STATEMENT BY

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH

REGARDING THE DEPARTMENT OF VETERANS AFFAIRS
FISCAL YEAR 2007 BUDGET REQUEST

FEBRUARY 14, 2006

The American Federation of Government Employees, AFL-CIO, which represents more than 600,000 federal employees who serve the American people across the nation and around the world, including 150,000 employees in the Department of Veterans Affairs (VA), is honored to submit a statement regarding the VA's Fiscal Year (FY) 2007 budget request for the Veterans Health Administration (VHA).

The VA's FY 2007 VHA Budget Fails to Address Chronic Shortfalls

The Administration's request for an 11.3% increase in funding for medical care looks like a step in the right direction – at first glance. However, a closer look reveals new and old budget gimmicks: higher co-pays and user fees, overly optimistic assumptions about collections and management efficiencies, and a hidden 13% cut in medical care dollars over the next five years, according to a new analysis by the Center on Budget and Policy Priorities.

This budget comes on the heels of years of shortfalls and short staffing, delayed construction and maintenance, and excessive, costly contracting out. VHA's dedicated employees and the veterans they serve are experiencing great uncertainty and hardship as the result of the current funding process. Medical facilities across the country have reported budget shortfalls for FY 2006, some as high as $30-40 million.

Widespread staffing shortages are taking their toll on VHA employees and veterans. In some facilities, official "hard hiring freezes" are in place, e.g. Puerto Rico/Virgin Islands, Togus, Maine, St. Louis, Missouri and Northern Wisconsin. Elsewhere, management is imposing "soft freezes" and "hiring lags" that significantly slow down the timeframe for bringing on new staff, e.g. facilities in New York, Florida, Idaho, Alaska, Wisconsin, North Carolina, Wyoming, Tennessee, California, South Dakota, Missouri, Minnesota, Nevada, Oregon and Texas. In either case, staffing shortages increase management's reliance on expensive contract care and temporary employees. VA staff are pressured or forced to work prolonged overtime.

Sometimes the effect of hiring freezes and lags is less obvious. For example, doctors and other direct care providers work overtime without pay because they must meet unrealistic performance goals (Portland, Oregon). Nurses who do not provide direct care get counted as if they do (Portland, Oregon.) A common VA practice is to keep inpatient units officially "open" even though beds are no longer available to patients because of staffing shortages (Pittsburgh, Minneapolis and Battle Creek, Michigan).

Understaffing has had an enormous effect on veterans' timely access to care. In fall 2005, over 12,000 veterans were on VISN 16 electronic waiting lists (EWL) for over 30 days, in VISN 23, 11,000 were on the EWL for more than 30 days. At the facility level, recent waiting lists have been as high as 3,000 facility-wide in Puget Sound, Washington, and 700 for primary care in Minneapolis. Veterans in Central Texas wait 6 to 8 months for specialty care.

Access to care is impacted by other practices as well. In Portland, Oregon, ambulances have been on "divert" status for two years. Veterans who are less than 100% service-connected disabled must go to other emergency rooms and often end up with large out-of-pocket bills. In Minneapolis, employees had to be pulled from other short-staffed units in order to open a new Polytrauma Unit.

Other FY 2007 Budget Concerns

AFGE is baffled and troubled by the proposed 34% cut in major construction funding. Many construction projects have already been held over from previous years. In addition, this proposal runs counter to the VA's priorities of ensuring access to a growing number of veterans, particularly those in rural areas.

Similarly, institutional care and state extended care facilities are neglected in this budget, even though the VA is facing a rapidly aging patient population. It is laudable to consider non-institutional alternatives where appropriate, but the VA is forced to contract out institutional care because some elderly and disabled veterans need a higher level of care but in-house beds are not available.

AFGE is concerned that the proposed $23 million cut in physicians pay is based on overly optimistic assumptions. The implementation process is far from over; personnel training is still underway and in many locations, compensation panels are still being formed. Locally, our members are being told that funding may not be available for *any* pay increases. To date, AFGE has been largely excluded from the physicians pay implementation process at the national and local levels, including the compensation panels making critical decisions about local market pay. AFGE urges the Committee to ensure that all aspects of the implementation process include AFGE representatives, consistent with the statute and the spirit of collaboration that existed during the legislative drafting process.

Veterans Deserve Assured Funding

Turning away hundreds of thousands of priority 7 and 8 veterans and increasing veterans' out of pocket medical costs through co-payments and user fees is not the answer. Soldiers returning from combat and their older counterparts cannot delay their medical needs because of erroneous projects and budget gimmicks. They should be able to count on access to VA's top-notch care in a timely manner. The past year's budget roller coaster has made a crystal clear case for

replacing the current flawed budget system with one that relies less on discretionary funding.

AFGE strongly urges Congress to pass the Assured Funding for Veterans Health Care Act of 2005 (H.R. 515), sponsored by Representative.Lane Evans (D-IL). H.R. 515 would require that annual VA health care funding be based on the number of enrollees and medical and hospital inflation.

The Vicious Cycle of Contracting Out and Underfunding

When hospitals and clinics lack funding for new hires and new imaging equipment, they are forced to contract out these services at much higher costs, resulting in further underfunding. Purchased (non-VA) care was the largest growing component (at 20% yearly) of the VHA budget from FY 2001 to FY 2004.

Contract care should be limited to short-term situations where specialty care or rural care cannot be provided in-house. Contracting out of laundries and food service is not a panacea for budget shortfalls either. VA's own reports indicate few or no savings from contracted out laundries, and in some cases, revenue losses. The inability (and in some cases unwillingness) to maintain or upgrade in-house laundry facilities creates the necessity to contract out laundry care, at the risk of lower hospital cleanliness. Contracting out of laundries, food service and other blue collar VA jobs deprives disabled veterans who fill many of these jobs with the chance for steady employment and self-sufficiency.

The VA's Business Process Reengineering (BPR) is not an outsourcing initiative, but rather aims to increase internal efficiencies through reorganizations and consolidations. Nonetheless, AFGE is concerned that budget pressures will encourage the use of BPR to move toward contracting out at a later date in order to fill service gaps resulting from consolidation. AFGE has another concern about BPR: The VA has stated that key employees should be part of the process, but to date, AFGE representatives have not been included in the process at either the national or local level. AFGE members stand ready and willing to contribute their expertise and insights on management efficiencies to the BPR process.

Collaboration and Its Cost Impact Must Be Closely Monitored

AFGE urges the Committee to carefully evaluate the costs and benefits of a joint venture between the Charleston VAMC and the Medical University of South Carolina (MUSC), and other joint ventures considered in the future. The VA is already a nationally recognized model for health care cost-effectiveness. An independent assessment by medical and economic experts is needed to determine which parts of veterans health care might best be improved through such collaboration. The VA should not look to MUSC to make that assessment.

AFGE shares the concern of veterans groups that a joint venture with a nongovernmental, non-VA organization could dilute VA's identity as the leader in providing specialized care for veterans. It is also unclear how two sets of personnel with different training and pay would work in the same facility.

AFGE appreciates the recommendation made by Congressman Michael Michaud (D-ME) at the September 2005 hearing that the VA and MUSC include veterans' service organizations and employee representatives in the exploration process. AFGE was pleased to hear at the Committee's February 8, 2006 budget hearing that key stakeholders will be included in the dialogue on the proposed joint venture. Our physician members in Charleston have valuable input to provide at the local level and our local president in Charleston has submitted a request to the Committee for participation in future meetings. AFGE also looks forward to being part of the national dialogue regarding joint ventures.

Summary

Persistent shortfalls and funding uncertainty are causing great wear and tear on the VA health care system. Needed medical services are being delayed or denied to hundreds of thousands of veterans. Dedicated employees are overworked and discouraged. AFGE urges the Committee to implement assured funding by supporting H.R. 515. In addition, AFGE should be included in national and local efforts to address VA's short and long term funding needs, and related dialogues about management efficiencies, joint ventures and physician pay.

AFGE greatly appreciates the opportunity to submit our views and recommendations to the Subcommittee on Health. We look forward to working with Chairman Brown and Ranking Member Michaud to ensure that the VHA budget adequately meets the needs of our veterans in FY 2007 and beyond.