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***The Veteran's Health Administration as a
Model for Universal Healthcare***

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I. INTRODUCTION

In America today, no issue divides citizens more than the debate over universal healthcare. American voters have enthusiastically ushered President Barack Obama into the White House on a platform of change, including a guarantee that all Americans would have access to healthcare.¹ This issue, which President Obama has invested much of his political capital, has yet to gain a consensus in Congress. Furthermore, this issue has grabbed the nation's collective attention and continues to serve as a call to action amongst people from across the political spectrum. "Single-payer," "socialized medicine," "eliminating fraud and reducing waste," "opting out," "rationing," and a host of other phrases have worked their way into the vernacular of many a lay person as casual conversations increasingly turn to the topic of healthcare. Some believe foreign nations' healthcare systems are excellent models on which to structure the United

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¹ SunTimes.com, *Obama Promises Universal Health Care by End of First Term*, CHI. SUN-TIMES, May 14, 2007, available at <http://www.suntimes.com/news/elections/385287,051407obama.article>.

States' healthcare system.² The poor quality of healthcare of other nations, however, is proof-positive that in the United States, we have the finest care available anywhere in the world.³ To decree that our healthcare system is irreparable would be disingenuous. Similarly, to claim the status quo is sustainable would lead this country to financial calamity.

Regardless of where any one group stands, it is clear a majority of Americans agree substantial changes are needed in the U.S. healthcare system.⁴ The question has ceased to be *if* healthcare changes are needed, but rather, *what* should be done? What can be done to realize the President's goal, and in fact the goal of a majority of Americans, to somehow change the healthcare system in the U.S.? Instead of looking outside our borders for the solution, the U.S. has within it a solid platform on which to begin the debate for the future of healthcare: the Veterans Health Administration.

II. BACKGROUND

In the past, for many Americans, the Veterans Health Administration (VA) conjured an image of a healthcare system that provided limited or substandard care, and up until the mid-1990s, such an image may not have been too far off the

² Generally, Kerry Capell, *Is Europe's Health Care Better?*, BUS. WK. Jun. 13, 2007, available at http://www.businessweek.com/globalbiz/content/jun2007/gb20070613_921562.htm.

³ See, e.g., Sarah Lyall, *Those Who Pay for Private Care Are Testing Britain's Health*, N.Y. TIMES, Feb. 21, 2008, at A12.

⁴ Rasmussen Reports, *54% Say Major Changes Needed in Health Care System, 45% Disagree*, Rasmussen Reports, Oct. 2, 2009, http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/october_2009/54_say_major_changes_needed_in_health_care_system_45_disagree.

mark.⁵ The nation's VA hospitals faced a myriad of challenges, including, the World War II population. World War II veterans were passing away at a rate of 1,000 per day, and those who survived moved to the Sunbelt States, which led to idle staff and surgeons at hospitals throughout the Midwest and Northeast.⁶ On the other hand, hospitals in Florida faced overcrowding and overworked staff.⁷ A 1995 audit of the Department of Veterans Affairs even discovered that twenty-one of 153 VA surgeons had gone at least a year without spending time in the operating room.⁸ It became clear the VA needed drastic restructuring to meet the needs of the changing composition of America's veterans.⁹

In order to address this crisis, President Clinton selected Dr. Kenneth W. Kizer as the Under Secretary for Health for the Department of Veterans Affairs, charging him with restructuring the VA's healthcare system.¹⁰ Dr. Kizer was responsible for overhauling the VA's 172 hospitals and 132 nursing homes into twenty-two self-contained systems responsible for providing all patient care.¹¹ Coming from a background in both business and academia, Dr. Kizer was especially well suited for the task at hand.¹² Many credit Dr. Kizer with bringing

⁵ Adam Oliver, *The Veterans Health Administration: An American Success Story?*, 85 MILBANK Q. 5 (2007).

⁶ PHILLIP LONGMAN, *BEST CARE ANYWHERE: WHY VA HEALTH CARE IS BETTER THAN YOURS* 43 (PoliPointPress 2007).

⁷ *Id.*

⁸ OFFICE OF INSPECTOR GENERAL, U.S. DEP'T OF VETERAN'S AFFAIRS, *AUDIT OF VETERANS HEALTH ADMINISTRATION RESOURCE ALLOCATION ISSUES: PHYSICIAN STAFFING LEVELS*; NO. 5R8-A19-113, available at <http://www.va.gov/oig/52/reports/1995/5R8-A19-113--psrptasc.htm>.

⁹ *Id.*

¹⁰ Douglas Waller, *How VA Hospitals Became The Best*, TIME, Sep. 4, 2006, at 36.

¹¹ Gilbert M. Gaul, *Revamped Veterans' Health Care Now a Model*, WASH. POST, Aug. 22, 2005, at A1.

¹² Robert Wood Johnson Foundation, *Physician Faculty Scholars*, <http://rwjpfsp.stanford.edu/nac/kizer.html> (last visited Oct. 09, 2009).

about sweeping improvements throughout the VA.¹³ Specifically, electronic health records (EHRs) and continuous quality improvement serve as launch-points for the universal healthcare debate.¹⁴

III. ELECTRONIC HEALTH RECORDS

In February 2009, the federal government allocated \$1.2 billion to states and regions across the country in an effort to digitize medical records.¹⁵ According to Vice President Biden, this will make healthcare more affordable, efficient, and safer.¹⁶ But how can a seemingly obvious change in the way in which patient data is captured and stored make such a significant impact? For the answer, we need only to look to the VA, which mandated entry of health records into its electronic database, dubbed "VistA," by 1999.¹⁷ Arguably, this shift to EHRs was borne out of necessity rather than cost savings. Because the VA assumed lifetime care for veterans, it was crucial that wherever the veteran went, his records followed. The continuity of medical record availability was made possible through portability. Implementation of an EHR database for the general population, however, would be a far more challenging task because not only

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Judith Burns, *UPDATE: Biden: \$1.2B From Stimulus To Computerize Medical Records-Report*, DOW JONES FACTIVA, Aug. 20, 2009.

¹⁶ *Id.*

¹⁷ Oliver, *supra* note 5, at 19.

would it require uniformity of software and digitization of existing records, but also because our current healthcare system inadvertently rewards inefficiency.¹⁸

Imagine the hypothetical case of a young couple embarking on a cross-country trip from Chicago to the west coast when suddenly tragedy strikes. Crossing through Colorado late at night, the driver dozes off and runs the vehicle off the highway. Although the injuries sustained were not fatal, they nevertheless required immediate medical care. In a world with EHRs, the emergency room doctors who tend to their injuries would be able to retrieve their medical history from some basic information provided by the couple. Even though they have never treated the patients before, they can glean from the records any information pertinent to their care.

The reality, however, is that only 1.5% of hospitals within the United States have a “comprehensive electronic-records system,” defined as one that is present in all clinical units, and 7.6% of hospitals have a “basic system” present in at least one of its units.¹⁹ Although these numbers are low, the greater obstacle for improving healthcare through electronic medical records is the lack of uniformity amongst the various EHR systems. For example, if your primary care provider adopted an EHR system and you were in the same accident in Colorado, the emergency room in which you were treated could only access your records if they too used the same software as your primary care provider for EHRs.

¹⁸ Ignacio H. Valdes, *The Coming Electronic Health Record Software Disaster*, LINUXMEDNEWS, Sep. 25, 2007, <http://linuxmednews.com/1190745985>; J.D. Kleinke, *Dot-Gov: Market Failure and the Creation of a National Health Information Technology System*, 24 HEALTH AFFAIRS 1246, 1250 (2005).

¹⁹ Ashish K. Jha Et Al., *Use of Electronic Health Records in U.S. Hospitals*, 360 NEW ENG. J. MED. 1628, 1628 (2009).

An essential part of VistA's effectiveness can be found in the uniformity of the VA hospitals, which use the exact same software.²⁰ Unless uniformity is mandated at the federal level, however, we can expect a slew of new software flooding the market until an industry standard is established.²¹ The result would be companies wasting significant amounts of money on soon-to-be obsolete products. Alternatively, if the federally mandated software is VistA and all healthcare providers are required to migrate to this system, opponents of "government-run health care" may argue that this provides the means through which the government can indirectly control healthcare by controlling the systems used by hospitals and having everyone's medical information readily accessible.²²

Just as challenging as the issue of software is inadvertent incentivisation of inefficiency. J.D. Kleinke, a medical economist noted: "Bad quality is good for business. And the surest road to bad quality is bad or no information."²³ Indeed, healthcare providers recognize that a patient they see today statistically will not be their patient a few years down the road.²⁴ Providers understand patients switch insurers because they switch jobs or their employers opt for different insurance policies.²⁵ On the other hand, the VA understands it must provide the veteran with long term care to which he or she is entitled, in effect

²⁰ See LONGMAN, *supra* note 6, at 22.

²¹ See Valdes, *supra* note 18.

²² Fred Lucas, *Stimulus Bill Raises Concerns Over Government Rationing of Health Care*, CNS NEWS, Feb. 11, 2009, <http://www.cnsnews.com/news/article/43358>.

²³ Kleinke, *supra* note 18, at 1250.

²⁴ LONGMAN, *supra* note 6, at 71-72.

²⁵ *Id.* at 76-77.

building a lifelong partnership.²⁶ As such, the VA has a vested interest in preventing chronic diseases which leads to lower costs toward the end of the patient's life. Utilizing VistA's graphing and charting abilities enables VA doctors to manage disease more effectively.²⁷ On the private side, preventing future disease essentially zaps the provider's bottom line.²⁸ In fact, outside the VA, nearly 20% of all medical tests are repeated because of lost patient records.²⁹ Dr. Jonathan Perlin, former Acting Under Secretary for Health, estimated that in 2005 it cost the VA approximately \$78 per year per patient to maintain electronic health records.³⁰ Dr. Perlin said this was roughly "the equivalent of not repeating one blood test."³¹

IV. CONTINUOUS QUALITY IMPROVEMENT

In 1999, the Institute of Medicine released a report that sent shockwaves through the medical community.³² In its report, *To Err is Human: Building a Safer Health System*, the Institute of Medicine discovered up to 98,000 people die annually in American hospitals due to medical error.³³ Furthermore, a study by the RAND Corporation found another 90,000 deaths were attributable to hospital infection, and 126,000 more were preventable through observance of evidence-

²⁶ *Id.* at 79.

²⁷ *Id.* at 75.

²⁸ *Id.* at 70.

²⁹ Oliver, *supra* note 5, at 19.

³⁰ Gaul, *supra* note 11, at A1.

³¹ *Id.*

³² See INSTITUTE OF MEDICINE, *TO ERR IS HUMAN, BUILDING A SAFER HEALTH SYSTEM* (Nat'l Academy Press 2000), available at http://www.nap.edu/catalog.php?record_id=9728#toc.

³³ *Id.*

based protocols for hypertension, heart attack, pneumonia, and colorectal cancer.³⁴ These statistics are disheartening to say the least; however, our current system promulgates a culture of protectionism. That is, there is a very real threat of malpractice that perpetually hangs over the head of every healthcare provider, thus making the motivation to conceal mistakes or the refusal to report safety violations outweighs the stigma attached to a doctor who has “broken ranks” with his colleagues in the name of patient safety.³⁵ Understanding that lawsuits threaten the livelihood and autonomy doctors, many organizations have recommended avenues through which patients’ safety is improved while simultaneously shielding doctors who attempt to mitigate the effects of errors from adverse action.³⁶ Suggestions from the American Medical Association, the Institute of Medicine, and even trial lawyers have proposed measures from voluntary and anonymous reporting within hospitals, to peer-review protections that would, in the case of malpractice litigation, shield from discovery doctors’ mortality and morbidity conferences.³⁷

Although the problems described above are certainly applicable to the VA, by the time this report was released, the VA had already enacted a unique approach to confront many of the mistakes prevalent within its system and had produced results much lower than the accident averages seen at many private

³⁴ RAND HEALTH, THE FIRST NATIONAL REPORT CARD ON QUALITY OF HEALTH CARE IN AMERICA 4 (2006) available at www.rand.org.

³⁵ Stephanie Mencimer, *The Casualties of Medicine*, LEGAL AFF., May/June 2003, at 60.

³⁶ *Id.*

³⁷ *Id.*

hospitals.³⁸ Before *To Err is Human* was released, Dr. Kizer had pushed for, and won, a policy of full disclosure of any medical errors which included anonymous reporting.³⁹ Important to note is the VA's policy of full disclosure was not intended as a form of punishment or as a method of placing blame, in fact it promised that only the most egregious of errors resulted in disciplinary action.⁴⁰ Instead, the VA used this process to look for systematic solutions to safety problems, leading to a thirty-fold increase in reported medical mistakes.⁴¹

Although the policy of full disclosure was a risky political decision (after all, what hospital discloses all of its mistakes?) it was based on the same solid principles which had been embraced by the aviation community for years.⁴² In furtherance of his belief in a policy of full disclosure, Dr. Kizer enlisted the aid of Dr. James Bagian, a former Air Force flight surgeon, astronaut, and NASA accident investigator, to lead the National Center for Patient Safety.⁴³ Dr. Bagian began with the premise that all parts of a system will fail at some point, and the challenge becomes discovering when and why they do and designing "fault tolerant" systems that minimize consequences.⁴⁴ Utilizing VistA once again, patients were fitted with bracelets that contained a unique barcode to identify the patient in the VistA system.⁴⁵ By scanning this barcode, VistA could retrieve the patient's EHR which would indicate the procedure for which he was in the

³⁸ LONGMAN, *supra* note 6, at 60, 62.

³⁹ *Id.* at 60.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.* at 63.

⁴³ *Id.* at 62.

⁴⁴ *Id.*

⁴⁵ *Id.* at 37.

hospital or the type of medication and dosage he required.⁴⁶ Furthermore, just within the Kansas Health Care system, utilizing barcodes in conjunction with medication dispensing prevented over a half-million dispensing errors by 2001.⁴⁷

The VA Hospital system has come a long way in improving the safety with which it delivers care, however it is by no means perfect. In 2005, Leape and Berwick lamented, “[w]hy has it [proven] so difficult to implement the practices and policies needed to deliver safe patient care?”⁴⁸ Though the overall healthcare system in the United States lacked progress on the patient safety front, they identified the VA “as a bright star in the constellation of safety practice” for the processes it had implemented.⁴⁹ When compared to the complexity of the countless measures offered to improve the nation’s healthcare system, the processes enacted by the VA have produced effective and quantifiable results. This is not to suggest that all will be made well within healthcare by having providers admit fault and saying “I’m sorry.” Instead, the VA’s model promotes an atmosphere of continuous quality improvement by understanding that mistakes will be made, identifying what can be done to mitigate the impact of the mistake, reducing the probability of occurrence, and promoting a culture wherein providers do not fear reprisal, but instead seek to better themselves system of which they are a part.

⁴⁶ *Id.* at 64.

⁴⁷ *Id.* at 65.

⁴⁸ Lucian L. Leape, MD & Donald M. Berwick, MD, *Five Years After To Err is Human, What Have we Learned?*, 293 JAMA 2384, 2387 (2005).

⁴⁹ *Id.* at 2386.

V. CONCLUSION

The healthcare reform debate presses on to this day. Although Congress may soon reach a consensus as to the size and scope of the changes Americans demand, there are certain aspects of the current American healthcare system that can serve as models to be included in the final bill. Congress should strongly consider the VA system, which in fifteen years went from a fledgling conglomeration of healthcare facilities into an integrated hospital system that is far more advanced in the area of EHRs than most hospitals across the nation. The VA system has nurtured a culture in which quality care is essential and obtained through continuous improvement.