

Washington Monthly: January/February 2005

The Best Care Anywhere

Ten years ago, veterans hospitals were dangerous, dirty, and scandal-ridden. Today, they're producing the highest quality care in the country. Their turnaround points the way toward solving America's health-care crisis.

By Phillip Longman

Quick. When you read “veterans hospital,” what comes to mind? Maybe you recall the headlines from a dozen years ago about the three decomposed bodies found near a veterans medical center in Salem, Va. Two turned out to be the remains of patients who had wandered months before. The other body had been resting in place for more than 15 years. The Veterans Health Administration (VHA) admitted that its search for the missing patients had been “cursory.”

Or maybe you recall images from movies like *Born on the Fourth of July*, in which Tom Cruise plays a wounded Vietnam vet who becomes radicalized by his shabby treatment in a crumbling, rat-infested veterans hospital in the Bronx. Sample dialogue: “This place is a fuckin' slum!”

By the mid-1990s, the reputation of veterans hospitals had sunk so low that conservatives routinely used their example as a kind of *reductio ad absurdum* critique of any move toward “socialized medicine.” Here, for instance, is Jarret B. Wollstein, a right-wing activist/author, railing against the Clinton health-care plan in 1994: “To see the future of health care in America for you and your children under Clinton's plan,” Wollstein warned, “just visit any Veterans Administration hospital. You'll find filthy conditions, shortages of everything, and treatment bordering on barbarism.”

And so it goes today. If the debate is over health-care reform, it won't be long before some free-market conservative will jump up and say that the sorry shape of the nation's veterans hospitals just proves what happens when government gets into the health-care business. And if he's a true believer, he'll then probably go on to suggest, quoting William Safire and other free marketers, that the government should just shut down the whole miserable system and provide veterans with health-care vouchers.

Yet here's a curious fact that few conservatives or liberals know. Who do you think receives higher-quality health care. Medicare patients who are free to pick their own doctors and specialists? Or aging veterans stuck in those presumably filthy VA hospitals

with their antiquated equipment, uncaring administrators, and incompetent staff? An answer came in 2003, when the prestigious New England Journal of Medicine published a study that compared veterans health facilities on 11 measures of quality with fee-for-service Medicare. On all 11 measures, the quality of care in veterans facilities proved to be “significantly better.”

Here's another curious fact. The Annals of Internal Medicine recently published a study that compared veterans health facilities with commercial managed-care systems in their treatment of diabetes patients. In seven out of seven measures of quality, the VA provided better care. It gets stranger. Pushed by large employers who are eager to know what they are buying when they purchase health care for their employees, an outfit called the National Committee for Quality Assurance today ranks health-care plans on 17 different performance measures. These include how well the plans manage high blood pressure or how precisely they adhere to standard protocols of evidence-based medicine such as prescribing beta blockers for patients recovering from a heart attack. Winning NCQA's seal of approval is the gold standard in the health-care industry. And who do you suppose this year's winner is: Johns Hopkins? Mayo Clinic? Massachusetts General? Nope. In every single category, the VHA system outperforms the highest rated non-VHA hospitals.

Not convinced? Consider what vets themselves think. Sure, it's not hard to find vets who complain about difficulties in establishing eligibility. Many are outraged that the Bush administration has decided to deny previously promised health-care benefits to veterans who don't have service-related illnesses or who can't meet a strict means test. Yet these grievances are about access to the system, not about the quality of care received by those who get in. Veterans groups tenaciously defend the VHA and applaud its turnaround. “The quality of care is outstanding,” says Peter Gayton, deputy director for veterans affairs and rehabilitation at the American Legion. In the latest independent survey, 81 percent of VHA hospital patients express satisfaction with the care they receive, compared to 77 percent of Medicare and Medicaid patients.

Outside experts agree that the VHA has become an industry leader in its safety and quality measures. Dr. Donald M. Berwick, president of the Institute for Health Care Improvement and one of the nation's top health-care quality experts, praises the VHA's information technology as “spectacular.” The venerable Institute of Medicine notes that the VHA's “integrated health information system, including its framework for using performance measures to improve quality, is considered one of the best in the nation.”

If this gives you cognitive dissonance, it should. The story of how and why the VHA became the benchmark for quality medicine in the United States suggests that much of what we think we know about health care and medical economics is just wrong. It's natural to believe that more competition and consumer choice in health care would lead to greater quality and lower costs, because in almost every other realm, it does. That's why the Bush administration—which has been promoting greater use of information technology and other quality improvement in health care—also wants to give individuals new tax-free “health savings accounts” and high-deductible insurance plans. Together,

these measures are supposed to encourage patients to do more comparison shopping and haggling with their doctors; therefore, they create more market discipline in the system.

But when it comes to health care, it's a government bureaucracy that's setting the standard for maintaining best practices while reducing costs, and it's the private sector that's lagging in quality. That unexpected reality needs examining if we're to have any hope of understanding what's wrong with America's health-care system and how to fix it. It turns out that precisely because the VHA is a big, government-run system that has nearly a lifetime relationship with its patients, it has incentives for investing in quality and keeping its patients well—incentives that are lacking in for-profit medicine.

Hitting bottom

By the mid-1990s, the veterans health-care system was in deep crisis. A quarter of its hospital beds were empty. Government audits showed that many VHA surgeons had gone a year without picking up a scalpel. The population of veterans was falling sharply, as aging World War II and Korean War vets began to pass away. At the same time, a mass migration of veterans from the Snowbelt to the Sunbelt overwhelmed hospitals in places such as Tampa with new patients, while those in places such as Pittsburgh had wards of empty beds.

Serious voices called for simply dismantling the VA system. Richard Cogan, a senior fellow at the Center on Budget and Policy Priorities in Washington, told *The New York Times* in 1994: “The real question is whether there should be a veterans health care system at all.” At a time when the other health-care systems were expanding outpatient clinics, the VHA still required hospital stays for routine operations like cataract surgery. A patient couldn't even receive a pair of crutches without checking in. Its management system was so ossified and top-down that permission for such trivial expenditures as \$9.82 for a computer cable had to be approved in Washington at the highest levels of the bureaucracy.

Yet few politicians dared to go up against the powerful veterans lobby, or against the many unions that represented much of the VHA's workforce. Instead, members of Congress fought to have new veterans hospitals built in their districts, or to keep old ones from being shuttered. Three weeks before the 1996 presidential election, in part to keep pace with Bob Dole's promises to veterans, President Clinton signed a bill that planned, as he put it, to “furnish comprehensive medical services to all veterans,” regardless of their income or whether they had service-related disabilities.

So, it may have been politics as usual that kept the floundering veterans health-care system going. Yet behind the scenes, a few key players within the VHA had begun to look at ways in which the system might heal itself. Chief among them was Kenneth W. Kizer, who in 1994 had become VHA's undersecretary for health, or, in effect, the system's CEO.

A physician trained in emergency medicine and public health, Kizer was an outsider who immediately started upending the VHA's entrenched bureaucracy. He oversaw a radical downsizing and decentralization of management power, implemented pay-for-performance contracts with top executives, and won the right to fire incompetent doctors. He and his team also began to transform the VHA from an acute care, hospital-based system into one that put far more resources into primary care and outpatient services for the growing number of aging veterans beset by chronic conditions.

By 1998, Kizer's shake-up of the VHA's operating system was already earning him management guru status in an era in which management gurus were practically demigods. His story appeared that year in a book titled *Straight from the CEO: The World's Top Business Leaders Reveal Ideas That Every Manager Can Use* published by Price Waterhouse and Simon & Schuster. Yet the most dramatic transformation of the VHA didn't just involve such trendy, 1990s ideas as downsizing and reengineering. It also involved an obsession with systematically improving quality and safety that to this day is still largely lacking throughout the rest of the private health-care system.

Americia's worst hospitals

To understand the larger lessons of the VHA's turnaround, it's necessary to pause for a moment to think about what comprises quality health care. The first criterion likely to come to mind is the presence of doctors who are highly trained, committed professionals. They should know a lot about biochemistry, anatomy, cellular and molecular immunology, and other details about how the human body works—and have the academic credentials to prove it. As it happens, the VHA has long had many doctors who answer to that description. Indeed, most VHA doctors have faculty appointments with academic hospitals.

But when you get seriously sick, it's not just one doctor who will be involved in your care. These days, chances are you'll see many doctors, including different specialists. Therefore, how well these doctors communicate with one another and work as a team matters a lot. “Forgetfulness is such a constant problem in the system,” says Berwick of the Institute for Health Care Improvement. “It doesn't remember you. Doesn't remember that you were here and here and then there. It doesn't remember your story.”

Are all your doctors working from the same medical record and making entries that are clearly legible? Do they have a reliable system to ensure that no doctor will prescribe drugs that will interact harmfully with medications prescribed by another doctor? Is any one of them going to take responsibility for coordinating your care so that, for example, you don't leave the hospital without the right follow-up medication or knowing how and when to take it? Just about anyone who's had a serious illness, or tried to be an advocate for a sick loved one, knows that all too often the answer is no.

Doctors aren't the only ones who define the quality of your health care. There are also many other people involved—nurses, pharmacists, lab technicians, orderlies, even custodians. Any one of these people could kill you if they were to do their jobs wrong.

Even a job as lowly as changing a bedpan, if not done right, can spread a deadly infection throughout a hospital. Each of these people is part of an overall system of care, and if the system lacks cohesion and quality control, many people will be injured and many will die.

Just how many? In 1999, the Institute of Medicine issued a groundbreaking study, titled *To Err is Human*, that still haunts health care professionals. It found that up to 98,000 people die of medical errors in American hospitals each year. This means that as many as 4 percent of all deaths in the United States are caused by such lapses as improperly filled or administered prescription drugs—a death toll that exceeds that of AIDS, breast cancer, or even motor vehicle accidents.

Since then, a cavalcade of studies have documented how a lack of systematic attention not only to medical errors but to appropriate treatment has made putting yourself into a doctor's or hospital's care extraordinarily risky. The practice of medicine in the United States, it turns out, is only loosely based on any scientifically driven standards. The most recent and persuasive evidence came from study by Dartmouth Medical School published last October in *Health Affairs*. It found that even among the “best hospitals,” as rated by *U.S. News & World Report*, Medicare patients with the same conditions receive strikingly different patterns and intensities of care from one another, with no measurable difference in their wellbeing.

For example, among patients facing their last six months of life, those who are checked into New York's renowned Mount Sinai Medical Center will receive an average of 53.9 visits from physicians, while those who are checked into Duke University Medical Center will receive only 20.9. Yet all those extra doctors' visits at Mount Sinai bring no gain in life expectancy, just more medical bills. By that measure of quality, many of the country's most highly rated hospitals are actually its shoddiest.

Worse, even when strong scientific consensus emerges about appropriate protocols and treatments, the health-care industry is extremely slow to implement them. For example, there is little controversy over the best way to treat diabetes; it starts with keeping close track of a patient's blood sugar levels. Yet if you have diabetes, your chances are only one-out-four that your health care system will actually monitor your blood sugar levels or teach you how to do it. According to a recent RAND Corp. study, this oversight causes an estimated 2,600 diabetics to go blind every year, and another 29,000 to experience kidney failure.

All told, according to the same RAND study, Americans receive appropriate care from their doctors only about half of the time. The results are deadly. On top of the 98,000 killed by medical errors, another 126,000 die from their doctor's failure to observe evidence-based protocols for just four common conditions: hypertension, heart attacks, pneumonia, and colorectal cancer.

Now, you might ask, what's so hard about preventing these kinds of fatal lapses in health care? The airline industry, after all, also requires lots of complicated teamwork and

potentially dangerous technology, but it doesn't wind up killing hundreds of thousands of its customers each year. Indeed, airlines, even when in bankruptcy, continuously improve their safety records. By contrast, the death toll from medical errors alone is equivalent to a fully loaded jumbo-jet crashing each day.

Laptop medicine

Why doesn't this change? Well, much of it has changed in the veterans health-care system, where advanced information technology today serves not only to deeply reduce medical errors, but also to improve diagnoses and implement coordinated, evidence-based care. Or at least so I kept reading in the professional literature on health-care quality in the United States. I arranged to visit the VA Medical Center in Washington, D.C. to see what all these experts were so excited about.

The complex' main building is a sprawling, imposing structure located three miles north of the Capitol building. When it was built in 1972, it was in the heart of Washington's ghetto, a neighborhood dangerous enough though one nurse I spoke with remembered having to lock her car doors and drive as fast as she could down Irving Street when she went home at night.

Today, the surrounding area is rapidly gentrifying. And the medical center has evolved, too. Certain sights, to be sure, remind you of how alive the past still is here. In its nursing home facility, there are still a few veterans of World War I. Standing outside of the hospital's main entrance, I was moved by the sight of two elderly gentlemen, both standing at near attention, and sporting neatly pressed Veterans of Foreign Wars dress caps with MIA/POW insignias. One turned out to be a survivor of the Bataan Death March.

But while history is everywhere in this hospital, it is also among the most advanced, modern health-care facilities in the globe—a place that hosts an average of four visiting foreign delegations a week. The hospital has a spacious generic lobby with a food court, ATM machines, and a gift shop. But once you are in the wards, you notice something very different: doctors and nurses wheeling bed tables with wireless laptops attached down the corridors. How does this change the practice of medicine? Opening up his laptop, Dr. Ross Fletcher, an avuncular, white-haired cardiologist who led the hospital's adoption of information technology, begins a demonstration.

With a key stroke, Dr. Fletcher pulls up the medical records for one of his current patients—an 87-year-old veteran living in Montgomery County, Md. Normally, sharing such records with a reporter or anyone else would, of course, be highly unethical and illegal, but the patient, Dr. Fletcher explains, has given him permission.

Soon it becomes obvious why this patient feels that getting the word out about the VHA's information technology is important. Up pops a chart showing a daily record of his weight as it has fluctuated over a several-month period. The data for this chart, Dr.

Fletcher explains, flows automatically from a special scale the patient uses in his home that sends a wireless signal to a modem.

Why is the chart important? Because it played a key role, Fletcher explains, in helping him to make a difficult diagnosis. While recovering from Lyme Disease and a hip fracture, the patient began periodically complaining of shortness of breath. Chest X-rays were ambiguous and confusing. They showed something amiss in one lung, but not the other, suggesting possible lung cancer. But Dr. Fletcher says he avoided having to chase down that possibility when he noticed a pattern jumping out of the graph generated from the patient's scale at home.

The chart clearly showed that the patient gained weight around the time he experienced shortness of breath. This pattern, along with the record of the hip fracture, helped Dr. Fletcher to form a hypothesis that turned out to be accurate. A buildup of fluid in the patient's lung was causing him to gain weight. The fluid gathered only in one lung because the patient was consistently sleeping on one side to cope with the pain from his hip fracture. The fluid in the lung indicated that the patient was in immediate need of treatment for congestive heart failure, and, fortunately, he received it in time.

The same software program, known as VistA, also plays a key role in preventing medical errors. Kay J. Craddock, who spent most of her 28 years with the VHA as a nurse, and who today coordinates the use of the information systems at the VA Medical Center, explains how. In the old days, pharmacists did their best to decipher doctors' handwritten prescription orders, while nurses, she says, did their best to keep track of which patients should receive which medicines by shuffling 3-by-5 cards.

Today, by contrast, doctors enter their orders into their laptops. The computer system immediately checks any order against the patient's records. If the doctors working with a patient have prescribed an inappropriate combination of medicines or overlooked the patient's previous allergic reaction to a drug, the computer sends up a red flag. Later, when hospital pharmacists fill those prescriptions, the computer system generates a bar code that goes on the bottle or intravenous bag and registers what the medicine is, who it is for, when it should be administered, in what dose, and by whom.

Each patient also has an ID bracelet with its own bar code, and so does each nurse. Before administering any drug, a nurse must first scan the patient's ID bracelet, then her own, and then the barcode on the medicine. If she has the wrong patient or the wrong medicine, the computer will tell her. The computer will also create a report if she's late in administering a dose, "and saying you were just too busy is not an excuse," says Craddock.

Craddock cracks a smile when she recalls how nurses reacted when they first were ordered to use the system. "One nurse tried to get the computer to accept her giving an IV, and when it wouldn't let her, she said, 'you see, I told you this thing is never going to work.' Then she looked down at the bag." She had mixed it up with another, and the computer had saved her from a career-ending mistake. Today, says Craddock, some

nurses still insist on getting paper printouts of their orders, but nearly all applaud the computer system and its protocols. “It keeps them from having to run back and forth to the nursing station to get the information they need, and, by keeping them from making mistakes, it helps them to protect their license.” The VHA has now virtually eliminated dispensing errors.

In speaking with several of the young residents at the VA Medical Center, I realized that the computer system is also a great aid to efficiency. At the university hospitals where they had also trained, said the residents, they constantly had to run around trying to retrieve records—first upstairs to get X-rays from the radiology department, then downstairs to pick up lab results. By contrast, when making their rounds at the VA Medical Center, they just flip open their laptops when they enter a patient's room. In an instant, they can see not only all of the patient's latest data, but also a complete medical record going back as far as the mid-1980s, including records of care performed in any other VHA hospital or clinic.

Along with the obvious benefits this brings in making diagnoses, it also means that residents don't face impossibly long hours dealing with paperwork. “It lets these twentysomethings go home in time to do the things twentysomethings like to do,” says Craddock. One neurologist practicing at both Georgetown University Hospital and the VA Medical Center reports that he can see as many patients in a few hours at the veterans hospital as he can all day at Georgetown.

By this summer, anyone enrolled in the VHA will be able to access his or her own complete medical records from a home computer, or give permission for others to do so. “Think what this means,” says Dr. Robert M. Kolodner, acting chief health informatics officer for the VHA. “Say you're living on the West Coast, and you call up your aging dad back East. You ask him to tell you what his doctor said during his last visit and he mumbles something about taking a blue pill and white one. Starting this summer, you'll be able to monitor his medical record, and know exactly what pills he is supposed to be taking.”

The same system reminds doctors to prescribe appropriate care for patients when they leave the hospital, such as beta blockers for heart attack victims, or eye exams for diabetics. It also keeps track of which vets are due for a flu shot, a breast cancer screen, or other follow-up care—a task virtually impossible to pull off using paper records. Another benefit of electronic records became apparent last September when the drug-maker Merck announced a recall of its popular arthritis medication, Vioxx. The VHA was able to identify which of its patients were on the drug within minutes, and to switch them to less dangerous substitutes within days.

Similarly, in the midst of a nationwide shortage of flu vaccine, the system has also allowed the VHA to identify, almost instantly, those veterans who are in greatest need of a flu shot and to make sure those patients have priority. One aging relative of mine—a man who has had cancer and had been in and out of nursing homes—wryly reports that he beat out 5,000 other veterans in the New London, Conn., area for a flu shot. He's

happy that his local veterans hospital called him up to tell him he qualified, but somewhat alarmed by what this implies about his health.

The VistA system also helps to put more science into the practice of medicine. For example, electronic medical records collectively form a powerful database that enables researchers to look back and see which procedures work best without having to assemble and rifle through innumerable paper records. This database also makes it possible to discover emerging disease vectors quickly and effectively. For example, when a veterans hospital in Kansas City noticed an outbreak of a rare form of pneumonia among its patients, its computer system quickly spotted the problem: All the patients had been treated with what turned out to be the same bad batch of nasal spray.

Developed at taxpayer expense, the VistA program is available for free to anyone who cares to download it off the Internet. The link is to a demo, but the complete software is nonetheless available. You can try it out yourself by going to <http://www1.va.gov/CPRSdemo/>. Not surprisingly, it is currently being used by public health care systems in Finland, Germany, and Nigeria. There is even an Arabic language version up and running in Egypt. Yet VHA officials say they are unaware of any private health care system in the United States that uses the software. Instead, most systems are still drowning in paper, or else just starting to experiment with far more primitive information technologies.

Worse, some are even tearing out their electronic information systems. That's what happened at Cedars-Sinai Medical Center in Los Angeles, which in 2003 turned off its brand-new, computerized physician order entry system after doctors objected that it was too cumbersome. At least six other hospitals have done the same in recent years. Another example of the resistance to information technology among private practice doctors comes from the Hawaii Independent Physicians Association, which recently cancelled a program that offered its members \$3,000 if they would adopt electronic medical records. In nine months, there were only two takers out of its 728 member doctors.

In July, Connecting for Health—a public-private cooperative of hospitals, health plans, employers and government agencies—found that persuading doctors in small- to medium-sized practices to adopt electronic medical records required offering bonuses of up to 10 percent of the doctors' annual income. This may partly be due to simple technophobia or resistance to change. But the broader reason, as we shall see, is that most individual doctors and managed care providers in the private sector often lack a financial incentive to invest for investing in electronic medical records and other improvements to the quality of the care they offer.

This is true even when it comes to implementing low-tech, easy-to-implement safety procedures. For example, you've probably heard about surgeons who operate on the wrong organ or limb. So-called “wrong site” surgery happens in about one out of 15,000 operations, with those performing foot and hand surgeries particularly likely to make the mistake. Most hospitals try to minimize this risk by having someone use a magic marker to show the surgeon where to cut. But about a third of the time, the VHA has found, the root

problem isn't that someone mixed up left with right; it's that the surgeon is not operating on the patient he thinks he is. How do you prevent that?

Obviously, in the VHA system, scanning the patient's ID bracelet and the surgical orders helps, but even that isn't foolproof. Drawing on his previous experience as a NASA astronaut and accident investigator, the VHA's safety director, Dr. James Bagian, has developed a five-step process that VHA surgical teams now use to verify both the identity of the patient and where they are supposed to operate. Though it's similar to the check lists astronauts go through before blast off, it is hardly rocket science. The most effective part of the drill, says Bagian, is simply to ask the patient, in language he can understand, who he is and what he's in for. Yet the efficacy of this and other simple quality-control measures adopted by the VHA makes one wonder all the more why the rest of the health-care system is so slow to follow.

Why care about quality?

Here's one big reason. As Lawrence P. Casalino, a professor of public health at the University of Chicago, puts it, "The U.S. medical market as presently constituted simply does not provide a strong business case for quality."

Casalino writes from his own experience as a solo practitioner, and on the basis of over 800 interviews he has since conducted with health-care leaders and corporate health care purchasers. While practicing medicine on his own in Half Moon Bay, Calif, Casalino had an idealistic commitment to following emerging best practices in medicine. That meant spending lots of time teaching patients about their diseases, arranging for careful monitoring and follow-up care, and trying to keep track of what prescriptions and procedures various specialists might be ordering.

Yet Casalino quickly found out that he couldn't sustain this commitment to quality, given the rules under which he was operating. Nobody paid him for the extra time he spent with his patients. He might have eased his burden by hiring a nurse to help with all the routine patient education and follow-up care that was keeping him at the office too late. Or he might have teamed up with other providers in the area to invest in computer technology that would allow them to offer the same coordinated care available in veterans hospitals and clinics today. Either step would have improved patient safety and added to the quality of care he was providing. But even had he managed to pull them off, he stood virtually no chance of seeing any financial return on his investment. As a private practice physician, he got paid for treating patients, not for keeping them well or helping them recover faster.

The same problem exists across all health-care markets, and its one main reason in explaining why the VHA has a quality performance record that exceeds that of private-sector providers. Suppose a private managed-care plan follows the VHA example and invests in a computer program to identify diabetics and keep track of whether they are getting appropriate follow-up care. The costs are all upfront, but the benefits may take 20 years to materialize. And by then, unlike in the VHA system, the patient will likely have

moved on to some new health-care plan. As the chief financial officer of one health plan told Casalino: “Why should I spend our money to save money for our competitors?”

Or suppose an HMO decides to invest in improving the quality of its diabetic care anyway. Then not only will it risk seeing the return on that investment go to a competitor, but it will also face another danger as well. What happens if word gets out that this HMO is the best place to go if you have diabetes? Then more and more costly diabetic patients will enroll there, requiring more premium increases, while its competitors enjoy a comparatively large supply of low-cost, healthier patients. That's why, Casalino says, you never see a billboard with an HMO advertising how good it is at treating one disease or another. Instead, HMO advertisements generally show only healthy families.

In many realms of health care, no investment in quality goes unpunished. A telling example comes from semi-rural Whatcom County, Wash. There, idealistic health-care providers banded together and worked to bring down rates of heart disease and diabetes in the county. Following best practices from around the country, they organized multi-disciplinary care teams to provide patients with counseling, education, and navigation through the health-care system. The providers developed disease protocols derived from evidence-based medicine. They used information technology to allow specialists to share medical records and to support disease management.

But a problem has emerged. Who will pay for the initiative? It is already greatly improving public health and promises to bring much more business to local pharmacies, as more people are prescribed medications to manage their chronic conditions and will also save Medicare lots of money. But projections show that, between 2001 and 2008, the initiative will cost the local hospital \$7.7 million in lost revenue, and reduce the income of the county's medical specialists by \$1.6 million. An idealistic commitment to best practices in medicine doesn't pay the bills. Today, the initiative survives only by attracting philanthropic support, and, more recently, a \$500,000 grant from Congress.

For health-care providers outside the VHA system, improving quality rarely makes financial sense. Yes, a hospital may have a business case for purchasing the latest, most expensive imaging devices. The machines will help attract lots of highly-credentialed doctors to the hospital who will bring lots of patients with them. The machines will also induce lots of new demand for hospital services by picking up all sorts of so-called “pseudo-diseases.” These are obscure, symptomless conditions, like tiny, slow-growing cancers, that patients would never have otherwise become aware of because they would have long since died of something else. If you're a fee-for-service health-care provider, investing in technology that leads to more treatment of pseudo-disease is a financial no-brainer.

But investing in any technology that ultimately serves to reduce hospital admissions, like an electronic medical record system that enables more effective disease management and reduces medical errors, is likely to take money straight from the bottom line. “The business case for safety...remains inadequate...[for] the task,” concludes Robert

Wachter, M.D., in a recent study for Health Affairs in which he surveyed quality control efforts across the U.S. health-care system.

If health care was like a more pure market, in which customers know the value of what they are buying, a business case for quality might exist more often. But purchasers of health care usually don't know, and often don't care about its quality, and so private health-care providers can't increase their incomes by offering it. To begin with, most people don't buy their own health care; their employers do. Consortiums of large employers may have the staff and the market power necessary to evaluate the quality of health-care plans and to bargain for greater commitments to patient safety and evidence-based medicine. And a few actually do so. But most employers are not equipped for this. Moreover, in these days of rapid turnover and vanishing post-retirement health-care benefits, few employers have any significant financial interest in their workers' long-term health.

That's why you don't see many employers buying insurance that covers smoking cessation programs or the various expensive drugs that can help people to quit the habit. If they did, they'd be being buying more years of healthy life per dollar than just about any other way they could use their money. But most of the savings resulting from reduced lung cancer, stroke, and heart attacks would go to future employers of their workers, and so such a move makes little financial sense.

Meanwhile, what employees value most in health care is maximum choice at minimal cost. They don't want the boss man telling them they must use this hospital or that one because it has the best demonstrated quality of care. They'll be their own judge of quality, thank-you, and they'll usually base their choice on criteria like: "My best friend recommended this hospital," or "This doctor agrees with my diagnosis and refills the prescriptions I want," or "I like this doctor's bedside manner." If more people knew how dangerous it can be to work with even a good doctor in a poorly run hospital or uncoordinated provider network, the premium on doctor choice would be much less decisive, but for now it still is.

And so we get results like what happened in Cleveland during the 1990s. There, a well-publicized initiative sponsored by local businesses, hospitals and physicians identified several hospitals as having significantly higher than expected mortality rates, longer than expected hospital stays, and worse patient satisfaction. Yet, not one of these hospitals ever lost a contract because of their poor performance. To the employers buying health care in the community, and presumably their employees as well, cost and choice counted for more than quality. Developing more and better quality measures in health care is a noble cause, but it's not clear that putting more information into health-care markets will change these hard truths.

Health for service

So what's left? Consider why, ultimately, the veterans health system is such an outlier in its commitment to quality. Partly it's because of timely, charismatic leadership. A quasi-

military culture may also facilitate acceptance of new technologies and protocols. But there are also other important, underlying factors.

First, unlike virtually all other health-care systems in the United States, VHA has a near-lifetime relationship with its patients. Its customers don't jump from one health plan to the next every few years. They start a relationship with the VHA as early as their teens, and it endures. That means that the VHA actually has an incentive to invest in prevention and more effective disease management. When it does so, it isn't just saving money for somebody else. It's maximizing its own resources.

The system's doctors are salaried, which also makes a difference. Most could make more money doing something else, so their commitment to their profession most often derives from a higher-than-usual dose of idealism. Moreover, because they are not profit maximizers, they have no need to be fearful of new technologies or new protocols that keep people well. Nor do they have an incentive to clamor for high-tech devices that don't improve the system's quality or effectiveness of care.

And, because it is a well-defined system, the VHA can act like one. It can systematically attack patient safety issues. It can systematically manage information using standard platforms and interfaces. It can systematically develop and implement evidence-based standards of care. It can systematically discover where its care needs improvement and take corrective measures. In short, it can do what the rest of the health-care sector can't seem to, which is to pursue quality systematically without threatening its own financial viability.

Hmm. That gives me an idea. No one knows how we're ever going to provide health care for all these aging baby boomers. Meanwhile, in the absence of any near-term major wars, the population of veterans in the United States will fall dramatically in the next decade. Instead of shuttering under-utilized VHA facilities, maybe we should build more. What if we expanded the veterans health-care system and allowed anyone who is either already a vet or who agrees to perform two years of community service a chance to buy in? Indeed, what if we said to young and middle-aged people, if you serve your community and your country, you can make your parents or other loved ones eligible for care in an expanded VHA system?

The system runs circles around Medicare in both cost and quality. Unlike Medicare, it's allowed by law to negotiate for deep drug discounts, and does. Unlike Medicare, it provides long-term nursing home care. And it demonstrably delivers some of the best, if not the best, quality health care in the United States with amazing efficiency. Between 1999 and 2003, the number of patients enrolled in the VHA system increased by 70 percent, yet funding (not adjusted for inflation) increased by only 41 percent. So the VHA has not only become the health care industry's best quality performer, it has done so while spending less and less on each patient. Decreasing cost and improving quality go hand and hand in industries like autos and computers—but in health care, such a relationship virtually unheard of. The more people we can get into the VHA, the more efficient and effective the American health-care system will be.

We could start with demonstration projects using VHA facilities that are currently under-utilized or slated to close. Last May, the VHA announced it was closing hospitals in Pittsburgh; Gulfport, Miss.; and Brecksville, Ohio. Even after the closures, the VHA will still have more than 4 million square feet of vacant or obsolete real estate. Beyond this, there are empty facilities available from bankrupt HMOs and public hospitals, such as the defunct D.C. General. Let the VHA take over these facilities, and apply its state-of-the-art information systems, safety systems, and protocols of evidence-based medicine.

Once fully implemented, the plan would allow Americans to avoid skipping from one health-care plan to the next over their lifetimes, with all the discontinuities in care and record keeping and disincentives to preventative care that this entails. No matter where you moved in the country, or how often you changed jobs, or where you might happen to come down with an illness, there would be a VHA facility nearby where your complete medical records would be available and the same evidence-based protocols of medicine would be practiced.

You might decide that such a plan is not for you. But, as with mass transit, an expanded VHA would offer you a benefit even if you didn't choose to use it. Just as more people riding commuter trains means fewer cars in your way, more people using the VHA would mean less crowding in your own, private doctor's waiting room, as well as more pressure on your private health-care network to match the VHA's performance on cost and quality.

Why make public service a requirement for receiving VHA care? Because it's in the spirit of what the veterans health-care system is all about. It's not an entitlement; it's recognition for those who serve. America may not need as many soldiers as in the past, but it has more need than ever for people who will volunteer to better their communities.

Would such a system stand in danger of becoming woefully under-funded, just as the current VHA system is today? Veterans comprise a declining share of the population, and the number of Americans who have personal contact with military life continues to shrink. It is therefore not surprising that veterans health-care issues barely register on the national agenda, even in times of war. But, as with any government benefit, the broader the eligibility, the more political support it is likely to receive. Many veterans will object to the idea of sharing their health care system with non-vets; indeed, many already have issues with the VHA treating vets who do not have combat-related disabilities. But in the long run, extending eligibility to non-vets may be the only way to ensure that more veterans get the care they were promised and deserve.

Does this plan seem too radical? Well, perhaps it does for now. We'll have to let the ranks of the uninsured further swell, let health-care costs consume larger and larger portions of payrolls and household budgets, let more and more Americans die from medical errors and mismanaged care, before any true reform of the health-care system becomes possible. But it is time that our debates over health care took the example of the veterans health-care system into account and tried to learn some lessons from it.

Today, the Bush administration is pushing hard, and so far without much success, to get health-care providers to adopt information technology. Bush's National Coordinator for Health Care Information Technology, Dr. David Brailer, estimates that if the U.S. health-care system as a whole would adopt electronic medical records and computerized prescription orders, it would save as much as 2 percent of GDP and also dramatically improve quality of care. Yet the VHA's extraordinary ability to outperform the private sector on both cost and quality suggests that the rest of the Bush administration's agenda on health care is in conflict with this goal.

The administration wants to move American health care from the current employer-based model, where companies chose health-care plans for their workers, to an “ownership” model, where individuals use much more of their own money to purchase their own health care. But shifting more costs on to patients, and encouraging them to bargain and haggle for the “best deal” will result in even more jumping from provider to provider. This, in turn, will give private sector providers even fewer incentives to invest in quality measures that pay off only over time. The Bush administration is right to question all the tax subsidies going to prop up employer-provided health insurance. But it is wrong to suppose that more choice and more competition will solve the quality problem in American health care.

VHA's success shows that Americans clearly could have higher-quality health care at lower cost. But if we presume—and it is safe to do so—that Americans are not going to accept the idea of government-run health care any time soon, it's still worth thinking about how the private health-care industry might be restructured to allow it to do what the VHA has done. For any private health-care plan to have enough incentive to match the VHA's performance on quality, it would have to be nearly as big as the VHA. It would have to have facilities and significant market share in nearly every market so that it could, like the VHA, stand a good chance of holding on to customers no matter where they moved.

It would also have to be big enough to achieve the VHA's economies of scale in information management and to create the volumes of patients needed to keep specialists current in performing specific operations and procedures. Not surprisingly, the next best performers on quality after the VHA are big national or near-national networks like Kaiser Permanente. Perhaps if every American had to join one such plan and had to pay a financial penalty for switching plans (as, in effect, do most customers of the VHA), then a business case for quality might exist more often in the private health-care market. Simply mandating that all health-care providers adopt electronic medical records and other quality protocols pioneered by the VHA might seem like a good idea. But in the absence of any other changes, it would likely lead to more hospital closings and bankrupt health-care plans.

As the health-care crisis worsens, and as more become aware of how dangerous and unscientific most of the U.S. health-care system is, maybe we will find a way to get our minds around these strange truths. Many Americans still believe that the U.S. health-care

system is the best in the world, and that its only major problems are that it costs too much and leaves too many people uninsured. But the fact remains that Americans live shorter lives, with more disabilities, than people in countries that spend barely half as much per person on health care. Pouring more money into the current system won't change that. Nor will making the current system even more fragmented and driven by short-term profit motives. But learning from the lesson offered by the veterans health system could point the way to an all-American solution.

Phillip Longman, a Schwartz Senior Fellow at the New America Foundation, is the author of *The Empty Cradle*; Basic Books, 2004.