THE AMERICAN JOURNAL of MEDICINE®

Veterans' Health Care: When Oversimplification Undermines Choice

Last summer's release of the Commission on Care's *Final Report*[1] brought a major policy issue front and center: how to provide high-quality, high-value care to veterans. Established "to strategically examine how best to organize the Veterans Health Administration,"[2] the Commission agreed with a previous independent assessment that US Department of Veterans Affairs (VA) care was "comparable or better" to private sector care available[3] and rejected radical restructuring (a path to near total privatization).

More recently, during his nomination hearing, VA Secretary David J. Shulkin, MD also opposed such dramatic change, telling Senators: "…the Department of Veterans Affairs will not be privatized under my watch".[4] The view was endorsed by the full Senate, which unanimously confirmed his appointment.

Notwithstanding such high-level and, notably, bipartisan support for maintaining VA's basic system, concerns about the right balance of care within VA and the community to meet veterans' needs will receive continued attention. It is therefore important to consider a proposal published in ***The American Journal of Medicine*** prior to the *Final Report*, which not only called for the type of radical restructuring the Commission rejected, but vastly oversimplified the policy question at hand. In *An Alternative Way to Provide for Healthcare for Veterans*,[5] Dr William Weeks suggested diverting the VA's budget to subsidize coverage under Medicare rather than pay for services delivered by VA. While cost is an important component of this policy question, comparing costs between different health systems with fundamentally different structures, payment mechanisms, and incentives is inherently complicated.[6] In other words, Weeks' "simple, cost-savings" proposal is, upon closer look, a fundamentally flawed analysis with numerous, negative policy implications.

The change Weeks advocates would reduce, rather than expand veterans' choices, and likely reduce the quality of veterans' care. While veteran patients would be the ones most acutely affected, all patients likely would be impacted in some way. At a time when the US health care system is struggling to accommodate the newly insured, facing a severe physician shortage, and straining to care for aging Americans, shifting the responsibility for veterans' health to Medicare is irresponsible public policy. Below are some of the consequences to seeking a seemingly "simple" solution to the inherently difficult policy question of providing high-quality, high-value care to veterans in today's health care environment.

First, Weeks' proposal ignores a fundamental question: whether a radical restructuring of VA (toward privatization) is the direction veterans favor. Both individual veterans and nearly all major veterans service organizations have argued strongly against substantial privatization. According to Sherman Gillums Jr,[7] former US Marine and Acting Executive Director, Paralyzed Veterans of America: "… millions of service-injured, low income, elderly, severely or catastrophically disabled veterans have already made their choice—and they chose VA."[7]

Second, Weeks' proposal derives from the flawed assumption that the private sector can suddenly absorb care for the 9 million veterans currently enrolled in the VA. It is naïve to assume Medicare providers would be able to take on such an enormous influx of new patients, especially given predicted physician shortages. By 2025, the US faces an estimated shortfall of 14,900 to 35,600 primary care physicians.[8]

Third, Weeks' proposal would virtually eliminate the nation's primary educational pipeline for future internists: VA. Each year, 18,500 internal medicine residents and fellows train at local VA facilities; an investment that represents approximately half of VA's near $700 million allocation for graduate medical education.[9] If VA's investment is pulled away, will Medicare be ready to pick up the tab? And if the nation's clinical training grounds start to shrink in number, will community providers (already struggling to meet productivity demands) step in? The impact would be catastrophic.

Fourth, such a restructuring would force VA to disband the nation's only research enterprise focused entirely on veterans' health care needs. For veterans, that means a devastating decrease in studies specifically aimed at better

Funding: None.

Conflict of Interest: None.

Authorship: The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States Government. Both authors had access to the data and a role in writing the manuscript.

Requests for reprints should be addressed to Carolyn M. Clancy, MD, MACP, US Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420.

E-mail address: Carolyn.Clancy@va.gov

0002-9343/$ -see front matter Published by Elsevier Inc.
http://dx.doi.org/10.1016/j.amjmed.2016.08.051

understanding and treating posttraumatic stress disorder, traumatic brain injury, spinal cord injury, pain, and chronic disease. It is unrealistic to assume that other federal government agencies or foundations could support, much less coordinate, a research agenda informed by veterans' needs.

Fifth, the commentary asserts that the "size and needs" of the veteran population have changed since the 1930 establishment of a separate health care system, implying that a decrease in veteran numbers is equivalent to a decrease in demand for services. The assertion neglects basic demographics; veterans, like the civilian population overall, are living longer, and with a greater burden of chronic illness.

Sixth, the commentary overlooks the fact that VA provides many services for veterans who are not currently covered under Medicare (eg, long-term care, residential rehabilitation treatment, work therapy, homelessness services, caregiver support, hearing and visual aids). Additionally, some services are provided at a more enhanced level compared with what Medicare provides, reflecting the special needs of veterans: spinal cord injury care, enhanced mental health care, and prosthetic services. VA has estimated that the costs of these services alone will be $20.4 billion in 2017.[10] Moreover, VA has led the way, through telehealth and related applications, in connecting veterans with services not readily available in their community; for example, over 10% of mental health visits are now delivered by telehealth, a substantial boon for those residing in rural areas. Is Medicare likely to support development of comparable services?

Seventh, the commentary ignores the substantial pharmacy cost savings VA obtains by bargaining with pharmaceutical companies, a feature that Congress expressly prohibited for Medicare.[11] Medications purchased by VA would cost up to 70% more if purchased through private sector plans.[6] One of the most dramatic examples of these savings is current treatment for hepatitis C (a condition that is particularly prevalent among veterans). Because of VA's bargaining ability, these treatments cost much less under Veterans Health Administration care than they do under Medicare.

Eighth, the commentary calculates the costs of shifting VA patients to Medicare by including only premiums that a typical Medicare patient pays for part B and part D coverage (including "donut hole") and Medigap coverage to reduce costs of deductibles. This proposal ignores the fact that, unlike private insurance, Medicare premiums do not reflect the total costs to Medicare for these patients. A recent analysis estimated that beneficiary premiums covered approximately 13% of Medicare costs.[12] The remaining 87% of costs to care for VA patients would be added to Medicare's budget.

Over the past 2 years, VA has worked diligently to address a myriad of complicated challenges, build stronger coalitions, and cultivate an environment of trust. Although much work lies ahead, signs of progress abound. As the recent Commission on Care report illustrates, charting VA health care's future direction requires balancing many goals that may be in tension with one another. However, the importance of thoughtfully navigating such complexity cannot be overstated. To again quote Mr. Gillums: "… any discussion on eliminating the VA health care system … is colored by what appears to be a circuitous attempt to 'pass the buck', because the problem is simply too complicated to resolve. But this complexity is derived from questions that should not be easy to answer …"[7]

Moving forward, VA welcomes well-researched, carefully considered strategies that put veterans first and acknowledge the full implications of any proposed change. VA's track record of providing care that is better than, or comparable with the private sector, is one that has been achieved over time, and with VA being held to a far higher standard of transparency. Transitioning to care that may be less coordinated and possibly more expensive for veterans warrants a comparable level of transparency. Strategies such as those put forth by Weeks, that seek to minimize or oversimplify policy and fiscal issues, ignore veteran concerns, and place undue burden on the current health care system are unhelpful and doomed to failure.

Carolyn M. Clancy, MD, MACP
David Atkins, MD, MPH
Veterans Health Administration
US Department of Veterans Affairs
Washington, DC

ACKNOWLEDGMENT

We gratefully acknowledge the thoughtful contributions of Regan Crump, PhD, Assistant Deputy Under Secretary for Health, VA, and Mark Yow, Chief Financial Officer, VA.

References

1. Commission on Care. *Final Report of the Commission on Care*. Washington, DC: Commission on Care; June 30, 2016.
2. US Department of Veterans Affairs. *Charter of the Commission on Care*. Washington, DC: US Department of Veterans Affairs; 2015.
3. Mitre Corporation. Independent assessment of the health care delivery systems and management processes of the Department of Veterans Affairs. Washington, DC: 2015. Available at: http://www.va.gov/opa/choiceact/documents/assessments/Integrated_Report.pdf. Accessed July 25, 2016.
4. "Shulkin unanimously confirmed to head Veterans Affairs," Washington Post, February 13, 2017.
5. Weeks WB. An alternative way to provide healthcare for veterans. *Am J Med*. 2016;129:554-556.
6. Congressional Budget Office. *Comparing the Costs of the Veterans' Health Care System with Private-Sector Costs*. Washington, DC: Congressional Budget Office; December 10, 2014.
7. Gillums S. Open letter to the Commission on Care: why privatizing VA healthcare would be a huge mistake. Available at: http://www.businesswire.com/news/home/20160324006345/en/Open-Letter-Commission-Care-Privatizing-VA-Healthcare. March 24, 2016. Accessed October 21, 2016.
8. Association of American Medical Colleges. New research confirms looming physician shortages particularly acute in specialties most needed by an aging population. Washington, DC: April 5, 2016. Available at: https://www.aamc.org/newsroom/newsreleases/458074/2016_workforce_projections_04052016.html. Accessed July 20, 2016.
9. US Department of Veterans Affairs, Office of Academic Affiliations position allocation database, FY16 data.

10. US Department of Veterans Affairs. VA medical care obligations for items that are more generous than typical private sector health plans (table) 2016.
11. Medicare Prescription Drug, Improvement and Modernization Act of 2003, 108-173. Available at: https://www.gpo.gov/fdsys/pkg/PLAW-108publ173/content-detail.html. Accessed March 26, 2017.
12. Cubanski J, Newman T. The facts on Medicare spending and financing. Issue Brief. The Henry J. Kaiser Family Foundation, July 20, 2016. Available at: http://kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/. Accessed August 11, 2016.