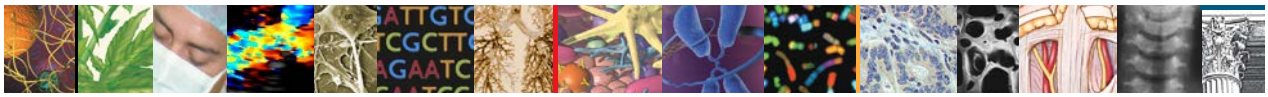

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Perspective

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A VA Exit Strategy

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Having been caught gaming its own performance-management system, the Veterans Health Administration (VHA) has been under fire. Although removing some people from key leadership positions has a strong symbolic effect, its impact may be short-lived: the VHA has a long history of surviving scandals. Criticized for poor quality of care in the 1980s, the agency admirably improved processes and care management. Yet problems of capacity and access to care represent a more fundamental, structural challenge.

Some recent commentators have suggested that the current scandal offers yet another opportunity to reform the VHA system. But the conclusion that adequate reform would entail making minor modifications to the VHA services that are currently provided is uninspiring. Perhaps now is the time for more sweeping reform of the VHA — reform designed with an eye toward recent trends, future projections, and a desire to improve veterans' access to high-quality health care.

The VHA finds itself in an unenviable position: it incurs the high fixed costs of a brick-and-mortar health care system, the largest salaried workforce in the federal government, and a large administration. To increase efficient use of these fixed-cost assets by spreading their costs across a larger base, the VHA has sought to increase enrollment among veterans. This effort has been successful and generated increased demand — about two thirds of enrollees actually use VHA services — which has led to calls for expanding and building more facilities. But the effort also resulted in the provision of services to more nonveterans, as well as in fast-growing medical appropriations that outstrip enrollment trends (see table).

The recent enrollment gains, however, are unlikely to continue, for three reasons. First, the veteran population is rapidly decreasing and is projected to drop by one third in the next 25 years (www.va.gov/vetdata/Veteran_Population.asp). Second, the vast majority of veterans already have access to health care: nearly 90% of veterans younger than 65 years of age have health insurance,[1] and 77% of VHA enrollees have some type of health insurance in addition to their VHA benefits, according to a 2011 VHA survey. Finally, these dually insured, enrolled veterans are not very dependent on VHA care, their VHA care appears to lack coordination with care obtained from other health care

U.S. Veteran Population, Patients Receiving Care through the VHA, and Annual Costs, 2001–2013.*

Fiscal Year	Veteran Population			Patients Receiving Care through the VHA				VHA Medical Appropriations	Annual Costs ($)	
	Total	No. Enrolled in VHA	% Enrolled in VHA	No. of Veterans	No. of Nonveterans	Total	% of Total Who Are Veterans	Billions of $	Per Patient Treated in the VHA	Per VHA Enrollee
2001	26,092,046	5,124,168	20	3,890,871	356,333	4,247,204	92	19.327	4,550.52	3,771.73
2002	25,627,596	6,248,949	24	4,290,717	380,320	4,671,037	92	21.316	4,563.44	3,411.13
2003	25,217,342	7,186,643	28	4,544,430	417,023	4,961,453	92	23.003	4,636.34	3,200.80
2004	24,862,857	7,419,851	30	4,713,583	453,250	5,166,833	91	25.647	4,963.78	3,456.54
2005	24,521,247	7,655,562	31	4,862,992	445,322	5,308,314	92	28.246	5,321.09	3,689.61
2006	24,179,183	7,872,438	33	5,030,582	435,488	5,466,070	92	30.291	5,541.64	3,847.73
2007	23,816,018	7,833,445	33	5,015,689	463,240	5,478,929	92	31.909	5,823.95	4,073.43
2008	23,442,489	7,834,763	33	5,078,269	498,420	5,576,689	91	34.025	6,101.29	4,342.82
2009	23,066,965	8,048,560	35	5,221,583	523,110	5,744,693	91	38.282	6,663.89	4,756.38
2010	23,031,892	8,343,117	36	5,441,059	559,051	6,000,110	91	42.955	7,159.04	5,148.56
2011	22,676,149	8,574,198	38	5,582,171	584,020	6,166,191	91	47.280	7,667.62	5,514.22
2012	22,328,279	8,762,548	39	5,680,374	652,717	6,333,091	90	50.575	7,985.83	5,771.72
2013	21,972,964	8,926,546	41	5,803,890	680,774	6,484,664	90	51.880	8,000.41	5,811.88
Compound annual growth rate (%)	–1.42	4.73		3.39	5.54	3.59		8.58	4.81	3.67

* Data on veteran population and enrollees are from the Congressional Research Service (http://fas.org/sgp/crs/misc/R43579.pdf); data on annual expenditures are from the Centers for Disease Control and Prevention (www.cdc.gov/nchs/hus.htm).

systems, and the VHA care they receive does not appear to be very efficient.[2] Newer federal programs — such as Medicare Part D, Medicaid expansions, and the insurance exchanges created under the Affordable Care Act (ACA) — offer veterans new care options and might further reduce reliance on the VHA. Fundamentally, the dual system is duplicative and inefficient.

The United States is a big country. Veterans are widely dispersed across it and have many other options for getting care through a variety of funding mechanisms; therefore, each VHA hospital is used by relatively few veterans and may have inadequate numbers of patients to safely perform, for instance, high-risk surgical interventions.[3] Although centralization of some services might make sense, it seems that such "national" centers are quite inconvenient for most potential patients and therefore provide specialty services primarily to nearby residents.[4]

Recent legislation proposes a two-part effort to improve access to care for veterans, by expanding the VHA workforce and access points and by encouraging the use of private-sector care for veterans who live at a distance from VHA facilities. The first part — adding more physicians or hospitals in an attempt to reduce VHA wait lists — will be very expensive and will not resolve these fundamental issues. The bigger and more important question is whether the United States really needs a separate, increasingly expensive, brick-and-mortar health care system for a relatively small and rapidly shrinking population. The second effort can be used to answer a more foundational question: Might vet-

erans and taxpayers be better served if true reform — designed to prepare the VHA for a thriving future while better serving veterans — were undertaken?

Such a reform might begin on three fronts. First, the VHA could transition out of the health care delivery business. Initial efforts could focus on high-cost inpatient care, for which economies of scale can be achieved and there is ample, high-quality capacity in the private sector at Medicare rates.[3] In the short run, the VHA might continue providing the type of care that its service population wants from it — for instance, primary care[1] — or care in which it has special expertise, such as mental health or rehabilitation services. Perhaps, in order to increase its denominator and generate a new revenue stream while shedding expensive hospital assets, the VHA could consider providing outpatient services in these areas of medicine to nonveterans, paid for by other insurance providers.

Second, the VHA could leverage the competencies of the Veterans Benefits Administration (VBA) and support utilization of private-sector health care by subsidizing premiums, deductibles, and copayments for enrolled veterans. Such a move would reduce costs to taxpayers ($6,000 a year would buy a lot of copayments and deductibles in Medicare, Obamacare, and private insurance), reduce veterans' out-of-pocket costs, and massively expand access to care for veterans without concurrently increasing fixed-cost obligations. Such efforts might also reduce duplication of payment for services within the federal government, potentially saving taxpayers billions of dollars.[5]

An audio interview with Dr. Weeks is available at NEJM.org

Finally, the VHA could take on the task of care coordination for its service population. Using its strong research enterprise in health services, the VHA could work with the VBA to identify the best local health care systems and ensure that the VHA's service population is directed to the highest-quality local care providers. Using benefits-design methods suggested by behavioral economics to encourage veterans to use these non-VHA providers would preserve veterans' choice, reduce health care expenditures, and most important, save veterans' lives by shifting them to hospitals with lower mortality rates.[3]

Clearly, there are obstacles to implementing such a plan. First, laws would need to be passed to allow for payment of deductibles, copayments, or premiums, particularly for other federal programs such as Medicare. Nonetheless, financial and care coordination across federal institutions might make sense to taxpayers. Second, VHA personnel might not be enamored of the proposal. Jobs and turf would be redirected to the private sector, which might raise concerns among policymakers who worry about the softness of the current economic recovery. Finally, it is not clear how veterans might respond if their benefits packages and access were changed in these ways; they would have to decide whether it was worth it to trade a visible, dedicated, brick-and-mortar system for enhanced access to the private system used by most of the population, and they would have to determine whether they trusted politicians to maintain access to that system. Undoubtedly, a pilot test of these reforms would be warranted before widespread implementation.

The VHA's current crisis provides an opportunity to dramatically rethink the role that the agency plays in improving access to high-quality, high-value care for its service population. To simply go on doing more of the same is to fail to recognize the challenge that the VHA's cost and population structure pose in the longer run. Just as they plan for new roles for the federal government as part of an exit strategy from a war that is winding down, politicians with longer-term views might envision a new way for the VHA to work with other federal departments and the private sector to reduce its overall and per capita costs, shed costly and unproductive assets, save taxpayers money, reduce veterans' health care expenditures, and improve veterans' outcomes.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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1. Kramarow EA, Pastor PN. The health of male veterans and nonveterans aged 25–64: United States, 2007–2010. National Center for Health Statistics data brief no. 101. August 2012 (http://www.cdc.gov/nchs/data/databriefs/db101.pdf).
2. Auerbach DI, Weeks WB, Brantley I. Health care spending and efficiency in the US Department of Veterans Affairs. Santa Monica, CA: RAND, 2013 (http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf).
3. Weeks WB, West AN, Wallace AE, et al. Reducing avoidable deaths among veterans: directing private-sector surgical care to high-performance hospitals. Am J Public Health 2007;97:2186-92.
4. Weeks WB, West AN. Where do Veterans Health Administration patients obtain heart, liver, and kidney transplants? Mil Med 2007;172:1154-9.
5. Trivedi AN, Grebla RC, Jiang L, Yoon J, Mor V, Kizer KW. Duplicate federal payments for dual enrollees in Medicare Advantage plans and the Veterans Affairs health care system. JAMA 2012;308:67-72.

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