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STATEMENT OF
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TO THE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

July 25, 2007

Good morning, Mr. Chairman and members of the Committee. Thank you for inviting me to testify before you today about healthcare funding for the Department of Veterans Affairs.

Funding for Veterans Healthcare - A Long Term Cost of National Security

In considering the funding of VA healthcare we should always remind ourselves that the benefits and services provided for veterans are inherently an extended cost of maintaining the armed forces and one of the long term costs of national security. The cost of VA healthcare is part of the price of our foreign policy.

Since establishing and maintaining the armed forces are the responsibility of the federal government, the federal government has an irrevocable obligation to pay for the costs of veterans. The federal government creates veterans, and the federal government must pay for the cost of veterans.

The High Cost of OEF/OIF Veterans

In considering funding for VA healthcare in the near term I believe that we should also keep in mind that based on the nature of the injuries and illnesses seen so far among veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) - i.e., with their high incidence of traumatic brain injury, multiple amputations and mental health problems, in particular - the relative cost of caring for these veterans will almost certainly exceed anything that we have ever seen before. That is, I believe the per capita or relative cost of healthcare for OEF/OIF veterans will exceed the cost of healthcare for veterans of any prior conflict. From a veteran's healthcare perspective, the war in Iraq is likely to be the most expensive of any war to date.

Because the nature of the morbidity being experience by OEF/OIF veterans is significantly different than what has been seen in prior wars it should also be understood that projecting the costs of services for these veterans will be more difficult than projecting the costs for veterans of prior conflicts. There is much to learn about how best to care for these veterans.

During the next several years, until the VA gains more experience in caring for the types of polytrauma and mental health problems seen among OEF/OIF veterans, it should be expected that budget predictions for the cost of caring for these veterans are probably not going to be as precise as desired, and there is likely to be greater need for supplemental funding or reprogramming of funds than in prior years.

The Many Facets of VA Healthcare Funding

In considering funding for VA healthcare, there are multiple policy and pragmatic aspects of the topic to which we could direct our attention this morning, including the adequacy of current funding; the reasons for increased spending for OEF/OIF veterans; the sustainability of recent spending trends; the ability to reliably project future spending needs; the seeming paradox of

rising costs in the face of a declining veteran population; the value and cost-effectiveness of VA healthcare; and the effect of the budget appropriations process on the delivery of VA healthcare services, to name some of the issues.

Since Professor Reinhardt has done such an excellent job of putting recent increased VA healthcare spending in context with increased spending for Medicare and healthcare overall I will not further comment on that in these prepared remarks. Likewise, he has done an excellent job of summarizing information about the disproportionately greater spending for healthcare in the U.S. compared to other developed countries and the inverse relationship between Medicare per capita expenditures and quality of care.

I observed a similar inverse relationship between expenditures and quality in VA healthcare in the 1990s, and I am pleased to say that some of the changes implemented as part of the transformation of VA healthcare in the latter 1990s have resulted in VA's demonstratively greater cost-effectiveness today compared to Medicare or private indemnity insurance.

I will also defer to Professor Reinhardt's comments on the sustainability of VA healthcare funding, and the more important question of whether the cost of U.S. healthcare overall is sustainable.

I would echo Dr. Reinhardt's comments that substantial evidence shows that a considerable fraction of U.S. healthcare spending cannot be justified on the basis of clinical outcomes or service satisfaction. Indeed, probably 25% to 30% of all healthcare spending in the U.S. is wasted.

If even a relatively small portion of these wasted funds could be recovered there would be more than enough money to ensure that all Americans had guaranteed access to healthcare.

In this regard, I think it is unfortunate that Medicare and private insurers have not expended more effort to understand and learn from the changes that occurred in VA healthcare in the latter 1990s. The evidence of VA's improved performance as a result of those changes is incontrovertible.

And while I do not want to overstress the point, it may be worth pointing out that during the five years that I served as Under Secretary for Health in the Department of Veterans Affairs, the VA healthcare budget increased a total of 6%, rising from $16.3 B in FY 1995 to $17.3 B in FY 1999. During this time there was a 24% increase in the number of patients who received hands-on care, as well as dramatic improvements in the quality of care and service satisfaction. (In the preceding 5 years, VA's healthcare budget increased 41%, rising from $11.6 B in FY 1990 to $16.3B in FY 1995, although the number of veterans served in FY 1990 was not much different than in FY 1995.)

During the same 5 year time period, non-VA healthcare spending increased well over 30% - an increase of more than 5 times greater than VA healthcare.

Since FY 1999, the VA healthcare budget has increased 131%, rising from $17.3 B in FY 1999 to a projected $40.0 B in FY 2008. Of course, the number of veterans using the system has essentially doubled during this time.

Potential Increased VA Healthcare Cost-Effectiveness

I would like to address a couple areas not commented upon by Professor Reinhardt.

The first of these is whether VA could achieve greater cost-effectiveness without compromising quality or service satisfaction. I believe that it could.

Notwithstanding the huge savings that were rung out of the system in the latter 1990s and VA's admirable cost-effectiveness today compared to Medicare and private health insurance, as noted by Professor Reinhardt in his testimony, I believe VA should assiduously seek to achieve cost

savings wherever it is reasonable to do so, and especially in non-patient-facing ways such as in the procurement of supplies and services. In this regard, I believe VA could achieve substantial savings almost immediately by doing two things.

The first would be to do as most of the top hospitals in the nation have been increasingly doing and that is to start reprocessing selected medical devices that are approved for marketing in the United States as Single-use Medical Devices (SUDs). Although this might appear on first impression to be unwise, the reuse of medical devices that are labeled for "single-use only" is a well established and safe practice regulated by the FDA and utilized by many of the nation's premier medical centers. Indeed, for many years, most of the hospitals rated as America's best hospitals have been reprocessing SUDs.

Reprocessing involves taking a medical device that has been used (or sometimes only the package has been opened and the device not used), cleaning and disinfecting it, verifying that it functions properly, repackaging it, sterilizing it and returning it for use. The more commonly processed SUDs are sequential compression device (SCD) sleeves used to prevent blood clots from forming in the legs of immobile patients; orthopedic drill bits, burrs and saw blades; biopsy forceps and snares; and endoscopic or laparoscopic scissors, graspers, dissectors and clamps. According to the FDA, about one-fourth of all hospitals and nearly half of large hospitals use reprocessed SUDs today. When these reprocessed devices are re-sold they are significantly cheaper than the original new device.

The two major benefits of using reprocessed SUDs are the lower cost of the devices and the decreased biomedical waste that must be disposed of. The latter both reduces hospital operationing costs and helps preserve landfill capacity.

Currently, as a matter of policy, VA does not use reprocessed SUDs, although the management of a number of VA hospitals would like to do so. I estimate that VA could achieve savings of $25 to 30 million in FY 2008 if it started to reprocess SUDs, with potentially significantly larger savings depending on the number and volume of reprocessed devices it ultimately utilized.

In considering reprocessing, it is important to understand that "single use" is a designation chosen by the manufacturer typically for economic reasons without consideration for the suitability of the device for reuse or reprocessing. As the GAO has noted, approval of a device as single-use simply means that the device can be safely and reliably used at least once, not that it cannot be used safely and reliably more than once. When you consider the nature of many of the items targeted for reprocessing (e.g., orthopedic drill bits and stainless steel external fixation rods) it is obvious that they should be reusable.

The second cost-savings step that VA could take would be to utilize state-of-the-art technology to optimize sourcing in the procurement process in what is generally known as expressive commerce or expressive bidding.

Expressive commerce and sourcing optimization are somewhat difficult to explain. They are sometimes confused with what is known as a reverse auction; however, sourcing optimization is not a reverse auction.

Expressive commerce and sourcing optimization are based on a set of highly sophisticated algorithms that allow buyers to present more of their demand at one time and allow sellers to be more creative in their responses. This has been made possible by software that allows literally thousands of options for combinations of goods and/or services at different pricings and other specifications to be processed in a bidding run.

While expressive bidding and sourcing optimization is an established best practice in private companies such as 3M, Proctor & Gamble and Johnson & Johnson, and it recently has been

adopted by the U.S. Postal Service, it is just now starting to be used by selected hospitals and healthcare providers, including UK's National Health Service and the University of Pittsburgh Medical Center.

The potential savings associated with expressive commerce are huge because of the vast arrays of options made possible by the technology.

Private hospitals that have used expressive bidding are typically seeing savings in the range of 12% to 18%. Based on VA's budget for medical and surgical supplies, pharmaceuticals and facilities maintenance, and factoring their already preferred government pricing, I would anticipate VA could achieve savings in the range of several hundred million dollars in the first year after starting to utilize expressive bidding (i.e., $500M to $700M), with probably much larger savings as experience was gained with the technology.

I believe that VA should vigorously pursue the above types of cost savings strategies as rapidly as possible, and they should rigorously look for other such opportunities. Just as we should expect VA healthcare to be a leader in quality and service satisfaction, it should also be a leader in cost-effectiveness and efficiency. We should expect VA to be a leader in providing best healthcare value.

The Need to Make the VA Healthcare Budget More Predictable and More Flexible

The last issue I would like to raise in these comments has to do with the challenges imposed upon VA healthcare managers by the unpredictability of the federal budget and the increasing rigidity of the VA healthcare budget.

More often than not, it seems, the federal budget is not passed on time, forcing the government to operate under a continuing resolution (CR) - sometimes for several months into the budget year. While this may be a mild inconvenience for some agencies or departments, it has definite untoward consequences for agencies like the VA that must provide critical services 24 hours a day, 7 days a week, 365 days a year.

Typically, when VA is forced to operate under a CR it must impose hiring freezes and take other personnel actions that will likely impede the delivery of services, or planned improvements in services, because it does not have its planned budget. Such forced practices often degrade services at the point of care.

While I do not have a suggested solution to this problem at the moment, I believe the unpredictability of the federal budget process does have significant deleterious effects on the delivery of VA healthcare on the front lines and this should be further investigated by this Committee.

Likewise, the increased compartmentalization of the VA healthcare budget in recent years (i.e., into medical services, medical administration, medical facilities, and information technology accounts) and the earmarking of funds in VA's Central Office (i.e., for prosthetics, mental health, geriatrics, etc.) combine to reduces field management's flexibility to spend on what may be most needed locally.

While I think I understand the intent of the compartmentalization of VA healthcare funds, and while I am sympathetic to the needs and desires of VA program leadership to ensure adequate and appropriate spending for their high priority program areas, the increased rigidity of the budget produced by these practices has the effect of imposing unintended artificial spending limits. I would urge the Committee to look into finding mechanisms that can ensure accountability and appropriate spending for priority programs but which also give field management the flexibility to spend their limited budget on the most important needs of the veterans they serve.

That concludes my prepared testimony. I would be pleased to answer any questions that the Committee might have.