

STATEMENT OF THE HONORABLE CHRISTOPHER H. SMITH, CHAIRMAN
HOUSE COMMITTEE ON VETERANS' AFFAIRS
MARCH 7, 2002

VA/DOD HEALTH RESOURCES SHARING (H.R. 2667)

Chairman McHugh, Chairman Moran, Ranking Member Snyder, Ranking Member Filner, I want to thank all of you for working together to make today's hearing a reality. It is a pleasure to be with you this morning to share my views on ways to improve the cooperation and collaboration between the Departments of Veterans' Affairs and Defense in fulfilling their health care obligations, and specifically on the legislation that I have introduced, H.R. 2667, to further this goal.

At the outset, let me say how much I appreciate the support of Armed Services Committee Chairman Bob Stump, the former Chairman of the Veterans' Affairs Committee, in moving ahead with today's hearing. His leadership, and your leadership, Mr. Chairman, in working with our Committee, has been exemplary. You, Chairman Moran, Mr. Snyder and Mr. Filner are truly demonstrating the advantages of Committees working together to benefit the men and women who are serving, have served or will serve our nation in the armed forces.

As Chairman of the House Committee on Veterans' Affairs, I have the privilege of working everyday to improve the quality of life for our nation's 25 million veterans and their families. Given the tight fiscal and budgetary realities that face our federal government, if we are to continue providing quality health care for all those who need it, we must make the best use of those resources that are currently available. Inefficiencies and duplication not only waste taxpayer dollars, they shortchange military personnel, retirees, and veterans seeking health care.

This year, the Departments of Veterans Affairs and Defense will spend nearly \$40 billion combined on health care for current or former military personnel and their families. Yet despite this enormous sum, there is still not enough to meet all of their health care needs. The federal government must find ways to maximize efficiency and minimize unnecessary, duplicative services that drain dollars from their primary purpose – providing timely, quality health care to present and former service personnel and their families.

Mr. Chairmen, I strongly believe that the federal government must aggressively seek to increase resource sharing between these two massive health care systems, whenever and wherever feasible. Although Congress has made efforts in the past to promote specific sharing, the results have been modest at best.

For example, we authorized the Mike O'Callaghan Federal Hospital at Nellis Air Force Base outside Las Vegas. It is a 96-bed Air Force-managed hospital with 52 VA-dedicated beds. This facility still has significant potential to serve as a model for sharing, but the VA and the Air Force were required to maintain separate budgets, financial, human resources, patient care records and data management systems. Combined, their annual budgets are over \$46 million, yet they effectively operate as two independent federal facilities within the same walls, with needless duplications of systems management and services, as well as inefficient use of resources.

Despite being co-located, they maintain separate pharmacies, one for veterans and the other for Air Force beneficiaries. Both the VA and the Air Force also maintain separate intensive care units, surgical operating rooms and support facilities and staff. Such duplication of facilities and services wastes funds that could be used to improve delivery of health care to both veterans and military communities.

In Albuquerque, New Mexico there is a VA-Air Force partnership between the VA Medical center and Kirkland AFB Hospital that provides admitting privileges to Air Force physicians. The relationship between the VA and Air Force at these facilities is a good beginning to sharing.

However, despite their promising sharing relationship, there remain many untapped areas where new efficiencies could be achieved in Albuquerque. For example, the Air Force and VA needlessly maintain separate dental clinics, central dental laboratory functions and separate supply chains. Also, the Air Force continues to maintain a management presence as though it were still operating as an independent hospital facility, even though most of its activities duplicate those of the VA.

Some facilities that are close neighbors – essentially co-located facilities – could become joint facilities, thereby almost certainly reducing administrative costs as well as staffing needs. With such savings, additional resources could be invested in patient treatment and technological improvements. For instance, at the San Diego VA Medical Center, the fiscal year 2001 budget is \$202 million, and at the Balboa Naval Medical Center, the fiscal year 2001 budget is over \$338 million. Although these facilities are only a few miles apart, no clinical sharing occurs between them. Does anyone doubt that money could be saved by reducing duplication of services, particularly expensive testing equipment and facilities?

For too many neighboring VA and DoD health facilities, separate management and operations are the only way they conceive of doing business, even when another federal medical

facility, also supported by public dollars, may be little more than a stone's throw away. I am convinced that this separateness is the result – at least in part – of deeply ingrained habits, entrenched organizational cultures and longstanding turf battles.

Perhaps the most illustrative example of the failure to pursue sharing agreements that we have seen recently is in Charleston, South Carolina, home to the Naval Hospital Charleston and the Ralph H. Johnson VA Medical Center. During a visit last year by Veterans' Affairs Committee staff, the Naval Hospital's Director, in the course of discussing the issue of resource sharing, also talked of the difficulty they experienced in recruiting and retaining pharmacy technicians to meet the demand for approximately 500 mailout prescriptions every day.

What the Navy did not see is literally right across the street: a VA Consolidated Mail Outpatient Pharmacy facility, one of eight nationwide, which produces 52,000 mailout prescriptions daily for eligible veterans. When our Committee staff and the Navy personnel met with the director of the VA facility, he told us that he would have little problem whatsoever in fulfilling an additional 500 prescriptions, which would increase the workload by less than 1% of their daily volume.

That was last April. Today, almost one year later, there has been no change. The new executive staff at the Naval Hospital seems unaware of our staff's visit, or of the possibility of utilizing the VA pharmaceutical facility. Nothing has changed.

These are just a couple of the many lost opportunities for resource sharing. I would commend to your attention a staff report published by the Committee on Veterans' Affairs that documents these, and other examples of VA and DoD facilities that have failed to take advantage of the benefits that come from sharing health care resources.

To move beyond the status quo, last July, I, along with Veterans' Affairs Committee Vice Chairman Mike Bilirakis and others, introduced H.R. 2667, the "Department of Defense – Department of Veterans Affairs Health Resources Improvement Act of 2001." This legislation takes another step towards fulfillment of the goals set out almost twenty years ago by Public Law 97-174, the "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act of 1982".

Our legislation would establish five health care sharing demonstration projects in five qualifying sites across the country. The purpose of the demonstration projects would be to reward those who are not daunted by current obstacles that prevent sharing where it is clearly possible.

H.R. 2667 would, to the extent feasible, require a unified management system to be adopted in the five demonstration sites to the extent feasible. A unified system would look at ways to eliminate differences between the budget, health care provider assignment, and medical

information systems. At the present time, the two Departments' information systems are still incompatible, and so this legislation would also encourage greater software compatibility. By making such systems communicate better, we can better ensure continuity of care, equality of access, uniform quality of service and seamless transmission of data.

In addition, the demonstration projects would provide for enhancement of graduate medical educational programs at the five sites. This will create a great opportunity for health professions students by giving them a combined exposure that has not been available to them before. It would also bring a better awareness and understanding of differences in the two beneficiary populations for new and experienced health care professionals alike.

Mr. Chairmen, H.R. 2667 is a realistic framework for taking direct steps to improve sharing, and I would urge both Subcommittees to consider moving rapidly on this legislation.

As the war on terrorism continues, and casualties occur, we are reminded once again of the absolutely vital role that our servicemen and servicewomen play in defending freedom, and of the gratitude and obligations that we as a nation owe them. At this very moment, in the frigid mountains of Afghanistan, they are making sacrifices on behalf of all Americans; some will make the ultimate sacrifice for their country.

In return, we must fulfill our obligation to provide the best and most efficient health care for them and their families, now, and after they return. I am convinced that this will be enhanced if we truly begin combining – when and where it is appropriate – the health care resources of the Departments of Veterans Affairs and Defense for the benefit of our soldiers, sailors, airmen and marines – past, present and future.

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