CITIZENS LEAGUE
530 Syndicate Building
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STATEMENT ON VETERANS ADMINISTRATION HOSPITAL

1. Madam Chairperson, Members of the Board, thank you for giving us an opportunity to appear.

2. In trying to deal with the issues raised by the proposal for a reconstruction of the Veterans Administration hospital in Minneapolis, we have found it helpful to go back and try to get in front of us clearly just what the VA hospital system is. In this respect, of course, one of the most useful documents is the report on the Veterans Administration hospital system by the panel of the National Academy of Sciences in 1977: a critical report in some respects, but helpful for its outside perspectives, on a subject on which outside perspectives are seldom offered.

   There was a good summary of its conclusions, recommendations and essential thrust carried in the New England Journal of Medicine, March 16, 1978, written by the chairman of the panel, Dr. Sol Farber. Let me quote a bit from his article in the Journal:

   "The Veterans Administration is the largest single provider of health care in the United States, with 171 hospitals, 85 nursing homes, 17 domicilaries. The total bed capacity of the VA hospital system is over 111,000.

   "The VA budget for health care in 1977 was about $5 billion. . . it is providing care for about 3 million out of about 30 million living veterans, mainly in its own facilities. A large proportion have low incomes, are single, widowers, or divorced. Only 17% of the users under age 65 have health insurance. Almost half the in-patients are receiving long-term, domiciliary, or psychiatric care. The VA serves a male population with defined social and economic, but not distinct medical, characteristics.

   "The VA health care system was established after World War I to provide care for veterans with service-connected disabilities. The lack of community facilities in the 1920s encouraged Congress to permit the VA to provide care for needy veterans with non-service-connected disabilities. Less than 30% of the 3 million veterans presently served by the VA have service-connected disabilities. Current eligibility laws make any veterans who states that he cannot afford medical care eligible for care in the VA system.

   "In analyzing this large acute-care segment, where the VA concentrates its activities and resources, the committee found several very important problems. These do not stem from mis-management, but have deep historical roots. Geographical distribution is uneven; rural areas of the country have little if any VA care. Almost everywhere in the system there is a marked imbalance between in-patient and out-patient facilities. In-patient facilities are inappropriately used. There are twice the number of medical and surgical beds necessary. This situation is not true in every hospital, but it is systemwide. The average length of stay in medical-surgical beds in VA hospitals is much longer than that of comparable patients in the community hospitals. Special facilities, such as

cardiac catheterization or renal dialysis are under-used. . . "

The report of the Metropolitan Health Board makes many of these same comments, though not all, with respect to the Minneapolis VA hospital specifically. Especially with respect to the average length of stay, which appears to be about twice the average in the general community hospitals.

3. The next thing to understand is the very large capital plant expansion proposed by the VA, seen in its nationwide dimensions. This was well summarized in an article in the magazine Modern Healthcare for April, 1980. Let me quote just a bit from that:

> "The largest multi-hospital system under single management, the VA medical system, will undergo a billion dollar facelift in the next few years. The VA will replace eight hospitals, and construct one new institution.
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> "The VA must build in the 1980s if it expects to meet expected service demands of World War II veterans, most of whom will be age 65 in this decade. Long term and geriatric care needs are expected to soar. Service-disabled veterans, however, will continue to receive care first.
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> "Seven VA medical centers are currently being replaced, and an 8th replacement is scheduled for Minneapolis, but it has not yet received complete funding. As a provider for more than one million in-patients annually, the VA is experiencing inflation on a grand scale. Three of its current replacement projects -- Baltimore, Seattle, and Little Rock, Arkansas -- will cost $57.7 million more than was budgeted, as a result of rising construction costs since fiscal 1978.
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> "Replacement hospitals are also being built at Richmond, Virginia, Bay Pines, Florida, Martinsburg, West Virginia, and Portland, Oregon. The total estimated cost for the seven projects if $795 million.
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> "The most costly projects is an 845-bed medical center in Minneapolis . . . all but one building in the Minneapolis VA medical center will be replaced . . . it now houses the largest educational and research programs in the VA system.
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> "Other notable projects include close to $61 million for nursing home construction and $10 million more for domiciliaries. More than $52 million is sought for out-patient improvements. More than $92 million will be spent on clinical improvements . . . "

4. Before turning to the issues involved in the local hospital, it might be useful to make a comment or two about the larger scope of this proposal. That is, in the form of a couple of questions.

First, why is the VA concentrating so much of its expenditure on hospital facilities, when a number of the facts about their system, and its population, would suggest that what is really required is housing, or long-term domiciliary and nursing care, or social service programs?

Second, why -- if we are to believe the NAS panel that the VA facilities are mal-distributed around the country, in relation to the veterans population --

is the VA building so large a hospital in the Twin Cities area (surely one of the metropolitan area's best supplied with hospital facilities), rather than in some other part of the country not so well served as this one, with both short-term and long-term health care facilities?

5. Early in March of this year the president of the Citizens League, Allan Boyce, at the direction of the Board, wrote letters to a number of federal officials, with respect to the proposal for the replacement hospital at Fort Snelling. Here is what he said:

"A real, and difficult, issue is emerging here in the Twin Cities area . . . with respect to the attitude of the federal government toward the size, and cost, of the hospital system. I wanted to be sure you are aware of the growing concern here . . . and the confusion . . . about whether the federal government really wants this community to put some restraints on the size and growth of its hospital system, or not.

For something like twenty years, now, we have been pressed by the federal agencies (both those concerned with hospitals, and those concerned with expenditures) to do a better job of hospital planning: to cut out unneeded beds, and to make sure that expansion and new investment is reasonably related to needs.

The Twin Cities area has been doing this . . . perhaps, as well as and as aggressively as any metropolitan area in the country. The health systems agency here is, I believe, well respected. Within the past year it has made some extremely difficult decisions, requiring a reduction in the hospital capital plant, and denying requests for new construction.

And this effort extends into the private sector, as well. The Citizens League, as a private, non-profit non-partisan public-affairs organization, has been involved with hospitals in a substantial way, throughout its 28-year existence. At our urging, in 1970, Hennepin County government and Metropolitan Medical Center (a private hospital complex) did enter into new relationships for the planning of their major developments in central Minneapolis . . . which resulted in a major physical and programmatic linkage of their two facilities. More recently, the Citizens League has played a leading role in encouraging both the Metropolitan Health Board and the community hospitals to reduce what we found to be a substantial excess of bed capacity in the area; and, further, to slow down the rate of hospital capital expansion.

It was a real shock, therefore, in the context of this community effort to restrain investment, to learn that the federal government -- through the Veterans Administration -- intends to do a $250-million replacement of its hospital in Minneapolis.

We understand the law and the program and the tradition of the Veterans Administration, in providing hospital care . . . and, in addition, hospitals . . . for veterans. We recognize the importance of the Minneapolis hospital, in the Veterans Administration system. We appreciate that it has not had substantial reconstruction in the past thirty years.

But it is important for the government to appreciate, from its side, the impact that such a decision to proceed with the reconstruction of the Veterans Administration hospital has, here, on the efforts other agencies are making to get this community to deal firmly with the need to reduce the size of its own hospital system. In effect, the federal government is declining to apply to itself the requirements for planning and coordination that it is requiring of the community system . . . since the Veterans Administration will not be submitting itself to the certificate-of-need process. We do understand that the Veterans Administration has asked the local health system agency to review its proposed plans, for program and for building. This will be helpful. There are some important questions arising about the relationship of the Veterans Administration hospital to the community system. One, of particular significance, has to do with its relationship to the proposal proceeding concurrently by the University of Minnesota for a $200-million replacement of University Hospitals, with which we know your hospital is closely affiliated, as a part of the teaching-hospital system.

Some people are -- here, as nationally -- questioning why the Veterans Administration should operate a hospital system at all . . . since most veterans, most of the time, are users of the general community hospital system. We have not made this suggestion ourselves. But it does seem to us that the Veterans Administration hospital system would be more widely supported if the agency were to cooperate fully with the community in decisions about the size, shape and structure of the hospital system which serves it."

We never did have a reply from the Office of Management and Budget. We did have responses from the other agencies. A letter signed by the Chief Medical Director of the Veterans Administration told us that the existing building is deficient; that the VA is happy to cooperate with our local health planning agency, through the A-95 process; said that the VA is severely limited by law in its use of community hospitals for veterans -- limited, that is, to an emergency, until the veteran can safely be moved to a VA facility; and advised us that the Committees on Veterans Affairs and the Appropriations Committees of the Congress would perform a review of the project which will be "at least as, and maybe more, strenuous and critical than what is required of the private health care sector."

A letter signed by the Director of the Bureau of Health Planning in the Department of Health, Education and Welfare thanked us for our letter; advised us that a certificate-of-need is a state, not a federal program; said that the Secretary of HEW has concluded that there is no basis in law for requiring coverage of federal facilities in state programs; and told us again that the VA will be cooperating in an A-95 review.

Another response from the Administration thanked us for our letter; assured us that the government is firmly committed to controlling the skyrocketing costs of health care in the country; said that the VA hospital is badly in need of replacement; said that the money provided in next year's budget is only planning money; and assured us again that they will try very hard to keep costs down and avoid duplication of services.

Similar comments have been received, quite uniformly, from the offices of various members of the state's congressional delegation. Most commonly, there is reference to the VA's mission under the law to provide health care and hospital care for veterans -- in the sense of owning and operating its own hospitals. These assumptions appear to be accepted by almost everybody involved, with the exception

of the National Academy of Sciences panel . . . which, of course, recommended that in a staged way, over a period of years, the VA program be merged into the general community hospital system in this country.

6. We have also read a good deal of the criticism of the NAS report, and heard it expressed orally in meetings and discussions around this community. It is perfectly clear, too, from this, what is a central misunderstanding involved. It is frequently assumed that the withdrawal of the VA from the operation of a hospital system would represent, at the same time, the withdrawal of the responsibility of the federal government for providing for medical and hospital care for veterans . . . thereby dumping this burden on other federal health care programs and/or on the health care programs of the states and localities, or the private sector.

   The NAS panel has said over and over again, and so clearly it should not be possible to misunderstand it, that it fully supports the entitlement given to veterans under the existing law, and is quarreling only with the question of the way in which that hospital care is provided, and by whom.

7. Like the other public agencies involved, the Metropolitan Health Board has also worked within the framework of existing law. The basic concept of the VA as a hospital system, rather than as an entitlement program, is not basically questioned. The document originated by the staff essentially quarrels only with the size of the hospital. It does, on page 38, discuss briefly, as an "alternative," the concept of the VA essentially buying hospital care in the community hospital market, but this notion is very quickly dismissed . . . with what we regard as a wholly inadequate analysis.

8. What is very clearly called for -- and required, for any effort to lay this whole question to rest -- is a serious in-depth look at the alternatives to the present VA mode of operation.

   It is clear this will not come from the Veterans Administration itself. Rather, it will have to be done by the parties on the outside.

   The NAS panel suggested that -- as a way to break out of this endless argument about continuing to do everything the same way, or doing everything a different way -- there be some community "demonstrations." Some experimentation . . . some tests . . . and that the question of what the VA program becomes, nationwide and longer-term, be settled not by discussion but by what actually happens when veterans are given the opportunity to react to a different system.

   What we propose is that Minnesota take the lead in organizing such a demonstration, as an extension of the discussion going on here currently.

   It does not appear realistic to expect that the process of planning that looks toward a whole new conventional hospital will be help up, pending the discussion of a possible alternative.

   But, especially considering the amounts of money involved, we think it is not unrealistic to suggest that, overlapping this period of planning, some effort be devoted to looking at a basic alternative, which would involve either the veterans individually or the VA as an organization, essentially buying into the hospital capacity that exists in the community system.

   This does not have to mean there would no longer be "a VA hospital" here in the

Twin Cities area. There could still be a building here (perhaps even a new building) that would be "the VA hospital." In it there would be VA personnel, to receive applicant veterans on precisely the same basis they are received today. Once admitted at the VA hospital, veterans are then taken to a place, on a floor of a hospital wing, where a bed is available for them. This could be in one building; or in another building. It could be on the grounds with the existing VA hospital; or it could be on a different site. It could involve a walking trip, or a driving trip. The study to design such a demonstration alternative should be, we think, funded by the Department of Health, Education and Welfare, through its division concerned with efforts at hospital cost control. The study should be conducted by the Metropolitan Health Board, in cooperation with the agencies that become responsible for the planning of the VA program and facilities.

The key persons in launching such a study, and in securing the funds for it, are, clearly, the members of the congressional delegation from Minnesota. We look to them for action.

Quite obviously, too, finally, any such study would require, at an early date, some indication from the hospitals in this community of the capacity they could, and would, make available, and the terms and conditions on which this would be done.