The Veterans Health Administration's COVID pandemic response was the best of any health care system in the United States

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What should we make of the nation's largest integrated health care system: a glimpse into medicine's future, or a relic whose time has passed? Ask those providing care within the Veterans Health Administration (VHA)—whether it be full-time physicians, medical students, residents, fellows, or dually appointed academic faculty—and you will likely hear passionate arguments advocating multiple perspectives.

We were fortunate to have worked together during the pandemic as leaders within the VA system, and in neighboring offices at the Denver VA facility. But evaluating the Federal pandemic response is complicated. A single perspective would fail to capture what makes the VA both uniquely strong and uniquely vulnerable. For this reason, we would like to offer a lighthearted debate between Fellows and friends. Supporting this resolution is Ron Robinson, MD, MPH, MBA, FACHE while Jay MacGregor, MD, MBA, FACS is in opposition.

Dr. Robinson

I was fortunate to lead two very different health care systems during the COVID-19 pandemic, spending the first nine months of the pandemic as CEO of two critical access hospitals in Northwest Kansas. This period was marked by great uncertainty not only related to the disease itself, but also to its impact on infrastructure (e.g., HVAC issues and patient movement), and supply chain (e.g., PPE, ventilators, and medications). Due in part to the very low population density in rural Northwest Kansas, the impact of the pandemic was felt more acutely in the reduction of outpatient services rather than an overwhelming number of inpatient admissions.

Decisions were made daily leveraging the expertise of the service line leaders, and open, rapid, human-centered communication enabled optimal decision-making. This nimble approach allowed the local hospital infrastructure to optimally support the population.

In November 2020. I transitioned to the VA in Denver and the contrast between the capabilities and concerns experienced by the nation's smallest critical access hospitals and the massive Denver VA couldn't have been more stark.

When I arrived at the VA, the Incident Management Team was functioning on a 24-hour cycle with clinical leaders rotating into the leadership positions on a weekly to biweekly basis. This structure allowed the institution to address the minute-to-minute clinical impacts of the pandemic, much like the operation of critical access hospitals. This bottom-up approach was singularly effective, and the engagement felt by the frontline staff was palpable despite the exigencies of the pandemic.

Perhaps the greatest strength of the VA's system is its interconnectedness. In addition to clinical care, teaching, and research, the Fourth Mission of the VA is the mandate to improve the nation's preparedness for its response to "war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to Veterans, as well as to support national, state, and local emergency management, public health, safety, and homeland security efforts."[1]

This rarely-utilized Fourth Mission highlights that a pandemic is precisely the challenge that the VA is uniquely prepared to address. Civil servant VA employees were deployed throughout the country to support areas of greatest need.

An additional benefit of the federal system is the collective knowledge and capabilities of those who have served this country in uniform. A remarkable 32 percent of VA staff are Veterans.[2] Military experience inculcates in employees the ability to respond in an organized fashion to external impacts. Whether retired or continuing to serve part-time in the National Guard or Reserves, there is no better workforce to address this challenge, or any challenge to our health care system.

Dr. MacGregor

During my time with the VA, I worked as a staff surgeon, section chief, department chief, and the leader of a multi-specialty service line. I began my VA career in a rural facility with limited resources and numerous subspecialty coverage challenges. This experience, unlike working in a resource-rich metropolitan area, highlighted the frustrations of an overly restrictive federal system. Access requirements—which were rigidly applied even during the worst days of the pandemic—show how an inflexible system was not able to respond to the needs of our community during the ever-changing pandemic.

The pandemic also highlighted an existential threat to the federal system: the VA system is rapidly becoming a health care insurer rather than a health care provider. The fastest growing line-item in federal health care spending is the cost of care purchased at non-VA facilities by non-VA providers. This care in the community spending is a byproduct of endless rules and regulations placed on capable and motivated VA employees.

If this current trend continues, the VA system will spend more money for care purchased outside of VA facilities than for care it provides within its own walls. This rapidly approaching moment, likely a financial point-of-no-return, will signal the move of the VA from a health care provider to a health care insurer.

The COVID-19 pandemic highlighted that even during a time of unprecedented crisis, the bureaucratic rules would not budge.

The VA's COVID-19 response in many ways seems to mirror the "race" to sequence the human genome. The Government's Human Genome Project, from 1990 to 2003, cost taxpayers $3 billion.[3] Celera Corporation, founded by Craig Venter in 1998, was able to outperform the government at approximately 10% of the cost with a total budget of $300 million.[3] Despite joining the race late and using investor funding, Celera exposed the inefficiencies of a large-scale government program. Mr. Venter felt that "the Human Genome Project was taking too long, proving too costly and that it was getting bogged down by non-essential discussions, such as who was going to take credit for it."[3]

The COVID-19 pandemic highlighted many of the same issues within VA health care. The cumbersome federal process was too slow, too expensive, and too restrictive to combat a rapidly changing pandemic.

Dr. Robinson

The size and scope of the COVID-19 pandemic requires a coordinated effort by the world's largest health care systems. The concerns Dr. MacGregor addresses are not unique to the VA. Any large system, whether it is the British National Health Service, or a multi-state integrated system in the United States, will be less nimble than a smaller hospital system. But with size also comes stability. Given that 70 percent of nonprofit health care systems are still running a deficit, the pandemic highlighted the importance of financially solvent systems that can weather the tremendous impact of a pandemic.

The federal system, with the backing of the U.S. government, is uniquely situated to survive any financial

pressures. This stability also allows providers the peace of mind to provide excellent health care without the fear of their hospital being acquired or their quarterly RVU total impacting their income (VA providers are salaried employees).

Dr. MacGregor

Dr. Robinson has addressed the strength of the VA system: the backing of the U.S. Government and the funding of the U.S. taxpayers. Even so, he has not addressed the relentless move of the VA system to become a payer for care rather than a provider of it. The strengths of the VA system—of which there are many—could soon be dwarfed by the VA's focus on simply paying for timely care at non-VA community facilities.

The pandemic highlighted that an inflexible system will remain just that—too rigid—if the option to send care to community facilities is not only easily available but also required by Executive Order.[4]

My contrariety is not directed toward the outstanding civil servants who work at VA facilities, but toward a system that was too bureaucratic and too cumbersome to allow these fantastic employees to combat the pandemic without federal regulations slowing them down.

A leadership advantage

While we may disagree on some of the issues discussed in this resolution, we can agree that our experiences as Fellows in Leadership were invaluable, especially during the pandemic. The Fellowship's community of practice—fellows, mentors, and the AΩA Board—offered a trusted resource during the uncertainty of the pandemic. The Inward Journey of Leadership (a core element of the Fellowship) is a mental model ideally suited for navigating the unrelenting challenges imposed by the pandemic.

Physicians continue to wrestle with the fallout from this career-defining experience: unprecedented burnout, conscious quitting, and early retirement. Whether it was serving on the frontlines of clinical care or leading an incident command center, we are forever grateful for the skills gained during the Fellow in Leadership program. The benefits of the Fellowship, we agree, are beyond debate.

Acknowledgments

Thank you for allowing us to openly discuss some of what makes VA great while also sharing some of the challenges inherent in the federal system. We would like to extend our deepest thanks for the selfless sacrifice of the Veterans of the U.S.

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