

Strategy Research Project

Reducing the Redundancy of the Veterans Affairs Hospital System

by

Lieutenant Colonel Philip Tennant
United States Army

Under the Direction of:
Professor Frederick Gellert



United States Army War College
Class of 2018

DISTRIBUTION STATEMENT: A

Approved for Public Release
Distribution is Unlimited

The views expressed herein are those of the author(s) and do not necessarily reflect the official policy or position of the Department of the Army, Department of Defense, or the U.S. Government. The U.S. Army War College is accredited by the Commission on Higher Education of the Middle States Association of Colleges and Schools, an institutional accrediting agency recognized by the U.S. Secretary of Education and the Council for Higher Education Accreditation.

REPORT DOCUMENTATION PAGE			Form Approved--OMB No. 0704-0188		
The public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0188), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.					
1. REPORT DATE (DD-MM-YYYY) 01-04-2018		2. REPORT TYPE STRATEGY RESEARCH PROJECT		3. DATES COVERED (From - To)	
4. TITLE AND SUBTITLE Reducing the Redundancy of the Veterans Affairs Hospital System			5a. CONTRACT NUMBER		
			5b. GRANT NUMBER		
			5c. PROGRAM ELEMENT NUMBER		
6. AUTHOR(S) Lieutenant Colonel Philip Tennant United States Army			5d. PROJECT NUMBER		
			5e. TASK NUMBER		
			5f. WORK UNIT NUMBER		
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Professor Frederick Gellert			8. PERFORMING ORGANIZATION REPORT NUMBER		
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES) U.S. Army War College, 122 Forbes Avenue, Carlisle, PA 17013			10. SPONSOR/MONITOR'S ACRONYM(S)		
			11. SPONSOR/MONITOR'S REPORT NUMBER(S)		
12. DISTRIBUTION / AVAILABILITY STATEMENT Distribution A: Approved for Public Release. Distribution is Unlimited. I understand this document will be included in a research database and available to the public. Author: <input checked="" type="checkbox"/>					
13. SUPPLEMENTARY NOTES Word Count: 5287					
14. ABSTRACT Current and future veterans will require health care. The Veterans Administration (VA) healthcare system with its problems of wait time, staffing, and budget, requires radical changes to improve the services that the VA provides more cost effectively. The VA has grown to be the second largest employer in federal agency. In 2018 its total budget was \$177.5 billion, \$69.8 billion covered medical salaries, medical programs, and research. The maintenance budget of VA medical facilities in 2018 equated to \$12.6 billion. The VA support two major age demographics, from Vietnam era and the Gulf War era, this presents different demands on a system that is experiencing problems in providing timely care. Understanding the veteran care models of different nations demonstrates others have made the transition from a sole medical care system for the veterans to one that services the community and veterans. By expanding the current VA program of the Veterans Access, Choice, and Accountability Act of 2014, allowing the veteran to use the private healthcare system, will facilitate the closure of the existing VA Hospitals providing for an overall budget savings for the VA.					
15. SUBJECT TERMS Veterans Administration, VA, Healthcare, Health Care, Budget, Privatization, Choice Act					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES 28	19a. NAME OF RESPONSIBLE PERSON
a. REPORT UU	b. ABSTRACT UU	c. THIS PAGE UU			19b. TELEPHONE NUMBER (w/ area code)

Reducing the Redundancy of the Veterans Affairs Hospital System

(5287 words)

Abstract

Current and future veterans will require health care. The Veterans Administration (VA) healthcare system with its problems of wait time, staffing, and budget, requires radical changes to improve the services that the VA provides more cost effectively. The VA has grown to be the second largest employer in federal agency. In 2018 its total budget was \$177.5 billion, \$69.8 billion covered medical salaries, medical programs, and research. The maintenance budget of VA medical facilities in 2018 equated to \$12.6 billion. The VA support two major age demographics, from Vietnam era and the Gulf War era, this presents different demands on a system that is experiencing problems in providing timely care. Understanding the veteran care models of different nations demonstrates others have made the transition from a sole medical care system for the veterans to one that services the community and veterans. By expanding the current VA program of the Veterans Access, Choice, and Accountability Act of 2014, allowing the veteran to use the private healthcare system, will facilitate the closure of the existing VA Hospitals providing for an overall budget savings for the VA.

Reducing the Redundancy of the Veterans Affairs Hospital System

To fulfill President Lincoln's promise "To care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's Veterans.

—Veterans Affairs Mission Statement¹

One of the major issues affecting the long-term health of the United States (U.S.) is the year-after-year budget deficits. As of November 30, 2017, the total national debt equaled to \$21 trillion with a fiscal year (FY) 2017 interest payment of \$459 billion.² In 2001 was the last time the United States had a balanced or surplus budget. From 2002 to 2017, the workings of the U.S. bureaucracy increased the national deficit by \$13.8 trillion, and future government projection outlay reveals further deficit spending.³

Looking toward the future and the further expansion of the deficit requires a willingness to transform the way the government does business by reducing those government services which the private sector can provide more efficiently. One of those is the health care that the Veterans Administration (VA) provides to the veteran. The U.S. healthcare system has three major groupings. Private/public, which provides health care to the general population, the military healthcare system serving the military members, retirees, and their families, and the veterans' healthcare system serving the veterans, and in certain cases, their families. Each of these systems has its own physical structures and provides services independent of each other.

The VA has failed to control of costs with a decreasing veterans population and plagued with issues effecting the VA healthcare hospital system ability to provide quality timely care which the private market should provide. Understanding the formulation of the VA health care budget environment which has a correlation to the demographics of the population seeking care and the care that the VA must provide. Considering the

current healthcare systems in the United States and how other nations provide care to veterans provides options that could change the VA healthcare system. Finally, the benefits that the VA healthcare systems provides to the medical education system in the development of trained health care providers. The VA medical benefits require a change to some form of privatizations to control costs, such as though the expansion of the VA Choice Act, this will reduce the requirements for VA medical resources, improving timely care, and provide more rapid adjustments to the care requirements of the veteran population.

At the start of the 20th century, the American hospital system was in its infancy. In 1873, the federal government created the first "...National Home for Disabled Volunteer Soldiers..." and these National Homes morphed into the future veteran hospitals we know today.⁴ By 1921 there was a construction program to expand the veteran hospitals to support the World War I veterans, bringing the total of Veteran hospitals to 54 in 1930.⁵ In the early 20th century, the public hospital system was very limited in that doctors, nurses, and staff either donated their time, or were minimally paid.⁶ The public medical system of the time could not support the influx of the veterans from World War I. There were 72 public hospitals with a capacity of 18,818 beds under the control of the Public Health Service serving the nation in FY 1921, and many of these hospitals were "unsatisfactory" and refused service to returning veterans.⁷

At the beginning of the 21st century, the U.S. hospital system was one of the best in the world. As of 2015, serving the public there are 5,564 hospitals that meet the American Hospital Association (AHA) standards. There are 4,862 community hospitals, which are short-term or specialty hospitals serving the public, including 401 psychiatric

hospitals. The federal government controls 212 hospitals. The remaining hospitals meeting the AHA standards are long term care hospitals and institutions, such as prisons and college infirmaries.⁸

The community hospitals have the capacity of 782,188 beds serving the public.⁹ Such a capacity at the community level points to possible overlaps of services provide by the three healthcare systems. The utilization of compacity at a hospital serving the public or the veteran runs at about 65 percent on average in 2014.¹⁰ This presents an opportunity that requires exploration in hopes of bettering the country's financial wellbeing. The Veterans Administration (VA) health care budget, driven by the changing needs of the veteran population, and the ongoing problems facing the veterans, impacts the long-term financial health of the nation.

Recommendation

The resource costs of maintaining infrastructure for three independent healthcare systems continue to escalate. The government cannot control the private/public health care costs, since it lacks the authority to regulate the cost.¹¹ That leaves the military and VA medical systems, where the government has direct budget control. The operations and locations of the military bases place restrictions on access to quality private/public health care. Thus, the focus should be on reducing the VA medical system costs by allowing veterans to access quality care anywhere and anytime. Currently the VA manages two systems where veterans can seek care: the VA medical system, and an insurance type program referred to as the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act).

The Obama administration originally created the Choice Act to address concerns of unacceptable delays of care for the veterans of the nation by using private medical

providers.¹² The Choice Act provided \$16 billion to cover the cost for utilization of non-VA hospital care and medical services, if the veteran lived outside a 40-mile radius from their home to a VA medical facility or if they faced extensive wait times. Over time the Choice Act has made improvements for veterans using non-VA facilities by reducing out of pocket costs such as copayments to primary and secondary health insurance. The VA now covers co-pays or deductibles directly with the providers. An additional improvement included the removal of restrictions on sharing of health information outside of the VA, this supported the alignment of the VA with other health care providers, ensuring that the veteran receives the correct and appropriate care required.¹³ Allowing access to facilities and services external to the VA was the biggest benefit of the Choice Act.

If the VA stays in the business of directly providing medical care, the cost of staffing and maintaining hospitals and outpatient clinics will continue to increase, consuming more and more of the annual U.S. budget. Even though the veteran population is decreasing, the demographic utilizing VA medical services is changing as the medical requirements continue to grow due to changes in the eligibility requirements. Due to the size of the VA bureaucracy, changes require time in making adjust to the needs of the veteran will continue to be a daunting challenge for the VA. Allowing for the further expansion of the VA Choice program, many be a form of privatization, will permit the veteran to receive services outside VA facilities, providing for the timely medical care using state-of-the-art equipment. The privatization of the VA healthcare system is a controversial topic which Congress will need to tackle and fund.

Additional, this recommendation has value in the military healthcare system. In 2015, military healthcare system had 9.44 million eligible enrollees of which 5.40 million were qualified retirees.¹⁴ The military healthcare system suffers similar issues that VA suffer, increasing cost, and serving a diverse population ranging from infants to the elderly. The recommendation of some form of privatization of the VA, thru the Choice Act should have merit within the military healthcare system to provide a more cost-effective model and not the \$48.5 billion military health care bill that was paid in FY 2015.¹⁵

VA Budget Overview

The VA has the largest employment base in the Executive branch, only second to the Department of Defense (DoD). A majority of the employment base supports the VA medical bureaucracy, administrations, support staff, nurses, doctors, etc. If each service within the DoD, Army, Navy and Air Force stood on its own, the VA employs more than the Army, which is the largest service in DoD.¹⁶ The VA budget ranks in the top five behind the Department of Health and Human Services, Social Security Administration, Department of Treasury, and the Department of Defense.¹⁷ The VA is a key government cost center due to the size of the employment base.

The annual VA budget contains both discretionary and mandatory spending. For 2018, \$69.8 billion of the \$177.5 billion total budget falls under discretionary spending, which is a majority of the funding provided for medical care. The remaining \$107.7 billion falls under mandatory spending, covering items such as disability compensation, pensions, education assistance and the Veterans Group Life Issuance program which allows for the service member to convert their Service-members' Group Life Insurance upon separation from service.¹⁸

The VA health care budget has grown significantly over the years, adding to the overall federal budget deficit (Table 1). FY 2010 to current provides an insight into the cost of the outpatient facilities and hospital costs. The cost for the physical medical facilities constitute 8-10 percent of the annual budget and ensuring the medical equipment and facilities meets all rules and guidelines consumes another 8 to 11 percent of the VA health care budget.¹⁹

Table 1. FY Budget for VA Health Care (in billions)²⁰

Fiscal Year	Total Medical & Research	Medical Facilities	Medical support and compliance
1995	\$16.4	-	-
2000	\$18.4	-	-
2005	\$31.5	-	-
2010	\$48	\$4.7	\$5.1
2015	\$57	\$4.7	\$5.9
2018	\$69.8	\$6.5	\$6.1

Veterans using non-VA facilities, which is normal for outpatient services, cost the VA \$3 billion in FY 2008, and increased to \$5.5 billion in FY 2014.²¹ FY 2014 inpatient utilization of VA facilities 483,800, compared to 136,760 using non-VA facilities.²² In FY 2014, of 9.1 million veterans eligible for VA medical care, 1.2 million used non-VA facilities.²³ This shows that the current system cannot provide all services required and that the current public system can support the additional load if VA hospitals or clinics begin to be phased out or merged with the public system.

Veteran Population

A decrease in the overall veteran population is likely in future years as the number of veterans from World War II, Korean and the Vietnam conflicts decrease, even with an increase in Gulf War era veterans joining the veteran population (Table 2). With the overall population of veterans decreasing in the long-term, the expectation is

that the work load would decrease. Due to modern medicine, more soldiers are living through injuries that they would not have been able to survive in the past. Many of the injuries require more care for the long-term. The VA projects that the enrollment in the VA healthcare system will continue to increase over the next few years (Table 3). This will further increase the cost and burden to the system. In response to the projected increase, the VA plans to add an additional 7,000 full-time equivalents (FTE) from 2017 to 2018, totaling 324,000 FTEs. To provide an historical comparison on the growth of the VA health system, in 2003 the VA had 190,255 FTEs supporting 7.1 million enrollees.²⁴ Employing such a large population has short and long-term costs. Short-term costs include insurance, 401k (Thrift Savings Plan) and taxes, while an example of a long-term cost is the government pension those employees earn. The 2009, a 40-year career cost of a general schedule (GS) federal employee at the GS-8 level is about \$4.27 million, and roughly \$11.3 million at the GS-15 level.²⁵ In the light of the increase of veterans enrolling for health care, the system was unable to keep pace with demand, creating a cross over into the public hospitals and clinics.

Table 2. U.S. Veteran Population²⁶

Date	All Veterans	WW2	Korean Conflict	Vietnam Era	Gulf War Era
9/30/2015	20,783,555	939,332	1,803,542	7,013,186	6,881,897
9/30/2020	18,823,868	299,824	1,018,962	6,058,417	7,755,819
9/30/2025	17,028,497	61,256	431,479	4,938,359	8,217,738
9/30/2030	15,466,321	7,795	123,848	3,684,151	8,178,227

Table 3. Veterans Enrolled in the VA Health Care²⁷

	2016 Actual	2017 Estimate	2018 Request	2019 Request
Enrolled in VA Health Care	9,046,663	9,213,064	9,302,552	9,372,658

In its early years, the VA provided health care only to the wounded, poor and homeless veterans. This level of service changed with the VA health care reform in June 1996. First, the eligibility rules opened the healthcare system to non-wounded and middle-class veterans. Second, it changed the services that the VA offered at the VA hospitals from acute care to comprehensive care. The approach of shifting from focusing on injury or illness to prevention and holistic care caused the VA health system to increase in size, which caused the opening of outpatient clinics in almost every congressional district.²⁸ The change in the care model and eligibility rules caused the cost of medical services and administrative costs to increase from \$17.8 billion serving 26 million veterans in FY 1996 to \$63.5 billion serving 20.3 million veterans in FY 2016. During FY 2016 the VA saw 6 million unique patients, whereas in FY 2007 the Veteran population was 23.7 million with 5.2 million seeking medical care.²⁹

With the veterans from the Vietnam era aging, and the increase of the Gulf War era veterans requiring medical care, VA costs will continue to increase. Inpatient hospital admissions have seen an increase over a 13-year span (Table 4). The data does not include service-related injuries, but in several annual budget requests, the VA refers to the increasing age of the Veteran population.

Table 4. Admissions³⁰

Fiscal Year	Inpatient Admission (in thousands)
2002	564.7
2005	585.8
2010	682.3
2015	699.1

The changes to the eligibility rules had a major impact on the population that the VA health system services. Even as the veteran population trends smaller year after

year, the demands for comprehensive VA health care increases. With this increased demand, there is cost associated in meeting the mission of the VA.

Issues Facing the VA System

The vast size and bureaucracy of the VA health system causes the inherent problems facing the system. The influx of Gulf War era veterans demonstrated the VA bureaucracy was "... accustomed to dealing with older vets from Vietnam and earlier wars or retirees with all the ordinary problems of aging, seemed incapable of adjusting to wartime circumstances...."³¹ The VA was unwilling to prioritize the veterans that sustain wounds in combat to the rest of the population that needed care.³² Since the VA serves the veteran community the veteran has a propensity to stay with what is they are accustom with, the veterans will generally stay within the VA system and receive care.³³ The growth of enrolled veterans has overwhelmed the current VA healthcare system, creating the opportunity for the expansion of the Choice Act.

The system continues to face issues of long delays, and in a few cases, veterans have died waiting for care. According to the Association of American Medical Colleges, by 2020 the United States will be facing a shortage of more than 91,000 physicians.³⁴ This shortage will put the struggling VA medical system under increasing pressure. A key provision of the Choice Act allowed veterans to schedule appointments in non-VA entities if the VA was unable to provide care within 30 days, allowing the veteran to seek timely care and to provide relief to the overburdened VA medical system. This was originally a three-year pilot.³⁵ Reporting required by the Choice Act, covering 2014 to 2017, revealed a 6% to 9% wait time greater than 30 days, and under a 1% wait time greater than 120 days (Table 5).

Table 5. Appointment Delays³⁶

Date	Scheduled appointments	Appointments greater than 30 days	Appointments greater than 120 days
12/1/2017	9,160,450	560,258	57,010
12/1/2016	7,328,991	518,812	48,141
12/1/2015	6,019,856	542,753	35,435
12/1/2014	5,737,248	378,398	13,873

The passing of the Choice Act has provided better reporting by the VA, which allows for increased transparency. Due to the additional transparency and attention the VA has garnered following the enactment of the Choice Act, VA health care has earned a place on the United States Government Accountability Office (GAO) High Risk Report for the last two reporting cycles. Published every two years, the 2017 High Risk Report calls attention to government agencies or programs that are "...vulnerabilities to fraud, waste, abuse, and mismanagement, or are most in need of transformation."³⁷ Due to the size of the bureaucracy, the VA provides ample opportunities for the vulnerabilities to manifest themselves. From 2010 to 2016, GAO provided 244 recommendations to reduce the vulnerabilities of the VA, of which 122 recommendations have been addressed. In the 2017 High Risk Report GAO, raises concerns about the ability of the VA to provide cost effective and timely access to care, including the ability to properly manage their budget.³⁸

Since the original passing of the Choice Act three years ago, there have been adjustments to the law in efforts to reduce the wait times for veterans. The VA system experiences long delays of care, normally for specialized care, and two possible ways to fix this are by utilizing the Choice Act and to increase hiring to improve capacity.³⁹ In April 2017, the President signed a law moving the pilot program into the main stream

process of the VA, with plans to increase its budget.⁴⁰ By signing the Choice Act continuation, the path forward for the VA is clearer.

In addition, the aging veteran population also qualifies for Medicare. The VA health and Medicare systems report separately and when a veteran receives care in one system, they could receive the same care in the other. This may lead to redundancy in primary care and medication disbursement, leading to additional cost.⁴¹ The redundancy also shows that a lack of record-sharing between the two will increase the cost of testing, due to duplication of testing. This redundancy also exists between the VA and the military health system. The GAO highlighted this issue by publishing an annual report about opportunities for cost savings by decreasing duplications. Since 2011, the GAO has identified six activities, which effects the veteran population receiving medical care from the VA.⁴² Collaboration, coordination, and sharing of data are critical to help drive down cost and reduce appointment wait times.

Comparison of Other Veteran Healthcare Systems

There are three major government health care integrators in the United States: Medicare, VA, and the military. In 2017, Medicare covered 58 million enrollees with 1.2 million physicians and 6,000 hospitals.⁴³ None of the physicians are government employees, nor are the hospitals owned by the government. The programs managed under Medicare are supported by 4,000 FTEs.⁴⁴ The VA's Veterans Health Administration (VHA) is the largest health care integrator in the United States, and employs an estimated 316,000 FTEs.⁴⁵ The VHA is the largest federal executive branch workforce within the government.⁴⁶ At the start of FY 2017, the VA supports 145 hospitals, 1,231 outpatient sites⁴⁷ and 8.9 million enrollees.⁴⁸ In comparison, the Military Health System (including the TRICARE program) provides services to 9.4 million

beneficiaries,⁴⁹ supported by 66 surgical hospitals and 191 clinics worldwide.⁵⁰ There are 63,000 FTEs with an additional 84,000 military personnel supporting the military health care needs.⁵¹

Comparing the true cost difference between the VA and private industry is a challenge. The VA has provided limited information concerning their costs and operational performance. The types of care provided by the VA and private industry will be different since private industry could provide more services due to the financial incentives, where the VA facilities do not have the same incentives. The Congressional Budget Office published a report in 2014 that provided the following cost comparisons based on 1999 Medicare payment rates (Medicare payments on average are 20-30% lower than commercial insurance payment rates): the full range of VA medical services would cost 21% more if delivered in the private sector; inpatient care, not including rehabilitation and nursing home facilities, cost 16% more in the private sector; and outpatient care costs 11% more than the VA. Concerns noted by GAO of this report: the age of the data, from 1999 to present, medical industry costs have increased sharply, the VA since the report has shifted their focus from inpatient to outpatient care and a change of demographics has occurred due the events of the Gulf War and Afghanistan.⁵²

Historically, the United States was not the only nation that had veteran-only hospitals. Australia, Canada, United Kingdom, and Finland had similar systems, but their veteran hospitals either closed or transitioned to become part of national health care.⁵³ Australia, Canada, and the United Kingdom either converted or closed their hospitals that operated under the veteran healthcare system. The process in the United

Kingdom started in 1953 with the transfer of veteran health care infrastructure and veterans to the national healthcare system. Canada made the transfer in 1963 and Australia transferred in 1988.⁵⁴ This allowed the veteran to secure care within their home communities. Nationalization of the veteran hospitals allowed for the "...further [development of] their specialized medical expertise by expanding their patient mix."⁵⁵ In other cases, the full care of veteran didn't fully transfer to the national healthcare system. Long-term care, remained outside of the national healthcare system such as in Canada and Finland, they established home care programs to provide care at home allowing for veterans to retain their independence longer.⁵⁶ Compared to the U.S. three-tier healthcare system, other nations provide military and veteran health care differently.

The nations of Australia, Canada, Estonia, Germany, United Kingdom, Israel, Japan, Netherlands, Poland, and Sweden have some form of national health care providing care to the general population. They have a separate military healthcare system with different levels of integration in the national medical system, in which the military receives priority. Upon military separation due to injury or retirement, the veteran transitions to the national healthcare system of the nation. Clinics are a different story, where many of the states' military have standalone clinics where service members can receive initial care before further treatment at the national hospital. In some cases, the family members fall outside of the military healthcare system that provides limited health care to the military. In the United States the family members receive admittance to military hospitals and clinics, requiring an increased level of specialty staffing due to the demographics of the patients. The family members from the nations fall under the national healthcare system a majority of the time but receive

additional benefits. These benefits differ among the countries. For example, Canada provides supplemental coverage for eye exams and medication at a discounted rate compare to the rest of the general population. Germany provides coverage at 80% of the cost if the spouse's income is less than \$20,000. The United Kingdom will only provide family coverage in the military clinic if it provides training for physicians. In Poland, the military clinics are open to the public. That hospitals serve the public and military at the same time provides infrastructure and equipment cost savings.⁵⁷

Separation from the U.S. military, based on length of service, condition of separation, injury, and other factors can qualify the veteran access to the VA healthcare system.⁵⁸ These veterans, based of years served, may also choose to stay within the military healthcare system seeing military doctors under the TRICARE or TRICARE for Life programs.⁵⁹ In FY 2015, veterans and retirees cost the U.S. military healthcare system \$9.3 billion.⁶⁰ In the nations listed earlier, upon separation from the military, the veteran joins family members in the national health care system. This is ideal because of the limited resources when providing continuation of care. Furthermore, this form of continued care in one system, supports the sharing of test results and prevents redundant prescriptions. Combining the national, military, and veteran health systems allows for less duplication of physical infrastructure, equipment, and employee costs.

Veterans Hospitals Additional Services

The VA hospital network provides additional services beyond caring for the veterans, such as training future doctors and conducting vital research. The medical education industry will need to develop a replacement of the current education benefits that the VA offers, which would be hard to replace due to the 70 years of involvement. The VA hospital system provides care to the veterans and training of the future medical

professionals. Memorandum Number 2 by General Omar Bradley in 1946 established close ties between the VA and the medical schools of the nation. The memorandum allows medical schools "...access to VA facilities and the medical school faculty would serve joint-appointments as VA staff physicians."⁶¹ Title 38 U.S. Code exemplifies the importance of the VA training mission, which mandates training of health care specialists while meeting the VA needs of providing care to the veterans of the nation.⁶²

Over the years the education mission has become more prominent in influence due to increasing costs of medical education. In 1990, VA hospitals had affiliations with 102 medical schools.⁶³ In 2000, the VA hospitals provided training and financial support to one-third of all medical residents within the nation. In 2007, the VA had 107 affiliation agreements.⁶⁴ By 2014 the demand increased and the VA provided educational opportunities to over 41,000 medical residents and an additional 23,000 medical students.⁶⁵ The difference between a medical student and resident is that the student is working towards a medical degree and the resident holds a medical license working with an attending physician learning a specialty.⁶⁶ Education integration was so great that 127 VA medical centers had affiliation agreements with 130 of 141 U.S.-accredited medical schools.⁶⁷ Over the years the VA also supported the medical schools by paying the salaries of many of the faculty who provided care to the veterans and taught at the hospitals.⁶⁸ The VA hospital system provides a unique educational opportunity in today's medical care system. Normally the admitted patient would stay in the hospital after being qualified through earlier tests and then discharged after recertifying the ailments. In the case of the VA, most patients tend to be in inpatient care longer, which provides

for more opportunities for education through the continuation of care in a hospital setting.⁶⁹

The VA hospitals provide a centralized research venue for the medical field, focusing on veteran medical issues. Research topic areas, such as post-traumatic stress disorder, traumatic brain injury and prosthetic effect, primarily came out of the Gulf War era.⁷⁰ Closing the VA hospitals may impact the research leading to future developments of solutions and cures that affect the veteran quality of life, due to the diffusion of veterans to different providers. Negative research effects could be negated by the VA or Department of Health and Human Services providing focus research grants in geographical areas based off veteran populations.

The current VA healthcare system is a form of national health service. It provides services to a group of the population in "...government-owned facilities staffed by government employees."⁷¹ The government-owned VA hospital system, provides a proving ground that could enlarge to form a national healthcare system. Lessons can provide insight from the VA medical system if there was a national desire to move toward a national healthcare system.

Implementing the Recommendation

From one city to the next the American public can access medical care. The veteran should be able to seek care at these locations, but current rules require veterans to first seek care at the VA, supporting the VA hospital and clinics systems.

At the beginning of 2017 the Veterans Affairs Secretary called for closing of 1,100 vacant or underutilized sites which cost the VA \$25 million a year.⁷² The VA infrastructure is also aging, as 57% of VA sites are over 50 years old and would cost millions to replace.⁷³ The realignment of services associated with the closures and the

aging infrastructure makes the concept of utilizing the public hospitals more viable. Reducing the VA medical system footprint serving the nation would require the Choice Act to provide additional funds to ensure payment for the services required by the veterans. But savings from lower number of facility and medical staff will offset the increases needed by the Choice Act. In 1998, GAO published a report consolidating four hospitals to three in Chicago. GAO projected that the VA has the potential to save over \$200 million of operating and maintenance (O&M) costs over a ten-year period by closing one of the hospitals. As the hospitals age the VA will have to incur renovation costs of \$6 to \$27 million. Additionally, with the sale or rental of the facility the VA had the ability to generate additional revenue.⁷⁴ In 1998, the O&M saving would be worth \$351 million in labor cost if the closing happened in 2016.⁷⁵ With the constant need for renovation and year after year cost of O&M, the reduction of infrastructure will save significant costs in both the near and far terms.

Other countries completed the transition of veteran care from a healthcare system that supports only veterans to one incorporating the veterans into the national population. One additional factor for the U.S. military is the inclusion of dependents and retirees in health care, while allied nations mostly provide access to the military healthcare system to the actual military personnel. These lessons from allies and partners have value; however, not all information will be applicable because the United States does not have a national healthcare system like most industrialized states. The U. S. health care system is a market-based system into which the VA and the military must integrate, as Medicare has done.

The VA and military can decrease their cost by reducing FTE count, medical equipment lifecycle replacement, certification of the medical equipment and operation and management of sites. To understand total savings will require further studies and additional transparency from the VA. To date, the VA has provided limited information about their cost and operational performance.⁷⁶

A major hurdle that the United States must tackle is the medical education system ties with the VA. With the VA medical system so intertwined with almost all the medical education apparatus, the removal of the valuable education opportunities and avenues will have significant ramifications if not mitigated.

Conclusion

The needs of the veterans' impact the services being offer and the growing VA health care budget. The increasing demands for future funding to maintain the military edge and healthy social programs will continue as challenges for the United States for years to come. The concept of reducing governmental and commercial redundancies is not new and examination of efficiencies will provide savings. Some would call redundancy a necessary evil, able to step in when the primary system fails or when the system is unable to maintain an accepted level of service. The question is: Does the cost merit the benefit?

With the current crushing debt, interest levels and the FY 2017 deficit of \$666 billion,⁷⁷ consideration requires ideas that could render a reversal of increasing expenditures. Clearly, the U.S. three-tier healthcare system requires evaluation as a source of savings. Shutting down or transferring VA hospitals to military or public use facilities would translate to a reduction of services and staff costs, which in turn could

have an impact on the shortages of physicians that the Association of American Medical Colleges forecasted.

The impacts that transform the VA health care utilization stem from the changed service model and the eligibility rules. These variations increased the population that the VA was providing care to. With the forecasted continual population growth of enrollees in the Veteran healthcare system, the current issues attributed to the demand exceeding the means will continue to plague the VA.

The use of the Choice Act program will help pass the demand to the public sector. The Choice Act is a step closer to how other nations have dealt with the multi-tiered system of health care. Once the VA healthcare system move merged with national, lessons will inform the possible creation of a truly integrated national healthcare system.

Endnotes

¹ U.S. Department of Veterans Affairs, "About VA: Mission, Vision, Core Values and Goals" (Washington, DC: U.S. Department of Veterans Affairs, August 20, 2016), https://www.va.gov/about_va/mission.asp (accessed December 13, 2017).

² TreasuryDirect, "Interest Expense on the Debt Outstanding" (Washington, DC: U.S. Department of Treasury, March 2, 2018), https://www.treasurydirect.gov/govt/reports/ir/ir_expense.htm (accessed March 16, 2018).

³ "The U.S. Federal Budget," *Inside Gov*, <http://federal-budget.insidegov.com/> (accessed December 3, 2017).

⁴ U.S. Department of Veterans Affairs, "About VA: History" (Washington, DC: U.S. Department of Veterans Affairs, May 18, 2017), https://www.va.gov/about_va/vahistory.asp (accessed December 3, 2017).

⁵ Ibid.

⁶ "Emergence of Public Hospitals: 1860-1930," *America's Essential Hospitals*, <https://essentialhospitals.org/about-americas-essential-hospitals/history-of-public-hospitals-in-the-united-states/emergence-of-public-hospitals-1860-1930/> (accessed December 3, 2017).

⁷ Surgeon General, *Annual Report of the Surgeon General of the Public Health Service of the United State* (Washington, DC: U.S. Department of Veterans Affairs, FY 1921), 272-73, <https://www.va.gov/vetdata/docs/PHSFY1921.pdf> (accessed December 14, 2017).

⁸ American Hospital Association, "Fast Facts on U.S. Hospitals," (Washington, DC: American Hospital Association, 2017), <https://www.aha.org/statistics/fast-facts-us-hospitals> (accessed December 3, 2017). AHA criteria, certified to provide acute services under Title 18 of the Social Security Act or meet the 10 alternative requirements; 1) maintain six inpatient beds for patients in excess of 24 hours, 2) constructed, equipped, and maintained to ensure health and safety, 3) identifiable governing authority responsible for the conduct of the hospital, 4) have a chief executive, 5) organized medical staff or fully licensed physicians, 6) patient will be admitted on the authority of a member of the medical staff, 7) registered nurse supervision are continuous, 8) current and complete medical record will be maintain, 9) pharmacy services will be provide by a registered pharmacist, 10) provide food services to meet nutritional and therapeutic requirements.

⁹ Ibid.

¹⁰ Congressional Budget Office, *Comparing the Cost of the Veterans' Health Care System With Private-Sector Costs* (Washington, DC: U.S. Congressional Budget Office, December 2014), 9, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/49763-VA_Healthcare_Costs.pdf (accessed February 10, 2018).

¹¹ Michael Lee, "Quora: Can the U.S. Government Control Health Care Costs?" *Newsweek Online* (May 14, 2017): <http://www.newsweek.com/quora-question-will-government-control-healthcare-cost-607095> (accessed February 12, 2018).

¹² Larry Lohmann, "The Veterans Choice Improvement Act: An Overview of the Changes to the Program to Extend the Program through 2017," *George Mason University Veterans and Servicemembers Legal Clinic*, <https://mvets.law.gmu.edu/2017/05/18/the-veterans-choice-improvement-act-an-overview-of-the-changes-to-the-program-to-extend-the-program-through-2017/> (accessed January 14, 2018).

¹³ Ibid.

¹⁴ Office of the Assistant Secretary of Defense (Health Affairs), *Evaluation of the TRICARE Program: Fiscal Year 2016 Report to Congress* (Falls Church, VA: Defense Health Agency, February 2016), 12, <https://health.mil/Reference-Center/Reports/2016/05/19/Evaluation-of-the-TRICARE-Program-Fiscal-Year-2016-Report-to-Congress> (access October 15, 2017).

¹⁵ Office of the Assistant Secretary of Defense (Health Affairs), *Evaluation of the TRICARE Program: Fiscal Year 2015 Report to Congress* (Falls Church, VA: Defense Health Agency, February 2015), 1, <https://health.mil/Reference-Center/Reports/2015/02/28/Evaluation-of-the-TRICARE-Program-Fiscal-Year-2015-Report-to-Congress> (access October 16, 2017).

¹⁶ Bureau of Labor Statistics, *Working for the Federal Government: Part 1* (Washington, DC: U.S. Bureau of Labor Statistics, September 2014), <https://www.bls.gov/careeroutlook/2014/article/federal-work-part-1.htm> (accessed February 10, 2018).

¹⁷ "The U.S. Federal Budget," *Inside Gov.*

¹⁸ Department of Veterans Affairs, *Budget in Brief* (Washington, DC: U.S. Department of Veterans Affairs, 2018), Bib 1, <https://www.va.gov/budget/docs/summary/fy2018/VAbudgetInBrief.pdf> (accessed December 10, 2017); Department of Veterans Affairs, “Life Insurance: Veterans Group Life Insurance” (Washington, DC: U.S. Department of Veterans Affairs, May 19, 2017), <https://www.benefits.va.gov/insurance/vqli.asp> (accessed March 13, 2018).

¹⁹ U.S. Department of Veterans Affairs, “Summary – Volume I 2010 Congressional Submission” linked from *Office of Budget: Annual Budget Submission* (Washington, DC: U.S. Department of Veterans Affairs, May 2009), 1B-1, <https://www.va.gov/budget/products.asp> (accessed December 10, 2017); U.S. Department of Veterans Affairs, “FY 2015 President’s Budget Request” linked from *Office of Budget: Annual Budget Submission* (Washington, DC: U.S. Department of Veterans Affairs, March 5, 2014): 10, <https://www.va.gov/budget/products.asp> (accessed December 10, 2017); U.S. Department of Veterans Affairs, *Budget in Brief*, Bib 2.

²⁰ U.S. Department of Veterans Affairs, *Office of Inspector General, Summary Report: Audits of VA – Medical Schools Affiliation Issues* (Washington, DC: U.S. Department of Veterans Affairs, January 29, 1997), <https://www.va.gov/oig/pubs/7r8-a99-026--medsch.pdf> (accessed December 13, 2017); U.S. Government Accountability Office, *Veterans’ Health Care: Fiscal Year 2000 Budget* (Washington, DC: U.S. Government Accountability Office, September 14, 1999), 1, <http://www.gao.gov/products/HEHS-99-189R> (accessed December 13, 2017); U.S. Department of Veterans Affairs, *Annual Benefits Report Fiscal Year 2005* (Washington, DC: U.S. Department of Veterans Affairs, September 2006), 14, https://www.benefits.va.gov/REPORTS/abr/historical/2005_abr.pdf (accessed December 13, 2017); U.S. Department of Veterans Affairs, *Summary – Volume I 2010 Congressional Submission*, 1B-1; U.S. Department of Veterans Affairs, *FY 2015 President’s Budget Request*, 10; U.S. Department of Veterans Affairs, *Budget in Brief*, Bib 2.

²¹ Peter Hussey et al, “Assessment B (Health Care Capabilities),” September 1, 2015, *RAND Corporation*, 115, https://www.va.gov/opa/choiceact/documents/assessments/Assessment_B_Health_Care_Capabilities.pdf (accessed December 14, 2017).

²² *Ibid.*, 117.

²³ *Ibid.*, 118.

²⁴ U.S. Department of Veterans Affairs, “National Center for Veterans Analysis and Statistics, Selected Veterans Health Administration Characteristics: FY 2002 – FY 2015” linked from *National Center for Veterans Analysis and Statistics* (Washington, DC: U.S. Department of Veterans Affairs, August 10, 2017), https://www.va.gov/vetdata/docs/Utilization/VHAStats_2015.xlsx (accessed November 20, 2017).

²⁵ Ryan Ellis, “How Much Does It Cost Taxpayers To Hire a New Federal Employee?” May 27, 2009, *Americans for Tax Reform*, <https://www.atr.org/cost-taxpayersbr-hire-new-federal-employee-a3303> (accessed February 10, 2018).

²⁶ U.S. Department of Veterans Affairs, “National Center for Veterans Analysis and Statistics: Veteran Population” (Washington, DC: U.S. Department of Veterans Affairs, August 2016), https://www.va.gov/vetdata/Veteran_Population.asp (accessed December 3, 2017).

²⁷ U.S. Department of Veterans Affairs, *Budget in Brief*, Bib 9.

²⁸ Colin D. Moore, "Innovation without Reputation: How Bureaucrats Save the Veterans' Health Care System," *Perspectives on Politics Online* 13, no. 2 (June 2015): 327-44, <https://www.cambridge.org/core/journals/perspectives-on-politics/article/innovation-without-reputation-how-bureaucrats-saved-the-veterans-health-care-system/79BABC6207B367058F4967AF6BEAAB26> (accessed November 27, 2017).

²⁹ U.S. Department of Veterans Affairs, "Expenditure Tables: Data for 1996 - 2016" linked from *National Center for Veterans Analysis and Statistics: Expenditures* (Washington, DC: U.S. Department of Veterans Affairs, 1996-2016), <https://www.va.gov/vetdata/Expenditures.asp> (accessed December 3, 2017).

³⁰ U.S. Department of Veterans Affairs, *National Center for Veterans Analysis and Statistics, Selected Veterans Health Administration Characteristics: FY 2002 – FY 2015*.

³¹ Robert Gates, *Duty: Memoirs of a Secretary of War* (New York: Alfred A Knopf, 2014), 137.

³² Ibid.

³³ J William Hollingsworth, MD and Philip K Bondy, MD, "The Role of Veterans Affairs Hospitals in the Health Care System," *The New England Journal of Medicine Online* 322, no. 26 (June 28, 1990): 1851-857, <http://www.nejm.org/doi/full/10.1056/NEJM199006283222605#t=article> (accessed November 27, 2017).

³⁴ Association of American Medical Colleges, "The VA and Academic Medicine: Partners in Health Care, Training, and Research," June 26, 2014, <https://www.aamc.org/download/383770/data/06262014.pdf> (accessed December 6, 2017).

³⁵ U.S. Department of Veterans Affairs, *Fact Sheet: Veterans Access, Choice and Accountability Act of 2014* (Washington, DC: U.S. Department of Veterans Affairs), 1, <https://www.va.gov/opa/choiceact/documents/choice-act-summary.pdf> (accessed December 16, 2017).

³⁶ U.S. Department of Veterans Affairs, "Data Releases 2012 - 2017" linked from *Veterans Health Administration* (Washington, DC: U.S. Department of Veterans Affairs, December 15, 2017), <https://www.va.gov/health/access-audit.asp> (accessed December 16, 2017).

³⁷ U.S. Government Accountability Office, "High Risk List" (Washington, DC: U.S. Government Accountability Office, 2017), <https://www.gao.gov/highrisk/overview#t=1> (accessed February 14, 2018).

³⁸ Government Accountability Office, "Managing Risks and Improving VA Health Care" (Washington, DC: U.S. Government Accountability Office, 2017), https://www.gao.gov/highrisk/managing_risks_improving_va_health_care/why_did_study#t=0 (accessed February 14, 2018).

³⁹ Peter Hussey et al, "Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans," *RAND Corporation Online* (2015): https://www.rand.org/pubs/research_reports/RR1165z2.html (accessed November 5, 2017).

⁴⁰ Dave Boyer, “Trump Turns Focus to Veterans, Signs Extension for Choice in Health Care,” *Washington Times Online* (April 19, 2017): <https://www.washingtontimes.com/news/2017/apr/19/donald-trump-signs-extension-veterans-choice-health/> (accessed December 16, 2017).

⁴¹ Eric J. Hester, MD, The VA and Medicare HMOs – Complementary or Redundant? *The New England Journal of Medicine Online* 353, no. 12 (September 22, 2005): 1302-303, <http://www.nejm.org/doi/pdf/10.1056/NEJMc051890> (accessed November 27, 2017).

⁴² U.S. Government Accountability Office, “Improving Efficiency and Effectiveness” (Washington, DC: U.S. Government Accountability Office, April 26, 2017), <https://www.gao.gov/duplication/overview> (accessed December 3, 2017)

⁴³ Centers for Medicare and Medicaid Services, “Medicare and Medicaid Basics” (Baltimore, MD: Center for Medicare and Medicaid Services, July 2017), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909330.html?DLPage=3&DLEntries=10&DLSort=0&DLSortDir=descending> (accessed December 10, 2017).

⁴⁴ Department of Health and Human Services, *Centers for Medicare & Medicaid Services, FY17 Justification of Estimates for Appropriations Committees* (Baltimore, MD: Center for Medicare and Medicaid Services, January 11, 2016): 28, <https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2017-CJ-Final.pdf> (accessed December 12, 2017)

⁴⁵ U.S. Department of Veterans Affairs, “VA Benefits & Health Care Utilization” linked from *National Center for Veterans Analysis and Statistics* (Washington, DC: U.S. Department of Veterans Affairs, 1st Quarter 2018), <https://www.va.gov/vetdata/docs/pocketcards/fy2018q1.pdf> (accessed December 3, 2017).

⁴⁶ Office of Personal Management, *Sizing up the Executive Branch 2016* (Washington, DC: U.S. Office of Personal Management, June 2017), 6, <https://www.opm.gov/policy-data-oversight/data-analysis-documentation/federal-employment-reports/reports-publications/sizing-up-the-executive-branch-2016.pdf> (accessed December 12, 2017).

⁴⁷ U.S. Department of Veterans Affairs, “VA Benefits & Health Care Utilization.”

⁴⁸ U.S. Department of Veterans Affairs, “National Center for Veterans Analysis and Statistics: State/Territory Summaries Reports” (Washington, DC: U.S. Department of Veterans Affairs), <https://www.va.gov/vetdata/stateSummaries.asp> (accessed November 20, 2017).

⁴⁹ Military Health System, “Patients by TRICARE Plan” (Fall Church, VA: Defense Health Agency), <https://health.mil/I-Am-A/Media/Media-Center/Patient-Population-Statistics/Patients-by-TRICARE-Plan> (December 3, 2017).

⁵⁰ Tricare, “Find a Military Hospital or Clinic” (Fall Church, VA: Defense Health Agency), <https://tricare.mil/mtf#zip=&radius=40&facility=&country=&state=®ion=&specialty=&service=&pageNo=0&pageCount=5&view=map&fids=> (accessed December 4, 2017).

⁵¹ Defense Health Program, *Fiscal Year 2017 Budget Estimates* (Fall Church, VA: Defense Health Agency, February 2016), DHP-21, <http://comptroller.defense.gov/Portals/45/Documents/>

[defbudget/FY2017/budget_justification/pdfs/09_Defense_Health_Program/DHP_PB17_Vol_I-II.pdf](#) (accessed December 12, 2017)

⁵² Congressional Budget Office, *Comparing the Cost of the Veterans' Health Care System With Private-Sector Costs*, 2, 5-7.

⁵³ Moore, "Innovation without Reputation: How Bureaucrats Save the Veterans' Health Care System," 327-44.

⁵⁴ U.S. Government Accountability Office, *Veterans' Health Care: Challenges for the Future* (Washington, DC: U.S. Congressional Budget Office, June 27, 1996): 15-16, www.gao.gov/archive/1996/he96172t.pdf (accessed February 16, 2018).

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ Resident AY 2018 Army War College, Carlisle, PA; Australia: Todd Ashurst, Estonia: Mati Tikerpuu, Canada: Kirk Gallinger, Germany: Markus Mayer, Israel: Amir Ebstein, Japan: Yutaka Okada, Poland: Krzysztof Nalbert, Netherlands: Edmondus Caelen, Sweden: Jonny Lindfors, United Kingdom: Angus McAfee.

⁵⁸ U.S. Department of Veterans Affairs, "Health Care Benefits Eligibility: Find Out If You Can Get VA Health Care as a Veteran" (Washington, DC: U.S. Department of Veterans Affairs), <https://www.vets.gov/health-care/eligibility/> (accessed February 13, 2018).

⁵⁹ TRICARE, "Retired Service Members and Families: Your Health Plan Options" (Fall Church, VA: Defense Health Agency), <https://tricare.mil/Plans/Eligibility/RSMandFamilies> (accessed February 13, 2018).

⁶⁰ Office of the Assistant Secretary of Defense (Health Affairs), *Evaluation of the TRICARE Program: Fiscal Year 2016 Report to Congress*, 31.

⁶¹ Moore, "Innovation without Reputation: How Bureaucrats Save the Veterans' Health Care System," 327-44.

⁶² U.S. Department of Veterans Affairs, "Office of Academic Affiliations: Medical and Dental Education Program" (Washington, DC: U.S. Department of Veterans Affairs, February 28, 2017), https://www.va.gov/OAA/GME_default.asp (accessed December 6, 2017).

⁶³ Hollingsworth "The Role of Veterans Affairs Hospitals in the Health Care System," 1851-857.

⁶⁴ Adam Oliver, "The Veterans Health Administration: An American Success Story?" *The Milbank Quarterly Online* 85 (March 2007): linked from U.S. National Library of Medicine, National Institutes of Health, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690309/> (accessed November 27, 2017).

⁶⁵ Association of American Medical Colleges, "The VA and Academic Medicine: Partners in Health Care, Training, and Research."

⁶⁶ University of North Carolina at Chapel Hill School of Medicine, “UNC Department of Obstetrics & Gynecology: Resident Physician or Medical Student?” www.med.unc.edu/obgyn/Patient_Care/specialty-services/womens-specialty-practice/resident-or-medical-student (accessed February 18, 2018).

⁶⁷ Association of American Medical Colleges, “The VA and Academic Medicine: Partners in Health Care, Training, and Research.”

⁶⁸ Oliver, “The Veterans Health Administration: An American Success Story?”

⁶⁹ Hollingsworth, “The Role of Veterans Affairs Hospitals in the Health Care System,” 1851-857.

⁷⁰ Association of American Medical Colleges, “The VA and Academic Medicine: Partners in Health Care, Training, and Research.”

⁷¹ Moore, “Innovation Without Reputation: How Bureaucrats Save the Veterans’ Health Care System,” 327-344.

⁷² Hope Yen, “Shulkin Says He’s Considering Closing 1,100 VA Facilities,” *Military Times Online* (May 3, 2017): <https://www.militarytimes.com/news/pentagon-congress/2017/05/03/shulkin-says-he-s-considering-closing-1100-va-facilities/> (accessed November 27, 2017).

⁷³ Ibid.

⁷⁴ U.S. Government Accountability Office, *VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services* (Washington, DC: U.S. Government Accountability Office, April 16, 1998), 2, <https://www.gao.gov/products/HEHS-98-64> (accessed February 18, 2018).

⁷⁵ Samuel H. Williamson, “Seven Ways to compute the Relative Value of a U.S Dollar Amount, 1774 to Present,” 2018, *MeasuringWorth.com*, https://www.measuringworth.com/calculators/uscompare/relativevalue.php?use2=a%3A7%3A%7Bi%3A0%3Bs%3A6%3A%22DOLLAR%22%3Bi%3A1%3Bs%3A12%3A%22GDPDEFINITION%22%3Bi%3A2%3Bs%3A3%3A%22VCB%22%3Bi%3A3%3Bs%3A9%3A%22UNSKILLED%22%3Bi%3A4%3Bs%3A7%3A%22MANCOMP%22%3Bi%3A5%3Bs%3A8%3A%22NOMGDPCP%22%3Bi%3A6%3Bs%3A10%3A%22NOMINALGDP%22%3B%7D&amount=200000000&year_source=1998&year_result=2018&button=Submit (accessed February 18, 2018).

⁷⁶ Congressional Budget Office, *Comparing the Cost of the Veterans’ Health Care System With Private-Sector Costs*, 2.

⁷⁷ Congressional Budget Office, “Budget” (Washington, DC: U.S. Congressional Budget Office), <https://www.cbo.gov/topics/budget> (accessed December 17, 2017).