



Testimony

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VETERANS' HEALTH CARE

Challenges for the Future

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Veterans' Health Care: Challenges for the Future

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the future direction of the Department of Veterans Affairs (VA) health care system. The VA health care system, with a \$16.6 billion budget, includes both (1) a health benefits program for over 26 million veterans and (2) a health care delivery and financing program including 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries.

VA has a number of fundamental changes under way in how it operates its health care delivery and financing systems. In addition, it is seeking authority to (1) significantly expand eligibility for health care benefits and (2) both buy health care services from and sell health care services to the private sector.

In exploring the future direction of the veterans' health care system, we will focus on

- changes in the veteran population and demand for VA health care services;
- how well the current VA health care system, and other public and private health benefits programs, meet the health care needs of veterans;
- actions that could be taken using existing resources and legislative authority to address veterans' unmet health care needs and increase equity of access;
- how other countries have addressed the needs of an aging and declining veteran population; and
- approaches for preserving VA's direct delivery system, alternatives to preserving the direct delivery system, and combinations of both.

During the past several years, we have conducted a series of reviews focusing on the relationships between the VA health care system and other public and private health benefits programs and the effects changes in those programs could have on the future of the VA health care system. We have also conducted a series of reviews to identify ways to improve the efficiency and effectiveness of current VA programs. My comments this morning are based primarily on the results of these reviews.¹

In summary, significant changes are occurring in the types and volume of services provided under the VA health care system. The average daily workload in VA hospitals dropped about 56 percent during the last 25 years, and further decreases are likely, thereby threatening the continued

¹A list of related GAO testimonies and reports appears at the end of this testimony.

viability of VA hospitals. In contrast, demand for both outpatient and nursing home care increased steadily over the 25-year period.

Nine out of 10 veterans now have public or private health insurance that meets most of their basic acute care needs. Still, about 10 percent of the veteran population has neither public nor private insurance to help pay for basic health care services. Such veterans tend to rely on public hospitals and clinics, and on VA health care facilities, to meet their health care needs. These programs, however, are unable to meet the basic health care needs of all veterans who need them. A small group of veterans report that they have been unable to obtain needed hospital and outpatient services. Most of these veterans do not live near a VA hospital or outpatient clinic.

While the acute care needs of most veterans are met through public and private health care programs, veterans needing specialized services, such as treatment for spinal cord injuries, blindness, and war-related stress, are more likely to find private-sector providers unable to meet their needs. In addition, neither public nor private-sector programs provide extensive coverage of nursing home and other long-term care services needed by an increasingly aging veteran population.

There are a number of ways that VA could address the unmet needs of veterans using existing resources and legislative authority. For example, it could reduce the resources spent in providing care to higher-income veterans with no service-connected disabilities (discretionary care category veterans) in VA facilities and use those resources instead to purchase more care from private providers under the fee-basis program for veterans with service-connected disabilities who do not live near a VA facility. Such resources could also be retargeted into expanding the availability of specialized services. Similarly, VA could increase the equity of veterans' access to VA care by improving the way it allocates resources to facilities and the consistency of its coverage decisions.

While such actions would enable VA to more effectively meet veterans' health care needs in the short term, the declining hospital workload makes it imperative that more fundamental policy decisions about the future of the direct delivery system be considered. Australia, Canada, and the United Kingdom reacted to similar declining utilization of their veterans' hospitals by closing those hospitals and integrating veterans' health care into their overall health care systems. These countries were able to preserve and enhance veterans' health care benefits without preserving the direct delivery system. In contrast, Finland continues to operate a

direct delivery system but has essentially converted its hospitals into long-term care facilities.

Two approaches could be pursued to increase the workload of VA hospitals and prevent or delay their closure. First, actions could be taken to attract a larger market share of the veteran population to the VA system—only about 20 percent of veterans have ever used VA care. Attracting enough new users to maintain the workload of VA hospitals could, however, add significantly to the government's cost of operating the VA system unless new sources of revenues are identified. A second approach for maintaining VA hospital workload would be to authorize VA hospitals to treat dependents or other nonveterans on a reimbursable basis. Such an approach might also strengthen VA's medical education and research missions by bringing a wider range of patients into the VA system. On the down side, it might raise questions about the extent to which the government should compete with private-sector hospitals.

Converting VA hospitals to provide nursing home and other long-term care services might also help preserve the direct delivery system. With the expected eight-fold increase in the number of veterans 85 years of age and older, demand for VA-supported nursing home care is expected to increase dramatically over the next 15 years. While the cost of converting hospital beds to nursing home care is generally less expensive than building new nursing homes, the cost of operating VA nursing homes is higher than the cost of purchasing nursing home care from private-sector nursing homes. Establishing cost-sharing requirements patterned after those used by states in their veterans' homes could enable VA to serve more veterans within available resources.

Several approaches could also be considered that would reduce or eliminate VA's direct delivery system. These approaches include (1) creating or expanding an existing VA-operated health financing program to purchase care from private providers; (2) issuing vouchers to allow veterans to purchase private health insurance; and (3) including veterans under an existing health benefits program, such as Medicare, the Federal Employees Health Benefits Program, or TRICARE. Under VA's current restructuring efforts, facilities are being increasingly encouraged to contract with private providers to improve access to care and reduce health care costs.

Because these approaches would address the primary reasons many veterans give for not using VA care—limited accessibility and perceptions

of poor quality and customer service—they would be likely to generate significant new demand. They could, however, be structured to supplement, rather than duplicate, veterans' coverage under other health programs.

Background

The VA health care system was established in 1930, primarily to provide for the rehabilitation and continuing care of veterans injured during wartime service. VA developed its health care system as a direct delivery system with the government owning and operating its own health care facilities. It grew into the nation's largest direct delivery system.

Over the last 65 years, VA has seen a significant evolution in its missions. In the 1940s, a medical education mission was added to strengthen the quality of care in VA facilities and help train the nation's health care professionals. In the 1960s, VA's health care mission was expanded with the addition of a nursing home benefit. And, in the early 1980s, a military back-up mission was added.

The types of veterans served have also evolved. VA has gradually shifted from primarily providing treatment for service-connected disabilities incurred in wartime to increasingly focusing on the treatment of low-income veterans with medical conditions unrelated to military service. Similarly, the growth of private and public health benefits programs has given veterans additional health care options, placing VA facilities in direct competition with private-sector providers.

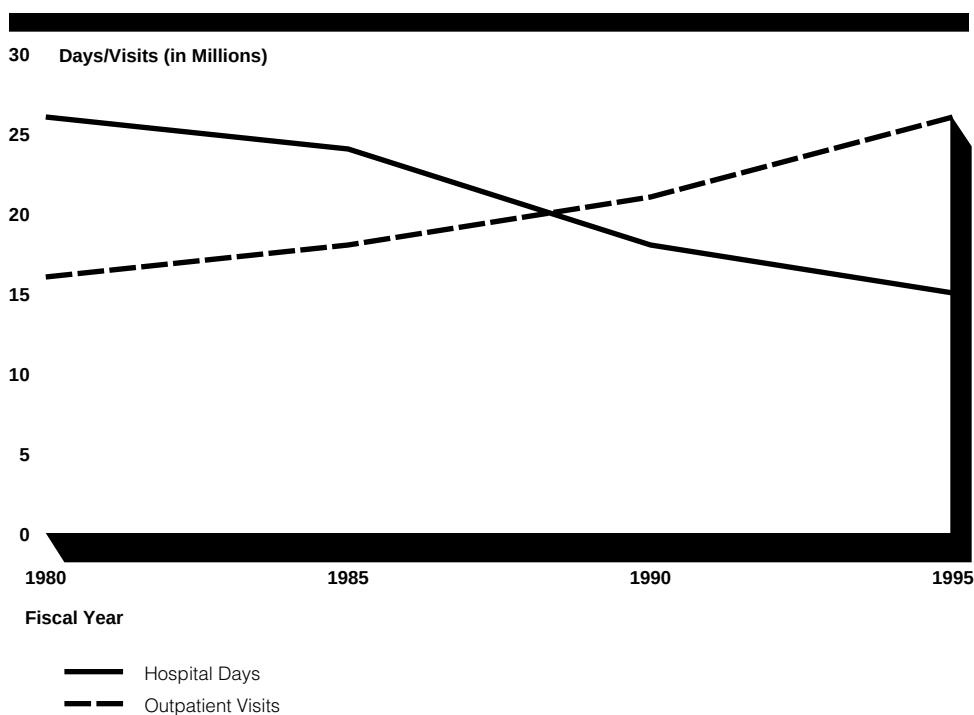
VA is in the midst of a major reorganization of its health care system. It has replaced its four large regions with 22 Veterans Integrated Service Networks (VISN), intended to shift the focus of the health care system from independent medical facilities to groups of facilities working together to provide efficient, accessible care to veterans in their service areas. The reorganization also includes plans to downsize the central office, strengthen accountability, and emphasize customer service. Under the reorganization, VA facilities are being encouraged to contract with private-sector providers when they can provide services of comparable or higher quality at a lower cost. VA sees the reorganization as creating "the model of a flagship health-care system for the future."

As the Veteran Population Declines and Ages, Demand for VA Services Is Shifting

The veteran population, which totaled about 26.4 million in 1995, is both declining and aging. VA has estimated that between 1990 and 2010, the total veteran population will decline 26 percent. The decline will be most notable among veterans under 65 years of age—from about 20 million to 11.5 million. In contrast, over the same period, the number of veterans aged 85 and older is expected to increase from 0.2 million to 1.3 million and will make up about 6 percent of the veteran population.

Coinciding with the declining and aging of the veteran population are shifts in the demand for VA health care services from inpatient hospital care to outpatient care. From 1980 to 1995, the days of hospital care provided fell from 26 million to 14.7 million, and the number of outpatient visits increased from 15.8 million to 26.5 million. (See fig. 1.)

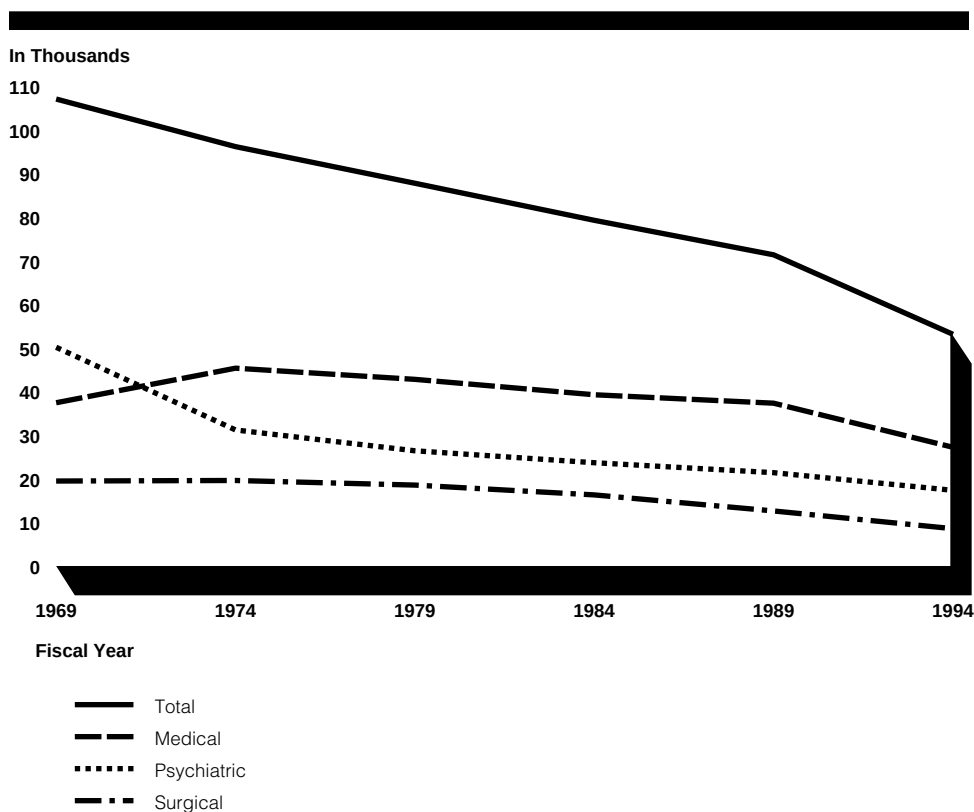
Figure 1: Changes in VA Facilities' Workload, Fiscal Year 1980-95



Over the same period, the average number of veterans receiving nursing home care in VA-owned facilities increased from 7,933 to 13,569, and VA's medical care budget authority grew from about \$5.8 billion to \$16.2 billion.²

Between 1969 and 1994, VA reduced its operating hospital beds by about 50 percent, closing or converting about 50,000 to other uses. The decline in psychiatric beds was most pronounced, from about 50,000 in 1969 to about 17,300 in 1994. (See fig. 2.) In fiscal year 1995, VA closed another 2,300 beds.

Figure 2: Operating Beds in VA Hospitals, 1969-94



Further Decline in Hospital Workload Likely

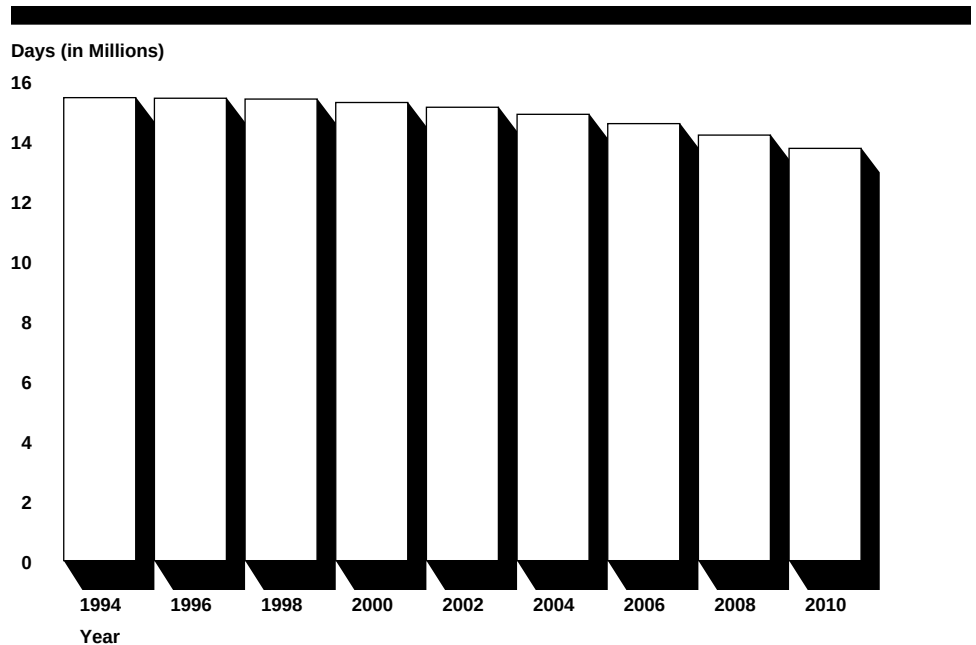
Several factors, such as the following, could lead to a continued decline in VA hospital workload.

²Not adjusted for inflation.

- Veterans who have health insurance are much less likely to use VA hospitals than veterans without public or private insurance, and the number of veterans with health insurance is expected to increase even without further national or state health reforms. This increase is expected because almost all veterans become eligible for Medicare when they turn 65 years of age, including those unemployed or employed in jobs that do not provide health insurance at the time they turn 65. Health reforms, such as those that have been debated in the past year, that would increase the portability of insurance and place limits on coverage exclusions for preexisting conditions would also increase the number of veterans with health insurance.
- The nature of insurance coverage is changing. For example, increased enrollment in health maintenance organizations (HMO)—from 9 million in 1982 to 50 million in 1994—is likely to reduce the use of VA hospitals. Veterans with fee-for-service public or private health insurance often face significant out-of-pocket expenses for hospital care and have a financial incentive to use VA hospitals because VA requires little or no cost-sharing. Veterans' financial incentives to seek hospital care from VA are largely eliminated when they join HMOs or other managed care plans because such plans require little or no cost-sharing. Proposals to expand Medicare beneficiaries' enrollment in managed care plans could thus further decrease the use of VA hospitals. On the other hand, health reforms that would create medical savings accounts could increase demand for VA hospital care because veterans might seek free care from VA rather than spend money out of their medical savings account to pay for needed services. Finally, increased cost-sharing under fee-for-service programs could encourage veterans to use the VA system.
- The declining veteran population will likely lead to significant reductions in use of VA hospitals even as the acute care needs of the surviving veterans increase. If veterans continue to use VA hospital care at the same rate that they did in 1994—that is, if VA continues services at current levels—days of care provided in VA hospitals should decline from 15.4 million in 1994 to about 13.7 million by 2010. (See fig. 3.) Our projections are adjusted to reflect the higher use of hospital care by older veterans.³

³The declining veteran population will lead to significant declines in VA acute hospitalization even as the acute care needs of the surviving veterans increase. The veteran population is estimated to decline from about 26.3 million in 1995 to just over 20 million in 2010. Although the health care needs of veterans increase as they age, the overall decline in the number of veterans will more than offset the increase and should lead to a further reduction in the number of days of VA hospital care. In addition, many veterans reduce their use of the VA system when they become Medicare-eligible.

Figure 3: Projected Age-Adjusted Days of VA Hospital Care, 1994-2010



Source: Based on VA annual reports, fiscal years 1980-94, and VA projections of the veteran population by age through 2010.

- Establishing preadmission certification requirements for admissions and days of care similar to those used by private health insurers could significantly reduce admissions to and days of care in VA hospitals. Currently, VA hospitals too often serve patients whose care could be more efficiently provided in alternative settings, such as outpatient clinics or nursing homes. Estimates of nonacute admissions to and days of care provided by VA hospitals often exceed 40 percent. Preadmission certification would likely reduce these admissions. VA is currently assessing the use of preadmission reviews systemwide as a method to encourage the most cost-effective, therapeutically appropriate care. The Veterans Health Administration is also implementing a performance measurement and monitoring system containing a number of measures that should reduce inappropriate hospital admissions. Several of these measures, such as setting expectations for the percentage of surgery done on an ambulatory basis at each facility and implementing network-based utilization review policies and programs, are intended to move the VA system towards efficient allocation and utilization of resources.

Eligibility and Clinic Expansions Contribute to Increase in Outpatient Workload

Between 1960, when outpatient treatment of nonservice-connected conditions was first authorized, and 1995, the number of outpatient visits provided by VA outpatient clinics increased from about 2 million to over 26 million. The increase in outpatient workload, due in part to changes in medical technology and practice that allow care previously provided only in an inpatient setting to be provided on an ambulatory basis, corresponds to expansions in VA eligibility and opening of new VA clinics.

In its fiscal year 1975 annual report, VA noted the relationship between “progressive extension of legislation expanding the availability of outpatient services” and increased outpatient workload.⁴ Among the eligibility expansions occurring between 1960 and 1975 were actions to authorize (1) pre- and posthospital care for treatment of nonservice-connected conditions (1960) and (2) outpatient treatment to obviate the need for hospitalization (1973). Workload at VA outpatient clinics increased from about 2 million to 12 million visits during the 15-year period.

Even with the expansions of outpatient eligibility that have occurred since 1960, most veterans are currently eligible only for hospital-related outpatient care. That is, they are eligible for those outpatient services needed to prepare them for, obviate the need for, or follow up on a hospital admission. Only about 500,000 veterans are eligible for comprehensive outpatient services. VA and others have proposed further expansions of VA outpatient eligibility that would make all veterans eligible for comprehensive outpatient services, subject to the availability of resources.

Just as eligibility expansions increased outpatient workload, VA efforts to improve the accessibility of VA care resulted in increased demand. Between 1980 and 1995, the number of VA outpatient clinics increased from 222 to 565, including numerous mobile clinics that bring outpatient care closer to veterans in rural areas. Between 1980 and 1995, outpatient visits provided by VA clinics increased from 15.8 million to 26.5 million.

⁴Veterans Administration, Annual Report of the Veterans Administration, Fiscal Year 1975 (Washington, D.C.: Veterans Administration, 1975).

VA has developed plans to further improve veterans' access to VA outpatient care through creation of access points.⁵ VA would like to establish additional access points by the end of 1996.

Aging Population Results in Increased Demand for Nursing Home Care

As the nation's large World War II and Korean War veteran populations age, their needs for nursing home and other long-term care services are increasing. Old age is often accompanied by the development of chronic health problems, such as heart disease, arthritis, and other ailments. These problems, important causes of disability among the elderly population, often result in the need for nursing home care or other long-term care services.

Between 1969 and 1994, the average daily workload of VA-supported nursing homes more than tripled (from 9,030 patients to 33,405). With the veteran population continuing to age rapidly, VA faces a significant challenge in trying to meet increasing demand for nursing home care. The number of veterans 85 years of age and older is expected to increase more than eight-fold between 1990 and 2010. Over 50 percent of those over 85 years old are expected to need nursing home care, compared with about 13 percent of those 65 to 69 years old.

Veterans More Likely to Have Unmet Needs for Specialized and Long-Term Care Services Than for Acute Care Services

Veterans are more likely to have unmet needs for specialized and long-term care services than they are for acute hospital and outpatient care. With the aging of the veteran population and prospects for insurance reform, veterans' unmet needs for acute care services are likely to decline in the future.

Most Veterans' Needs for Hospital and Outpatient Care Are Met

With the growth of public and private health benefits programs, more than 9 out of 10 veterans now have alternate health insurance coverage. Still, about 2.6 million veterans had neither public nor private health insurance in 1990 to help pay for needed health care items and services. Without a demonstrated ability to pay for care, individuals' access to health care is restricted, increasing their vulnerability to the consequences of poor

⁵VA defines an access point as a VA-operated, -funded, or -reimbursed private clinic, group practice, or single practitioner that is geographically separate from the parent facility. In general, access points provide primary care to all veterans and refer those needing specialized services or inpatient stays to VA hospitals. To date, nine hospitals have opened 12 new access points. Of the 12 new access points, VA staff operate 4 and contract with county or private clinics to operate the remaining 8.

health. Lacking insurance, people often postpone obtaining care until their conditions become more serious and require more costly medical services.

Most veterans who lack insurance coverage, however, are able to obtain needed hospital and outpatient care through public programs and VA. Still, VA's 1992 National Survey of Veterans estimated that about 159,000 veterans were unable to get needed hospital care in 1992 and about 288,000 were unable to obtain needed outpatient services. By far the most common reason veterans cited for not obtaining needed care was that they could not afford to pay for it.⁶

While the cost of care may have prevented the veterans from obtaining care from private-sector hospitals, it appears to be an unlikely reason for not seeking care from VA. All veterans are currently eligible for hospital care, and about 11 million are in the mandatory care category for free hospital care. Other veterans are required to make only nominal copayments.

Many of the problems veterans face in obtaining health care services appear to relate to distance from a VA facility rather than their eligibility to receive those services from VA. For example, our analysis of 1992 National Survey of Veterans data estimates that fewer than half of the 159,000 veterans who did not obtain needed hospital care lived within 25 miles of a VA hospital. By comparison, we estimate that over 90 percent lived within 25 miles of a private-sector hospital.

Of the estimated 288,000 veterans unable to obtain needed outpatient care during 1992, almost 70 percent lived within 5 miles of a non-VA doctor's office or outpatient facility. As was the case with veterans unable to obtain needed hospital care, those unable to obtain needed outpatient care generally indicated that they could not afford to obtain the needed care from private providers. Only 13 percent of the veterans unable to obtain needed outpatient services reported that they lived within 5 miles of a VA facility, where they could generally have received free care.

Distance from VA health care facilities plays a role both in the likelihood of using VA health care services and in the volume of services used. The likelihood of using both VA hospital and outpatient care declines significantly for veterans living more than 5 miles from a VA facility. For example, among veterans living within 5 miles of a VA outpatient clinic,

⁶About 55 percent cited inability to pay for care as the reason for not obtaining needed hospital care. Veterans cited a variety of other reasons, but none was cited by more than 10 percent of the veterans unable to obtain needed hospital care.

there were 131 users for every 1,000 veterans compared with fewer than 80 users per 1,000 veterans living at distances of over 5 miles from a VA outpatient clinic. Similarly, veteran users living within 5 miles of a VA outpatient clinic made over twice as many visits to VA outpatient clinics as veterans living over 25 miles from a VA clinic.⁷

Veterans Have Uneven Access to VA Services

Even those veterans living near VA facilities, however, can have unmet needs because of unequal access to care. Veterans' ability to obtain needed health care services from VA frequently depends on where they live and which VA facility they go to. VA spends resources providing services to high-income, insured veterans with no service-connected disabilities at some facilities, while low-income, uninsured veterans have needs that are not being met at other facilities.

Although considerable numbers of veterans have migrated to the western states, VA resources and facilities have shifted little. As a result, facilities in the eastern states are more likely to have adequate resources to treat all veterans seeking care than are facilities in western states, which frequently are forced to ration care to some or all higher-income veterans as well as to many veterans with lower incomes.

Medical centers' varying rationing practices also result in significant inconsistencies in veterans' access to care both among and within the centers. For example, as we reported in 1993, higher-income veterans without service-connected disabilities could receive care at 40 medical centers that did not ration care, while 22 other medical centers rationed care even to veterans with service-connected disabilities. Some centers that rationed care by either medical service or medical condition turned away lower-income veterans who needed certain types of services while caring for higher-income veterans who needed other types of services.⁸

Specialized Services Not Always Available

Veterans' needs for specialized services cannot always be met through other public or private-sector programs. Frequently, such services are either unavailable in the private sector or are not extensively covered under other public and private insurance. Space and resource limits in VA

⁷Veterans living greater distances from VA clinics may have a tendency to visit multiple clinics during their outpatient visits, at least partially offsetting the lower number of visits.

⁸VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

specialized treatment programs can result in unmet needs, as in the following examples:

- Specialized VA post-traumatic stress disorder programs are operating at or beyond capacity, and waiting lists exist, particularly for inpatient treatment. Although private insurance generally includes mental health benefits, private-sector providers generally lack the expertise in treating war-related stress that exists in the VA system.
- Inadequate numbers of beds are available in the VA system to care for homeless veterans. For example, VA had only 11 beds available in the San Francisco area to meet the needs of an estimated 2,000 to 3,300 homeless veterans.
- Public and private health insurance do not include extensive coverage of long-term psychiatric care. Veterans needing such services must therefore rely on state programs or the VA system to meet their needs.
- VA is a national leader both in research on and treatment and rehabilitation of people with spinal cord injuries. Similarly, it is a leader in programs to treat and rehabilitate the blind. Although such services are available in the private sector, the costs of such services can be catastrophic.

Veterans Have Unmet Needs for Long-Term Care Services

Finally, veterans frequently have unmet needs for nursing home and other long-term care services. Medicare and most private health insurance cover only short-term, post-acute nursing home and home health care. Although private long-term care insurance is a growing market, the high cost of policies places such coverage out of the reach of many veterans. As a result, most veterans must pay for long-term nursing home and home care services out of pocket until they spend down most of their income and assets and qualify for Medicaid assistance. After qualifying for Medicaid, they are required to apply almost all of their income toward the cost of their care.

Veterans able to obtain nursing home care through VA programs can avoid the spend-down and most of the cost-sharing required to obtain service through Medicaid. VA has long had a goal of meeting the nursing home needs of 16 percent of veterans needing such care. In fiscal year 1995, VA served an estimated 9 percent of veterans needing nursing home care.

Options for Retargeting Resources Toward Veterans' Health Care Needs

VA could use a number of approaches, within existing resources and legal authorities, to better target resources toward addressing the unmet health care needs of veterans. With limited resources, one approach would be to shift resources from providing services to one group of veterans to paying for expanded services for a different group of veterans. For example, resources spent in providing care for higher-income veterans without service-connected disabilities could be shifted toward improving services for veterans with service-connected disabilities and lower-income veterans whose health care needs are not being met. About 15 percent of the veterans with no service-connected disabilities who use VA medical centers have incomes that place them in the discretionary care category for both inpatient and outpatient care. Another approach could be to narrow the types of services provided—such as the provision of over-the-counter drugs—and use the resources spent on those services to pay for other higher-priority services.

Veterans' equity of access to VA health care services could be improved within existing legislative authority in the following ways:

- VA could better define the conditions under which the provision of outpatient care would obviate the need for hospitalization. Such action would help promote consistent application of eligibility restrictions, but VA physicians would still be placed in the difficult position of having to deny needed health care services to veterans when treatment of their conditions would not obviate the need for hospitalization. This problem can be addressed only through legislation to (1) make veterans eligible for the full range of outpatient services or (2) authorize VA to sell noncovered services to veterans.
- VA could reduce inconsistencies in veterans' access to care by better matching the resources of VISNs and individual medical centers with the volume and demographic makeup of eligible veterans requesting services at each center. In effect, VA would be shifting some resources from medical centers that have sufficient resources, and therefore, do not ration care. Such resource shifts could mean, for example, that some higher-income veterans at those medical centers might not obtain care in the future. But the shift would also mean that some veterans with lower incomes who had not received care at the other medical centers might receive care in the future.
- VA could place greater emphasis on use of the fee-basis program to equalize access for those veterans who do not live near a VA facility or who live near a facility offering limited services. VA has specific statutory authority to contract for medical care when its facilities cannot provide

necessary services because they are geographically inaccessible. While this approach would help some veterans, current law severely restricts the use of fee-basis care by veterans with no service-connected disabilities. Such veterans are eligible only for limited diagnostic services and follow-up care after hospitalization. VA's recent efforts to establish access points will improve accessibility for some veterans, but VA has not applied the outpatient priorities for care or the eligibility requirements for fee-basis care in enrolling patients and providing services. As a result, access points could divert funds that could be used to provide access to VA-supported care for high-priority veterans to pay for services for discretionary-care veterans. The concept of access points appears sound—to increase competition and therefore reduce costs of contract care. To be equitable, however, care provided through access points could be made subject to the same limitations that apply to fee-basis care for other veterans. Increased use of fee-basis care, either through fee-for-service contracting or capitation payments, is not, however, without risks. The capacity of VA's direct delivery system serves as a control over growth in VA appropriations. Without changes in the methods used to set VA appropriations, removing the restrictions on use of fee-basis care could create significant pressure to increase VA appropriations. In other words, the result might be expanding priorities for care covered under the fee-basis program to match the priorities currently covered at VA facilities rather than reordering priorities within available resources. This expansion of priorities could occur because VA's budget request does not provide information on the priority categories of veterans receiving care from VA.

- Finally, VA could ensure that its facilities use consistent methods to ration care when demand exceeds capacity.

Other Countries Integrated Their Veterans' Hospitals Into Their Health Care Systems or Shifted the Focus of Their Facilities

Faced with aging and declining veteran populations, Australia, Canada, and the United Kingdom closed or converted their veterans' hospitals to other uses. They preserved and enhanced veterans' health benefits without maintaining their direct delivery systems. For example, they supplemented services covered under other health programs or gave veterans higher priorities for care or better accommodations under those programs. Veterans' service organizations, originally skeptical about the changes, now generally support them.

In all three countries, falling utilization rates, coupled with (1) the need to treat the effects of an injury rather than the injury itself and (2) the increased chronic care needs of an aging population made maintaining

medical expertise increasingly difficult. For example, Australia's veterans' hospitals had trouble retaining skilled staff and maintaining affiliation with medical schools as their patient mix became increasingly geriatric.

The United Kingdom decided in 1953 that transferring its veterans' hospitals to the country's universal care system would both increase utilization of the former veterans' hospitals and allow them to preserve and further develop their specialized medical expertise by expanding their patient mix. Canada, in 1963, and Australia, in 1988, made similar decisions on the basis of continuing decline in acute care use of their veterans' hospitals and the ability and desire of veterans to obtain care in their communities.

What we learned from our examination of these countries' veterans' health care programs was that health reforms, either nationally or within the veterans' system, that allow veterans to choose between care in VA facilities or community facilities decrease demand for care in VA facilities. In other words, any change in our veterans' health care system—such as the establishment of access points or other contract providers—that gives veterans greater access to community providers will likely decrease demand for that type of care in existing VA facilities.

In contrast to Australia, Canada, and the United Kingdom, Finland continues to operate a direct delivery system. It, like Canada, however, shifted the emphasis of its veterans' health care system from acute to long-term care services to meet the changing needs of an aging veteran population. By 1993, it had converted almost half of the beds in its primary hospital to nursing home care. Both Canada and Finland also developed home care programs to help veterans maintain their independence as long as possible.

Approaches for Preserving and Alternatives to Preserving the Direct Delivery System

Most of VA's \$16.6 billion health care budget goes to maintain its direct delivery infrastructure. It is invested in buildings, staff, land, and equipment. As the Congress deliberates the future of veterans' health care, it will inevitably face the question of whether to act to preserve health care benefits or the direct delivery system or both, as envisioned under VA's planned reorganization.

Preserving Direct Delivery

Three basic approaches might be used, individually or in combination, to preserve the direct delivery system: build demand for hospital care by

Increase VA's Market Share of Veterans

increasing VA's market share of the veteran population; allow VA to use its excess hospital capacity to serve veterans' dependents and other nonveterans; and convert VA hospitals to other uses, such as meeting the increasing demands for VA-supported nursing home care.

One approach for preserving the direct delivery system would be for the VA system to increase its market share of the veteran population. About 80 percent of the veteran population has never used VA health care services. Bringing more of those veterans into the VA system could increase demand for VA hospital care.

Decreasing veterans' out-of-pocket costs does not appear to be a viable strategy for attracting new veteran users. All veterans are currently eligible for medically necessary VA hospital care without limits, about 9 to 11 million with no out-of-pocket costs. The remaining veterans would incur some cost-sharing if they sought care from VA facilities, but generally much less than they would incur in seeking care from private hospitals using their Medicare or private insurance.

Strategies that could be successful in attracting new users include the following:

- Improving customer service. Many veterans have negative perceptions of both VA customer service and quality of care. VA, as part of its response to the Vice President's National Performance Review, has developed plans to improve customer service, including establishing standards for such things as waiting times. Similarly, VA has improved its accreditation scores from the Joint Commission on Accreditation of Healthcare Organizations; its average score is now higher than that of private-sector hospitals. Finally, VA is improving the privacy and amenities in many of its hospitals. For example, bedside telephones are being installed in all hospitals, and the number of private and semiprivate rooms is being increased. As veterans' perceptions change, demand for care is likely to increase.
- Improving access to outpatient care. Improved access, either through establishment of additional direct delivery clinics or through contract care, could have the secondary effect of increasing demand for hospital care. VA hospitals could, over the next several years, open hundreds of access points and greatly expand market share. There are over 26 million veterans, and 550,000 private physicians could contract to provide care at VA expense. VA's growth potential appears to be limited only by the availability of resources and statutory authority, new veteran users' willingness to be referred to VA hospitals for specialty and inpatient care,

and other health care providers' willingness to contract with VA hospitals. This approach to filling VA hospital beds, however, would require significant budget increases if new access points modestly increase VA's market share of hospital and outpatient users. For example, VA currently serves about 2.6 million of our nation's 26 million veterans in a given year and 4 to 5 million veterans over a 3-year period. About 40 percent of the 5,000 veterans enrolled at VA's 12 new access points had not received VA care in the 3 years before they enrolled. Most of the new users we interviewed had learned about the access points through conversations with other veterans, friends, and relatives or from television, newspapers, and radio.

- Expanding eligibility. Expanding eligibility for outpatient care could also attract new users to the VA system. Although such users would be brought into the system through expanded outpatient eligibility, many of the new users would likely use VA hospitals for inpatient care. A 1992 VA eligibility reform task force estimated that making all veterans eligible for comprehensive VA health care services could triple demand for VA hospital care.

Expand Care for Nonveterans

A second approach for increasing the workload of VA hospitals would be to expand VA's authority to provide care to veterans' dependents or other nonveterans. Currently, VA has limited authority to treat nonveterans, primarily providing such services through sharing agreements with military facilities and VA's medical school affiliates.

Allowing VA facilities to treat more nonveterans could increase use of VA hospitals and broaden VA's patient mix, strengthening VA's medical education and research missions. Without better systems for determining the cost of care, however, such an approach could result in funds appropriated for veterans' health care being used to pay for care for nonveterans.

In addition, VA would be expanding the areas in which it is in direct competition with private-sector hospitals in the surrounding communities. Essentially, every nonveteran brought into a VA hospital is a patient taken away from a private-sector hospital. Thus, expanding the government's role in providing care to nonveterans could further jeopardize the fiscal viability of private-sector hospitals. In rural communities without a public or private hospital, however, opening VA hospitals to nonveterans might improve the availability of health care services for the entire community and, at the same time, help preserve the direct delivery system.

Convert VA Hospitals to Nursing Homes or Other Uses

A third approach to preserving the direct delivery system would be to convert VA hospitals to provide nursing home or other types of care. Although converting existing space to provide nursing home care is often cheaper than building a new facility, converting hospital beds to other uses would increase costs. Construction funds would be needed to pay for the conversions, and medical care funds would be needed to pay for the new nursing home users treated in what had been empty beds.

VA could, however, serve more veterans with available funds if it were authorized to (1) adopt the copayment practices used by state veterans' homes or (2) establish an estate recovery program patterned after those operated by increasing numbers of state Medicaid programs. Unlike Medicaid and most state veterans' homes, the VA nursing home program has no spend-down requirements and minimal cost-sharing. Only higher-income veterans with nonservice-connected disabilities contribute toward the cost of their care, making copayments that average \$12 a day.

Alternatives to Preserving the Acute Care Hospitals

Actions taken by Australia, Canada, and the United Kingdom suggest that veterans' benefits can be preserved and even enhanced without preserving the system's acute care hospitals. Alternatives to maintaining the current direct delivery system include (1) establishing a VA-operated health financing system to purchase care from other public and private providers (or expanding an existing program); (2) including veterans under an existing health benefits program, such as Medicare, the Federal Employees Health Benefits Program, or TRICARE; and (3) issuing vouchers to enable veterans to purchase private health insurance. Under any of these approaches, many existing VA facilities might be closed, converted to other uses, or transferred to the community.

Purchase Care From Public and Private Providers

VA already purchases health care services from public and private-sector providers in many ways. For example, it purchases services from its medical school affiliates and other government facilities through sharing agreements; it purchases care for eligible veterans geographically remote from VA facilities directly from private physicians through the fee-basis program; it contracts with groups of public or private-sector providers on a capitation basis to provide primary care services to veterans; and it operates a health financing program, the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), to purchase care for survivors and dependents of certain veterans.

Expanding or combining these programs into a single health financing program could increase VA's purchasing power in the health care marketplace, allowing it to purchase health care services at lower prices. For example, expansion of capitation funding could shift risks for controlling veterans' health care costs from the government to private providers contracting with VA. And increasing the use of private-sector providers within the VA health care system could retain the focus on veterans' health care needs that might be lost by merging veterans' health care with another program.

Include Veterans Under an Existing Program

On the other hand, additional economies would be likely to be achieved by merging the veterans' health program with one or more of the existing federal health programs. For example, Medicare has many years of experience in negotiating and monitoring contracts with managed care plans and fee-for-service providers to ensure that the interests of both beneficiaries and the government are protected. Although the Health Care Financing Administration continues to face problems in identifying and eliminating fraud and abuse, it nonetheless has more experience than VA in wide-scale contracting.

Similarly, the Department of Defense (DOD) is in the midst of implementing its TRICARE system nationwide. TRICARE, a managed health care program, offers military beneficiaries alternatives to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), a fee-for-service program. TRICARE offers beneficiaries eligible for CHAMPUS two new options for health care in addition to the CHAMPUS program. The options vary in the amount of choice beneficiaries have in selecting their physicians and the amount beneficiaries are required to contribute toward the cost of their care received from civilian providers.

- TRICARE Standard, or the current fee-for-service CHAMPUS program, gives beneficiaries the greatest freedom in selecting civilian providers but requires the highest beneficiary cost-sharing.
- TRICARE Extra is a preferred provider option through which beneficiaries receive a 5-percent discount on the TRICARE Standard cost of care when they choose a medical provider from the contractor's network.
- TRICARE Prime is an HMO-like alternative that provides comprehensive medical care to beneficiaries through an integrated network of military and contracted civilian providers. Beneficiaries selecting this option must enroll annually in the program, agreeing to go through an assigned military or civilian primary care physician for all care. Low enrollment fees and

copayment features provide financial incentives for beneficiaries to select this option, the most highly managed of the three options.

Under an agreement between VA and DOD, VA facilities can apply to become providers under TRICARE Prime. To date, no VA facilities are participating in TRICARE other than as fee-for-service providers. In many respects, VA's restructuring efforts parallel DOD's efforts in establishing TRICARE. Expanding TRICARE to include veterans' health benefits and VA facilities and physicians might further expand health care accessibility and options for beneficiaries of both programs.

Finally, veterans could be allowed to enroll in the Federal Employees Health Benefits program, which provides federal employees and annuitants and their dependents a choice of private health insurance programs, including traditional fee-for-service plans, preferred provider plans, and HMOs. Enrollment costs and cost-sharing vary widely, depending on the plan selected.

Issue Vouchers to Buy Private Insurance

Of the various health care options, offering veterans vouchers to use in purchasing health care services would give veterans the maximum choice. Acting individually to purchase care or insurance, veterans would probably be unable to obtain the same prices on health care services and policies that they could obtain through the volume purchasing advantages of the federal health care programs. For example, individual health insurance policies are generally much more expensive than comparable coverage obtained through a group policy such as those available under the Federal Employees Health Benefits Program.

Any of the options for increasing the use of private-sector providers would address the primary reasons many veterans give for not using VA care: perceptions of poor quality and customer service and limited accessibility. As a result, these options would be likely to generate new demand. Such new demand could be expected to create upward pressure on VA appropriations unless actions were taken under current budget rules to offset new costs. The new options could, however, be structured to supplement, rather than duplicate, veterans' coverage under other health programs. For example, eligibility for veterans with nonservice-connected disabilities might be limited to those without other public or private insurance. Benefits for other veterans might be limited to services not typically well covered under other public and private insurance, such as dental and vision care and long-term care services.

Conclusions

The VA health care system is at a crossroads—particularly in view of the dramatic changes occurring throughout the nation's health care system. These changes raise many important questions concerning the system.

- Should VA hospitals be opened to veterans' dependents or other nonveterans as a way of preserving the system?
- Should veterans be given additional incentives to use VA facilities?
- Should some of VA's acute care hospitals be closed, converted to other uses, or transferred to states or local communities?
- Should additional VA hospitals be constructed when use of existing inpatient hospital capacity is declining both in VA and in the private sector?
- Should VA remain primarily a direct provider of veterans' health care?
- Should VA become primarily a purchaser of health care from other providers for veterans?

Decisions regarding these and other questions will have far-reaching effects on veterans, taxpayers, and private providers. We believe that attention is needed to position VA to ensure that veterans receive high-quality health care in the most cost-efficient manner, regardless of whether that care is provided through VA facilities or through arrangements with private-sector providers.

The declining veteran population in the United States, in concert with the increased availability of community-based care, makes preserving the current acute care workload of existing VA health care facilities exceedingly difficult. VA will have to attract an ever-increasing proportion of the veteran population if it is to keep its acute care facilities open. Other countries have successfully made the transition from direct providers to financiers of veterans' health care without losing the special status of veterans.

The cost of maintaining VA's direct delivery infrastructure limits VA's ability to ensure similarly situated veterans equal access to VA health care, and funds that could be used to expand the use of fee-basis care are used instead to pay for care provided to veterans in the discretionary care category at VA hospitals and outpatient clinics.

Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions that you or other Members of the Subcommittee may have.

Contributors

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Related GAO Products

VA Health Care: Efforts to Improve Veterans' Access to Primary Care Services (GAO/T-HEHS-96-134, Apr. 24, 1996).

VA Health Care: Approaches for Developing Budget-Neutral Eligibility Reform (GAO/T-HEHS-96-107, Mar. 20, 1996).

VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs (GAO/T-HEHS-96-99, Mar. 8, 1996).

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