Brookings Institution sponsored a much-needed conference to explore this relation; this volume is a compilation of the arguments presented by economists, policy makers, and attorneys, as well as a summary of the discussion and other comments stimulated by the conference.

The resulting book illuminates some basic but central questions: What are the costs of health care litigation? What are its benefits? What reforms should we consider to lessen any negative impact of litigation on costs?

Dollar costs considered by the participants are both direct and indirect, and are incurred by both defendants and plaintiffs. Direct litigation costs include attorneys' fees, witness fees, court and preparation costs, medical-examination fees, lost income, and other out-of-pocket expenses incurred in prosecuting or defending a lawsuit. Perhaps the most obvious direct cost is payment made as compensation to an injured patient, although it is estimated in this book that only 28¢ of every dollar paid for malpractice claims actually reaches the victim. Indirect dollar costs include liability-insurance premiums and the salaries of such professionals as in-house counsel, risk managers, and claims adjustors. The social costs of litigation involve such things as the unnecessary tests and procedures of "defensive medicine," as well as the reluctance of physicians and providers to embrace measures that might reduce costs but at the same time might broaden legal exposure. As might be expected, the contributors to this volume differ widely about the extent and cause of these costs.

There is a divergence of opinion over the individual and collective benefits of health care litigation, against which the costs must be balanced. The primary benefits cited are the compensation of injured patients and quality control through the fear of personal and corporate liability. As Mariner points out in her excellent chapter, the fairness of liability imposition is a distinct issue from the efficiency of the compensation system, and both concepts in turn must be distinguished from concern about total costs.

Several proposed reforms of our current approach of strict liability are debated briefly. Alternatives include both systematic change (e.g., more reliance on administrative regulation such as licensure, looking to market-place forces, no-fault, and a workers' compensation model) and procedural modifications (e.g., mandatory arbitration, damage ceilings, and shorter statutes of limitation). No consensus was achieved, but the discussion is intelligent and clear.

This volume is slim but interesting and thought provoking. Deserving particular merit is the cogent analysis of malpractice costs and benefits by economist Danzon, who tellingly separates myth and perception from reality, and advocates minor but valuable alterations that would improve the present legal system without relinquishing its advantages.

If one message pervades this book, it is that we cannot effectively fashion reforms of health care litigation until we decide what goals we seek from that system of compensation and liability. Physicians, insurers, administrators, attorneys, and the public must distill and clarify the values to be served. Only then can we accurately evaluate the costs of realizing those values and determine how we shall foot the bill.

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NOTICES

Notices submitted for publication should contain a mailing address and phone number of a contact person or department. We regret we are unable to publish all Notices received.

NATIONAL CANCER INSTITUTE

The Division of Cancer Prevention and Control of the Institute is now accepting applications for its Cancer Control Science Associates Program. The program is intended to attract qualified individuals from a variety of health science disciplines into the field of cancer control research. The three-year period of duty begins on July 6, 1986, and the deadline for receipt of applications is November 22, 1985.

Contact Nancy E. Garner, CCSAP, NIH/NCI/DCPC/CCAB, Blair Bldg., Rm. 4A01, Bethesda, MD 20205-4200; or call (301) 427-8788.

HEALTH POLICY REPORT

JOHN K. IGLEHART

The Veterans Administration Medical Care System Faces an Uncertain Future

THE vast medical care system that serves the nation's military veterans faces an uncertain future that is framed by the humanitarian instincts of society, a conservative administration that seeks to decrease public spending, a population of veterans that is rapidly aging, and a private health sector that may have more hospital beds and physicians that it can efficiently deploy in the future. This complex set of forces is emerging in a chaotic fashion that makes it difficult for the federal government to plan for, much less control, the future in relation to the medical care program of the Veterans Administration (VA).

The VA is something of an anomaly in a capitalist country. A tax-financed, centrally directed agency that reflects a brand of socialism with which many Americans are uncomfortable, the VA nevertheless enjoys a high degree of support among a variety of Democratic and Republican lawmakers. This steadfast commitment derives from a belief articulated more than a century ago by Abraham Lincoln; etched on the VA headquarters building today is his declaration that the nation has an obligation "to care for him who shall have borne the battle and for his widow, and his orphan."

Although political support for the VA has remained high, it — like all federal agencies — has been subjected to sharper budgetary discipline as a consequence of the congressional budget process instituted a decade ago and the continuing efforts of presidents to control spending for veterans. In inflation-adjusted terms, total spending for veterans (income security, medical care, education, training, and rehabilitation) peaked in 1976. The decline in spending since then will continue if the administrations's budget projections to 1990 are followed. Spending for the medical care program, which was $3.5 billion in 1975, has grown marginally (in inflation-adjusted terms) and reached $8.9 billion this year.

President Reagan's rhetoric on behalf of veterans has been more positive than the funding provided for veterans' programs in his administration's annual budget proposal, but this is a pattern that has generally been followed in all recent administrations. Another element of this pattern is that, for the past 10 years, Congress has consistently appropriated more for veterans programs than the chief executive has sought. In 1985, for example, the President proposed a VA medical care budget of $8.8 billion, but Congress appropriated an additional $173 million. In the two previous fiscal years, Congress appropriated $277.4 million and $165.8 million more than requested by the President.

This report will discuss several major policy issues facing the VA as the agency girds for a future that will

include the provision of medical care to the large cohort of World War II veterans who will turn 65 during the next decade. In a subsequent report, I will explore some of the important relations the VA maintains with outside organizations, including its network of affiliations with medical schools and teaching hospitals, and the state of its discussions with private hospitals and physicians who are facing weakened patient demand while the VA remains relatively aloof from the competition of the medical marketplace.

The VA is a vast enterprise. Its annual budget of $27 billion and more than 220,000 full-time employees makes it the third largest federal agency. Its programs of support for veterans have a substantial impact on the lives of millions of Americans. For example, in 1984, the VA provided $13.9 billion in compensation and pension payments to 4 million veterans and their survivors, $1.3 billion for educational assistance payments to 629,000 trainees, and $122.9 million in burial benefits. It guaranteed or insured more the 251,000 loans to veterans and operated the fifth largest individual life-insurance program in the United States. The VA also serves as a jobs program in that 20 per cent of VA employees are veterans of the Vietnam War era.

In addition, in 1984, the VA provided medical care to 1.3 million inpatients in 172 medical centers and treated an additional 92,000 veterans in non-VA hospitals and extended care homes. The VA medical staff cared for veterans during 18.6 million outpatient visits and provided clinical training to more than 100,000 students from affiliated schools in all health care disciplines. The VA also spent $218 million for medical research, rehabilitation research and development, and other health services research. About 5300 principal investigators participated in research programs and cooperative studies sponsored by the VA.

The VA and its programs are subject to the continuous scrutiny of congressional committees, veterans service organizations, and the President's Office of Management and Budget (OMB). The House and Senate Veterans Affairs Committees are unique in that they are the only congressional panels with legislative authority over such a singular interest. They are highly protective of that interest, as are the House and Senate Appropriations subcommittees that approve the VA's annual budget. (The House and Senate Aging Committees, which are also advocacy panels on behalf of a single interest group, have no authority to legislate, only to exhort through public hearings and published works.)

No detail of the VA seems too small for examination by the OMB, congressional committees, or — in instances in which the agency is trying to close or relocate a facility — individual legislators. For example, the House and Senate appropriations panels that oversee the VA have sought, through directives contained in committee reports, to mandate the location of outpatient ambulatory clinics. Congress generally has a powerful influence on the VA when it comes to establishing priorities in its medical construction program, although legislators have many views on this issue. The House Veterans Affairs Committee has tended to favor continued emphasis on hospital construction, whereas its Senate counterpart has been more bullish about promoting alternatives to inpatient care. On different occasions, Congress has directed the VA to hire an assistant chief medical director for geriatrics and service chiefs for podiatry and optometry at its central office. The relation between Congress and the VA is akin to the relation between Britain's National Health Service and Parliament.

The VA and its advocates represent a classic example of an "iron triangle" of interests that make their way through the Washington policy swirl. In this instance, the triangle consists of the agency itself, the congressional committees that oversee and often protect its interests, and veterans' service organizations, many of which operate under a federal charter. Together, these groups espouse the cause of the VA at every turn. The interlocking nature of this influential triad is well reflected by the movement of numerous staff members between its organizations.

The Reagan administration was given a demonstration of the broad influence of the veterans' lobby during its first assault on the federal budget deficit (or, as it became known in statute, the Omnibus Budget Reconciliation Act of 1981). Within weeks of taking office, Reagan and the OMB sent Congress proposals for reductions in his predecessor's final annual spending plan, which was under consideration on Capitol Hill. Among the proposals was a scheme to reduce VA spending by $863 million, nearly two thirds of which was slated for medical care and construction programs.

In putting together the coalition of legislators necessary to win approval of these spending reductions in the Democratically controlled House, the Reagan administration learned quickly that it would need more than the votes of Republicans to win a majority of votes for its proposals. Thus, the administration sought to enlist conservative Democrats in its budget-cutting cause, many of whom are from the South and Southwest. One of the leaders of that block of Democrats (the "Boll Weevils") was Representative G.V. (Sonny) Montgomery of Mississippi, chairman of the House Veterans Affairs Committee. Montgomery, however, objected strongly to Reagan's proposed cuts in the VA budget and declared he could not support the administration unless it abandoned its plans to trim spending for VA's medical care program.

In two meetings that took place in 1981 in the office of David A. Stockman, director of the OMB, Montgomery voiced his objections and then reached a compromise agreement with the administration, according to participants in the arrangement. If the administration would restore the medical care budget for the VA, Montgomery would accept other proposed VA cuts (about $441 million) and embrace Reagan's first major effort to trim federal spending. Montgomery also

elicited a commitment from Stockman that the administration would not seek sharp VA budget cuts in the future.

Although veterans' service organizations have never supported Reagan's proposed VA budgets (or those of most previous presidents), the early agreement between Stockman and Representative Montgomery has influenced administration policy since 1981. Recently, Republican leaders in the Senate have been more willing than the administration to trim VA spending. If Republican legislators do propose cuts, however, the President has almost always supported them.

Another important turning point in the development of the administration's view of the VA came in 1982 when Stockman and his lieutenants considered delegating the agency's functions to the private sector. Had this idea been put into effect — and Stockman never did anything more than muse about the prospect — it would probably have taken the form of providing vouchers to eligible veterans for use in obtaining medical care from private physicians and hospitals. Stockman came to realize, however, that the veterans' powerful lobby would have resisted such a change vigorously and that, in any event, the voucher system would probably have cost more than the VA's current medical care system. In regard to proposals for changes in the VA system, Donald W. Moran, a deputy to Stockman during his 4½ years as OMB director, said in an interview:

> By 1982, I had instructed the OMB staff never to even mention the notion of an alternative system to the VA, whether it be labeled mainstreaming, vouchering or whatever. We concluded that transforming the VA through extensive private sector arrangements was simply not a direction that we favored. We decided early on [that] a more feasible policy direction was to focus VA's limited dollars on veterans with service-connected injuries and strive to make improvements in the current program that were consistent with the administration's overriding priority of reducing federal spending. Later we concluded that one dimension of this policy should include an income-related test because the VA's current method of screening veterans (a verbal pledge by the veteran that he lacked the resources to seek care elsewhere) simply is inadequate.

The overriding goal of the VA medical care program is to provide timely high-quality care, within the law and government regulations, to eligible veterans now and in the future. As the Reagan administration has continued to seek ways to decrease domestic spending, however, the question of how many of the 28 million living veterans should be eligible for care has been given a great deal of attention. An article in *The Wall Street Journal* on April 22 considered this question by providing the following illustration:

> Thomas Corey was shot in the neck while fighting in Vietnam. Henry Koepke slipped off a swimming pool ladder three years after his Army discharge. Carl Goldsmith's multiple sclerosis was discovered four years after he left the military. These three men have two things in common: they are quadriplegics, and they all are entitled to the same level of free service from the nation's largest medical system — the one run by the U.S. Veterans Administration.

The central question raised by these examples according to John Cogan, a former associate OMB director who was quoted in the article, is

> whether taxpaying Americans should continue to pay for veterans' care regardless of their (veterans') income, regardless of whether their disability was related to service in the military. If so, then the taxpayer should recognize that the cost of maintaining current VA medical-care policy, with no eligibility restraints, will exceed $30 billion by the year 2000.

The issue involves more than the administration's relentless assault on social spending; demography is also an important factor. There are 28 million veterans in this country, of whom about 11 million served in World War II. These veterans are rapidly reaching 65, the age at which, under current regulations, all veterans are eligible for free care. There are now about 4 million veterans over 65, but by the year 2000, there will be about 9 million. Since neither Congress nor the administration contemplates a major expansion of the VA's medical service in the future, the issue of how to deal with all these potential patients comes down to fashioning policies that will limit access to VA medical care. The administration's proposed approach, which was unveiled this spring, is to require most veterans with nonservice-connected injuries to take an income-assessment test before they are given access to free care.

Under the proposal, a veteran with such injuries or illnesses whose annual family income, including assets, was below double the maximum annual VA pension rate based on family size ($15,000 for a veteran and one dependent) would be deemed eligible for free care as long as he was not given precedence over a veteran with a service-connected injury and staff and financial resources were available. A veteran with a higher annual income would not become eligible to receive VA care until he had exhausted all assets above a level equal to $15,000. This stipulation would require a veteran to sell any fluid personal assets, except his home and one automobile, worth more than $15,000. A veteran who required emergency care and care in certain extraordinary circumstances still could be admitted to VA institutions, but would be billed for the cost of such care up to his expected contribution.

The administration also proposed that if a veteran with a nonservice-connected injury was covered by a private insurance plan, that plan would be required to reimburse the VA for the medical expenses it covered. The VA would then bill the veteran for the difference between the insurance company payments and the costs to the VA. According to administration estimates, both proposals would yield savings of $265 million in 1986.

Such savings, although not large, represent the sort of chipping away that is likely to increase as the government decreases its obligation to care for veterans with nonservice-connected injuries. The House and Senate Veterans Affairs Committees, at separate meetings in September, approved the concepts behind these proposals, but developed a more generous

means test. The House panel took the lead in this regard under the leadership of its chairman, Representative Montgomery, and its ranking Republican, Representative John Paul Hammerschmidt of Arkansas.

Under the Montgomery–Hammerschmidt proposal then, which the House Veterans Affairs Committee approved by a vote of 14 to 12 on September 11, the VA would be required — if it deemed the care necessary — to provide medical care to veterans in the following categories: veterans whose injuries were service-connected, former prisoners of war, veterans exposed to certain herbicides and ionizing radiation, veterans of World War I who were drawing pensions, and veterans with one dependent whose income did not exceed $25,000 (for each additional dependent, this income limit would increase by about $3,200). The administration's proposal incorporates a similar priority order for serving veterans. The major difference between the means test in the Montgomery–Hammerschmidt proposal and that in the administration's proposal is that the former has no "spend-down" provision. That is, a veteran would not have to dispose of his fluid assets to reach the threshold of $25,000. The Senate Veterans Affairs Committee approved a similar means test proposal on September 26.

The VA estimates that a means test at the level of $25,000 would not prevent the vast majority of veterans who now depend on free medical care from receiving such care. The agency's experience demonstrates that most recipients of VA medical care have no private health insurance and have low incomes, and that they are elderly and suffer chronic health problems. But the means test would represent the first major step down the road of limiting access to VA medical care to veterans on the basis of income. Since 1980, the VA has had the statutory authority to impose a means test on veterans under 65, but it has never implemented that test. Yet, according to a 1984 survey conducted by the VA (whose accuracy it now questions), about 20,000 to 30,000 veterans a month are denied free medical care for nonservice-connected ailments. The agency's medical centers and clinics turn away such veterans because they lack the facilities, staff, or financial resources to care for them.

There is no agreement on whether a means test would yield savings. At a hearing called by the House Veterans Affairs Subcommittee on Hospitals and Health Care and the House Select Committee on Aging on April 23, Dr. Donald L. Custis, director of medical services of the Paralyzed Veterans of America and chief medical director of the VA from 1980 to 1984, testified:

> I think it is a mistake to claim that a means test is a cost-containment mechanism or will cut back on the volume of veteran care in the system. I think that for every individual veteran that is found to be, through a means test, able to pay for private care, his place is going to be filled by three or four veterans who are in line right behind him trying to gain access to the system.

A VA report entitled "Caring for the Older Veteran" has argued that the medical care program of the VA must be expanded greatly if it is to serve the needs of the population of older veterans. The release of this document itself represented an interesting chapter in the ongoing struggle between the VA and the OMB. The two agencies debated the assumptions made in the report for months. Finally, the report was released last July on a Friday afternoon (in time only for coverage by poorly read Saturday morning newspapers) without fanfare or a news conference. Moreover, very few copies of the report were printed.

The VA report incorporates a number of important points that bear directly on the agency's future. It discusses the impending dramatic demographic change in the veteran population and makes the point that because of the VA's aging constituency, the agency will have to change its priorities and place more emphasis on noninstitutional long-term care and relatively less emphasis on acute care. The report does suggest that the VA's particular institutional character will offer important advantages in addressing these policy challenges.

Veterans tend to cluster in age groups that are related to service in major conflicts. Thus, although there is a steady influx of veterans from the armed services in peacetime, the numbers are small when compared with those who enter the veteran population after a major mobilization. As a result, there are large peaks in the veteran population that represent World War II, the Korean conflict, and the war in Vietnam. Veterans from the first two of these wars are moving into the age groups that have the greatest need for medical care and other benefits, as Table 1 shows.

Because of the size of the mobilizations accompanying the major conflicts, as "Caring for the Older Veteran" pointed out, veterans older than 65 will represent an increasing proportion of all men over 65 during the next two decades. In 1980, 27 per cent of all American men over 65 were veterans. In 2000, that proportion will reach 63 per cent. Under current eligibility rules, this would mean that almost two of every three elderly American men will be eligible for VA medical care if they elect to use it. Who will elect to use this care is a question that has a variety of answers, depending on whom is asked and what assumptions are made about the issue.

Table 1. Age Mix of Veterans Population (in Millions), 1980–2020.*

Year	Total No.	No. over 65 (%)	No. 45–64 (%)	No. under 45 (%)
1980	28.6	3.0 (10.5)	14.3 (50.0)	11.3 (39.5)
1990	27.1	7.2 (26.6)	11.5 (42.4)	8.4 (31.0)
2000	24.3	9.0 (37.0)	10.2 (42.0)	5.1 (21.0)
2010	20.7	8.1 (39.1)	7.9 (38.2)	4.7 (22.7)
2020	17.5	7.8 (44.6)	5.0 (28.6)	4.7 (26.8)

*Data from the Veterans Administration.

At this point, analysts who address the question seem to be playing an educated guessing game because there are so many variables that could change in the future. One set of variables revolves around new policies involving Medicare and Medicaid. As the government tightens funding for these major health financing programs, VA care will become more attractive to veterans whose economic circumstances place them at the border of eligibility for free care.

To address the question of future need, the VA report on the aging veteran tried to measure how much care the agency would have to provide if it were available to all veterans who were eligible for care and in need of it, and who would use that care if it were readily available. The agency employed several different estimating methods. One approach used medical districts or metropolitan areas in which VA care is used heavily as models for real need and extrapolated their use rates to the entire country. For an alternative approach, an opinion poll of veterans' stated plans and expectations was conducted by Louis Harris and Associates. The Congressional Budget Office, for a 1984 report, "Veterans Administration Health Care: Planning for Future Years," used an empirical method based on past demand for medical care. The VA and the Congressional Budget Office studies differ sharply in the assumptions they make about the average length of stay at veterans' hospitals and in their estimates of the VA's future needs.

For example, the congressional study estimated that if the average length of stay for VA patients remained fairly constant, the VA would need 18 per cent more hospital beds by 1990 and 36 per cent more by 2000. However, the study estimated that if VA aggressively pursued policies to reduce lengths of stay, as recommended in a recent report by the General Accounting Office, the current number of hospital beds available would be sufficient in 2000.

The VA study indicated that more beds will be needed. Its estimates for increases in hospital beds ranged from 45 to 136 per cent by 1990 and from 68 to 208 per cent by 2000. However, the General Accounting Office released a report on August 8 ("Better Patient Management Practices Could Reduce Length of Stay in VA Hospitals") that said:

> GAO performed two different reviews of patients at VA hospitals. In one review at seven hospitals, GAO's consultant team of physicians and nurses from the Washington State Professional Standards Review Organization reviewed 350 randomly selected medical files of patients who had been discharged from these hospitals during fiscal year 1982. Based on the consultant's review, GAO estimates that nearly 43 per cent of the total days spent by medical and surgical patients at these seven hospitals . . . were medically avoidable. About 20 per cent of the total days were attributable to the absence of efficient management practices at the hospitals, while 23 per cent were attributable to the unavailability of less costly levels of care. The VA service chiefs in the hospitals agreed with 86 per cent of the avoidable days identified by the consultant. In a second review, GAO's chief medical advisor visited six of the seven VA hospitals during fiscal 1984 to evaluate the medical conditions of patients in medical and surgical beds. He evaluated nearly 800 patients, representing about 44 per cent of the total medical and surgical patients in the hospitals at the time of his visits, and concluded about 31 per cent of these patients did not belong in medical and surgical beds. VA physicians who were treating these patients agreed with the determination for 96 per cent of the patients. They pointed out, however, that less costly levels of care for these patients were often not available.

The VA's report on the aging veteran pointed out that its estimates of future need presumed no major shift in health insurance coverage among veterans over 65, "although Medicare and Medicaid may well provide less insurance in the future than they currently do." The complex interaction between the VA and the non-VA medical care system is a subject that is essentially ignored by the federal government. Different congressional committees oversee the VA and the two largest health financing programs, Medicare and Medicaid, and the executive agencies that administer these different efforts have few binding ties. Yet, Dr. John W. Rowe, director of the Division on Aging at Harvard Medical School, pointed out the importance of interaction between these programs in congressional testimony on April 23:

> Increasing costs for patients in one sector will naturally drive patients with dual eligibility to the less restrictive or less expensive option. For instance, we project that if further [monthly premium] increases in Medicare Part B cause only 10 per cent of elderly veterans currently using the non-VA health-care system to give up their private physician as a source of care and turn to the VA, the VA can anticipate an increase of roughly 15,000 veterans seeking hospitalization and 40,000 requesting outpatient care.

As publication of "Caring for the Older Veteran" suggests, the VA has begun to address the many issues that arise because of the aging of the veteran population. In the specialty of geriatric medicine, the VA has taken the lead in developing noninstitutional approaches to caring for elderly veterans, but its progress has been slowed by budget restrictions and the difficulty of reallocating resources in an entrenched bureaucracy that resists rapid change. As Dr. Rowe, who also directs a VA Geriatric Research Education Clinical Center in West Roxbury, Massachusetts, said in his congressional testimony:

> You can say the VA is the giant of geriatrics, but there are only 10 GRECC's [geriatric research education clinical centers] and only 49 hospital-based home care programs. But there are 172 medical centers. So 123 of the medical centers don't even have a hospital-based home care program yet.

The VA's medical care program faces a challenging future with many unanswered questions. The commitment of Congress to the agency and its mission has remained steadfast. This commitment will be subject to more testing in the future as the agency seeks to shift resources, convert hospital beds to long-term care beds, and prepare in other ways for aging veterans. The Reagan administration will continue to chip away at the VA's funding base, but it has shelved any thoughts it might have had about seeking broader changes in the agency. The VA's relation with the private medical care sector is likely to have an influential role in the agency's future. I will report on the status of this relation in a subsequent essay.