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CARE OF THE ELDER VETERAN: NEW DIRECTIONS FOR CHANGE

by Mark Schlesinger and Terrie Wetle

Prologue: The medical care system that serves the nation’s military veterans occupies a unique place in American society. Publicly financed and centrally administered by the Veterans Administration (VA), the system is designed to fulfill what society has determined is its obligation to, as Abraham Lincoln declared so eloquently a century ago, “care for him who shall have borne the battle and for his widow, and his orphan.” The VA is a vast federal agency—the third largest with an annual budget nearing $30 billion—and it enjoys broad support in Congress. Increasingly, though, because of its size, the aging of its constituency, the federal government’s budget-cutting exercise and questions about its appropriate future role, the VA has come under sharper scrutiny. A variety of reforms of the VA’s medical care system have been proposed, such as tightening its eligibility requirements, establishing a voucher system that would entitle veterans to care in the private sector, and narrowing the VA’s focus. Most proposed reforms have run into a stonewall of opposition from VA’s vaunted lobby and the reformers stymied. Nevertheless, the pressures that suggest some future changes will be necessary remain. In this essay, authors Mark Schlesinger and Terrie Wetle advance a different proposal for reform which, they say, is more in accord with the VA’s capacity and political reality. The proposal seeks to draw upon the strengths of the current VA medical care system and encourage a more active collaboration with other public and private systems of care. Schlesinger and Wetle both reside at Harvard University; Schlesinger is at the John F. Kennedy School of Government, and Wetle is assistant professor at the medical school. They have been working closely with a variety of members of Congress on VA reform. Schlesinger holds a doctorate in economics from the University of Wisconsin and is research coordinator for the Center for Health Policy and Management at the Kennedy School. Wetle holds a doctorate in urban studies from Portland State University and is assistant director of the Division on Aging at Harvard Medical School.
With an aging veteran population, the Veterans Administration (VA) health care system faces unprecedented challenges. As the World War II cohort reaches older age, the number of veterans over the age of sixty-five will almost double by 1990 and will increase another 2.5 percent by the year 2000. This will increase health care use and create pressures for the VA to cover a broader array of services to deal with chronic illness; the aging veteran population is predicted to increase demand for VA hospital care by 20 to 30 percent and demand for VA nursing home care by more than 80 percent by the year 2000.

While the demand for VA health care is rising, the VA’s ability to supply that care is increasingly circumscribed. Like other federal programs, the Veterans Administration faces budget cuts aimed at reducing the deficit. Current plans developed by the Office of Management and Budget, for instance, call for a 20 percent reduction in VA-operated hospital beds by 1990.

At the same time, the VA’s role as a provider of health care is coming under increased scrutiny and criticism by groups as politically diverse as the American Enterprise Institute, the National Academy of Sciences, the Congressional Budget Office, local health planners, and Ralph Nader’s health policy group.

Caught between increasing demand and decreasing political and financial resources, the Veterans Administration’s role in the American health care system is likely to change. To protect the quality of health care received by elder veterans and to avoid undesirable repercussions for the rest of the health care system, it is important that these changes reflect a well-conceived strategy of reform. Taken together, past proposals calling for a narrowing or phasing out of health care under VA auspices define one broad strategy. This paper presents another, quite different, approach which integrates VA health services into the larger system of health and social services for elder Americans. It is based on the argument that past proposals are neither politically realistic nor provide the basis for good health care for elder veterans.

Past Proposals For Reform

Over the past ten years, there have been a number of proposals for changing the mandate of the VA health care system. Several themes run through these proposals.

**The VA should finance rather than provide services.** Under this approach, the VA would provide some form of insurance or voucher with which veterans could purchase care from other sources. This approach, termed “mainstreaming,” is most often advocated for outpatient or hospital care for acute illness. Mainstreaming is thought to produce a variety of benefits. First, integrating treatment for the veteran into the rest of
the health care system is predicted to better assure the quality of that care. Lindsay argues that, “Such a system would retain the essential quality-control features provided by customers’ monitoring in a market framework, while financial responsibility for most of the care would be borne by the Veterans Administration.”

Second, since veterans would use health care facilities in the general community, there would be no need for “costly renovation or replacement of very old VA hospitals.” Finally, mainstreaming is perceived to increase access to care by allowing veterans to seek treatment at hospitals or physicians’ offices located near their home.

The VA should specialize in the provision of long-term care. This narrowed focus is advocated for two reasons. First, having long been faced with large numbers of disabled and chronically impaired veterans, the VA has developed a reputation for providing better care than is available in the general health care system. Second, as the veteran population ages, more veterans are likely to turn to the VA for nursing home care because it is less well-covered by public and private insurance than is acute care.

The VA should narrow eligibility for its services. Recognizing future budget constraints, a number of proposals have been designed to limit access to allow only those veterans most in need of VA services to receive care under VA auspices: those with service-connected disabilities and those with limited income. The first group merits care because of costly conditions which “may require life long attention;” the second group merits care because of limited means to pay for services from private providers.

Taken together these proposals suggest that the role of the VA as provider of health care services should be restricted or eliminated. A report by the Heritage Foundation argues that “it is time to return to the drawing board with a sharply circumscribed view of the mission for the Veterans Administration in the 1980s.”

This conclusion rests on several assumptions. First, most past reform proposals have implicitly or explicitly assumed that a centrally administered health care system, such as the VA, offers no significant advantages over the decentralized health care system extant for the general population. In fact, centralization is typically portrayed as a liability. One study, for example, examined “the interplay of individuals under two alternative systems—one in which the coordination is supervised by a central authority [the VA], and the other in which activity is coordinated by individual reaction to market signals [the private hospital system]” and concluded that “in many respects greater reliance on the market-based coordination might be preferred.”

Second, the VA health system is typically viewed as static. This viewpoint likely stems from the perception that government agencies in general do not innovate, or the belief that political and other factors constrain
the ability of the VA to be innovative. It has been asserted that “the private sector would resist the use of the VA as a model for any important health care activity.” For these reasons, the VA health care system tends to be analyzed, not in terms of the care it might provide, but in terms of the treatment it has provided in the past.

Finally, past proposals have assumed that health care provided under VA auspices can be delivered apart from the rest of the health care system. It is argued that the amount of health care provided by the VA is sufficiently small that veterans in need of treatment can be readily absorbed into the general health care system. Changes in the general health care system, in turn, are asserted to have little impact on the delivery of services within the VA. Recent projections by the Congressional Budget Office of demand for care in the VA, for instance, assumed that “benefit reductions that may occur in Medicaid and Medicare are unlikely to change the propensity among older veterans to use VA services.”

Viewed through the filter of these three broad assumptions, the VA health care system appears to be an isolated and rather unpromising mechanism for care of elder veterans. It is not surprising that past proposals have almost uniformly called for a reduced role for VA health care. We believe, however, that this is a jaundiced and unrealistic picture of the health care which is and can be provided under the auspices of the Veterans Administration. The VA health care system has real strengths relative to other providers of care. By building on those strengths, a system of care can be developed which offers high quality services for elder veterans and which is more in accord with the capabilities and political constraints on the Veterans Administration than are most past proposals for reform.

A Different Perspective On The VA Health Care System

It is our contention that the VA health care system and its relationship to the general health care system differ in important ways from their implicit portrayal in previous reform proposals.

VA health care cannot be considered in isolation. Changes within the general health care system do affect use of VA facilities and vice versa. Both the amount and nature of VA care provided have been shown to be sensitive to changes in the extent of insurance coverage and availability of services in the general health care system. It is projected, for example, that if future increases in copayments under Medicare Part B lead 10 percent of elderly veterans to give up a private physician as a regular source of care, the VA could anticipate an increase of 15,000 veterans seeking hospitalization and 40,000 requesting outpatient care. The same study estimated that if the number of beds designated as swing or long-term care beds in community hospitals were reduced, there would
be a significant increase in admissions to VA medical centers, in the back-
log of patients unable to be discharged from VA hospitals, and in the
number of patients inappropriately placed in VA facilities (Exhibit 1).\textsuperscript{19} Conversely, if the Veterans Administration were to close all extended
care facilities it fully or partially supports, over 50,000 elder veterans
would be shifted into the community, leading to extended lengths of hos-
pital stays.\textsuperscript{20}

\textbf{Exhibit 1}
\textbf{Responses Within The VA Health Care System To A 50 Percent Reduction In The}
\textbf{Supply Of Long-Term Beds In Community Hospitals}\textsuperscript{a}

<table>
<thead>
<tr>
<th>Aspect of treatment within the VA system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions to VA hospitals from the</td>
</tr>
<tr>
<td>community health care system</td>
</tr>
<tr>
<td>Number in 1981</td>
</tr>
<tr>
<td>735,274</td>
</tr>
<tr>
<td>Predicted change</td>
</tr>
<tr>
<td>+ 4.1%</td>
</tr>
<tr>
<td>Patients in VA extended care facilities who</td>
</tr>
<tr>
<td>could be discharged if appropriate services were available</td>
</tr>
<tr>
<td>Number in 1981</td>
</tr>
<tr>
<td>7,733</td>
</tr>
<tr>
<td>Predicted change</td>
</tr>
<tr>
<td>+13.8%</td>
</tr>
<tr>
<td>Patients in VA extended care facilities who</td>
</tr>
<tr>
<td>were not in appropriate setting for treatment</td>
</tr>
<tr>
<td>Number in 1981</td>
</tr>
<tr>
<td>3,923</td>
</tr>
<tr>
<td>Predicted change</td>
</tr>
<tr>
<td>+17.1%</td>
</tr>
</tbody>
</table>

\textsuperscript{a}Numbers represent beds designated as swing or long-term care beds in 1981 American Hospital Association Survey.


The VA health care system should not be viewed as static. The VA has displayed an impressive ability to innovate, particularly in the deliv-
er of geriatric care. Systemwide initiatives, include the development in
the mid-1970s of the Geriatric Research, Education, and Clinical Centers.\textsuperscript{21} Others have occurred at the local level, such as new programs in day care for elders, foster housing, and coordination of services provided by the VA and community-based agencies.\textsuperscript{22}

Advantages of a centrally administered system. The recent rapid
growth of private multihospital chains has made apparent the advantages
they possess over independent facilities, including more sophisticated
management and easier access to capital.\textsuperscript{23} The VA operates the largest
chain of facilities in this country, with many of the same advantages as its
private counterparts. The central administration of the VA allows system-
wide planning, which can assure an appropriate array of services for el-
der veterans. In contrast, the large number of community-based agencies
involved in the care of elders encumbers efforts to coordinate services. In
Massachusetts, for example, planning for extended care is distributed
among five cabinet-level departments, three commissions, and a bevy of
local health planning boards. Planning efforts are further complicated by
the divergent objectives of the agencies; as one recent evaluation noted,
“the many studies and white papers notwithstanding, there is usually
disagreement within state government as to the preferred direction for long-term care policy.”

Case management is also facilitated by systemwide coordination. Elders seeking care in the community are often confronted by a complicated array of services without the information to competently assess their options. Illnesses often go untreated or are treated in inappropriate settings. Although the VA has not been immune to these problems, operation of a system of health care facilities provides the opportunity for more effective integration.

Viewed from this perspective, the appropriate role for the VA in caring for a population of aging veterans appears rather different from that offered in most past reform proposals. Strategy for reform must reflect the interaction of VA and non-VA systems and should also take into account the special health needs of the elderly and the relative strengths of the VA health care system.

A New Direction For The VA Health Care System

The strategy of reform developed below, drawn from a Harvard/VA collaborative project, leads to prescriptions which are diametrically opposed to many past reform proposals. We argue that the array of services and eligibility for services provided under VA auspices be broadened rather than narrowed and that services be further integrated both within the VA system and between the VA and general health care system, rather than specialized and fragmented.

Broadening the array of services. Proposals to focus the VA on a narrow range of services such as long-term care hope to capture the lower costs and better quality thought to come from specialization. However, specialization entails its own costs. When acute care is delivered in one service system and long-term care in the other, providers have few incentives to reduce costs by substituting one type of care for the other. Furthermore, the movement of patients between care systems disrupts continuity and quality of care.

The broader the array of services within a single system, the greater the ability to substitute less costly, more appropriate services for those which are more costly. Therefore, rather than narrow the services provided, we propose that the VA expand its array of services. Currently the VA’s mandate has defined health care in rather narrow and exclusively medical terms. In the hospital-based home care (HBHC) program, for example, VA regulations prohibit the provision of “nonmedical types of services, such as domestic, custodial, or homemaker services which although beneficial to the veteran and may obviate the need of VA institutionalization are not considered medical treatment.”

A broader array of services would better meet the needs of elder veter-
ans. For example, case management, though not strictly a medical service, can promote more efficacious and efficient use of the medical services that are provided. Similarly, integration of health and social services under a single delivery system increases the probability that each type of service will be used most appropriately.  

Broadening the mandate of the VA health care system can also reduce costs. In some cases, less expensive personnel could be substituted for those now employed. In addition, the strict medical definition of need denies care to elder veterans who require aid with activities of daily living, but who have no acute medical disorders. Rules such as these encourage unnecessary institutionalization for elders who cannot manage at home without assistance.

**Integrating VA and community-based services.** The efficacy of VA health care could be increased by better coordination of benefits within the VA and between VA and general health care systems. The need for increased integration within the VA is exemplified by procedures for determining eligibility for pension and medical benefits. Currently, the VA offers special benefits for veterans judged to be housebound or to require aid and attendance. Integration of this assessment with ongoing health care would encourage tailoring of these benefits to fill gaps in services provided under the auspices of health care, a means for VA assessments of financial and/or functional needs to be communicated to health care providers.

The care of elder veterans would also be made more efficacious and efficient if services were better coordinated between VA and community-based providers. Such integration offers several advantages. First, because shifts in the array of services in one system can have major effects on the delivery of care in the other, continued segregation of the planning functions in the two systems leaves each subject to unpredictable and relatively uncontrollable fluctuations in supply of services in the other system.

Second, integrating VA and non-VA services allows each system to better capture economies of scale and to better utilize the existing programs and institutions. In a number of areas, the VA's hospital-based home care program has proven expensive or infeasible because too few veterans needing the service lived near the VA medical center. In other parts of the country, renovation or construction of VA hospitals has been proposed when underused non-VA facilities existed in the community. Sharing programs or facilities would allow the VA to more flexibly respond to changes in the demand for its services over time and across different parts of the country.

The VA's nursing home program provides a model for such integrated services. Roughly 40 percent of extended care paid for by the Veterans Administration is provided in community nursing homes, another 30
percent in facilities operated by state governments. Studies indicate that these sharing arrangements have been generally quite successful, reducing costs of caring for elder veterans, holding down construction costs, and assuring adequate quality of care.

Broadening eligibility and targeting services. Concerns about growing needs and restricted budgets have provided much of the impetus behind proposals to narrow the categories of veterans eligible to use VA facilities. There can be little doubt that the Veterans Administration does face a budget crisis. Reducing utilization by narrowing categorical eligibility, however, is an ill-conceived response to these resource constraints.

As resources become increasingly scarce relative to the demand for care, it is important to direct those resources to the veterans most in need of health care. Unfortunately, it is virtually impossible to define a reasonable set of categories which provide eligibility only to veterans who are truly in need. Eligibility to the VA has been defined statutorily as much in terms of obligation as in terms of need. It is widely perceived that certain veterans, such as those with service-related disabilities, are owed access to VA health care facilities even if they have no unusual health care needs or their needs are met by other providers. Although categorical eligibility to government services must be defined in relatively simple terms, such as age or income, the health care needs of the elderly are often shaped by a far more subtle combination of medical and social factors. Moreover, it may prove politically infeasible to adopt some of the most useful categorical limitations. A good predictor of institutionalization among elders is social isolation. Yet legislation restricting use of the VA health care facilities to only those veterans who are divorced, widowed, or without other social support would be unpalatable to Congress. Given these limitations, categorical restrictions on eligibility seem a poor method for directing scarce resources. A more promising approach is to allow relatively unrestricted access to the system, but to target resources to those most in need by establishing programs which evaluate the health care needs of elders and continue to monitor health status over time. The Veterans Administration is moving in this direction by operating more than fifty geriatric assessment programs, twelve in formal geriatric evaluation units designed to assess the needs of hospitalized elder veterans. To be most effective, these existing programs should be expanded to consider social as well as medical factors, to incorporate ambulatory as well as hospitalized veterans, and to incorporate outreach programs to identify health care needs in the elderly before they seek care in the VA.

Expanding the targeting approach has several advantages over restricting eligibility. Targeting can be more readily adapted to the individual needs of the elder veteran and is less subject to the historical and political factors which have shaped eligibility criteria. Targeting is based on ongoing assessments; as an individual’s health status changes over time, so can
the resources which he receives. In contrast, eligibility criteria exclude some individuals from the VA system entirely, many of whom may be unwilling or unable to find another regular source of care.

If health assessments are used as a basis for allocating resources, there is little reason to establish additional categorical restrictions on eligibility. In fact, under appropriate circumstances, it may be desirable to actually expand eligibility to nonveterans for some services. As noted above, both the VA and community-based health care systems profit from increased integration and sharing of services such as seen in the VA-medical school affiliations.

In some cases, broader access for nonveterans offers opportunities to reduce costs and improve quality of care. For example, the hospital-based home care team caring for an elder veteran could efficiently provide similar care for a spouse. Moreover, by potentially preventing institutionalization of the spouse, this may help ensure that the veteran is not socially isolated and thus at risk for costly nursing home care. In institutional settings, providing care to the families of elder veterans may improve the quality of life.41 State homes for veterans, partially supported by the VA, are currently able to admit spouses and dependents of veterans, maintaining family units and preventing artificial gender-based segregation of elders.

Conclusion

The strategy for reform developed here is very different from most past proposals. It expands rather than contracts the purview of the VA health care system. It treats the VA as an integral part of our larger health care system, rather than as an isolated and now-outmoded vestigial appendage. It addresses budgetary constraints by promoting targeting within the service delivery system, rather than by imposing categorical constraints on access to that system.

We believe that this approach offers important advantages over those presented in the past. First, it reflects the special health care needs of the elderly—the importance of health care assessment, case management, and continuity of care. Second, it builds on the strengths of the VA system rather than highlighting its weaknesses. The Veterans Administration has a history of fruitful affiliations with community-based providers, including academic medical services, state-operated homes and hospitals for veterans, and community nursing homes. This proposal extends that historical precedent to more completely integrate the provision of services in VA and non-VA health care systems. Additionally, this approach is politically realistic. Proposals which reduce or eliminate the role of the VA health care system are likely to engender an impressive array of opposition from veterans groups, members of Congress, and medical
This proposal meets the objectives of proponents of the VA by further building political affiliations supporting the health care system. It also reduces the opposition to VA health care by diffusing criticism that the VA is too isolated from the community and unresponsive to its needs. The strategy developed here also differs to some extent from the VA’s own perception of its appropriate role. This proposal calls for the VA to expand beyond its current definition of medical care. It also advocates a more active role for the VA, reaching out both to other providers of services and to veterans who are not currently using VA facilities. In so doing, this strategy conflicts to a certain degree with the incentives for individual and institutional behavior which have evolved within the Veterans Administration. To implement this strategy, it will therefore be necessary to alter existing incentive systems and to change congressionally mandated definitions of eligibility and priorities for resource allocation.

Certainly these changes will not come easily. Large institutions possess considerable inertia and significant changes are likely to be opposed by many within the organization. Nonetheless, we believe that this proposal is compatible with the general direction in which the VA has been evolving and that it builds upon demonstrated strengths of VA health care. Finally, though the proposal may result in increased aggregate costs under the VA’s budget, it will reduce unintentional cost shifting between VA and non-VA health care systems, is likely to improve quality of care, and will serve larger numbers of elders who need care.

The analysis presented in this article was stimulated by a research project, supported in part by the Veterans Administration (VA), which developed a series of options for the care of elder veterans. The views expressed here go beyond the intent of the original project, are the sole responsibility of the authors, and do not reflect the policies of the VA. The authors thanks Diane Piktialis, Margaret MacAdam, John Mather, Richard Adelson, and the many project participants for their contributions to the initial project and to our understanding of the VA and non-VA service systems.
NOTES

6. Starr, Discarded Army; Lindsay, Veterans Administration Hospitals; and Lindsay, “Veterans Benefits.”
7. Congressional Budget Office, Veterans Administration Health Care; National Academy of Sciences, American Veterans; and Lipsky et al., “Veterans’ Health Care.”
8. Lindsay, Veterans Administration Hospitals, 78.
9. Congressional Budget Office, Veterans Administration Health Care, 49.
15. Lindsay, Veterans Administration Hospitals, 80.
19. These findings were calculated from data collected by the VA in its 1981 annual census. Providers of care in the VA reported on the number of elder veterans who were currently receiving care in VA facilities but who would ideally have been discharged to home or community-based providers. The number of inappropriately placed veterans in
each VAMC was regressed on characteristics of the veteran, the availability of VA resources, and the supply of health care facilities in the community. See Schlesinger et al., “Utilization of the VA.”


21. Thompson, Health Policy, 209.

22. Veterans Administration, Older Veteran, 42-50.


28. For a more in-depth analysis of this issue, see Wettle and Rowe, eds., Older Veterans: Linking VA and Community Resources. Several of the themes developed here echo recommendations made by a Twentieth Century Fund task force on policies toward veterans constituted in the early 1970s. This task force recommended preserving the basic structure of the VA health care system, incorporating comprehensive care for veterans with serious service-connected disabilities and employing the VA to “support, augment and improve the general health care system of the nation.” See Twentieth Century Fund Task Force, Those Who Served, 27-28. The VA's care for chronic illness has been addressed by Lipsky and colleagues. See Lipsky et al., “Veterans Health Care.”


33. The VA's hospital-based home care program is a good example. Because it relies more heavily on physicians than does Medicare-financed home care, the VA program can undoubtedly support sicker elders at home than can most community-based home care programs. See General Accounting Office, Medicare Home Health Services: A Difficult Program to Control, Pub. No. HRD-18-155 (Washington, D.C.: U.S. Government Printing Office, September 1981), 25. Not all veterans need such intensive home care. however, VA studies show that the two most common problems dealt with in home care
visits were “care provider stress” and “other social and emotional problems.” See Veterans Administration, *Services and Costs of the VA Hospital Based Home Care Program* (unpublished paper, February 1980), 10. The VA’s HBHC program is, moreover, rather expensive; in the late 1970s costs under the VA’s hospital-based home care program averaged more than twice the rate paid nationally by Medicare for home care. See M. Schlesinger, T. Wetle, and J. Morse, “Improving Care of the Older Veteran: Issues and Options,” in *Older Veterans: Linking VA and Community Resources*, ed. Wetle and Rowe, 419. Some veterans could be adequately and less expensively served by a program which in some circumstances substituted homemaker and social workers for medical personnel.

34. Planners within the Veterans Administration have recognized this issue. In its 1984 report, *Caring for the Older Veteran*, the VA defined as an objective the integration of “DM&S/DVB medical and benefit services so that veterans have access to a complementary and mutually supportive array of VA and non-VA services” (p. 65).

35. Demkovich, “Planning Hospitals.”

36. The VA also has an extensive and apparently successful affiliation with medical schools throughout the country—almost 80 percent of the medical schools in the country and two-thirds of the VA hospitals are involved in affiliations of this sort. See H. Sapolsky, “America’s Socialized Medicine: The Allocation of Resources Within the Veterans’ Health Care System,” *Public Policy* (Summer 1977): 368.


40. Veterans Administration, Older Veteran, 49-50.

41. If the VA participated in a sharing arrangement with community-based home care agencies, it could exchange these services for the care of some elder veterans.

42. Sapolsky and Wallack, “Veterans’ Health Care System.”