

ISSUE BRIEF

**NATIONAL
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FORUM**

Restructuring the VA Health Care System: Safety Net, Training, and Other Considerations

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A discussion featuring

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Restructuring the VA Health Care System

The Veterans Health Administration (VHA) is a system in transition, changing its focus, expanding its activities, and restructuring its services. A system rooted in specialty-based hospital services is being replaced by one built on ambulatory and primary care. While the original focus of the Veterans Administration (now the Department of Veterans Affairs but still referred to as the VA) was providing hospital care for veterans with service-connected disabilities, eligibility over the years has been expanded to include both inpatient and outpatient care for veterans with non-service-connected disabilities as well. From a centralized budgeting and decision making system that was often slow, cumbersome, and unresponsive to local concerns, the VHA has now moved to a decentralized network system.

Driving these reforms are the myriad changes taking place within the larger healthcare system and within government, particularly budgetary constraints in the face of rising healthcare costs, the growth of managed care, increasing competition for the healthcare dollar, a government-wide effort to reduce the budget deficit, and the needs of an aging population of veterans.¹ Although these changes are affecting all sectors of the healthcare system, they pose particular challenges for the VHA. In 1995, the VHA began to respond to these various challenges and enunciated a vision and a blueprint for restructuring in *Vision for Change*.²

The Department of Veterans Affairs relies almost exclusively on federal appropriations for its operating costs. Historically, Congress has had a strong and stable commitment to veterans, and the attitude of the VA has been said to be one of “we ask, you give.” As John Iglehart notes, “Time and again, politicians of every stripe reaffirmed their belief—reinforced by the veterans’ lobby—that veterans are served better medically through a separate system.”³ However, operating within a shrinking budget environment and facing competing claims on the federal dollar, the VA has been receiving a diminishing proportion of the federal budget. In fiscal year (FY) 1977, VA spending was 5 percent of total federal spending; in FY 1996, that percentage was reduced to 2.5.⁴ Furthermore, although the shift to managed care has had major implications for the practice of medicine in the private sector, providers there have never been totally insulated from cost implications. In contrast, VA physicians have been

cushioned from decisions relative to costs and, since budgets were based on historical costs, the incentives were never in the direction of cost control.

Changes in the demographic composition of veterans pose another major challenge for the VA. There are currently 26 million veterans, but their numbers are declining and their average age, currently 57.7 years, is increasing. It is projected that there will be 26 percent fewer veterans by the year 2010 but that 40 percent of the veterans alive then will be over the age of 65. Between 1990 and 2010, the number of veterans over the age of 85 is expected to grow from 154,000 to 1.3 million.⁵ This substantial growth among the “old old” will generate considerable new demand on both the acute and the long-term care components of the VA.

Fundamental questions about the role and future of the VHA are coming from many sectors. Even Kenneth W. Kizer, M.D., M.P.H., the under secretary for health at the Department of Veterans Affairs and the main architect of the changes taking place, recently asked:

In a country where health care delivery is primarily a private-sector function, should the federal government be in the business of directly providing health care? How much should the government spend for veterans hospitals and other capital assets, and should these be exclusively for the use of veterans?⁶

In fact, since his arrival in Washington in late 1994 from California, Kizer has been challenging the prevailing philosophy of the VHA and reshaping the system, modelling it on a managed care plan with an emphasis on prevention, primary care, and case management.

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This Forum session will examine the changes under way in the VHA and their implications for the veterans served and the stakeholders of the system. The discussion will focus on the appropriateness of a managed care model for the various veteran populations and the extent to which the VA is fulfilling its multiple missions, given the transformation now taking place. In light of recurring suggestions to integrate the VHA and mainstream medicine and proposals for Medicare to pay for services provided to beneficiaries over the age of 65, the Forum will also examine how the VHA is coping with the reconfiguration of the larger marketplace relative to the population it serves.

BACKGROUND

The modern VA healthcare system began during World War I with the establishment of hospitals to treat combat-related injuries and to rehabilitate veterans with service-connected disabilities. A second role was added to the VHA in 1924 during a period of excess hospital capacity. Veterans service organizations (VSOs) successfully lobbied for free hospital care for medically indigent veterans without service-connected disabilities. Permitting access to such low-income veterans placed the VA in the role of a safety net provider. During the 1940s and 1950s, two additional missions were added by Congress: health professions education and medical research. Both were intended to enhance the quality of care provided in VA institutions. More recently, Congress has charged the VA with the responsibility of participating in the nation's response to national emergencies.

From a modest start and a narrow focus, the VA has grown to be one of the nation's largest healthcare systems, now having 173 hospitals, nearly 600 outpatient clinics, 133 nursing homes, 40 domiciliaries, 206 counseling centers, and 185,000 employees. The percentage of veterans served depends upon the population considered eligible for service. The Government Accounting Office (GAO) reports that these facilities serve about 10 percent of the total veteran population each year.⁷ Yet VA health care is not an entitlement for all 26 million veterans. Congress appropriates resources and specifies the priorities of veterans for care, within available resources. The highest priority, "mandatory" veterans, are those with service-connected disabilities and the poor. Almost all (95 percent) of the more than 2.5 million veterans the VA treats annually come from within this "mandatory" subgroup of only 9.5 million veterans. The VA and many VSOs view this high-priority, mandatory population as the VHA's primary

service population. Because not all persons need or seek care in any one year, the VA has served about 35 percent of the individuals in this mandatory population over the past three years.

There are many indications of change in VHA services. The number of inpatient days has been declining dramatically over the past three years. Although the number of patients served has increased, annual admissions have decreased by more than 250,000 since 1994 and the number of outpatient visits has increased by more than 6.6 million. The VA has diminished the centrality of the hospital, making it "a component of a larger, more coordinated community-based network of care."⁸ Additionally, says the VHA, over 77 percent of the eligible population can identify a primary care provider, productivity standards and clinical care outcome measures are being developed, VHA staffing has declined 13 percent, 42 hospitals have been merged into 20 local systems, and more attention is being paid to customer satisfaction.

MULTIPLE MISSIONS

In contrast to private-sector managed care organizations, the VA has four statutory missions, each vying for attention and resources. While its patient care mission is the primary focus, it must be balanced with the three other congressionally mandated responsibilities.

Patient Care

The first mission of the VA is to provide health care to eligible veterans. In light of the changes in the veteran population, the role of safety net provider has assumed prominence. Typically, veterans who utilize VA services are older, poorer, and more likely to have a psychiatric diagnosis, and they have a high incidence of substance abuse disorders. Homeless veterans accounted for 13.5 percent of all hospital admissions in FY 1996 and 47 percent of substance abuse admissions.⁹ In fact, the VA is the nation's largest direct provider of services to the homeless.¹⁰ This function is often referred to as the VA's "fifth mission" although it is not mandated by statute. Of the more than 2.5 million veterans served annually, 70 percent have incomes under \$21,610 per year.¹¹ The GAO notes, "From its roots as a system to treat war injuries, VA health care has increasingly shifted toward a system focused on treating low-income veterans with medical conditions unrelated to military service."¹² In FY 1995, only about 12 percent of the patients treated in VA hospitals received treatment for service-connected disabilities and another 28 percent

had service-connected disabilities but were treated for conditions not related to those problems. Almost all the rest were poor and had no service-connected condition. It is for just these patients, asserts Kizer, that a role will always exist for the VHA. He estimates that about a quarter of the veteran population, those who are most socially compromised—the poor, the homeless, the mentally ill, and substance abusers—will never be attractive to private-sector providers. Writing in *Health Affairs*, Nancy J. Wilson and Kizer note that “as long as local market forces dominate the healthcare industry and state and local funding vary, the stabilizing influence of a national safety net like the VA healthcare system becomes ever more important.”¹³

The shift in the site of care from in-hospital to outpatient services is reflected in utilization patterns. Between FY 1994 and FY 1997, the number of acute care admissions to VA hospitals fell 247,412, or 24 percent. During that same period, the number of outpatient visits increased by 23 percent, from 26.0 million to 32.6 million, according to the VHA.

The aging of the veteran population is evidenced by the increase in nursing home care. The number of veterans in VA nursing homes and VA-supported state nursing homes increased 27 percent between 1990 and 1996, from 42,175 to 53,550 veterans. Most of that increase was in VA-supported state nursing homes. Demand for the Blind Rehabilitation Service is increasing too as a result of the aging population. The service was initially developed to rehabilitate veterans blinded in combat. Most blind veterans currently using these services have lost their sight as a result of degenerative conditions. It has been suggested that the safety net provider role will become even more significant for this population as conventional insurance does not adequately cover blind rehabilitation.¹⁴

Health Professions Education

The second statutory mission of the VA is health professions education and training. The VA provides clinical opportunities to more than 100,000 students and trainees in more than 40 disciplines. About 54,000 nurse, dentist, optometrist, podiatrist, physical and occupational therapist, psychologist, and other trainees rotate through VA programs each year. In addition, the VHA reports that 34,000 medical residents and 22,000 medical students rotate through the VA healthcare system annually.

Currently, according to the VHA, 107 of the nation's 125 medical schools have affiliation agreements

with 131 VA medical centers. Ten thousand VA clinicians have academic appointments and a similar number of academic faculty direct or provide care for veterans and teach residents and students. The VA funds over 8,500 medical residency positions, approximately 11 percent of all positions in the nation. The role of the VA in medical training is so pervasive that, according to VA estimates, more than 65 percent of all physicians currently practicing in the United States have received all or part of their training through the VA.

This arrangement benefits the VA by strengthening the VHA's workforce, supplementing its clinical expertise, and increasing its ability to attract high-quality talent. In fact, one VA neurologist has noted that medical school affiliations have been the salvation of the VA and that quality standards would not be maintained without these relationships.¹⁵ In return, the VA-supported residency positions have provided medical schools with additional sources of support for patient care, teaching, and clinical research. The VA also provides medical schools with training sites and, especially important at this time, with ambulatory training sites.

The response to consolidation of services in Chicago VA hospitals is one illustration of the significance of the VA to medical schools. The strategy of consolidation is being pursued by the VA to promote efficiency. There is general agreement that duplication within the system can be eliminated and that savings can be achieved by hospital consolidation, or as the VA calls it, integrations. However, according to an article in the *Chicago Tribune*, efforts to consolidate two VA hospitals met with a “howl” of protest from the Chicago campus of the University of Illinois School of Medicine, which has enjoyed a long affiliation with the VA's West Side Hospital. School officials were fearful that the VHA planned to transfer West Side's medical and surgical units to the VA's North Side facility, Lakeside Hospital, an affiliate of the University of Illinois' rival, Northwestern University Medical School. The dean of the University of Illinois warned that if West Side Hospital were left as an ambulatory care facility, “it would gut the medical program at the country's largest medical school.”¹⁶ In July 1997, Chicago congressional representatives forced a hearing that put the entire process of consolidations on trial. The GAO testified on behalf of a more comprehensive approach rather than the incremental one being used by the VA. Although the GAO, as well as all others testified to the importance of stakeholder involvement, they acknowledged how difficult it had been for the competing medical

schools to address this issue and suggested using independent planners with no vested interests in the geographic area.¹⁷

The alignment of the affiliations between medical schools and VA medical centers and the nature of residency training have been caught up in the whirl of change that is affecting all segments of the VA. Like the rest of American medicine, the VA's healthcare system has been dominated by specialists. Now, however, the mandate to enroll all eligible veterans and assign each to a primary care provider is increasing the demand for primary care physicians and diminishing the need for specialists. In some cases, specialists are assuming these primary care responsibilities; in other cases, the ranks of specialists are being decreased through attrition or release.

To further support the shift to primary care, the VHA's Residency Realignment Committee, chaired by Robert Petersdorf, M.D., a noted former medical school dean and past chairman of the Association of American Medical Colleges, recommended eliminating 250 residency positions in disciplines other than primary care. The committee further recommended shifting 750 residency positions from specialty disciplines to primary care as defined by the VA. This realignment would increase the number of primary care positions to 49 percent of all VA residency positions.¹⁸

The VHA is in the process of implementing the recommendations contained within the committee's final report. However, in so doing, primary care has been defined as a "philosophy and method of care delivery" and not as a set of disciplines. Noting that it may be more appropriate for specialists with primary care skills to care for patients with chronic illnesses, the VA has launched two new initiatives to train specialists in primary care. The first program focuses on eight specialty areas, among which are rheumatology, gastroenterology, and neurology. The second program covers residency training in general psychiatry, geriatric psychiatry, and addiction psychiatry. It is anticipated that residents completing those programs will demonstrate primary care competencies such as the ability to assess and manage common diseases and the ability to implement health promotion and disease prevention strategies.¹⁹

Research

The statutory mission of research was added to the VHA in 1958. Its programs have been responsible for many innovations in medical practice that go beyond

the veteran community. Among the many breakthroughs developed through the VA have been the first artificial kidney, the development of the cardiac pacemaker and the first successful liver transplant; isotopic medicine procedures that detect thyroid disorders; and prosthetic devices, such as hydraulic knees and the robotic arm. The Geriatric Research, Education, and Clinical Centers (GRECCs) that integrate service, education, and research for the aging veteran population have made the VA a leader in geriatric care.

By congressional mandate, the VHA's research program is obligated to include biomedical research, mental illness research, prosthetic and other rehabilitative research, and health services research. It is also stipulated that the research be consonant with the VA's healthcare mission and correspond to veterans' specific needs. Aggregate support for the research program is approximately \$1 billion. Included in that amount in FY 1997, according to the VHA, was \$262 million from a specific congressional appropriation for the VA's intramural research program, \$397 million from extramural grants, and \$320 million in indirect support from the medical care budget. It is expected that the percentage of funding for research from sources outside of the VHA will increase as it pursues collaborative partnerships. One example of this collaboration is the VHA's partnership with the Juvenile Diabetes Foundation, which is providing matching funding for diabetes-related research.

Vision for Change, the blueprint for the VHA's restructuring, called for an examination of the VHA's research effort and a determination of whether research dollars were being properly allocated. The report of the Research Realignment Committee, issued in October 1996, suggested a reordering of research priorities by establishing designated research areas (DRAs). These areas would be those in which

the VA has a particularly strong strategic interest because of the prevalence of conditions within the VA patient population, the uniqueness of a specific patient population and its disease burden to the VA system, or the importance of the question to health care delivery within the VA.

The committee recommended establishing 13 DRAs, among which are dementias; substance abuse; central nervous system and associated diseases, including spinal cord dysfunction and traumatic brain injury; and cancer. It further recommended that a national research advisory council be established to revise these priority areas as necessary and to designate relative funding levels for the DRAs.²⁰

The ability to monitor the nature of research priorities will be a challenge for the VHA. However, as the veteran population ages and the disease burden increases or shifts, it will be critical for the VHA to address these issues through research and service. The GRECCs in particular have been a successful model for coordinating research, education, and service although they have never been expanded to their full complement of 25. The VSOs have recommended establishing one GRECC dedicated to research on the care of elderly patients with spinal cord injuries.²¹ A new series of specialized mental health centers, Mental Illness Research, Education, and Clinical Centers, modeled on the GRECCS, are now being established.

Medical Preparedness

The final mission, added to the VA in 1982, designates the VA as backup to the Department of Defense medical care system and to the Public Health Service and the National Disaster Medical System in times of natural and technological disasters. The VA has coordinated significant medical support during the hurricanes and flooding disasters of recent years. It is anticipated that this function will become even more significant because of the “devolution of the military healthcare system . . . [and] because the VA provides many of the physical resources needed to operationalize federal disaster plans.”²² In fact, Kizer asserted recently, the VHA is

for all intents and purposes the federal government’s only direct response capability. The U.S. Public Health Service no longer has any resources with which to respond to a disaster or national emergency. Likewise, as a result of DOD’s downsizing and its needs for continuous military readiness, they are increasingly less able to respond to civilian disasters or national emergencies.

BALANCING THE MISSIONS

Like their counterparts in the private sector, physicians at VA hospitals are being held accountable for achieving certain levels of productivity. However, unlike academic health center M.D.s in the private sector, and certainly unlike most HMO M.D.s, a larger proportion of VA physicians both perform research *and* provide patient care. The VHA says that more than 70 percent of VA researchers see patients daily. In contrast, only 25 percent of researchers funded by the National Institutes of Health see patients.²³ Therefore, research activities that can enhance the quality of care provided can also reduce the clinical productivity of the

physician. A recent report by the GAO highlighted the difficulties of holding physicians accountable for certain levels of productivity and suggested that, as productivity is emphasized, teaching and research missions may be compromised. The report notes that this emphasis has led to the loss of talented researchers in some cases and, in others, to reductions in the number of students welcome on the clinical services.²⁴

VISION FOR CHANGE: THE VA’S REFORM PLAN

Armed with a mandate to reconstruct the VA, Kizer has overseen fundamental changes in the delivery, management, organization, and philosophy of VA medical care. These changes include decentralizing decision-making authority, adopting new eligibility rules, revising the funding allocation method, shifting care from inpatient to outpatient settings, enrolling eligible veterans and assigning them to primary care teams, and consolidating services across medical centers.

Decentralization

As a first step toward restructuring the VA, its 173 hospitals have been organized into 22 regional systems known as Veterans Integrated Services Networks (VISNs). Each network (drawn primarily on the basis of patient referral patterns) of providers and facilities assumes responsibility for the health of a population of eligible veterans in defined geographic areas. VISN directors are responsible for budgeting and decision-making within their jurisdictions.

While this organizational restructuring may produce efficiencies and greater flexibility in responding to local needs, concern is being voiced regarding accountability and variability in quality. Veterans advocacy groups are especially concerned about the integrity of the VA’s specialized services, such as spinal cord injury programs and prosthetics services. A primary goal of these groups is to maintain and improve these programs. Even before reforms were instituted, the GAO cautioned that increasing the demand for routine outpatient services could hinder the VA’s capacity to provide specialized services. While they noted that data on unmet needs were not maintained by the VA, they pointed to several examples to support their contention that not all veterans’ needs were being met. Among the examples they provided were post-traumatic stress disorder (PTSD) programs. Although the Vietnam War ended 20 years earlier, the number of veterans seeking services for PTSD has been

increasing and programs are operating at or above capacity, with waiting lists of 900 to 1,000.²⁵

Management and Oversight

In transferring the authority from headquarters to the 22 VISNs, the number of staff members in Washington was cut by 25 percent, and their role has changed from program management to policy development and oversight. Some observers have referred to this as the balkanization of the VA and have suggested that 22 independent fiefdoms are operating without adequate central oversight. Although the VISNs have been instructed to communicate their plans to VA headquarters, decisions are not consistently communicated and stakeholders are not consistently included in discussions at the VISN level. At a recent congressional hearing, the American Legion testified that clinical programs were being closed without notifying headquarters in advance.²⁶ One VA official commented that inpatient substance abuse programs are sometimes closed without prior notification. In a Senate report (105-53) addressing the VA appropriations bill for 1998, it was suggested that current oversight may be inadequate, and the VA was requested to submit a plan for improved monitoring of the networks.

Resource Allocation

There is wide variation in expenditures for patient care in regions across the country. To address these marked variations in costs and their inherent inequities, the VA has moved to an allocation methodology based not on historical costs but on a prospective capitation rate per veteran. The new allocation method abolishes the practice of directly funding each of the VA's 173 hospitals. The reformed payment method, mandated by Congress, funds each of the 22 VISNs, with the goal of securing access for veterans with similar eligibility priority and economic status, regardless of where they reside. Funding is based on the number and type of veterans served, adjusted for factors such as regional labor costs and case mix. Network directors are responsible for distributing the funds among hospitals, ambulatory care clinics, nursing homes, domiciliaries, and other treatment facilities within their catchment area. The funds are provided to the network at the beginning of the fiscal year with no restrictions on their distribution. Eighty-eight percent of the VA's medical appropriation is allocated to the networks in this way. The remaining 12 percent of the appropriation is for central administration and for restricted clinical uses, such as for prosthetics and Persian Gulf referral centers.

Under the Veterans Equitable Resource Allocation System (VERA), implemented in April 1997, two patient care groups have been established, one for basic care patients and one for special care patients. Basic care patients are those with relatively routine healthcare needs who receive their care primarily in outpatient settings. Ninety-six percent of the VA's patients receive basic care, but these patients represent 62 percent of the dollars allocated. Special care patients—such as terminally ill HIV-positive veterans and those with spinal cord injuries or chronic mental illness—are high-intensity users of VHA services. Although they constitute only 4 percent of VA patients, special care patients account for 38 percent of the dollars.²⁷

The new allocation methodology will allow the system to adapt to change and allow funding to follow the veteran. However, it will also result in losses for the northern industrial states, the Rust Belt, and increased funding for the Sunbelt states. States such as New York, Pennsylvania, Illinois, and Michigan stand to lose 7 to 15 percent of their funds over the next three years. States such as Florida, Texas, and Arizona could gain as much as 16 percent.²⁸

Like any managed care capitated system, VERA gives the VISNs incentives to attract veterans who do not require extensive services. VA officials, aware that there is a potential for gaming, have developed performance measures to discern any unusual changes in workload, increases in waiting times, or changes in customer satisfaction.

Eligibility Reform

When queried, about 18 percent of veterans who do not use the VA health system cited "didn't know was eligible" as a reason.²⁹ In fact, Congress has created a notoriously complex system of eligibility. Especially prior to 1996, determination of eligibility had been particularly onerous for both veterans and providers. VA health care is not an entitlement program like Medicare or Medicaid. And eligibility for VA services does not guarantee a defined package of services. Until 1996, all veterans were technically eligible for some care, although the actual provision of care was based on the availability of space and resources. But most otherwise eligible veterans had limited access to outpatient services and the provision of still other services, such as dental care, was tied to a prior hospital stay.

Reforms enacted in the Veterans Health Care Eligibility Reform Act of 1996 eliminated the distinctions between inpatient and outpatient care. This erased

the complicated eligibility restrictions previously applied to outpatient care. It established two eligibility categories and seven enrollment priority categories. The first eligibility category includes veterans to whom the VA shall furnish needed hospital and outpatient care. However, as was historically the case, the obligation of the VA to this group of eligible veterans is effective only to the extent of appropriated resources. The second category includes veterans to whom the VA may furnish care, but only to the extent that resources are available and only if the veteran pays a copayment for care. This group comprises higher-income veterans with non-service-connected disabilities.

Eligibility rules for VA nursing homes and domiciliaries are unchanged. The VA may provide these services as clinically appropriate, within available resources. Veterans with the highest priority for these services are those with service-connected disabilities rated at 10 percent or more. Lowest priority is assigned to veterans who have no other special eligibility status and whose income exceeds the means test. Currently, for an individual with no dependents, that income level is above \$21,610.

This legislation also requires the VA to enroll patients based on priority categories, with the highest priority given to veterans with service-connected conditions and indigent veterans. It requires the VA to maintain system-wide capacity for the 12 special-emphasis programs that include treatment for spinal cord injury, blindness, amputation, and mental illness. The legislation permits the VA to provide a continuum of services by permitting preventive health services to be delivered even if the veteran is not currently undergoing treatment.

Both the Congressional Budget Office (CBO) and GAO concluded that eligibility reform would generate additional demand for services, primarily due to increased use of outpatient services. The CBO also estimated that rising utilization would, by extension, produce dramatically increased costs. GAO noted, however, that eligibility reform would not address most veterans' unmet service needs because

many of the problems veterans face in obtaining healthcare services appear to relate to distance from a VA facility or the availability of the specialized services they need rather than their eligibility to receive those services from VA.³⁰

Despite the expansion of eligibility, it is not clear that greater numbers of veterans will be served as, generally, appropriations have been adequate only for

those veterans in the high-priority groups, such as service-connected disabled or indigent veterans. However, since enactment of eligibility reform legislation, the VA has been treating increasing numbers of veterans supporting these new patients through economies generated from its shift from expensive inpatient care to outpatient services. Further, eligibility reform legislation did not address the needs of an aging veteran population or expanded access to nursing home care or other non-institutional long-term care alternatives.

Primary Care/Ambulatory Care

In the reconfigured system, emphasis is being placed on primary care as the entry point into a system providing a continuum of services. In FY 1994, less than 20 percent of VA patients were followed by a primary care provider. Within a two-year period, 77 percent of patients reported that they were being followed by a primary care provider, and the VHA reports that, in actuality, more than 95 percent of patients are enrolled with a primary care provider. It is anticipated that universal primary care will be achieved within the next year.

In the reconfigured system, ambulatory settings are the preferred site of care. The following statistics confirm the extent to which this goal has been achieved.³¹

- Since 1994, 22,580, or 42 percent, of all acute care hospital beds have been closed.
- Ambulatory surgery increased from 35 percent of all surgery performed in FY 1995 to 69 percent in FY 1997.
- Twenty-seven of 121 PTSD programs (22 percent) have shifted or are in the process of shifting from inpatient to outpatient.
- One hundred and twelve of 190 substance abuse programs (59 percent) have shifted or are in the process of shifting from inpatient to outpatient.

QUALITY OF MEDICAL SERVICES

The structural changes taking place at the VHA have generally been validated by Congress, the VSOs, and staff internal to the agency. Nevertheless, reports of compromised quality of care at VHA facilities continue to surface. Recent newspaper accounts have revealed a spate of "adverse events" in VA medical centers and clinics, including scaldings, overdoses, and falls. Criminal investigations continue in Florida VA hospitals into

the role of employees in the deaths of four patients. The deaths of 45 patients at a Missouri hospital remain unexplained. The *St. Petersburg Times* has reported on several unusual or avoidable deaths, attributing them to flawed clinical judgment, failure to verify credentials of staff physicians, poor physical maintenance, and incompetence among the nursing staff.³²

A recent article in the *New York Times* reports on similar potentially preventable deaths in upstate New York. The Office of the Medical Inspector at the VA reviewed the records of patients who died in two hospitals in New York State in 1995 and 1996. It concluded that 6.4 percent of the patients received poor care and an additional 10.5 percent had received care of marginal quality.³³

The *New York Times* article suggested that the problems of quality had been aggravated by the allocation method, which has diverted resources away from the Northeast. The *St. Petersburg Times* suggested other causes for the large number of cases. That article indicated that no systematic review of medical accidents has taken place, thus allowing the errors to recur. And, because the VA does not track the number of unusual deaths, it is unable to provide a firm accounting of adverse events within their jurisdiction. In fact, the story stated, the “VA’s top health care official in Florida acknowledged he was not aware of the total until he had the department add up the deaths in response to the [St. Petersburg] *Times*’ question.”³⁴

A Senate minority report released on December 19, 1997, questioned the quality of care provided by the VA healthcare system. In a letter accompanying the report to secretary-designate Togo D. West, Jr., Sen. John D. Rockefeller IV (D-W. Va.), the ranking minority member of the Senate Committee on Veterans Affairs wrote: “The sad truth is that we can’t accurately answer the basic question ‘Do our veterans receive the highest quality of care in VA hospitals and clinics?’” The report, he said, “shows clearly that the VA simply does not have the programs and systems in place to adequately monitor, track and analyze the quality of care provided.”³⁵

Rather than focusing on specific patient incidents, the report concentrated on the quality assurance mechanisms established by the VHA to monitor patient care. The report’s findings included the following:

- Although the VA has made many efforts to address quality of care issues, many of these efforts “were

short lived, poorly executed, poorly tracked . . . and often abandoned.”

- Data may be collected but it is not analyzed and monitoring does not take place.
- The VA has “squandered” many opportunities to improve quality.
- Quality concerns have not been emphasized and the entire quality management program lacks cohesion.

The report recommended establishing a national advisory board to direct the quality management program, placing the responsibility for quality assurance directly under the under secretary for health, and training employees in quality management practices for a minimum of 40 hours a year.³⁶

Kizer, in his response, expressed some dismay at the allegations and the timing of the report. In a letter to Rockefeller, he noted that the report was issued on the heels of the VA’s being presented an award for “exceptional work in improving care of those approaching the end of life . . . when so many efforts have failed to make an impact.” He also noted that he had just received an invitation to present at the Institute of Medicine’s National Roundtable for Healthcare Quality. The project director had invited him after reviewing quality of care indicators at the VA and requested that he discuss the strategies used by the VHA for achieving such successes. Much of the letter provided information documenting “unprecedented improvement in the quality of VA health care.” He ended by challenging the recommendations, noting that they had already been addressed.³⁷

Quality will continue to be a challenge and issue for the VHA. In addition to the report recently issued by Rockefeller, a second report will be released in the middle of February. At the request of Sen. Arlen Specter (R-Pa.), the chairman of the Senate Veterans Affairs Committee, and Rockefeller, the ranking minority member, the Office of the Inspector General is evaluating the VHA’s current quality assurance activities. In the letter requesting this evaluation, it was noted,

our concern is based on our sense that the various elements of the Department’s overall QA effort are not functioning so as to assure those with an interest in the system that the quality of care is being monitored appropriately, effectively and in a timely manner.³⁸

Additionally, it is anticipated that the Senate Committee on Veterans Affairs will hold an oversight hearing on quality in March.

FUNDING

Funding for the medical care programs of the VA is through an annual discretionary appropriation. Of the \$40.1 billion appropriation to the VA in FY 1997, \$17 billion was for medical care services. The president's budget request of \$17.5 billion for FY 1998, although presented as an increase over FY 1997 levels, actually represented a decrease of more than \$54 million. According to VHA Budget Office figures, the total request represented \$16.959 billion in appropriated funds and \$468 million in recovered third-party reimbursements that previously had been returned to the treasury.

It has been a goal of the VA, the VSOs, and Congress to diversify the funding sources available to the VA in order to reduce its reliance on the federal appropriation process. The administration request was also accompanied by two legislative proposals that would have permitted the VA to achieve that goal. Under prior law, the VA could collect private third-party reimbursements but had to transfer the collected funds to the treasury after subtracting the administrative costs associated with realizing the recoveries. Although many VA patients are eligible for Medicare, existing law prohibits the VA from seeking reimbursement from the Medicare program.

The proposals accompanying the administration's FY 1998 budget would have changed those policies. They called for permitting the VA to retain all private third-party collections and for setting up a Medicare subvention demonstration project that would pilot a method of determining the billing relationship with Medicare for dual-eligible veterans. While the recovery piece passed, the Medicare subvention initiative was ultimately omitted from the authorization bill. Given the uncertainty of recoveries, Congress stipulated that if the VA collections fell more than \$25 million short of that projected, automatic spending provisions would protect VA healthcare funding.

Although VSOs have long advocated for the right to retain third-party recovered funds, those recovered funds were always viewed by the veterans' community as an enhancement to the budget and not as a substitute for appropriated funds. The VSOs now oppose this initiative because they note, as stated by the Vietnam Veterans of America, that this "tenuous proposal offers no security whatsoever for sufficient and sustained funding, because . . . the collection targets are untested, extraordinarily optimistic, and very tenuous at best."³⁹

The president's budget and the administration's decision to hold the federal appropriation to about \$18

billion a year for the next five years inflamed the VSOs. Had Congress passed the Medicare subvention initiative, the VHA would still have had only about \$18.5 billion in fiscal year 2002. What riled the veterans' community was a budget analysis that projected that \$20.6 billion would be required in 2002 for the VA to maintain its current workload. The Paralyzed Veterans of America, a small but influential VSO, maintained that the budget presented "an unprecedented attack on veterans."⁴⁰

The VA budget is predicated on increasing the number of veterans served and achieving increased efficiencies within the system. Particularly, says the VHA, it is based on reducing by 30 percent the cost of care on a per patient basis, increasing by 20 percent the number of veterans served, and increasing to 10 percent of its operating budget revenues from non-appropriated sources. The VSOs have expressed skepticism that such goals can be achieved.

The VA appropriation for FY 1988 was signed into law on October 27, 1997. It included an appropriation for medical care of \$17.057 billion, representing a slight increase from fiscal year 1997. The appropriation for medical and prosthetic research was \$272 million, an increase of \$10 million over the previous year.

THE VA AT THE CROSSROADS

Over the years, the VA's healthcare system has built up a loyal cadre of defenders. Chief among these groups are the VSOs. The VSOs acknowledge the need for change and are generally supportive of the efforts under way, recognizing their inevitability. They maintain, however, that they, along with other stakeholders such as the academic affiliates, have not been adequately involved in decisions affecting the way VA care is delivered. Rather, they assert,

network managers fall back on the predictable formula of calling veterans' groups and others to the table at the last minute to present leadership's decisions. Last-minute information does not equate to meaningful involvement in the decisionmaking process and does not produce the same result.⁴¹

Despite their support for change, the VSOs are adamant in their refusal to allow the system to be dismantled and incorporated into the larger system. They cite the VA's "unparalleled expertise and resources" in providing certain specialized services, such as spinal cord injury care and prosthetic services, and the limited availability of these services in the private sector.⁴² They also note that, since the federal government created

veterans, it is the federal government's responsibility to take care of those who have earned their benefits through personal sacrifice on behalf of the United States. Therefore, they maintain, veterans' programs should always be viewed as a priority for funding.⁴³

The VSOs are not only concerned about protecting a separate system of care or about their inclusion in decision making. Of even greater concern to them is the potential for cost considerations to take precedence over patient needs. They fear that adequate steps have not been taken to prevent the incentives inherent in a capitated system to compromise care. Of particular concern are the special-emphasis programs, "the shining jewel of the VA." Veterans are fearful that with so much attention being paid to cost control, access will be restricted to these resource-intensive services. Reacting to such fears, Kizer suggests that incentives in the VA are quite different from those in the private sector. "Since VA has no shareholders and pays no dividends . . . any savings that are achieved go back into taking care of more patients or doing a better job of taking care of its current patients." Unlike for-profit managed care companies, savings are not diverted to higher executive salaries and bonuses. In fact, Kizer suggests that, because the incentives are so different, the VA may be one of the few entities able to test whether managed care is a better model than traditional indemnity insurance.⁴⁴

CONCLUSION

The VA is at a crossroads. While it is moving to a system in which primary care is the norm, the GAO points out that "the VA health care system was neither designed nor intended to be the primary source of health care services for most veterans."⁴⁵ Although there is agreement that the VA's special services are unparalleled in excellence, some observers suggest that those services can be cut loose and incorporated into the larger healthcare system. Others, such as Jordan Cohen, M.D., president of the Association of American Medical Colleges, dismiss that option by noting that

one of the main reasons for the success of the VA's unique programs for patients with special needs is the infrastructure provided by comprehensive VA medical centers. This common support system is the necessary foundation upon which VA builds expertise in the specialized areas such as cardiac care, long term care, and substance abuse treatment.⁴⁶

Whatever form it takes, the escalating competition for federal dollars will force the VA to deal with diminish-

ing budgets and increasing scrutiny and a continued demand for enhancing the quality of care provided.

THE FORUM SESSION

Kenneth W. Kizer, M.D., M.P.H., the VA's under secretary for health, will provide an overview of the history and goals of restructuring the VHA. Dr. Kizer's professional experience prior to joining the VA includes positions in the private sector, philanthropy, and academia as well as in state government, where for over six years he served as director of California's Department of Health Services. He has held senior academic positions at the University of California, Davis, and continues as an adjunct professor of public policy at the University of Southern California. He has also served on the boards of a number of professional societies and been a consultant to several foreign countries. Dr. Kizer is board certified in five medical specialties and has authored over 300 articles, book chapters, and reports in the medical literature.

Laura Miller, M.P.A., the VA's network director for the VA Health Care System of Ohio, will describe her regional experience with the restructuring of the VHA. Ms. Miller is responsible for six inpatient VA facilities, one independent outpatient clinic, and six active community-based outpatient clinics (CBOCs) in the state. Ten pending CBOCs are in the planning stages in the network. She began her career in 1978 as a presidential management intern and, after advancing through several top management positions—including director of VA Medical Center Pittsburgh, Highland Drive—was appointed to her current position in 1995.

Richard B. Fuller, national legislative director of Paralyzed Veterans of America, will discuss the concerns of veterans as consumers of care, addressing especially issues of quality and access. Mr. Fuller served for eight years on the professional staff of the House Committee on Veterans' Affairs, with primary responsibilities in the areas of veterans' health and education legislation. Since 1987, he has worked in the field of public policy and government relations, specializing in health policy for a wide variety of health advocacy, consumer health research, and provider nonprofit organizations in Washington, D.C.

Richard Ryan, Jr., D.Sc., president and chief executive officer of the University of Osteopathic Medicine and Health Sciences in Des Moines, Iowa, will comment on the VHA restructuring from the medical school–research community perspective. Dr.

Ryan's association with federal medicine and the VA began as a disabled Korean War patient at the Bricksville VA Hospital in Fairview Heights Ohio in 1955. Since that time, Dr. Ryan has had more than 30 years' experience in numerous dean's positions at Harvard University and Tufts University, has served as a member of the Special Medical Advisory Group of the VA, and has been a consultant to the Paralyzed Veterans of America and the Disabled American Veterans; he is considered by many to be a leading expert on academic medicine and federal health services. From 1974 to 1977, Dr. Ryan served as director of the West Roxbury, Massachusetts, VA Hospital and as director of the First Medical District in New England. He holds a doctoral degree in health services administration from Harvard University School of Public Health.

Stephen P. Backhus, M.B.A., director of veterans' affairs and military health care (VA&MHC) issues at the U.S. General Accounting Office, will provide the GAO's perspective on the VHA restructuring. Since joining the GAO since 1973, Mr. Backhus has served in many different capacities. In his current assignment, he is responsible for evaluating the healthcare systems of the Department of Veterans Affairs, the Department of Defense, the Indian Health Service, and the Bureau of Prisons. He is also responsible for evaluating programs providing certain nonhealth benefits, such as disability compensation and pensions, to veterans and their dependents or survivors. Immediately prior to accepting this position, he was the associate director for VA&MHC issues and for six years was an assistant director responsible for evaluating the military's \$15 billion per year healthcare system.

The discussion will center on the following questions:

- What are the unique features and role of the VA healthcare system? Should it continue to be a separate system or should care be incorporated into the larger healthcare system?
- What are the implications for the VHA of a diminishing number of veterans and an aging population? Are changes needed in VHA services as a result of the aging veteran population? What should be the policy relative to long-term care? What are the implications for various elderly subgroups? Those with spinal cord injuries? Gulf War Syndrome? Substance abuse?
- How is the VHA's version of managed care affecting patient outcomes? Are the incentives inherent in a capitated system jeopardizing care? Are they

undermining the VHA's mission to provide specialized care to specialized veteran patient populations? Is managed care compromising the safety net mission of the VA?

- How can the VHA assure the veteran population of high-quality, accessible care?
- How do changes in Medicare and Medicaid policies affect the veteran population? To what extent do the populations served by these programs and by the VHA overlap? Should eligibility requirements be changed as policy changes occur in the larger healthcare system?
- Have state health reforms affected the number of low-income veterans using the VA? What impact will this have on future funding needs?
- Are changes needed in the VHA's role as a safety net provider? What are the barriers to fulfilling the VHA's safety net mission? What subgroups of the safety net population are not being served? Have state health reforms affected the number of low-income veterans using the VA? What impact will this have on future funding needs?
- What are the internal mechanisms or external yardsticks that the VA will use to guide itself or be held accountable to its users and stakeholders?
- Are there further efficiencies to be achieved in the VA's healthcare system? Will the missions of the VHA be compromised by pushing for further efficiencies?

The Forum thanks Gregg Pane, M.D., Chief, Office of Policy, Planning and Performance, Veterans Health Administration, for providing or verifying much of the VHA data in this paper.

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