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Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

November 2000

VA HEALTH CARE

Expanding Food Service Initiatives Could Save Millions

GAO-01-64

Contents

Abbreviations

AFGE	American Federation of Government Employees
NFS	Nutrition and Food Services
OMB	Office of Management and Budget
SPV	Subsistence Prime Vendor
VA	Department of Veterans Affairs
VCS	Veterans Canteen Service

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United States General Accounting Office
Washington, D.C. 20548

November 30, 2000

The Honorable Terry Everett
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) provides food service for more than 36,000 inpatients daily in its hospitals, nursing homes, and domiciliaries.[1] VA's Nutrition and Food Services (NFS) program spends about $324 million annually to provide these services in 177 inpatient locations. About 70 percent of these expenditures are for the cost of labor of 7,000 NFS wage-grade employees[2] who cook and prepare food; distribute food to patients; and retrieve and wash plates, trays, and utensils.[3]

As agreed with your office, we assessed three major initiatives VA has taken to lower the costs of its inpatient food services: (1) consolidation of food production, (2) employing Veterans Canteen Service (VCS) workers to provide inpatient food services, and (3) competitive sourcing to determine if it is more cost effective to maintain services in-house or contract with the private sector.[4] We assessed the extent to which these initiatives have reduced costs in some inpatient locations and what additional savings may be possible if these initiatives are implemented in other locations.[5]

[1]A VA domiciliary is a residential rehabilitation and health maintenance center for veterans who do not require hospital or nursing home care but are unable to live independently because of medical or psychiatric disabilities.

[2]Numbers of employees in this report refer to full-time equivalent employees.

[3]These costs represent the direct production and distribution costs of inpatient food services. We excluded the clinical dietetic, technical, and administrative costs of NFS dietitians and other general schedule employees.

[4]VCS is a unit of VA that has authority to provide, at reasonable prices, merchandise and services (for example, food and vending machines) at VA inpatient locations and other health care locations (38 U.S.C. 7801).

[5]For baseline data on VA's inpatient food services, see *VA Health Care: Food Service Operations and Costs at Inpatient Facilities* (GAO/HEHS-00-17, Nov. 19, 1999).

To conduct our work, we obtained data on food services from VA's 22 health care networks for all VA's inpatient locations for fiscal year 1999. We also obtained data from VA headquarters officials and conducted site visits and telephone interviews with local VA officials and with contractors. (See app. I for a complete description of our scope and methodology.) Our work was performed between October 1999 and November 2000 in accordance with generally accepted government auditing standards.

Results in Brief

To reduce the costs of inpatient food service operations over the past two decades, about one-fifth of VA's 177 inpatient locations have consolidated food production, shifted to VCS workers, or contracted with private-sector food service organizations. If VA systematically evaluated these options and implemented the most cost-effective one at each inpatient location, VA could save an estimated $79 million annually—about one-quarter of its inpatient food service expenditures.

To enhance efficiency, VA has consolidated 28 food production locations into 10. These locations transport food to other inpatient locations, generally within 90 minutes' driving distance. Currently, VA operates 63 unconsolidated production locations that are within similar driving distance of another production location. Our assessment suggests that consolidating these 63 locations into 29 production locations could save an estimated $12 million annually. To achieve these savings, VA could be required to make a one-time investment of an estimated $11 million for equipment.

In addition, VA recently began to employ VCS workers, whose wage rates are lower than NFS employees, to provide inpatient food services at nine inpatient locations. The wage differences result from differences in how wage rates for their respective pay schedules are determined, but both are federal government employees with the same standard government benefit coverage. VCS job descriptions are similar to those of NFS and both receive similar training when providing inpatient food services. When VCS workers provide inpatient food services, NFS dietitians continue to ensure that patients at these locations receive quality nutrition as part of VA's health care program. Three other inpatient locations are scheduled to make the change from NFS to VCS employees. Before these changes, VCS only provided retail food services for employees, visitors, and outpatients at these and other inpatient locations. NFS employees still provide inpatient food service at 166 other inpatient locations; our assessment suggests that having VCS employees provide inpatient food services at these 166

locations could save an estimated $67 million annually in addition to $12 million in estimated savings from consolidations.

VA also currently uses food service contractors to a limited extent. Contractors provide food service at two VA long-term-care inpatient locations that do not have VCS retail food services. VA may be able to reduce costs through competitive sourcing at other locations to determine if in-house or private sector operation is more cost effective. We cannot estimate potential savings from competitive sourcing because of uncertainty regarding the availability of interested contractors at each VA location, the price of contractor services, and variability by location in VA's ability to decrease the costs of its in-house service delivery as part of a competitive process. Difficulty in estimating potential savings is compounded by NFS's limited contracting experience and VCS's unwillingness to combine its retail business with NFS inpatient business when contractors are solicited.

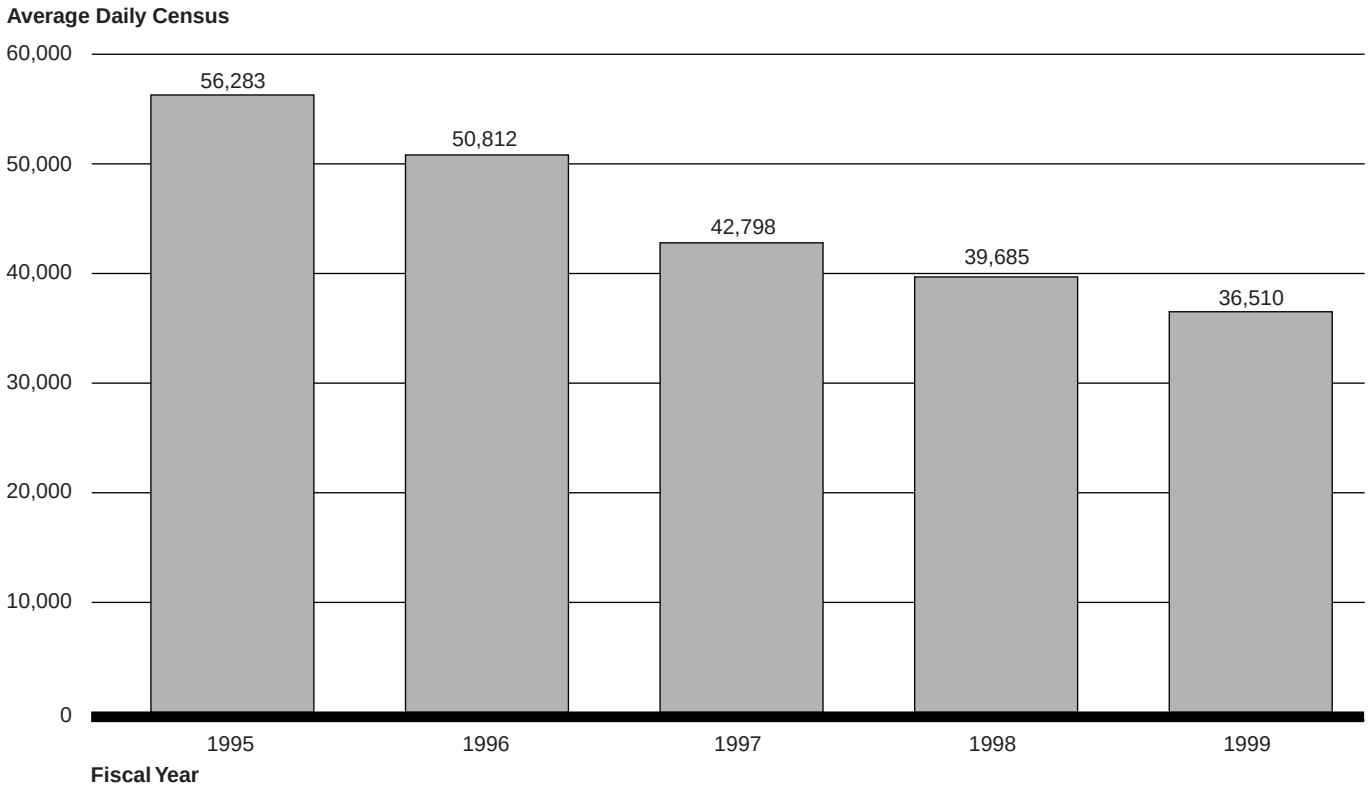
We recommend that VA systematically assess each inpatient food operation to determine if consolidation, employment of VCS workers, competitive sourcing, or a combination of these options would reduce costs while maintaining quality, and then implement the least-costly options in a timely manner. VA agreed in principle and stated that it has already initiated actions to implement these recommendations. However, VA did not provide concrete plans or timelines for implementing the least-costly options. By contrast, the American Federation of Government Employees, AFL-CIO (AFGE) opposed the use of all three options we recommended that VA assess, citing a number of concerns. Foremost, AFGE questioned whether VA should focus its cost containment strategies on efforts that, in its view, could further impoverish current workers or compromise food quality. While we understand and appreciate AFGE's legitimate concerns about current workers' wages and employment and the quality of food provided to veterans, we believe VA can adequately address these concerns when implementing our recommendations.

Background

In 1995, VA began transforming its delivery and management of health care to expand access to care and increase efficiency. As part of this transformation VA decentralized decision-making and budgeting authority to 22 Veterans Integrated Service Networks, which became responsible for managing all VA health care. The networks and their health care locations became responsible for responding to changing inpatient food service needs and for maintaining or improving quality.

Since 1995, the networks have focused on providing care in the most appropriate setting by following headquarters' guidance and responding to performance measurement incentives. This has resulted in an increase in outpatient care and a decrease in inpatient care. The inpatient average daily census numbers have declined by 35 percent during this period (see fig. 1).

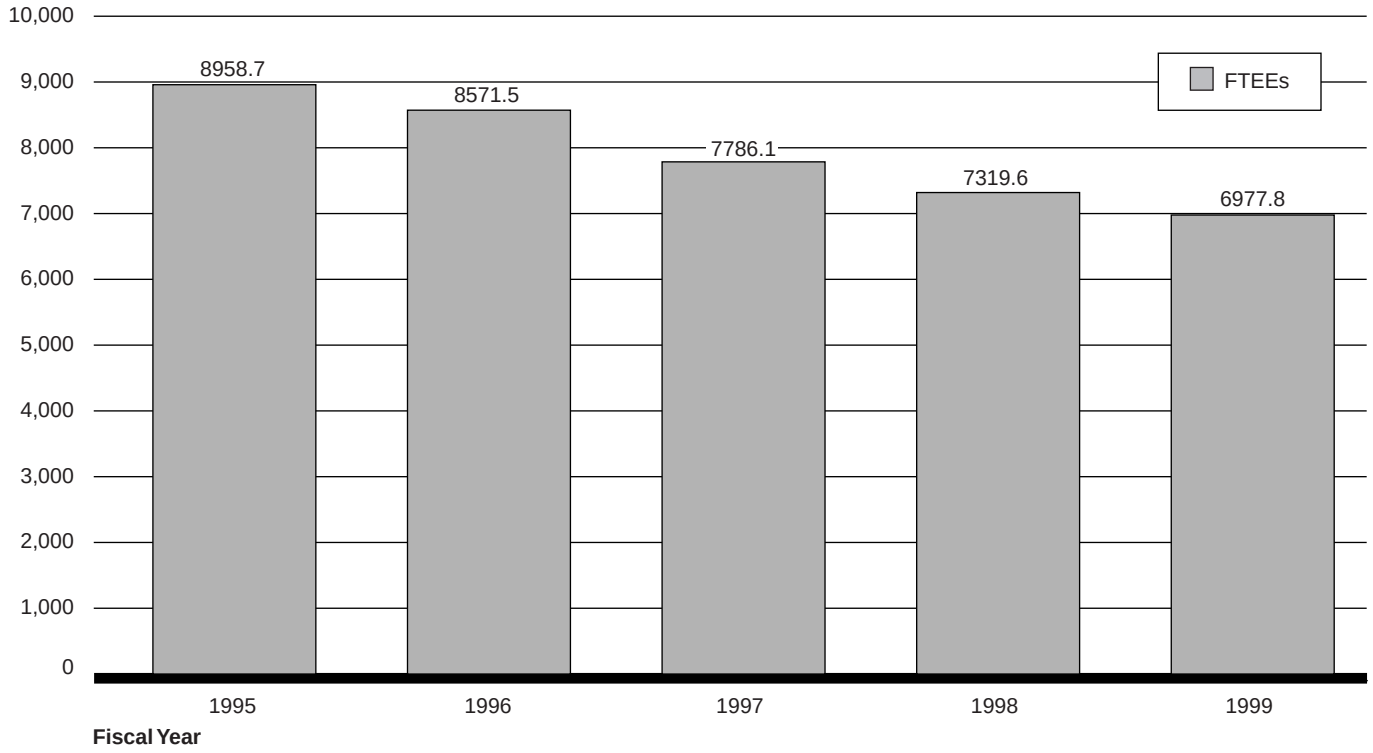
Figure 1: Reduction in Average Daily Inpatient Census, FY 1995–FY 1999



Source: VA.

Because the decreased number of inpatients meant less need for food services, VA downsized its inpatient food service staff by about 22 percent as a result of actions taken by networks and inpatient locations (see fig. 2).

Figure 2: VA Decrease in Food Service Workers, FY 1995–FY 1999



Note: Numbers of employees refer to full-time equivalent (FTEE) positions.

Source: GAO calculations based on data from VA.

Unlike most health care systems, VA divides its food service operations into inpatient and retail operations, usually with separate kitchens and staff at each inpatient location. The NFS program, funded by appropriations, is responsible for ensuring that VA's inpatients receive quality nutrition as an integrated part of their health care. VCS is generally responsible for providing food and other retail services to outpatients, visitors, and employees at VA's health care delivery locations. Although the law authorizes VCS to receive appropriations, VCS has operated for many years solely on funds earned from sales.

As with direct health care services, VA's networks have also explored ways to improve services that support health care, such as food service operations. While VA networks have the option to focus exclusively on improving the efficiency of in-house provision of food service, they also

have the option of competing their in-house operations versus contractors to improve efficiency. VA could do this through the Office of Management and Budget (OMB) Circular A-76 process. In the A-76 process, the government identifies the work to be performed—described in the performance work statement—and prepares an in-house cost estimate, based on its most efficient organization, to compare with the best offer from the private sector.

Additional Consolidation of Food Production Locations Could Save Millions of Dollars

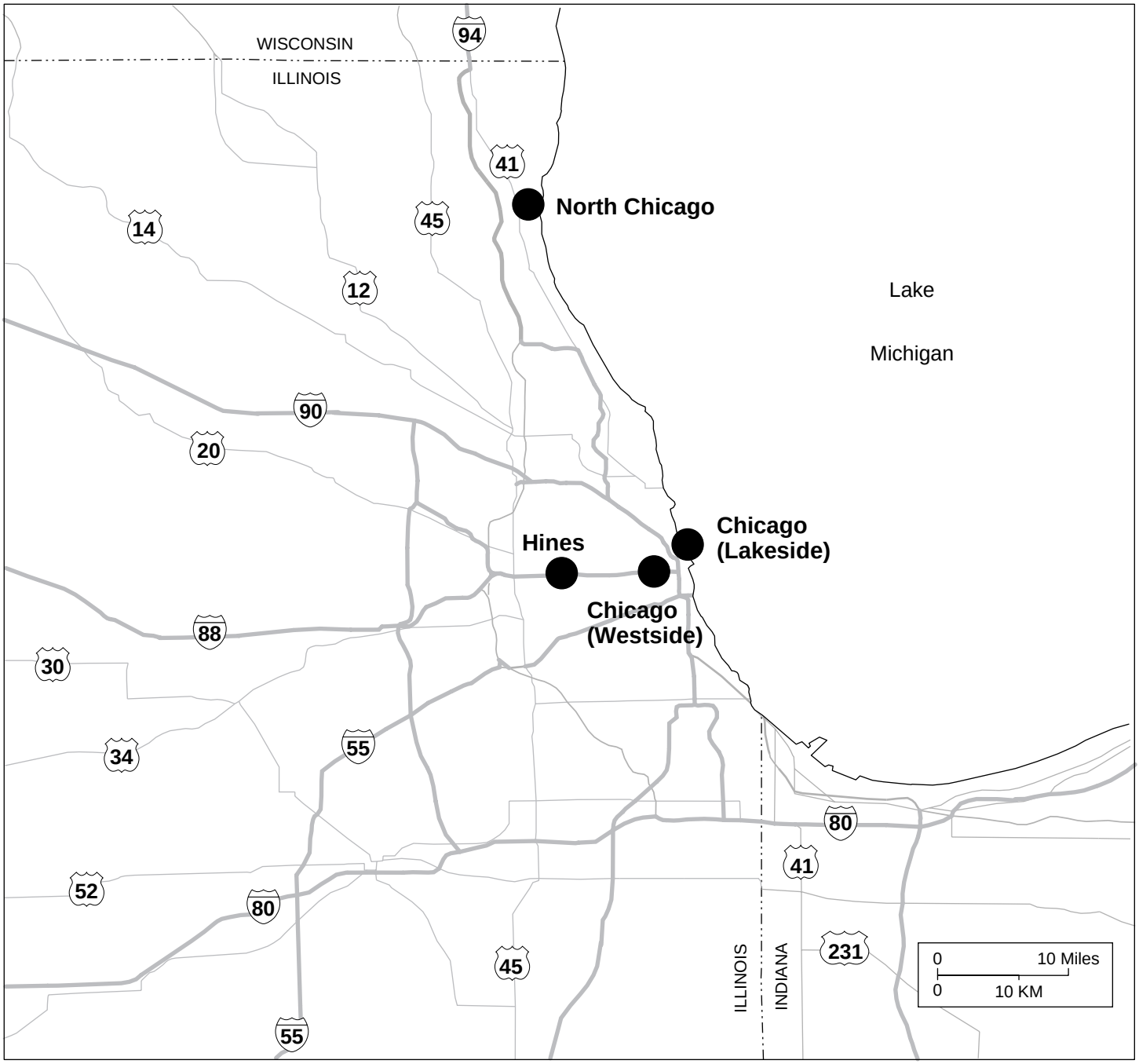
To enhance the efficiency of food service, VA has consolidated food production (the cooking and preparation of food) for 28 inpatient locations into kitchens at 10 VA inpatient locations. One of these consolidations took place in the Central Texas Healthcare System and resulted in elimination of food production at two facilities. This example illustrates key elements of the consolidation process. Before consolidation, the Temple, Waco, and Marlin locations each produced their own food for average daily inpatient populations of 664, 679, and 74, respectively. After consolidation, food for Waco and Marlin was produced at Temple because adequate space was available and driving distances (the time needed to transport food) to the receiving locations were less than 90 minutes. The consolidation was phased in over about 3 years and completed in 1998. The consolidation required one-time equipment purchases of about $1 million and resulted in recurring annual labor savings of about $1.3 million.[6] Labor savings were achieved by a reduction of 32 employees, primarily through attrition and buyouts.

The Central Texas Healthcare System produces food in one location and transports it to other locations using an advance food preparation and delivery system. Food is prepared in advance and chilled for serving up to 5 days later. The chilled food can be transported in refrigerated trucks from one location to another without losing freshness or becoming unsafe. The food is reheated at the location where it is served. VA reports that patient satisfaction at the Central Texas Health Care System is higher, as measured by patient surveys, since consolidation. VA's NFS dietitians continue to have responsibility for ensuring food quality and that the nutrition needs of patients are met.

[6]No equipment purchase was required at Waco because it already had the equipment needed for food delivery and reheating.

Additional VA health care regions provide opportunities for consolidation. For example, four VA locations in the Chicago area are within a 1-hour drive of one another (see fig. 3); in fact, three are within 20 minutes of each other. Yet all four continue to prepare their own food for inpatients. The Chicago network is developing plans for food consolidation for some of these locations.

Figure 3: VA Inpatient Food Production Locations in Chicago Area



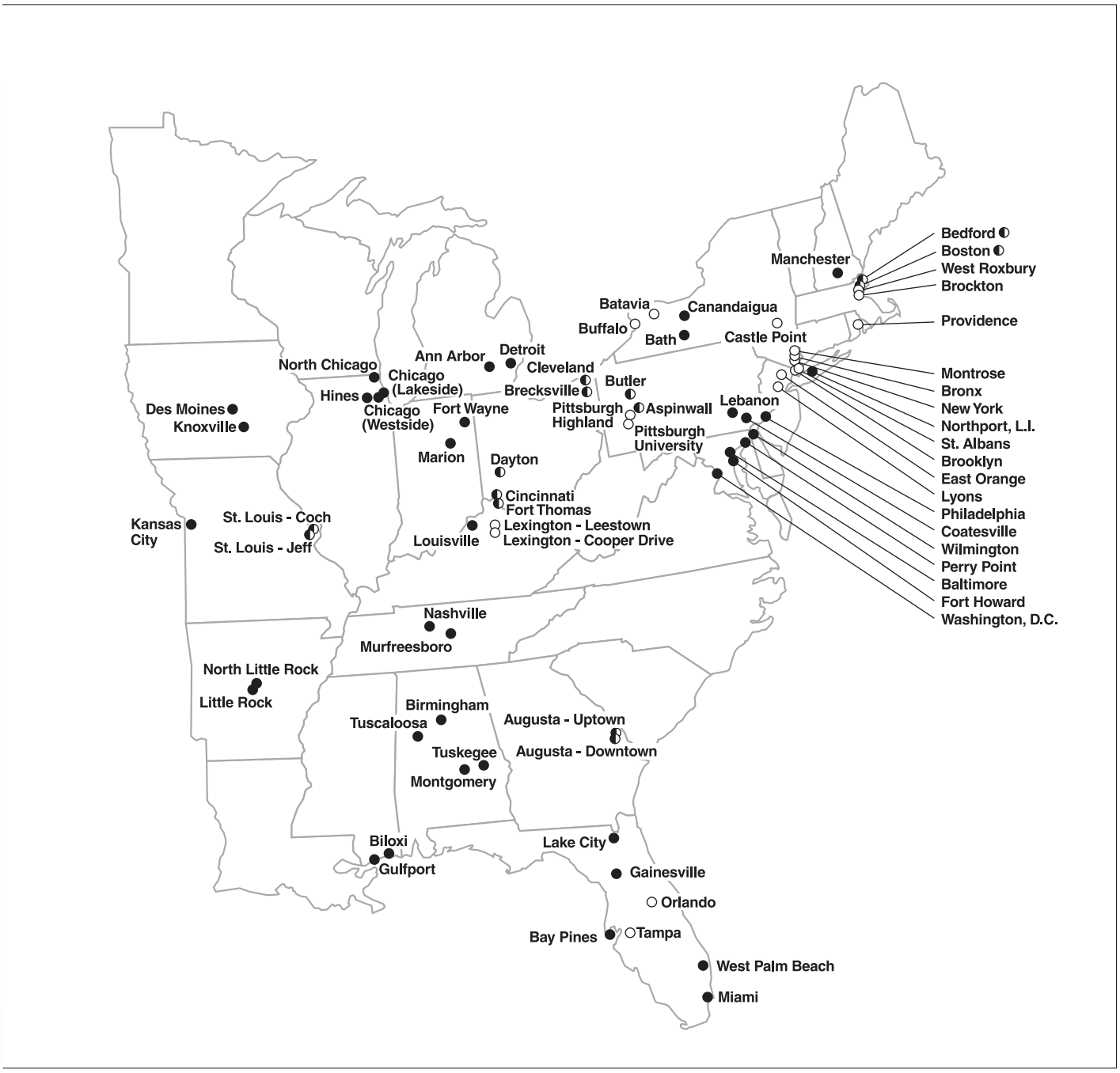
Source: GAO analysis.

Overall, VA currently has 63 unconsolidated production locations within 90 minutes' drive of another production location.[7] Our analysis suggests that VA could increase its efficiency by consolidating food production for these 63 locations into 29 production locations (see fig. 4).[8] These consolidations could save an estimated $12 million annually from a reduction of 348 employees, with as many as 38 positions eliminated in a single location. To achieve these savings, we estimate that VA may have to make a one-time investment of an estimated $11 million to purchase advance food preparation and delivery equipment. (One-time expenditures are held to this amount because 24 of the potential consolidation locations already own the advance food delivery equipment, which makes up the bulk of equipment costs.)

[7]We define consolidation as one VA location preparing at least 80 percent of the food consumed at another location. Some consolidations do not reach 100 percent production at one location for consumption at another because some receiving locations continue to prepare certain food items, such as breakfasts or salads.

[8]Some of these 29 locations already produce food for other VA locations.

Figure 4: VA Inpatient Locations: Food Production Consolidations and Candidates for Consolidation


Bedford
Boston
West Roxbury
Brockton
Manchester
Providence
Batavia
Canandaigua
Buffalo
Bath
Castle Point
Montrose
Bronx
New York
Northport, L.I.
St. Albans
Brooklyn
East Orange
Lyons
Philadelphia
Coatesville
Wilmington
Perry Point
Baltimore
Fort Howard
Washington, D.C.
Ann Arbor
Detroit
North Chicago
Chicago (Lakeside)
Cleveland
Butler
Hines
Brecksville
Des Moines
Knoxville
Chicago (Westside)
Fort Wayne
Pittsburgh Highland
Aspinwall
Lebanon
Pittsburgh University
Marion
Dayton
Cincinnati
Fort Thomas
Kansas City
St. Louis - Coch
St. Louis - Jeff
Louisville
Lexington - Leestown
Lexington - Cooper Drive
Nashville
Murfreesboro
North Little Rock
Little Rock
Birmingham
Tuscaloosa
Augusta - Uptown
Augusta - Downtown
Tuskegee
Montgomery
Biloxi
Gulfport
Lake City
Gainesville
Orlando
Bay Pines
Tampa
West Palm Beach
Miami

Source: GAO analysis.

Making the changes required to consolidate food production requires management commitment to a process that may take several years and much effort to achieve but one that could yield significant savings. Network officials indicated in our survey of VA's health care networks that 29 production locations are considering or planning to consolidate food production. In commenting on a draft version of this report, VA stated that networks 1 (Boston), 3 (Bronx), 8 (Bay Pines), 12 (Chicago), and 22 (Long Beach) have conducted feasibility studies to consider consolidated production. VA has already consolidated some food production locations in these networks. However, these networks could potentially consolidate 14 additional locations into 7 locations.

VA's actual savings from consolidations could exceed our estimates for two reasons. First, VA's Central Texas Health Care System consolidation, from which we obtained a benchmark for estimating potential savings, does not appear to have yet achieved its full savings potential, which suggests that our savings may be understated. VA officials have indicated that several food service positions will not be filled when they become vacant. Some positions were retained to minimize involuntary separation of employees. Second, we used a 90-minute driving distance to determine potential consolidations and it seems possible that VA could elect to use greater distances. For example, the VA facility in Dayton is preparing and delivering food as far as Butler, Pennsylvania—a 6-hour drive. The Dayton facility has technologies that can keep food safely chilled for more than 30 days. In addition, two facilities in Texas that are about a 2-hour drive from one another are currently in the process of consolidating their food systems. Using greater travel distances could allow more facilities to be consolidated, thereby increasing cost savings.

Expanded Employment of VCS Workers Could Save Millions of Dollars

VA can save millions of dollars in labor costs by employing VCS workers, rather than NFS workers, to provide inpatient food service. These savings can be achieved because these workers are paid, on average, about 30 percent less than NFS wage grade employees. The wage differences between the two result from differences in how wage rates for their respective pay schedules are determined.[9] VCS job descriptions are similar

[9]The Office of Personnel Management developed the criteria used for both wage rate schedules under 5 U.S.C. 5341.

to those of NFS and both receive similar training when providing inpatient food services. VCS workers are federal government employees paid under the Non Appropriated Funds Regular Wage Rate Schedule. NFS workers are also federal government employees but are paid under the Federal Wage System Regular and Special Production Facilitating Wage Rate Schedule. Both VCS and NFS employees have the same standard government benefit coverage. VA is able to employ VCS workers to provide inpatient services through NFS agreements with VCS under the Economy Act.[10]

Recently, nine VA locations began to employ VCS workers rather than NFS workers to provide inpatient food services (see app. II for a list of these locations). In some of these locations, VCS employees provide all inpatient food services; in others VCS workers are only beginning to be included in inpatient food services. In all cases, NFS dietitians continue to ensure food service quality. Before these changes to VCS inpatient food service, VCS had only provided retail food service at these locations.

Three of the locations converting to VCS labor were at Marion, Illinois, and the Jefferson Barracks and John Cochran locations in St. Louis, Missouri. These examples illustrate different stages of VCS conversion and different sizes of health care facilities.

VA began its VCS conversion in Marion, Illinois, in 1997. Today, Marion employs mostly VCS workers to serve an average daily census of 95 patients. VA reports that patient satisfaction is higher, as measured by patient surveys, than it was before and that NFS dietitians continue to be responsible for quality. When the conversion to VCS employees is complete, VA estimates that $375,000 a year could be saved through reductions in wage costs. NFS workers have left Marion inpatient food service through normal attrition, including retirement, moving to other VA jobs, or leaving VA voluntarily. Personnel changes were monitored by the facility's Labor Management Partnership Council, which included union representation. Those employees who remain retain their NFS salaries.

St. Louis's two locations began VCS integration in 1999. Today the consolidated St. Louis locations serve an average daily census of 301

[10]The Economy Act (31 U.S.C. 1535) permits one government agency or a unit within an agency to purchase services from a unit in the same agency or another agency when in the best interest of the government.

inpatients by employing NFS employees and a VCS manager. Other VCS employees are being recruited. When fully implemented, VA estimates that St. Louis could save $803,000 in wage costs annually. St. Louis expects to follow Marion's experience in protecting current NFS employees' job security and salary and phasing in VCS conversion.

Our analysis suggests that VA could lower labor costs by an estimated $67 million annually (in addition to the estimated $12 million consolidation savings discussed earlier) if less-expensive VCS workers are employed in place of NFS workers at 166 additional locations. The Marion and St. Louis experiences suggest that the full extent of these savings would be realized over a number of years as VCS conversion is phased in. However, some savings can be achieved in the first year of implementation. Currently, NFS wage grade workers provide inpatient food services at these 166 locations. VCS employees could cook and prepare food, distribute food to patients, and retrieve and wash dishes, trays, and utensils for inpatients at these locations while NFS dietitians continue to assure quality.

Three locations—Kansas City, Leavenworth, and Topeka—are scheduled to begin conversion to VCS inpatient food service provision. In our survey of VA health care networks, VA officials indicated that another location is considering conversion. Making the changes required to convert to VCS inpatient food service provision requires management commitment to a process that may take several years and much effort to achieve but has the potential for significant cost savings.

Actual savings may vary from our estimates because of many local factors at each inpatient location. To determine actual savings through the use of VCS employees, VA would need to conduct studies of each inpatient food location and weigh alternatives for providing the lowest-cost food service while maintaining quality. VA would also need to incorporate in this process consideration of the effect such changes could have on other VA priorities, such as maintaining job opportunities for veterans and compensated work therapy patients.

A key element of such a study is recognition that VA's inpatient food service operations are developing along the lines of other hospital food service operations, which are changing the nature of the hospital food service industry. This includes the use of more pre-prepared food products, less need for specialized cooking skills, and more reliance on computer ordering for preparation and placement of food on patient trays. All of these processes reduce both the need for a higher-skilled work force and

the degree of training needed to successfully produce and distribute hospital food, whether VA inpatient food service is provided by NFS or VCS. NFS and VCS managers agree that employees can be trained more quickly today than in the past to provide inpatient food services. VCS managers also believe that higher turnover rates for lower-paid employees would not adversely affect services.

VA May Be Able to Achieve Additional Savings by Using Competitive Sourcing

VA uses private contractors for inpatient food services at two inpatient locations—Sodexho Marriott at its Anchorage domiciliary and SkyChef at the Honolulu nursing home. These locations have no VCS retail food services and have only a long-term-care inpatient mission. In addition, both locations began inpatient food services with a contractor rather than with NFS employees.

While VA has used competitive sourcing only to a limited extent, our analysis suggests that VA may be able to lower costs by determining if in-house or private sector provision of food services is more cost effective. VA could realize additional savings by competing, through the use of OMB's Circular A-76, the costs of government provision of these services versus the costs of private-sector provision. Our work at the Department of Defense shows that, by competitive sourcing under OMB Circular A-76, costs decline through increased efficiencies whether the government or the private sector wins the competition to provide services.[11] This work indicates that savings are probable for VA, but we cannot estimate potential savings from competitive sourcing because of uncertainty regarding the availability of interested contractors at each VA location, the price of contractor services, and the extent to which VA food services units are able to decrease their operating costs in a competitive process.[12]

Savings from competitive sourcing might be higher if VA expanded competitive sourcing to include locations that combine NFS inpatient and VCS retail operations. When food contractors provide services to non-VA hospitals, they usually operate both inpatient and retail as one operation

[11]See *DOD Competitive Sourcing: Some Progress but Continuing Challenges Remain in Meeting Program Goals* (GAO/NSIAD-00-106, Aug. 8, 2000) for a discussion of the benefits of competing various efficiency options using the OMB Circular A-76 process.

[12]See *DOD Competitive Sourcing: Savings Are Occurring, but Actions Are Needed to Improve Accuracy of Savings Estimates* (GAO/NSIAD-00107, Aug. 8, 2000) for a discussion of calculating savings under the OMB Circular A-76 process.

and most of their profits come from retail sales, according to food service contractors with whom we spoke.

However, VA may not offer the most attractive business opportunity for food contractors for two reasons. First, VCS opposes consideration of contracting for retail food services because it uses profits from a minority of profitable locations to subsidize operations at the remainder. Moreover, VCS believes that some of its other retail activities, such as vending of toiletries and personal articles that are not generally provided by food service contractors, are not viable without retail food. This is important to VCS because it receives no appropriations and funds its operations based on revenues earned.

Second, the small size of VA inpatient workloads at many locations may be less attractive to contractors because there is less opportunity to spread fixed costs over higher volume. For example, 27 percent of VA locations have an average daily census of less than 100 inpatients, and 56 percent have an average daily census of less than 200. However, it may be possible for potential contractors to combine food services at smaller locations with services at other nearby VA and non-VA locations to generate higher volume.

To achieve savings through competitive sourcing, VA would need to conduct studies of each inpatient food location to weigh alternatives for providing the lowest-cost food service while maintaining quality. In these studies, VA would need to consider the effect such changes could have on other VA priorities, such as maintaining job opportunities for veterans and compensated work therapy patients. To date, however, VA has done little to explore either its own experience with using contractors or contractor interest. Although fostering competition among government and private contractors to provide food services can be a time-consuming process, it offers opportunities to create more efficient and less costly operations when in-house organizations win the competition, or savings when private competitors win. This process can be demanding, however, and requires strong management commitment to achieve.

VA could foster competition among government and private providers in the provision of inpatient food service by using the competitive process of OMB's Circular A-76. VA could compete all its food service operations or any part of these services at each location. VA could consider competitive sourcing alone or in combination with consolidation or use of VCS employees, as we discussed earlier.

Conclusions

VA has opportunities to save millions of dollars by systematically considering consolidating food production, employing VCS workers to provide inpatient food services, and competitive sourcing. VA already has experience in implementing these options at a number of locations, although VA's experience with food service contractors is limited. VA has not, however, systematically compared these options at all 177 inpatient locations. Using a systematic approach to assess available options at each location would allow VA to provide food service at the lowest cost consistent with maintaining quality.

Recommendations for Executive Action

We recommend that the Acting Secretary of Veterans Affairs direct the Under Secretary for Health to direct the 22 networks to (1) systematically assess each inpatient food service location to determine if consolidation, employment of VCS workers, competitive sourcing, or a combination of these options would reduce costs while maintaining quality; and (2) implement the least-costly options in a timely manner.

Agency Comments and Our Evaluation

We received written comments on a draft of this report from VA's Acting Secretary and the National President of AFGE. Their comments and our responses are discussed in the following sections. The comments in their entirety from VA and AFGE are in appendixes III and IV, respectively.

Department of Veterans Affairs

VA agreed in principle with our recommendations, noting that it is already consolidating food production locations, converting to VCS inpatient food service provision, and using competitive sourcing. VA should be commended for its progress to date. However, VA has not systematically assessed each of these options at each location as we recommend. VA stated that the three options we identified are part of its Nutrition and Food Service strategic plan for improving quality and cost effectiveness. In our review of the plan, we found the VCS option to be clearly identified. However, the consolidation option discussed in the plan appears to deal with NFS consolidation with other services rather than consolidating food production locations and we found no reference to competitive sourcing. In addition, we found no reference to the systematic assessments we recommend. We believe the strategic plan could help VA implement our recommendations if the plan clearly specified that all three options we

identified to reduce costs are to be systematically assessed for each location.

Although VA agreed with our recommendation for timely implementation, it provided no operational plan or timeline for conducting the assessments we recommended. VA states that it is assessing the feasibility and subsequent implementation of these options at a deliberate pace to carefully consider relevant factors. We agree that VA should carefully consider these factors but believe the recommended assessments should be completed as expeditiously as possible. Delay means that millions of dollars per year may be spent unnecessarily on food services.

VA expressed several specific concerns on a number of issues.

Consolidation of food production. VA raised issues regarding (1) the need to do a study at each location, (2) transportation of perishable food, (3) costs, (4) VA's Subsistence Prime Vendor (SPV) program, and (5) integration of NFS employees with environmental management services. First, VA stated that studies of food consolidation have already been done in Veterans Integrated Services Networks 1 (Boston), 3 (Bronx), 8 (Bay Pines), 12 (Chicago), and 22 (Long Beach), suggesting that additional studies are not needed at each location in these networks. We commend VA's efforts to study ways to reduce costs in these networks. However, based on our discussions with NFS officials at several of these networks and reviews of several of these studies, we disagree that VA has systematically assessed all three options in each network. VA focused more on the potential for consolidations, but this option may be even more cost-effective if implemented in conjunction with the use of VCS employees or competitive sourcing in these networks. Because VA has not assessed all three options, it may not have identified the least-costly options in each network.

Second, VA stated that the safety of transporting perishable food products and related logistics are key factors in determining the viability of consolidating VA facility food production. VA's statement suggests that, as a result, fewer locations may be able to consolidate than we estimated and that the speed of consolidation could be slow. We agree that VA needs to carefully consider these factors, but we factored in the transportation and logistical issues in our analysis based on VA's experience. As discussed in the report, VA has successfully addressed these factors in 28 other locations that are comparable to the potential locations we identified. Therefore, we do not view such factors as reasons for not moving ahead

expeditiously but rather as factors that require strong management commitment in order to realize potential savings.

Third, VA stated that large capital investment costs for equipment and space are key factors affecting the viability of potential consolidations. Again, we agree. However, investment costs must be assessed within the context of potential savings. For example, once fully implemented the savings realized in 1 year under the consolidation of food services in the Central Texas Healthcare System exceeded the investment costs, making that consolidation viable. We included in our assessments of the viability of consolidation at other VA locations the costs of a blast chill system of food production, such as that operated by the Central Texas Healthcare System, and the costs of the related advanced food delivery equipment.[13] Therefore, the potential consolidation locations we identified could result in annual savings greater than the required investment costs within a reasonable time period.

Fourth, VA also stated that its SPV program needs to be considered in consolidation decisions. The SPV program reduces the costs of food items through high-volume purchases by all of VA and certain other government agencies. We agree that the SPV program should be considered in consolidation decisions at each location, but we are doubtful that this would affect a decision on whether to consolidate. Our review of consolidations showed that savings result from reduced labor costs, not reduced food costs. Moreover, we are doubtful that the SPV program will affect food costs in a consolidation because the same number of patients will be fed whether consolidation occurs or not and all VA locations already participate in the SPV program.

Fifth, VA stated that integration of NFS employees with environmental management services should be considered in consolidations. NFS integration with environmental management services includes having some employees work in both services so that an employee with downtime in food services can work in environmental services and vice-versa. Again, we agree that this factor should be considered in consolidations at each location, but it is unclear how this would affect a consolidation decision. While integrating NFS workers with other services can reduce food production costs without consolidation by shifting unneeded staff time and charges to other services, it is unlikely to reduce costs to the degree they

[13]The blast chill system can chill food for up to 5 days before the food is consumed.

would be reduced in consolidation. Consolidation reduces costs primarily through economies of scale whereby fewer workers in one location can produce food for patients in two or more locations than the smallest number of workers combined could produce food separately at each location. Therefore, consolidation would provide greater cost savings. In addition, NFS integration with environmental management services could be included in a consolidation.

Employing VCS workers. VA raised issues regarding (1) time needed to phase in conversions, (2) variability in savings by location, (3) separation costs, and (4) training costs.

First, VA stated in its comments, and we agree, that the savings from converting to VCS workers would take years to fully achieve. However, VA officials told us that some savings are possible in the first year of implementation. The magnitude of savings possible makes it worth the effort even if several years are required to fully achieve savings. Our report reflects this point. Our savings estimate of $67 million represents the total potential annual cost reductions for employing VCS workers to provide inpatient food services and not the savings that could be realized in fiscal year 2001. VA would not realize the full savings at each location for a number of years because VCS workers would only be phased in when NFS workers left through normal attrition such as retirement, voluntarily leaving for other VA jobs, or for jobs outside VA.

Second, VA stated that potential savings from employing VCS workers to provide inpatient food services would vary from location to location, making it difficult to project a total cost benefit at this time. We agree that actual savings achieved would likely vary from location to location. However, we estimated total potential savings assuming that VA's locations could save an average of about 30 percent of combined wage and benefit costs. This rate approximates the rate VA is realizing in its conversion to VCS employees at Marion, Illinois. VCS headquarters managers and network and facility officials in the VCS conversions studied agreed that using a 30 percent savings rate is reasonable for estimating nationwide savings.

Third, VA also suggests that our estimated savings for employing VCS workers are overstated because of additional separation costs for NFS employees that would be required to implement this option. We do not agree. In the VCS conversions we reviewed, NFS workers typically continue working until they leave through normal attrition including

retirement, moving to other jobs in VA, or leaving VA voluntarily. Thus, no special separation costs are incurred.

Fourth, VA states that training costs could reduce our estimated savings. VA said these training costs would be for (1) NFS workers who leave food service to take other VA jobs, (2) VCS employees who replace NFS employees, and (3) part-time workers providing food service. We do not agree that these costs would reduce our estimated savings. As previously discussed, in VCS conversions NFS workers are expected to leave through normal attrition such as retirement, voluntarily leaving for other VA jobs, or voluntarily leaving for jobs outside VA. The training for NFS employees taking other jobs would be required whether NFS or non-NFS employees were hired for those jobs. Similarly, training for VCS employees replacing NFS employees would be required whether the replacements were VCS or other employees. Finally, both VCS and NFS already use many part-time workers and VA indicates it will continue this strategy. As a result, these training costs would be required in any event and are not additional costs.

Competitive sourcing. Although VA concurred with our recommendation to consider competitive sourcing as an option in providing food services, VA raised concerns about the opportunities to use contractors in VA's inpatient settings. We agree, as stated in the report, that VA may not offer the most attractive business opportunity for food contractors because of VA's unique structure for providing inpatient and retail food services separately at its locations and because of the small inpatient workload at most locations. Because of these and other uncertainties we could not estimate the number of locations that could benefit from competitive sourcing or the potential savings. Nonetheless, we believe that competitive sourcing should be considered because of its potential to increase efficiency. As previously discussed, our work in other areas has shown that the competitive sourcing process reduces costs through increased efficiency whether the government or a contractor wins the competition to provide services.

American Federation of Government Employees

AFGE opposed all three options we included for study in our recommendations, expressing a number of concerns regarding these options. AFGE's overarching concern is whether VA should focus its cost containment strategies on efforts that, in its view, could further impoverish current workers or compromise food quality. While we understand and appreciate AFGE's legitimate concerns about current workers' wages and employment and the quality of food provided to veterans, we believe VA can adequately address these concerns when implementing our

recommendations. In the past, VA has demonstrated the ability to implement comparable options without adversely affecting food service workers. Further, our discussions with VA officials indicate that they remain sensitive to the importance of taking appropriate steps to prevent adverse effects on current food service workers.

We discuss AFGE's specific concerns below.

Employing VCS workers. AFGE expressed six concerns about employing VCS workers in place of NFS workers to provide inpatient food service. First, AFGE stated that our estimate of $67 million in annual savings from employing VCS workers is misleading. AFGE said that the savings we estimated would be a one-time occurrence and establish a new baseline once achieved. We do not agree. Because there is no specific appropriation for inpatient food services, VA will not return savings from its food service operations to the U.S. Treasury and thereby establish a new lower baseline budget for VA. Rather, VA retains the savings achieved through management efficiencies in its budget, thereby making the savings available for other purposes in each subsequent year.

Second, AFGE suggested that part of the savings we estimated are based on the government paying less for its match of employee health care premiums because lower-paid VCS employees will less frequently participate in government-sponsored health care plans than NFS employees. We did not assume that government costs would be less because fewer VCS workers would participate in government-sponsored health care plans than NFS workers. Information provided by VA shows that the proportion of NFS and VCS workers currently purchasing health insurance through government plans is 32 and 25 percent, respectively.

Third, AFGE said that our estimated savings for VA in employing VCS workers are overstated because they do not include increased federal costs for programs such as Medicaid, the Earned Income Tax Credit, the CHIP (Children's Health Insurance Program), Head Start, Housing and Urban Development rent subsidies, and other expenses related to increasing the ranks of the working poor. We disagree that our savings are overstated because our assessment of VA's recent experience suggests there would be little or no additional costs to other federal programs as a result of VCS conversion. Based on VA's experience to date, no NFS worker has had his or her wages reduced or lost employment under the VCS conversions we reviewed and no VCS worker was required to accept lower wages and benefits than they already had or could obtain elsewhere. In VCS

conversions, NFS workers are being replaced as a result of normal attrition, including retirement, voluntarily moving to other jobs in VA, or voluntarily leaving for non-VA jobs. As such, the departing NFS workers would have the same impact on other federal programs as if there were no VCS conversion. Current VCS workers who replace NFS workers maintain their wages and benefits and therefore have no impact on other federal programs. Newly-hired VCS workers who replace NFS workers choose VCS over other employment opportunities. Presumably, wages for these new workers are competitive with wages in jobs these workers otherwise would have taken.

Fourth, AFGE raised questions regarding the legality of VCS providing inpatient food services in place of NFS employees under the Economy Act. AFGE questioned if VCS could enter into an agreement under the Economy Act and supervise civil service employees, such as NSF employees, and if VCS and NFS employees with similar job descriptions could be paid different wages. We found no legal deficiency in these areas under VA's use of the Economy Act. An "instrumentality of the United States," VCS is authorized to receive and has received appropriated funds credited to a revolving fund. VCS's revolving fund is a permanent, indefinite appropriation available to cover its operating expenses. Therefore, we agree with VA that VCS can be a party to an agreement under the Economy Act. In addition, VCS employees hold "excepted" positions within the federal civil service and are not barred from supervising NFS employees. Finally, VCS employee positions are exempt under 38 U.S.C. 7802 (5) from requirements of title 5 of the United States Code regarding equal pay and VCS employees are subject to a different pay scale than NFS employees.

Fifth, AFGE said that it will take years to realize the estimated savings. We agree that it will take years to fully realize these savings, as our discussion of Marion and St. Louis indicate, but some savings can begin to accrue in the first year of implementation. Moreover, the amount of savings possible makes it worth the effort even if several years are required to fully achieve them.

Sixth, AFGE said that higher VCS turnover rates will create problems for converting to VCS provision of inpatient food services. We do not agree. Based on experience to date, VCS managers at headquarters and at Marion have stated that turnover has not affected their ability to provide inpatient food services or affected quality.

Consolidation of food production. AFGE expressed two concerns related to consolidation of food production and incorrectly stated that we said that VCS opposes consolidation. First, AFGE said that our estimates of kitchen consolidation savings are overstated because we underestimate the financial and practical costs of losing in-house food production. We do not agree. Our savings estimates account for additional costs required by consolidation that were identified by VA officials and representatives of the food service industry who have consolidated food production locations. As we discuss in our evaluation of the Central Texas Healthcare System, our savings model is conservative and probably understates savings.

Second, AFGE stated that consolidations lower the quality of food provided to veterans. For example, AFGE expresses concerns regarding frozen food and other issues. We disagree. As we discussed in the report, VA reports that patient satisfaction increased at the Central Texas Healthcare System after consolidation, as measured by improvements in the taste and temperature of food. The Central Texas Healthcare System received an award from VA headquarters for reducing costs and maintaining quality in its consolidation activities. The award included citations for (1) provision of consistently high-quality meals, (2) improvements in timeliness, (3) increased patient satisfaction, and (4) maintenance of quality controls. Moreover, in all VA locations that consolidate, NFS dietitians continue to have quality control responsibility to ensure that veterans' nutrition needs are met.

AFGE also stated that we noted that VCS opposes privatization and centralization. We said that VCS opposes privatizing the services it provides, but we did not say that VCS opposes consolidation. In fact, VCS officials told us that VCS does not oppose consolidation.

Competitive sourcing. AFGE expressed five concerns about competitive sourcing. First, AFGE stated that there is no evidence that contracting saves money. We believe it is important to distinguish between an objective to contract and an objective to compete government versus private service provision. Our recommendation is that VA consider competitively sourcing food service operations rather than outright contracting as an end in itself. Competitive sourcing can result in the government either retaining its position as service provider, or contracting with a private provider. As we have discussed, our work shows that competitive sourcing reduces cost through increased efficiency. The costs are reduced whether government or the private contractor wins the competition. We believe it would be a

mistake to eliminate the competitive sourcing option for reducing VA's costs.

Second, AFGE expressed concern as to whether VA would use the OMB Circular A-76 process for competitive sourcing or contract without the benefit of a public-private competition. We agree that VA could, under limited circumstances specified in OMB's Circular A-76, convert to contract performance without cost comparison. However, our recommendation to VA was that it consider competitive sourcing rather than contracting. VA agreed in principal with our recommendation.

Third, AFGE also expressed concern about the quality of food service under contracting. We do not share AFGE's concern because the same quality controls VA currently uses for in-house provision of food service could be included and enforced in the contract if a private firm chooses to compete and wins the competition under competitive sourcing. We note that some of VA's medical affiliates, including major university hospitals, provide inpatient food service through contractors.

Fourth, AFGE expressed concern that veterans currently employed in VA's in-house food production could lose their jobs if a contractor wins the competition. We agree this is possible. As stated in the report, we believe that VA should include this as a consideration in its assessments of food service at each location. We note, however, that government employees adversely affected by decisions under the OMB A-76 process competition often are offered positions with winning contractors. VA could specify, as other agencies have, that a contractor hire such employees if it wins the competitive sourcing competition.

Fifth, AFGE stated that there is little opportunity for a contractor to provide services less expensively than VA if VA uses lower-paid VCS employees. AFGE believes that the only way to lower costs in contracting is to lower wages and does not believe this is possible if a contractor is competing with VCS's wage rates. We disagree. Competitive sourcing is an incentive to both government and the contractor to increase efficiency as much as possible to achieve cost reductions. These increased efficiencies can be achieved through improvements in process operations that reduce the amount of capital or human resources needed to process the same workload.

As arranged with your staff, we are sending copies of this report to the Honorable Hershel W. Gober, Acting Secretary of Veterans Affairs; interested congressional committees; and other interested parties. We will make copies available to others upon request.

If you have any questions about this report, please call me at (202) 512-7101. Other staff who contributed to this report are listed in appendix V.

Sincerely yours,

Stephen P. Backhus
Director, Health Care—Veterans' and
Military Health Care Issues

Scope and Methodology

We reviewed the Department of Veterans Affairs (VA) inpatient food services for fiscal year 1999 to assess potential savings nationwide if VA were to implement system-wide the three types of initiatives it has used in some of its VA inpatient health care locations: (1) consolidating food production, (2) employing Veterans Canteen Service (VCS) rather than Nutrition and Food Service (NFS) workers to provide inpatient food services, and (3) competitive sourcing.

We interviewed VA headquarters officials in NFS, VCS, the Office of General Counsel, and other offices. We obtained documents from headquarters on the consolidation of food service, the use of VCS labor, and contracting with private food service contractors.

We obtained data on food services at each inpatient location by surveying each Veterans Integrated Service Network. We obtained information on food service needs, how VA provides services, costs, and number of meals at each VA inpatient location. Networks and locations also provided us with information on advance food technologies and excess capacity, and with additional information on consolidating food services, the use of VCS, and private contractors.

We also obtained additional data through interviews, documents, and physical inspections of kitchen facilities and food delivery at VA locations. We visited Veterans Integrated Service Network 17 (Dallas) locations in Temple, Marlin, Waco, and Dallas. We also visited locations in Marion, Illinois, and Jefferson Barracks and John Cochran in St. Louis, Missouri, in Veterans Integrated Network 15 (Kansas City).

To estimate savings from consolidation, we first identified areas with multiple food production locations, using the criterion that two or more locations were located within 90 minutes' driving distance of each other. We then examined the combined workloads and costs of unconsolidated locations in these markets to determine whether savings could be achieved through consolidation. Locations were considered to be already consolidated if they received 80 percent or more of their food from another location or produced 80 percent or more of the food for another location.

Our analysis of VA cost data and discussions with VA officials suggested that the ratio of employees to the average number of daily patients (average daily inpatient census) is an appropriate measure for benchmarking savings in food services. We confirmed this relationship using 1999 data by regressing average daily patients on total employees. The resulting model

showed that the average daily patients accounted for 86 percent of the variation in staffing.

We computed savings estimates for the consolidations using the staffing ratio of one employee per 6.7 average daily patients. This staffing ratio was achieved by the Central Texas Healthcare System after completing consolidation of inpatient food services at Temple, Marlin, and Waco. To validate this measure we spoke to VA officials representing both NFS and VCS, who agreed that using the Central Texas Healthcare System staffing ratio after consolidation was a reasonable, perhaps conservative, estimate of achievable staffing levels. Some VA production locations, in fact, are more efficient (lower ratio of employees to the average number of daily patients) than operations at the Central Texas Healthcare System.

To calculate total savings from food consolidation we first multiplied the total average number of daily patients of the proposed market by the Central Texas Healthcare System staffing ratio (one employee per 6.7 average daily patients) to arrive at a projected employee total for the consolidated market.[1] We then subtracted this projected total from the fiscal year 1999 employee total of the individual locations in an area to determine the number of employees not needed, if any. Cost savings for the area were computed by multiplying the number of positions saved by the average salary costs of NFS wage grade, including benefits, within each market. We aggregated savings from each market to determine the total savings from food consolidation.

The one-time investment for equipment was estimated by assuming that one location in each consolidated area required an advance food preparation system and every location required an advance food delivery system. To project the total cost of advance food preparation equipment (a fixed cost that includes items such as the blast chiller), we multiplied the cost of Central Texas Healthcare System's advance food preparation system (purchase amount adjusted to 1999 dollars) by the number of locations within areas that required this system. We calculated the total cost for the advance food delivery systems (a variable cost that includes items such as reheating carts, trays, and plates) by multiplying the total average daily patients of locations without this system by Central Texas

[1]We adjusted the average daily inpatient census workload of locations where NFS provides noninpatient meals (or provides meals to non-VA locations) by adding one inpatient to the average daily inpatient census for three noninpatient meals served daily.

Healthcare System's cost per average daily patients (adjusted to 1999 dollars).

We calculated the costs of transporting food from a central location using data obtained from the Central Texas Healthcare System. To project the total costs of transportation for the consolidated areas, we multiplied the annual cost of one leased refrigerated truck by the total number of consolidated areas. Because this cost recurs each year, we subtracted this cost from the annual recurring savings from consolidation.

We determined the potential savings from converting from NFS to VCS labor by applying a 30 percent savings reduction to NFS employee costs. VCS salaries are based on the Department of Defense's survey of food service worker wages in a local area, and are competitive with the private sector. Nationally, NFS salaries average about 70 percent of total NFS food production costs. VCS salaries are normally about 30 percent below NFS salaries. VCS headquarters established this percentage, and network and facility officials have agreed that using a 30 percent savings rate is reasonable.

We also conducted a literature review of the food services industry, interviewed selected non-VA food service officials and officials from the private vendor sector and food service industry organizations, and visited contractor food production facilities.

We validated survey data used to construct cost estimates by comparing questionable data supplied on the 1999 survey with VA data sources. When necessary, we also contacted survey respondents and/or VA officials to clarify or correct data. We performed our review between October 1999 and November 2000 in accordance with generally accepted government auditing standards.

Locations Converting From Nutrition and Food Service to Veterans Canteen Service Workers, April 2000

VA inpatient location	Year conversion agreement signed	Percentage VCS inpatient food service workforce[a]	1999 Average daily census
Martinez, California	1996	100	97
Marion, Illinois	1997	70	95
Poplar Bluff, Missouri	1998	41	50
Wichita, Kansas	1998	21	36
Columbia, Missouri	1999	13	88
Mather, California	1999	100	9
Orlando, Florida[b]	1999	100	10
St. Louis Jefferson Barracks, Missouri[c]	1999	0[d]	218
St. Louis John Cochran, Missouri[c]	1999	0[d]	83

[a]NFS dietitians continue to provide quality assurance but are not part of the inpatient food service workforce.

[b]Food is produced at Tampa, Florida, location.

[c]VCS food manager is on staff at the St. Louis consolidated locations; recruiting continues for other VCS positions.

[d]Most food is produced at St. Louis Jefferson Barracks location.

Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

OCT 25 2000

Mr. Stephen P. Backhus
Director, Health Care Team
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Backhus:

The Department of Veterans Affairs and the Veterans Health Administration have reviewed your draft correspondence report, ***VA HEALTH CARE: Expanding Food Service Initiatives Could Save Millions*** (GAO/HEHS-00-178). We agree in principle with the report's recommendations as we are already implementing the initiatives GAO identifies in a deliberate and appropriate manner. However, we question the estimated $79 million in annual savings.

The Veterans Health Administration's (VHA) Nutrition and Food Service (NFS) strategic plan contains as an integral part for improving quality and cost effectiveness:

- consolidation of food production;
- employing Veterans Canteen Service (VCS) workers to provide inpatient food services, and
- competitive sourcing to determine whether in-house or contract services are more cost effective.

VHA's deliberate pace in assessing the feasibility and any subsequent implementation of these options is based on a number of significant factors including cost, capital investment, logistics, and safety of transporting perishable food products. VHA has been studying this initiative for some time. In addition to the facilities cited in the report as having completed assessments, several other Veterans Integrated Service Networks (VISNs) identified by GAO as candidates for assessments have conducted feasibility studies to consider consolidated food production (VISNs 1, 3, 8, 12, and 22). For example, VISN 12 will be implementing cook/chill with plans to consolidate bulk food production between VAMC Hines and the VA Chicago Health Care System. The cost of capital investment and transportation were pivotal issues considered by these VISNs in their assessments.

2. Mr. Stephen P. Backhus

Relative to the report's discussion of converting NFS employees to VCS employees, we have a number of concerns regarding the level of conversion that GAO suggests and the resulting estimated savings. Although VHA has already begun implementing this initiative and further conversions are under consideration, we believe that variances in potential savings from site to site make it difficult to project a total cost benefit at this time.

In this connection, we note that a 1994 Office of Management and Budget cost comparison study of NFS operations determined that in-house rather than contract managed operations were more cost effective and efficient.

The enclosure details VA's comments to your draft report and its recommendations. We appreciate the opportunity to comment on GAO's draft report.

Sincerely,

Hershel W. Gober
Acting

Enclosure

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO
GAO DRAFT REPORT, ***VA HEALTH CARE: Expanding Food Service Initiatives Could Save Millions***
(GAO/HEHS-00-178)

GAO recommends that I direct the Under Secretary for Health to direct the 22 networks to:

1. **systematically assess each inpatient food service location to determine if consolidation, employment of VCS workers, competitive sourcing, or a combination of these options would reduce costs while maintaining quality and**

Concur in Principle - The cost, logistics, and safety of transporting perishable food products and the large capital investment in equipment and space needed for cook/chill systems are all factors that determine the viability of consolidating VA facility food production sites. In addition to the VA facilities cited in the report as having completed assessments, several other Veterans Integrated Service Networks (VISNs) identified by GAO as candidates for assessments have conducted feasibility studies to consider consolidated food production (VISNs 1, 3, 8, 12 and 22). For example, VISN 12 will be implementing cook/chill with plans to consolidate bulk food production between VAMC Hines and the VA Chicago Health Care System. The cost of capital investment and transportation were pivotal issues considered by these VISNs in their assessments.

These circumstances equally affect such decisions in the private sector. In a recent survey of 70 private sector hospitals, capital investment was the primary reason cook/chill was not implemented. In addition, based on a January 2000 survey of the top 100 hospitals with self-operated food services and the top 50 contract-managed food service hospitals, VHA's implementation of the cook/chill option at 23 percent of VHA's 145 sites is comparable to the private sector. In that survey 27 percent of the top 100 and 14 percent of the top 50 hospitals were identified as cook/chill operations.

We plan to continue our assessments and consolidate food services where feasible. However, there are other factors having significant impact on food production sites that we believe are not adequately discussed in the report. The VA Subsistence Prime Vendor (SPV) Program has had a major impact on NFS production sites by providing access to convenience pre-prepared food products, decreased inventory management and just-in-time purchasing. Along with VA, there are 45 other government agencies (OGAs) that use the SPV contract. These OGAs include military hospitals, state veterans homes, and nursing homes. This improved OGA access to the contract increases the advantage of volume purchasing and results in lower food pricing for VA. Also, in the past 5 years, VHA has implemented the option of integrating NFS with environmental

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO
GAO DRAFT REPORT, ***VA HEALTH CARE: Expanding Food Service Initiatives Could Save Millions***
(GAO/HEHS-00-178)
(Continued)

management services to improve staff resource utilization through multi-skilling and cross training of Wage Grade employees. There are currently 6 VA facilities with such integrations.

2. implement the least-costly options in a timely manner.

Concur - Regarding GAO's discussion of converting NFS employees to VCS employees, VHA has already begun implementing this initiative, and conversion is under consideration. However, we have a number of concerns relative to the level of conversion that GAO suggests and the resulting savings that GAO projects. Although some VA locations may have a 30 percent salary difference between NFS and VCS, this is not the case at all sites. Also, because the report does not discuss a timeline for conversion, there is a difference in the net salary dollar savings from the salary costs alone. For instance, where this initiative has been implemented in VHA, NFS food production staff was transferred to VCS at the NFS salary rate. These employees are being replaced through attrition with lower graded VCS employees, and only then will potential salary savings be generated. Provision must also be made for re-training costs for reassigned staff or separation costs for terminated employees. According to the Department of Labor, it costs between $6,000 and $8,000 to train minimally skilled entry-level employees. These costs need to be considered in the estimate of savings.

Non-direct cost issues for this initiative, such as labor management obligations, employee morale, training, etc., are considerable and will affect decisions on whether or not to pursue conversions at each site. Another issue that needs to be factored into the potential for savings is that significant numbers of NFS and VCS employees are part-time employees and tend to have higher turnover rates than full-time employees. A recent survey of 206 medium to large private sector companies showed that turnover costs for each employee began at $10,000. The benefits of using part-time employees generally outweigh these additional costs, however, we believe they would have an effect on the projected savings and should be considered. While VHA intends to pursue additional use of this initiative, for the reasons already discussed we are not convinced that we will be able to achieve the level of conversion that GAO projects or achieve the savings it cites, especially in any immediate timeframe.

Finally, there are a number of issues unique to VA that make the competitive sourcing option less viable than in the private sector. For instance, the vast majority of private sector contractors charge a per unit additional charge for

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DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO
GAO DRAFT REPORT, ***VA HEALTH CARE: Expanding Food Service Initiatives Could Save Millions***
(GAO/HEHS-00-178)
(Continued)

providing inpatient nourishments, snacks and supplemental feedings. These costs are already included in VA costs. Also, recent health care surveys indicate that food service operations in private sector hospitals provide 45 - 48 percent of the nonpatient meals (cafeteria/employee feeding, catering, vending and other nonpatient meals) at facilities, without which they are generally not interested in providing the labor intensive, high cost food service required by inpatient services. GAO correctly states that VA does not include VCS food production when considering contracting for NFS food production. However, as many VA facilities with long-term care missions are remotely located, long-term care patients, family and friends must rely on the VCS retail non-food operation for day-to-day personal grooming and other needs. Private sector hospitals generally do not face this issue. We believe it is a significant issue in any decision to contract out services and will affect any assessment of potential cost savings. Finally, the literature suggests that even in the private sector, hospitals that originally contracted out food production operations have returned to in-house operations because of escalated contract costs.

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Comments From the American Federation of Government Employees

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO
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Bobby L. Harnage
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6s/97421

October 17, 2000

Mr. Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
United States General Accounting Office
Washington, DC 20548

Dear Mr. Backhus:

I am writing to respond to GAO's draft report to the House committee on Veterans' Affairs Subcommittee on Oversight and Investigations on proposed changes to VA Food Service operations. The American Federation of Government Employees, AFL-CIO (AFGE) represents 125,000 workers at the Department of Veterans' Affairs, including many of those whose jobs are the subject of your report. It is on their behalf and to represent their views that I offer the following comments.

The draft report considers three major structural changes to the provision of inpatient food service at Veterans' Health Care facilities: 1) Utilizing lower paid Veterans' Canteen Service (VCS) workers to do the work currently performed by Veterans' Food Service (VFS) workers in order to save DVA money on wages and benefits, 2) Centralizing food service production at remote facilities to be delivered, heated, and served by either VCS or VFS workers at Veterans' Health Care Facilities, and 3) engaging private contractors to do the work currently performed by VFS workers, again to try to save DVA money on wages and benefits. I will comment on each of these proposed changes separately.

Replacing VFS Workers with VCS Workers

AFGE's first question is whether the DVA should focus its cost containment strategies on efforts to further impoverish its lowest paid employees. GAO has estimated that expanding this impoverishment strategy to an additional 166 inpatient locations would save $67 million annually.

We have two reactions to this estimate. The first is incredulity that an agency of the U.S. Government would consciously pursue a strategy to reduce the pay of the low level federal employees who provide some of the most basic and

To Do For All That Which None Can Do For Oneself

important care to our nation's ailing veterans. The report's callous attitude toward those who prepare, deliver, feed, and clean up meals for inpatient veterans is shameful. While this work is admittedly not glamorous, it cannot be argued that it is unimportant. Preparation of nutritious meals is only one side of inpatient food provision. AFGE members who labor in these positions are routinely required to spoon-feed, cajole, cut-up, replace, and reheat – in short, provide direct patient care. This proposal both literally and figuratively devalues this important work and as such is beneath contempt.

AFGE also questions GAO's methodology in arriving at the $67 million annual savings figure from impoverishing the working poor. Assuming that the DVA is able to staff what are now VFS positions at even lower wages than are now paid, the savings would be a one-time occurrence. The $67 million figure is misleading – once the wages and benefits were cut, the new level would become the new baseline. The $67 million annual savings is only relative to current baseline data. A clearer way to present this savings would be to describe it as a one-time savings, derived from lowering wages by roughly 40 percent (from between $11.71 to $15.68 per hour under the FWS to between $6.89 per hour and a few at $10.11 per hour at the top of the Non-appropriated fund scale), and assuming that the WG workers who had formerly been able to afford to purchase health insurance coverage through the Federal Employees Health Benefits Program (FEHBP) would no longer be able to do so, thus saving the government its share of premiums for this group.

In addition, the $67 million one-time savings to DVA would not translate into a $67 million savings for the federal government. The government would bear increased costs for Medicaid, the Earned Income Tax Credit, the CHIP (Children's Health Insurance Program), Head Start, HUD rent subsidies, and other expenses related to increasing the ranks of the working poor. All in all, the one-time $67 million savings, reduced by an unknown amount in anti-poverty spending, would hardly justify the cruelty of lowering the pay of these already poorly-paid federal workers.

The Office of Personnel Management (OPM) estimates that there are currently some 250,000 federal employees who are eligible to participate in the FEHBP but decline to do so, largely because they cannot afford their share of premiums. This number reflects only those who are eligible for FEHBP but who are also do not have coverage from another source. The ranks of these uninsured federal employees will surely grow if the VA pursues this wage reduction for its food service workers. Average premiums for federal workers in 2001 for FEHBP plans will be $81.18 biweekly for family coverage, and $36.52 biweekly for

individual coverage. A VCS worker who earns the $14,331 annual salary in the VCS NAF scale would take home around $440 every two weeks if s/he were lucky enough to have a full time position. Family coverage in FEHBP would eat up 18 percent of his or her salary (premium conversion would not lessen this burden) leaving a paltry $180 per week for food, shelter, and transportation. Is this a living wage? Is this what the U.S. government considers adequate for those who care for our nation's ailing veterans?

The argument that the conversion of Wage Grade VFS position into NAF VCS positions requires no change in position descriptions raises the question, if the assertion is true, of why the federal government is not adhering to its own "equal pay for equal work" or pay equity policies. The tolerance of such disparities has allowed the DVA to pursue this "race to the bottom" which exploits the government's lowest paid, most vulnerable workers. Pay equity is not about pursuing the lowest common denominator, it is a policy intended to raise standards for jobs and individuals whose status has been unfairly devalued. The VAMC-VCS plan is a perversion of pay equity.

The VAMC-VCS agreements specify that no individual employees will suffer a wage reduction as a result of its implementation. How then does the VAMC save money on labor costs by "integrating" the VCS into the VFS? They rely on the historically high turnover in these very low-paid positions. According to the DVA, turn over for food service workers employed in the VFS is roughly 11% per year for full time employees and 28% per year for part-timers. Thus it will take just over four years to start realizing the labor cost savings from the full-time positions and almost nine years to realize the labor cost savings from the VFS part-time position.

The issue of turnover is also relevant to this plan from another perspective. The VFS workers who receive the relatively higher but still low pay under the WG system are likely to remain in the job long enough to develop skills and provide continuity of care for the VA's inpatients. The turnover rates for the extremely low-paid VCS workforce provide a stark contrast. Full-time VCS food service positions face a turnover rate of 29.43% per year or 100% every 3 years. Part-time VCS food service positions turn over at a rate of 80.82% per year. Roughly 45% of VCS food service workers are part-time. This translates into 100% turnover every every 15 months for this workforce.

The extremely low wages provided to NAF food service workers explain these extraordinarily high turnover rates. The plan to put inpatient food service in the hands of a workforce that is manifestly not valued, that has been targeted by

GAO and VA management for wage reduction, and that flees for brighter prospects at such rapid rates should be reconsidered on these grounds alone. Our nation's veterans deserve to have food and care provided by workers whose first thought is not how to find a better job.

Another question is whether Congress envisioned chartering the Veterans' Canteen Service to function as source of low wage workers for agencies trying to evade either the General Schedule or the Federal Wage System. The agreements between the various VAMCs and their local VCS raise a serious legal question of whether the employees in question will retain their status as federal employees.

The VCS is an "instrumentality of the U.S." established in part to permit the creation of a revolving fund for depositing receipts and expending monies for the payment of goods and labor necessary to its operations. It does not fall within the definition of an Executive Branch entity. And under the contracts between the VAMC and the VCS currently in existence, VCS employees supervise NFS employees. AFGE believes that this is currently illegal, and would thus require an act of Congress to continue to go forward.

While the VCS employees are hired by the Secretary of DVA and may be performing a "federal function under authority of law," they are not civil service employees. This is apparent from the provisions of 38 USC 7802 that states that the VCS employees are only subject to the provisions of title 5 with respect to preference eligibles, workers' compensation, and retirement. They are not civil service employees, and thus cannot legally supervise civil service employees because the definition of "employee" includes the requirement that the worker in question be supervised by another civil service employee.

Centralization of Food Service Production

AFGE opposes the proposed expansion of plans to centralize food service production for VAMCs. We believe that the VA has overestimated the savings likely to result from this consolidation, mostly by underestimating the financial and practical costs of losing in-house food production capability.

The elimination of on-site, in-house food preparation only for inpatients also raises questions. The GAO draft notes that the VCS has no interest in either privatization or centralization. They recognize that their customers would balk at the poor quality of reheated foods prepared at remote locations. AFGE believes that quality concerns should be given the same serious considerations, even

when the "customers" are ailing veterans. If the staff and visitors to VAMCs deserve freshly prepared food, veterans deserve no less.

Loss of in-house production capacity consigns veterans to whatever frozen meal is on-hand, without the flexibility that the changes in diet which are so common in an inpatient setting require. AFGE has received numerous negative reports from locations where the only food available to inpatients is frozen meals from remote production facilities. The meals only rarely include fresh fruit and vegetables, and patients complain bitterly about issues such as the portion size, quality, and failure to honor requests in a timely manner.

Contracting with Private Sector Food Service Corporations

GAO is right to question whether private contracting has any potential to save money for the VA in the area of the provision of food service. Although contracting out is almost always promoted as a means of lowering costs, there are no data to test whether the federal governments roughly $120 billion per year experiment with privatization to lower costs has actually delivered on its promise. On the contrary, there is evidence that service contracting either costs government agencies more in the long run, or saves money only on the basis of underpaying those employed to do the government's work.

Although the GAO draft recommends "competitive sourcing" as the method for pursuing private food service contracts, the fact is that the procedures described in OMB Circular A-76 for public-private competition are only ever used in the Department of Defense (DoD), and DoD only uses the A-76 in about 25 percent of its privatizations. The danger is that the VAMC will take the seemingly innocuous recommendation from the VA that it use A-76 for public-private competitions in food service and use it to contract out non-competitively.

Contracting out for food service at VAMCs carries many of the same risks and costs as the proposed centralization of food service production. Consideration must also be given to the fact that on average nationally, 36 percent of those employed by the VFS are veterans. Those who will loose their federal jobs, seniority, pensions, and health insurance to private contractors will be, at the rate of 36%, veterans.

AFGE can report anecdotal evidence that eliminating on site, in-house food production capacity has a negative impact on patient care and patient satisfaction. VAMC staff report that patients' food preferences are not honored, the quality of food is low (brewed decaf coffee vs. warm water and a packet of

Sanka), choice is narrow, and portion size is low (four pieces of fresh fruit to be shared by 12 patients).

We believe that the reason the DVA has resorted to cutting wages for food service workers as the means of saving money because alternatives such as contracting out will not save money. Inpatient food service is costly and labor-intensive. The GAO draft expresses skepticism about the prospects for realizing savings through private contracting on the grounds that the functions provided by the VCS have the highest potential profit margins, and without that work in the mix, private contractors may not be interested in bidding on the inpatient work. In the context of something as labor intensive as producing, serving, clearing, and cleaning up meals for patients, the only way to lower costs is to lower wages. Since the VA itself is contemplating lowering wages to very near the federal minimum wage, there is little room for a contractor to maneuver and still earn a profit, if the VA is serious about pursuing privatization as a means of saving money and is not pursuing this course for other reasons.

I thank you for the opportunity to comment on the GAO's draft report. If you have further questions on these comments, please feel free to contact either Jacqueline Simon of AFGE's Public Policy Department at (202) 639-6408, or Linda Bennett of AFGE's Legislative Department at (202) 639-6456.

Sincerely,

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