Policy Analysis

Cato Institute Policy Analysis No. 207: 70 Years of Federal Government Health Care: A Timely Look at the U.S. Department of Veterns Affairs

April 27, 1994

Robert E. Bauman

Robert E. Bauman represented Maryland in the U.S. House of Representatives from 1973 until 1981. From 1990 to July 1993 he was an attorney in the Office of the General Counsel of the U.S. Department of Veterans Affairs in Washington, D.C., and in the Office of VA District Counsel in Florida. Parts of this paper originally appeared on the *Wall Street Journal*, December 6, 1993, editorial page; used with permission.

Executive Summary

An important historical fact is being completely ignored in the national debate on health care reform: for most of this century the U.S. government has owned and operated the largest health care system in the nation, the Veterans Health Administration of the U.S. Department of Veterans Affairs. With 171 hospitals, 362 outpatient clinics, 128 nursing homes, a $16-billion 1994 budget, and 266,000 employees, the VHA is socialized medicine writ large.

Although the VHA has produced many worthwhile results, thousands of patients wait for medical attention for hours every day, hundreds of millions of dollars are paid out in medical malpractice claims, and billions of dollars go for annual taxpayer subsidies. Furthermore, 90 percent of eligible veterans choose private alternatives over VHA health care and the massive bureaucracy running it.

The history of the VHA provides cautionary and distressing lessons about how government subsidizes, dictates, and rations health care when it controls a national medical monopoly. The record of the VHA also reveals what happens when politicians attempt to micromanage a health care system to meet the demands of well-organized consumer groups. The major question raised by the VHA experience is why anyone seriously advocating improved health care for all Americans would support government control and regulation of medicine.

Introduction

Often ignored by both sides in the current debate over President and Mrs. Clinton's national health care proposals is one exceedingly relevant but, to some, highly discomforting fact: the U.S. government already owns, finances, and operates the largest health care system in the United States, the Veterans Health Administration (VHA), the principal agency of the U.S. Department of Veterans Affairs (VA).[1]

For various political reasons, both proponents and opponents of the president's proposed national health care plan find it convenient to overlook the lessons of the VA and its massive health care bureaucracy, lest the American public focus on what federal government health "care" is truly like. Undoubtedly, supporters of the Clinton plan would prefer Americans not dwell on the VA's unsettling example as predictive of what may lie ahead on the road to compulsory national health care. Those opposed to the president's plan, mostly congressional "conservatives" in both parties, have long supported the VA as an expedient exception to their repeated arguments against big spending, big government,

and "socialized medicine."

The VA provides a cautionary example of what happens when Washington politicians put the federal government into the national health care business and then try to micro- manage the resulting medical system in a continuing attempt to please well-organized consumer constituents.

No one should, and I do not, denigrate the vitally important contribution that America's fighting men and women have made to preserving our freedoms. But our considerable debt to those who have served in the armed forces also compels a frank and long-overdue discussion of health programs for American veterans. That is especially pertinent now as President Clinton asks Americans to embrace federal control of the private health care sector. Before yielding control of one-seventh of the U.S. economy and some of our most personal and private medical decisions to the federal government, it is essential that we examine how well government has managed federal health care.

The VA: Immune from Serious Scrutiny

Few politicians dare question the fundamental assumptions of federal veterans' programs established, in Abraham Lincoln's memorable phrase, "to bind up the nation's wounds; to care for him who shall have borne the battle; and for his widow and his orphan" (now the official VA motto).[2] And so the U.S. Department of Veterans Affairs, its underlying justifications, and the costly programs it administers largely escape critical public scrutiny.

The Committees on Veterans' Affairs of both the Senate and the House have traditionally demanded of the VA more and better service for their veteran constituents but have rarely asked if there might be a better way. That is so, even though such a basic reexamination of the VA would be particularly appropriate at this juncture as part of any major overhaul of the national health care system. Indeed, organized veterans' groups and VA bureaucrats both feared for the system's future independent existence while awaiting the specifics of Clinton's health care proposals.

The Clinton health plan leaves the VA virtually untouched, not only guaranteeing its continued multi-billion- dollar annual taxpayer subsidies, but suggesting that the VA expand its often-criticized operations to include not only veterans but their spouses, children, and other family members.[3]

One of the major reasons Capitol Hill politicians of all ideological colors jump when veterans speak is simple electoral expediency. The government's policy toward veterans has traditionally been dictated by powerful veterans' organizations whose Washington lobbying and election-day clout is legendary. Clinton's secretary of veterans affairs, Jesse Brown, is a decorated combat veteran and a long-time lobbyist for the Disabled American Veterans, which was founded in 1920 and is one of several major veterans' groups with their own political action committees and many active, vocal members in every state and congressional district.

The American Legion (the oldest of the groups); the Veterans of Foreign Wars; the Vietnam Veterans of America; the Disabled American Veterans; and numerous smaller groups including the Jewish War Veterans, the Catholic War Veteans, the Paralyzed Veterans of America, and many others all maintain close watch on the votes cast by every member of the Senate and the House on veterans' matters. Those groups issue congressional voting score cards, endorse presidential and congressional candidates for election and reelection, and make contributions to candidates' campaign committees. Many sitting members of the Senate and the House are themselves veterans and dues-paying members of the groups that lobby them for their votes. Whether incumbent politicians are veterans or not, they all respect the political power of the numerous veterans' "posts" in their districts; they know from personal experience that it is far better to have the vets (and their friends and relatives) on your side than against you on election day.

National conservative political groups, which place welfare cuts, increased Medicare and Medicaid benefits, and foreign aid spending on their score cards, rarely rate members of Congress on veterans' issues (often viewing such votes as part of "national defense"). Congressional consevatives thus have it both ways; they support spending billions of dollars annually to please veterans, while preserving 100 percent conservative voting records as opponents of big spending.

The formidable power of the veterans' lobby was starkly underscored in October 1992 when, abruptly in midcampaign, a nervous President George Bush dumped his old friend and former congressional colleague, VA secretary Edward J.

Derwinski of Illinois, in a futile attempt (a majority of veterans voted for Bill Clinton anyway) to appease veterans' groups opposed to Derwinski's mild reforms of the VA. The main irritant: faced with having to propose the possible closing of three costly and highly underutilized rural VA hospital centers (in Alabama, Virginia, and Montana), Secretary Derwinski had had the audacity (and common sense) to suggest that the hospitals expand their diminishing operations by becoming test sites for a new federal health care concept and allowing treatment of both veterans and non- veteran Medicaid patients at VA facilities. Never mind that rural VA facilities often have many empty beds, the organized veterans' groups, highly offended that their free federal health benefits were being lumped together with those of welfare recipients, went wild chanting "VA for vets only!" and "Derwinski must go!" He did.

The VA's highly politicized VHA is the largest health care system, public or private, in the United States and one of the largest in the world. With massive annual taxpayer funding, the government operates 171 VA medical centers with 80,000 beds, 362 outpatient and community clinics that receive 23 million patient visits annually, 128 nursing homes with 71,000 patients, and 35 domiciliary facilities that care for 26,000 people each year. There is at least one VA medical center (as the VA terms its hospitals) in each of the 48 contiguous states, the District of Columbia, and Puerto Rico. A new VA hospital will open soon in West Palm Beach, Florida (a state that already has three); another near Orlando is in the planning stage; and VA plans call for new hospitals in Honolulu, Hawaii; Anchorage, Alaska; and Fairfield, California.[4]

Few Americans realize how deeply the VA health care system involves the U.S. government in what conservatives used to call "socialized medicine." In total spending and number of employees, the VA is the second largest cabinet-level federal department, behind only the Department of Defense (which has its own extensive medical care system). As of July 30, 1993, the VA had 266,274 employees. The majority of those employees (243,028) work in the VHA; many thousands of them (7,163 as of July 30, 1993) are paid salaries in excess of $100,000; and all are exempted by federal statute from most personal liability for medical malpractice.[5]

Thousands of other VA workers are employed in special operations in Philadelphia, Pennsylvania; St. Paul, Minnesota; Austin, Texas, and Hines, Illinois, administering educational, survivors', and other benefits; pensions (which Congress by its always unanimous roll-call vote indexes annually to inflation); life insurance and home loan guarantees; national cemeteries; a canteen system; and other operations. About 5,000 very well paid top VA officials (many of them doctor-administrators who no longer actively practice medicine) and more than 400 lawyers manage the immense system from departmental headquarters on Lafayette Park, across from the White House.

In a time of supposed austerity, the total VA budget for fiscal year 1994 is $35.9 billion, up $1 billion from 1993. Clinton personally authorized that increase at Secretary Brown's urging. Nearly $16 billion of that sum will go for health care; the balance will be spent on pensions and other benefits. Few in Congress have ever voted against a VA appropriation and survived. And Congress has been consistently generous; in fiscal year 1970 total VA health care outlays were $1.8 billion; by 1980 they had grown to $6.5 billion; today they are $16 billion.[6]

Defenders of the VA point to its significant medical and research accomplishments: one of the best spinal cord injury centers in the nation (at Palo Alto, California); advanced geriatric care; provision of 6 percent of all national adult AIDS care; treatment and research on post- traumatic stress disorders; studies of the aging process and Alzheimer's disease; rehabilitation of the blind; development of the cardiac pacemaker, the CT scan, prosthetics, and improved drug therapy for the mentally ill; and major research on drug addiction, alcoholism, and schizophrenia. In addition, the VA has training affiliations with hundreds of medical, dental, and other schools.[7]

Few defenders of the VA would even consider, much less admit, the possibilities raised by a fundamental question: should the federal government be engaged at all in those health care and research activities, or could the private sector do it better?

History

The United States has the most comprehensive system of assistance to its veterans of any nation in the world. More than half of those massive benefits for veterans take the form of direct health care and related medical services.

The earliest known American veterans' benefits were granted by Plymouth Colony in 1636 when the Pilgrims made

communal provision for colonists injured fighting in the Pequot Indian wars. Other colonies followed suit in providing for disabled veterans: Virginia (1644), Maryland (1661), New York (1691), and Rhode Island (1718). In 1776 the Continental Congress encouraged Revolutionary War enlistments with promises of disability pensions. That lure was so successful that benefits were still being paid by the United States to the enlistees' surviving dependents until 1911. Indian wars, the Civil War, and the Spanish-American War all gave Congress cause to add veterans' disability, widows' and survivors' pensions, and other benefits during the 19th century.

The first federal health care for veterans came in the 1811 congressional authorization of a U.S. Naval Home, which did not open until 1833, in Philadelphia. In 1863 an adjoining facility, the Philadelphia Naval Hospital, with 130 beds, was authorized. In 1851 Congress established in Washington, D.C., a U.S. Soldiers Home, which is still in operation today.

In the post-Civil War era Congress created a series of branch "homes" to provide domiciliary, hospital, and incidental medical care for disabled and impoverished Union veterans (Confederate veterans were barred). Many of the states did the same, and the dual system treated honorably discharged Union and U.S. veterans until the United States entered World War I in 1917.

Congress responded to the perceived needs of the veterans of the Great War with war-risk life insurance, increased pensions, disability compensation, family allotments, and vocational rehabilitation. Administrative duties were split among the Bureau of War Risk Insurance in the Department of the Treasury; the Public Health Service, which examined veterans for eligibility for benefits; and the Bureau of Pensions of the Interior Department. In 1921 the U.S. Veterans Bureau was created, and in 1922 that bureau took charge of all Public Health Service hospitals serving veterans.

The origins of the present U.S. Department of Veterans Affairs were mired in the muck of scandal, a recurrent bureaucratic blemish familiar in varying degrees at the VA to this very day.

More than two years after World War I ended in 1918, over 300,000 disabled American soldiers were being cared for with differing degrees of efficiency by half a dozen disparate federal agencies. The battle wounded for the most part received adequate medical care, but the 70,000 veterans suffering from tuberculosis and mental disorders (in the contemporary phrase, "shell shocked") were often shunted from one public institution to another, if they received any care at all.

Elected by the largest majority of any American president until then, the popular Republican U.S. senator Warren Gamaliel Harding of Ohio swept into office in 1921 promising, among many other things, to right the veterans' wrongs. To remedy the anomalies of veterans' health care, Harding consolidated the War Risk Insurance Bureau, parts of the Public Health Bureau, and other agencies into the new U.S. Veterans Bureau. The president named as bureau director one of his poker-playing acquaintances, U.S. Army colonel Charles Forbes, a winner of the Congressional Medal of Honor and a veteran heartily endorsed by the then-new American Legion.[8]

Forbes brought with him as the bureau's general counsel a crafty, vulpine California lawyer, Charles F. Cramer, who promptly bought Harding's former house in Washington for $60,000.

Before 1921 a special U.S. Army architectural staff had been in charge of the location and construction of veterans' hospitals and had economically and efficiently built 19 new facilities. Forbes, as one of his first official acts, persuaded the president to issue an executive order transferring to his control both the hospital construction program and all purchase and disposal of veterans' supplies, until then administered by the Army's Quartermaster Corps. That gave Forbes power over more than 50 large storage buildings at Perryville, Maryland, crammed with scarce medical supplies, drugs, hospital furnishings, clothing, tools, and equipment accumulated during the war. As director, Forbes also controlled the Veterans Bureau budget of more than a half billion dollars, the largest budget of any federal government agency at that time and an astronomical sum in 1922 dollars. He promptly loaded the bureau staff with friends, relatives, and assorted hangers-on.

Forbes set about secretly selling off the Perryville supplies at greatly reduced prices, taking huge kickbacks from eager purchasers. He was soon living a life of Washington luxury, ostensibly on his government salary of $10,000 a year. In

the spring of 1922, putting Cramer in charge of the Veterans Bureau, Forbes embarked on an extensive national tour, financed partly by money from construction contractors. Entertaining lavishly as he went, Forbes personally picked building sites for new veterans' hospitals at hugely inflated prices, skimming a large percentage of the price paid for each piece of land as his fee from the sellers. Hospital construction contracts with similar kickback arrangements were handed out by Forbes to willing conspirators.

In late 1922 the president, privately alerted to what was going on at the Veterans Bureau, forced Forbes to resign in disgrace, and shortly thereafter, Cramer, Forbes's accomplice throughout, committed suicide. In 1925 Forbes was convicted of conspiracy and accepting bribes, fined $10,000, and sentenced to two years in Leavenworth Federal Prison. All in all, hardly an auspicious beginning for what would become the modern VA.

Eight years later the Veterans Bureau, together with the Pension Bureau, the National Homes for Disabled Volunteer Soldiers, and other veterans' programs once again were consolidated into a new independent agency, the Veterans' Administration, by Executive Order no. 5398, signed by President Herbert Hoover on July 21, 1930. The Hoover order was the generic charter of the VA as it has evolved to this day.[9]

In 1930 there were about 4.7 million veterans.[10] Many of those men were unemployed, and in May 1931 an estimated 17,000 of them marched on Washington demanding that Hoover and Congress grant them cash bonuses for their wartime service, as several states had already done. On July 28, after two months of mounting frustration, about 5,000 of the marchers resorted to violence, overwhelming the outnumbered District of Columbia police. The shaken D.C. commissioners asked Hoover to provide military forces to restore order. After several hours of street fighting, 600 troops under the command of the new Army chief of staff, Gen. Douglas MacArthur, assisted by Majs. Dwight D. Eisenhower and George S. Patton, routed the veterans from their camps along the Mall and on the Anacostia River flats.[11]

The Great Depression also created an unprecedented demand by veterans for free hospital care. The 54 existing VA hospitals rapidly filled, permitting President Franklin D. Roosevelt's New Dealers to justify still more expansion of VA medical facilities.

During World War II the VA's existing medical and nursing staffs were stripped of personnel for foreign military efforts. Those medical staff members who remained "stateside" were finally commissioned as U.S. Navy or U.S. Army officers and assigned to the VA system in order to keep it operating.[12]

The end of World War II brought the VA to a major crossroads; from 1941 to 1945 the total number of American veterans had increased fourfold, to over 19 million.[13] A basic policy choice had to be made: should the VA expand its facilities and staff to meet the growing demand for medical services, or should the government pay the private health care sector for veterans' medical services?

Congress was also considering what government might do to help the private medical sector. One of the major results was passage in 1944 of the Hill-Burton Act, which authorized federal grants, loans, and loan guarantees for construction of private and nonprofit hospitals, whose numbers soon mushroomed because of generous federal financing.[14] The Hill-Burton largesse over the years has undoubt- edly been one of the major reasons for today's national glut of unoccupied and underutilized hospital beds (a surplus often cited, ironically, by advocates of the Clinton and similar health care plans as supposed evidence of the free market's inability to allocate resources properly).

A VA Doctor Remembers

Robert K. Moxon, M.D., now retired after a distinguished career in military and VA medicine, praises the general competence of, and the quality of care rendered by, VA doctors, past and present. But he also vividly recalls his first encounters with "VA bureaucracy and inefficiency" shortly after World War II. As an active-duty physician at the Philadelphia U.S. Naval Hospital, Moxon saw VA patients integrated with naval and other categories of patients. He says that "in the VA clinic, chaos was endemic, principally through matters of unclear eligibility with numerous patients claiming service-related injuries such as being 'gassed' in World War I. There were also the 'professional veterans' who managed to use the hospital as a temporary residence."[15]

At that postwar juncture, the political goals of the national veterans' organizations coalesced with the internal agenda of the VA bureaucracy. Congress removed VA physicians from most civil service restrictions, and within the VA, the Department of Medicine and Surgery was born--a department that would become, in this writer's observation of its recent operation, a national "old-boy" mutual-protection employment and research network.

Basking in the glow of victory on postwar Capitol Hill, members of Congress tripped over each other in a wholesale rush to offer government assistance to "America's brave fighting men" (some few added "women"), the valiant souls who had vanquished the Nazis, the Japanese, and all the other enemies of democracy. America was now the "leader of the free world" and had to set an example by providing for the veterans who had fought to make us so. How best to repay our collective debt? Build VA hospitals, expand veterans' pensions, increase existing benefits, and invent new ones.

Thus was born the GI Bill that provided educational benefits (which eventually would cost taxpayers $14.5 billion); VA home loan guarantees of more than $50.1 billion for 5.9 million home loans to World War II veterans and $26 billion for 1.7 million loans to Korean veterans (the default and foreclosure rates are high); vocational rehabilitation; and increases in pensions and compensation--all of which are costing American taxpayers over $36 billion in 1994.[16]

Moxon remembers that one of the first new VA hospitals built after the war (they were now to be called "medical centers") was in Philadelphia, and he says: "It was clearly redundant. The honest voices of those of us who argued that the health and medical needs of veterans could be far better met by existing military hospitals and private-sector facilities were ignored or drowned out by the political muscle of VA itself and their voluble supporters." Moxon points out that at that time VA officials began a concerted national effort to have individual VA hospitals affiliate with nearby medical schools, "eventually arrogating to VA a major role in private medical education by making the VA system seem indispensable to medical schools for training doctors. This promoted the permanent entrenchment of the VA in the medical community but did little to enhance medical education except to provide medical schools with a modest increase in the number of essentially indigent patients for teaching purposes."[17] Private medical school affiliation has proved highly effective in enhancing the VA's professional standing. Today more than half of all practicing physicians in the United States received part of their medical education as interns in VA facilities, and the VA estimates that 100,000 more health professional trainees are added each year.[18]

Moxon is not alone in his professional judgment of the VA's problems. Many doctors have voiced the opinion that staff shortages and poor management have reduced the quality of care at many VA facilities. Testifying before the Senate Veterans' Affairs Committee on March 5, 1993, John T. Lord, M.D., a former military physician now in practice at the Anne Arundel Medical Center in Annapolis, Maryland, said the VA hospital system was "archaic" and did not provide "a high-quality product as defined by efficiency, effectiveness, accessibility or satisfaction." He argued that the VA should be completely restructured as "an access point for veterans," offering those services it can best provide and purchasing from private medical providers services it cannot render well. Lord suggested that the VA as a self-contained unit should eventually be ended and the system integrated into the larger private health care sector.[19]

VA Health Care Today

The VA administers the largest American health care system, but--and this is very important to keep in mind-- that health care is available only to those veterans who meet certain eligibility criteria established by federal laws and regulations. Given the pending Clinton health care plan, the arcane system of determining eligibility for VA medical treatment (and the availability of various types of VA medical services) can be highly instructive as an example of how federal bureaucrats can and do control (and ration) medicine.

Consider, for example, a contemporary case history: An elderly Navy veteran, discharged from service years ago with a finding of 100 percent physical disability based on serious service-connected mental neurosis, now lives in rural New York, 70 miles from the nearest VA medical center in Syracuse. Because the VA determined that the veteran is totally unable to travel anywhere (much less to Syracuse), it pays for his medical treatment (on what the VA calls a "fee basis"), which is provided by private doctors near his home. The veteran's medical condition deteriorated markedly two years ago after he was diagnosed with cancer. The VA paid for his cancer treatment, and his private

physicians advised immediate nursing-home care. VA officials say they cannot pay for the veteran's nursing-home care because VA rules allow for payments only when the veteran is physically transferred to a nursing facility from a VA medical center where he is a patient. Because the veteran's 100 percent service-connected disability prevents him from traveling, he has never been and cannot be a patient at the Syracuse VA medical center, a limitation the VA has acknowledged for years by paying his medical bills for local private care.

As of January 20, 1994, that case, after two years of VA procedural appeals, was still pending before the Board of Veterans Appeals (BVA) in Washington, and the burdened relatives of the dying veteran were still seeking indigent nursing-home care to allow him a comfortable death.[20]

That is not an isolated example of VA bureaucracy at work. According to the Associated Press, as of February 1994 there were 377,000 claims pending before the BVA, and 870,000 claims are expected by 1995. On average, it takes 200 days to obtain an initial ruling on a veteran's claim to health or other benefits and more than two years to get a final BVA ruling. Veterans' groups complain loudly to Congress about the "emergency crisis"; 73-year-old Sam Ledwith, of Valley Stream, New York, a former Marine who fought in the Pacific in World War II and in the Korean War, sums it up succinctly: "Overall, the systems stinks." It took Ledwith over four years of VA hospital visits and BVA appeals before the VA restored his 40 percent disability rating for hearing loss that it had cut in half in the 1980s.[21]

Needless to say, the lengthy appeal time renders moot many final VA decisions concerning individual veterans' eligibility for health care. Small comfort to relatives that in most cases the VA does pay burial expenses for honorably discharged veterans.[22]

Government Decides Whom It Will and Will Not Treat

The VA eligibility system is a patchwork of many levels of possible medical coverage. Even Secretary Brown admits that the VA "is hobbled by a very complex set of eligibility criteria."[23] In general, eligibility is based on personal characteristics of the individual veteran, such as service- connected injuries, which entitle the veteran to access to all VA services as either an inpatient or an outpatient. Eligibility may also result from other conditions or illness that may have been incurred during service but are not combat related (such as cancers said to be caused by use of the Agent Orange defoliant in Vietnam or the strange new maladies claimed to have befallen those who fought in the Persian Gulf War).[24] The eligibility of veterans, and in some cases of their dependents, may also depend on the type of health service being requested (inpatient or outpatient, for example) and its availability at any given time or facility.[25] Most people familiar with veterans' matters agree that there is a dire need for immediate simplification of eligibility rules.

Ninety-seven pages of Title 38, Part 4 of the Code of Federal Regulations[26] and thousands of pages of internal VA departmental medical manuals describe what is, and is not, an officially VA-eligible disease or medical condition.[27] VA medical boards constantly hold thousands of individual hearings (veterans can appeal denials) on the question of eligibility for treatment.[28]

Income status is also a major factor; poor veterans are guaranteed what amounts to VA medical welfare. Few people mention the fact that 52 percent of all veterans who receive VA health care do so, not because they were wounded in service to their country, but because they once were in the armed services and are now unfortunate enough to be officially defined by VA law and regulation as poor. As the chairman of the House Committee on Veterans' Affairs, Rep. G. V. (Sonny) Montgomery (D-Miss.), put it bluntly: "VA's patients are disproportionately older, sicker and poorer."[29]

Only 45 percent of those who receive VA health care do so on the basis of medical conditions that are service connected, but their care is, for the most part, mandatory and free of charge to them--it is paid for by all taxpayers.[30] For those veterans, free treatment will continue uninterrupted under Clinton's proposed Health Security Act.[31]

What Might Happen

In October 1993 the General Accounting Office issued a report entitled "VA Health Care--Restructuring Ambulatory

Care System Would Improve Services to Veterans," a report to the chairman of the Subcommittee on Oversight and Investigations of the House Committee on Veterans' Affairs. That report raises some interesting questions.

For instance, what do you suppose would be the chances for congressional approval of the Clinton health care plan if Americans peered into the future and discovered:

Over half of patients (55 percent) with routine medical problems wait from one to three hours to be seen for a few minutes by an overworked doctor struggling with increasing numbers of patients and piles of government forms, regulations, controls, and policy directives.[32]

One of nine patients identified as suffering "urgent" medical or psychiatric problems is forced to wait up to three hours to see a doctor.[33]

Because of lengthy waiting lists, patients in need of specialized care, such as cardiac or orthopedic diagno=sis, even at the system's best medical facilities, cannot be seen by a specialist for 60 to 90 days and wait months more if surgery or other special testing and procedures are required.[34]

Those real-life scenes are neither scare projections by opponents of Clinton's plan nor descriptions of the historically inefficient British or Canadian government-run medical systems.[35] They are the disturbing findings of the GAO study, which covered 215 VA facilities, including 158 medical centers and 57 satellite and independent outpatient facilities, operated by the VHA during 1993.

What's Wrong?

The VA has more than seven decades of experience, is financed with hundreds of billions of tax dollars, and has an immense professional medical staff; yet patients wait hours and even months for needed health care. From 1983 to 1992 American taxpayers were held responsible for $254,806,804 in damages under the Federal Tort Claims Act because of thousands of medical malpractice claims against VA personnel.[36] (In 1993 alone, 801 new claims were filed and $41 million was paid out for past claims, law suits, and settlements.)[37]

This is the reason: the VA is the quintessential government bureaucracy--administratively officious, laden with red tape and meddlesome regulatory minutia destructive of both quality patient care and staff conduct. Three volumes of the U.S. Code (Title 38) and a full volume of the Code of Federal Regulations, plus scores of volumes of federal personnel, medical, and administrative policy restrictions govern each VA employee's every move. Thousands of pages are filled with fine print, detailed descriptions of medical conditions, degrees of disability and potential eligibility, even mathematical variations thereof (disabilities are rated from 1 to 100 percent)--a maze that is supposed to produce pension benefits and free health care.

Small wonder that it requires a phalanx of more than 400 VA attorneys constantly working to interpret and reinterpret the arcane substantive and procedural provisions. Along with lawyers from the Civil Division of the U.S. Department of Justice and the U.S. Attorneys' offices across the nation, VA lawyers also must defend thousands of malpractice claims filed by injured patients or their bereaved survivors who blame the VA for the wrongful death of a veteran.

A partial list of events that occurred at VA medical centers at Tampa and Big Pines, Florida, from 1991 to 1993, about which I have personal knowledge, follows.

For more than three months after abdominal surgery, an elderly hospitalized veteran continued to complain of weakness and stomach pain. A VA radiologist misread the x-ray showing the infection-causing laproscopic sponge overlooked by a VA surgeon (since resigned). Cost to the taxpayers: $100,000 in damages.

A senior VA orthopedic specialist (since retired), near the end of his daily shift, misdiagnosed a young veteran with severe lower back pain who was unable to stand up and ordered him to bed for rest. Result: permanent paraplegia and a $1-million settlement.

A psychotic and professedly suicidal patient, who was allowed to sit for more than four hours in a VA waiting room,

finally walked to his car, got his gun, and shot himself in the mouth. His fate: to live his few remaining years as a quadriplegic paralyzed from the neck down, unable to breath without mechanical support.

Another psychotic veteran, misdiagnosed by a harried psychiatrist and given no anti-depressant medication, was left unattended in the psychiatric unit and hanged himself on a coat hook.

An elderly, hard-of-hearing, overworked cardiologist ordered no tests for a veteran who insisted that he was suffering acute coronary pain; the doctor believed the vet was a malingerer and thus delayed life-saving heart surgery for six months.

For 20 years doctors at one VA medical center freely provided Valium to a nervous-stomached veteran who became addicted to benzodiazapines; while on vacation he went to a Florida VA medical center, was abruptly removed from Valium, and went into seizures. He survived, but the incident cost taxpayers a $50,000 settlement.

Two years of hearings and paperwork were required to remove permanently from duty a depressed VA nurse deemed to be a threat to patients.

Other events, reported by the VA's "Newslink" daily E-mail, occurred elsewhere in the VA system during the same period.

At the Salem, Virginia, VA medical center, several patients repeatedly wandered into the woods and were found dead, a year after their last disappearance.

At the Atlanta, Georgia, VA medical center, several top officials were removed after being charged with years of open sexual harassment of numerous female staff members.

At the Miami VA medical center, a technician misread vital signs after open-heart surgery and a father of two died. The federal court awarded nearly $2 million to the survivors. At the North Chicago VA medical center, operations were suspended after an alarmingly high death rate was attributed to continuing surgical incompetence.

VA doctors and other medical personnel have long since created their own self-protective old-boy network. That incestuous relationship is best illustrated by the manner in which a federal statute meant to protect patients from medical incompetents has been applied (or rather, not applied) at the VA medical center at Bay Pines, Florida. The Medical Professional Review Act, which became effective in 1991, requires any "health care provider" to report to a national centralized data bank any doctor whose conduct leads to a payment as a result of a medical malpractice claim or legal action by a patient.[38]

At Bay Pines the "peer review" committee of doctors uniformly exonerated their medical colleagues regardless of the charges against them. Even the missing-sponge case mentioned earlier was not deemed malpractice and thus was not reported to the national data bank. Similar no-fault findings were adopted in all other malpractice cases during the time I represented the hospital, even when legal liability was established by VA lawyers and cash settlements were paid to mistreated patients by the VA. I was told by lawyers in the VA General Counsel's Office in Washington that the same "see no evil" data bank nonreporting was rife throughout the VA medical system. So much for veterans' rights.

And then there are the unusual views of the long-time medical chief of staff at one of the nation's largest (and most trouble-prone) VA medical centers. The center's chief (in spite of it's being contrary to federal and state law) constantly pushes his own personal policy dictating that all incoming patients be designated DNR (do not resuscitate). Simply put, that means that hospital staff are expected to avoid declaring a medical emergency, but if they must, they do not use any extraordinary means to save the patient. The chief doctor views his lethal expedient as a means of rationing scarce hospital beds and reducing budgetary costs at his VA facility.

Who Uses the VA's Medical Services?

As evidenced by the GAO report, one of the major problems with the VA system is growing demand for "free" medical services. Veterans with service-connected disabilities or conditions, and those at the poverty level, are eligible

for free VA medical treatment. Other veterans can receive free health care on an "as available" basis depending on the case load of the facility (which contributes to the long waiting lines). The fewer than 3 million veterans who were treated by the VA in 1992 made more than 23 million individual visits to VA facilities.[39]

Such highly inefficient multiple patient visits occur because the VA does not generally permit patient telephone consultations with medical personnel; does not usually allow refills of prescriptions without a personal appearance by the veteran; and, at most facilities, does not make scheduled appointments for general triage and treatment. That means "first come, first serve," with a glut of veterans showing up early each morning, then sitting in jammed waiting rooms for hours until they can be seen by doctors. Even before the first aspirin is administered, it usually takes VA staff an hour or longer just to complete the paperwork determining if the prospective patient is eligible to receive VA health benefits.[40] "I pack a lunch and take a book," one unidentified veteran is quoted as saying.[41] "Be prepared to spend the day there," retired 69-year-old U.S. Army Maj. Elmer S. Erickson told a Miami Herald reporter at a Florida VA clinic. "You will eventually see a doctor."[42]

Another reason for increased patient demand at VA facilities is the distortion of "service connection." The concept has become a political football, its elastic definition snatched away from medical experts by the politicians. A combat-wounded soldier or sailor suffers a definable medical injury that establishes his or her VA eligibility. But what happens when the U.S. government sprays Agent Orange all over Vietnam and 30 years later thousands of veterans claim to be suffering various medical problems as a result?

The medically debatable outcome: Secretary Brown ruled on September 27, 1993 (after years of VA studies costing millions of dollars), that certain types of respiratory cancers suffered by veterans (cancers equally attributable to smog or excessive tobacco use) are now to be presumed by law to be based on exposure to Agent Orange. That makes any Vietnam War veteran with those respiratory conditions eligible for a disability pension and free health care. The five-year cost: $350 million and ascending. President Clinton praised Brown's decision, saying it was "a continuation of the costs of war."[43]

A similarly costly VA scenario is now developing with the "Gulf War Syndrome," a mysterious malady said to be afflicting thousands of veterans of the Persian Gulf War. Under pressure from the news media, veterans' groups, and their friends in Congress, the VA has designated a special medical task force to investigate eligibility of the new disease.[44]

Although the cloak of national defense is easier to apply to medical problems in the VA context, similar health care bidding wars are almost inevitable under the Clinton health care plan.

There is a far more telling indictment of the massive VA health system. There are now an estimated 26.7 million American veterans, most of whom are eligible for some degree of VA medical care, but fewer than 10 percent of them seek VA assistance.[45] The other 90 percent apparently prefer to go elsewhere when ill. In fiscal year 1992 only 2.7 million veterans used the VA health care system.[46] Even many of the VA-eligible poor veterans prefer private-sector Medicaid- paid health care providers. Those who can afford their own private physicians would not even consider the hassle of the VA medical system.

Given the GAO findings, imagine the turmoil should even 25 percent of eligible veterans show up at VA clinics and hospitals. As Montgomery observed, the veterans who do seek VA treatment are mostly middle-aged (Vietnam) or elderly (World War II or Korea) and near or below the poverty level (i.e., medically indigent).[47]

Dr. Clinton's Soothing Prescription for the VA's Future

During the generally confusing first year of the Clinton administration, the internal circles of the VA, especially top administrative and medical personnel, experienced a deep-seated, widespread anxiety. That malaise was prompted only partially by the change in the White House, although many second-level VA officials, theoretically nonpartisan, had come to power under the regimes of Presidents Reagan and Bush.

Nerves became even more frayed when the Clintons made clear that they were serious about national health care reform. VA bureaucrats wondered where the VA would fit into that brave new world and worried that the VA might

disappear altogether, eaten up by a greater, even more bureaucratic national health system. Some VA top brass argued that the federal government already had a national health care system in place--the VA. So why be redundant? "Use the VA" (and us), they said, as the base for a glorious new page in America's history of the pursuit of life, happiness, and less liberty.

The VA bureaucrats need not have worried. Together with their allies in the organized veterans' groups (one of whom, Jesse Brown, was picked by Clinton to head the VA), the VA staff provided the talent of no fewer than 33 of its members for Hillary Clinton's secret health task force, which hammered out the statutory structure for America's new medicine. By the time the Clinton plan actually was reduced to 1,342 pages of proposed legislation in November 1993, the VA had ensured itself a significant role in health care "reform." The VA's massive structure was not to be dismantled as insiders had feared.

The Clinton proposal projects an expanded VA system treating not only more veterans but their spouses and dependents as well. Although required to offer a benefits package to all veterans through newly created local health care alliances, the VA will continue to provide free health care to veterans with service-connected disabilities and to indigent veterans. In addition, Secretary Brown would be given wide powers to draw up rules governing expanded VA benefits for veterans and their families. If the Clinton plan becomes law, the VA also will be permitted to receive payments for its services from Medicare, Medicaid, and private insurers.[48]

Caring for veterans' dependents would force VA facilities to provide types of medical services, including pediatrics and obstetrics, that they generally do not now offer. Some argue that such new services could be "contracted out" by the VA to private health care providers, but that raises a logical question: why cannot all of the VA be contracted out to the private sector?[49]

In spite of the verbal smoke screen of "competition" raised by Secretary Brown and the anointed White House health guru, Ira Magaziner, the Clinton health care plan allows the VA to continue as a federally funded, cabinet- level department, essentially independent of, but associated with, the president's new health scheme. Magaziner soothed participants in a VA senior management conference on November 2, 1993, assuring them that the president's plan would provide the opportunity for the VA "to compete for the tens of millions of veterans VA does not now serve who would be able to bring their employer and individual contributions to the veterans' system rather than bring them to some other health plan."[50]

To entice the 90 percent of America's nearly 27 million veterans who do not presently do so to go to the VA for health care, Magaziner envisioned the VA's offering them a full range of medical services comparable to those offered by private-sector health care providers. In other words, the VA would "compete" as one of many possible places for consumers to spend their health care dollars and would also continue to receive federal funding for its traditional veterans' health programs. The VA would also be paid by insurance companies for those who chose VA over private-sector health care hospitals or health maintenance organizations.

Magaziner did not explain why millions of veterans would be willing to pay for VA services that until now they have refused, even though those services are free of charge. Nor did he explain how a system that cannot now adequately serve 2.6 million veterans would suddenly obtain the magic capacity to treat 26 million veterans and their dependents. Magaziner even held out hope that Congress could reduce annual VA appropriations, replacing taxpayer funding with private insurance payments on behalf of satisfied customers.

That misplaced idealism was officially shared by the president, who projected $1 billion in "savings" from increased VA "efficiency" as part of a total $91 billion in "savings" (later pared down to $58 billion) under his proposed national health plan.[51]

The president's estimates were blown out of the water in January 1994 by the Congressional Budget Office's official estimates for the Clinton plan. The latter estimates showed zero savings and an increase of more than $74 billion in the federal deficit over the next five years, and an increase of $126 billion by 2004.[52]

As if to underscore the hypocrisy of it all, within days of the Magaziner-VA session, Sen. Jay Rockefeller (D- W.Va.), chairman of the Senate Committee on Veterans' Affairs, announced that the president (apparently without regard to

Magaziner's wishful thinking) had agreed to establish a special capital improvements fund to renovate ailing VA hospitals ("halls and walls") with a $1-billion first installment in fiscal year 1995, $600 million in 1996, and $1.7 billion in 1997. (That is in addition to the $1-billion VA operating fund increase Clinton approved for fiscal year 1994.) Rockefeller intoned solemnly, "We can and must bring spending under control, but we can't offer veterans the health care they deserve while simultaneously cutting the VA budget to the bone."[53]

When the president's budget for fiscal year 1995 was sent to Congress in January 1994, the VA made out like the proverbial bandit: the total VA budget was upped another $1.3 billion to the highest figure ever, $39.2 billion. Of that sum, $16.1 billion (increased a half billion from 1993) goes for VA health care for a projected patient case load of 2.8 million, up only 27,000 from 1993. Secretary Brown predicted those numbers would permit the VA to build one new medical center, five new nursing homes, and one new outpatient clinic.[54] So much for Clinton's projected $1 billion in VA savings.

Promising ever greater expansion of free medical benefits for service-connected conditions and low-income veterans is standard operating procedure for both political parties, and perhaps especially for a president who won with only 43 percent of the popular vote in 1992. The business- as-usual political approach to the VA will undoubtedly please Congress (carefully monitored by organized veterans' groups), which, with knee-jerk predictability and for back- home veterans' consumption, will loudly demand even more money for the VA.

Apparently Hillary Rodham Clinton's health care task force never gave any thought to privatizing the VA medical anachronism and cutting it loose from the federal treasury. Under the president's plan the politically untouchable VA may have to "compete" in the free marketplace for additional new customers, but it will do so sitting on a federally funded cushion of nearly $40 billion a year (and rising), courtesy of the American taxpayers. No other "health care provider" can make that statement.

The VA: A Warning for Clinton

As does the VA, the Clinton health care plan diminishes the realm of private choice, giving government the power to decide what medical services will be available under various health care plans, yet to be devised. The Clinton plan imposes general federal control over available services; that control is to be exercised by a new layer of bureaucracy to be known as the National Health Board. The board will set minimum standards of medical treatment to be administered by new state and local government agencies called "health care alliances." As does the VA, the Clinton plan will allow government to decide who will be eligible for emergency care; hospitalization; treatment by a general practitioner or a specialist; inpatient or outpatient treatment; mental health or substance abuse treatment; family planning and pregnancy-related services, including abortion; testing; and nursing-home or hospice care.[55] How many additional pages of the Code of Federal Regulations, one may reasonably ask, will be required to determine our personal eligibility for crucial health care?

The existing VA system may well be the precursor of our future national health care system if Bill and Hillary Clinton have their way. On November 3, 1993, in remarks denouncing the American insurance industry's opposition to parts of his health care plan, Clinton said, "There's a lot of money in the health care system that doesn't have a rip to do with health care; . . . [it's] over-complicated, burdensome, bureaucratic."[56] The president might have been describing the U.S. Department of Veterans Affairs.

Conclusion

Although this analysis does not purport to devise solutions for the ills that beset the U.S. Department of Veterans Affairs, a good start would include drastically curtailing any further expansion of the VA and delegating health care for deserving eligible veterans to private health care providers, reimbursable by the government.

Barring another major military conflict that requires large numbers of Americans to serve in the armed forces, within a generation or two the VA health care system will run out of eligible clients. (Some rural VA medical facilities are already seriously underused.) With the inevitable demise of veterans with service-connected conditions and other specially eligible veterans, the justification for VA medicine as it exists today will come to an end. If Congress had the political courage to consider making policy changes, even gradually, the federal government could eventually extricate

itself completely from owning, operating, and financing the VA hospital and health care system.

Unfortunately, the major issues and problems outlined in this historical review and analysis of the VA's operations will be present, and magnified, under the Health Security Act promoted by President and Mrs. Clinton. The fact that the notorious state of the VA has been unworthy of even a concerned murmur (much less been the subject of criticism) in the current debate does not speak well for individual freedom of medical choice or for the future of quality health care in America.

Such immense political cowardice on the part of our so- called leaders constitutes a statement about the ultimate chances for our survival as a nation. American folk wisdom long ago produced an appropriate phrase (which now takes on new meaning) to describe life's frustrating moments: "It's enough to make you sick."

Notes

[1] The abbreviation VA has been used since July 21, 1930, when President Herbert Hoover signed an executive order creating the Veterans Administration. On October 15, 1988, the VA became the 14th cabinet-level agency, the U.S. De partment of Veterans Affairs (also known as the VA).

[2] Abraham Lincoln, Second Inaugural Address, March 4, 1865, The Quotation Dictionary (New York: Macmillan, 1962), p. 159.

[3] David Masci, "Veterans," Congressional Quarterly, Sep tember 25, 1993, p. 2559.

[4] U.S. Department of Veterans Affairs, Office of Public Affairs News Service, "VA Fact Sheet," August 1993.

[5] Ibid.; and Title 38, U.S.C. sec. 7316 (1993).

[6] Congressional Research Service, "Veterans' Health Care Program: A Fact Sheet," CRS document 93-366 EPW, April 1, 1993.

[7] Ibid; also see G. V. Montgomery, "Why Maintain a Health Plan for Vets?" Roll Call, October 18, 1993.

[8] The following discussion is drawn from Francis Russell, The Shadow of Blooming Grove: Warren G. Harding in His Times (New York: McGraw-Hill, 1968).

[9] Veterans Administration, "VA History in Brief," VA pamphlet 06-83-1, May 1986.

[10] Ibid.

[11] Douglas MacArthur, Reminiscences (New York: McGraw-Hill, 1965), pp. 92-97.

[12] Veterans Administration.

[13] Ibid.

[14] See 42 U.S.C. 291 et seq. (1993).

[15] Robert K. Moxon, letter of December 7, 1993, to the author; quoted with permission.

[16] Veterans Administration.

[17] Moxon.

[18] U.S. Department of Veterans Affairs.

[19] Quoted in David Masci, "Veterans: New Players and New Priorities," Congressional Quarterly, March 20, 1993,

pp. 672-74.

[20] Case no. C 49 95 343, U.S. Board of Veterans Appeals.

[21] Associated Press, "Some Vets Wait for Years for Claims," Miami Herald, February 17, 1994, p. 8A.

[22] Lee E. Sharff, Eugene Borden, and Fred Stein, Veterans' Benefits Handbook (New York: Prentice Hall, 1992), pp. 64-65.

[23] Jesse Brown, letter to the editor, Wall Street Journal, December 27, 1993, p. 7.

[24] Philip J. Hilts, "Gulf War Syndrome: Is It a Real Dis ease?" New York Times, November 23, 1993, p. B7; see also 38 U.S.C. sec. 1112 (1993).

[25] Congressional Research Service.

[26] 38 C.F.R. Part 4 (1993); authority: 38 U.S.C. sec. 1155; 72 Stat. 1125.

[27] See 38 C.F.R. sec. 1112 (1993).

[28] Sharff et al., p. 80 et seq.

[29] Montgomery.

[30] Congressional Research Service.

[31] Montgomery.

[32] General Accounting Office, "VA Health Care--Restructur ing Ambulatory Care System Would Improve Services to Veter ans," Report to the chairman of the Subcommittee on Over sight and Investigations of the House Committee on Veterans' Affairs, GAO/HRD-94-4, October 1993, pp. 17-19.

[33] Ibid., p. 19.

[34] Ibid., pp. 5, 33. My own personal observations of the nonemergency waiting times at the VA medical centers at Tampa and Bay Pines, Florida, confirm similar findings, especially for orthopedic (60 to 90 days) and cardiac (12 to 18 months) surgery.

[35] See National Review 45, no. 24 (December 13, 1993): "Special Health Care Supplement."

[36] See 28 U.S.C. sec. 1346(b) et seq.; and 28 U.S.C. sec. 2671 et seq.

[37] Smith.

[38] 42 U.S.C. 11101 at 11131 (1993); see also Federal Regis ter, November 28, 1991, p. 55461.

[39] Montgomery.

[40] General Accounting Office, chap. 2, p. 17 et seq.

[41] Ibid., p. 14.

[42] Gregory Spears, "Vets Facing Long Waits for VA Medical Care," Miami Herald, October 31, 1993.

[43] Quoted in Jesse Brown, "VA to Award Additional Benefits for Agent Orange-related Illnesses," U.S. Department of Veterans Affairs, Office of Public Affairs, September 27, 1993.

[44] Hilts.

[45] U.S. Department of Veterans Affairs.

[46] Congressional Research Service.

[47] Montgomery.

[48] Masci, "Veterans: New Players and Priorities," p. 674; and "VA to Face Challenge," Health Care Reform Reporter 1, no. 22 (November 18, 1993): 13.

[49] Masci, "Veterans," p. 2559.

[50] Quoted in "VA to Face Challenge."

[51] Alissa J. Rubin, "The Health Alliance: A Broker between Consumers, Doctors," Congressional Quarterly, October 30, 1993, p. 2974.

[52] Associated Press, "Analysts Say Health Care Plan Would Increase Deficit," Miami Herald, February 9, 1994, p. 5A.

[53] Quoted in ibid.

[54] Figures provided by Office of Public Affairs, VA Medical Center, Bay Pines, Florida, February 17, 1994.

[55] Alissa J. Rubin, "Clinton's Health Plan Envisions Reor ganized Marketplace," Congressional Quarterly, September 18, 1993, pp. 2458-63; and Rubin, "The Health Alliances: A Broker between Consumers, Doctors," pp. 2970-77.

[56] Quoted in Douglas Jehl, "Clinton Joins Counterattack on Insurer's Ads," New York Times, November 4, 1993.