

STATEMENT BY
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BEFORE

THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

REGARDING

DEPARTMENT OF VETERANS AFFAIRS
PHYSICIAN AND DENTIST SALARY AND BENEFIT ISSUES

ON

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Chairman Simmons and members of the Subcommittee, I am Lactancio Fernandes. I am a fellow of the American College of Chest Physicians and I work as a pulmonary care physician at the VA Gulf Coast Health Care System.

As a Major in the United States Air Force Reserve, 919th Medical Squadron, my most recent annual tour was spent in support of Operation Iraqi Freedom. As President of Local 1045 of the American Federation of Government Employees, AFL-CIO, I represent nearly 1,200 doctors, nurses, allied health care workers and other hospital staff at the VA facilities in Biloxi and Gulfport, Mississippi, Mobile, Alabama, and Pensacola and Panama City, Florida. I am honored to present my union's views on issues confronting VA's ability to retain and recruit needed medical providers.

Addressing VA's ability to retain and recruit needed primary care and medical specialty providers is essential if the VA is to meet the current and future demand for veterans' medical care. Our members are frustrated and deeply concerned that hundreds of thousands of veterans must wait months for appointments to see us. Today's hearing is ultimately about ensuring that the VA will have the physicians and dentists it needs to provide veterans with meaningful access to high quality medical care.

Pay and benefits are key to retaining and recruiting direct care providers, but we believe that enhancing the culture of medical professionalism will also yield great strides in VA's ability to hire and keep physicians and dentists. Like other civil servants, physicians and dentists choose to work at the VA because it offers an opportunity to help people, hone and develop our professional practice, and perform meaningful and challenging work. In short, it is the nature of the work, not just the size of the paycheck, which matters.

Decisions on restructuring, staffing, administrative duties, and rationing of care affect how we are able to practice medicine. Ensuring that front-line medical providers have a voice in decisions which involve medical practice and quality of care issues is absolutely essential if the VA is to be the employer of choice for doctors and dentists and provide world-class health care.

For example:

- Front-line medical providers need to be part of VA's dialogue on developing a staffing model for primary care, long-term care, and specialty care to ensure that the methodology accounts for time spent not only on direct patient care but administrative tasks, research, coordination of care and ongoing professional development and education.
- VA's ongoing efforts to refine a computerized medical record system would benefit from extensive feedback from the very doctors who must expend patient care time entering data.
- When VISN or facility management establish additional requirements for prescribing atypical antipsychotic drugs the voice of front-line physicians is essential to ensure that cost-containment efforts do not undermine or restrict veterans access to effective treatment.

Current law creates unnecessary constraints on the ability of front-line physicians and dentists to work with VA management to address the ongoing challenges the VA faces in the delivery of direct patient care. As you consider improvements to the physician and dentist pay system we urge you to consider improving the participation of front-line physicians and dentists in decisions which affect their practice. Ensuring that direct care providers have a seat at the decision making table will create a stronger culture of medical professionalism, improve morale, and make successful implementation of new policies and procedures more likely. Giving doctors and dentists a real say in shaping workplace decisions that impact on patient care will boost VA's ability to hire and keep medical providers.

AFGE would welcome the opportunity to work with the Subcommittee to explore workable ways to expand and invigorate the opportunities for direct care physician representatives to be part of VA's ongoing dialogue on how to improve its delivery of care to veterans.

As this Subcommittee considers the VA's proposed new pay and benefit system for physicians and dentists it is important to assess what the current system offers in terms of establishing competitive salaries.

Positive components of the current system include:

- A guaranteed annual General Schedule (GS) nationwide pay adjustment,
- the recognition of the value of full-time physicians and dentists through a guaranteed pay adjustment,
- encouraging a stable patient-physician relationship and long-term commitment to caring for veterans through guaranteed length of service pay,
- incentive pay for ongoing professional learning and advanced credentials through guaranteed compensation for board certification, which recent research has shown is linked to improved patient outcomes,
- flexibility to provide additional compensation for medical specialties,
- flexibility to increase compensation to meet specific geographic challenges in recruitment and retention, and
- the ability to reward exceptional qualifications within a specialty.

This pay system is more transparent, fair, credible, and equitable because many of the key pay components are guaranteed and not discretionary. It also makes the system easier to administer and less subjective or vulnerable to bias or discrimination than a system which places all components of pay for each individual physician at the discretion of VA facility management. As the Subcommittee moves forward in refining the existing pay system we would urge you not to eliminate the guaranteed status of key objective pay components.

The values of the current special pay provisions have been diluted over the years because the statutory dollar limits are not indexed. A simple and rational approach to addressing this weakness in the pay system would be to adjust all current guaranteed and discretionary pay components upward by the same

percentage as the GS across-the-board pay increase. This would in effect index the current statutory dollar limits.

Using the GS across-the-board raise to increase both the base salary and specialty pay is rational because the GS across-the-board increase is based upon the Employment Cost Index (ECI). This Bureau of Labor Statistics (BLS) index measures the change in compensation costs for private sector, State and Local government employers. By using the GS pay increase on the full salary amount, provider salaries remain competitive. This would also be consistent with other current federal pay systems, and would not require significant effort by the VA to administer.

Discretion in VA's Current and Proposed Pay System to Set Market Based Salaries

While the current discretion in setting geographic and specialty salary rates may give VA flexibility it also makes the system vulnerable to arbitrary, inconsistent and biased compensation decisions. With this vulnerability come inconsistency, favoritism and discrimination, which erode the core merit principle of equal pay for work of equal value. The inconsistent and biased exercise of discretion hurts morale.

Having key components of the current physician pay system be based on guaranteed and objective measures has gone a long way toward preventing pay discrimination on the basis of race, ethnicity, gender, or veterans status. However, the current system's discretionary pay components in geographic pay and specialty pay have meant a return of a "good ole boy" system in some facilities. Problems with such discretion are not limited to cronyism but outright discrimination. Employment discrimination lawsuits are a costly check and balance to abuse in the pay system.

We are very concerned that VA's proposed pay system strips away any guarantees for objectively and fairly setting physician and dentist salaries. Senior front-line physicians would no longer be guaranteed compensation for their full-time status, long-term commitment to caring for veterans or board certification. These factors might be considered in placing an individual physician or dentist along the base pay band and in appraising his salary for the market pay band but the facility administrator could also ignore or discount these objective factors. Under the proposed legislation, two primary care doctors working at the same medical center who have the same years of service in the VA and are both board certified in the same specialty could have salaries that vary by \$25,000 or more.

The VA's proposed legislation would also allow the VA absolute discretion to reduce the salaries of doctors and dentists. Further, the VA would contend that these reductions in pay would not be subject to review by an independent third

party. How can telling doctors that they could have their pay reduced and will have no recourse should such an adverse action occur help the VA retain and recruit highly qualified staff?

We understand that the VA would set the initial base pay amount as a salary floor. We are concerned, however, that this floor is still inadequate given the absolute discretion proposed in the legislation. For example, the VA could set two doctors' base salaries at \$110,000 and over the years raise their salaries to \$130,000. The VA would still have statutory authority to cut one doctor's pay by \$20,000 and she would have little to no recourse.

The VA suggests that decreases in a doctor's pay will be the result of downward changes in market salary trends. The proposed legislation authorizes the VA broad authority to interpret and apply "market data." For example, the provision on the market pay band includes factors such as "personal qualifications, and individual experience." These subjective assessments would have nothing to do with market trends but would nonetheless be part of the market-based component of pay. Using these subjective non-market factors, facility administrators could cut physicians' pay.

This Subcommittee wisely put a stop to negative pay adjustments in the VA's nurse pay system. Should the Subcommittee move forward on VA's physician and dentist pay proposal we urge you not to give the VA authority to decrease a medical provider's pay.

VA's explanation of the market-based tier also makes clear that the target for pay comparability is the 50 percentile of AAMC salaries in the broad geographic area, plus or minus 10%. Facility administrators under tight budget constraints could ignore market data repeatedly to keep salaries minus 10% of the already low benchmark of the median AAMC salary levels. We have seen how facility administrators have ignored salary data to repeatedly deny Registered Nurses any pay raises. What safeguard mechanisms and accountability would be in place to ensure that facility management would not regularly set salaries at minus 10% of the median AAMC salary rates?

Should the Subcommittee allow any level of individualized pay setting we urge you to ensure that discretion in setting pay is balanced by statutory checks and balances, independent review and accountability mechanisms to ensure reliability, validity, and transparency in any both establishing the regulatory framework and for specific pay decisions.

Pay for Performance

Does a pay system that sets out to reward individual employees for contributions to productivity and quality improvement and punishes individual employees for making either relatively small or negative contributions to productivity or quality

improvement work? The data suggest that they do not, although the measurement of productivity for service-producing jobs is notoriously difficult.

Although individualized merit pay gained prominence in the private sector during the 1990's, there is good reason to discount the relevance of this experience for the federal government as an employer. Merit based contingent pay for private sector employees over the decade just past was largely in the form of stock options and profit-sharing, according to BLS data. The corporations that adopted these pay practices may have done so in hope of creating a sense among their employees that their own self interest was identical to the corporation's, at least with regard to movements in the firm's stock price and bottom line. However, we have learned more recently, sometimes painfully, that the contingent, merit-based individual pay that spread through the private sector was also motivated by a desire on the part of the companies to engage in obfuscatory cost accounting practices.

These forms of "pay for performance" that proliferated in the private sector seem now to have been mostly about hiding expenses from the Securities and Exchange Commission (SEC), and exploiting the stock market bubble to lower actual labor costs. When corporations found a way to offer "performance" pay that effectively cost them nothing, it is not surprising that the practice became so popular. However, this popularity should not be used as a reason to impose an individualized "performance" pay system with genuine costs on the federal government.

Jeffrey Pfeffer, a professor at Stanford University's School of Business, has written extensively about the misguided use of individualized pay for performance schemes in the public and private sectors. Pfeffer's research shows that performance systems never achieve their desired results, yet "eat up enormous managerial resources and make everyone unhappy."

Professor Pfeffer explains that pay for performance myths are based on conceptions that human nature is uni-dimensional and unchanging. In economics, humans are assumed to be rational maximizers of their self-interest, and that means they are driven primarily, if not exclusively by a desire to maximize their incomes. The inference from this theory, according to Pfeffer, is that "people take jobs and decide how much effort to expend in those jobs based on their expected financial return. If pay is not contingent on performance, the theory goes, individuals will not devote sufficient attention and energy to their jobs."

Further elaboration of these economic theories suggest that rational, self-interested individuals have incentives to misrepresent information to their employers, divert resources to their own use, to shirk and "free ride", and to game any system to their advantage *unless* they are effectively thwarted in these strategies by a strict set of sanctions and rewards that give them an incentive to

pursue their employer's goals. In addition there is the economic theory of adaptive behavior or self-fulfilling prophesy, which argues that if you treat people as if they are untrustworthy, conniving and lazy, they'll act accordingly.

But do pay for performance systems work? Pfeffer answers with the following:

Despite the evident popularity of this practice, the problems with individual merit pay are numerous and well documented. It has been shown to undermine teamwork, encourage employees to focus on the short term, and lead people to link compensation to political skills and ingratiating personalities rather than to performance. Indeed, those are among the reasons why W. Edwards Deming and other quality experts have argued strongly against using such schemes.

Consider the results of several studies. One carefully designed study of a performance-contingent pay plan at 20 Social Security Administration (SSA) offices found that merit pay had no effect on office performance. Even though the merit pay plan was contingent on a number of objective indicators, such as the time taken to settle claims and the accuracy of claims processing, employees exhibited no difference in performance after the merit pay plan was introduced as part of a reform of civil service pay practices. Contrast that study with another that examined the elimination of a piece work system and its replacement by a more group-oriented compensation system at a manufacturer of exhaust system components. There, grievances decreased, product quality increased almost tenfold, and perceptions of teamwork and concern for performance all improved.¹

Compensation consultants like the respected William M. Mercer Group report that just over half of employees working in firms with individual pay for performance schemes consider them "neither fair nor sensible" and believe they add little value to the company. The Mercer report says that individual pay for performance plans "share two attributes: they absorb vast amounts of management time and resources, and they make everybody unhappy."

One further problem cited by both Pfeffer and other academic and professional observers of pay for performance is that since they are virtually always zero-sum propositions, they inflict exactly as much financial hardship as they do financial benefit. In the federal government as in many private firms, a fixed percentage of the budget is allocated for salaries. Whenever the resources available to fund salaries are fixed, one employee's gain is another's loss. What incentives does this create? One strategy that makes sense in this context is to make others look bad, or at least relatively bad. In addition, competition among workers in a

¹ "Six Dangerous Myths about Pay" by Jeffrey Pfeffer, Harvard Business review, May-June 1998, v.76, no. 3, pg. 109(11).

particular work unit or an organization may rationally lead to a refusal on the part of individuals to share best practices or teach a coworker how to do something better. Not only do these likely outcomes of a zero-sum approach obviously work against the stated reasons for imposing pay for performance, they actually lead to outcomes that are worse than before.

What message would the VA be sending to its medical providers and prospective employees by imposing pay for performance system? At a minimum, if performance-based contingent pay is calculated on an individual-by-individual basis, the message is that the work of lone rangers is valued more than cooperation and teamwork and focusing on veterans. Further, it states at the outset that there will be designated losers - everyone cannot be a winner; someone must suffer.

Apart from grave concerns about how performance pay depletes administrative resources and pits one physician against another, we also have questions about the specifics of the so-called "corporate goals" for physicians and dentists who treat veterans. We are concerned that the "corporate goals" upon which performance pay will be based will adversely impact professional autonomy to make necessary direct patient care decisions.

As part of VA's cost-cutting measures, would the VA adopt "corporate goals" which give physicians an incentive to restrict or dampen veterans' access to needed medical tests, treatments or prescription drugs? Would the "corporate goals" try to encourage doctors to see more patients but spend so little time with each patient as to undermine the quality of the doctor-patient relationship? Would the VA promote "corporate goals" that would encourage facility administrators and medical providers to erode VA's capacity to provide more costly inpatient psychiatric care, substance abuse treatment, or spinal cord injury care? Because performance pay could be based upon VA's ability to recoup money from third party payers would the VA "corporate goals" in effect reward physicians who do not treat or who spend less time treating veterans who have no insurance?

How will front-line physicians and dentists' representatives and veterans advocates be involved in developing and evaluating the performance pay "corporate goals"? Will there be effective transparency and accountability measures, including independent third-party reasonableness reviews, access to independent grievance procedures, internal assessments and regular direct care provider evaluations of the system? Such safeguards are key to minimizing waste, fraud and abuse.

Given that experts find that pay for performance systems eat up enormous managerial resources and usually make everyone unhappy we are skeptical of the possible benefits from VA's proposed third tier for pay. The added potential pitfalls of VA's "corporate goals" undermining veterans' access to high quality

medical treatment lead us to urge the Subcommittee to proceed with utmost caution in considering VA's pay for performance proposal.

Pay for performance is the wrong answer to the wrong question. It's not that VA's physicians and dentists don't perform well and will only do so if their annual raise depends on it. More money needs to be put into VA's budget to hire additional staff. More money is needed so that federal salaries are competitive with salaries paid in the private sector. Reallocating existing money so that you solve that problem for some and make things worse for others under the banner of "performance" is dishonest and will do lasting damage to the delivery of health care for veterans.

Questions with the Market Tier

VA's proposed legislation is open-ended in defining what data it will use to support its quasi-market based pay tier. Our understanding is that by regulation the VA would use AAMC data and target the combined three tiers of salary to approximate the 50th percentile of pay, plus or minus ten percent.

As previously discussed, we have grave concerns with the amount of discretion facility administrators would have in interpreting the data and applying it to individual medical providers. We also have a number of questions as to whether AAMC data is the most suitable benchmark upon which to base VA pay decisions.

Many medical schools have undergone revisions in their faculty pay that do not seem applicable to VA medical practitioners. It is my understanding that more schools are adopting a "eat what you kill" philosophy that requires faculty to essential raise 50% to 70% of their salary through outside research grants. Adopting this philosophy for full-time VA primary care and specialty doctors by proxy of the AAMC salary data does not make sense. We ask that the Subcommittee consider whether other databases or a combination of salary surveys might be more relevant to helping the VA achieve pay comparability with the private sector.

Even if the AAMC salary surveys were the appropriate database, why is the 50th percentile the magic number for ensuring that VA achieves pay comparability? Under VA's nurse locality pay system the VA cannot be the pay leader but it can go much higher than the 50th percentile to achieve competitive salaries for nursing staff, including nurse practitioners. Under the Federal Employee Pay Comparability Act, signed into law by George H. W. Bush, federal employee salaries under the General Schedule are to progressively increase over several years to reach 95% comparability with the private sector pay.

It is our understanding that the VA's proposed regulations implementing the proposed legislation would mean only 30% of VA's physicians and doctors would receive a significant pay increase at the expense of the remaining 70%.

Before proceeding with such a radical change in how VA sets pay we urge you to explore why such a limited number of physicians would benefit from this pay proposal, whether these physicians are full-time or part-time, provide specialty or primary care, front-line providers or administrators and whether there are other alternatives to addressing the unique salary demands for these physicians that do not adversely impact on the other 70% of the physicians and dentists.

Leave and Benefit Issues

The VA's proposed legislation fails to address a leave issue of concern for many full-time VA physicians and dentists -- the 24/7-availability policy. The current VA regulation governing annual leave for physicians, dentists, podiatrists and optometrists requires that these employees be charged for annual leave on weekends, even when their normal schedule is Monday through Friday. Eliminating the weekend charges of annual leave would be a significant step in improving the working conditions for VA's medical care providers. We would welcome the opportunity to work with the Subcommittee to address this problem.

In order to improve VA's retention of nurses during a national shortage, the 107th Congress changed how sick leave would be calculated for purposes of retirement annuities for Registered Nurses under the Federal Employee Retirement System (FERS). We believe that such a change for VA physician and dentists would also enhance VA's retention and recruitment efforts.

Funding to Support Hiring and Retaining Needed Staff

As long as the VA operates under a cloud of fiscal uncertainty it will not be able to plan to hire and retain needed staff in a competitive market. Without a dedicated new funding stream to allow the VA to retain and recruit physicians and dentists at more competitive rates we risk diverting funds away from retaining other needed staff to ensure safe medical care for veterans.

The Subcommittee's challenging and crucial work in addressing the ongoing fiscal uncertainty of veterans' health care funding will also help ensure the VA maintains adequate staffing levels to address current waiting lists and future demand for care.

Conclusion

Thank you again for the opportunity to share our concerns with you and to raise questions about how VA's proposed new pay system would work. I would be happy to answer your questions.