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Report to the Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate

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VETERANS' HEALTH CARE

Implications of Other Countries' Reforms for the United States

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The Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

Dear Senator Murkowski:

Reform of the nation's health care system would have a major effect on the Department of Veterans Affairs (VA) health care system, one of the nation's largest direct delivery systems.[1] Health reform would give many uninsured and low-income veterans the freedom to choose between VA and other health care providers. This would likely result in many veterans' choosing to leave the VA system unless it changes or VA benefits change to encourage those now in the system to stay or those not in the system to start using VA facilities. Without such changes, VA would likely lose nearly 50 percent of its acute hospital workload.

Health reform is not the only challenge facing the VA health care system, however. The veteran population is aging and declining. Planning the future of the veterans direct delivery system and, more importantly, the future of veterans health benefits, is one of the major challenges facing the Congress as it debates health reform.

What changes should be made in the direct delivery system and in veterans health benefits? This report responds to your request that we study changes in veterans health care systems and benefits in other countries that implemented universal health care systems to learn from their experiences. We limited our review to the four countries—Australia, Canada, Finland, and the United Kingdom—that operated separate direct delivery systems for veterans when they implemented a universal health care system.

In developing our response, we (1) determined the basic reasons why other countries implemented universal care and how these programs operate, (2) identified how eligibility for veterans health care benefits in other countries compares to that in the United States, (3) determined how

[1]Under a direct delivery system, most health care services are provided by salaried providers in system-owned facilities. VA operates a direct delivery system that includes 171 hospitals, 240 outpatient clinics, 126 nursing homes, and 35 domiciliaries to serve the nation's approximately 27 million veterans. Domiciliaries provide care on an ambulatory self-care basis to people disabled by age or disease who do not need the level of services available in hospitals or nursing homes.

changes to the age and status of the veteran population in the United States compares to the veteran populations in the other countries, (4) determined what changes occurred to the veterans health care systems in the other countries over time and the effects of those changes on veterans health care benefits, and (5) identified the potential effects of health reform on our veterans health care system and health benefits on the basis of other countries' experiences.

Following is a summary of our findings:

- Australia, Canada, Finland, and the United Kingdom implemented universal health care systems for the same basic reasons the United States is currently debating health care reform. The four countries implemented universal care systems between 1948 (United Kingdom) and 1984 (Australia) primarily to improve access to care and control health care costs. For example, about 2 million of Australia's 13 million residents were uninsured before universal care was implemented. U.S. health reform proposals aim to reduce the number of Americans without health insurance and control health care costs. (See section 1.)
- Eligibility for veterans health care benefits is much more limited in other countries than in the United States. The four countries we studied generally limit eligibility for veterans health benefits to veterans with injuries incurred during military service, veterans with wartime injuries, veterans who served during wartime, or a combination of the above. By contrast, the United States bases eligibility on service in the uniformed services for a minimum length of time (currently 2 years), but veterans are eligible for differing services on the basis of such factors as income, existence of service-connected disabilities, and availability of space and resources. As a result, between 4 and 43 percent of the veterans in the four countries studied are eligible for veterans health care benefits in addition to health care coverage provided under their universal coverage systems compared to nearly 100 percent of 26.8 million U.S. veterans. (See section 2.)
- Veteran populations in the four countries are aging and declining more rapidly than in the United States. Because eligibility is generally linked to wartime service and the four countries have not been engaged in a major extended conflict since World War II, most of their veterans are over 65 years old. For example, over 93 percent of eligible Finnish veterans were 65 years old or older in 1989, and the number of veterans eligible for veterans health benefits has declined by half since the end of World War II. Although the U.S. veteran population is also aging and declining, only 31 percent of U.S. veterans were aged 65 or older in 1993. (See section 3.)

- Veterans health systems and benefits in the four countries evolved over time, and no longer focus primarily on direct delivery of acute hospital care. Veterans hospitals initially focused primarily on specialized treatment of war-related disabilities and rehabilitation. Demand for acute hospital care subsequently declined because, (1) as veterans recovered from their war injuries, they needed fewer specialized acute care services; (2) the number of veterans eligible for veterans health care declined as the population aged or war injuries healed; and (3) veterans had the freedom to choose between care in veterans hospitals or hospitals in their communities.

  The falling utilization rates, coupled with (1) the need to treat the effects of an injury rather than the injury itself and (2) the increasing chronic care needs of an aging population, made it increasingly difficult for the countries to maintain medical expertise. For example, Australia's veterans hospitals had trouble retaining skilled staff and maintaining affiliation with medical schools as its patient mix became increasingly geriatric. To improve utilization and maintain medical expertise, veterans hospitals were frequently opened to nonveterans or certain other government beneficiaries were made eligible for care in veterans hospitals.

  Australia, Canada, and the United Kingdom closed or transferred veterans hospitals. The United Kingdom decided in 1953 that transferring its veterans hospitals to the country's universal care system would (1) increase utilization of the former veterans hospitals and (2) allow them to preserve and further develop their specialized medical expertise by expanding their patient mix. Canada, in 1963, and Australia, in 1988, made similar decisions on the basis of continuing decline in acute care use of its veterans hospitals and the ability and desire of veterans to obtain care in their communities. Training and research missions of the veterans hospitals were generally transferred with the hospitals.

  Although Finland continues to maintain its acute care system, it, like Canada, shifted the emphasis of its veterans health care system from acute to long-term care services to meet the changing needs of an aging veteran population. By 1993, it had converted 100 of the 227 beds at its primary veterans hospital to long-term care use. Both Finland and Canada developed home care programs to enable veterans to maintain their independence as long as possible. (See section 4.)

- Maintaining the direct delivery system is not the only option for preserving veterans health benefits. Three of the four countries preserved and

enhanced veterans health benefits without maintaining their direct delivery systems. For example, some countries supplemented services covered under the universal care system or gave veterans higher priorities for care or better accommodations. Veterans service organizations in those countries generally support the changes that have been made in their veterans health care systems and veterans benefits. Current U.S. reform proposals focus on preserving the direct delivery system as the means for maintaining veterans health care benefits.

The administration's Health Security Act, and the Mitchell and Gephardt proposals, would make fundamental changes both in how VA operates and in the benefits to which veterans using VA are entitled. In this regard, they would (1) transform VA facilities into a series of managed care plans to compete with private-sector plans and (2) expand entitlement to free comprehensive health care services as an incentive for veterans to enroll in VA health plans. (See section 5.)

- Health reform in the United States that gives veterans the choice of care in VA or community facilities will affect the future of the direct delivery system. Any reform of the U.S. health care system or reform of the veterans health care system that would give veterans increased access to community providers will likely decrease veterans' demand for care in existing VA facilities. Canada's experience suggests the potential effects on our VA health care system if it remains unchanged through health reform as it would under most of the health reform proposals that have been introduced. Use of Canadian veteran facilities declined following implementation of universal hospital care in 1961, which gave veterans access to care in their communities. When universal coverage was first implemented, Canadian veterans, like U.S. veterans, were required to obtain most of their inpatient and outpatient care through veterans hospitals and had limited access to health care services in their home communities unless they had alternative health care coverage.

  On the other hand, Australia's experience more closely suggests the likely effect of the administration's health reform proposal. To improve access to care for its aging population, Australia—before it implemented universal health care—had authorized veterans living in nonmetropolitan areas (that is, areas outside the state capitals) to use public hospitals close to their homes with the veterans program paying for their care if the treatment period was short and did not involve surgery. Veterans living in metropolitan areas could use public hospitals if they obtained prior approval from the Department of Veterans Affairs. In the fiscal year

preceding implementation of universal care, public and private hospitals accounted for about 43 percent of the acute care bed days provided to veterans through the veterans program. Under the Health Security Act, VA would similarly focus on increased contracting for care in community hospitals. (See section 5.)

- Regardless of whether health reform occurs in the United States, the changing health care needs of an aging and declining veteran population should prompt reform of the veterans health care system and benefits. None of the current health reform proposals adequately focuses on the growing long-term care needs of aging veterans. Only the administration's Health Security Act proposes changes in the current system; those changes could erode VA's ability to meet the long-term care needs of America's veterans. (See section 5.)

In summary, the declining veteran population in the United States, in concert with increased availability of community-based care—through either implementation of a universal health care program or an expansion of the veterans health care program through contracting or new construction—would make it increasingly difficult to preserve the current acute care workload of existing VA health care facilities. VA would have to attract an ever-increasing proportion of the veteran population if it is to keep its acute care facilities open. Other countries have successfully made the transition from direct providers to financiers of veterans health care without losing the special status accorded veterans.

We did not obtain formal comments on this briefing report. We did, however, discuss the contents of this report with VA program officials, including the Acting Deputy Undersecretary for Health and the Chief, National Health Care Reform Office.

VA officials said that the report shows useful insights into the potential effects of health reforms in the United States, but does not support the conclusion that a direct delivery system is not essential or that increased choices for veterans would mean a significant decline in demand for care at VA facilities. The officials said that they believe the VA direct delivery system is a vital component of the nation's health system and that significant numbers of veterans will choose a VA health plan if the Congress includes VA in health reform as proposed by the President.

We continue to believe that maintaining a direct delivery system is one option for preserving veterans health benefits. Three of the four countries

we studied, however, were able to maintain and enhance their veterans benefits without maintaining their direct delivery systems. The VA officials did not, in our opinion, provide convincing arguments to support their contention that the VA direct delivery system is a vital—and irreplaceable—component of the nation's health care system. Both Canada and Australia transferred the auxiliary missions of their veterans health care facilities—medical education, research, and medical readiness—to other hospitals. While such transfers would be more difficult in this country because of the size of the veterans direct delivery system, it should not preclude consideration of such transfers.

The significant financial incentives the administration's Health Security Act, and the Mitchell and Gephardt proposals, would give veterans to enroll in VA health plans may enable VA health plans to enroll enough veterans to preserve its direct delivery system. The administration, however, based its analysis of the cost impact of the veterans health care provisions on enrollment of only 2.3 million veterans, far short of the number of enrollees that would be needed to maintain utilization of VA's current facilities. Nearly 8 million veterans might need to enroll in VA health plans if VA is to maintain full utilization of its current facilities. Thus the administration's plans could cost tens of billions of dollars more than VA estimates. Much of the increased cost would be funded entirely through VA appropriations.

Additional comments from the VA officials and our evaluation appear in Section 5.

Scope and Methodology

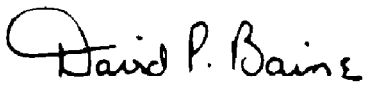
The countries included in our review were selected through (1) discussions with VA officials and representatives from the Paralyzed Veterans of America and (2) a literature search. In each country, we interviewed officials responsible for operating their veterans and universal health care systems and representatives of veterans service organizations (app. I lists those contacted).

We obtained information on each country's veterans health care system before and after implementation of universal health care, including (1) who is eligible for veterans health care, (2) the countries' health care missions, (3) the number and types of medical facilities operated, (4) the types of services provided, and (5) expenditures on the systems. Additionally, we obtained reports and other documentation explaining the major changes in their veterans health care systems and why the changes

were made. Finally, we obtained and analyzed data on U.S. health reform proposals, focusing primarily on the administration's Health Security Act.

We are sending copies to the Secretary of Veterans Affairs, other congressional committees, and other interested parties. Copies will be available to others upon request. Please call me at (202) 512-7101 if you or your staff have any questions. Major contributors to this briefing report are listed in appendix II.

Sincerely yours,



David P. Baine
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Delivery Issues

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Abbreviations

DVA	Department of Veterans Affairs—Australia
DVAC	Department of Veterans Affairs—Canada
NHS	National Health Service
RSL	Returned and Services League of Australia
SAO	State Accident Office
VA	Department of Veterans Affairs—United States

Other Countries Implement Universal Coverage to Improve Access, Control Costs

Universal health care systems were established in the four countries between 1948 (United Kingdom) and 1984 (Australia) primarily to improve access to care for all citizens and to control health care costs. Three of the four countries operate health financing systems, paying for health care services provided by public and private providers; the United Kingdom operates a direct delivery system (see table 1.1).

Table 1.1: Universal Health Care Systems in Australia, Canada, Finland, and the United Kingdom

Country	Universal Health Care System
Australia	Universal health insurance covers comprehensive inpatient and outpatient care provided in public and private hospitals and by private physicians. Six state and two territory governments plan for and administer health care services delivered by public and private providers.
Canada	Universal health insurance covers medically necessary inpatient and outpatient care. Ten provinces and two territories plan for and administer health care services delivered by public and private providers.
Finland	Universal health care consists of federally subsidized inpatient and outpatient services provided by municipalities[a] and a health insurance program that partially covers the costs of private physician services.
United Kingdom	Universal direct care system provides comprehensive inpatient and outpatient care in health care facilities owned and operated by the system.

[a]A municipality is similar to a county in the United States and, on average, has a population of 11,000 citizens.

Universal Health Care in Australia

Australia initiated its universal health insurance program, Medicare, in February 1984 to improve citizens' access to quality health care.[2] Australia first attempted to develop a universal health insurance system in 1973, but it did not succeed. Before that time, about 2 million of the 13 million Australian citizens did not have guaranteed access to health care services that were largely provided on a fee-for-service basis by private physicians or by state governments through public hospitals. These 2 million citizens either paid for health care out of their own pockets, or the physicians and hospitals provided charity care.

Australia's universal health care system covers comprehensive inpatient and outpatient care that is provided in public and private hospitals and by private physicians. Citizens electing to be treated as public patients receive free inpatient care in public hospitals operated by six state and

[2]Other persons residing legally in Australia are also covered by the universal care program.

two territory governments; citizens with private insurance that elect to be treated as private-pay patients in public hospitals pay for part of the inpatient care. Outpatient care is provided by private physicians and may or may not be fully paid for by the universal health care system. Private health insurance is available and pays for costs not covered by the universal health care system.

The states and territories continue to operate their own public hospitals and determine the medical services that the hospitals offer so that, collectively, the hospitals provide the health care services covered by the universal health care system. Hospitals may specialize in certain medical fields to avoid competing with other hospitals. Private hospitals also operate in the states and territories and receive payments through the universal health care system.

All Australians can obtain free inpatient care in public hospitals. Citizens who have private health insurance in addition to their Medicare coverage—about half of the population—can either (1) receive treatment at a private hospital or (2) receive treatment in a public hospital as a private-pay patient. The universal health care system pays 75 percent of its schedule fee for inpatient services provided to citizens using their private health insurance, and the private health insurance pays the remaining 25 percent. If citizens choose to enter public hospitals as private-pay patients, they have their choice of physician and are treated in semiprivate or private rooms rather than wards. Private-pay patients in public and private hospitals incur additional costs for their accommodations, and the private health insurance pays for these costs as well as for services not covered under the universal care program such as dentistry, chiropractic, podiatry, and optometry.

Comprehensive outpatient care is also covered by the universal health care system. Outpatient care is free if provided at community health clinics. Outpatient care is also provided by private physicians and may or may not be fully paid for by the universal health care system, depending upon physician billing practices. Private physicians generally render outpatient care on a fee-for-service basis and are reimbursed on the basis of the system's fee schedule. Physicians who directly bill the system must accept payment of 85 percent of the fee as payment in full; however, physicians also have the option to bill patients. In this case, the patient can be charged more than the fee schedule amount. The patient pays the entire bill and then collects 85 percent of the fee schedule amount from the universal health care system.

The universal health care system is funded by the federal government from general revenue and a means-tested health insurance levy equal to 1.4 percent of taxable income. In Australia's fiscal year 1992, total health expenditures from all sources totaled $22 billion (in U. S. dollars) or 8.6 percent of gross domestic product.[3]

Universal Health Care in Canada

Canada's universal health care program is also called Medicare. It developed in two phases; under federal legislation, all provinces and territories covered hospital care by 1961 and physician care by 1972. In the 1950s, federal and provincial health and finance officials determined that (1) private health insurance did not provide adequate services to enough Canadians, (2) hospital costs were unaffordable for many and rising, and (3) many hospitals were in financial difficulty. As a result, Canada enacted the Hospital and Diagnostic Services Act of 1957, which all provinces and territories implemented by 1961. On the basis of a general lack of affordable health insurance and the high cost of physician care, Canada enacted the Medical Care Act of 1968, which resulted in coverage for medically necessary physician care by 1972 in all provinces and territories.

Canada's universal care program is a federally mandated, province- and territory-administered program that covers Canadians for medically necessary hospital and physician care. Under the program, the federal government establishes guidelines for the health care insurance plans of the 10 provinces and 2 territories. While the plans vary to some extent, all must cover medically necessary physician and diagnostic services and inpatient hospital care and can cover a broad range of supplemental benefits such as dental care, prosthetics, and long-term care. Private insurance companies cannot offer coverage for medically necessary physician, diagnostic, and hospital services, but can offer insurance for supplemental benefits such as prescription drugs, dental care, and vision care whether or not they are included in provincial or territorial plans.

The provinces and territories rely on the private and public health care delivery systems to provide covered health care services. Most physicians are in private practice; about 95 percent of Canadian hospitals are nonprofit entities operated by local governments, voluntary organizations, or other agencies. The universal health care program relies extensively on primary care physicians to provide basic medical care and to refer patients to specialists and hospitals. Canadian citizens can go to the physician or

[3]In fiscal year 1992, the United States spent about 12 percent of its gross domestic product on health care.

clinic of their choice but do not pay directly for primary or specialist physician care or hospital services. There are no deductibles, copayments, or dollar limits on coverage. Physicians are paid by the provincial or territory insurance plans on a fee basis; fees are negotiated annually between the provinces and territories and the provincial medical associations. Hospitals' operating costs are paid out of annual budgets negotiated with the province or territory.

The universal health care program is funded through a combination of federal and provincial/territorial taxes. The federal government provides block grant monies to the provinces and territories, which, in turn, provide additional tax revenues as necessary. In 1991, total health care expenditures from all public and private sources represented 9.9 percent of Canada's gross domestic product.

Universal Health Care in Finland

Finland's universal health care system, administered by the Ministry of Social Affairs and Health and the Social Insurance Institute, provides comprehensive care to all citizens. The system developed in two phases over a 10-year period. In 1963, Finland passed the Sickness Insurance Act and began providing citizens partial refunds of private physician examination and treatment expenses, dentist fees, and prescription drug costs. Before the act, Finland had few primary care physicians, most of whom were self-employed. Citizens typically paid for primary care services out of their own pockets, resulting in unequal access for those of modest means. The act equalized citizens' access to health services and choice of provider regardless of income.

The second phase occurred in 1972, when Finland passed the Primary Health Care Act. At that time, about 90 percent of public health care resources was devoted to specialized medical care, primarily at hospitals, and 10 percent to primary care services. Also, the supply of services throughout the country was inadequate, the use of primary care services was uneven, and health care costs were growing rapidly. After the act, Finland shifted its emphasis to primary health care and prevention. Finnish officials told us that the act (1) caused the federal government to subsidize municipal health centers, (2) led to regional equality in the coverage of services, and (3) slowed the growth of health care costs.

The system covers inpatient and outpatient services, long-term care, dental care, mental health care, laboratory services, and prescription drugs. It is based primarily on federal subsidies to Finland's 455

municipalities that provide a complete range of public health care services at local health centers. Costs of private health care services are partially covered by a universal insurance program.[4]

Municipalities, either individually or collectively, operate health centers that generally consist of public hospitals, maternal and child health centers, laboratories, and local physician offices. The system emphasizes primary health care services such as maternal and child health care, medical and dental care, ambulatory care, and prevention of communicable and noncommunicable diseases. Most primary health care services are free for citizens, but dental care provided to adults as well as treatment provided in hospitals require copayments and deductibles. Charges for long-term care are means tested and may not exceed 80 percent of a person's monthly income.

Annually, the federal government develops revolving 5-year plans that set out the health care goals and objectives for the country, including operating costs for primary health care services and public hospitals. Municipalities, in turn, are required to develop plans that conform to the national plan to receive their federal subsidies. The amount of the subsidy for municipalities is based on a number of factors, such as the municipality's population age structure, population density, and financial capacity.

In 1991, total health care expenditures in Finland from all sources represented 9.2 percent of gross domestic product. This included the costs of private health care, which have represented about 20 percent of total national health care costs in Finland since the mid-1970s.

Universal Health Care in the United Kingdom

The United Kingdom's universal health care system, known as the National Health Service (NHS), was established on July 5, 1948, to make health services available to every citizen regardless of age or income. Before the NHS, health care was provided on an unequal basis by a patchwork of municipal, state, charitable, and private health care organizations. Between World Wars I and II, citizens increasingly criticized this system until consensus developed that a universal health care system was necessary.

[4]This program also provides other benefits, including compensation for travel and accommodations relating to health care.

The NHS provides preventative, diagnostic, and treatment services to all citizens regardless of age or income. Primary care physicians are paid by the NHS to serve as gatekeepers and refer patients, depending on their medical need, to clinics, hospitals, or medical centers that are NHS-owned, operated, and staffed. The Department of Health administers the NHS and allocates monies to 14 regional health authorities to fund citizens' medical care. Costs are not tracked by services provided to individual patients; patients receive no bills.

Some NHS medical expertise in artificial limbs, spinal cord injuries, burns, and plastic surgery was originally developed in veterans hospitals and was transferred to the NHS when it absorbed the veterans hospitals between 1953 and 1961. For example, the Stoke Mandeville veterans hospital was a leader in treating spinal cord injuries and continues that leadership today as an NHS hospital.

Total health care expenditures in the United Kingdom represented 6.2 percent of gross domestic product in 1990. This includes a small but growing private health care sector financed by direct payments and private insurance. About 10 percent of the population carries private insurance, mainly to shorten the waiting time for elective surgery.

Other Countries Have More Limited Eligibility Criteria for Veterans Health Benefits Than the United States

Because of other countries' more restrictive eligibility criteria, only some of their veterans are eligible for veterans health benefits—a low of 4 percent in the United Kingdom to a high of 43 percent in Australia. However, in the United States, nearly all veterans are eligible. Each of the four countries generally bases eligibility on war service or injury while the United States bases eligibility on service regardless of whether the veteran participated in a war (see table 2.1).

Table 2.1: Comparison of Eligibility Criteria and the Number of Eligible Veterans in Four Countries and the United States

Country	General eligibility criteria	Number of eligible veterans versus all veterans[a]
Australia	Veterans who were injured or contracted a disease in an overseas conflict, served in World War I or Vietnam, or are former POWs.	260,000 out of 600,000 (1993)
Canada	Veterans who sustained a disabling injury during war or other designated periods of service or who meet certain low-income criteria.	197,000 out of 580,000 (1992)
Finland	Veterans who sustained a disabling injury or contracted a disease during war.	40,000 out of 250,000 (1992)
United Kingdom	Veterans who sustained a disabling injury or contracted a disease during war or any other period of military service.	196,000 out of 5 million (1992)
United States	Veterans discharged under other than dishonorable conditions.	Nearly all of the 26.8 million (1993)

[a]Numbers exclude nonveterans who may be eligible for veterans benefits, such as widows or dependents of veterans.

Eligibility Criteria in Australia

Before World War II, only veterans who were injured or suffered a disease while serving in an overseas conflict were eligible for Australia's veterans health care benefits. After World War II, Australia expanded eligibility to other veterans and dependents, including veterans with cancer or tuberculosis, all those with World War I service, former prisoners of war, Vietnam veterans in need of urgent treatment, war widows, and certain dependent children.

Eligibility Criteria in Canada

Canada bases eligibility for veterans health care benefits on a veteran's injury or income. Eligibility for medical or institutional long-term care

services not covered by a provincial or territorial health plan is generally limited to those veterans who (1) incurred a disabling injury during war or other designated periods of service[5] or (2) meet certain low-income criteria. Eligibility for veterans home health care benefits not covered by provincial or territorial plans is extended to veterans over 65 years of age who meet the above injury or income criteria.

Eligibility Criteria in Finland

Only disabled veterans injured during the Finnish civil war of 1918 or World War II are eligible for the veterans health care system. Disabled veterans are those who sustained an injury or contracted an illness in a war or a warlike circumstance and incurred a permanent disability of 10 percent or more. Civilians injured and disabled during wartime are also classified as disabled veterans and are eligible for veterans health care benefits. Severely disabled veterans—those who are rated 30 percent or more disabled—are eligible for additional health care benefits, such as free nursing home care.

Eligibility Criteria in the United Kingdom

Eligibility for veterans health benefits is based on a veteran's wound, injury, or disease that resulted in a temporary or a permanent disability of at least 1 percent. Generally, these veterans sustained their disability during World War I or II. However, certain others are also eligible for this system, including Merchant Marines and Civil Defense volunteers disabled during World War II and veterans who suffered disabling injuries during any period of military service.

Eligibility Criteria in the United States

Eligibility for veterans health care benefits is based on service for a minimum length of time. All veterans discharged under other than dishonorable conditions are eligible. Those persons enlisting after September 1980 and officers commissioned on, or beginning active service after, October 1991 must complete 2 years of active duty, or the full period of their initial service, to be eligible.

Although nearly all U.S. veterans are eligible for veterans health benefits, VA uses a complex priority system to determine which veterans receive care. This system considers such factors as (1) whether they meet an income test, (2) whether they have a service-connected disability, (3) the

[5]For example, veterans who served as part of a United Nations peacekeeping force are eligible for veterans health care benefits.

severity of the disability, and (4) the availability of space and resources at VA medical facilities.

Veteran Populations in Other Countries Are Aging and Declining More Rapidly Than in the United States

The veteran populations in the four countries studied have already aged and declined while the U.S. veterans population is just now beginning to age and decline. This is due to these countries' more restrictive criteria for veterans health benefits that generally base eligibility on injuries occurring during wartime or military service and the fact that they have not engaged in a major extended conflict since World War II. Currently, about 72 percent of the veterans eligible for veterans health care benefits in the four countries are age 65 or older. Additionally, each country has experienced a decline in the number of eligible veterans. Despite its broader eligibility criteria, the United States too is beginning to experience an aging and declining veteran population as the size of our military forces declines (see table 3.1).

Table 3.1: Percent of Eligible Veterans Aged 65 or Older and Declining Numbers of Eligible Veterans

Country	Percent of eligible veterans aged 65 and older	Declining numbers of eligible veterans and projected declines for the future
Australia	85 (1992)	312,000 in 1975 v. 265,000 in 1993 205,000 projected for 2002
Canada	99 (1993)	202,000 in 1961 v. 197,000 in 1992[a] 91,000 projected for 2011
Finland	93 (1989)	90,000 in 1945 v. 40,000 in 1992 5,000 projected for 2010
United Kingdom	72 (1991)	738,000 in 1947 v. 196,000 in 1992[b]
United States	31 (1993)	26.8 million in 1993 13 million projected for 2040

[a]Through the years, Canada expanded eligibility for veterans health care benefits to several categories of veterans previously excluded, such as veterans who served as part of a United Nations peacekeeping force. As a result, the number of eligible veterans did not decline significantly between 1961 and 1992. However, the total number of all veterans declined and will continue to decline in the future. Canada's veteran population declined from 1.1 million in 1961 to 580,000 in 1992 and is expected to decline to 393,000 in 1999.

[b]Projections were not readily available.

Other Countries Maintained Veterans Health Care Benefits as They Modified Their Direct Delivery Systems

Australia, Canada, Finland, and the United Kingdom continue to provide veterans with special health care benefits even though they significantly modified their direct delivery systems. Previously, each country operated a hospital-based system that provided acute care services to disabled veterans. However, as the veteran population aged, the number of veterans declined, and veterans' access to community care improved, the countries changed how they provided veterans health care benefits. The United Kingdom no longer operates a direct delivery system while the veterans health care systems in Australia and Canada are transitioning from direct providers of care to payers of care. Although Finland continues to operate a direct delivery system, it changed the system's focus to meeting the long-term care needs of its aging veteran population. Veterans in three countries today receive most or all of their health care by or through the universal care programs; Australia pays for veterans care provided by public, private, or veterans medical facilities.

Despite these changes to their direct delivery systems, all of the countries preserved and enhanced the health care benefits provided to their veterans as their systems evolved. For example, Australia authorized and paid for much of its veterans inpatient care at public and private hospitals before the country implemented its universal insurance program. This helped to preclude older veterans from having to travel long distances to obtain care in veterans hospitals. Finland built 22 new nursing homes during the 1980s and 1990s to provide for the long-term care needs of its aging veterans; the United Kingdom provides veterans priority care of their disability under the universal direct delivery system. Veterans service organizations generally support the changes made to the veterans health care systems in their countries because veterans health care benefits have been maintained.

Australia's Veterans Health Care System Pays for Care in Public and Private Facilities and Operates Its Own Facilities

Australia's veterans health care system, managed by the Department of Veterans' Affairs (DVA), is gradually shifting from a hospital-based direct service provider to a purchaser of health care services. The system consists of (1) payment for services provided at public and private hospitals and (2) direct delivery of services provided on an inpatient and outpatient basis at veterans hospitals. Veterans organizations generally support the changes that have been made to the system over the past three decades. In 1992, Australia paid about $923 million (U.S. dollars) to operate its veterans health care system.

Veterans receive care in public hospitals as if they were private-pay patients rather than Medicare patients. This means that they (1) can choose their own physician rather than accept the physician appointed by the hospital and (2) receive semiprivate rooms. If treatment cannot be provided at a public hospital, DVA will pay for veterans care at a private hospital under contract with DVA for providing services to veterans.[6] When care is not available at private hospitals with a DVA contract, DVA will pay for care provided at other private hospitals. Veterans obtain primary health care services from private physicians (general practitioners) who, when necessary, refer veterans to specialists for further treatment or to hospitals. DVA pays for the physician services. Community-based allied health professionals, such as physiotherapists, provide care to eligible veterans at DVA expense.

DVA also operates hospitals (four general, two auxiliary, and one psychiatric) that provide veterans with comprehensive inpatient care. Plans call for DVA to transfer these hospitals to the states by July 1995.

DVA does not directly provide long-term care services for older veterans. The Department of Human Services and Health has policy responsibility for providing home care services and nursing home care for veterans and for all other citizens. These services are provided by state and local government and by community providers. Examples of home care services are meals on wheels and housekeeping. The Department of Human Services and Health and state governments jointly fund home care services under what is known as the Home and Community Care program. The recipients of these services, including veterans, may be required to contribute toward their cost. Veterans receive the same care as the general population and do not have priority for treatment or support. DVA pays for the government portion of the costs for nursing home care, with veterans, like other citizens, making copayments.

In recognition of the aging veteran community, DVA funds a range of community support programs including in-home respite care, day clubs for the lonely and isolated beneficiaries, a joint venture scheme that provides funding to exservice clubs to establish community programs, and support for caregivers and people who volunteer for community programs.

Australia's veterans health care system began changing in the mid-1970s, at which time it operated a multimission direct delivery system. Table 4.1

[6]Factors to be considered in treating veterans in private hospitals include (1) relative waiting times in the public and private hospitals, (2) distances to be traveled, and (3) costs of care.

shows the major changes that have occurred in the system in the last three decades.

Table 4.1: Evolution of Australia's Veterans Health Care System

Time frame	Event
Pre-1984	Operated a multimission direct delivery system of nine veterans hospitals and contracted for physician care in the communities. Community patients authorized to use veterans hospitals (1973) Veterans living in nonmetropolitan areas authorized to use public hospitals without prior approval from DVA. Veterans living in metropolitan areas could use public and private hospitals with prior approval from DVA.
1984	Australia implemented universal health care.
1988	Decision made to discontinue direct delivery system.
1990	Veterans Independence Program established.
1992-1993	Two hospitals transferred to the states, one closed, and negotiations ongoing for the remaining hospitals. Veterans in affected areas given option to use former veterans hospital or public hospitals without prior DVA approval and given greater access to private hospitals.

Australian Veterans Health Care System Before 1984

Before 1984, the veterans health care system (1) directly provided inpatient care and hospital-related outpatient services (most physician care was provided by local medical officers under contract to the system), (2) trained medical professionals, and (3) conducted medical research. DVA operated general hospitals in the capital cities of the six states and three auxiliary/psychiatric hospitals. The general hospitals provided acute medical and surgical care to veterans and specialized in geriatrics and wound management—one hospital (Concord Repatriation Hospital, Sydney) specialized in burn treatment. These hospitals also trained health care professionals and conducted medical research. The auxiliary/psychiatric hospitals provided convalescent care, psychiatric services, rehabilitation, and extended care.

Veterans used private physicians—known as local medical officers—for their day-to-day medical care in their home communities at DVA expense. These primary care physicians provided routine care and made referrals to specialists and hospitals.

Veterans living in nonmetropolitan areas (that is, areas outside the state capitals) were authorized to use public hospitals without obtaining prior approval from DVA. Veterans in metropolitan areas could also use public

and private hospitals but only for emergency care or with prior approval from DVA. With the aging of the veteran population, travel to veterans hospitals was harder for veterans and their families. Giving veterans greater flexibility to obtain care in public and private hospitals, rather than restricting them to care in veterans hospitals, therefore facilitated access to care. Veterans could now be treated as private patients at public hospitals, and, if the public hospitals could not provide the needed health care, veterans could go to a private hospital.

In 1973, DVA authorized veterans hospitals to use their excess capacity to treat community patients. This was later set at a maximum of 20 percent of available beds. DVA was concerned that the aging veteran population (mostly World War II veterans) was transforming veterans hospitals into geriatric facilities, resulting in poorer quality and fewer types of services available for veterans. DVA hoped that caring for community patients would allow the hospitals and staff to maintain their medical expertise and expand services. Also, Australia's universities were concerned about fewer training opportunities for their students at veterans hospitals since these hospitals were increasingly focusing on geriatric care.

In Australia's fiscal year 1983 (July 1, 1982, through June 30, 1983), approximately 43 percent of the over 1 million bed days of acute hospital care veterans received through DVA were provided by public and private hospitals. During the same year, Repatriation General Hospitals provided over 120,000 bed days of care to community patients, about 17 percent of the total bed days they provided.

Universal Health Care Did Not Affect the Veterans Health Care System

Implementation of Australia's universal health care program in 1984 did not significantly affect the demand for veterans health care because veterans already had benefits that exceeded those provided by the new program. As well as being treated in veterans hospitals, veterans were admitted to public hospitals on a priority basis and were treated as private-pay patients, which gave them their choice of physician and care in semiprivate rooms. Thus, universal health care did not improve veterans access to care or their health care benefits. Neither did universal health care cause DVA to change the services it provided nor the number and types of medical facilities it operated.

The 1983-84 annual report for the veterans program notes that as of the end of the financial year no evidence existed of any significant effect on the veterans health care system attributable to the introduction of

universal coverage. In fact, the bed days of care provided by veterans hospitals both to veterans and to community patients increased slightly.

Australia Decided to Discontinue Its Direct Care System

In 1988, DVA decided to discontinue its direct delivery system and to transfer its general hospitals, along with their training and research missions, to the states. Several factors accounted for this decision. One, it became apparent to DVA during the 1980s that the aging veteran population was requiring fewer of the specialized acute care services offered by the veterans hospitals. Two, the number of veterans had declined, reducing demand for its services. At that time, Australia operated six general hospitals and four auxiliary/psychiatric hospitals.

DVA transferred its first general hospital to the state of Tasmania in 1992. Commencing with the transfer of the veterans hospital to the state of Tasmania, DVA allowed all veterans in the state to choose among the previous veterans hospital, public hospitals, and selected private hospitals at DVA expense. Previously, veterans living near the veterans hospitals were authorized to use public or private hospitals only on an exception basis.

In 1993, it transferred a second general hospital to the state of New South Wales and closed one auxiliary and one psychiatric hospital in the state of Victoria. As of July 1993, negotiations were ongoing for transferring one general hospital to the private sector as the state decided not to accept this hospital as it already had sufficient public hospital capacity. The DVA was also negotiating the transfer of three other general hospitals to the states and had plans to transfer or close the two remaining auxiliary/psychiatric hospitals.

In negotiating the transfers, DVA had several major objectives. These were to (1) maintain high quality care at the hospitals, (2) preserve the employment rights and working conditions of hospital staff, and (3) turn over the hospitals' training and medical research to the states.

As part of the negotiations, the states did not require the two transferred hospitals to be renovated because they were comparable to public hospitals in services and amenities. For example, one of the hospitals already had an emergency room that had been created in 1976. Also, televisions and telephones generally did not have to be installed because they are not common in either veterans or public hospitals. However, individual showers had to be added.

Veterans Service Organizations Support Changes Made to the Veterans Health Care System That Preserved Health Care Benefits

Veterans service organizations generally support the actions of the DVA to preserve the veterans health care system and benefits. The primary veterans service organization—the Returned and Services League of Australia (RSL)—supported DVA's admission of community patients to veterans hospitals to ensure that the hospitals retained their expertise and staff and thus provided needed care to veterans. At the same time, the RSL supported veterans hospital affiliations with universities, which allowed medical students to be trained as health professionals and for research to be conducted. The RSL supported the expanded authorization for veterans to use public and private hospitals nearer to their homes because it agreed that it was difficult for aging veterans and their families to travel long distances to veterans hospitals.

The RSL supported the transfer of the veterans hospitals into the state health systems on condition that the government meet a list of requirements that the RSL compiled in 1991 and felt was necessary to ensure that veterans would receive the same benefits they had under the veterans direct delivery system. These requirements included

- guaranteed continued access to veterans hospitals at no cost to the veteran,
- total health care services for veterans must be at least equal to those provided in veterans hospitals, and
- assurances that sufficient beds are available in public and private hospitals to meet requirements of veterans in each state.

At the time of our study, the government had responded to some of the requirements, and the RSL was awaiting further response. RSL officials did not indicate to us their satisfaction or dissatisfaction with the government's responses.

Veterans service organization officials told us that they would have strongly resisted any attempts to eliminate the veterans health care system as a result of implementing universal health care. They stated that veterans benefits were better than those available to other citizens before implementation of universal care, and the veterans service organizations did not want veterans to lose these extra benefits because the country implemented its universal health insurance program.

Canada's Veterans Health Care System Supplements Universal Health Care and Focuses on Long-Term Care

Over the past three decades, the veterans health care system, administered by the Department of Veterans Affairs—Canada (DVAC), evolved from a direct provider of both inpatient and outpatient services to a system that now supplements care paid by the universal health insurance program and focuses on the long-term care needs of its veterans. Veterans service organization officials we spoke with support the changes that have been made to the veterans health care system since veterans health care benefits have been maintained. Costs to supplement Canada's universal care program and operate long-term care programs and facilities totaled $463 million (U.S. dollars) in 1992.

Veterans receive most of their health care through the universal health insurance plans operated by their province or territory. DVAC supplements these plans by paying for noncovered inpatient and outpatient services needed by veterans. This policy ensures that all veterans receive the same benefits regardless of where they live. For example, DVAC may pay for prosthetics in one province and prescription drugs in another because of differences in coverage among the provincial plans.

DVAC meets the needs of its aging veteran population in several ways. It contracts with 40 community health facilities across Canada that provide veterans priority access to long-term care services. Although it is negotiating their transfer to the provinces, DVAC still operates a 700-bed hospital devoted to providing eligible veterans long-term care services and one 50-bed domiciliary that can be accessed by any eligible veteran. Further, DVAC operates the Veterans Independence Program, which provides older veterans counseling on available services, health information, and care to help them remain healthy and live in their homes and communities.

The current system has changed significantly since the 1950s when it was based on direct delivery of health care services. Table 4.2 shows the major changes to Canada's veterans health care system in the past five decades.

Table 4.2: Evolution of Canada's Veterans Health Care System

Time frame	Event
1950s	Operated a multimission direct care delivery system consisting of 21 medical facilities.
Late 1950s	Expanded eligibility to nonveterans.
1961	Canada implemented universal coverage of hospital care.
1963	Government study recommended that the direct delivery system be discontinued.
1966 - 1983	Eighteen of the 21 veterans facilities transferred to the provinces. Implemented the forerunner of the Veterans Independence Program. Also, Canada implemented universal coverage of physician care in 1972.
1993	Negotiations ongoing to transfer the one remaining hospital and one domiciliary to the provinces.

The Veterans System Previously Focused on Treating Veterans' War-Related Injuries

During the 1950s and early 1960s, the veterans health care system (1) provided medical and surgical services for treating veterans' war-related disabilities as well as direct care services to indigent disabled veterans in 21 medical facilities, (2) trained medical professionals, (3) conducted medical research, and (4) provided backup for the military hospital system in time of conflict. The medical facilities consisted of 13 hospitals located in the major urban areas that provided both inpatient and outpatient care, two large psychiatric facilities, and six domiciliary care homes. Veterans hospitals often affiliated themselves with university medical schools for teaching and medical research purposes and became national leaders in such areas as geriatric care, head trauma treatment, and prosthetics.

An Aging Veteran Population Causes a Variety of Problems for Veterans Direct Delivery System

Within 10 years after the end of World War II, use of veterans hospitals began declining, which threatened the medical expertise that the hospitals had developed. Many World War I veterans were now in their sixties and began needing long-term care, while World War II veterans no longer needed acute care treatment of their war injuries. Between 1954 and 1961, utilization of available beds in veterans hospitals fell by 14 percent, while the number of beds declined by 8 percent.

During the late 1950s, standards of medical care at veterans hospitals were high, according to Canadian veteran health care officials. However, as noted in the 1960 DVAC annual report, the aging veteran population, which increasingly needed long-term care services and less acute care, posed a

threat to this expertise and the ability to recruit and retain skilled medical professionals.

DVAC attempted to counter the falling utilization and threatened loss of its medical expertise by expanding eligibility and authorizing veterans hospitals to admit beneficiaries of other government health care programs, including the Royal Canadian Mounted Police and aboriginal Canadians. This action, however, taken during the mid-1950s, failed to result in any significant increase in utilization.

Implementation of universal hospital coverage in 1961 greatly improved veterans' access to hospital care; however, it reduced utilization at veterans hospitals. According to DVAC officials, universal hospital coverage decreased workload at veterans hospitals because veterans generally chose to receive care in nearby community hospitals rather than at the more distant veterans hospitals. Access to veterans facilities had become a problem for older Canadian veterans who lived outside of the urban areas served by the veterans hospitals because they often had to travel long distances for health care. As veterans aged, traveling to these facilities became harder.

Canada Decided It No Longer Needed a Separate Veterans Direct Care Delivery System and Switched Its Focus to Long-Term Care Services

On the basis of changing health care needs of an aging and declining veteran population and the introduction of universal coverage for hospital care, Canada decided in 1963 that it no longer needed a separate direct delivery system for veterans. Further, Canada began shifting its focus from acute care to long-term care as hospitals converted beds for acute care services to beds for veterans' long-term care needs. By the early 1960s, 70 percent of the veterans hospital beds were being used for long-term care services.

A 1963 government report noted that veterans hospitals faced a probable decline in the quality of acute care they could provide as the patient population continued to age. The study concluded that with the declining number of eligible veterans, most of whom needed long-term care instead of acute hospital care, and the increased costs of operating hospitals, the veterans health care system should stop delivering direct care.

DVAC began transferring its medical facilities to the provinces in 1966, and, by 1983, all but one hospital and two domiciliaries had been transferred. During this period, Canada also implemented universal coverage of

physician care. This improved veterans' access to outpatient care for those who used veterans hospitals for their outpatient services.

To transfer its hospitals, DVAC had to negotiate with the provinces. The following is part of the transfer negotiations:

- The medical education, research, and military backup responsibilities of each former veterans hospital remained with that hospital, preserving these capabilities. In effect, DVAC no longer has research, medical training, or military backup responsibilities because the provincial hospitals have assumed these missions.
- DVAC agreed to upgrade its hospitals to community standards. Although most veterans hospitals were structurally sound and provided comparable medical treatment in terms of quality, they frequently did not meet the privacy requirements of a community hospital. For example, veterans hospitals often had multibed rooms rather than private or semiprivate rooms and did not have individual showers. Also, while amenities like televisions and telephones in each room compared with those of community hospitals, veterans hospital furnishings were often old and worn and had to be replaced.
- DVAC contracted with community health facilities in each province to provide veterans access to long-term care beds.

As of 1993, DVAC was negotiating the transfer of the remaining two facilities—one hospital and one domiciliary—to the provinces. Both facilities provide long-term care services to veterans.

Veterans Service Organizations Support Changes Made to the Veterans Health Care System and DVAC's Focus on Long-Term Care

Officials of the Royal Canadian Legion, a major Canadian veterans service organization, told us that they are satisfied with the health care benefits provided Canadian veterans. They support the concept that the veterans health care system supplement universal health care services. Officials also told us that they supported transferring the veterans hospitals to the provinces because the declining utilization of veterans hospitals no longer justified a separate hospital system. They also endorsed reserving a number of long-term care beds for veterans' use on a priority basis in communities across Canada.

The Legion wants Canada to maintain a separate veterans health benefits system that advocates for veterans health care issues and that supplements the universal care program; the Legion opposes efforts to eliminate the veterans health benefits system and merge it with the

universal care program. Annually, Legion officials meet with DVAC officials to promote continued improvements in veterans health care benefits.

Finland's Veterans Health Care System Continues to Operate a Direct Delivery System, but Now Focuses on Long-Term Care

Finland continues to operate a direct delivery system for veterans, but the system has changed its focus to meet the long-term care need of its aging veteran population. It is administered by the State Accident Office (SAO) in the Ministry of Social Affairs and Health. The system (1) pays operating costs of 2 hospitals, 2 outpatient clinics, and 24 nursing homes; (2) reimburses municipalities for special health care benefits provided veterans such as home care, day care, and housekeeping services; and (3) pays copayments and deductibles incurred by veterans under the universal health care program for treatment of their disabling injuries. All veterans are covered by the universal health care program but do not receive priority for treatment over other citizens. Veterans service organizations support the veterans health care system and the benefits provided veterans. In 1992, system expenditures totaled $227 million (U.S. dollars).

As shown in table 4.3, the system began during World War II. It was not significantly affected by implementation of universal health care and has evolved over time to meet the changing health care needs of veterans.

Table 4.3: Evolution of Finland's Veterans Health Care System

Time frame	Event
1940s	Veterans service organizations built and operated medical facilities, without government assistance, to treat the special injuries of veterans.
1948	Legislation passed creating a veterans health care system.
1963/1972	Finland implemented universal health care system that did not affect the veterans direct delivery system.
1970-1990s	System focuses on long-term care needs of veterans by (1) paying for services that allow veterans to remain at home, (2) converting acute care beds to long-term care beds, and (3) building nursing homes.

System Started During World War II

Veterans health care in Finland began during the 1940s when veterans service organizations began building and operating medical facilities for treating veterans with disabling war injuries such as loss of limbs, blindness, and brain injuries. At that time, municipalities had primary responsibility for providing health care services to all veterans and other citizens in Finland. The municipal facilities generally lacked the

experience and resources to meet all the specialized care needs of disabled veterans.

In 1948, Finland implemented legislation creating a veterans health care system under which the federal government, through the SAO, began paying for the operating costs of veterans medical facilities owned by the veterans service organizations. The SAO also began paying the copayment and deductible costs of inpatient and outpatient services provided by the municipalities and private providers to treat disabled veterans' war injuries.

By 1962, the year before Finland began implementing its universal health care program, veterans could receive free care at three medical and surgical hospitals,[7] two outpatient clinics, and two nursing homes funded by the SAO, but owned and operated by veterans service organizations, as well as care provided by municipal health care facilities, or by private providers.

Universal Health Care Implementation Did Not Affect the Veterans Health Care System

SAO officials told us that Finland's universal health care program, implemented during the 1960s and 1970s, did not affect veterans health care system operations nor the demand for veterans health care. That is, the number and types of medical facilities funded, types of services provided, and eligibility criteria of the veterans health care system did not change because the country implemented universal health care. Several reasons explain this: One, universal health care did not improve disabled veterans' access to care because they previously received free care for their war injuries at local municipal health care facilities or at the veterans medical facilities. Thus, utilization of the veterans facilities was not affected. Two, officials told us that the system's role of providing for disabled veterans health care needs by supplementing the services delivered by the municipalities did not change. The municipalities continued to be the primary provider of health care services in Finland after universal health care implementation.

System Changes Made to Focus on Veterans Long-Term Care Needs

The aging of the veteran population caused Finland to start changing its veterans health care system between the implementation of universal health care and the 1990s. The objective of the changes has been to allow older veterans to function independently at home for as long as possible. These changes include the following:

[7]In 1978, Finland replaced two hospitals located next to each other with one new hospital.

- Severely disabled veterans can get grants for housing repair and renovation work. These grants fund such projects as building or renovating bathrooms, widening doors, and constructing ramps so that older veterans can continue to live at home.
- The government began reimbursing municipalities in 1986 for the special health care services they provide severely disabled veterans, such as home care, day care, and housekeeping services. This change resulted from the government's determination that the veterans health care system was too institutionally focused and its desire to ensure that services were available to severely disabled veterans living at home.
- The government funded construction and operation of 22 new nursing homes during the 1980s and early 1990s. Although the nursing homes are owned and operated by municipalities and veterans service organizations, their operating expenses are paid by the SAO. Only severely disabled veterans are allowed to use the nursing homes and they incur no charge, regardless of their income.

The aging of the country's disabled veterans also resulted in changes to the types of services provided at the Kauniola veterans hospital we visited. This is the primary hospital for treating veterans disabling war injuries. The chief physician at the hospital told us that the health care needs of disabled veterans change as they age and that the hospital, in response, has changed its services. For example, after World War II, the hospital primarily provided acute care services for treating disabled veterans' war wounds, such as brain and eye injuries, so that they could reenter the workforce. However, by 1993, the hospital had shifted its services to providing more geriatric care to disabled veterans, whose average age was 74. Additionally, the hospital had converted 100 of its 227 beds to long-term care use. Some of the veterans needing long-term care services had been at the hospital for 10 to 15 years.

SAO officials told us that during the first quarter of the next century, Finland will no longer need a veterans health care system. The average age of the 40,000 disabled veterans in 1993 was 75, with 16 percent over 80. By the turn of the century, half of the estimated 22,000 remaining veterans will have reached the age of 80.

Veterans Service Organizations Opinions of Finland's Veterans Health Care System

Officials at two of the largest veterans service organizations in Finland told us that they support the veterans health care system and the health benefits provided to disabled veterans. Officials stated that benefits did not diminish following universal health care implementation and praised

the federal government for continuing its funding for veterans benefits in the recessionary 1990s. Further, one official said that maintaining a separate veterans health care system resulted in greater respect by the general population for disabled veterans and the sacrifices they made for their country.

Veterans service organizations historically have been very active in promoting the health care needs of disabled veterans and ensuring that the federal government provides for these needs. For example, veteran service organizations were responsible for promoting construction of the 22 new nursing homes to meet the long-term care needs of Finland's aging veterans. They are also seeking improved veterans access to heart bypass surgery through the universal health care system. Current policy is for younger men and women to have first access to this surgery, but the veterans organizations believe that Finland's older disabled veterans should have better access to this service.

United Kingdom's Veterans Health Care System Relies on Universal Health Care to Provide Most Veterans Health Care Benefits

The National Health Service's direct delivery system provides and pays for the vast majority of health care that disabled veterans receive. Veterans have priority for treatment for their disabilities provided at NHS facilities. For health care unrelated to their disabilities, veterans receive health care at NHS facilities without additional priority for care.

The War Pensions Agency, an executive arm of the Department of Social Security, which administers the veterans health care system, does not own or operate any veterans health care facilities. Rather, it arranges and pays for veterans health care that is not available through the NHS, including skilled nursing care; medical equipment such as eyeglasses and hearing aids; home nursing equipment; and home adaptation grants. The Agency also pays subsistence, loss of earnings, and transportation expenses when disabled veterans get treated for their service-connected disabilities at NHS medical facilities.

Since nearly all disabled veterans' medical needs are covered and paid for by the NHS, the Agency's yearly medical expenditure is quite small. Payments for the financial year ending in April 1994 were $10.5 million (U.S. dollars), with about 70 percent of these funds spent on around-the-clock skilled nursing care for 220 severely disabled veterans in nursing homes.

The system once consisted of a combination of specialized hospitals and contracted health care. As the number of disabled veterans declined and their specialized care needs diminished, the need for veterans hospitals decreased. Eventually the government merged the veterans hospitals with the NHS without any loss in veterans health care benefits (see table 4.4).

Table 4.4: Evolution of United Kingdom's Veterans Health Care System

Time frame	Event
Pre-1948	Operated a direct care delivery system consisting of 12 hospitals and numerous clinics and paid for care provided in public hospitals.
1948	United Kingdom implemented the NHS.
1953	Decision made to (1) have the NHS provide and pay for veterans care in NHS facilities, (2) provide veterans priority of care in NHS facilities for their disabilities, and (3) pay for care not provided under the NHS. Also, hospital merger begun.
1961	Hospital merger completed.

Veterans Health Care System Before the National Health Service: A Combination of Direct Delivery and Contract Care

Shortly before implementation of the NHS in 1948, the Ministry of Pensions operated a veterans health care system consisting of (1) direct care provided at 12 veterans hospitals with about 4,200 beds and numerous clinics that treated the special war disabilities of veterans and (2) contracted care provided by public and private hospitals and clinics for treating veterans' war-related injuries. Veterans hospitals were located near large population centers and specialized in treating war disabilities such as amputations, spinal cord injuries, paraplegia, head and eye injuries, and tropical diseases. These hospitals treated veterans discharged from military hospitals as well as veterans readmitted for further treatment. For the year ending in March 31, 1948, veterans hospitals provided specialized treatment to 21,000 disabled veterans; public and private hospitals treated 85,000 disabled veterans.

Public and private hospitals, clinics, and physicians under contract with the Ministry treated disabled veterans for tuberculosis, mental illness, and routine care related to their disabling injuries. The Ministry contracted for care for two reasons. First, it was more efficient to contract for services than to hire permanent medical staff. Second, it enabled veterans to obtain much of their care near their homes and families rather than having to travel to veterans hospitals.

The veterans health care system also provided care to civilians. For example, Stoke Mandeville hospital, known for its spinal cord injury and

paraplegia work, was already treating a number of civilian patients before implementation of the NHS. Further, because of their research and expertise in artificial limbs, Ministry facilities supplied artificial limbs to the general population as well as to disabled veterans.

Between 1948 and 1953 Veterans Hospitals Treated Fewer Veterans but More Civilians

When the United Kingdom was implementing the NHS in 1948, veterans were losing eligibility for veterans health care benefits as they completely recovered from their war injuries. Also, veterans needed less and less specialized care in veterans hospitals. As a result, both the number of eligible veterans and utilization rates in veterans hospitals declined. For example, between March 1948 and March 1950, the number of disabled veterans decreased from about 767,000 to about 725,000, a reduction of about 9 percent. The Ministry's 1950 annual report noted a drop in veterans' use of veterans hospitals from about 26,000 to 21,000 for the year; this use further declined to about 16,000 in 1952. The Ministry's annual report that year stated that veterans' medical needs generally did not include the specialized care offered in veterans hospitals.

As veterans' demand for specialized care decreased, so too did the number of veterans hospitals and beds. Between 1948 and 1953, the Ministry closed 5 of its 12 hospitals, the total number of hospital beds fell from about 4,200 to 2,000, and many of the remaining hospitals reported empty beds. For example, one veterans hospital reported that 137 of its 260 beds were empty as of August 31, 1953. During this period civilian use of the Ministry's specialty hospitals increased, which helped somewhat to offset their excess bed capacity. The Ministry's March 1949 annual report accurately forecasted that hospital expertise in spinal cord injury treatment would become increasingly available for NHS patients as the number of disabled veterans needing treatment continued to decrease. For example, by 1953 the majority of new admissions to the Stoke Mandeville hospital were civilians needing spinal cord injury treatment. The Ministry's Artificial Limb Service and hospitals specializing in eye treatment, plastic surgery, and certain war injuries were also treating an ever-increasing number of civilian patients. In 1953, veterans hospitals treated over 1,800 civilians—about 14 percent of all patients treated that year.

The number of veterans receiving treatment in public and private hospitals during this time also declined. For example, the Ministry's March 1948 annual report noted that 85,000 veterans received care in public and private hospitals while the March 1951 report noted that about 23,000 received care in NHS or other hospitals—a 73-percent decrease in 3 years.

A Declining Veterans Population That Needed Fewer Specialized Acute Care Services Finally Led to Merging Ministry Hospitals

Because (1) the number of veterans eligible for care in veterans hospitals was declining and (2) those eligible for care needed less specialized medical treatment, the United Kingdom decided in 1953 to merge its veterans hospitals with the NHS. The government believed that the merger would result in increased utilization of the veterans hospitals and allow them to preserve and further develop their specialized medical expertise by treating more NHS patients with comparable injuries. The seven remaining veterans hospitals merged into the NHS between 1953 and 1961. According to veterans health care system officials, the privacy considerations, amenities, physical condition, and quality of care in the veterans hospitals compared with those at NHS hospitals at the time of the transfers.

Although it dismantled the separate veterans hospital system, the government maintained special health care benefits for disabled veterans. As part of the merger decision, (1) the NHS would provide and pay for veterans care in NHS facilities, (2) eligible veterans would receive priority for treatment of their disability in NHS facilities, and (3) the veterans health care system would pay for any necessary care of veterans not covered under the NHS. Additionally, the Ministry of Pensions was unified with the Ministry of National Insurance under the Ministry of Pensions and National Insurance in August 1953. The Ministry of Pensions was no longer a separate government agency.

Veterans Service Organization Is Satisfied With Veterans Health Care Benefits

The Royal British Legion, a major veterans service organization, is satisfied that veterans health care needs are adequately met since merger of the veterans hospitals with the NHS. Reasons cited include (1) veterans receive priority of treatment for their war injuries in any NHS hospital, (2) funding for veterans additional health care needs not covered under the NHS has been adequate, and (3) quality of care in NHS hospitals compares with that provided in the prior veterans hospitals and surpasses that available under the prior patchwork health care system.

Originally, the Legion opposed turning veterans hospitals over to the NHS. However, the opposition was mild because the Legion realized that the declining numbers of eligible veterans could not sustain a separate veterans hospital system. Further, the Legion agreed that the NHS had been providing quality care for 5 years before the government decided to merge the veterans hospitals with the NHS and that the NHS was a vast improvement over the former civilian health care system.

The Legion also opposed bringing the Ministry of Pensions under the Ministry of Pensions and National Insurance because disabled veterans would no longer be represented by a separate government agency. In response to this opposition, the government assured the Legion that the interests of veterans would not be compromised. Legion officials told us veterans benefits and interests have been maintained since the merger.

Implications of Changes in Other Countries' Veterans Health Care Systems for the United States

Although significant differences exist in the veterans health benefits in the United States and the four countries studied, the evolution of the four countries' veterans health care systems provides useful insights into the potential effects of health reforms in the United States on our veterans health care system. Specifically, our work in the four countries shows the following:

- Maintaining a direct delivery system is not the only option for preserving or expanding veterans' health benefits.
- Increasing veterans' freedom to choose between VA and non-VA health care providers will likely result in significant declines in demand for care in veterans facilities, unless financial or other incentives are used to entice veterans to choose VA health care.
- Unless the patient mix in VA hospitals is broadened, veterans hospitals could find it increasingly difficult to (1) attract and retain physicians, (2) maintain expertise in treating the specialized health care needs of veterans, (3) maintain their medical education mission, and (4) serve as a backup to the military.
- Regardless of whether the United States implements health reform, a declining veteran population, coupled with VA's move toward managed care, will likely reduce demand for acute care at veterans hospitals.
- U.S. veterans will, like those in other countries, increasingly need long-term care services as the population continues to age.

Maintaining a Direct Delivery System Is Not the Only Option for Preserving Veterans Health Benefits

While maintaining a direct delivery system is one option for preserving veterans health care benefits under a universal care system, it is not the only option. Three of the four countries studied preserved and enhanced veterans health benefits without maintaining their direct delivery systems. Most of the U.S. reform proposals do not specifically address the role of VA in a reformed health care system. Those proposals that do address VA, however, focus primarily on preserving the direct delivery system.

Australia, Canada, and the United Kingdom closed or transferred ownership of (or have developed plans to do so) their veterans hospitals to other public or private organizations. In each country, however, veterans reportedly continue to receive health benefits that exceed those available to the general public under the universal care program. Although all the countries preserved and, in most cases, expanded veterans health benefits, they did it in different ways:

- Most veterans health care in the United Kingdom is delivered and paid for through the universal care program. Veterans receive priority treatment for their service-connected disabilities in universal care hospitals; the veterans program supplements any care not available through the universal care program, primarily nursing home care.
- In Canada, most veterans health care is delivered and paid for through the universal care program. Because covered services under the universal care program vary by province, the Department of Veterans Affairs supplements provincial plans to ensure that veterans continue to receive the same services available under the former direct delivery system.
- Australia's Department of Veterans Affairs continues to operate a separate veterans health benefits program but increasingly contracts for care with public and private hospitals; veterans hospitals are being turned over to the states or to private organizations. Veterans in Australia essentially obtain care from the same hospitals and physicians participating in the universal care program but have higher priorities for care and better accommodations by obtaining their care through the veterans program.

Although none of the major U.S. health reform proposals we reviewed would eliminate VA's current role as a direct provider of acute health care services, most would not authorize changes that would enable VA to maintain its acute care workload. The administration's original Health Security Act and the Mitchell (S. 2357) and Gephardt (H.R. 3600) proposals that replaced it would authorize VA to transform its facilities into a series of managed care plans to compete with private-sector health plans. VA envisions an expanding network of outpatient clinics, increased contracting for health care services, and increased flexibility to close underutilized hospitals. Finally, the Dole/Packwood proposal (S. 2374) is intended to give VA sufficient flexibility to compete as a health care provider under any state-enacted health reforms.

VA officials, in commenting on a draft of this report, said that it is essential for VA to maintain a direct delivery system. The ability of other countries to give up their direct delivery systems should not be compared to the United States veterans health care system because of significant differences between health care in the four countries and the United States. Specifically, they said that

- the size of our VA system and the scope of services provided are vastly different from those that existed in the veterans health care systems of the four countries when they adopted universal coverage and

- the health systems in the four countries, as opposed to those in the United States, are either government-operated or government-financed and controlled.

The size of our veterans health care system does not, in our opinion, preclude a comparison with the other countries because the VA system, while large compared to those in other countries, is nonetheless small relative to the country's overall health care system. There are 171 VA hospitals compared to approximately 6,800 public and private hospitals in the United States. While the number of veterans hospitals is greater than in the other countries, this alone does not prohibit the option of transferring or selling them to the public or private sector nor would it preclude closing facilities or converting them to other uses such as long-term care. Moreover, about 90 percent of patients using VA hospitals receive treatment only for nonservice-connected conditions. The fact that VA provides health care services to only about 8 percent of veterans in any given year provides further indication that the private sector is capable of providing the types of health care services needed to meet the general health care needs of veterans.

Nor, as VA suggests, are there significant differences in the scope of services provided by the veterans health care systems in the United States and the four countries studied. As detailed in Section 4, the four countries provided all necessary services to treat their veterans' service-connected injuries, just as our VA does currently. In other countries, eligible veterans have certainty of treatment while our veterans, because of complex eligibility criteria, are uncertain of the VA care they will receive. Finally, as sections 1 and 4 of this report illustrate, the scope of services available to veterans in other countries exceeds those available to nonveterans.

Our work, rather than suggesting that the ability of a country to preserve veterans health benefits without a direct delivery system depends on the type of universal health care system adopted by a country, suggests the opposite. That is, veterans health benefits can be preserved without a direct delivery system regardless of how the universal care system is structured. As described in section 1, the universal care systems in the four countries range from a direct delivery system (United Kingdom) to a single payer (Canada). Notwithstanding differences in their universal health care systems, three of the four countries decided to preserve and enhance veterans health care benefits without a direct delivery system (see section 4). Wide differences also exist in the approaches to health reform in the United States. Universal care proposals range from

government-administered, private-sector managed care plans (Clinton/Mitchell/Gephardt) to a Canadian-style single payer system (McDermott/Wellstone).

VA officials said that because VA's training, research, and military backup missions serve the country as well as veterans, it is essential to retain VA's direct delivery system. We recognize that VA has a role in training a significant portion of this country's medical professionals. However, as noted in section 4, Canada had the same additional missions as our VA but successfully transferred them to the provinces when it decided to give up its direct delivery system. Australia too transferred its research and training missions without apparent detriment to the country. We believe that maintaining these missions should be secondary to designing a veterans health benefits program that best meets the needs of America's veterans.

Several health reform proposals could inhibit VA's ability to meet its other missions. For example, the administration's original Health Security Act and the Mitchell and Gephardt bills could diminish VA's ability to back up the military's health care system. Currently, most VA care is discretionary, subject to the availability of space and resources. This gives VA considerable flexibility to deny or delay treatment to veterans to make room for returning war casualties. Under the Health Security Act and the Mitchell and Gephardt bills, VA would have the same contractual obligation to treat enrollees, both veterans and dependents, as other health plans. As a result, VA would no longer have the same flexibility it now has to deny or delay care to veterans in the discretionary care category. Further, these proposals could inhibit VA's ability to conduct research on service-related health conditions or train medical professionals because veterans choosing other plans could generally come to VA for treatment only if their health plans agreed to pay VA for the care.

VA officials said that the White House Working Group, in developing the administration's Health Security Act, considered options other than maintaining a direct delivery system and concluded that maintaining a viable VA direct delivery system is a priority. VA officials, however, did not describe what other options the Working Group considered or the reasons the Working Group felt these options were not viable. We believe the information presented in this report, which may not have been available to the Working Group, shows that veterans health benefits can be preserved and enhanced without a direct delivery system.

U.S. veterans service organizations believe that maintaining a direct delivery system for veterans is the only way to ensure that veterans health needs continue as a national priority, according to VA officials. As section 4 points out, veterans service organizations in Australia, Canada, and the United Kingdom held similar opinions when their countries considered giving up veterans direct delivery systems. Today, these veterans service organizations support the changes in how veterans obtain health care because, in those countries, veterans special health care status and benefits have been preserved and enhanced.

VA officials further stated that a direct delivery system is essential because VA provides specialized services that may not be reasonably available in the private sector. Under health reform as detailed in the Health Security Act and the Mitchell and Gephardt bills, however, the main focus is on providing the same standard benefit package that veterans would receive under any competing health plan, not on preserving specialized services. Under these proposals the availability of specialized services could deteriorate, even with the maintenance of effort provisions under the Gephardt bill. The Gephardt bill, however, would make nursing home care an entitlement for most service-connected veterans and would entitle core group veterans (primarily service-connected and low-income veterans) enrolling in VA health plans to the full range of VA outpatient services not included in the standard benefit package.

The countries we visited that eliminated their direct delivery systems (see section 4), maintained their specialized services for veterans by transferring the specialties to the universal care systems or paying for such services to supplement the universal care system. Spinal cord injury treatment in the United Kingdom and burn treatment in Australia are two examples. Finally, VA does not need to maintain a full-service direct delivery system to maintain its specialty services; VA could instead focus on direct delivery of specialized services for eligible veterans.

Health Reforms That Increase Veterans Freedom to Choose Providers Will Likely Reduce Demand for Care in Veterans' Facilities

Reforms of the U.S. health care system or of the veterans health care system that would give veterans increased access to community providers will likely reduce demand for care in existing VA facilities unless VA attracts an increasing number of veterans through expanded benefits or reduced cost sharing. Canada and Australia both experienced significant declines in use of their veterans hospitals after veterans got increased freedom to choose their source of care. Canada's experience suggests the potential effects on our VA system if it remains unchanged through health reform, as it would under all but the administration, Mitchell, Gephardt, and Dole/Packwood bills. On the other hand, Australia's experience more closely suggests the likely effect of the administration's proposals.

In June 1992, we reported that many current VA users would likely stop using VA facilities under a universal care system unless changes were made in the VA health care system.[8] We estimated that demand for inpatient care could decline by about 47 percent and demand for outpatient care by about 41 percent if the U.S. implements a universal health care system. At about the same time, the Paralyzed Veterans of America similarly estimated that up to half of current VA hospital users might leave the VA under health reform. Many factors could affect the extent of any decline in VA use, including the comprehensiveness of the services provided, the cost sharing required, and the nature and extent of any changes in VA eligibility and services.

In Canada, whose former VA system most closely resembled veterans health care in this country, the decline resulted when veterans' access to community care improved through implementation of universal care. Like U.S. veterans, Canadian veterans were required to obtain most of their inpatient and outpatient care through veterans hospitals and had limited access to health care services in their home communities unless they had alternative health care coverage. Canada implemented universal coverage without changing the structure of its veterans health care program, much as all but the administration and Mitchell and Gephardt proposals would do in this country. As a result, use of Canada's veterans facilities declined as veterans who formerly had to travel long distances to veterans hospitals gained improved access to community providers. Within a few years after implementing universal hospital coverage, Canada decided to close its veterans hospitals.

[8] VA Health Care: Alternative Health Insurance Reduces Demand for VA Care (GAO/HRD-92-79, June 30, 1992).

Unlike Canada's, Australia's veterans had considerable freedom to choose their health care providers even before implementation of universal coverage. Initially, Australia, like Canada and the United States, required veterans to use its veterans hospitals for most of their care. Unlike Canada and the United States, however, Australia always allowed its veterans to obtain outpatient care through "local medical officers," essentially private practice physicians in their home communities. The local medical officers could arrange admissions to both veterans hospitals and other public and private hospitals.

Veterans living in nonmetropolitan areas could obtain care in public hospitals without obtaining prior approval from DVA; veterans in metropolitan areas could also use public and private hospitals but were required to obtain prior approval from DVA. With this freedom to choose between veterans and public or private hospitals, public and private hospitals accounted for about 43 percent of the hospital days of care provided to veterans through DVA in the year before Australia implemented universal care.

Australia is giving veterans additional flexibility to use public and private hospitals as it transfers hospitals to the states. Beginning in 1992, Australia authorized veterans living in states where the veterans hospital had been transferred to use public hospitals at DVA expense without obtaining prior approval. The conditions for accessing private hospitals have also eased.

The current Australian veterans system most closely resembles the structure of the U.S. veterans health care system proposed under the administration's original Health Security Act and the Mitchell and Gephardt proposals. Under these proposals, VA plans to give veterans greater freedom to choose where they obtain health care by expanding its provider network through contracts with community hospitals and providers and through new construction/leasing of VA facilities.

While such an expansion in the number of providers is essential if VA is to compete under health reform, it is likely to have the same effect on use of VA facilities as the other health reform proposals unless VA health plans increase VA's market share of the veteran population or veterans are replaced by other patients. In other words, if VA continues to serve about 2.3 million veterans per year but serves them through a network of VA and community providers, then those veterans' use of VA facilities will decline. But, if VA decides to treat veterans' dependents or other nonveterans in its

hospitals or is able to enroll more than 2.3 million veterans in its health plans, then it may be able to maintain its existing hospitals' workloads.

VA officials, in commenting on a draft of this report, said that we have ignored the impact of the administration's health reform proposals on demand for VA care. They noted that the proposals would fix VA's complex eligibility rules, provide new funding streams, and broadly expand access to the VA system for veterans and their dependents. They also noted that the proposal would provide substantial financial incentives for up to 9 million veterans to enroll in VA health plans. Finally, they noted that the financial incentives would be even greater under the Mitchell proposal because employers would not be required to pay more than 50 percent of the cost of their employees' health insurance premiums.

We agree that incentives such as free care and additional benefits could enable VA to maintain or expand utilization at its facilities and have revised this report accordingly. We also note, however, that the government's costs for providing enrollment incentives to expand utilization have not been adequately reflected in the administration's estimates of the cost impact of the veterans health care provisions of the Health Security Act. The cost estimates are based on enrollment of about 2.3 million veterans.

In May 1994, and again in June 1994, we testified that under the administration's original Health Security Act, a core group of about 9 million veterans, primarily those with service-connected disabilities or low incomes, would be entitled to free comprehensive benefits if they enrolled in VA health plans. That is, they would not be required to pay their 20-percent share of the premium or other out-of-pocket costs. VA would assume payment for these costs, which could require over $15 billion annually in appropriations.[9]

The Mitchell bill provides even greater financial incentives for veterans to enroll in VA health plans. Under this proposal, employers would not initially be required to contribute toward their employees' health insurance premiums, and, even if an employer mandate were subsequently imposed, would not be required to pay more than 50 percent of the premiums. Thus, employed veterans would have a strong financial incentive to enroll in VA health plans to avoid paying 50 percent or more of their health insurance premium. Further, the Mitchell bill would

[9]VA Health Care Reform: Financial Implications of the Proposed Health Security Act (GAO/T-HEHS-94-148, May 5, 1994).
VA Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

essentially extend free comprehensive benefits to all veterans who served in Desert Storm and Vietnam, regardless of service-connected status or income.

While the Mitchell bill contains financial incentives for veterans to enroll, it also contains a significant disincentive to enrollment in VA health plans by essentially shifting the financial risks for VA health plans from the government to VA health plan enrollees. Unlike other health plans that would be required to provide services covered under the standard benefit package to all enrollees, VA health plans would provide items and services consistent with the standard benefit package only to the extent that adequate funds were appropriated to cover their costs. If appropriations are insufficient, VA may reduce the standard benefit package. In other words, veterans enrolled in a VA health plan may receive fewer health benefits than the rest of the population that enrolled in other health plans. All of the countries in our study provide eligible veterans health care benefits that exceed those available to the general population.

In May 1994, VA officials testified before the Senate Committee on Veterans' Affairs on the cost impact that the administration's Health Security Act would have on its operations. At that time, VA reported that its cost estimates were based on 2.3 million veterans enrolling in VA health plans—the number who use the system annually. However, this enrollment figure, and therefore VA's cost estimates, are greatly understated if VA is to sustain its current workload.

This is because more individuals generally enroll in an HMO or private health insurance plan than actually use health care services in any given year. An HMO or private health insurance plan knows how many enrollees it has and can calculate the average health care utilization across all of its enrollees, not just those who used health care services in the past year. VA, however, does not have comparable data because veterans do not currently "enroll" in the VA health care system. As a result, VA knows how many veterans used VA services in any given year, but not how many other veterans would have used VA had they needed health care. VA officials told us that over a 3-year period, there are about 4 million distinct users of VA services. Using this as a conservative estimate of current VA users, VA would need to enroll 4 million veterans, not the 2.3 million it reported to the Congress, to continue serving its current users with no other changes in the VA system.[10]

[10]We think this is a conservative estimate because 3 years may not be a long enough time to identify a true user population.

But, VA plans to make another important change; it plans to allow veterans enrolling in VA health plans to use community facilities and providers under contract with VA health plans at no additional cost to the veteran. If half of VA health plan enrollees chose to get care from community providers rather than from VA facilities, the number of veterans VA health plans would need to enroll would double, to about 8 million, if workloads at VA facilities are to be maintained. While the number of enrollees VA health plans would need to enroll to maintain utilization of VA facilities would depend on many factors, such as where those enrolling in VA health plans live in relation to VA facilities, we believe it is likely that at least half of the enrollees would choose community providers.

Many veterans, given a choice between care in VA facilities and non-VA facilities closer to their homes, with no difference in out-of-pocket costs, would likely choose non-VA care. Our prior work suggested that VA might lose as much as 47 percent of its acute hospital workload and 40 percent of its outpatient workload if veterans obtained better access to community providers through a universal health care program. The administration's Health Security Act would essentially give veterans this same increased access to community providers through enrollment in VA health plans, but with an added incentive for many veterans—free care regardless of whether they choose to get care from VA facilities or through community providers under contract with their VA health plans.

Clearly, the cost of enrolling 8 million veterans would far exceed the cost the administration used in estimating the cost impact of the veterans health care provisions of the Health Security Act. As stated in our May and June 1994 testimonies, the cost of enrolling low-income, Medicare-eligible veterans (half of current VA users) would be paid entirely through VA appropriations.

Treating veterans' dependents in VA facilities could reduce the number of veterans needed to sustain the direct delivery system. Although VA officials said they plan to treat dependents in VA facilities to the extent space permits, VA previously indicated that it planned to treat dependents entirely through contracts.

Limiting Use of Veterans Hospitals to Veterans Could Facilitate Decline in Capabilities

One of the problems faced by other countries that could increasingly affect our VA facilities as the veteran population continues to age is the declining capability to provide a full range of health care services. Other countries found that limiting their veterans hospitals to treatment of veterans was causing a decline in their ability to provide a full range of health care services and increasing difficulties in attracting and retaining staff. Canada, Australia, and the United Kingdom all acted to expand their patient base by bringing nonveterans into their hospitals. For example, when Australia's veterans health care system's expertise in wound management and burn treatment was threatened by the loss of trained staff, it authorized nonveterans to use veterans hospitals to provide a more diversified patient mix. It placed limits on the resources that could be used to treat nonveterans to ensure that veterans would continue to have priority for care.

Unless the patient base of VA hospitals is similarly expanded, our veterans hospitals are likely, as happened in other countries, to increasingly focus on geriatric care, losing the capability to provide a full range of health care services. This, in turn, could limit the ability of veterans hospitals to back up the military health care system in wartime or civilian hospitals in domestic emergencies. Finally, it could make it increasingly difficult for VA to recruit and retain physicians and to fulfill its medical education mission.

Currently, VA has limited authority to provide care to nonveterans; it provides such services primarily through sharing agreements with DOD. The administration's proposed Health Security Act would expand VA's authority to provide services to nonveterans through sharing agreements and authorize the Secretary of Veterans Affairs to enroll veterans' dependents in VA health plans. The Secretary of Veterans Affairs has stated his intention of providing services to dependents. VA officials, in commenting on a draft of this report, said that VA would, under the Health Security Act, provide services to dependents in VA facilities to the extent space allows.

Even If No Health Reform Occurs, a Declining Veteran Population Will Reduce the Need for Acute Hospital Beds

A declining veteran population, combined with incentives for VA hospitals to avoid or shorten hospital stays to compete under managed care, could reduce veterans' future demand for acute hospital care. On the basis of the experiences of the four countries studied, the United States can expect continuing significant declines in VA acute hospital utilization even if no national health reform occurs. This is because the veteran population in the United States, estimated to decline by one half over the next fifty years, is steadily declining.

Each country studied experienced significant declines in acute hospital utilization as their eligible veteran populations declined. For example, in Finland, the number of eligible veterans dropped from 90,000 in 1945 to 40,000 in 1992; much of the acute hospital capacity has been converted to long-term care. Similarly, the number of eligible veterans in the United Kingdom declined from 738,000 in 1947 to 196,000 in 1992 while the number of acute hospital beds in the veterans system dropped by 52 percent (from about 4,200 to 2,000) between 1948 and 1953.

Because the United States maintains a large standing military, has significantly broader eligibility criteria, and has engaged in two major conflicts since World War II (Korea and Vietnam), the U.S. veteran population will not decline or age as rapidly as the veteran populations in the other countries studied. Nevertheless, the U.S. veteran population has already started to decline. Barring wars or a buildup of military forces, the number of veterans will decrease by about 50 percent between 1990 and 2040.

Similarly, acute care usage of our veterans hospitals is declining. VA acute hospital discharges, which steadily increased from 1984 to 1988, dropped about 13 percent between 1988 and 1992, from an average of 7,100 per hospital in 1988 to an average of 6,200 per hospital in 1992. In fiscal year 1993, about 33 percent of VA acute medical beds, 35 percent of acute surgical beds, and 35 percent of neurology beds were empty on an average day.

Such declines suggest that VA will have to either (1) capture a steadily increasing market share of the veteran population or (2) expand treatment to nonveterans if it is to maintain acute care workload at its hospitals.

VA officials, in commenting on a draft of this report, said that they generally agree with our statement that the declining veteran population will reduce the future need for acute care, but they also maintained that

the decline in demand will not occur until well into the next century, around the year 2025. This, they said, is because older veterans have significantly more episodes of acute care than do younger veterans.

However, as noted above, acute care utilization rates of veterans hospitals are already falling as the veteran population declines. While it is true that the elderly use more health care services than younger veterans, overall utilization will likely continue to decline as the number of World War I and World War II veterans declines at increasing rates. In addition, we believe that the decline in utilization will accelerate under VA's move to a managed care system. Currently, VA's average hospital length of stay is significantly longer than in the private sector; we believe that this average will fall as VA implements a managed care system designed to move people out of the hospital sooner than in the past. Also, under a managed care system, VA will be shifting certain inpatient procedures, such as cataract surgery, to an outpatient basis. This too will drive down utilization rates of acute care services in veterans facilities.

Veterans Have Increasing Needs for Long-Term Care Services

VA, like the government agencies in the other countries studied, faces the challenge of meeting the health care needs of an aging population. None of the health reform proposals that we reviewed focuses specifically on the changing health care needs of an aging veteran population, although the Gephardt bill would expand entitlement to nursing home care and outpatient services not covered under the standard benefit package.

One of the most significant changes in other countries' veterans health care systems has been the increased emphasis on long-term care services. Each country has expanded the availability of long-term care or initiated home care programs:

- Australia instituted a Hostel Development Scheme in 1992 to help veterans access residential long-term care services.[11] In that year Australia also created a pilot program, the Veterans Independence Program, to promote independence and quality of life of the veteran community in their local environment. The program, currently being extended, aims to increase the

[11]Australia's Department of Veterans Affairs does not provide nursing home care. Nursing home care is available to all Australians through a program administered by the Aged and Community Care Division of Australia's Department of Human Services and Health. Under the program, each resident pays about $168 per week and the government, about $600 per week for nursing home care (Australian dollars). DVA pays the government portion of the cost for nursing home care for eligible veterans. The program is not part of Australia's universal care program, Medicare.

veterans' awareness of community support programs to defer the need for residential care.

- Finland funded construction of 22 nursing homes during the 1980s and early 1990s and pays for veterans home-based long-term care services.
- Canada initiated a home care program in 1981 and contracts for nursing home care for veterans in provinces that do not cover nursing home care under their universal care programs.

The United States has also increasingly focused its medical facility construction program on nursing home care, but nursing home care continues to be an optional benefit for all veterans and VA provides only limited home care services. None of the current health reform proposals that we reviewed focuses specifically on the growing long-term care needs of veterans. Only the administration's original Health Security Act and the Mitchell and Gephardt bills propose changes in the current VA health care system; those changes could lead to a degradation in VA's ability to meet the long-term care needs of veterans.

Under the original Health Security Act, VA health plans would be required to provide up to 100 days of posthospital skilled nursing home care to enrollees, including both veterans and nonveterans. In addition, veterans would continue to be eligible for nursing home care that exceeds the benefits covered under the comprehensive benefit plan under current eligibility and space and resource limits. The veterans health care provisions of the original Health Security Act and the Mitchell bill could reduce veterans' access to the VA nursing home benefit because (1) VA's space and resources might be used in providing acute nursing home care under the comprehensive benefit package, and (2) veterans enrolling in non-VA health plans might be unable to access the benefit because of requirements that they be hospitalized in a VA hospital before admission to a VA-supported nursing home.

The Gephardt bill would require that the Secretary ensure that VA's overall capacity to provide the specialized treatment and rehabilitation services not included in the comprehensive benefit package not be reduced below existing levels. Because the veteran population is aging and demand for long-term care services is increasing, maintaining current levels of effort could actually erode VA's ability to meet the long-term needs of veterans. In addition, the Gephardt bill would create a new entitlement to nursing home care for service-connected veterans and a new entitlement to outpatient services not included under the standard benefit plan for core

group enrollees (primarily service-connected and low income veterans) enrolled in VA health plans.

VA officials, in commenting on a draft of this report, agreed that veterans will increasingly need long-term care services as the population ages. They said that current VA long-term care programs would be maintained and enhanced through the Health Security Act. We do not believe that the VA can be certain of its ability to maintain and enhance its long-term care programs, particularly under the original Health Security Act and Mitchell bill for the reasons cited above. In addition, while the Gephardt bill creates a new entitlement to nursing home care for service-connected veterans, nonservice-connected veterans would still be limited to treatment on a space and resources available basis. Any increase in services for service-connected veterans could thus result in a corresponding decrease in services for nonservice-connected veterans unless additional funds were appropriated.

Agencies and Organizations Contacted by GAO in the Four Countries Studied

Australia	Department of Veterans Affairs Department of Human Services and Health Concord and Heidelberg Repatriation General Hospitals Returned and Services League of Australia Totally and Permanently Disabled Soldiers' Association of Victoria Incorporated
Canada	Department of Veterans Affairs—Canada Department of Health and Welfare Royal Canadian Legion
Finland	State Accident Office Advisory Board on Veterans' Affairs Ministry of Social Affairs and Health State Social Insurance Institute Kauniala Hospital for War Veterans Finnish War Veterans Federation Disabled War Veterans Association of Finland Oulunkyla Rehabilitation Hospital
United Kingdom	Department of Social Security Department of Health Royal British Legion

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