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Report on
PORTLAND VETERANS ADMINISTRATION HOSPITAL

To the Board of Governors,
City Club of Portland:

I. INTRODUCTION

In September, 1981, a petition was filed with the City Club Board of Governors signed by 33 Club members. The petition requested a vote of the Club opposing the construction of the Veterans Administration (VA) hospital in Portland. The Board, after review of the petition, returned it to the sponsors stating that one resolution¹ in the petition was outside of the scope of City Club activities as outlined in the Club's charter. The Board asked the sponsors to restate the petition and resubmit it for consideration.

After resubmission in January, 1982, the amended petition was presented to the membership on February 19, 1982. The petitioners asked for a City Club vote on the following resolutions:

"THEREFORE BE IT RESOLVED, that the choice of physician and hospital in a home community is a right of every American, whether he be covered by private or governmental health insurance; and

"BE IT FURTHER RESOLVED, that the City Club of Portland affirm its opposition to commencement of construction of the proposed Oregon Veterans' Hospital prior to completion of a mainstream health care study for Oregon veterans."

Following discussion by the Club, a substitute motion was proposed and adopted. The motion, as adopted, read:

"BE IT RESOLVED, that the Board of Governors of the City Club appoint a special committee with a charge to study the issue of the delivery of health care to Veterans by building additional Veterans' hospitals or by utilizing community facilities. Particular reference should be made to the proposed Veterans' hospital on Marquam Hill and such other related questions as the Board deems appropriate.

"BE IT FURTHER RESOLVED, that the Committee be directed to report its findings to the Board of Governors and the membership as promptly as possible but in no event later than nine months from this date..."

The Board then formed this committee and charged it to: "(1) determine whether there is reasonable evidence that the interests of the public, and the needs of the veterans in the region who will use the proposed new Veterans Hospital complex, can be equally or better served by existing community health care providers; and (2) make appropriate recommendations."

The Committee was requested to return to the City Club membership with a report by June, 1982, if possible, but in no event later than September, 1982.

1. The resolution requested a lobbying effort with the Veterans Administration, the Oregon Congressional delegation and the President.

In response to the charge, your Committee embarked on an extensive study of what we perceived to be the questions raised by the charge. Your Committee interpreted the charge to include three broad questions: What is the current VA health care system? What is the alternative system proposed by the opponents of the hospital? What impacts do these two systems have on the community?

Your Committee chose not to view the charge as one that asked us to decide whether or not the replacement hospital should be built, or as one that asked us to define "mainstreaming" in detail and determine whether it would work. Additionally, the Committee deemed the long-running political controversy over whether the hospital should be located in Vancouver, or in Portland at Emanuel Hospital or on Marquam Hill to be outside of the scope of the charge.

Instead, your Committee viewed its charge as one of educating City Club members about the existing private and VA health care systems in place in the community and of analyzing whether the availability of private, non-governmental health care resources is a consideration important enough to be included in VA decisions on building hospital facilities.

Certain basic definitions are necessary in understanding the controversy about the VA hospital. Throughout this report, the shorthand term "mainstreaming" is used to include all proposals for veterans health care that include the use of local medical facilities and personnel as opposed to VA facilities and personnel.

The "community" is defined as that area of Oregon and Southwest Washington served by the VA hospital in Portland.

II. BACKGROUND

Congress first established a network of veterans hospitals and other facilities after World War I and created the Veterans Administration in 1930 to manage those facilities. After World War II, this system expanded with the creation of the Department of Medicine and Surgery of the VA. Today's VA facilities, which include 172 hospitals, 92 nursing homes, 16 veterans' homes, and 222 outpatient clinics, comprise the largest medical care system in the United States.² The VA system is separate from the system of military hospitals and facilities maintained for active military personnel and their dependents.

The VA Medical Center in Portland was constructed in 1928 on Marquam Hill. Presently it is a general medical and surgical facility offering a complete range of medical services to approximately 11,000 veterans each year. Most of the Portland facility's patients come from 29 Oregon and 8 Washington counties, although veterans from every state are eligible for care. (The criteria for eligibility are discussed in more detail in Section D. Statutory and Regulatory Basis of the VA.)

The history of the proposal to replace the existing VA facility on Marquam Hill dates back to 1962, when plans began for expansion of the present hospital. Active consideration of expanding the facility began

2. From data supplied by the Disabled American Veterans in May, 1982.

in 1975. The following chronology highlights the planning:

- 1975 A demographic study is completed by the VA which determines the area's veteran health care needs through 1985, and concludes that an 830-bed hospital and a 120-bed chronic care unit should be built in Portland.
- 1975-76 An independent health planning consultant is retained by the VA and presents recommendations for a new 950-bed medical center in Portland.
- 1977 The VA designates Marquam Hill as the preferred site for a new facility, overriding the consultant's study. The VA indicates the study did not place enough emphasis on health care and expresses preference for the development of existing property over the acquisition of new property. The VA revises its estimate of bed needs to 770 beds. Congress reduces this number to 738 beds. No change is made in the requirement for a 120-bed chronic care unit.
- 1978 Congress directs the VA to maintain a general medical facility in Vancouver and to build a facility in Portland capable of providing more extensive medical procedures. The Portland facility is to have no fewer than 600 beds. Congress appropriates \$130.2 million for the hospital regardless of the site chosen.
- 1979 A draft Environmental Impact Statement is issued evaluating three alternatives: the Marquam Hill site, the Emanuel site, and a no-build alternative.
- 1980 The VA Administrator issues a Record of Decision selecting Marquam Hill as the construction site. The proposed bed level for the Portland VA hospital is reduced to 490 beds because of limited funding. The bed level for the Vancouver facility is set at 120 beds of which 60 are long-term, or chronic care beds.
- 1981 Coalition for Better Veterans Care, Inc., et al vs. Administrator of the Veterans Administration (a lawsuit aimed at stopping the construction of the hospital), is heard in court and dismissed. Among other objections, the plaintiffs contended that the VA should have considered a mainstreaming alternative in the Environmental Impact Statement. The VA contended that the suggested alternative did not need to be evaluated because "Congress would not allow money appropriated for construction of a hospital to be used for any other purpose" (i.e., mainstreaming), and that "existing laws governing VA medical care limit the agency's authority to pay for non-VA treatment." An additional \$30.37 million is included in the VA's final budget for the 1982 fiscal year for construction of the hospital.
- May, 1982 A construction cost figure of \$176.1 million is set for both the Portland and Vancouver facilities. Phase I (site preparation) of new hospital construction is completed.

Mid-July, 1982	Phase II (mass excavation and steel frame erection) construction bids are awarded.
August 13, 1982	Groundbreaking ceremony scheduled.

III. FINDINGS AND DISCUSSION

The VA hospital issue is complex and involves many interests as well as a multitude of questions. The interests include Congress and the Veterans Administration, veterans organizations, the veterans who use the VA hospital and those who are eligible but do not, local, non-VA health care providers, regional health care planners, local government officials, and last, but not least, the taxpayers who finance the system.

Questions such as the availability of local health care resources, costs of services, VA policy and statutory authority, the needs and preferences of veterans, the relationship between the VA and medical schools, and the planning process of allocating health care resources are involved in the issue. Before discussing the information given to your Committee on these questions, some context, therefore, is helpful.

Portland's VA hospital is a 50-year old facility that has been remodeled and renovated over the years. The VA proposes replacing that facility with a totally new one at the same site. This is in line with national VA policy, based on budgetary considerations, of replacing older hospitals rather than renovating further. Four other VA hospitals were due for replacement at the same time as Portland's but, for budgetary reasons, were delayed. The appropriation for the Portland hospital was retained at the request of U.S. Senator Mark Hatfield, Chairman of the Senate Appropriations Committee.

Although the existing hospital will be replaced, the facility will not be closed, leveled and rebuilt. Instead, patients will be accommodated throughout the construction period in the existing facility.

Nothing in the testimony presented to your Committee indicated that the present VA hospital would close if it were not replaced. Your Committee, therefore, in reviewing the testimony and materials presented, viewed the issue as a series of options that included mainstreaming all or part of the health care presently provided by the VA, replacing the existing hospital, or leaving the hospital as it is now.

A. The Concept of Mainstreaming

Mainstreaming, as defined by its advocates, means that veterans would not be treated in hospitals operated by the VA, but, rather, in public and private hospitals along with the rest of the general public. Under mainstreaming, all medical needs of veterans would be provided by non-VA physicians, staff, and facilities. The veteran needing medical care would go to the facility or doctor of the veteran's choice, usually the one closest to the veteran's residence which is able to provide the service needed. For example, if veterans in Klamath Falls or Baker became ill, they would be admitted to hospitals in or near their home towns rather than coming to Portland for admission to the VA hospital.

Some witnesses argued that mainstreaming would result in the economies of scale that come from the efficient use of local community build-

ings and equipment to their fullest capacity. This, they say, would result in less cost to the federal government and is preferable to erecting new hospitals when existing facilities are underutilized.

The concept of mainstreaming includes a scheme for payment by the federal government to the community health care providers. Proponents of mainstreaming have come up with many and varied payment proposals. The most commonly discussed is a plan whereby the veteran would be provided with a card or a number, and the health care provider would be reimbursed for services provided. Multnomah County's Project Health and the Department of Defense CHAMPUS program were given as prototypes of health insurance plans that provide care for persons eligible for government financed health care coverage.

A commonly discussed disadvantage of some plans of this sort is the tendency of the government to reimburse at less than the amount billed. Medicare payments, because they are less than the amounts charged to non-Medicare patients, must be offset by health care providers by increasing the amounts paid by private insurers such as Blue Cross. It was argued by some witnesses that such inequities make the patient who is underfunded less attractive to the health care provider. Consequently, some argue, community health care providers will not be anxious to accept veterans who would be paid for at an 80 or 90 percent level. There is, however, nothing in existing law to prevent full reimbursement for VA patients in a direct reimbursement system.

A second drawback mentioned by opponents of mainstreaming is the possibility that veterans who are eligible for VA care but who do not now use those benefits would choose to do so under a mainstreaming program. That, witnesses told your Committee, would increase the VA's costs above the current level.

Witnesses told your Committee that the Veterans Administration has studied mainstreaming as a general concept from time to time. However, no specific examples of any such studies were produced. It appears to your Committee that mainstreaming studies that might have been performed by the government probably did not progress beyond the intellectual exercise of conjuring arguments against the concept to meet the assertions of the concept's proponents. Witnesses told the Committee that mainstreaming was never considered as an available option or as a plausible alternative to replacing the Portland hospital. Once the decision to construct a new hospital was made by the President and the Congress, the VA viewed a mainstreaming study as a waste of its resources.

Information reviewed by your Committee did reveal that in some limited cases the VA does contract with local health care providers for care for eligible veterans (i.e., mainstream). The exceptions are: women veterans, veterans in Alaska and Hawaii, and some veterans with chronic care needs.

B. Bed Availability

Key to the success of any mainstreaming program is whether there are sufficient resources in the community to provide health care services to veterans now served by the VA. One important measure of that availability is the number of hospital beds that could be used by the veteran population now served by the VA hospital in Portland.

Before discussing the specifics, a few definitions are necessary. There are several ways to count hospital beds: "Licensed beds" mean the maximum number of beds which a hospital can legally operate, whether or not those beds are staffed and ready for use. "Available beds" are defined by the State Health Planning and Development Agency as a bed which is "set up, staffed and available for use." While licensed beds are not as readily available, they can be brought into service in a relatively short time, according to Committee witnesses. In addition, your Committee confined its research to acute care beds, not chronic care (nursing home) beds, because the Portland VA hospital is an acute care facility. (For a discussion of acute and chronic illnesses, see the following section.)

Hospital beds are further defined by use. The State Health Planning and Development Agency classifies beds in the following categories: medical/surgical, obstetrical, and pediatrics. For veterans health care needs, medical/surgical beds are the most appropriate.³

With that as a background your Committee then reviewed the data on available medical/surgical hospital beds in the area:

Available beds	3598 ⁴
Additional licensed beds	500 ⁵
Average daily patient census	2570 ⁶

These figures reveal an occupancy rate of 71.4 percent⁷ for medical/surgical beds for the six-county area around Portland. For the other two health planning areas of the state (eastern Oregon and southwestern Oregon), the occupancy rates are 50 percent and 67 percent. Federal guidelines recommend occupancy rates of 80 percent.

Comparing these figures to the VA hospital, the data reveal:

Unused community beds	
(six-county Portland area)	1028
VA patient census	321 ⁸

3. Some few beds in this category may not be available for male veterans since this category includes gynecology. Overall, the data indicate that this number is probably small.
4. State Planning and Development Agency figures for the six-county area near Portland (Multnomah, Washington, Clackamas, Columbia, Clatsop and Tillamook Counties). The figure represents the "census day" of September 30, 1981 and does not include VA hospital figures.
5. Figures obtained from Northwest Oregon Health System (the regional health planning authority for the six-county area).
6. Ibid.
7. The occupancy rate does not include two Kaiser hospitals in the six-county area because of conflicting data. Kaiser statisticians told your Committee that their overall occupancy rate for 1981 was 85 percent, although other figures derived from Northwest Oregon health Systems data were higher. The overall impact of Kaiser occupancy rates, however, was not sufficient to change the Committee's conclusions on bed availability.
8. VA data on average daily patient census was derived from Northwest Oregon Health Systems data for August 1980 through February 1982.

Even if VA patients were added to the community hospitals, the occupancy rate would be within federal guidelines.

C. Acute and Chronic Care Needs

Acute illness means a short-term, episodic illness which has a relatively rapid onset and requires immediate attention. Examples are a broken bone, a stroke, or an attack of appendicitis. Chronic illness, on the other hand, is long-term, requires treatment over a span of time and, often involves more than one occurrence. Examples are hypertension, diabetes or arthritis. Some chronic conditions (such as hypertension) lead to acute illness (a stroke). And, in older people particularly, the neat division of patients into acute and chronic is difficult. Acute problems (a broken hip) are complicated by chronic illness (heart disease).

Supporters of the hospital told your Committee that the VA system is designed to care for adult patients who often have multiple disabilities and problems, both acute and chronic. Witnesses argued that the breadth of services provided by the VA for unique problems of veterans contrasted with the sub-specialized nature of private health care delivery mechanisms. Your Committee was told that the VA provides special research into unique veterans health problems such as delayed stress syndrome and Agent Orange-related problems. The private system could not conduct this level of research, we were told, because of the lack of financial capability or motivation.⁹ The fragmentation of veterans health care by mainstreaming would make research coordination very difficult, witnesses said. This is disputed in reports of the difficulty Viet Nam veterans have in receiving VA attention to delayed stress syndrome and Agent Orange related-problems.

Hospital proponents also told your Committee that the VA provides facilities for unique service-related injuries and cite rehabilitation and burn centers as examples. In Portland, however, only 35 percent of the patients seen at the existing general medical facility are treated for service-related conditions. The rest, 65 percent, are admitted for non service-related conditions.¹⁰

Both VA and private providers agree that, as the veteran population ages, more chronic care services will be needed. That is also true of the general population. According to a National Academy of Sciences report, over 25 percent of the VA's male patients presently are in VA chronic care facilities, veterans homes, or private chronic care facilities on contract with the VA. In addition, significant numbers of veteran patients with chronic care needs are placed in VA medical, surgical, and psychiatric beds.¹¹

At present there are no VA chronic care beds in the Portland-Vancouver area. The VA contracts for all its chronic care bed requirements in

9. Letter, Ferry, May 12, 1982.

10. VA court case figures. Although figures varied depending on the source, these were quoted by Judge Belloni in deciding the case.

11. Committee on Veterans' Affairs, Study of Health Care for American Veterans, prepared for the U.S. Senate by the National Academy of Sciences National Research Council, 95th Congress, 1977, p. 209.

this area (i.e., mainstreaming). In 1977 VA estimates for Portland and Vancouver needs were set at 82 and 50 private chronic care beds, respectively.¹² The need for chronic care beds in the area, however, may be understated greatly by these numbers, because large numbers of patients placed in VA acute care beds might be placed more appropriately in chronic care beds. The VA plans a 120-bed facility in Vancouver which includes 60 chronic care beds, 30 beds for alcohol treatment, and 30 acute care beds.

According to the National Academy of Sciences, the VA 1975 annual patient census reports some 19,000 patients in hospital beds nationwide had been in bed 90 days or more on the day of the census. (The average length of stay in a private hospital is 7.5 days. In VA hospitals it is 16.1 days.¹³) Although not all of these long term VA patients should have been placed in chronic care beds, a study for the U.S. Senate Committee on Veterans' Affairs concludes that 7,000 of the veterans in VA general hospitals and a few thousand more in psychiatric hospitals should have been placed more appropriately in chronic care facilities.¹⁴

Witnesses told your Committee that both the VA and Oregon's public and private hospitals have too many acute care beds and not enough chronic care beds. A May 1977 report from the General Accounting Office to the Subcommittee on HUD-Independent Agencies, Senate Committee on Appropriations, studied three new VA hospitals authorized for construction and reached the same conclusion. The Surveys and Investigations Staff of the U.S. House Committee on Appropriations, which studied plans for replacing the Portland and Vancouver VA hospitals in 1977, concurred with the General Accounting Office's findings and recommended that the number of planned acute care beds be reduced.¹⁵

The lack of chronic care beds in both the VA and community hospital systems becomes even more serious as one considers the aging of America's veterans. According to one report, by 1990, the number of veterans over the age of 65 will rise from three million to over seven million; by 1995, 60 percent of all elderly males in the U.S. will have once worn a military uniform.¹⁶

In comparing the cost of providing acute care, your Committee found it difficult to make comparisons between the private and public sectors. In 1981, private hospital costs rose 15.9 percent - compared to a 9.4 percent rise in the consumer price index, while VA hospital costs rose only 8 percent.¹⁷ However, it is almost impossible to equate the two, because certain capital costs included in private hospital budgets, appear to be excluded from VA budget figures.

12. Committee on Appropriations, Plans for Replacement of the Veterans Administration Hospitals in Portland, Oregon, and Vancouver, Washington, prepared for the U.S. House by the Surveys and Investigative Staff, October 1977, p. 45.

13. Ibid, p. 50.

14. Committee on Veterans' Affairs, Study of Health Care for American Veterans, p. 209.

15. Committee on Appropriations, October 1977, p. 50.

16. Phil Keisling, "Old Soldiers Never Die: Can We Pay for the VA's Version of the Baby Boom?" The Washington Monthly.

17. Ibid.

D. Statutory and Regulatory Basis of the VA

In order to understand the mainstreaming concept proposed by opponents of the VA hospital, some background on the statutes and regulations governing the VA is necessary.

The statutes enacted by Congress provide that "within the limits of Veterans Administration facilities,"¹⁸ the Administrator of the Veterans Affairs may furnish hospital care or nursing home care to:

1. any veteran for a service-connected disability;
2. any veteran for a non-service-connected disability if such veteran is indigent;
3. any veteran whose discharge or release from active military service was for a disability incurred or aggravated in the line of duty;
4. any veteran who is in receipt of or entitled to disability compensation;
5. any veteran who is a former prisoner of war;
6. any veteran of the Vietnam conflict who in the course of his service may have been exposed to certain toxic chemicals;
7. any veteran who in the course of his service may have been exposed to radiation from the detonation of certain nuclear devices; and
8. any veteran over the age of 65 for a non-service-connected disability.

The Administrator has broad discretion to furnish medical and nursing home care to veterans within the practical limits of the VA's facilities. Veterans Administration facilities are defined in statute as:¹⁹

1. Facilities over which the Administrator has direct jurisdiction;
2. Government facilities for which the Administrator contracts; and
3. Private facilities for which the Administrator contracts under such special circumstances as:
 - geographical inaccessibility of a VA facility
 - lack of appropriate treatment available in veterans or government facilities
 - life-threatening illness
 - care for women veterans
 - services in non-contiguous states, territories or possessions (Alaska, Hawaii, Puerto Rico).

The administrative regulations, adopted by the VA, also allow the VA to grant individual authorization or enter into contracts for the use of public or private hospitals for the care of veterans. However, admissions to public and private facilities at VA expense will only be authorized to:

- a. treat service connected disabilities;
- b. treat non-service connected disabilities associated with service-connected disabilities;
- c. provide vocational rehabilitation;

18. 38 USC Sec. 610 describes who is eligible to receive VA care.

19. The definition appears in 38 USC Section 601 (4)

- d. treat women veterans;
- e. treat veterans in Puerto Rico and other possessions (until September 30, 1982), and veterans in Alaska and Hawaii subject to certain limitations;
- f. treat certain "emergent (emergency²⁰) conditions"; and
- g. treat veterans who are totally and permanently disabled as a result of their service.

Veterans may be admitted to private or public hospitals at VA expense when a VA facility or other federal facility is not "feasibly available." The VA can pay only reasonable and necessary charges and only at rates charged the general public.

In summary, Congress has authorized the VA to use private hospital facilities to treat all veterans entitled to care under the law when VA or other government facilities are not accessible. While the regulations adopted by the VA do not provide for the treatment of indigent veterans with non service-connected diseases or disorders in community hospitals, that is a self-imposed limitation. Under the federal statute, if there were not a VA or other government hospital in Portland capable of treating veterans, the Administrator of Veterans' Affairs has the authority to contract with private hospitals or public hospitals such as the Oregon Health Sciences University to treat the population of veterans now served by the Portland VA hospital. In fact, in Oregon and Southwest Washington at the present time, the VA does mainstream chronic care patients.

E. VA and Regional Health Planning

During testimony before your Committee, several witnesses stated that the debate over bed availability in community hospitals versus replacement of the existing VA hospital results, in part, from the exclusion of the VA from regional health planning.

Congress specifically exempted the VA from the requirements of the National Health Planning Law²¹ enacted in the early 1970s. That law requires other hospitals to obtain a Certificate of Need before building new facilities or expanding services as a way to reduce the duplication of services provided among private hospital facilities.

To obtain a Certificate of Need, health facilities in each Health Systems Agency (the federally funded regional health planning agency) must submit to the board of the Health Systems Agency an application for expansion of beds, services, physical plant or, in some cases, equipment. The Board, which is made up of health care providers and consumers, reviews the application and, if it is within the goals of the area health plan, issues a Certificate of Need. In the Portland area, Northwest Oregon Health Systems is the reviewing agency.

Exempting the VA from this process, witnesses said, has created an overbuilding problem. The overbuilding occurs, your Committee was told, because the veteran population is "double counted" - once, for the Veterans' Administration planning and once for local planning. Thus, the

20. 38 CFR 17.50 b.

21. 42 USC 300 k et seq.

same group of people is included in the projected facilities needs of two providers - community hospitals and the VA.

In a 1977 report to a Senate Subcommittee on HUD, the Government Accounting Office noted that:

"...health systems agencies, such as Northwest Oregon Health Systems, count total population in their service areas in determining bed needs but do not consider the existing Federal hospital beds in their area as part of their bed capacity. VA and other Federal agencies count the population they serve but do not consider community or other Federal agencies' hospital beds available. In effect, the same population is counted twice and hospital capacities for new construction are estimated on the basis of these populations.

"The Government bears the direct costs of the new VA hospital beds and also shares in the increased costs resulting from excess community hospital beds, many constructed with Federal funds and supported operationally through Medicare, Medicaid and Federal health benefit programs."²²

Witnesses stated that independent action by the VA thwarts participation by the local government and community in any VA decision to build or not to build a facility. Review by the local governments such as City of Portland is limited to reviewing proposed sites.

In 1977, in a non-binding vote, the Board of Directors of Northwest Oregon Health Systems voted 25 to 9 against the VA proposal for Portland. The Board also asked Congress to examine the feasibility of using community hospitals for the delivery of care to veterans. The Oregon Medical Association agreed. In 1978, the Association adopted a resolution stating that the VA proposal was not justified on the basis of medical need.²³

F. The Relationship between the VA Hospital and the OHS University

Another factor in the VA debate is the close working relationship the Oregon Health Sciences University (OHSU) enjoys with the VA hospital.

The VA policy of affiliation with medical schools began in 1946. It serves two purposes: 1) to acquire, for the VA, qualified physicians to handle its patient care responsibilities, and 2) to expand residency training and provide expanded clinical services for medical students.

In Portland, the administrators of both the OHSU and the VA hospital believe that their well-established relationship is mutually beneficial. That relationship, specifically with the School of Medicine, is multi-faceted. It includes:

1. Staff and Financial Support to the University

About 40 full time equivalent faculty positions at OHSU are funded by the VA, according to witnesses. This includes partial funding of 85 faculty members out of a total of approximately 340. These faculty

22. Appropriations Committee, October 1977.

23. The Oregonian, April 24, 1978.

members are involved in the care of VA patients and the supervision and instruction of students assigned from OHSU to the VA. The \$900,000 a year this represents is significant. If the replacement building were not built and the VA continued in the present facilities, witnesses believe there would be no change in the VA hospital and medical school financial arrangements for staff. But if a mainstreaming program diverted patients from the VA hospital, new or old, OHSU would lose funds and staff members. This would adversely affect the student/faculty ratio which already ranks in the poorest one-third of medical schools nationwide.

Almost without exception staff physicians at the VA hospital also hold teaching appointments at the OHSU.

2. Proximity of the VA and the OHSU

Although not one of the issues your Committee concentrated on in this study, one of the most visible and heated issues in the past VA hospital discussions has been that of the hospital's location. Proponents of the Marquam Hill site have argued that close proximity to the OHSU Medical School is essential. During the lawsuit against the VA, testimony stated that 240 or more medical personnel make at least one trip daily between the VA hospital and the OHSU and would waste time and money and increase traffic congestion if they commuted across the river to a site off Marquam Hill.²⁴

Yet the Congressional Investigative Staff of the U.S. House Committee on Appropriations, after interviews of all parties in Portland, found that physical proximity, if within a few miles from the OHSU Medical School, was not a serious factor in determining where to locate a VA hospital in Portland.²⁵

Although a larger facility could have been built at another site, the VA chose to build a smaller hospital for the same funds, and remain on Marquam Hill.

3. Students and patients

Witnesses said that medical students benefit from treating older indigent patients, like those at the VA, through observing the complicating effects of alcoholism, chronic lung disease, and diet on acute problems. The witnesses questioned whether these older indigent patients would be available for student observation in private hospitals. In addition, with budget problems arising in private hospitals many of them are cutting back on teaching programs. At this time, witnesses believe that asking those hospitals to bear the increased costs of student and resident supervision and teaching is not likely to produce the 18 to 25 teaching slots needed for students. Lack of VA facilities also would affect 18 residents, 20 percent of the total number currently in the program at the OHSU, because they receive part of their training at the VA hospital.

24. Coalition for Better Veterans Care, Inc., et al vs. Administration of the United States of America, civil no. 81-365-BE.

25. Committee on Appropriations, October, 1977.

4. Research and Medical Services

Witnesses stated that the research facilities and grants available through the VA hospital are an important part of the research at the University. At this point, other monies do not appear to be available to replace those if they disappear. In 1980, this subsidy amounted to \$1.5 million for research with 53 full-time equivalent employees assigned to that function at the VA.

For the VA, OSHU provides access to services such as radiation therapy, CT scans, laboratory procedures and specialized surgical procedures such as open heart surgery.

G. Public Opinion - Veterans and Non-Veterans

Throughout the VA hospital debate, both opponents and proponents of the hospital have sought support from veterans and the non-veteran public. While veterans themselves are the most directly affected by the outcome of the debate, general public opinion is also of value. Whichever system is favored, the money to fund it will come from public tax dollars.

Veterans' organizations, such as the American Legion, the Veterans of Foreign Wars, and the Disabled American Veterans, have been the most visible in the debate. These organizations have consistently opposed attempts to change the present VA health care system. Accordingly, they have supported the plan to replace the present Portland VA hospital. Opposition to the new hospital, they suggest, is motivated by a desire to bail out Portland's presently overbedded private health care sector.

Veterans organizations see the VA health care system as a visible symbol of the nation's commitment to providing medical care for veterans as a debt owed and willingly paid to those who have answered the government's call to arms.

Further, the veteran's organizations argue that the VA system must be maintained as is because:

1. It is doubtful that the private sector could and would provide comparable care for veterans;
2. Many of the VA health care services are specially tailored to the needs of disabled veterans, and;
3. The VA system is the primary national security back-up to the military hospital system.

An opinion poll of all veterans in the Oregon/Southwest Washington area, not just members of a veterans organization, showed different results. The 1980 Grubb-Stern Marketing Research poll, done for the Coalition for Better Veterans Care, showed that 73.1 percent of the veterans polled would prefer VA paid care with their own doctor and hospital to care in a VA hospital.²⁶ Only 22 percent of those polled had ever received VA care and only 20 percent were members of veterans organizations.

26. Information on sample size and wording of questions for this and other polls cited is in Appendix C.

The poll contradicts the veterans organizations' position that veterans prefer to keep the VA system unchanged.

A GMA Research poll, done for KATU television, indicated general public support for the concept of VA paid care in existing community hospitals. In that poll, done in 1981, 67 percent supported VA paid care in local hospitals.

In a somewhat different manner, the VA itself surveys VA patients. Nationwide Patient Satisfaction surveys ask VA patients to compare the care they have received in VA and non-VA hospitals. Of those who had received care in both, 80 percent preferred the care in VA hospitals.

H. The Oregon Economy

The present recession in Oregon has been a powerful factor in the Portland VA Hospital debate. Proponents of the replacement facility argue that the \$176.1 million appropriated for the project could not come at a more opportune time for Oregon. There is little doubt that construction of the new facility will provide a greatly needed boost to Oregon's slumping construction and building industries. Since funds for the replacement hospital come from federal tax dollars, Oregon taxpayers will share the costs of this construction boost with taxpayers across the entire country. Proponents of the new hospital fear that the millions of dollars appropriated for the new facility could be lost to Portland and spent elsewhere in the VA system should construction be stopped.

Opponents of the hospital argue that short-term parochial interests must be set aside. They believe that the Portland VA Hospital will be the most expensive hospital, on either a per-bed or per-square foot basis, ever considered in the United States.²⁷ Opponents conclude that Oregonians concerned about their federal tax dollars and the long-term costs associated with the facility should demand that mainstreaming in the Portland area be considered before further construction takes place.

Hospital opponents also believe that the existence of a new facility would provide overwhelming pressure to use the facility rather than to mainstream veterans.

Some leaders of the political and business communities told your Committee that they were concerned that any delay of the new VA construction project would have a serious negative economic impact on the community. The economic impact of a \$176.1 million construction project is significant. An estimated 1,760 jobs are created directly by the construction and, indirectly, there are benefits from materials produced and taxes paid by companies and individuals involved in the project. Proponents of the hospital believe that if it is not built, there is no guarantee that the funds will be available for mainstreaming or other uses.

27. Petition signed by members of the City Club submitted to the Board of Governors of the City Club, January 1982.

IV. CONCLUSIONS

Based on the preceding information, your Committee reached the following conclusions:

1. There are, at present, sufficient available community hospital beds in the area served by the current VA hospital to meet the current acute care needs of veterans.
2. Although there are specialized facilities for rehabilitation and burn treatment elsewhere in the VA system, the majority of veterans treated at the VA hospital in Portland are treated for non service-related conditions, and present the same health care problems as any other community member.
3. The decision to build the VA hospital in Portland apparently was made without serious consideration of a mainstreaming alternative to the building of an acute care hospital.
4. As a consequence of this incomplete decision-making process, neither the federal government nor the public can be sure that the construction by the VA of a replacement acute care facility in Portland is needed or justified.
5. By law, federal facilities are exempt from regional health planning. This is one of the causes of the current disagreement concerning the construction of the VA hospital.
6. The needs of the Oregon Health Sciences University (OHSU) have been one of the primary concerns in the VA hospital controversy. The Oregon Health Sciences University is dependent on VA funds to maintain even its current poor faculty/student ratio. But if the existing VA hospital were not replaced, and the VA system maintained as it is now, there would be little or no effect on the OHSU.
7. If the existing Veterans hospital were replaced by a mainstreaming program utilizing community hospitals, the OHSU would lose the federal funds derived from its affiliation with the VA. Under these circumstances the OHSU would have to develop alternative sources of funding and become more closely affiliated with existing community hospitals, which the University appears to be reluctant to do.
8. While recognizing that loss of the VA subsidy would have serious implications for the OHSU, your Committee found nothing in statute that prohibits the VA from contracting with the OHSU for the provision of health care services for veterans if the hospital were to be replaced with a mainstreaming program. This would provide the same patients for the University paid for with VA funds.
9. The VA itself already uses mainstreaming in the states of Alaska and Hawaii, for women veterans, and, in Oregon, for chronic care patients. Developing a system that assures good quality acute medical care for veterans entitled to such care, however, has not been done. There appears to be no direct prohibition in statutes to mainstreaming, although it is clearly not VA policy.

10. The VA hospital is seen by veterans as tangible proof of the promise that they will always have a source of medical care if they cannot obtain it elsewhere. If any concept of mainstreaming is to succeed, it will be necessary to assure the veteran that the elimination of the physical plant is not the abandonment of this "last resort" right to health care.
11. Although veterans organizations have consistently supported the present VA system, a poll of all veterans in Oregon and Southwest Washington indicates that they, like the general public polled separately, support VA paid health care in community facilities.
12. Developing a workable mainstreaming alternative to the present VA system should include not only acute and chronic care needs of veterans but other potential treatment needs such as delayed stress syndrome, traumatic injury, and Agent Orange-related conditions. The ability of both the VA and the private sector to treat such service-connected conditions should be realistically assessed.

V. RECOMMENDATIONS

Your Committee, therefore, submits for City Club consideration these recommendations:

1. The concept of mainstreaming all aspects of veterans health care should be examined by Congress.
2. Oregon's Congressional delegation should determine, before construction of the Veterans hospital proceeds any further, whether the construction of the Portland acute care hospital is inevitable. Specifically, the delegation should determine if there are ways to preserve the funding for the construction while a study is performed to determine whether the acute care services which the proposed hospital will provide could be more economically and efficiently provided by existing community health care providers.
3. If the Congressional delegation finds that the funds for construction of the acute care facility can be preserved, then further construction should be stopped while a mainstreaming study is conducted. If the funds cannot be preserved, your Committee believes it does not have sufficient information to make a recommendation concerning whether or not the acute care project should be cancelled.
4. Furthermore, the Veterans' Administration health care program should be included in and subject to the federally mandated health planning and certificate of need laws.

Respectfully submitted,*

Peggy Bird
Louise Engel
Floyd Hinton
James McCreight
Charles Pruitt
George Ivan Smith
Jan Kitchel, Chairman

*The Committee wishes to recognize the contributions of Larry Bigham and Philip Blume who participated in earlier stages of the study. Also, the Committee appreciates the valuable assistance of our research intern, Susan Hajda.

Approved by the Research Board and the Board of Governors on July 15, 1982 and ordered distributed to the membership for discussion and action on August 6, 1982.

Appendix A
PERSONS INTERVIEWED BY THE FULL COMMITTEE

John Atkins, Legislative Assistant for Veteran Affairs, U.S. Representative Les AuCoin
 Raymond Crerand, Associate Administrator, Providence Medical Center, and Executive Committee member, Northwest Oregon Council of Hospitals
 Sylvia Davidson, Commissioner, National Council for Health Planning and Development, past President, Northwest Oregon Health Systems, and former Chairman, State of Oregon Health Commission
 Bruce Etlinger, Co-Chairman, Coalition for Better Veterans Health Care
 J.H. Ferry, Director, Portland Veterans Administration Medical Center
 M. Roberts Grover, M.D., Associate Dean, School of Medicine, Oregon Health Sciences University
 Senator Mark O. Hatfield, U.S. Senate, State of Oregon
 Tom Higgins, Director, Multnomah County Human Services Department
 Prebble LaDage, Staff Assistant to Director, Portland Veterans Administration Medical Center
 Leonard Laster, M.D. President, Oregon Health Sciences University
 Solomon Menashe, President, Oregon Physician Service (OPS-Blue Shield)
 Peter A. Nathan, M.D., Co-Chairman, Coalition for Better Veterans Health Care
 Richard A. Rix, Executive Director, Northwest Oregon Health Systems
 LaVorn A. Taylor, District Counsel, Veterans Administration

Appendix B
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Disabled American Veterans

Letter from Duane T. Rold, Commander, to committee member Charles Pruitt.

Northwest Oregon Health Systems

Letter from Robert H. Elsner, President, to Chairman Mrs. Corky Kirkpatrick, Columbia Region Association of Governments.

U.S. House of Representatives

Letter from Congressman Denny Smith to Committee Chair Jan Kitchel.

U.S. Senate

Letter from Senator Bob Packwood to Executive Officer, Rick Gustafson, Metropolitan Service District.

Letter from Senator Bob Packwood to Committee Chair Jan Kitchel.

U.S. Veterans Administration

Letter from Bruce S. Binda, Administrative Officer for Outpatient Activities, to Executive Director Steven Berkshire, Northwest Council of Hospitals.

Letter from Robert E. Coy, VA Acting General Council, to Assistant U.S. Attorney Thomas C. Lee, Esq.

Letter and materials from J.H. Ferry, Director Portland VA Medical Center, to committee member Charles Pruitt.

Letters and materials from LaVorn Taylor, VA District Counsel, to committee.

Appendix C
EXCERPTS FROM POLLS CITED*

I. GMA Poll

Method: From May 11 through May 13, 1981, GMA Research conducted the GMA Poll in the Portland, Tri-County area for KATU television. All interviews were conducted by telephone from the GMA Research central location phone bank in Portland. Respondents (384) 18 years of age and older were scientifically selected for interviewing. The sample was evenly split between male and female respondents.

Results from a sample of 384 are accurate within +5% with 95% confidence.

Question: If you could determine how the Veterans Administration would spend funds allocated for the health care of Oregon veterans, would you prefer health care services be provided at the new regional VA hospital in Portland or the same health care services be provided using existing community hospitals and doctors of the veterans' choice?

<u>Response</u>	<u>Percent</u>
The same health care services be provided using existing community hospitals and doctors of the veterans' own choice	67%
Health care services be provided at new regional VA hospital in Portland	24%
Undecided	8%
Refused	<u>1%</u>
Total	100%

II. Grubb-Stern Marketing Research Poll

Method: During the first two weeks of February, 1980, a telephone poll was conducted by Grubb-Stern for the Coalition for Better Veterans Care. A total of 310 veterans were interviewed with a +5% accuracy rate and a 92% confidence level.

Veterans who were phoned lived in a number of population centers in Oregon and Southwest Washington, including:

Portland (3-county)	Clark County, WA	Salem
Longview-Kelso	Albany	Corvallis
Eugene-Springfield	Medford	Astoria
Coos Bay	Pendleton	The Dalles
Bend	Klamath Falls	La Grande
Baker		

The number of interviews per metropolitan area was determined on a proportional basis to the area population.

For this sample, 69 or 22.3% of the veterans contacted had received medical treatment from a VA hospital, while 241 or 77.7% had not.

A. VA versus Non-VA Medical Services

Question: For those health problems which require hospitalization and for which the VA pays the cost, would you prefer to use:

Hospitals and Doctors of Own Choosing	73.1%
A VA Hospital with VA Doctors	26.9%
Totals	100.0%

B. Preference for Choosing Own Outpatient Clinic or a VA Outpatient Clinic

The following was the second major question of the study.

Question: For those health problem which are normally treated at an outpatient clinic or doctor's office and for which the VA pays the cost, would you prefer to use:

Doctor or Outpatient Clinic of Own Choosing	76.6%
Veterans Administration Outpatient Clinic	23.4%
Totals	100.0%

C. Preference for Allocation VA Health Care Dollars

The third major question of the study was as follows.

Question: If you as a veteran could determine how the VA would spend their allotted money for your health care, would you prefer:

New VA Hospital and Outpatient Clinic in Portland	37.9%
Current Medical Benefits in Community Facilities of Own Choosing	62.1%
Totals	100.0%

D. Member of a Veterans Organization

MEMBER OF A VETEANS'S ORGANIZATION BY STATUS OF LAST VISIT

Yes	19.5%
No	80.5%
Totals	100.0%

E. Views of Veterans Who Have Received Treatment from a VA Hospital

Previous analysis indicated that 69 veterans had previously received VA medical treatment. Selected questions were included to generate specific information on their views and attitudes towards the treatment received and a comparison to treatment received from community, non-veterans facilities.

The table below shows that 80% of the veterans were moderately or very satisfied with the care they received during their last visit to a VA hospital.

OPINION OF LAST VISIT TO A VA HOSPITAL

Reaction	#	%
Not satisfied	8	11.6
Slightly satisfied	5	7.3
Moderately satisfied	17	24.6
<u>Very satisfied</u>	<u>39</u>	<u>56.5</u>
Totals	69	100.0

Only 11.6% of those polled were not satisfied with the care they received on thier last VA hospital visit.

III. VA Patient Satisfaction Survey

In 1979 VA hospital patients filled out questionnaires in a nationwide survey for the Veterans Administration. The number of patients from the Portland-Vancouver area included in the sample was not available in the information provided by the Veterans Administration.