Health Associate Program University of Colorado Denver, Colorado
July 1977-June 1981	Co-Director, Child Health Associate Program, University of Colorado School of Medicine Denver, Colorado
Oct. 1977-Dec. 1977	Associate Director for Medicine SEARCH/AHEC Program University of Colorado Health Sciences Center Denver. Colorado
Oct. 1977-June 1978	Director, General Pediatrics Program Department of Pediatrics University of Colorado School of Medicine Denver. Colorado
Jan. 1978-June 1988	Associate Professor of Pediatrics University of Colorado School of Medicine Denver. Colorado
Jan. 1978-Aug. 1980	Director, SEARCH Program (University of Colorado's Area Health Education Centers Program) University of Colorado School of Medicine Denver, Colorado
Sept. 1980-Aug. 1981	Robert Wood Johnson Health Policy Fellow Institute of Medicine National Academy of Sciences, Washington, D.C.

Dec. 1980-Aug. 1981	Legislative Assistant (Health), U.S. Senate, Senator Dave Durenberger (R. Minn.) Washington, D.C.
Sept. 1981-June 1990	Head, Section of Developmental, Psychosocial Pediatrics and Child Abuse University of Colorado School of Medicine Denver, Colorado
Sept. 1981-June 1992	Director, The C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect Denver, Colorado
Jan. 1985-June 1990	Vice-Chairman for Clinical Affairs Department of Pediatrics University of Colorado School of Medicine Denver, Colorado
Sept. 1986-Aug. 1987	Interim Head, Section of General Pediatrics University of Colorado School of Medicine Denver, Colorado
July 1988-Present	Professor of Pediatrics University of Colorado School of Medicine Denver, Colorado
July 1990-Feb. 1992	Acting Dean University of Colorado School of Medicine Denver, Colorado
March 1992-Present	Dean University of Colorado School of Medicine Denver, Colorado

HONORS

April 1986	AOA Lecturer Medical University of South Carolina
June 1987	AOA (Faculty Member) Election, University of Colorado
October 22, 1989	C. Henry Kempe Memorial Award for Contributions to the Field of Child Abuse and Neglect, awarded at the 8th National Conference on Child Abuse and Neglect Salt Lake City
April 1990	Distinguished Service Award. Boulder County Victim Assistance Program
March 1992	James E. Strain Community Service Award Pediatrics (Colorado Chapter AAP)
March 1992	C. Henry Kempe Award for Service to Children (The Lubchenco Perinatal Centers and the Kempe Club)
May 1992	St. Geme Award for Promoting the Mission of University of Colorado School of Medicine
May 1993	The Kempe Award, Kempe Children's Foundation
August 1993	Distinguished Child Advocacy Award. Division of Children, Youth and Families. American Psychological Association
September 1993	Special Award, SEARCH/AHEC Annual Meeting and Preceptor Conference
October 1995	Ray E. Helfer Award of American Academy of Pediatrics and National Alliance of Children's Trust Funds
May 1996	Brandt F. Steele Award

OTHER ACTIVITIES

1975-1977	Secretary, March of Dimes Task Force on Maternal and Infant Care in Rural and Isolated Areas
1975-1978	Consultant, Pediatric Cardiology Association Program Corpus Christi, Texas
1976-1977	Consultant, Headstart Program Cheyenne, Wyoming
1977-1980	Faculty Advisor Academy of Child Health Associates
1979-1985	Program Advisor, Robert Wood Johnson Foundation Rural Infant Care Program
1981-1983	Consultant Commission on Health and Welfare National PTA
1982-1984	Associate Editor Child Abuse and Neglect: The International Journal
1984-1986	Co-Editor-in-Chief Child Abuse and Neglect: The International Journal
1984-1990	Member, Board of Directors National Committee for the Prevention of Child Abuse
1985-1989	Board of Directors, Robert Wood Johnson Health Policy Fellowship Program Institute of Medicine
1985-1987	President, Colorado Council for Child Protection

1987-Present	Editor-in-Chief Child Abuse and Neglect: The International Journal
1989-1991	Chairman, U.S. Advisory Board on Child Abuse and Neglect Department of Health and Human Services
1989-1994	Member, U.S. Advisory Board on Child Abuse and Neglect Department of Health and Human Services
1993-Present	Member, Board of Denver Health and Hospitals
1994-Present	Member, Editorial Board, Academic Medicine

PROFESSIONAL SOCIETY MEMBERSHIPS

1981-1983	Council, Western Society for Pediatric Research
1982-1986	Council, Colorado Chapter, AAP
1982-1986	Council, International Society for the Prevention of Child Abuse and Neglect
1985-1988	Director, Ambulatory Pediatric Association
1985-Present	American Academy of Pediatrics
1986-Present	American Professional Society on the Abuse of Children
1988-Present	Elected, American Pediatric Society
1990-1992	President-elect, International Society for the Prevention of Child Abuse and Neglect
1990-1993	Board of Directors, American Professional Society on the Abuse of Children
1991-Present	American Medical Association

1991-Present	Colorado Medical Society
1992-1994	President, International Society for the Prevention of Child Abuse and Neglect

COMMITTEE WORK

1977-1979	Member, Academy of Pediatrics Task Force on Immunization Policy
1977-1980	Member, Selection Committee, Academy of Physician Assistant Programs
1981-1984	Member, Government Relations Committee American Academy of Pediatrics
1982-1984	Member, Advisory Council on Adolescent Health, Colorado State Health Department
1982-1985	Member, American Medical Association Child Abuse Task Force
1982-1987	Member, Public Policy Committee Ambulatory Pediatric Association
1983-1985	Member, Denver Medical Society Committee on Child Abuse and Neglect
1984-1987	Member, Governor's Task Force on Child Abuse and Neglect
1985-1991	Member, Governor's Victim Assistance Advisory Council
1985-1988	Chairman, American Academy of Pediatrics Task Force on Child Abuse and Neglect
1985-1994	Member, American Academy of Pediatrics Council on Child and Adolescent Health
1987-1988	Chairman, Public Policy Committee Ambulatory Pediatric Association

1987-1994	Chairman, American Academy of Pediatrics Committee on Child Abuse and Neglect
1988-1989	Member, Youth Protection Advisory Panel Boy Scouts of America
1989-1993	Member, Governor's First Impressions Advisory Council, State of Colorado
1992-Present	Member, Board of Directors Hasbro Foundation
1993-Present	Member. Pew/Colorado Trust Panel on Health Professions in Colorado
1993-1994	Chair, Committee on Curriculum for Domestic Violence American Medical Association
1993-1995	Member, Advisory Board for the Office of Generalist Physician Program American Association of Medical Colleges
1994-Present	Member, Advisory Board, Robert Wood Johnson Clinical Scholars Program
1994-Present	Member, Task Force on Medical School Finances Association of American Medical Colleges
1994-Present	Member, Task Force on Strategic Planning for Health Care Reform Association of American Medical Colleges

UNIVERSITY COMMITTEES

Search Committees

1978	Member, Search Committee for Dean CU School of Medicine
1983	Member. Search Committee for Chairman. Department of Family Medicine CU School of Medicine

1987	Member, Search Committee for Public Relations Director CU Health Sciences Center
1987	Member, Search Committee for Development Director CU Health Sciences Center
1994	Chair, Search Committee for Director, Colorado Area Health Education Centers System

Other Committees

1975-1977	Planning and Fiscal Policy Committee CU School of Medicine
1983-1984	Faculty Senate CU School of Medicine
1985-1989	Medical Indigency Task Force University Hospital
1985-1990	Delegate University Hospital Medical Board
1985-1987	Vice President University Physicians, Inc.
1986-1988	Member, Clinical Enrichment Committee University Hospital
1987-1988	Chair, Alternative Delivery Systems Committee University Hospital
1987-1990	Member, Joint Affiliation Committee for the University and Children's Hospital
1987-1990	Chair, Pediatric Quality Assurance Committee
1989-1990	Chair, Pediatric Department Promotions Committee

1990-Present	Member, Resource Council to the University Hospital Board of Directors
1990-Present	Member, Audit and Finance Committee University Hospital Board of Directors
1990-Present	Member, Education and Research Committee University Hospital Board of Directors
1990-Present	President, University Physicians, Inc.

PATENTS HELD

None

REVIEW AND REFEREE WORK

American Journal of Diseases of Children

Pediatrics

Clinical Pediatrics

JAMA (Journal of the American Medical Association)

Journal of Clinical and Consulting Psychology

Grant reviewer for Robert Wood Johnson Foundation, Carnegie Foundation and William T. Grant Foundation

Reviewer for Office of Technology Assessment, Congress of The United States Position Papers, 1986-1988

Grant reviewer, National Institute of Justice, 1991-present

Reviewer for National Academy of Sciences, 1993.

MAJOR SCIENTIFIC INTERESTS

General Pediatrics

Child Abuse and Neglect

Health Policy: Primary Care Education for New and Traditional Health Professionals

RESEARCH GRANTS AND OTHER MAJOR FUNDED PROGRAMS (PRINCIPAL INVESTIGATOR)

1974	Food and Drug Administration Measles Vaccine Efficacy - $1,600
1978-1981	SEARCH Program (Colorado Area Health Education Centers) - HHS Contracts - $5.089,670
1980	Robert Wood Johnson Foundation, Health Policy Fellowship - $35,000
1983-1985	Childhelp USA contract - $360,000
1983-1986	Friends of Kempe Center Support - $850,000
1984	Healthcare for School Age Children in the Next Decade, HHS, HRSA - $60.000
1986-1991	National Clinical Child Abuse and Neglect Resource Center, NCCAN, OHDS, HHS - $994,000
1986-1989	Hope for the Children Support - $1,220,000
1988	State of Iowa, Evaluation of Child Protective Services - $200,000
1989-1990	Commonwealth of Virginia - Sexual Abuse Training $150,000
1989-1991	Kempe Children's Foundation Support - $750,000
1990-1991	State of Ohio - Sexual Abuse Training - $80,000
1990-1992	Colorado Trust, Rural Training for Child Abuse Professionals - $150,000 (2 years)

BIBLIOGRAPHY

Original Papers

1. Krugman, R.D., and Goodheart, C.R.: Thermal inactivation of cytomegalovirus. Virology 23:290, 1964.

2. Gold, E., Febrier, A., Hatch, M.H., Herrman, K.L., Jones, W.L., Krugman, R.D., and Parkman, P.D.: Immune status of urban children determined by antibody measurement. NEJM 289:231, 1973.

3. Krugman, R.D., Meyer, B.D., Enterline, J.C., Parkman, P.D., Witte, J.J., and Meyer, H.M., Jr.: Impotency of live virus vaccines as a result of improper handling in clinical practice. J of Peds 85:512-514, 1974.

4. Jones, A.A., and Krugman, R.D.: The child health associate act; licensure of an allied health profession. Ethics in Science and Medicine 59:216, 1976.

5. Krugman, R.D., Hardy, G.E., Jr., Sellers, C., Parkman, P.D., Witte, J.J., Meyer, B.C., and Meyer, H.M., Jr.: Antibody persistence after primary immunization with trivalent or poliovirus vaccine. Pediatrics 60:80-82, 1977.

6. Krugman, R.D., Witte, J.J., Parkman, P.D., Herrman, K.L., Meyer, H.M., Jr., Wende, R.D., Meyer, B.C., and Dungca, R.: Combined vaccine studies: The simultaneous administration of measles-mumps-rubella trivalent oral poliovirus vaccine. Public Health Reports 92:220-222, 1977.

7. Krugman, R.D., Rosenberg, R., McIntosh, K., et al: Further attenuated live measles vaccines: The need for revised recommendations. J Pediatr 91:766, 1977.

8. Silver, H.K., Makowski, E., McAtee, P., and Krugman, R.D.: Utilization of Gyniatricians as primary care health providers for women. J Reproductive Medicine 22:157, 1979.

9. Fryer, G.E., Patrick, D., and Krugman, R.D.: Primary care in Colorado: A needs assessment. Colorado Medicine 77:264-269, 1980.

10. Krugman, R.D.: The Will Donohoe Lecture: Pediatric education: Past, present and future. South Dakota Journal of Medicine 33:21-25, 1980.

11. Silver, H.K., Ott, J.E., Fine, L.L., Moore, V., and Krugman, R.D.: Assessment and evaluation of child health associates. Pediatrics 67:47, 1981.

12. Fryer, G.E., and Krugman, R.D.: Survey based needs assessment: A paradigm for planning the decentralization of continuing health professional education. Evaluation and Program Planning 4:239-247, 1981.

13. Krugman, R.D., Tabak, E., and Fryer, G.E.: The effectiveness of the AHEC concept in Colorado. J of Med Ed 57:87-90, 1982.

14. Lane, P.A., Hathaway, W.E., Githens. J.H., Krugman, R.D., and Rosenberg, D.A.: Fatal intracranial hemorrhage in a normal infant secondary to vitamin K deficiency. Pediatrics 72:562-564, 1983.

15. Krugman, R.D., and Krugman, M.K.: Emotional abuse in the classroom: The pediatrician's role in diagnosis and management. AJDC 138:284-286, 1984.

16. Krugman, R.D.: The multidisciplinary treatment of abusive and neglectful families. Pediatric Annals 13(10):761-764, 1984.

17. Weissberg, M.P., Fryer. G.E., Jr., Krugman. R.D.: Educational parity in university and rural training sites. J of Med Ed 60(1):68, 1985.

18. Krugman, R.D.: The coming decade: Unfinished tasks, new frontiers. Child Abuse and Neglect 9:119-122, 1985.

19. Krugman, R.D.: Fatal child abuse. an analysis of 24 cases. Pediatrician 12(1):68-72, 1985.

20. Jones, D.P.H., and Krugman. R.D.: Can a 3 year old bear witness to her sexual assault and attempted murder? Child Abuse and Neglect 10(2):253-258, 1986.

21. Krugman, R.D., Betz, L., Fryer. G.E., Jr., Lenherr, M.: The relationship between unemployment and child abuse in Colorado, 1970-1984. Child Abuse and Neglect 10(3):415-418, 1986.

22. Fryer, G.E., Poland, J., Bross, D., and Krugman, R.D.: The child protective service worker: A profile of needs, attitudes and utilization of professional resources. Child Abuse and Neglect 12:481-490, 1988.

23. Haynes-Seman, C., and Krugman. R.D.: Sexualized attention: Normal parental nurturance or early sexual abuse? Am J Orthopsychiatry 59(2):238-245, 1989.

24. Krugman, R.D., Bays, J.E., Chadwick, D.C., et al: Guidelines for the evaluation of children who are sexually abused. Pediatrics 87:254-260, 1991.

25. Krugman, R.D.: Child abuse and neglect: critical first steps to respond to a national emergency (the pediatrician's role). AJDC 145:513-515, 1991.

26. Krugman, R.D.: The battered child at 30. What can be learned from Saul Krugman at 80? Festschrift for Saul Krugman. Pediatrics (Suppl.) 90(1):154-156, 1992.

27. Krugman, R.D.: Child Abuse and Neglect. AJDC 147(5):517, 1993.

28. Fryer, George E., Jr., Miyoshi, Thomas J., Stine, Curtis, and Krugman, Richard D.: Colorado's Decentralized Medical Education to Increase the Number of Graduates Practicing Primary Care in Rural Areas. Academic Medicine 68:310, 1993.

29. Sirotnak, Andrew P., and Krugman, Richard D.: Physical Abuse of Children: An Update. Pediatrics in Review 15(10):394, 1994.

30. Krugman, R.D.: Presidential Address: Future Prevention of Child Abuse and Neglect. Child Abuse and Neglect 19(3):273-279, 1995.

31. Fryer, George E., Jr., Stine, Curtis, Krugman, Richard D., and Miyoshi, Thomas J.: Geographic benefit from decentralized medical education: Student and preceptor practice patterns. Journal of Rural Health 10(3):193-198, 1994.

32. Ryan, Gail, Miyoshi, Thomas J., Metzner, Jeffrey L., Krugman, Richard D., and Fryer, George E.: Trends in a National Sample of Sexually Abusive Youths. Journal of the American Academy of Child & Adolescent Psychiatry 35 (1):17-25, 1995.

REVIEWS, CHAPTERS, AND SYMPOSIA

1. Ott, J.E., Fine, L.L., More, V., and Krugman, R.D.: The Child Health Associate Seminar in Role Development in Proceedings of the Second National Conference on new Health Practitioners. March, 1974.

2. Krugman, R.D.: Immunizations: Twenty common questions and answers. Postgraduate Medicine 59:159, 1975.

3. Krugman, R.D.: A Model for Delivering Maternal and Infant Care in Rural and Isolated Areas in Proceedings of the Bi-Regional Institute on Delivery of Health Care to Mothers and Children in Rural Areas. San Francisco, April 25-27, 1977.

4. Schmitt, B.D., Krugman, R.D., and Kempe, C.H.: Child Abuse and Neglect. IN Practice of Pediatrics, V. Kelley, ed. Philadelphia: Harper and Row, 1982.

5. Schmitt, B.D., Krugman, R.D., and Kempe, C.H.: "Child Abuse." in Nelson's Textbook of Pediatrics, R. Berman and V. Vaughn, eds. Philadelphia: W.B. Saunders, 1983.

6. Benjamin, K., and Krugman, R.D.: Report of a Conference: Health Care for School Age Children in the Next Decade. Office of Maternal Child Health, Department of Health and Human Services. April 1984.

7. Krugman, R.D.: Child abuse and neglect: The role of the physician in recognition and management. Primary Care 11:527-534, 1984.

8. Krugman, R.D.: Recognition of sexual abuse in children. Pediatrics in Review 8(1):25-30, 1986.

9. Krugman, R.D.: The Process of Assessment in The Battered Child, fourth edition. R.E. Helfer and R.S. Kempe, eds. Chicago: University of Chicago Press, 1987.

10. Krugman. R.D., and Jones. D.P.H.: Incest and Other Forms of Sexual Abuse in The Battered Child, fourth edition. R.E. Helfer and R.S. Kempe, eds. Chicago: University of Chicago Press, 1987.

11. Schmitt, B.D., and Krugman, R.D.: Child Abuse in Nelson's Textbook of Pediatrics. R. Berman and V. Vaughn, eds. Philadelphia: W.B. Saunders Co., 1987.

12. Fischler, R., and Krugman, R.D.: The physician's role in child abuse and neglect: Physical abuse. Today's Child, August 1987.

13. Fischler, R., and Krugman, R.D.: The physician's role in child abuse and neglect: Sexual abuse. Today's Child, September 1987.

14. Goldfarb, A., Bross. D.C., Denson, D., and Krugman, R.D.: The START Handbook. Investigation of criminal child abuse and neglect cases. Kempe Center, 1987.

15. Krugman, R.D.: Recognizing abuse and neglect. The Early Childhood Update 3:4, 1987.

16. Krugman, R.D.: University Hospital Child Protection Teams. IN The New Child Protection Team Handbook. D.C. Bross, R.D. Krugman, M. Lenherr, D. Rosenberg, and D.B. Schmitt, eds. Garland, New York: Garland Press, 1988.

17. Krugman, R.D.: Future Directions and Challenges in The New Child Protection Team Handbook. D.C. Bross, R.D. Krugman, M. Lenherr, D. Rosenberg, and B.D. Schmitt, eds. Garland, New York: Garland Press, 1988.

18. Michaels, L., Bross, D.C., and Krugman, R.D.: Medical Care Neglect: Legal and Medical Issues: Guidelines for Child Personnel. Kempe Center, 1988.

19. Krugman, R.D., and Ryan, G.: Adolescent sexual offenders: Another hidden pediatric problem. AJDC 142:385, 1988 (Abstract).

20. Krugman, R.D., Bross, D.C., and Heger, A.H.: Sexual abuse of children, AAP Update, 10(3), American Academy of Pediatrics, 1989.

21. Krugman, R.D.: Child abuse and neglect: New light on a dark problem. Current opinion in Pediatrics. Current Science 1:1, 1989.

22. Krugman, R.D.: Physical and Sexual Abuse in Ambulatory Pediatrics, IV. M. Green and R.J. Haggerty, eds. Philadelphia: W.B. Saunders Co., 1990.

23. Krugman, R.D.: Child Maltreatment in Current Diagnosis. R.B. Conn. ed. Philadelphia: W.B. Saunders Co., 1990.

24. Krugman, R.D.: The Future Role of the Pediatrician in Child Abuse and Neglect in Pediatric Clinics of North America, 37:1003-1011, 1990.

25. Krugman, R.D.: Child Abuse and Neglect in Preventing Mental Health Disturbance in Childhood. S.E. Goldston, C.M. Heinicke, R.S. Pynoos, and J. Yager, eds. Washington: American Psychiatric Press, 1990.

26. Child abuse and neglect: Critical first steps in response to a national emergency. DHHS, Washington, D.C.: Government Printing Office, 1990. [First report of U.S. Advisory Board written by Krugman, R.D., Davidson, H., Melton, G., and Gold, B.]

27. Ryan, G., Metzner, J., and Krugman, R.D.: When the abuser is a child: The assessment and treatment of the juvenile sexual offender in Understanding and Managing Child Sexual Abuse. K. Oates, ed. Sydney: W.B. Saunders Co., 1990.

28. Krugman, R.D.: Medical Diagnosis of Sexual Abuse in Annual Review of Psychiatry, v. 10. A. Tasman, ed. Washington: American Psychiatric Press, 1991.

29. Schmitt, B.D., and Krugman, R.D.: Child Abuse in Nelson's Textbook of Pediatrics. R. Berman and V. Vaughn, eds. Philadelphia: W.B. Saunders Co., 1991.

30. Krugman, R.D.: Sexual Abuse in Comprehensive Adolescent Medicine. S. Freedman, M. Fisher, and S.K. Schoenberg, eds. St. Louis: Quality Medical Publishing, 1991.

31. Rosenberg, D.A, and Krugman, R.D.: Epidemiology and outcome of child abuse. Annual Review of Medicine 42:258-267, 1991.

32. Krugman, R.D.: Child abuse and neglect in Maternal and Child Health Practices, 3rd ed. Helen M. Wallace, George M. Ryan, and Allan C. Oglesby, eds. Oakland, CA: Third Party Publication, 1994.

33. Krugman, R.D.: The importance of child abuse, its consequences, its costs and how it can be addressed. Journal of the Australian Academy of Forensic Science, 24(3,4):48-56, 1992.

34. Krugman, R.D.: The Detection and Prevention of Child Abuse: Society's Role. Keynote address, Proceedings of the Third Asian Conference on Child Abuse and Neglect. Kuala Lumpur, Malaysia. 1993.

35. Krugman, Richard: Child Abuse and Neglect. World Health 46(1), 1993.

36. Krugman, R.D.: Universal Home Visiting: A recommendation from the U.S. Advisory Board on Child Abuse and Neglect. Future of Children 3:184-191. 1993.

37. Sirotnak, A. and Krugman, R.D.: Physical Abuse. Pediatrics in Review. 15:394-400, 1994.

38. Krugman, R., Child Abuse in Current Pediatric Diagnosis and Treatment, 12th ed. Hay, Groothuis, Hayward, and Levin, eds. Norwalk: Appleton & Lange, 1994.

39. Reicheart, S. and Krugman, R.D.: Medical Evaluation of Child Sexual Abuse in The Battered Child (5th ed.), M.E. Helfer, R.S. Kempe, and R.D. Krugman. eds. University of Chicago (in press).

40. Hymel, K. and Krugman, R.D.: Sexual Abuse in Comprehensive Adolescent Medicine (2nd ed.), S. Freedman, M. Fisher and S.K. Schoenberg, eds. St Louis: Quality Medical Publishing (in press).

41. Starling S. and Krugman, R.D.: Sexual Assault in Comprehensive Adolescent Medicine (2nd ed.), S. Freedman, M. Fisher and S.K. Schoenberg, eds., St. Louis: Quality Medical Publishing (in press).

42. Krugman, R.D.: Child Abuse and Neglect: A Worldwide Problem. International Review of Psychiatry, (Vol. 2), E. Gould-Leger, F. Lieh-Mak, C.Nadelson. H.M. Visotsky, K. Tardiff, J.R.T. Davidson, E.P. Benedek, eds., Washington, D.C.: American Psychiatric Press, Inc. (in press).

43. Krugman, R.D.: Positioning an Academic Medical School for Survival: How Many Moving Targets Must We Hit to Make It? in Urban Medical Centers: Balancing Academic & Patient Care Functions. Eli Ginzberg, ed. Boulder: Westview Press, 1996.

44. Krugman, R.D.: Child Abuse and Neglect: A Worldwide Problem in International Review of Psychiatry, Vol. 2. Felice Lieh Mak, M.D. and Carol C. Nadelson, M.D., eds., Washington, D.C.: American Psychiatric Press, Inc., 1996.

45. Krugman, R.D.: Child Abuse, Neglect and Disabled Children in Mosby's Resource Guide to Children with Disabilities and Chronic Illness. Helen M. Wallace, M.D., M.P.H., Robert F. Biehl, M.D., M.P.H., John C. MacQueen, M.D. and James A. Blackman, M.D., M.P.H., eds., Mosby-Year Book, Inc., 1996, pp 137-144.

46. Krugman, R.D.: Fictitious Accounts of Sexual Abuse by Children. Professor R. Kim Oates, Dr. David P.H. Jones, Mr. D. Denson, and Andrew Sirotnak, M.D. The University of Sydney Department of Paediatrics & Child Health, The New Children's Hospital, Sydney, Australia and The C. Henry Kempe National Center for the Prevention of Child Abuse and Neglect, Denver, CO: 1996.

BOOKS

1. Krugman, R.D., and Welch, T.R.: Pediatrics - a Continuing Education Review. New York: Medical Examination Review Book Publishing Company, 1976.

2. Krugman, R.D.: Review of Pediatrics. Philadelphia: W.B. Saunders, 1980.

3. Krugman, R.D.:Review of Pediatrics, Second Edition. Philadelphia: W.B. Saunders, 1983.

4. Krugman, R.D.: Review of Pediatrics, Third Edition. Philadelphia: W.B. Saunders, 1987.

5. Bross, D.C., Krugman, R.D., Lenherr, M., Rosenberg, D., and Schmitt, B.D., eds.: The New Child Protection Team Handbook. New York: Garland Press, 1988.

6. Krugman, R.D.: Review of Pediatrics, Fourth Edition. Philadelphia: W.B. Saunders, 1992.

7. Helfer, M.E., Kempe, R.S., Krugman, R.D. The Battered Child, fifth edition. Chicago: University of Chicago, (in press).

EDITORIALS AND COMMENTARIES

1. Krugman, R.D.: Immunization dyspractice: The need for no-fault insurance. Pediatrics 56:159, 1975.

2. Krugman, R.D.: Preventing sexual abuse of children in day care: Whose problem is it anyway? Pediatrics 75:1150, 1985.

3. Krugman, R.D.: Where you stand depends on where you sit. AJDC 139:867-868, 1985.

4. Krugman, R.D., and Kempe, R.S.: Why don't you see what you can do. Festschrift Commentary for Brandt Steele, M.D. Child Abuse and Neglect 11:305-307, 1987.

5. Krugman, R.D.: It's time to wave the yellow flag. Child Abuse and Neg 12:293-294, 1988.

6. Krugman, R.D.: Advances and retreats in the protection of children. New Engl J Med 320:531-532, 1989.

7. Krugman, R.D.: The more we learn the less we know with reasonable medical certainty. Child Abuse and Neglect 13:165-166, 1989.

8. Fulginiti, V.A., and Krugman, R.D.: Cleveland, England: Child abuse in the public eye. AJDC 143:651-652, 1989.

9. Krugman, R.D.: Commentary on criminal prosecution in cases of child abuse. Pediatric Annals 18(8):513-514, 1989.

10. Krugman, R.D.: The yellow flag is still up. Pediatrics in Review 15: 1993.

11. Krugman, R.D.: Sexual Politics and Child Protection: They Don't Mix. Pediatrics 94:45-46, 1994.

12. Krugman, R.D.: Letter commenting on Suicide in Prepubertal Children. Journal of the Academy of Adolescent and Child Psychiatry.

13. Krugman, R.D.: The Review of Child Maltreatment Fatalities: Snatching Victory from the Jaws of Defeat. Child Abuse & Neglect 19:843-845, 1995.

14. Krugman, R.D.: Media Can Be Key in Curbing Child Abuse. Rocky Mountain News 32:69A, May 24, 1996.

15. Krugman, R.D.: Suppose It Were A Genetic Disorder? Child Abuse & Neglect 21:25-246. 1997.

STATEMENT OF
Marjorie R. Quandt *
June 17, 1998

Before the

Subcommittee on Health
of the Committee on Veterans' Affairs, US House of Representatives

Mr. Chairman, you have invited me to discuss my vision of the future role of the VA health care system.

First, let me state that if the current atmosphere and questionable support ofthe veteran health care system continues, the future role of the VA health care system is end game. Second, there is every reason to believe that if Congress will act without regard to local votes, we achieve better leadership in the executive branch, and veterans organizations will be rational, the future role of VA health care can be valuable not only to veterans, but to the general public until probably 2025.

Before I describe my vision of VHA's future, let me state a few historical facts and present some veteran population data.

The principle of caring for veterans of the United States actually predates the Continental Congress. The cost of that care was borne by the United States and individual states from the Continental Congress up until after WWII when legislation enacted by Congress greatly expanded benefits. All of these increased supports were directly funded by the US. It is only since market forces began an onslaught on medical care costs in the eighties and nineties, that dedicated US funding has appeared to peak.

Assuming no future US wars, there will be fewer than 18 million veterans in 2015 and an estimated sixteen million in 2020. Veterans are currently 10 per cent of the population. In 2015 and 2020 veterans will represent 6 per cent and 5 per cent of the population respectively. Those veterans 75 years and older will represent 22.4 percent of the veteran population in 2015 and 24 per cent in 2020, while the truly old, those 85 years and older, will comprise 7.4 per cent.

Let me give you an idea how long government support of wounded veterans must continue after a war. There were veterans of WWI who entered a military hospital in 1919 suffering from poison gas exposure, moved to a VA facility and were still in that same VA hospital in 1980. There are veterans of WWII who suffered spinal cord injuries in the 1940s and who will be treated after 2000. The same can be said for thousands of psychiatric patients from that same period of service. Certain Vietnam Conflict veterans will experience similar needs for health coverage. It is safe to say that veterans of the Gulf War Conflict who have been treated since 1990-91 will still be treated in 2060 and beyond. The cost of war is not just the cost for the period of conflict; it is an ongoing expense. "The price of freedom" is visible daily in DoD and VHA facilities, and it is a price that an ethical government must pay.

Why do I claim those who would expand VA's patient base by permitting Medicare eligible veterans to enter VHA facilities, allow so-called Category A veterans to go to the private sector at VA expense, or provide coverage to wives and children regardless of eligibility category, are promulgating end game to VHA? Each and every one of these proponents has forgotten the primary purpose of VHA: to care for those with service connected disabilities and the least able to pay for their own care. Some sociologists and ethicists would call this latter group the least fortunate among us. One has only to look at the income level of other than service connected to realize that VHA has been a system for poor veterans for well over 40 years. While the VA has been described as caring for all eligible veterans, the medical program has only been funded to care for the service connected and "least fortunate" veterans.

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Historically this funding equates to coverage of some 10 per cent of the total veteran population, or about 23 per cent of the service connected and poor veteran population at risk. These efforts to enlarge the patient pool come too late in the evolution of our national health care policy which now more than ever embraces market place competition.

To move beyond the historical funding practice now pits what is left of the VHA system against the massive market force of the private health/medical sector. By its very size VHA cannot compete with it. A system which represents 3 per cent of the nation's expenditure on health cannot compete against the other 97 per cent of expenditures. This may be what certain proponents want--an excuse to close out a dedicated veterans system. Those who would extend contracts, certain sharing agreements and admit "rich" veterans with insurance to VHA ignore the fact that professional capability is not what it was five years ago, and certain capacities no longer exist. This presents the tempting opportunity to admit these economically better off veterans ahead of poor in order to gain funds. These "patches" also run the risk of eroding quality of service to the service connected. Those who would change eligibility to include family members, beyond service connected family members now entitled, ignore the expense to modify the system to care for these new beneficiaries. The Medicare subvention ploy is another specious effort. Who has done a market survey to determine how many veterans with Medicare truly want to come to VHA? Will application forms be revised to determine if this is a veteran who now seeks VA care because he is suddenly declared eligible, or will VHA automatically begin billing Medicare for any veteran with Medicare? How deep will be the discount VHA must give Medicare? Will it come anywhere near covering VHA costs? As far as I know you have yet to see a valid cost comparison between Medicare's cost coverage in the private sector and VHA's costs. Without Congressional barriers, how much of Medicare funds could start flowing to VHA instead of into the private sector?

In my view none of the sponsors of these rescue efforts have considered the whole picture. They have taken one piece of the puzzle and applied it. Some are well meaning; others have a vested interest. One or two In my mind are wolves in sheep's clothing. There is an aspect of market place activity which Congress would do well to permit the VA at the earliest opportunity. The Secretary must have authority to sell certain facilities and invest the money received in the market in order to gain capital for direct patient care. Congress should amend USC Title 38 to permit the sale of unused VHA physical plants with active investment of proceeds in private or government instruments. If VA is to maintain quality it must be able to raise money for investment purposes to obtain additional capital to provide quality care.

In addition to using the market to raise funds, VA must also take a hard entrepreneurial look at its residential program. The domicilary program is one whose purpose is no longer necessary or especially effective in the current health care delivery environment. "Doms" are retained more for sentimental reasons because the "Dom" was the first program in VHA. VA would better serve this group of persons by testing and then implementing a life care system. These should be either VA funded or leased with veteran co-payment, an expanded community residential program, an arrangement with veterans organization or States, or some other innovative supportive living program paid for by the veteran with health care provided by the VA. At an average obligation of $80.82 per patient day in FY 1997, VA's residential program costs about $30 more per day than some of the best, continuing care centers in the country. The amenities and life style in the latter far exceed VA's residential care.

With a revised USC Title 38, VHA could accelerate its moves to increased outpatient and other non-bed care. In order to gain capital to fund health care for veterans in the future, VHA must have the capability to move care sites as the population moves. This cannot be done by retaining old facilities or excess space. In January 1998 there were 6 million square feet of unneeded space in VHA facilities. To the extent this must be kept clean, heated and cooled, maintained and secured, it is a drain on direct patient care. Nor should VA be permitted to build any new or replacement hospitals or bed towers. By 1999, 90 per cent of VA hospitals representing 85 per cent of beds will be in facilities over 29 years of age.

Congress should establish a law that VHA will build no more medical facilities, but will lease space in existing private sector sites suitable for managed care. It is time VHA emulated some of the states which are leasing or selling facilities to gain revenue. I refer to West Virginia and Maryland which are making psychiatric facility sites available for hotels and resorts. Biloxi and Perry Point, to name two VA units, are ideal sites for alternate uses. Northport, Lyons, Dublin, Lexington, Reno, Jefferson Barracks in St. Louis, White River Junction, North Chicago, the Brentwood section of Los Angeles, Roseburg, and part of Palo Alto would be suitable for commercial or residential developments. Prescott, AZ, is an ideal site for a senior retirement community, not only because of climate, but because of its proximity to a community college.

Based on .7 beds per 1000 veterans, the current rate of beds in VA, the following states will not have enough veteran population to support a 150 bed general-medical acute hospital in 2015: Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Rhode Island, South Dakota, Utah, Vermont, W. Virginia, and Wyoming. These physical plants should be sold or converted as discussed above. In return for the closed facilities, VHA would provide managed care in free standing, modern OPCs. The number would depend upon the planning module used. It is my understanding VHA no longer publishes policy planning modules for clinics. Using the rate of 6,000 veterans for a community based clinic, or 25,000 veterans for a free standing more sophisticated clinic, most of those states would attain more dispersed and accessible veteran health care. It will be necessary for VISNs to negotiate the rate paid for inpatient care in private sector community hospitals. VHA medical staff will be required to meet credentialing and medical staff requirements in order to provide care in the private sector facility.

All other states will be faced with closing one or more facilities. These should also be sold or converted. There will be a need for only 1300 acute beds in California compared to more than 3300 in FY 1996. Similarly Florida's need will go from more than 2100 beds to about 850. As mentioned New Mexico will not have a veteran population to support a 150 bed facility. It is possible by 2015 that the Albuquerque Federal Health Center will be totally DoD operated with provision for some 89 beds for veteran care. Even today there are insufficient inpatients to make the new GM&S unit at North Chicago viable; this should be transferred to Great Lakes Naval Training Center now to save taxpayers' money.

By taking the above actions, VHA can gain more working capital through reshaping its delivery program. This will not solve the entire funding problem, but will allow greater concentration of dollars on direct care of the core group.

Let me now turn to the other half of my vision for the future. There is a second major federal health care program currently facing serious problems: the Department of Defense (DoD) system. This is another group of citizens being ill-served by budget negotiations and protection of other national priorities.

The requirement to fund a smaller military while retaining unneeded bases and buying expensive equipment and weaponry, has diverted needed monies from primary responsiblities to our military forces: adequate housing and other infrastructure necessities and maintaining a health care capability at readiness standards. DoD's medical care program cares for a largely healthy, young population of active military and dependents. In fact, day-to-day, the DoD system cares for women and children. Retirees and their dependents because of decreased funding believe they have been abandoned by a government that promised them health care.

Perhaps there is recognition at last in the FY 1999 budget that the country has no idea what defense truly costs. There is a move to improve budgetary presentation of future costs of veterans benefits and ensuring they are paid up-front. It is believed this would not only solidify the promise we have made to military members, but also ensure that the public realizes all the important pieces of maintaining the world's strongest national defense.

I would like to think that a guilty conscience caused OMB executives to include the following paragraphs on page 154 of the FY 1999 budget sent to Congress:

> "The Nation has long viewed veterans programs as a key way to attract the high-quality people needed for our volunteer armed forces. Americans recognize veterans benefits as an appropriate part of the compensation provided for service in the military. Veterans programs are inextricably linked with national defense; without defense, veterans programs would not exist.
>
> Because the Veterans Affairs Department funds and administers these benefits, however, the Federal Government has accounted for them differently than other defense-related budget costs. They appear in the budget's Veterans Benefits and Services function, not the National Defense function. Also, the budget does not report the full size of these obligations. Rather than recognize the benefits and future Federal obligations that military members earn through their service, the budget reports only the amounts paid in a single year to veterans. Thus, neither the Defense Department (DOD) nor Congress gets a full picture of defense personnel costs when making decisions about the size and scope of our military, making it far harder to consider which package of benefits might best attract and retain quality military personnel....."

Can Congress honestly say that DoD has the proper number of medical specialists in its ranks should we enter another large scale military effort? Does Congress believe that DoD is sufficiently staffed for the future care of casualties as the US keeps up its world policeman role? It is said there will be only two great powers in the future: America-Europe and China. Futurists claim any other combination of powers, or a China-India-Iran axis will put us back to cold war status.

The military and veterans' health care systems have much in common. Each is a direct responsibility of the US Government; one to protect national security and the other because national security was protected at specific points in time. Both programs require a direct are component; both possess research and education functions which must be maintained for readiness and quality, and both make a contribution to the health of the general civilian population.

On January 15, 1998, I was invited to appear before the Congressional Commission on Servicemember and Veterans Transition Assistance to discuss forecasts for the 21st century. The question to be answered at the health care section on projections, predictions and trends was: will the benefit programs in place today meet the needs for tomorrow's veterans?

My conclusion was that if both DoD and VHA continue on their present paths that servicemembers and veterans will be ill served by their country. It is the vision of the future I explained on January 15, that I would like to explain to you now.

The DoD health care system covers 3.4 million beneficiaries comprising active military, active guard and reserve and retired personnel and dependents. VHA cares for 3.1 million patients, including a small number of sharing patients. Between the two systems there are at least 331,000 full time equivalent employees. Both have widely dispersed facilities, some in the same community. There are economies of scale to be achieved by more closely aligned operation of these systems. A federally sponsored managed care organization of 6.5 million citizens is two-thirds the size of the current Kaiser-Permanente program.

I am aware there has been considerable antipathy over the years to a formal merger of federal health care systems. I am also aware since my discussion in January VA people have taken a rather pragmatic view of the proposal, but DoD representatives are unimpressed.

My proposal melds the two federal programs through closer adherence to existing cross-servicing and sharing agreements for the foreseeable future, and would lead to one service under DoD by about 2015 to

2025. This allows DoD and VHA to retain selected facilities, pay systems, rank and grade structures, and solidly plan a formal merger. Education and research programs could continue independently, or where desirable, combine. The back-up requirement of VHA would be sustained, and perhaps better placed.

My discussion has said little about DOD, other than Congress's remembering its ethical duty. That is because I believe given a choice, Congress will fund the arm of government needed to protect the interests of the country as a whole. If the US is to have the quality military system required for its role, monies must begin to move toward DoD. The dwindling size of the veteran population is also not lost on law makers.

If one looks at workload, DoD should assume all acute care for DoD and VHA. In some cases this would mean the duty station for active military medical corps personnel would be in VHA facilities. It is entirely possible a DoD active duty member would serve as Director or Chief of Staff, as well as Service Chief in VHA facilities. VHA should increase the number of community based clinics in at least nineteen states where it will provide acute as well as other levels of health care to veterans, military retirees and eligible dependents. In all instances rehabilitative, psychiatric and subacute care would be provided by VHA personnel in VA or DoD facilities. Thus, every DoD facility will have VHA clinical staff assigned to it. Just as a DoD physician could be a service chief in a VHA facility, a VHA physician will be the service chief in many DoD units. Conducting an acute care mission will enhance DoD's readiness responsibilities; chronic care is a mainstream strength of VHA. This type of "triage" between the two systems makes the best use of both.

To the extent that an active military is cared for in a VA site or vice versa there should be fund transfers based on cross-servicing at capitated rates. Both systems have moved toward capitation and a joint task force could work out the financial exchange.

There will be a need to change USC Title 38, and USC Title 10, to allow admission of dependents without regard to other priority of primary beneficiaries. Any other legal restriction which prevents an easy movement of beneficiaries between the two systems should be removed, including barriers for retirees and eligible dependents.

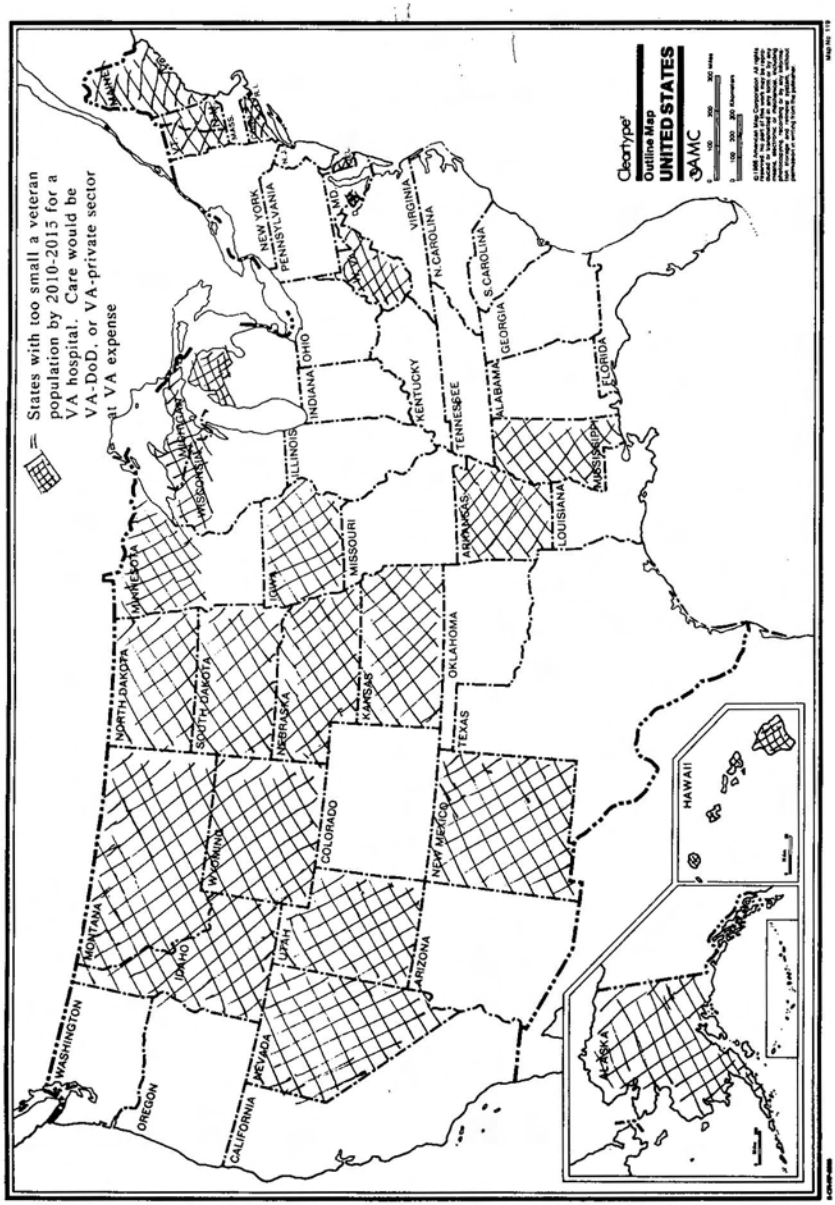
On March 27, 1998, VA's Under Secretary for Health's Special Committee on the Treatment of Veterans with Serious Mental Illness and the Connecticut-Massachusetts VA Mental Illness Research Education and Clinical Center sponsored an interdisciplinary conference of VA and non-VA national experts to examine the obligation to the least well off in setting mental health service priorities. The consensus statement from this conference declares "civilized societies have a deep and irrevocable obligation to people with serious mental illness." The very same moral obligation exists for a country whose military have suffered catastrophic and other injuries in that country's defense. The same moral obligation exists toward the least well off members of society who entered the military and came away from service unble to adjust to the society they re-entered.

The current funding, support mechanisms for both DoD and VHA health care systems are designed to bring about very weakened programs. Some of the sought after funding mechanisms are seen to be drying up. At the most these programs, such as MCCR, offer relief only on the margin, and it's a very small margin. Other plans to pit the federal sector against the private sector through subvention of Medicare funds can only lead to continued dilution and unnecessary battles for patients. The end game now in progress will be messy to say the least.

For those who would abolish the veteran health care system, there is a lesson to be studied north of our border. It has taken more than 25 years for the Canadian Government to divest itself of the sixteen veterans' hospitals it operated. The closure of that system was not inexpensive. It required the federal government to make capital improvements in the facility, pay each province in which there was a DVA hospital a grant to accept the hospital, as well as a fund protecting the transferred employees' retirement rights and benefits. (There was no excessing or selling facilities as VHA did early in the Vietnam Conflict.) Canada could take this step because it had a

national health insurance program. Further it had acquired no large number of new veterans since WWII. The picture is totally different in the US.

Merging the DoD and VHA health systems would not be the first time programs in the US were re-organized. The size and funding of both programs, with innovative leadership, could be fashioned into a high quality system by the early 21st century which will fulfill the obligation of a moral nation.


= States with too small a veteran population by 2010-2015 for a VA hospital. Care would be VA-DoD, or VA-private sector at VA expense
Cleartype
Outline Map
UNITED STATES
AMC
WASHINGTON
OREGON
CALIFORNIA
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IDAHO
MONTANA
WYOMING
UTAH
ARIZONA
COLORADO
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
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AADS
American Association of Dental Schools

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July 1, 1998

The Honorable Cliff Stearns
Chairman
Veterans' Affairs Subcommittee on Health
U.S. House of Representatives
Room 338 Cannon House Office Bldg.
Washington, DC 20515

Dear Chairman Stearns:

On behalf of the American Association of Dental Schools (AADS), I would like to submit the following comments concerning ***The Future of the Veterans Healthcare System*** for inclusion in the June 17, 1998 hearing record.

AADS represents all 55 dental schools in the United States, as well as advanced dental education, hospital dental residency programs, and allied dental education institutions. It is within these institutions that future practitioners, educators, and researchers are trained; significant dental care provided; and the majority of dental research conducted. AADS is the one national organization that speaks exclusively for dental education.

The nation's dental schools have forged strong ties with their local VA medical facilities because of the VA's important role in the educational and training process in dentistry. Each year over 1,000 dentists and 1,200 dental residents rotate through the VA health system, reaping the benefits of working with experienced clinicians and exposure to complex patient treatment cases rendering an excellent clinical experience as part of their training. The VA benefits from this relationship through the contribution dental residency training has made to the quality of care rendered at VA medical centers and affiliated patient care settings.

We applaud the VA for restructuring its healthcare delivery system to respond to changes in the marketplace while continuing to provide the highest quality of care to our nation's veterans. The VA's new emphasis on primary care and disease prevention through the implementation of innovative programs in ambulatory care and in community-based settings provides opportunities to enhance the partnerships between the VA and the nation's dental schools. Community-based settings are primarily where underserved populations receive dental care and where many dental residents receive their training. Our member schools are eager to explore enhanced relationships with the VA both at the predoctoral and postdoctoral levels in dentistry. The AADS seeks support from the Congress and the VA central office as expanded partnerships are pursued at the local level in areas such as shared residency support and innovative training and patient care activities.

As the VA continues to undergo restructuring to meet the needs of our nation's veterans in the 21st century, the AADS strongly urges the VA to emphasize interprofessional collaboration in all of its patient-care activities. We believe the VA can achieve greater efficiencies by becoming a catalyst for training and patient care programs that foster a closer working relationships among physicians, dentists, and other health care professionals. The VA should be a model for fully integrating oral health into the primary care delivery system and develop interdisciplinary models of care that incorporate an oral health professional as a key member of the patient's primary care team. We, as a nation, must facilitate greater public awareness of the interrelationship of oral health to general health and the interrelationship of oral diseases to systemic diseases, through public health policy, health professions education and training, and the delivery of patient care through our health care system.

Leadership for the Future
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AADS supports the recent recommendations made by the VA's Special Medical Advisory Group calling for the VA to increase opportunities for the education and training of associated health professions, and we hope the VA will use this opportunity to increase its number of dental training positions. The AADS is very concerned over the loss of some dental training programs during the initial implementation phase of the VHA reorganization. We believe, however, that the Committee's recommendation is reflective of the need to address current workforce trends.

Dentistry does not have the problem of excess practitioners. In fact, having reduced dental school enrollment by one third, dentistry is now faced with a probable shortage early in the next century. As you may know, there are not enough dental residency training positions to accommodate U.S. dental school graduates. In its 1995 study of dental education, the Institute of Medicine (IOM) recommended that postdoctoral residency training in general dentistry or a specialty program be available for every dental school graduate, and that this goal should be achieved within five to ten years. We hope the realignment of the VHA's associated health professions training programs will result in an increased number of dental training positions, making significant progress towards the IOM's recommended goal.

As the VA strives to increase access to primary care by expanding the training opportunities in the associated health professions, there must be a recognition of the overwhelming debt burden young people undertake when choosing a career to enter the dental profession. Barriers such as debt and insurance coverage have led to geographic and population-based underserved communities, including those eligible populations served by the VA healthcare system, which often have little or no access to primary oral health services.

Research training provided through the VA and other Federal programs is extraordinarily important to dentistry as dental education responds to the significant scientific shifts within the profession. These advances require changes in today's dental faculty and the preparation of new faculty able both to convey this knowledge and to conduct the quantity and quality of research related to craniofacial diseases and disorders in the academic community in order to enhance the health of the public.

On average, fewer than one clinical scholar or potential clinical scholar graduates from each of the nation's 55 dental schools annually. At least 200 graduates per year are necessary too supply the institution's needs, roughly four times the number being produced in 1990. Thus, there is a shortage from two points of view: one, to address the research needs and two, to fill faculty slots with capable clinicians, teachers, and researchers. At least 50 percent of a dental school's faculty should be clinical scholars. A significant increase in training support would substantially alleviate the shortage of oral health researchers by encouraging graduates with clinical degrees to enter careers in research and academia.

While there are substantial costs associated with starting a dental practice, decisions to pursue careers in clinical research and serving disadvantaged, underinsured and uninsured populations, are significantly influenced by the graduating debt of dental students. The average indebtness for 1997 dental school graduates reporting debt was over $94,000, an increase of almost 12 percent from 1996. Thirty-four percent of graduates of private dental schools reported a debt of $150,000 or more, whereas 32.5 percent of graduates from all dental schools reported debt of over $100,000.

Given the high debt load that many graduating dentists incur, it is no wonder that many choose to enter private practice, in which the average net income of full-time dental practitioners has increased 33 percent from 1990 to 1994, from $94,200 to $125,730. We are concerned about the VA's continued ability to recruit and retain dental practitioners given the high return on the educational investment found in private practice. One way to address these needs would be through the creation of Federal loan forgiveness programs and increased funding for training designed to encourage dentists to pursue careers in dental public health, academia, and research. As the restructuring of the VA healthcare system continues with an eye to the future, the AADS would like to work with the VA to develop strategies to ensure that these remain viable career options, which will also ensure that there is an adequate supply of well-trained professionals to meet the oral health needs of our nation's veterans.

Once again, the AADS thanks you for the opportunity to present our views on ***The Future of the Veterans Healthcare System.***

Sincerely,

Richard W. Valachovic, DMD
Executive Director

Post-Hearing Questions
Concerning the June 17, 1998, Hearing

for
Dr. Kenneth W. Kizer
Under Secretary for Health
Department of Veterans Affairs

from
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives

1. Dr. Kizer, you are to be commended for compelling VA to find efficiencies that we could not have imagined the agency producing five years ago. I also know VA has developed a number of ways of assessing VA's adherence to prevention and chronic disease care guidelines that really are state-of-the-art. You have attached some of VA's quality indicators to your written testimony. You and GAO testify that quality is improving. Why do you believe that VSOs still perceive that many of the transformations taking place in VA are ultimately threatening to at least some of the quality of care veterans receive?

Response: The Veterans Health Administration (VHA) is engineering unprecedented organizational change. Americans have traditionally associated healthcare with hospitals and procedures. As we have moved to more outpatient or ambulatory care, we have closed beds, developed non-hospital/non-traditional treatment programs, integrated medical centers, and contracted for care. All of this has moved things away from what is comfortable and familiar. This change in process of care is especially unsettling in some key veteran health areas such as spinal-cord injury (SCI), blind rehabilitation and post-traumatic stress disorder. Data so far support the changes, but the VSOs rightly want to see the outcomes.

Efforts are being taken to inform VSOs of the positive improvements in care occurring in our facilities across the nation. Our mid-year report on Network performance data continues to show improvement in the quality of care provided to veterans with diabetes, hypertension, and obesity. Rates of immunization and screening to assure early detection and treatment of cancer and alcohol abuse have increased markedly. Care is being shifted to ambulatory settings, and increased emphasis is being placed on patient safety, risk management, and customer satisfaction. Our commitment to full disclosure of information that bears on veterans' knowledge of care provided is embraced in the work currently underway related to the Consumer Bill of Rights. We will continue to work diligently on every front to increase veterans and VSOs confidence in ongoing quality improvement in VHA.

2. Dr. Kizer, I agree with your statement about those who "lament the vagaries of the market driven...healthcare system" yet see fit to turn over a number of VA's functions to the private sector. But strategic plans for VA seem to indicate that VA will be doing far more contracting in the future. Are there certain VA functions that only VA should manage or provide? What are they?

Response: It continues to be our position that VA should have authority to manage <u>all</u> medical care delivery functions with the greatest degree of flexibility for the benefit of veterans. Having said this, though, it is worth once more noting that healthcare delivery is a local activity. In certain situations it might be necessary to contract out for certain services to provide the best care or to obtain the best value for taxpayer dollars. This is a well-tested principle that has worked well for veterans over the years. Recently, VA has been given additional authority to contract for services. This gives us additional flexibility, which we need to build a more supple and responsive delivery system. Having the ability to contract out is not the same as abandoning any functions, but rather it is a

further opportunity for gaining another option to provide for the medical care needs of veterans.

3. How can VA assure that incentives for finding savings in veterans' healthcare do not perversely influence those providing care for veterans in VA or elsewhere?

Response: The performance measures for which Network Directors are held accountable advance the strategic goals of the VHA. The measures are divided among five domains of value - cost, technical quality, access, patient reported outcomes (service satisfaction), and functional status. These domains provide a check and balance system. For example, in the cost domain, there is a measure to reduce bed days of care which will ultimately assist in shifting care to an ambulatory care setting; however, we need to ensure that patients are not adversely affected by reduced inpatient care. Thus, we have measures in the domain of patient reported outcomes that assess patients' satisfaction with their care through annual patient surveys, as well as other technical quality of care outcome measures.

4. Are you aware of any evidence from VA's own studies or elsewhere that indicates shifting mental health programs like PTSD or substance abuse treatment from an inpatient to an outpatient basis impacts the quality or effectiveness of services delivered? Were there any considerations, other than fiscal ones that lead to VA's decision to transfer so much of this care?

Response: While fiscal considerations were important, there were other reasons to promote a shift of care from inpatient to outpatient services for PTSD. Among these other reasons was the desire to improve both accessibility and patient satisfaction without sacrificing quality of care. It should be noted that even before this shift of services occurred, two-thirds of VA care for PTSD was provided on an outpatient basis. Furthermore, the shift from inpatient to outpatient care has not eliminated the availability of inpatient or residential specialized PTSD programs for veterans who need such levels of care in most parts of the country. We are currently examining in greater detail the impact on quality and effectiveness of services with the shift from inpatient to outpatient care. We do know that the numbers of veterans receiving both inpatient and outpatient care for PTSD has increased, and we publish the results of our ongoing monitoring of VA's PTSD programs in reports from VA's Northeast Program Evaluation Center (NEPEC). We also are analyzing issues such as numbers of veterans served and locus of care across the past three years; this analysis should be complete by the end of September 1998. It will encompass a longitudinal analysis of the PTSD Special Emphasis Program Measures, which include measures of quality of clinical programs. In addition, we currently are gathering baseline data on patient functional levels, using measures such as the Global Assessment of Functioning (GAF) scale for PTSD as well as for other disorders. As we continue to gather GAF and other data on quality and patient functioning, we will be able to document the effectiveness of services delivered over time. Likewise, we will be able to make course corrections if such are needed.

5. Dr. Kizer, the President asked VA to identify and respond to deficiencies its healthcare system had in complying with standards the Administration developed and would require other managed care providers in the private sector to adhere to should the "Patient Bill of Rights" he forwarded to Congress become law. How did VA respond to this executive order?

1) **Information Disclosure**
VA has information available that would assist its consumers in making informed healthcare decisions. Although much of the information is already provided to our consumers, there remains variability within the VA healthcare system on what and how information is provided to patients and their families. Under Eligibility Reform, PL 104-262, VHA is able to provide needed medical services in the most clinically appropriate setting for enrolled veterans, rather than being constrained by previous statutory

restrictions that placed limitations on care depending on a veteran's eligibility status. Information on the Uniform Benefits Package for VHA will be provided to veterans as part of the information package given to veterans when they enroll. Information on customer satisfaction surveys is required to be posted in public areas in each facility.

VA collects a variety of information regarding it's health care professionals, including credentialing information, provider profiles and performance information. The Department does not routinely provide such information to patients and families. Due to Privacy Act issues, not all information can be disclosed, but for all information that is releasable, a decision will be made on how to provide this information to consumers.

VA has the authority and will take action to comply with the Consumer Bill of Rights in this area to ensure more uniformity in regard to information disclosure. VHA is taking action to ensure consistent information disclosure throughout the VA system.

2) **Choice of Providers and Plans**
Within available resources, VA provides access to sufficient numbers and types of providers to assure that all covered services are accessible without unreasonable delay. VA will continue to focus on performance improvement by providing better access through community-based outpatient clinics, sharing agreements and provider contracts.

At this time, Continuity of Care, as defined by the Bill of Rights, would not be an issue for VA. VA does not anticipate having to involuntarily disenroll any veteran except those guilty of enrolling under false pretenses.

3) **Access to Emergency Care**

Note: *Issues concerning emergency care are under OMB review. Additional information will be provided under separate cover.*

4) **Participation in Treatment Decisions**
VA clearly meets or exceeds both the letter and spirit of this section.

5) **Respect and Nondiscrimination**
VA clearly meets or exceeds both the letter and spirit of this section.

6) **Confidentiality of Health Information**
VA clearly meets or exceeds both the letter and spirit of this section, but will continue to give VHA personnel ongoing instruction on patient rights and privacy rights and individual responsibility through the VHA Office of Employee Education.

7) **Complaints and Appeals**
Although VHA has patient advocates and other appeal mechanisms at each facility, there has not been a consistent process, including external review, to deal with clinical decisions. A VA-wide work group was formed to analyze this complex issue and submitted their recommendations to me a few weeks ago. On July 2, 1998, I accepted the recommendation to enter into a national contract with an outside organization to handle external appeals and directed that a task force be established to implement this decision. This action will bring VA into compliance with the Bill of Rights in this area.

8) **Consumer Responsibilities**
VA will develop and provide its patients information on patient responsibilities. Patient responsibilities will also remain an ongoing part of VA's patient education activities.

6. Why has VA been reluctant to support my bill, H.R. 3702 that would allow VA to reimburse emergency care to veterans enrolled in VA for healthcare?

Response: *Issues concerning emergency care are under OMB review. Additional information will be provided under separate cover.*

7. Committee staff was briefed on the enrollment process this winter and were told that VA would begin enrolling veterans in February or March. It's now June and I'm told that VA has not yet begun to enroll veterans and hasn't even finished its enrollment application form. What's the hold up? When should we anticipate enrollment to begin for the fiscal year beginning four months from now?

Response: VHA began the enrollment process on June 29, 1998. The new enrollment form is in the draft regulations, which have been cleared by OMB and have been published at 63 Fed. Reg. 37299 (1988) (to be codified at 38 C.F.R. Part 17) (proposed July 10, 1998.)

8. You have heard the VSOs express concern about the enrollment process limiting care to current users. Where do you anticipate the threshold for enrolling priority groups to lie (in other words, what priority groups may be left behind)?

Response: The VA has decided to enroll all seven priority groups in FY 1999. We believe VA resources will be sufficient nationally to support the demand for services, although I would not be surprised if some facilities or VISNs required assistance from reserve funds.

VA has good information about veterans who have used our healthcare system, but not about those who have not. After examining several different assumptions about the possible behavior of new enrollees – e.g., how much they might use the system and for what services, VA decided that VHA could meet the demand for services from these veterans who have never used the system, in addition to current users. We will be maintaining a reserve of at least $125 million in Headquarters to rapidly adjust for any funding imbalances that might occur at the network level. In addition, we will be tracking utilization figures monthly to identify any shortages of certain specialist services (e.g., orthopedics) which may be in relatively short supply. In the near term, it is quite possible that some VISNs and/or facilities may experience longer waiting times for some services. However, I expect such problems to be resolved as networks expand their staff or contracting arrangements to cover the increased demand for services.

9. Explain, in your own opinion, why you think the nation needs a healthcare system devoted to veterans. Why will it continue to require such a system in the foreseeable future?

Response: The Nation has made a commitment to its veterans to "care for him who shall have born the battle," a promise that should not and cannot be abrogated based on economic considerations alone. Veterans have health problems that are unique to their military service and that require specialized expertise and programs.

In addition, the VA healthcare system is a national asset with billions of dollars invested in infrastructure, medical service systems, and education and research assets. The nation would become poorer if VA facilities were arbitrarily downgraded or eliminated.

Finally, the VA healthcare system has become an important social and medical safety net for homeless and poor ex-soldiers who could not easily obtain care anywhere else in a timely manner. For example, VA provides a significant portion of mental health admissions in the United States. Most of these veterans have no jobs and no health insurance. Even those that have jobs may not have access to mental health services because many insurers exclude or severely limit the provision of such care. Abandoning chronically ill and seriously mentally ill veterans would result in serious ethical and social problems, raise acute public policy dilemmas that state and municipal governments would find impossible to solve without additional federal funding. If VA ceased to exist, veterans who depend on VA for such services would be left without needed care. In addition,

some of VA's functions (e.g., emergency management) are inherently governmental and are not now provided by any other agency.

10. VVA today testified that they are very concerned about the Hepatitis C virus that some state may be affecting the veteran population in epidemic proportions. Has VA considered including a screening measure for veterans at risk of Hepatitis C exposure on its Preventive Care Index?

Response: The intent of VA's preventive care index is to assess risk behaviors (tobacco or alcohol use), appropriate use of immunizations to prevent disease (influenza, pneumococcus), and early detection of cancer where recognition may lead to better outcomes. Screening per se is not preventive. Instead the screening delineated in VA's Information Letter establishes a diagnosis of hepatitis C, and should not be included in the Preventive Care Index. VHA also is very concerned about the magnitude of this problem and is in the process of establishing a center that will be specifically focused on hepatitis.

11. VA also does a high volume of care for veterans with the HIV virus and AIDS. Are you considering including this measure for veterans at risk of HIV exposure on VA's preventive care index?

Response: The VA is the largest single provider of HIV care and services in the United States. Concerning screening for HIV, every VA facility has the capability for HIV testing which takes place for a variety of reasons. Veterans may request testing and it is offered when medically appropriate such as when veterans present with medical conditions suggestive of immune deficiency or with risk factors for HIV exposure. For example, regular HIV testing is offered when veterans initiate substance abuse treatment or present with a sexually transmitted disease. In 1996, VA administered nearly 50,000 HIV tests and thus is the largest single source of HIV testing in the nation. It is important to emphasize that the VA conducts all HIV tests in the context of extensive patient education and counseling about confidentiality and risk reduction prior to and after the HIV test. HIV testing education and counseling are performed by professional staff specifically trained for this purpose. In 1996, VA employed approximately 1,100 trained HIV testing counselors.

I have asked the Director of our HIV/AIDS Service to develop a clinical guideline on standards for risk assessment for HIV infection and will explore adding HIV screening and risk education to the Preventive Care Index.

12. Dr. Kizer, I think you are aware that VA's model National Drug Formulary may be used as a prototype for other healthcare providers. The VSOs, certain VA and non-VA clinicians, and certainly pharmaceutical manufacturers have raised significant concerns about the Drug Formulary's impact on patient care. First, can you briefly address their concerns about patient care?

Response: Patient care concerns may be grouped into three categories: 1) access to pharmaceuticals, 2) the quality of the pharmaceuticals, and 3) utilization of the pharmaceuticals.

1) One of the goals of the National Drug Formulary (NDF), which is reflected in VA policy, is to improve access to pharmaceuticals for all veterans. An additional aspect of this policy is the requirement that the pharmaceuticals listed in the NDF be available at all VA medical facilities. The first iteration (May 1997) of the NDF was based upon existing usage of pharmaceuticals within the VHA, and the consensus is that the NDF increased the number of pharmaceuticals available at many VA medical facilities. Only six therapeutic categories are "closed" by the NDF, the remaining other 270 classes are open and VISNs can add additional drugs as needed. In those cases where a physician determines that a non-formulary product best suits the needs of a patient, a non-formulary process, which is also defined in policy, can be utilized. Monitoring of the non-formulary usage in the six closed classes indicates considerable use of the non-formulary process. VHA's NDF policy requires all VISN directors to assure that a timely

and convenient non-formulary process exists at all VA medical facilities. Contrary to what some individuals have said, VA's NDF is not highly restrictive.

2) The NDF only contains FDA-approved medications. The selection of products for formulary listing involves a broad range of heath care providers. For example, input from specialty areas, i.e., AIDS, mental health, SCI, neurology, was/is sought and obtained. Additionally, to make best-value formulary selections an objective, peer review process is in place; scientific, evidence-based literature is the foundation for formulary selection.

3) Formularies are not a new component of healthcare delivery systems in either the private or public sector. VHA has employed drug formularies for over 30 years. What has changed is formulary management. In the past, the sole function was to determine what drugs could and could not be prescribed. Today, formulary management includes clinical protocols to ássist clinicians in using drugs effectively and efficiently, and the means to measure and improve disease outcomes associated with pharmaceutical utilization. The coordinated approach of scientific, evidence-based selection of pharmaceuticals and scientific, evidence-based treatment protocols is being used to improve and measure the quality of care. Drug utilization review and drug use evaluation programs continue at VA medical centers. Their goal is to continually evaluate the effectiveness, safety, and appropriateness of drugs prescribed for patients.

Formulary management today, more than ever, is important for the patient and the VA healthcare system. In the face of the escalating numbers and complexity of drug products, fast tract FDA approvals, rising drug prices, and direct-to-consumer advertising, the formulary management process provides the healthcare system with the ability to objectively discriminate between superior and marginal drugs. This relates to improved safety and effectiveness. An increasing number of FDA-approved drugs are being removed from the market due to safety issues. During the past year alone, Posicor, Phen-Phen and Duracet have been removed. None of these had been placed on the VA's national Formulary.

13. Second, has VA completed the physician survey it intended to use to assess clinicians' satisfaction with the new formulary? What were the results?

Response: The following represents raw data from the survey: A more in-depth analysis of the survey data is underway.

Total of 2,067 surveys returned out of 4,600 distributed.

Respondents were 73 percent male, 27 percent female, representing 59 percent internists, 5 percent neurologists, 5 percent surgeons (not urologists), 3 percent urologists and 22 percent psychiatrists.

99 percent were VA attending physicians, 14 percent P & T Committee members and 20 percent practice in a place with a formulary (other than VA).

RESULTS:

1. Eighty-two (82) percent know of VANF.

2. Forty-one (41) percent have referred to VANF.

3. Most (62 percent) feel that access to prescription drugs is either unchanged (28 percent) or increased (33 percent); 32 percent disagree.

4. Slightly more than 44 percent feel that access to over-the-counter drugs is either unchanged/increased; 40 percent disagree.

5. Most (74 percent) agree or are neutral that they can prescribe needed drugs to patients; 25 percent disagree.

6. Most (79 percent) agree or are neutral that their patients can obtain non-formulary drugs; 19 percent disagree.

7. There is a relative split as to whether VA has a more restrictive formulary: 38 percent agree, 35 percent disagree or are neutral, 27 percent don't know.

8. Most (56 percent) agree or are neutral that the VANF enhances the provision of quality care to their own patients; 29 percent disagree.

9. Most (61 percent) agree or are neutral that the VANF enhances provision of quality care to other VA patients; 20 percent disagree.

10. Few (19 percent) agree that the VANF diminishes the ability of VA trainees to work outside VA, 62 percent disagree or are neutral.

11. There is a split in assessment of workload: 34 percent thought the VANF added to work, 33 percent neutral, 27 percent disagree.

For drugs in selected therapeutic classes in which national contracting occurred, the following positive, negative and don't know responses were given in response to the degree the choices affected the care provided to patients by the respondent:

Drug Class	No or (+) effect	Negative effect	Don't Know
H2 Blocker	71%	17%	12%
HMG CoA	76%	7%	17%
Alpha Blocker	73%	8%	18%
PPI	71%	12%	17%
LHRH Agonist	53%	2%	45%
ACE Inhibitor	76%	7%	17%

Again, the data are still raw and statistical analysis has not been completed. We also plan to conduct similar surveys in the future to ensure that the formulary process remains contemporary and able to react to the dynamics of new therapies and changing treatment modalities. Please understand that I requested this survey be done so that we could improve the NDF where it needs it or to improve understanding of how to use the NDF if that is a problem.

14. Explain the weights ascribed to various components of VHA's performance contract. Specifically, how is financial management (efficiency and productivity measures) weighted relative to the measures of quality?

Response: There are four parts to the Network Directors' performance agreements, one of which contains the performance measures. The other three involve "core competencies" of executives, the 10 dimensions of VA's quality framework, and various areas of organizational emphasis such as fair workforce treatment, and occupational safety. The Performance Management Workgroup, an advisory group to the Under Secretary for Health regarding performance management issues, is currently discussing a specific weighting method for the four parts of the 1998 agreements. In response to your specific question, although, there is no formal weighting system for the five domains of value into which the performance measures are divided, the domains of quality contain more than twice as many measures than the domain of cost (efficiency and productivity measures). This increased emphasis on quality measures, therefore, constitutes a de facto weighting system substantially favoring quality over cost.

15. Would you like to comment on either the role for VA described by Ms. Quandt or Mr. Backhus?

Response: I believe, Ms. Quandt, in her testimony emphasizes "thinning out VA assets" and limiting the pool of veterans who would have access to care. During my tenure as Under Secretary for Health, I have tried to improve access to VA care for all veterans. I think the record will show that through restructuring the old VA medical system, it has become possible to serve more veterans and reduce cost of care at the same time. Mr. Backhus accurately described many of our past restructuring activities and I would agree with his assessment that VA must build upon both its own and on community resources to meet the challenges to the system in the coming years.

In recent years, HMOs have become the dominant players in the healthcare industry and the sharpest competitors for veteran patients. However, accumulating evidence of certain unacceptable practices engaged in by some managed care organizations is about to alter the ground rules of the present competitive environment. The competitive economic edge enjoyed by these HMOs could evaporate under rule changes. In the changed environment, VA healthcare may become the best medical care value especially since it is already a good deal now. Even independent of market trends that are favorable to VA, the challenges discussed by Ms. Quandt and Mr. Backhus can be met if VA continues to make progress at the same or similar rate in the future as it has done during the past 2-3 years. I am optimistic because I see that more and more VA employees have come to the realization that the key to VA's becoming a preferred healthcare provider, depends on life-long learning and being responsive to changes occurring in the larger healthcare environment.

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★
(202) 861-2700 ★

July 22, 1998

Sandra McClellan
Room 333 Cannon House Office Building
Washington, DC 20515

Dear Ms. McClellan:

I am submitting my response to questions raised by Representative Evans from the June 17, 1998 House Veterans' Affairs Subcommittee on Health's hearing.

1. I am aware that you have discussed elements of your GI Bill for health with other VSOs. Your testimony indicates that other members of the veterans' community support your recommendations. Specifically, what elements do you believe are supported by others; where do you believe there is disagreement?

I believe the other veterans service organizations support the following elements of the GI Bill of Health:

- *care and treatment to service-connected disabled veterans remains a top priority and at no cost to the veteran.*
- *access to VA health care by all veterans.*
- *recovery of third-party reimbursement from health care insurers, both public and private.*
- *expanded access points for health care, through both contracting for services and construction of VA facilities.*
- *improve, strengthen and preserve specialized services.*
- *using third-party reimbursement to supplement rather than offset federal appropriations.*
- *defined health benefit packages.*

I believe the other veterans service organizations do not yet agree on the following elements of the GI Bill of Health:

- *opening access to VA health care to all dependents of veterans. (However, dependents of retired military personnel are currently using the system in some VISNs. It is also an acceptable means to resolve underutilization concerns.)*
- *allowing veterans and their dependents to purchase, on a premium basis, defined health benefit packages.*

2. Mr. Robertson, your testimony states that all veterans identified under Title 38, U.S.C. should receive care at no cost. The law allows all honorably discharged veterans to use VA health care, if space and resources are available. Where would the third party funding come from?

Under the new enrollment system, veterans are placed into seven priorities. Veterans in priorities 1-6 would be paid for from annual discretionary appropriations. All priority 7 veterans and all dependents would pay VA for health care services and treatments received. Third-party reimbursements would come primarily from premiums, co-payments and deductibles paid by veterans and their dependents, as well as third-party insurers, both public and private.

The GI Bill of Health would provide two defined health benefit packages (basic and comprehensive) and supplementals for specialized services. The intent is to provide all service-connected veterans rated 50 percent or higher the comprehensive health benefit package and any appropriate supplemental package needed at no cost to the veteran. VA would provide funding based on a capitated formula through annual discretionary appropriations.

All service-connected veterans rated 40 percent or less would be provided the basic health benefit package and any appropriate supplemental package needed at no cost to the veteran. VA would provide funding based on a capitated formula through annual discretionary appropriations. Should a veteran want to purchase the comprehensive health benefit package or additional supplemental packages, the veteran would be offered discounted premium rates based on the veterans' eligibility and degree of disability.

All other priority veterans would be provided the basic health benefit package and any appropriate supplemental package needed at no cost to the veteran. VA would provide funding based on a capitated formula through annual discretionary appropriations. Should a veteran want to purchase the comprehensive health benefit package or additional supplemental packages, the veteran would be offered discounted premium rates based on eligibility.

All other nonpriority veterans and dependents could purchase defined health benefit packages, as desired, on a premium basis. Access to supplemental packages would be limited and on a premium basis. Those having private health care coverage could pay deductibles or copayments as agreed to by VA and the private health care insurer.

3. Under your proposal, would the government be responsible for funding health care to meet the health care needs of veterans' family members?

As stated in my testimony, the government would pay for those veterans and dependents they are required by law to pay for, everyone else is responsible for their own health care coverage.
For an example, dependents eligibile for Medicare, TriCare, Medicaid, or CHAMPVA would be covered by the federal government under the same capitated formula used to covered veterans and the defined health benefit package to which they would be entitled, as determined by that federal program.

This would comply with President Lincoln's pledge to care for the orphan and widow.

I am prepared to answer any additional questions.

Sincerely,

Steve Robertson, Director
National Legislative Commission

THE INDEPENDENT BUDGET

A Budget for Veterans by Veterans

July 20, 1998

The Honorable Lane Evans
Ranking Democratic Member
House Committee on Veterans' Affairs
333 Cannon House Office Building
Washington, DC 20515-6335

Dear Representative Evans:

In reference to your letter of June 22, 1998, attached is PVA's response to your post-hearing questions concerning the hearing of the Subcommittee on Health on June 17, 1998.

Sincerely,

AMVETS

Disabled American Veterans

Paralyzed Veterans of America

Veterans of Foreign Wars of the United States

Attachment

A Joint Project of:

AMVETS
4647 Forbes Boulevard
Lanham, Maryland 20706
301/459-9600

DISABLED AMERICAN VETERANS
807 Maine Avenue, S.W.
Washington, D.C. 20024
202/554-3506

PARALYZED VETERANS OF AMERICA
801 Eighteenth Street, N.W.
Washington, D.C. 20006
202/872-1300

VETERANS OF FOREIGN WARS
OF THE UNITED STATES
200 Maryland Avenue, N.E.
Washington, D.C. 20002
202/543-2239

House Committee on Veterans' Affairs

Subcommittee on Health Hearing

June 17, 1998

Follow-Up Questions for IBVSOs

Question

1) I know there is a great deal of confusion about enrollment and your testimony states that the VSOs feel the enrollment process could have a major impact on veterans' current access to VA health care. Have you and the other IBVSOs communicated to your members about enrollment? What are your members' specific concerns?

Answer

1) The Independent Budget Veterans Service Organizations (IBVSOs) have communicated with our members regarding the implications and potential problems associated with the enrollment system mandated by the "Veterans' Health Care Eligibility Reform Act of 1996," P.L. 104-262, 110 Stat. 3177. As the implementation date of October 1, 1998 nears, we are even more concerned about the full ramifications and implications to our members and other veterans relying on the Department of Veterans Affairs (VA) health care system. As stated in our testimony, with the VA facing a budget crunch, no one is really quite certain how many veterans will be enrolled, and how far down the enrollment hierarchy ladder individual medical facilities will be able to go before veterans are literally turned away from the system.

Question

2) Your testimony raises concerns about the new revenue streams VA is bringing into the system and the potential for VA to have perverse incentives to treat higher income veterans at the expense of treating veterans with higher priorities to care. Do the IBVSOs support VA's 30-20-10 plan? If not, how would you prefer to see VA funded?

Answer

2) At this point the VA's "30-20-10 plan" is more a catch phrase than a realistic approach to ensuring that VA meets its commitment to veterans. With the VA facing flat-lined budgets it is easier to come up with a slogan that attempts to put a good face on a bad situation. There are real questions, and real concerns, over the VA's ability to accomplish its mission to provide adequate, quality health care in this budget environment. This, coupled with ongoing VA decentralization could very well lead to a climate where veterans with a checkbook receive care and service-connected or low-income veterans must sit and wait upon the President and Congress to provide sufficient appropriated dollars. The IBVSOs have supported alternative funding streams, but only as a supplement to, not a substitute for, full and adequate appropriations. Veterans, and the Cabinet-level Department that is charged with seeing to their needs, are a national commitment – they should not be haphazardly funded by user fees and co-payments and insurance reimbursements.

Question

3) As some of VHA's chief stakeholders, I think it is important to have a vision for VHA's future. What do you believe is the "best-case" scenario for VA? How can Congress help VA achieve it?

Answer

3) Congress can make certain that the promises made to veterans are kept, that they receive the benefits owed to them and the health care they deserve. If the federal government lives up to its commitments then the future of the VA will be bright.

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

July 7, 1998

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Evans:

Enclosed is our response to your questions pertaining to my June 17, 1998, testimony before the House Subcommittee on Health on the challenges facing VA's future role in serving veterans. If you have any additional questions, please contact me at (202) 512-7101.

Sincerely yours,

Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

Enclosure

1. Do you believe VA's loss of workload in nursing homes and psychiatric care settings is attributable to VA finding more appropriate treatment options for them or are reductions primarily budget-driven?

We believe that VA's changing workload in nursing home and psychiatric care settings is primarily attributable to VA's desire to find more appropriate treatment options. Years ago, private and state-operated entities began placing patients in alternative settings when it was determined that outcomes achieved in non-institutional settings were equivalent to those achieved on an inpatient basis. VA appears to be implementing treatment practices that are more comparable to those used in the private sector, although we have not evaluated VA's practices to determine the extent to which this is the case. We recognize, however, that VA may be more aggressive in seeking to serve veterans in alternative settings because of budget driven considerations, such as VA's new resource allocation methodology.

2. Do you believe VA's future lies in how well it competes for new veterans and their dependents? What potential trade-offs might this entail for those veterans currently using the system?

We do not believe that VA's future necessarily depends on how well VA competes for new veterans and their dependents. For example, VA could successfully meet current users' needs by operating an integrated system of VA and non-VA providers. In recent years, VA has made progress in its transition from a predominantly direct deliverer of care to an integrated system of VA-operated and privately-operated providers. We recognize, however, that VA could have to compete for an increased patient workload and enhanced revenues if it continues to predominantly deliver care in its existing structures, in the future.

In this regard, VA's efforts to compete with other providers for new veterans and dependents could result in delays, denials, or reduction in the quality of care for current veteran users in some circumstances. For example, current users could be exposed to risks if VA were to find it necessary to adjust its services because of shortfalls in revenues anticipated from serving new patient populations. In addition, negative outcomes for current users could also develop if VA found it necessary to give a higher priority to new patients in order to attract or retain them.

3. If VA's future lies in recruiting new veterans and their dependents, how does GAO envision the health care system differing from any other nationwide non-profit health maintenance organization? Would the VA health care system serve any unique purpose?

VA's health care system would have to be similar to other non-profit health maintenance organizations in order to successfully compete for patients. In so doing, of the medical services that VA provides would duplicate services available through private sector providers.

VA's health care system, however, would differ from such organizations in two ways. First, VA's system could continue to offer unique ways to provide such specialized health care as rehabilitative or psychiatric services. Second, the system includes medical research, health care education, and backup medical care in time of national emergency.

4. How do VA's special emphasis programs fit into the future GAO envisions for VA? Are there still types of care VA has unique expertise in delivering that VA could not contract for in the private sector?

We believe that VA's special emphasis programs should play a critical role in VA's future. This is because VA has developed considerable expertise in the treatment of such conditions as spinal cord injury, physical and blind rehabilitation, prosthetic devices, and psychiatric and neuropsychiatric illnesses. These appear to be the types of cases which VA may have difficulty contracting for in the private sector.

HONORABLE LANE EVANS
QUESTIONS SUBMITTED FOR THE RECORD TO
MS. MARJORIE QUANDT
FOR THE HEARING OF JUNE 17, 1998

I. Ms. Quandt, how would you envision VA allocating the funds associated with disposal of VA property and assets? Would it stay with the facility or be put in a centralized fund? What do you see as the highest priorities for reinvesting these funds?

My inclination would be to place funds in headquarters accounts. While devolution is paramount today, VHA is first and foremost meant to be a national system of care--not independent, competing islets of veteran health care.

Let us assume Congress recognizes the merits of divesting VHA of under used facilities. Let us further assume that the total value of land and under used physical plants is worth $7 billion on the open market. (This is about half the value of VHA physical assets.) VISNs do not have qualified manpower to find the buyer at the best price. More importantly, the assumption is that receipts will be invested in the market for the highest rate of return, and VISNs have no one with such "Wall Street broker" skills. The highest priority for reinvesting these funds is to make money. Thus, VA wants to receive the best price on sale and the highest return on re-investment. An activity of this type is best handled at headquarters where highly qualified professionals can be obtained through direct employment or contract.

Interest or dividends earned on invested funds should go into the medical care or construction accounts, perhaps on an 80-20 split. These funds should not go to the Treasury unless VHA is completely abolished.

VISNs will obtain their fair share of these new funds based on VERA, its eventual successor, and veteran population. Direct patient care should receive the bulk of funds followed by leasing efficient, modern space or contracting for whatever bed care is needed. Major construction should be the lowest priority.

II. Suppose an obsolete or unsafe veterans' hospital exists in a place where there is still relatively high demand for it--would you still advocate that VA let it deteriorate and send the patients it serves to other care providers?

VHA has already proven how it handles unsafe facilities--Sepulveda and Martinez are the lone examples. These facilities were abandoned, further demolished and care moved to ambulatory clinics and adjacent VHA hospitals or DoD facilities. VA cannot afford to be culpable by retaining what it knows to be an unsafe facility, whether it is unsafe due to earthquakes or other major causes. Therefore, unsafe is not even part of the discussion.

Obsolete is another matter. Why is a facility obsolete? Did the eligible population move away or die off; has there been a failure to maintain modern, quality equipment and systems, or did the practice of medicine and health care change so radically beds are not needed? It is foolish to maintain a facility which has become obsolete because of lack of eligible population. The cost per case becomes a waste of

taxpayer money. Failure to maintain modern, quality systems represents poor quality medicine. Congress could rectify the latter situation with better budgets. The issue of medicine changing so radically that care moves from bed to non-bed and other levels such as residential care results in a situation again in which the cost per case is too high to be competitive or cost effective. The General Accounting Office very ably pointed this out in its April 1998 study of VA Hospitals.

The heart of veterans' health care is not bricks, mortar and acreage. The time has come when VA must abandon its 100 plus year life cycle for facilities. Let us assume a facility is obsolete. VHA should require a cost comparison on the specific hospital to determine current veteran population and projected population for the next 10 years particularly with respect to age changes and most common conditions treated. Next the delivery of care now and how it will be performed in the next five years should be compared. The cost to bring the facility up to standard as far as fire/safety and modern equipment/systems is the third step. Lastly, the capital cost per case as well as direct patient care cost should be compared against providing care in leased space or contract care with VHA physicians/clinicians as direct providers. When cost of improving the obsolete facility is greater than alternatives, the facility should be sold.

III. You envision a VA-DOD system where VA has a limited number of general medical-surgical hospitals, VA users would mostly rely upon acute care services operated by DOD, and VA would offer primary care, but mostly serve to meet veterans' longer-term and rehabilitative care needs. Other than a sense of indebtedness, what would lead you to believe DOD would be interested in entering such a relationship with VA when its mostly younger and healthier beneficiaries would stand little to gain from VA's longer term care services?

This question takes a very short-range view of health care. One might say a view of only a moment. The popular press, one Congressional commission and the FY '99 budget all carry indications that DOD is having trouble recruiting and retaining qualified troop strength. The Washington Times reports there is a rising number of recruits who score in the lowest mental category--known as "cat fours." Ninety percent of recruits have not finished high school, and the Air Force has a shortage of pilots. Conclusions reached from these facts are that the military's lesser retirement package is a continuing disincentive to make the military a career. Pay, housing, loans, education benefits and health care are all a part of such a benefit package. It is known in some communities that retired military placed in TRICARE feel abandoned by DOD. Some $8 billion has been put in the FY 99 DOD budget for improved housing and hospital construction among other perquisites. Younger, healthier members would see that one of their perquisites on retirement would be continuation of a coordinated service for them and their dependents whether the condition was acute or chronic. They would be living with a fully coordinated, integrated health care system committed to them and to their dependents. In other words, a promise made on recruitment becomes a promise kept on retirement and after armed conflict.

Had Congress and the various administrations required VHA and DOD to plan more carefully, the move to TRICARE might have been delayed if not altogether avoided. There is still an opportunity with some 331,000 FTEE to design a coordinated, managed health care system which can provide quality care under the direction and control of

DOD-VA. One could assume with 331,000 FTEE, not all of whom will be in a redesigned system, sufficient quality professional staff are present or included in the person-power strength.

Your question leads me to believe you consider my proposal will only provide very limited VA beds. VA would continue to provide whatever hospital support is required wherever the veteran population is sufficiently large to support a free standing VA hospital, such as in Illinois, Pennsylvania, Oregon and so forth. VA would also provide care in DOD facilities in these states to cover CHAMPUS, CHAMPVA and retirees. In the 19 states identified on the map in my testimony, VA would provide care in community clinics operated by VHA, in DOD facilities, and in-patient care elsewhere in the private sector under the direction of VA staff, or VA-DOD staff. The requirement that VA physicians and other clinicians apply for staff privileges in these latter communities retains VA control of patient care and continuity of care. VA presence would be expanded in these 19 states bringing care closer to the veteran or retiree and his/her dependents. This should be especially true in North and South Dakota, Wyoming and Montana.

Last of all remember it is expected in the future that only the most serious cases such as organ transplants, 3-D heart or brain surgery, burn cases and major trauma cases will be hospitalized. The remainder will be outpatients or cared for in special convalescent units if not at home. Nor should one forget the impact of biopharmacology on the delivery of health care.

IV. **Do you believe that the private sector can adquately meet veterans' special and longer-term needs in areas where neither VA nor DOD will have facilities?**

This is a difficult question to answer. I do not believe the general private sector presently can adequately meet veterans' special and long-term needs when we consider spinal cord injured, blind rehabilitation, psychiatry, PTSD or the sequela of short-term military skirmishes such as Gulf War Syndrome. If one looks at the private sector the general population has had fewer resources, except for such nationally known centers as The City of Hope, The Chicago Rehabilitation Institute, The Rusk Institute, some prominent alcohol and drug rehabilitation centers and the Shriners' Children's Hospitals. Other than those choices, the general population might hope to find such care at the state University Hospital, or in large tertiary care facilities in major metropolitan areas. The care given would not be sustained as it has been in VA, and for many financial coverage would be a challenge.

V. **DOD is placing a growing portion of its care in the private-sector through its TRICARE program. It is closing more and more of its hospitals and replacing hospital beds at many remaining facilities with basic primary care mostly delivered on an outpatient basis. Only a handful of hospitals left in the DOD system have more than a general medical-surgical capability. Are you ultimately advocating "mainstreaming" for DOD and VA federal health care systemns?**

In the rush to balance the budget Congress and administrations ignored the requirement to fund adequately the country's defense system, including the incentive

elements of housing, schools and health care. DOD has been forced to move to TRICARE because the demise of the Cold War lulled policy makers into a sense of security and willingness to spend DOD moneys on other discretionary programs. Pork barrel projects of unnecessary planes and equipment not requested by DOD have also diverted moneys from the basic components of a sound defense system and manpower policy. The move to primary care is brought about by advances in medicine and changes in delivery practices.

It is a matter of time before another BRAC Commission is requested for DOD. It would be well if the ground rules in the future recognized health care as part of the commitment made on recruitment. Existing hospitals in any such bases could be transferred to the VA if the retiree and veteran populations were large enough. Such a case might have been made for the hospitals at Victorville (CA) AFB or at K. I. Sawyer (MI) AFB.

Mainstreaming, which has gained a pejorative connotation in veteran politics, may someday be necessary for VA's health care system. This would be true if the quality of care deteriorated below that of the general population, or if VA could not attract quality professional staff. It is extremely difficult to envision DOD care being totally mainstreamed. Even our allies who have adopted national health systems have maintained a health care system for active military.

My proposal of merging the best of DOD and VHA is to stave off mainstreaming movements. Between the two systems there are funds for patient care, medical research, education and better coordination of contingency requirements. Furthermore some of the R&D and management engineering activities of DOD can be used to assist in developing a medical care system which stresses management of care by professional care givers rather than budget examiners.

In my opinion the current direction of both systems will lead to mainstreaming in the not too distant future if administrations and Congress persist in their failure to recognize that preparation for readiness requires a fully staffed medical service and medical service corps, and that the sequela of war is sustained, coordinated health care.

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