MEETING THE HEALTH CARE NEEDS OF ELDERLY VETERANS
AND
THE ROLE OF THE DEPARTMENT OF VETERANS AFFAIRS
IN THE U.S. HEALTH CARE SYSTEM

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ABSTRACT

The Department of Veterans Affairs faces a tremendous potential overload in demand for health care services, due in part to the aging of U.S. veterans. The American College of Physicians believes the elevation of the Department to the executive branch of the government should become the means of clarifying current problems and the opportunity to take effective actions to resolve them. The V.A. must be supported as a recognized leader in the provision of a continuum of geriatric treatment programs, in research, and in health care education. Federal budget requests must accurately represent V.A. needs; federal agencies should investigate reports of budgetary shortfalls or quality-of-care problems and help devise and implement solutions. Accurate assessment of strengths and weaknesses of V.A. facilities, and of complementary services within and outside of the system, will allow improved cooperation among V.A. and other providers. V.A. management should encourage efficient and flexible local approaches to health care delivery within available resources. When changes in public health policy are contemplated, the impact on V.A. health care, education and research must be considered.

(This paper updates and expands on "The Role of the Veterans Administration in an Evolving Health Care System," American College of Physicians, March 1985.)

INTRODUCTION

The Department of Veterans Affairs (V.A.)--known as the Veterans Administration prior to March 1989--is composed of the Veterans Health Services and Research Administration (VHSRA), the Veterans Benefits Administration and the National Cemetery System. Although the bulk of its budget is directed to veterans' benefits (58.5%), the Department, through its VHSRA, operates the largest single health care system in the United States. In 1988, its 172 medical centers, 119 nursing homes, 26 domiciliary facilities, and 60 independent or satellite clinics throughout the United States and Puerto Rico provided directly for 1.1 million inpatient care episodes and 21 million outpatient visits (Table 1) (1). In addition, the V.A. contracted for 94,092 episodes of hospital care and paid for care on a fee basis for 1.8 million outpatient medical visits. The Department has affiliations with over 1,000 American schools for the health care professions. Approximately 96,000 students and trainees per year receive supervised clinical and administrative experience in V.A. medical centers. The Veterans Health Services and Research Administration--previously the V.A. Department of Medicine and Surgery (DM&S)--employs 193,798 people, including approximately 12,200 physicians (excluding residents in training). In FY 1988, DM&S expenditures for medical care and research programs alone amounted to $10.2 billion. Additional expenditures of from one-half to one billion dollars are incurred annually for construction and maintenance of facilities.

Despite the number and diversity of these resources, the V.A. health care system faces a tremendous potential overload in demand for services in the final decade of the twentieth century. The aging of U.S. veterans from World War II and the Korean conflict is resulting in a veteran population with a rapidly rising proportion greater than age 65, already higher than that of the general population. At the same time, the number and percentage of elderly persons in the community at large is growing quickly, expanding the demand for geriatrics services. Consequently, the number of older veterans using V.A. health care benefits is expected to increase dramatically in the 1990s. Accurate assessment of the health care needs of veterans and assurance of adequate funding for legislated V.A. health services have become critically important.

Modern high-quality health care, especially for the elderly, requires a degree of coordination of multiple resources and services that in the United States was pioneered by the Veterans Administration. In this paper, ACP will address issues that are directly relevant to the provision of high-quality health care to elderly veterans but that also have implications for the care of younger veterans and for society in general. To lend informed support to the Department of Veterans Affairs, health professionals, policy makers and the public need to better understand both the historical importance of health care for veterans and the V.A. medical system's valuable role as a national example of coordinated, comprehensive clinical care, teaching and research.

Since colonial times the American people have recognized an obligation to provide care for indigent and disabled war veterans, through pensions and, later, through direct medical benefits (2). Although Congressional action in 1930 (during the Great Depression) initiated the V.A. system, its current

organization was developed in a spirit of optimism in the United States during the post-World-War-II period of an expanding economy. At the end of World War II, as the system grew dramatically, its needs increased for well-trained health professionals and for mechanisms to assure that high quality care was provided. To meet these needs, the V.A. also undertook a major role in medical education and research through its affiliations with the nation's medical schools. The system was designed to furnish priority medical care to veterans with service-connected disabilities, while also providing medical care for needy nonservice-connected (NSC) veterans. Following World War II, the Korean Conflict, and the war in Vietnam, Congress has reaffirmed the national policy commitment to provide a complete medical, hospital, and extended care service of high quality for eligible veterans by expanding benefits and coverage and constructing and renovating facilities.

The American College of Physicians (ACP) is the largest national medical specialty society, representing more than 63,000 general internists and subspecialists professionally committed to serving the medical needs of adults and adolescents. ACP strongly supports the Department of Veterans Affairs in its efforts to assure high quality health care for the nation's 27.4 million veterans. The College recognizes that the Department has mandated missions: to develop, maintain and operate a national health care delivery system for eligible veterans; to carry out a program of education and training of health personnel; to carry out a program of medical research; and to furnish health care services to members of the Armed Forces during a war or national emergency, and to encourage sharing of resources between the Department of Defense and the Department of Veterans Affairs. ACP also encourages improved interaction between the V.A. and other suppliers of health services in the United States so that these various elements can respond with increased efficiency to changing national conditions and needs for the 1990s. The establishment in March 1989 of the Department of Veterans Affairs in the executive branch of the federal government, with a Secretary in the President's Cabinet, represents a renewed declaration of commitment to U.S. veterans; it should become the means of clarifying current problems within the V.A. health care system and the opportunity to take effective action to resolve them.

POSITION

1. In response to the geriatric imperative caused by rapidly increasing numbers of veterans age 65 and over, the Department of Veterans Affairs must be adequately supported as a recognized leader for the nation at large through its role in: 1) the provision of a continuum of treatment programs; 2) the support of research in geriatrics; and 3) the education and training in geriatrics of physicians, nurses, dentists and other health care professionals. These three major initiatives to meet the health care needs of elderly veterans, when strengthened and expanded, should serve as a model for the development of other national health care programs targeted toward the elderly.

RATIONALE

The Department of Veterans Affairs serves a beneficiary population whose proportion greater than age 65 is increasing much faster than that of the population in general. This is a recent and rapid development: in 1980, the proportion of veterans 65 and over was approximately the same as that in the general population. By 1990, it will be double that of the general population, and by 2000, nearly triple that proportion.

As of September 1988, there were about 6.4 million veterans who were aged 65 and over. By 1990, the number of elderly veterans is expected to grow by some 9% reaching a total of 7 million; by the year 2000 it is projected to be approximately 8.9 million. The number of veterans age 75 and over, the age group that requires the greatest amount of resources per capita, is expected to increase even more rapidly from approximately 1.3 million in 1988 to about 3.8 million by the year 2000. Veterans 85 years of age or over, whose individual utilization of services is even more extensive, will increase from about 215,000 in 1980 to approximately 450,000 in the year 2000. These dramatic increases reflect the aging of the cohort of veterans of World War II (9.4 million) and the Korean conflict (5.0 million), who in 1988 comprised around 70% of all civilian males aged 60-64 (3,4).

The Department of Veterans Affairs has pioneered a unique continuum of treatment programs to meet the needs of the elderly and other veteran patients requiring long-term care. In addition to traditional acute and ambulatory care services, it provides a broad range of institutional and non-institutional long term programs for patients who do not require continuing hospital care but who are not able to live independently.

At the most intensive level of long term care, the Department of Veterans Affairs provides hospice care consisting of both inpatient and home care at ten V.A. medical centers. It provides nursing home care on any given day to approximately 32,000 patients through three sources: V.A. operated nursing homes, community contract nursing home care, and State Home nursing homes. As an alternative to nursing home care, the Department operates a program of adult day health care at fifteen medical centers and 55 contract centers. A hospital-based home care program at 73 medical centers provides an intensive level of home care delivered by an interdisciplinary team to approximately 4,313 patients on any given day. Approximately 20% of these patients are terminally ill and might otherwise be occupying hospital beds. Domiciliary (V.A. and State Home) and community residential care home programs provide medical care to approximately 21,100 veterans who no longer need hospital or nursing home care but are not able to live independently. The newest V.A. patient treatment modality is a respite care program designed to provide periodic relief for the caregivers of disabled veterans. This program is operated at 70 medical centers.

While this array of programs is impressive, they are not universally available at all V.A. medical centers. Furthermore, some of these programs are threatened by recent financial cutbacks made in response to budget shortfalls and deficits in the federal budget (vide infra); continued effort should be made to ensure their availability to all veterans in need of these services. They should be used as a model for communities seeking to develop alternatives to hospital care.

In addition to patient care activities described above, particular emphasis has been given to research on health care problems related to aging. Much of this research is conducted in ten Geriatric Research, Education and Clinical Centers (GRECCs) designed to foster teaching and research on aging in a clinical context. Resources are concentrated at each of these specialized centers to encourage advances in medical knowledge in geriatrics and gerontology and to translate advancements into the delivery of patient care. One of the major achievements of the program has been the development of geriatric evaluation units which provide intensive assessments by an interdisciplinary team to improve the problem identification, treatment, and placement of older patients who may have remediable impairments, multiple chronic disease, and interacting psychosocial problems. These activities could be enhanced with the establishment of additional sites and satellite centers to assist in the dissemination of services and knowledge. Indeed, Congress has expressed its desire to see such expansion, but funds have not been made available.

The training of health care professionals in the area of geriatrics/gerontology is a component of a variety of programs conducted at V.A. medical centers in collaboration with affiliated institutions. Work with elderly patients is an integral part of the clinical experience of the approximately 96,000 health trainees including 31,000 resident physicians and 42,000 nursing and associated health students who train in V.A. medical centers each year. Geriatrics training now is required in all internal medicine residency programs (5) and V.A. training can provide examples for other institutions working to implement this requirement. However, it is crucial that V.A. physician training place increased emphasis on ambulatory care. Residency Review Committee requirements for internal medicine now specify that at least 25 percent of the residents' time must be spent in ambulatory care settings (5). Funding and facilities for such training have been relatively deficient in V.A. programs, since the system traditionally had been hospital based and relatively bed-bound with a congressionally mandated requirement to maintain a fixed (approximately 90,000) bed component.

The Department of Veterans Affairs supports a major training program in geriatric medicine for physicians. This includes a two to three year program designed to develop a cadre of physicians who are committed to clinical excellence and to becoming leaders of local and national geriatric academic programs. A strong geriatrics fellowship program provides resources that also benefit residents and other staff, improving the environment for geriatrics education and clinical care throughout an institution. As of June 1988, 179 fellows had completed the program. About 90 percent of the graduates continue to practice geriatric medicine and about 40 percent remain in the V.A. system. With the establishment of examinations for certification of added qualifications in geriatrics, these special fellowship slots were converted to residency training positions in geriatrics comparable to other specialty training programs in the system. A similar program had been developed in geriatric dentistry. Twenty-five fellows have completed this program as of June 1988.

Other specific geriatric training includes: 1--an interdisciplinary team training program that provides a structured approach to the delivery of health services by emphasizing the knowledge and skills needed to work in an interactive, interdisciplinary group; 2--a masters level clinical nurse speciality program and a gerontological nurse fellowship program; 3--geriatric training for other allied health care professionals at V.A. medical centers and Geriatric Research, Education and Clinical Center sites.

Continuing education opportunities in geriatrics are also provided for V.A. health care personnel throughout the V.A. medical center system. These activities are made available through seven Regional Medical Educational Centers, eight Cooperative Health Education Programs, two Dental Education Centers, the Continuing Education Center, and ten Geriatric Research, Education and Clinical Centers. Together, these centers provided over 250 training activities in the area of geriatrics in Fiscal Year 1988.

These V.A. programs in patient care, research, and education in geriatrics present an impressive and comprehensive array of geriatric services unmatched by other health care systems in the nation. They can and should serve as a model for national health planning policy.

POSITION

2. The fundamental goal of the V.A. health care system must remain the delivery of high quality health care services to eligible veterans. The allocation of V.A. resources should continue to reflect priorities set by Congress for the treatment of veteran health care needs; funding must be adequate to meet these needs. The U.S. Office of Management and Budget and the Veterans Health Services and Research Administration are urged to ensure that federal budget requests accurately represent the fiscal needs of the V.A. health care system. Appropriate federal agencies also should investigate thoroughly any reports of budgetary shortfalls or warnings of quality-of-care problems within the system, and should help local V.A. health care units to devise and implement solutions when unmet needs exist.

RATIONALE

The Department of Veterans Affairs performs many functions including the provision of a wide range of health care services for eligible veterans. Because of the increasing number of elderly veterans, the Department has also assumed a major new role in geriatrics, as discussed above. However, the primary purpose of the V.A. health care system must still be to assure that eligible veterans of all ages receive needed health care services of high quality. V.A. policies should continue to be guided by this fundamental goal.

Within the Department of Veterans Affairs, a complex set of statutorily defined priorities exists for admission to ambulatory and domiciliary care facilities. As an example, Appendix 1 shows V.A. regulations for outpatient services. In general, highest priority for these services is given to treatment of veterans with service-connected disabilities. Medical services are provided by contract with other health care facilities for a qualifying spouse or child of a totally disabled or deceased veteran with a service-connected disability and for surviving dependents of those who died while on active duty.

Priorities for V.A. inpatient care have recently been redefined by Congress. Now service-connected veterans, nonservice-connected veterans who meet a "means" test, and other special groups are mandated eligibility for V.A. inpatient care as part of a first priority group (A). Other veterans with higher incomes (groups B and C) also have eligibility for V.A. inpatient care on a discretionary or space available basis and, in the case of group C, with a small copayment. *

During FY 1988, there were 1,130,720 discharges from V.A. medical centers and from other facilities where patients were treated under V.A. auspices. Approximately 94% of these patients were Category A, about 3% Category B, and 3% Category C. Only about 12% of patients were veterans receiving care for service-connected disabilities; another 24% were veterans with service-connected disabilities who required care for other illnesses. The remaining 64% were predominantly nonservice-connected (NSC) veterans with economic hardship.

These figures indicate that the Department of Veterans Affairs will need to continue to commit substantial resources for the care of nonservice-connected veterans, including long-term care for increasing numbers of dependent elderly veterans. As discussed earlier in this paper, the V.A. has pioneered several varieties of long-term care, and these programs require continued support in light of V.A. and national fiscal difficulties.

Under Public Law 99-272, Congress initiated a means test by which veterans 65 years of age and over no longer are eligible automatically for V.A. inpatient care regardless of financial need. If their illnesses are not service-connected, they are subject to the same income screening process as other veterans. In spite of this screening and the fact that most veterans 65 and over are eligible for Medicare benefits, a substantial portion of V.A. patients come from this older age group. A recent V.A. survey showed that, of those receiving acute in-hospital services, about 46% were 65 or over (6). One may expect the percentage of older patients, including nonservice-connected veterans, treated by the Veterans Health Services and Research Administration to rise with time.

Nonservice-connected veterans who depend upon the Department of Veterans Affairs for health care services are predominantly those who have low incomes, lack other insurance, and are geographically or otherwise isolated from other health care providers. For many veterans, the Department provides an essential alternative to accepting Medicaid. Many NSC veterans have made no provision to

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(* Note: As of January 1, 1989, the means test grants eligibility in group A for non-service connected veterans with annual incomes less than or equal to $16,466 (single) or $19,759 (married); group B eligibility covers those with incomes of $16,467-$21,954 (single) or $19,760-$27,443 (married); group C includes those with incomes of $21,955 or more (single) or $27,444 or more (married). The group C copayment is the amount ordinarily paid as a deductible under Medicare, currently $560 per year. In each category, the income limits are extended by $1,098 per year for each dependant. From: V.A. Medical Care Fact Sheet. Department of Veterans Affairs, Veterans Health Services and Research Administration; 1989.)

assure care from other sources. Unless the V.A. provides for these veterans, either other governmental programs will have to assume the burden for their care or many will be unable to obtain needed health care services. In addition, demographic changes alone will dictate that the Department of Veterans Affairs also devote extensive resources to long-term care services for these elderly veterans.

Because the V.A. requires no copayments or deductibles for NSC veteran applicants who meet means test criteria, it is reasonable to expect that as Medicare copayment requirements increase, more veterans will apply for V.A. care. Public perceptions of changes in the quality or accessibility of services under Medicare, including possible dissatisfaction with the diagnosis-related-groups (DRGs) payment system, could influence materially the degree to which veterans rely upon the Department. Cost containment pressures resulting in alteration of benefits by other third party payers, changes in employment with consequent changes in health insurance coverage, and changes in Medicaid coverage and eligibility requirements could have similar effects.

Institutional facilities operated or supported by the Veterans Health Services and Research Administration offer eligible veterans long-term care services that are generally in short supply outside the V.A. Non-institutional services too, such as ambulatory care, home health care, adult (geriatric) day care, and hospice care provided by the V.A. will become increasingly demanded, because these treatment modes also are rarely covered by other public programs or by private insurance. Even today, however, these V.A. services are not adequate to meet demand. Without proper planning to meet increased future needs, they certainly will become even less adequate.

Indeed, recent reports of local and national budgetary shortfalls and allegations of quality-of-care problems in the V.A. health care system highlight the importance of accurate needs projections in year-to-year planning. Although recently publicized complaints regarding declining quality of care within the system largely are anecdotal in nature, the VA's fiscal difficulties are a matter of record. Medical directors surveyed by Congress at each of the nation's 160 V.A. medical centers reported an average of more than $1 million in unfunded operating expenses per center in FY 1987 for a national total of more than $220 million (7). As of July 1988, DM&S projected a Fiscal Year 1989 national shortfall of $820 million (8).

The House Committee on Veterans' Affairs explains these fiscal difficulties to some extent by noting that, for several years, V.A. Central Office managers and medical center directors responded to increasing demands for care in the face of federal budget deficit-reduction directives by reprogramming funds from such accounts as equipment, minor construction and plant maintenance to cover payroll and other recurring expenses. Such diversion of funds, confirmed by the comprehensive survey of directors cited above, served as a temporarily effective stop-gap but also concealed the growing magnitude of the problem. Thus, each year's budget request calculation was based on a progressively eroded resource base, with the final figure increasingly understated (9). The 1989 annual independent budget prepared by the Veterans Service Organizations (VSOs) predicted the Department of Veterans Affairs would need $10.8 billion for the year, $400 million more than the total budget figure submitted by OMB and DMS (10), but the VSOs note that their own calculation does not correct for the above erosion (9).

In light of this continued diversion of funds intended for equipment, construction and maintenance, and considering the V.A.'s difficulties in recruiting and retaining qualified physicians and other health professionals (discussed in position 4, below), it is not hard to imagine that, in some instances, quality of health care in V.A. settings has suffered. Reported anecdotes include claims that facilities are in disrepair and understaffed, and outpatient appointments and hospital admissions are inordinately delayed. The American College of Physicians calls for more systematic collection of data on the effects of recent budgetary shortfalls on the quality of care in the V.A. system, and for increased attention to the evaluation of yearly fiscal needs for the Veterans Health Services and Research Administration to assure that high-quality care can be provided in a timely fashion to all veterans who are entitled to it. It is possible that continued budgetary shortfalls could lead to decay and dissolution of the system.

POSITION

3. Continuing national pressures to restrain health care costs mandate the most economical use of existing health care resources. This means that cooperation and sharing among V.A. and other health care providers should be promoted to improve the efficiency and effectiveness of health care delivery by the Department of Veterans Affairs, as well as its partners.

RATIONALE

It is a certainty that as the veteran population ages, health care needs and demands for services will increase. Consequently, V.A. facilities will serve patients with more complex problems requiring additional care, and using more staffing and resources. Not all elderly veterans entitled to V.A. coverage will require health care services, and not all of those requiring care will utilize the Department of Veterans Affairs. However, as discussed earlier, any reduction of coverage or benefits outside the V.A. system is likely to increase the proportion of eligible veterans who enter the V.A. system.

The Department of Veterans Affairs has long been aware of the impending increase in demand for services by elderly veterans and has sought to improve efficiency. Efforts have been made to increase coordination of V.A. services with other community resources. Emphasis has been given to outpatient care and to providing hospital-based home care, adult day health care, residential care, hospice care, and a variety of other support services. Current V.A. plans call for emphasizing V.A. extended care, particularly nursing home care, and outpatient services. Past and current V.A. medical care expenditures by type of care are illustrated in Table 2. The V.A. ambulatory and extended care strategy seeks to establish expanded non-institutional capacity that will enable it "to provide essential health and supportive services to eligible veterans of all ages, emphasizing a full array of health care services...to decrease the need for hospital treatment to the maximum extent consistent with high quality" (11,12).

Unfortunately, it is at best doubtful that this strategy is supported adequately by current V.A. budget allocations. For example, the Fiscal Year 1989 VSO Independent Budget Report points out that conversion of outmoded or underutilized V.A. inpatient facilities to nursing homes has fallen progressively behind schedule. The report also states that, according to V.A. management officials, provision of outpatient care to Category A veterans is being limited in the majority of V.A. medical centers by variable and financially-motivated interpretations of current eligibility rules (PL 99-272), under which most Category A veterans are entitled to such care if it will "obviate the need" for inpatient care. In some cases, this is translated into denial of non-emergency ambulatory care to indigent veterans with nonservice-connected illness, on the grounds that their current condition is not severe enough to require hospitalization. Such interpretations are driven by inadequate resources; case decisions frequently are made without reference to the clinical judgement of involved physicians (10). As discussed above, thorough investigation and reparation of such inadequacies should be a V.A. priority.

When services are not obtainable at its own local facilities, the Department of Veterans Affairs becomes a major purchaser of medical and surgical care furnished by non-V.A. providers. Federal law provides authority for the Department of Veterans Affairs to share, provide or purchase specialized medical resources with federal (for example, Department of Defense) and state health care institutions, and with local community hospitals. The program has grown steadily each year in both the scope of services provided and obtained. An end result of the broadening of the range of sharing opportunities has been the increased cost-effective delivery of high quality medical care to veterans and non-veterans alike. As medical care continues to become more complex and more costly, the interdependence of the Veterans Health Services and Research Administration with the rest of the health care system will intensify.

The Veterans Health Services and Research Administration maintains that medical resource sharing is a basic planning tenet of its strategic planning process. Medical District Initiated Program Planning (MEDIPP) requires each V.A. medical center to explore its potential role as a sharing partner in its community. Since 1978, the Department of Veterans Affairs in this capacity has provided more than $102 million in medical services and technologies to the non-federal sector, while purchasing in excess of $304 million in health care resources from non-V.A. entities. The specialized medical resources most often shared with community health care institutions are services in pathology, renal transplant, radiology, nuclear medicine and lithotripsy. Lithotripsy and magnetic resonance imaging, as the newest technologies, have emerged as the "big growth" items in the sharing arena since the inception of the Shared Procurement Program outlined in Public Law 99-166. The latter program urged the Department to purchase expensive, advanced medical technology as a joint venture with non-federal institutions.

The utilization of community health care resources is further encouraged through Public Law 89-785 which also provides authority to purchase the services of scarce medical personnel. The acquisition of services to be performed in V.A. facilities by personnel in certain medical disciplines accounted for $47.7 million in FY 1988, almost triple the $17 million expended in FY 1985 and significantly larger than FY 1986 expenditures ($23.6 million). While the two largest personnel service categories are radiology and anesthesiology, remarkable increases in the past three years have been noted for nursing, physical therapy, and cardiopulmonary perfusionist services.

The Department of Veterans Affairs is already a major user of services from the community, where such services are authorized, are not available in a V.A. facility, or are justified by a veteran's circumstances or considerations of cost-effectiveness. The V.A. paid for 94,000 patients to be treated in non-V.A. facilities in FY 1988, and for 1.8 million fee-basis visits to non-V.A. doctors. The V.A. purchases nursing home care for many more patients in community nursing homes than it treats in its own nursing homes. Long-term survey data from the National Center for Health Statistics have indicated that about 86% of all veterans customarily receive their health care from community sources, while about 14% receive care under V.A. auspices (13). Of this 14% some obtain their care from community providers, as mentioned above. Current legislation, however, requires the Department of Veterans Affairs in most instances to provide care in its own facilities to veterans without service-related injuries. Of those who utilize the V.A. care system, many have income, insurance, and family limitations that may help explain difficulties they may have had in obtaining care in non-VA systems. Also, about 29% of the minority of veterans who do use V.A. hospitals have psychiatric disorders for which community hospitals generally do not provide adequately. Finally, excess community beds often are not located in the areas of greatest veteran need for health care services or facilities.

POSITION

4. The strengths and weaknesses of each individual V.A. facility should be assessed in the light of the health care needs of veterans in a specified area, the availability and complementarity of services at other V.A. medical centers in the medical district, and the feasibility of using Department of Defense or community resources where V.A. facilities or services are unavailable. The management, planning, and resource allocation processes within the Veterans Health Services and Research Administration should be structured to allow the most efficient and flexible local approaches to health care delivery within available resources.

RATIONALE

At one time, the V.A. health care system was criticized as being hierarchical, centrally controlled, and poorly responsive to rapidly changing local needs. The federal budget process usually provided incentives to spend all that was budgeted before the close of each annual period, thus discouraging long range budgetary planning. Budgetary rigidity also prevented V.A. installations from making needed changes at the local level.

In an effort to address these deficiencies, the V.A. devised the Medical District Initiated Program Planning (MEDIPP) process to encourage needs assessment and planning initiated from the grass roots (V.A. medical center) level (14).

MEDIPP seeks to obtain input from, and provide information to, constituencies interested in health care planning concerning the Department of Veterans Affairs. In the MEDIPP context, the term constituency refers to individuals or

groups either internal (within the V.A.) or external (outside the V.A.). Examples of external constituencies are veterans served and their service organizations, members of Congress, other executive agencies, affiliated institutions, local chambers of commerce, hospital associations and health planning agencies. Examples of internal constituencies are those elements of the Department of Veterans Affairs that are not directly involved in the VHSRA MEDIPP process, such as the Secretary's Office, Office of Procurement and Supply, Office of Facilities, Inspector General, Veterans Benefits Administration and the National Cemetery System.

Planning initiatives are funneled up through district, region, and central office levels for review. The process has been more decentralized in recent years, with substantial review and decision functions devolving upon the regions and districts.

A development parallel to MEDIPP has been the implementation of resource allocation strategies and methods similar to those used under Medicare for reimbursement of medical care costs. The use of these strategies has provided substantial incentives for improved management and efficiency at individual VAMC's. Both MEDIPP and changes in resource allocation should encourage long-term planning rather than short term manipulation.

It should be noted that within the overarching set of federal laws and regulations (which affect the operations of all agencies), health care eligibility criteria, and an overall resource ceiling or specified resource pool, hospital directors have some autonomy in personnel matters as well as in how resources can be spent within their dollar ceiling. More flexibility for local management is eagerly sought and a commendable goal.

The Deparment of Veterans Affairs' ambulatory care system has been characterized by some as undersized and underfinanced (15). Attempts since 1976 to control ambulatory and hospital care costs reduced access to ambulatory care at V.A. hospitals and at some clinics. Access to long-term ambulatory care has been limited for many veterans without service-connected disabilities. These restrictions appear to run counter to the current intent of Congress and medical planners to minimize the need for more costly hospitalization.

Other bureaucratic impediments to cost-effective patterns of practice are said to have included resource-allocation policies that compensated medical centers and clinics more for having a patient return for a number of separate visits than for scheduling multiple appointments on the same day, restrictions on the size of ambulatory care staff based on inappropriate inpatient staffing ratios, slowness to modernize facilities, and administrative inertia that caused inordinate delays in obtaining proven technologies and equipment (e.g., scanners). Attempts by the Department of Veterans Affairs to address some of these problem areas include reimbursement of outpatient care based on a new system of counting clinic stops, continued development of better staffing standards for guidance purposes, the reorganization of V.A. facility planning, and the identification of an ambulatory care focus in the clinical affairs office component of the V.A. central office.

Although the Department of Veterans Affairs has made more progress in providing continuity of care than much of the rest of the health care system, its ability to assure such care for NSC veterans is seriously impeded by its imprecise and confusing eligibility requirements. As the veteran population continues to

age, the Department will need to expand its ability to perform functional assessments and case management for the coordination of a full range of community based services. Furthermore, because it deals almost exclusively with older males and cannot effectively provide care for spouses or other family members, the V.A. often fails to address community care or home care that would serve the needs of family units. This fragmented support by the Department often leads to suboptimal efforts on the part of other agencies in the community. At times even well-recognized cost efficient services such as "meals on wheels" may be withheld.

Another recognized weakness of the V.A. system has been its inability to adjust its pay practices adequately to reflect local job market differences and changing needs for health care professionals and administrators. Special pay provisions were established for the Department of Veterans Affairs to enable it to recruit and retain qualified physician staff. However, adjustments in V.A. physician salaries have not kept pace with compensation changes outside the V.A. system. Salary ceilings tied to politically sensitive Congressional salaries cause the Department difficulties in attracting and retaining senior level physicians and skilled specialists. Limitations on the applicability of special pay provisions deter physicians from entering top administrative positions. Civil Service rules and compensation policies have also caused difficulties for many V.A. facilities in filling nursing, therapist, and technical positions. Increased efforts are needed to make V.A. salaries parallel more closely local market conditions and to address support services, fringe benefits and other components of the working environment that permit a better degree of competitiveness in the job market.

Advocates for the Department of Veterans Affairs maintain that it has pioneered the delivery of high quality cost effective health care. They note that the private sector is only just beginning to face the challenge of providing services within budgetary restraints and could benefit from some of the methods used by the Department (e.g., greater use of triage and geriatric evaluation units). Conversely, examination and application of some of the recent cost containment strategies developed in the private sector have already led to improvement in the delivery of V.A. care.

An objective appraisal is needed for both V.A. and non-VA community facilities. Effective planning requires data on the strengths and weaknesses of each V.A. facility in conjunction with local and regional health care resources. Once needs and available resources are clearly identified, innovative and flexible approaches should be encouraged to utilize both community and DoD facilities to supplement V.A. care where appropriate.

Statutory provisions impeding local V.A. autonomy and hindering efficient management should be revised. Restrictions limiting use of V.A. facilities may need to be changed to encourage the Department, when capacity and resources permit, to share and cooperate to an even greater degree with community providers and to receive appropriate compensation for the use of V.A. facilities and services.

Efforts to restrain rising health care costs without impeding the delivery of services should encompass all aspects of health care, including the V.A. system. The recent surge of innovation and experimentation in both the private and public sectors should be examined for applicability to both V.A. and non-VA facilities.

POSITION

5. The Department of Veterans Affairs has emerged as an integral component of the national health professions educational and biomedical research enterprise. Therefore, when changes in national public health policy are contemplated, it is essential that the impact on these important V.A. functions be taken into account.

RATIONALE

The Department of Veterans Affairs plays a major role in the nation's health care education programs. As detailed in ACP's 1985 policy paper on "Financing Graduate Medical Education," training of physicians serves the public good and is worthy of continued public and private support (16). Nowhere has this become more clear than in the quality of care that has become available in V.A. hospitals since 1945. The Department has affiliations with over 1,000 health professions schools throughout the United States and Puerto Rico. Some 96,000 students and trainees received all or part of their supervised clinical and administrative experience in V.A. medical centers during 1988. Of these, 21,000 were medical students--nearly one-third of the nation's total undergraduate medical school enrollment and double the number similarly participating a decade before. In addition, 31,000 resident physicians (more than a third of the nation's total) participated in approximately 8,350 V.A. supported medical residency positions at 139 V.A. medical facilities affiliated with 103 medical schools.

The ability of the Department of Veterans Affairs to deliver high quality care depends to a large extent on its affiliation agreements with medical schools. A loss of affiliation agreements would jeopardize not only the Department's educational and research programs, but also would deprive the Department of its major guarantee of high quality care and seriously impair opportunities to recruit and retain the best professional personnel. It is essential that the V.A. maintain a balance of services, including ambulatory and in-patient care and alternatives to hospital care such as long-term and home care facilities, to provide these training opportunities.

Research activities of the Department of Veterans Affairs are extensive. Approximately $212 million was obligated for V.A. medical and prosthetic research in FY 1987, and $192 million for FY 1988. High priority areas of V.A. medical research include schizophrenia, alcoholism and other substance abuse, aging, spinal cord injury, delayed stress, and the long-term effects of nutritional and other health impairments of former prisoners-of-war. Research is also directed toward health problems prevalent among veterans, including cancer, diabetes, chronic heart disease, and chronic pulmonary disease. Particular emphasis is given to health care problems related to aging, and the Department of Veterans Affairs is acknowledged to be a major force in the field of geriatrics (vide supra). AIDS has now become an area of major interest. The V.A. also encourages studies that emphasize practical applications for medical care such as prosthetics and sensory aids to help the disabled. The support of health services research and of controlled clinical trials has yielded large gains in the cost effectiveness of medical care both within and outside the V.A. system. The Department also is to be commended for its

leadership in the development of cooperative clinical trials and this activity should receive continued support.

The capability of participating in a diverse spectrum of research activities is a strong recruitment and retention factor for health care personnel in the V.A. system. The extent and high value of V.A. programs in medical education and research have made the Department of Veterans Affairs an integral part of the nation's medical educational system. Major changes in the V.A. health care system would undoubtedly produce significant repercussions for academic medical centers. By the same token, changes in the medical education system (e.g., reduction of medical school class size or elimination of schools) would likewise affect the Department of Veterans Affairs. Therefore, proposals for significant change in V.A. health care should be evaluated prior to implementation to determine possible effects upon the national medical education enterprise and vice versa. If a significant change that would affect the educational system is decided upon, academic medical centers and training programs must be given adequate prior notice so they can develop plans to lessen any adverse impact of the change.

Changes in national policies affecting health care and/or the Department of Veterans Affairs must not be made in isolation. Development of new policies must include recognition of interrelationships among health care systems and the ramifications that policies directed at any one system will have upon the provision of medical care provided throughout the nation.

The American College of Physicians supports efforts aimed at streamlining and improving the delivery of V.A. medical services and stands ready to work with Congress, the Department of Veterans Affairs, veterans' organizations and others dedicated to the provision of optimal health care for our nation's veterans.

# # #

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APPENDIX 1

PRIORITIES FOR OUTPATIENT CARE AND SERVICE
DM&S CIRCULAR 10-86-71
JUNE 24, 1986

Outpatient Care and Services

1. The initial and continuing care of eligible patients in an outpatient status will be effectively managed according to priorities established in this attachment.

2. Those persons with emergent conditions requiring immediate medical attention will be provided emergency care without regard to priorities.

3. The initiation of care in an outpatient program or the continuation of care after its initiation will be based on a professional determination of the need for care, and the applicant or patient will be scheduled and/or seen according to the following priorities and in sequence indicated within these priorities.

PRIORITY I

a. Veterans requiring care for service-connected disabilities or for disabilities incurred in line of duty for which they were released or retired from the active military, naval or air service. (This category also includes Spanish-American War veterans requiring care for any disability).

b. Veterans receiving care for disabilities under 38 USC Chapter 351.

c. Veterans with a service-connected disability or disabilities rated at 50 percent or more.

d. Veterans with service-connected disabilities or retired for disabilities incurred in line of duty, requiring care for nonservice-connected disabilities (including any veteran requiring examination to determine the existence or rating of a service-connected disability).

(NOTE: Veterans needing medical services to continue in a rehabilitation program are categorized in either priority 1 (a), (c) or (d), as appropriate.)

PRIORITY II

Veterans who are former prisoners of war including former members of the armed forces of the governments of Czechoslovakia or Poland eligible for V.A. care under 38 CFR 17.55 who were POWs and/or veterans who are receiving care for conditions possibly related to exposure to Agent Orange, other hazardous substances or ionizing radiation.

PRIORITY III

Veterans in receipt of increased pension or special allowance based on the need for regular aid and attendance or by reason of being permanently housebound, or who, but for the receipt of retired pay, would be in receipt of such increased pension or special allowance, and veterans of the Mexican border period or World War I.

PRIORITY IV

a. Nonservice-connected veterans receiving V.A. pension requiring posthospital care (OPT-NSC).
b. Nonservice-connected veterans receiving V.A. pension requiring pre-bed care (OPT-PBC).
c. Nonservice-connected veterans receiving V.A. pension requiring care to obviate the need for hospitalization.

PRIORITY V

a. Veterans in receipt of vocational training under 38 USC Chapter 15.
b. Beneficiaries receiving authorized examinations for V.A. pension, dependency and indemnity compensation or examinations for insurance purposes.

PRIORITY VI

Other category A NSC veterans eligible for care without payment of deductible.

a. Requiring post hospital care (OPT-NSC).
b. Requiring pre-bed care.
c. Requiring care to obviate need for hospitalization.

Category B NSC veterans eligible for care without payment.

a. Requiring post hospital care (OPT-NSC).
b. Requiring pre-bed care.
c. Requiring care to obviate need for hospitalization.

PRIORITY VIII

Category C NSC veterans eligible after agreeing to pay deductible.

a. Requiring post hospital care (OPT-NSC).
b. Requiring pre-bed care.
c. Requiring care to obviate need for hospitalization.

PRIORITY IX

a. CHAMPVA beneficiaries receiving care at V.A. facilities.
b. Former members of the armed forces retired from the service on the basis of length of service who are to be provided outpatient care as beneficiaries of the armed forces.

PRIORITY X

a. Persons authorized examination or treatment under approved sharing agreements.

b. Beneficiaries from other Federal agencies, except as described in Priority IX (b).

c. Veterans of Nations allied with the United States in World War I or II receiving medical care under the authority of 38 CFR 17.45.

TABLE 1

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY
ANNUAL OPERATING STATISTICS - MEDICAL PROGRAMS
FY 1988, 1987 AND 1986

ITEM	FY 88	FY 87	FY 86
Facilities Operating At End Of Yr			
Medical Centers	172	172	172
Hospital Care	(172)	(172)	(172)
Outpatient Care	(172)	(172)	(172)
Nursing Home Care	119	117	117
Domiciliary Care	26	16	15
Independent or Satellite Clinics	60	56	56
Independent Domiciliary	1	1	1
Employment (Net Full-Time Equivalent)	202,178	202,651	202,890
Obligations (In Millions)	10,540	9,960	9,544
Medical Care	10,230	9,673	9,275
Research In Health Care	215	210	186
Medical Administration And Miscellaneous Operating Expenses	47	42	50
Other Medical Programs	48	35	33
Inpatients Treated	1,224,375	1,465,703	1,461,523
V.A. Facilities	1,130,283	1,371,757	1,364,918
Other Facilities	94,092	93,946*	96,605
Average Daily Inpatient Census	95,673	97,442	98,853
V.A. Facilities	69,516	71,346	73,189
Other Facilities	26,157	26,096	25,664
Outpatient Medical Visits (000)	23,232	21,890	20,188
V.A. Staff	21,473	20,093	18,458
Fee-Basis	1,759	1,797	1,730
Outpatient Prescriptions Dispensed (000)	51,138	52,219	50,818

Source: Veterans Administration, Department of Medicine and Surgery, Office of Resource Management, December 1988.

* FY 1987 figures include 255,094 one-day dialysis treatments. Beginning with FY 1988, this workload is excluded from inpatient data and included in outpatient data.

TABLE 2

V.A. MEDICAL CARE OBLIGATIONS FY 1977, FY 1987, AND FY 1988

(IN MILLIONS OF DOLLARS) 1/

TYPE OF CARE	ACTUAL OBLIGATIONS		
	FY 1977	FY 1987	FY 1988
V.A. Hospital	2,897	5,532	5,711
V.A.	2,838	5,367	5,517
Contract	54	162	190
State	5	3	4
Nursing Home	239	873	955
V.A.	144	493	535
Community	72	326	353
State	23	54	67
Domiciliary	82	123	140
V.A.	69	109	125
State	13	14	15
Outpatient	825	2,076	2,318
Other Costs 2/	335	1,069	1,106
TOTAL	4,376	9,673	10,230

1/ Figures may not add due to rounding.

2/ These costs include the costs of other medically related programs--medical care for dependents of service-disabled veterans, education and training, and miscellaneous administrative costs.