"Investing in a Better VA: Examining the Role of Infrastructure in Veterans' Access to Care and Benefits"

Statement before the Committee on Veterans' Affairs

United States House of Representatives

By Phillip Longman

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Good afternoon Chairman Takano, ranking member Bost, and other members of the committee. Thank you for holding a hearing on this vitally important topic and for giving me the opportunity to testify in front of you today.

My name is Phillip Longman. I am currently the policy director for the Open Markets Institute, where I focus on the growing problem of corporate monopoly in the health care sector. I am also a senior editor at the Washington Monthly and serve on the advisory board of the Veterans Healthcare Policy Institute.

But I am testifying here today strictly on my own behalf.

My involvement with veterans' health issues begins with the death of my wife, Robin, to breast cancer, in 1999. I never blamed her doctors for her demise. But the chaotic and poorly coordinated care we experienced at one, very prestigious academic medical center here in the nation's capital set me on a journey. I wanted to find out who might have ideas for improving the safety and quality of U.S. health care.

I wrote up the unexpected results of my research in a book called *Best Care Anywhere*. In it I describe how a large and growing body of peer-reviewed literature showed that, on metric after

metric, the much-maligned Veterans Health Administration has been outperforming the rest of the U.S. health care system.[1]

The book, which is now in its third edition, led to my appointment by then-Senate Majority Leader Harry Reid to serve on the Commission on Care. This commission was charged by Congress and the White House with developing a strategic plan for the future of veterans' health care, which it delivered in 2016.

Based on this background and perspective, I would like to offer the following four opening observations:

- First, in dealing with the VA, never forget to ask the question: *"compared to what?"* In 2014, the VA suffered enormous reputational damage after damning national headlines about unacceptable wait times at some VA facilities. But as I argued at the time, and as subsequent studies have shown, wait times at the VA were no worse in the aggregate than those found throughout the rest of the health care system.[2] Since then, research shows that in three out of four specialties evaluated, the access to care at the VA now surpasses access in the private sector.[3] Yet perversely, many people are still under the impression that we need to privatize more VA health care because otherwise veterans will have to wait too long for treatment. The reality is closer to the opposite.

- Second, *beware false thrift.* The VA, despite all the political and bureaucratic upheavals it has been through in recent years, continues to offer care that, as a rule, combines higher quality with lower cost. Recently, for example, researchers compared veterans who received emergency room treatment at the VA with those treated at non-VA hospitals. The VA patients not only had a 45 percent survival advantage, but the cost of their care was also 21 percent below what private sector hospitals charged.[4] Meanwhile, the kind of coordinated primary and mental health care offered at the VA is generally not available at any price in the private sector.[5] Such findings underscore the reality that, while it is appropriate for the VA to outsource some specialty services in some locations, in general outsourcing will lead to poorly coordinated, lower quality care that doesn't serve veterans well and is far more expensive to taxpayers.[6]

- Third, *learn the lessons of the pandemic.* The coronavirus revealed and aggravated vast, long-standing racial, class, and regional inequalities in our health care system.[7] After years of hospitals closing and downsizing, particularly those in rural and low-income urban areas, more and more Americans now live in places that have become "medical deserts."[8] At the same time, even rich hospitals serving affluent patients have put margin over mission; as a result, they have virtually no surge capacity to deploy in the face another pandemic or mass casualty emergency and have cut back on routine services that don't offer high financial returns.[9] Instead of shrinking VA health care, we should be expanding its public health mission and giving more people access to it.

- Finally, consider using the VA to combat the *growing problem of health care monopolies.* The majority of Americans now live in areas dominated by one large, monopolistic health care system, such as Partners in Boston, UPMC in Pittsburgh, or Sutter in San Francisco.[10] In such places, the local VA hospital often provides the only remaining effective competition in the local health care market. Shut the local VA hospital down in these areas, and what will happen? Not only will veterans likely face lower quality care and more problems of access,[11] but also, everyone seeking care in the community will be exposed to just that much more monopoly pricing — for everything from dialysis treatment to lab work to hospital stays. The widespread cornering of local health care markets by predatory corporate health care giants makes expanding the VA role in the U.S. health care system even more of an urgent matter for the public interest.[12]

Thank you for listening. I look forward to your questions.

Endnotes

[1] See for example, Claire O'Hannon, et al., "Comparing VA and Non-VA Care, A Systematic Review," *Journal of General Internal Medicine*, 32, 105-121 (2017). See also William B. Weeks, et al., "Veterans Health Administration Hospitals Outperform Non-Veterans Health Administration Hospitals in Most Health Care Markets," *Annals of Internal Medicine*, (March 19, 2019). https://www.acpjournals.org/doi/10.7326/M18-1540
For a survey of this literature and explanation of its findings, see for example, Phillip Longman and Suzanne Gordon, "A System worth Saving," The American Foreign Legion (2016).
https://www.legion.org/sites/legion.org/files/legion/publications/59VAR0817%20Longman%20Gordon%20Report.pdf

[2] Phillip Longman, "VA Care: Still Best Care Anywhere?" *Washington Monthly*, June 3, 2014.
https://washingtonmonthly.com/2014/06/03/va-care-still-the-best-care-anywhere/
See also Alicia Mundy, "The VA Isn't Broken," *Washington Monthly*, March/April/May 2016.
https://washingtonmonthly.com/magazine/maraprmay-2016/the-va-isnt-broken-yet/

[3] Madeline Penn et al., "Comparison of Wait Times for New Patients Between the Private Sector and United States Department of Veterans Affairs Medical Centers," *AMA Network Open (*2019).

[4] David Chan, "Is There a VA Advantage? Evidence from Dually Eligible Veterans." Stanford University mimeo (2020) http://conference.nber.org/conf_papers/f145428.pdf
See also Suzanne Gordon and Russell Lemle, "The Importance of the VA Advantage," *The American Prospect*, March 21, 2021. https://prospect.org/health/importance-of-the-va-advantage-veterans-health-care/
As I discuss in my book, the VA's superior cost-effectiveness results from factors such as better care coordination, particularly of primary care and mental health services; pioneering use of electronic medical records; expertise in the unique needs of veterans; and a financial structure that allows it to put mission before margin.

[5] Edward Machtinger, "A Trauma Doctor Raises Questions Over VA Outsourcing," Veterans Health Policy institute, accessed May 25, 2021, https://www.veteranspolicy.org/post/a-trauma-doctor-raises-questions-over-va-outsourcing

[6] According to the Commission on Care, fully replacing VA care with a voucher system for unmanaged care in the private sector would double the total systemic cost, far exceeding the projected outlays to modernize VA facilities and keep them open. This is largely because of the induced demand from veterans currently covered by other forms of insurance and because of the VA's greater cost effectiveness. See Commission on Care, *Final Report*" (2016) Appendix A: "Financing the Vision and Model," pp 171 ff. https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

Note also that many VA hospitals play a critical role in graduate medical education, particularly by sponsoring vitally needed residency programs for primary care doctors. See Phillip Longman, "First Teach No Harm," *Washington Monthly*, July/August 2013. https://washingtonmonthly.com/magazine/julyaugust-2013/first-teach-no-harm/
Closing VA teaching hospitals would therefore put huge strains on medical schools and the nation's supply of doctors, as well as imperil the VA's critical role in medical research.

[7] "Introducing the Best Hospitals for America," *Washington Monthly*, July/August 2020.
https://washingtonmonthly.com/magazine/july-august-2020/introducing-the-best-hospitals-for-america/

[8] Eli Saslow, "'Out here, it's just me': In the medical desert of rural America, one doctor for 11,000 square miles," *The Washington Post*, September 28, 2019. https://www.washingtonpost.com/national/out-here-its-just-me/2019/09/28/fa1df9b6-deef-11e9-be96-6adb81821e90_story.html
See also Alan Sager, "An Expert on Hospital Management Warns about the VA's Infrastructure Future," Veterans Health Policy Institute, accessed May 25, 2021, https://www.veteranspolicy.org/post/an-expert-on-hospital-management-warns-about-the-va-s-infrastructure-future
See also Jordan Rau and Emmarie Huetteman, "Urban Hospitals of Last Resort Cling to Life in Time of COVID," *Kaiser Health News,* September 17, 2020.
https://khn.org/news/urban-hospitals-of-last-resort-cling-to-life-in-time-of-covid/

[9] Phillip Longman and Udit Thakur, "Elite Hospitals Have an Epidemic of Greed," *Washington Monthly*, July/August 2020. https://washingtonmonthly.com/magazine/july-august-2020/elite-hospitals-have-an-epidemic-of-greed/

[10] Martin Gaynor, Statement before the Committee on the Judiciary Subcommittee on Competition Policy, Antitrust, and Consumer Rights U.S. Senate, "Antitrust Applied: Hospital Consolidation Concerns and Solutions," May 19, 2021.
https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf
Gaynor's testimony summarizes a large body of literature showing not only that vertical and horizontal consolidation is proceeding at a torrential pace in the health care sector, but also that the resulting loss of competition is a major cause of medical price inflation. See also: "Hospitals and Monopoly," Open Markets Institute, website, https://www.openmarketsinstitute.org/learn/hospitals-monopoly.

[11] As the Commission on Care's Final Report stressed, "Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers." p. 28.

[12] The Commission on Care's Final Report contains detailed recommendations for establishing pilot programs that would open up currently underutilized VA facilities to a broader population, such as non-veteran spouses of veterans. See Appendix C: Pilot Projects for Evaluating Expanded Care, pp. 201ff. For a vision of how underutilized VA facilities might be incorporated into a broader "Civilian VA," see Phillip Longman, "Best Care Everywhere," *Washington Monthly*, October 2007.
https://washingtonmonthly.com/magazine/october-2007/best-care-everywhere-2/