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VETERANS' HEALTH CARE

Challenges Facing VA's Evolving Role in Serving Veterans

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Veterans' Health Care: Challenges Facing VA's Evolving Role in Serving Veterans

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 and 183,000 employees. This year, VA will serve about 2.9 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.

¹Lower-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.

VA's health care system has grown from 54 locations to about 400 locations as its role evolved. By 1990, VA operated over 150 medical centers that may have included one or more hospitals, nursing homes, domiciliaries, and outpatient clinics. VA also operated numerous freestanding outpatient facilities, including some that provide primary and specialty care and others 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, suggest 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: Improving Veterans' Access Poses Financial and Mission-Related Challenges ([GAO/HEHS-97-7](#), Oct. 25, 1996).

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: 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).

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