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the roller-coaster image of the VA

Only a few years ago, the Veterans Health Administration (VHA)—the portion of the U.S. Department of Veterans Affairs (VA) devoted to the delivery of health services, as opposed to the Veterans Benefits Administration, which focuses on the administration of pension and disability benefits—was cited as the poster child of what both government and private health care could become.^a

The VA was viewed as providing low-cost, forward-thinking health care; its innovations included the early adoption of patient safety measures such as bar-coding for prescription drugs and the adoption of an electronic health record system known as VistA. To some extent, favorable opinions of the VA may have been exaggerated: Some of the VA's most ardent supporters compared the VA's statistics with all of American health care rather than the care provided by other integrated health systems, and there were concerns about potential access problems, especially relating to scheduling issues. Furthermore, variations in care have existed within the VA for some time. Even so, the VA generally was believed to provide excellent care, at least in the best of its hospitals.

The Image Shattered

The reports of waiting lists, double sets of books, secret lists of unseen veterans, and veterans possibly even dying while waiting to be seen started leaking out late last year. As a result of several audits that have been released over the past few months, it is clear that there was a substantial amount of truth in the charges that were being raised.

a. See, for example, Longman, P., *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone*, Third Edition, San Francisco: Berrett-Koehler Publishers, Inc., March 2012.

The Government Accounting Office (GAO) performed an audit of 23 clinics at four VA medical centers, chosen to reflect the range of variation in size, complexity, and location of VA sites. In a report released in mid-March, the GAO concluded that appointment times reported by the VHA were unreliable and ambiguous. It also found inconsistent implementation and oversight of the VHA's scheduling policy.

In June, results of an audit ordered by the White House indicated that more than 57,000 veterans had been waiting for initial appointments at VA hospitals and clinics for more than 90 days after requesting them. This audit examined experiences of veterans at 731 VA hospitals and large clinics. Such wait times obviously are substantially in excess of the VA's goal of seeing first-time patients within 14 days. Although 57,000 is a significant number, the fact that about 6 million appointments were scheduled as of mid-May provides some context regarding the scale of the VA operations.

A disturbing finding of the White House audit was that 13 percent of the schedulers reported that supervisors had told them to falsify waiting times to make them appear shorter than they were. A partial audit released at the end of May also found that 64 percent of the VA facilities had widespread tampering with the scheduling of appointments.

In addition to the delays and scheduling "irregularities," VA internal records showed wide variances in quality and treatment results. This finding should not come as a surprise and has been widely discussed among analysts familiar with VA data for years, but it was made public by *The Wall Street Journal* for the first time in early

June.^b For example, the now-infamous Phoenix VA, where delays and deaths attributed to neglect had been first reported, has a rate of (potentially fatal) bloodstream infections from IVs that is 11 times higher than the top-ranked VA hospitals. It also had a 32 percent higher mortality rate within 30 days of discharge than better-ranked VA hospitals. The need for more-uniform outcomes is not limited to the VA, but because the VA is more of a system than much of American health care, it should be more capable of achieving higher rates of comparability than U.S. healthcare providers that are not part of such a sophisticated system.

Is the System Underfunded?

Although the lack of sufficient funding is always the easiest excuse for why “bad things happen,” not everyone agrees that underfunding is the primary problem. It is true that, because of the wars in Iraq and Afghanistan, the past 10 to 12 years have seen a profound increase in the numbers of severely wounded veterans returning home compared with previous years. But the increase in funding of the VA also has been substantial.

Congress has provided all funding that the secretary of veterans affairs has requested during the current administration. The VA also was provided with its annual funding for health care a year in advance to ensure that it would not run out of money in the face of continuing resolutions or other budgetary problems that Congress has had difficulty resolving. This advance allowed the VA to function without disruption during the government shutdown.

Others have challenged the notion that funding is adequate and have called for more money to be made available, especially to hire and retain additional physicians and other mental health specialists.

Aside from the funding issue, there is widespread agreement that the VA needs to adopt a modernized scheduling system and undergo a culture change, given that VA leaders condoned falsifying

records to meet unachievable standards instead of advocating working to change the standards or reporting that the standards were impossible to meet with current systems in place.

Attempting a Bipartisan Solution

Senators Bernie Sanders (I-Vt.) and John McCain (R-Ariz.) reached agreement in early June on a bill that should quickly pass the Senate. The bill would allow veterans on a wait list or living far from a VA facility to seek private care, and it would lease medical centers to reduce backlogs, provide an additional \$500 million to attract and retain physicians, offer in-state tuition to public universities for veterans (or spouses of deceased veterans), increase the secretary’s power to fire poorly performing employees (with appeal rights), and create an independent commission on scheduling and healthcare services.

It is unclear whether the measure will get through the House as easily as it is expected to clear the Senate because the speaker’s office has already signaled the House that members will need to review the measure’s cost.

In the near term, it will be important to take steps to fix the VA’s widely publicized problems. There is strong bipartisan sentiment that we owe our returning and existing veterans at least that much. Whether the VA is likely to remain an important American institution indefinitely is less clear. Most countries that have achieved universal or near-universal coverage do not have separate institutions to treat their veterans. Over time, the United States may also find that it makes the most sense to limit the VA’s responsibility to caring only for those conditions that require complex intervention and are directly related to war injuries and to allow the private sector to take on veterans’ other medical care needs. ●

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