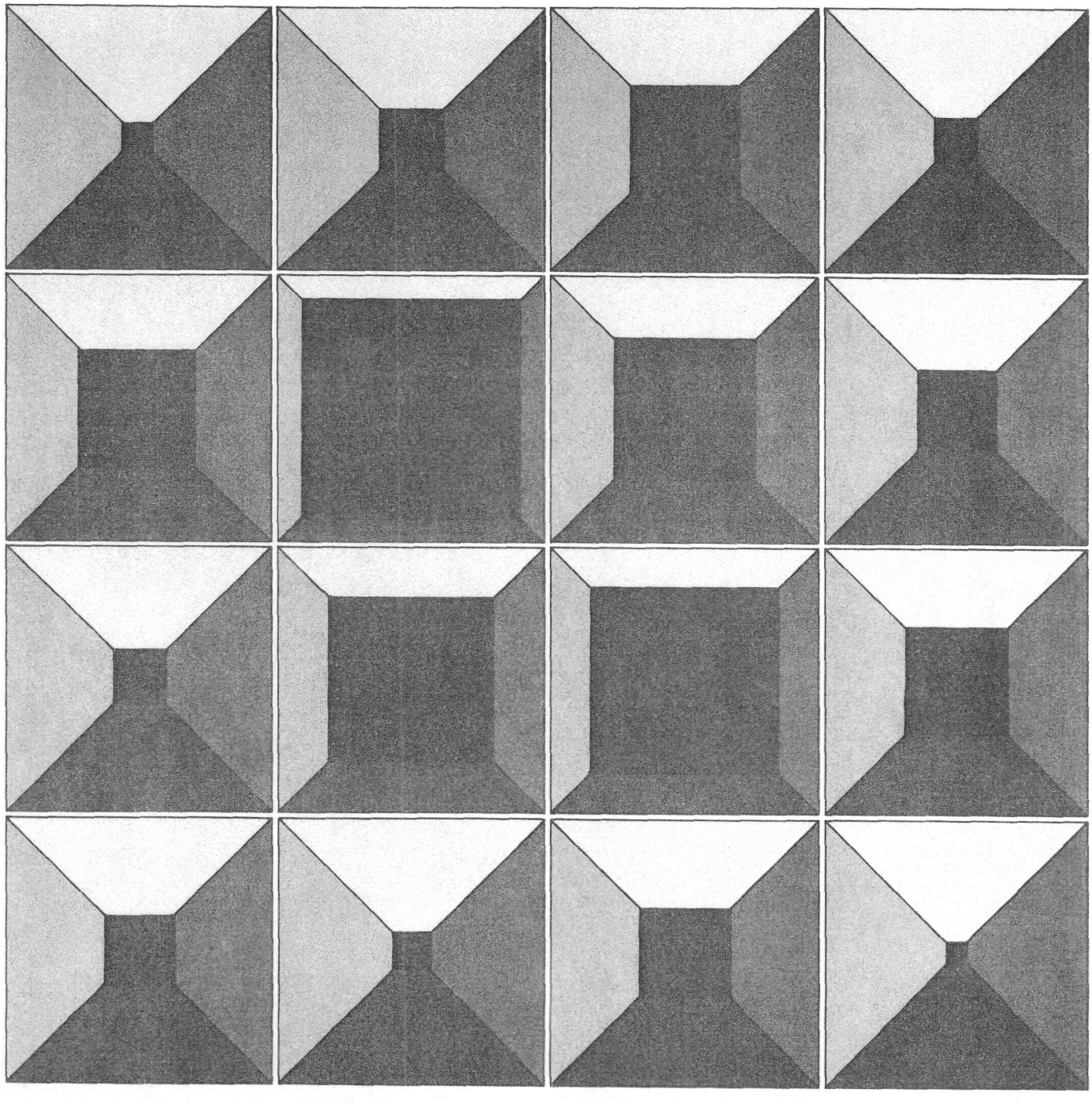
A CBO Study

Veterans Administration Health Care: Planning for Future Years

April 1984

Congress of the United States
Congressional Budget Office



VETERANS ADMINISTRATION HEALTH CARE: PLANNING FOR FUTURE YEARS

The Congress of the United States
Congressional Budget Office

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PREFACE

Congressional concern is growing over the impact that an aging veteran population will have on the health care provided by the Veterans Administration (VA). This study was prepared at the request of the House and Senate Budget Committees. It analyzes the short- and long-range problems facing the VA system, and discusses some cost-effective alternatives for meeting the demand for major VA medical care in future years. In keeping with the mandate of the Congressional Budget Office (CBO) to provide objective and impartial analysis, the study offers no recommendations.

Dorothy M. Amey of the Human Resources and Community Development division of the CBO prepared the paper, under the supervision of Nancy M. Gordon and Paul B. Ginsburg. Many persons inside and outside CBO provided valuable technical and critical contributions. The author especially wishes to thank Carleton Evans, Stan Wells, and William Page of the Veterans Administration; Normal Rabkin and T.J. Sullivan of the General Accounting Office; and Rick Hanushek, Kathleen O'Connell and Kathleen Shepherd of CBO. Several members of the Human Resources and Community Development division helped to ready the paper for publication, including Wilhelmina A. Leigh, Roberta Drews, Sandra Christensen and members of the computer and secretarial staffs. Francis Pierce edited the paper, assisted by Nancy H. Brooks. Ron Moore typed several drafts of the paper and Mary Braxton prepared it for publication.

Rudolph G. Penner
Director

April 1984

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SUMMARY

As the nation's veteran population ages, the health care system run by the Veterans Administration (VA) will experience increased demands for care. All of the four million veterans age 65 or older are potential users of VA hospital and nursing home care. Their number will increase to 7.2 million in 1990 and to about 9 million by the year 2000. If they request and receive care at the same rate as today, the real costs of providing veterans' health care could almost double within the next decade.

This paper discusses the main problems created for the VA health care system by the aging veteran population. It begins by describing the current VA system and then turns to assessing the probable demand for VA medical care, and the resources needed to meet the demand. It concludes by examining alternative ways to reduce the costs.

THE VA SYSTEM

The Veterans Administration extends to eligible veterans free or highly subsidized health care services, including hospital, ambulatory, and nursing home care. The VA provides most of this care at its 172 hospital centers, where it also operates outpatient clinics and 101 nursing home units. Most long-term-care services, however, are either provided under contract in community nursing homes or subsidized in state veterans' homes. Despite its extensive network of medical services, the VA annually assists only about three million veteran patients, most of whom either have service-connected disabilities or are deemed unable to defray the costs of medical care elsewhere.

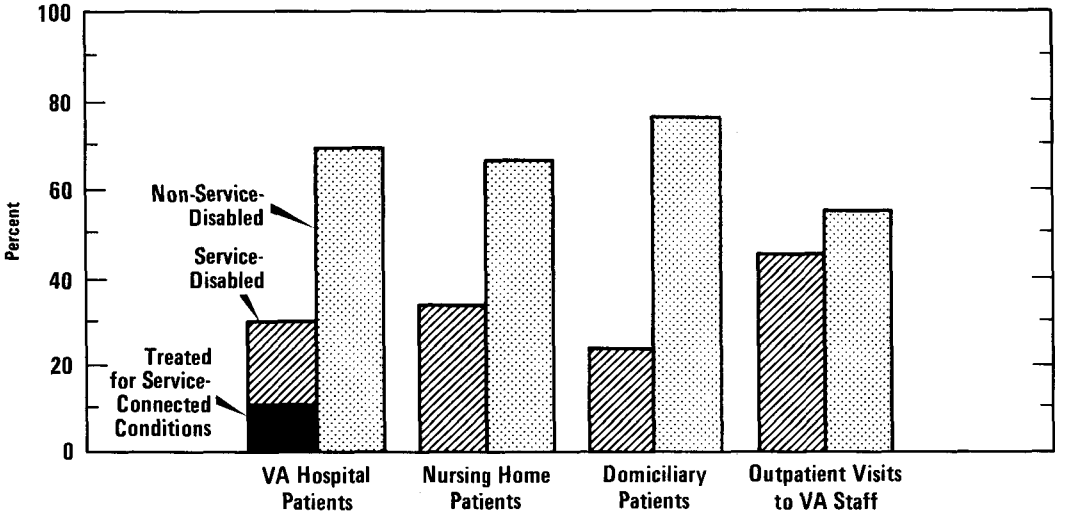
In 1983, total medical care outlays for the VA system were $8.3 billion--up from $2.7 billion in 1973 and reflecting a 12 percent average annual growth rate. Unlike entitlement programs such as Social Security, funding for VA medical care is fixed directly by the Congress through the annual appropriations process and the VA is required to provide care only so far as resources permit. Each year the VA's central office allocates funds to the regional and local medical centers based on the previous year's spending and workload. These allocations also take into account the expected resource needs over the next few years, as assessed by the medical directors. To date, funding has been sufficient to meet the medical needs of veterans who applied for care.

Those eligible for care are admitted according to a set of priorities: first the service-disabled who require treatment of their service-connected conditions; next the service-disabled requesting care for non-service-connected conditions; and finally, special categories of veterans such as those age 65 or older or those who are unable to defray the costs of their care.

Although veterans with service-connected disabilities receive priority care, the great majority of VA patients are not in this category. About 70 percent of VA hospital patients have no service-connected conditions and about two-thirds of the service-disabled are treated for non-service-connected conditions. This indicates the predominance of general medical care in the VA system (see the Summary Figure).

Summary Figure.

Profile of VA Patients in 1982 by Type of Care



SOURCE: Veterans Administration.

NOTE: Hospital data represent discharges, while data for nursing homes and domiciles were gathered by inpatient census.

TRENDS IN USE AND SERVICES

While the VA has served increasing numbers of veteran patients over the last decade, the relative amounts of different types of care have changed. More veterans are being served in nursing homes today than in the early 1970s and fewer of them receive domiciliary care. The number

receiving VA hospital care--the largest service in the VA system--has increased, but fewer patients remain in VA hospitals on a given day.

Hospital Care

Hospital use rates among veterans 65 and over rose in the early 1970s and then dropped, a pattern that contrasts with the steady increase in hospital discharges among veterans under age 65 and among service-disabled veterans. In recent years, about one-fourth of VA hospital patients have been age 65 or older.

Over the last decade, VA hospitals have served 30 percent more patients with an 18 percent reduction in bed capacity--from 97,700 beds in 1973 to 80,100 at the end of 1982--because of a reduction in the average number of days patients were hospitalized. Reductions in bed capacity have been spread across medical centers, and were caused mainly by a declining use of psychiatric acute care beds and an increase in the availability and use of nursing homes and outpatient clinics for both psychiatric and physical ailments.

Nursing Home Care

Nursing home utilization trends in recent years have varied for veterans of different age groups. Although requests for VA-supported nursing home care have increased overall and for most age groups, some decline has been noted among veterans age 65 to 84.

Since the program began in 1965, a large share of VA-supported nursing home care has always been given through community nursing homes under contract and through state veterans' homes using limited per diem payments. The VA has been supplying more care, however, to veterans by increasing its owned and operated beds--up 40 percent since 1973 to 9,100 beds. In 1982, the mix of placement of veterans on an average daily basis was 35, 39, and 26 percent in VA, community, and state homes, respectively.

Other Services

Perhaps the fastest growing service the VA has provided in recent years has been outpatient (or ambulatory) care. After 1973, veterans without service-connected disabilities were allowed to receive outpatient treatment if it would obviate the need for hospitalization. In 1982, there were 15.9 million visits to VA staff--up 75 percent since 1973. In addition,

new programs such as geriatric day care (also called adult day care) and hospital-based home care were started to enable veterans to remain at home rather than stay in hospitals for long periods.

THE FUTURE DEMAND FOR CARE

If different groups of veterans--such as the over-64 and the service-disabled--requested and received care in future years at the same rates as today, the VA would be serving an increasingly older clientele primarily by providing more nursing home resources. While hospital care would continue to be a major part of VA health services in future years, the demand for it would not increase as much as that for other services.

According to current population projections, the trend of increasing demand for both hospital and nursing home care should end after about 2015, when the number of veterans 65 and over will have decreased substantially. This expectation is based on the assumption that use rates will not change significantly over time.

Future VA Hospital Care

The future number of hospital patients receiving care daily can be estimated under two alternative assumptions. First, if average lengths of stay remain the same in 1990 as now, the VA would serve about 26 percent more patients daily at its hospitals than in 1982 and would need to increase the number of hospital beds by 18 percent. On the other hand, if the VA aggressively pursues policies to lower lengths of stay, past trends suggest that fewer patients would be served daily than now and fewer beds than currently used--almost 14 percent less--would be required in 1990. The latter approach would imply, however, a need for about 6,000 additional nursing home or domiciliary beds in that year. It would also mean that current hospital bed levels would be sufficient for veteran needs in 2000 (see Summary Table 1).

Future Demand for VA Nursing Home Care

A dramatic increase in nursing home care is expected before the year 2000. The level of care can be estimated under the two different scenarios used to estimate hospital care, since there are significant interactions between the two types of care. If average hospital lengths of stay remained the same in 1990 as now, the demand for nursing home care would increase about 40 percent by 1990, with the proportion of care given veterans 65 and

over rising from about 60 to 78 percent. The requests for nursing home care would be met by supplying about 35,000 beds, at least 3,400 of which would be additional VA nursing home beds (above the 1982 level of 9,100), if the current placement of veterans in nursing homes is continued (see Summary Table 1); this would leave about 6,500 beds above current levels to be supplied in non-VA nursing homes under contract or per diem arrangements. If lengths of hospital stay were reduced, the number of additional VA beds would increase by at least another 2,400 depending upon the mix of VA and non-VA facilities in 1990.

In the year 2000, assuming that current policies continued and that average lengths of stay remained the same, the demand for nursing home care would be more than double that of 1982. This dramatic increase would be caused mainly by the large increase in the number of veterans in the high-use category--those age 85 or older. The VA would be supporting care in more than 50,000 nursing home beds by that time.

Future Demand for Other Services

The use of outpatient care will, like other services, depend greatly on the VA's hospital length-of-stay policies. If patients were kept in hospitals for the same average time as now, about 16.8 million VA staff visits could be expected in 1990 and about 16.4 million after 2000. Policies to reduce lengths of stay further would require more outpatient care--perhaps 21 million VA staff visits--and greater resources by 1990.

Increases in domiciliary care could also be expected in future years as a result of more requests from veterans 65 and over. A continuation of current use rates would imply a need for about 500 to 1,000 additional domiciliary beds in VA and state homes. On the other hand, if use rates continued to decline as in the past, the current number of beds would be more than sufficient.

Sensitivity of Estimates

The estimates described above are sensitive to assumptions regarding use rates, patient care mix, and the availability of adequate professional staff, as well as average length of hospital stay. For example, in assessing the impact of an older clientele, current use rates of veterans in specific age groups were combined with projections of the age distributions for 1990, 1995, and 2000. Requests for care in future years might, however, be affected by future cutbacks in other medical care programs--such as Medicare and Medicaid--that currently allow the majority of veterans to

SUMMARY TABLE 1. PROJECTIONS OF VA MEDICAL CARE IN 1990 AND 2000, ASSUMING CURRENT PRACTICES AND USE RATES, BY TYPE OF FACILITY

Type of Care	Average Daily Number of Patients (thousands)	Change in Patients Since 1982 (percent)	Projected Number of Beds (thousands)
		1990	
Current Hospital Average Length of Stay			
VA Hospital	82	26	94
Nursing Home a/	34	40	35
Domiciliary b/	13	4	13
		2000	
VA Hospital	95	46	109
Nursing Home a/	50	107	52
Domiciliary b/	13	6	14
		1990	
Reduced Hospital Average Length of Stay			
VA Hospital	60	-8	69
Nursing Home a/	39	60	41
Domiciliary b/	13	6	14
		2000	
VA Hospital	65	0	79
Nursing Home a/	55	125	58
Domiciliary b/	13	6	14

SOURCE: Congressional Budget Office.

a. The number of nursing home patients and the required number of beds represent the overall census of VA-supported patients in VA, community, and state veterans' nursing homes.

b. The numbers of domiciliary patients and beds represent the total for VA and state domiciliaries.

receive care in non-VA facilities and not at VA expense. Recent program changes are expected to have little impact on VA health care, however.

COSTS AND IMPLICATIONS OF CONTINUING CURRENT POLICIES

The two components of VA medical care costs that are discussed here--operating and construction costs--would both increase significantly by 1990, if current policies were continued. The separate cost impacts are described below. Some possible limitations on available resources and other implications of the rising demand for care are also addressed.

Future Costs

Under current practices, the VA would pay at least 40 percent more in real--that is, inflation-adjusted--operating costs by 1990. Outlays for hospital care alone could reach $6.3 billion in 1982 dollars by 1990, compared to $4.4 billion in 1982, if the average length of stay does not fall further. 1/ Even greater increases in VA funding for nursing home care would be needed--50 percent if average hospital lengths of stay remained the same (see Summary Table 2). After inflation, total costs for all types of care would be about $15.4 billion in that year, assuming present lengths of stay, or $14.1 billion with reduced hospital lengths of stay.

The costs of constructing new nursing home facilities would vary depending on the amount of care provided in VA rather than in non-VA facilities, and also on policies regarding length of stay. Assuming the current mix of facilities, for example, providing additional VA nursing home resources between 1985 and 1990 through new construction would cost about $400 million, and by 1995 at least $900 million, assuming no reduction in hospital length of stay. In addition, some VA hospitals would require extensive renovation or replacement--costing between $1.4 billion and $2.9 billion by 1990--to accommodate the needs of veterans, unless reduced-length-of-stay policies meant that fewer hospital beds were needed. If hospital costs were cut substantially by lowering average lengths of stay, nursing home construction costs could double.

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1. These increases in real costs reflect both demographic changes and the cost of technological improvements and increased patient intensity, but not prices for medical services, which could double before 1995.

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SUMMARY TABLE 2. PROJECTED COSTS OF VA MEDICAL CARE IN 1990, ASSUMING CURRENT UTILIZATION RATES CONTINUE (In billions of 1982 dollars)

Type of Care	1982 Actual	1990 Current ALOS a/	1990 Reduced ALOS a/
VA Hospital	4.38	6.28	5.20
Nursing Home	0.47	0.71	0.79
Domiciliary	0.10	0.13	0.13
Outpatient	1.38	1.70	2.00
Construction b/	0.43	0.85	.70
Other Services	0.85	1.02	1.03
Total	**7.60**	**10.70**	**9.85**

SOURCE: Congressional Budget Office.

a. Average length of stay in VA hospitals.

b. The 1990 costs represent the average annual construction costs of new projects begun between 1985 and 1990.

Some Implications

A factor that could exacerbate the need for expanded resources is the possibility that a shortage of non-VA beds might prevent a continuation of the current mix of nursing home care facilities. The growth of private facilities could be inhibited by state certificate-of-need review policies, resulting in fewer beds available for VA-subsidized veteran patients, unless the VA coordinates its planning efforts with these local agencies.

Although this paper addresses the VA financial burden in future years, that burden is part of the overall federal outlays for health care. If

veterans continue to request and receive VA care at the same rate as currently, a growing proportion of them will have Medicare, or perhaps Medicaid, coverage. This could mean a reduction in costs for both the other federal programs and for the federal government overall, if VA costs are easier to control. On the other hand, total federal costs could increase, since the VA pays more of the veteran's medical costs than Medicare does. In sum, the manner in which the VA medical care system meets the future demand will affect other federal programs as well.

OPTIONS

Continuing current policies--that is, meeting all of the demands expected to be placed on the VA system--is only one of many options available to the VA for responding to the likely increase in requests for medical care. The VA could reduce future costs by adopting one or more of the following strategies: continuing current policies, but more efficiently and cost-effectively; placing more veterans in non-VA nursing homes under contract; and restricting eligibility for care or reducing the scope of VA benefits.

Continue Current Policies More Efficiently

The VA could limit the escalation in costs by converting some underutilized hospital beds to nursing home beds, converting some hospitals to nursing homes, or recovering some costs from third-party health insurers. Savings to the VA would range from $60 million to $600 million per year between 1985 and 1990, depending on the specific change.

In addition, the VA could care for more patients on an outpatient rather than an inpatient basis--for example, by expanding outpatient clinics for psychiatric care and increasing hospital-based home care. Savings would range from $80 million to $100 million per year between 1985 and 1990.

Contract for More Care in Non-VA Nursing Homes

Alternatively, the VA could provide more care in non-VA facilities--meeting a higher proportion of the demand for nursing home care by contracting with community nursing homes or by increasing grants to states to build more state veterans' homes. By placing more veterans--those who do not require lengthy stays in VA nursing homes, for example--in community nursing homes, the VA could save about one-third of the costs in VA-operated nursing-homes. One advantage of greater interaction with

private-sector services is that it would avoid a large build-up of new VA facilities that would result in excess capacity after the year 2015. Opponents of this option would prefer that the VA continue providing services in its own facilities in order to assure federal control over the availability and quality of care, and to prevent a break in service in some locations.

Restrict Eligibility or Reduce the Scope of Benefits

Another way to limit the growth in resources devoted to VA health care would be to restrict eligibility for care--for example, by concentrating VA resources on service-disabled veterans and those who meet a strict means test. About one-fourth of the VA clientele in 1990 would be affected by this option. Those in favor of it suggest that, in times of budget stringency, VA care should be guaranteed only for the service-disabled and the poor. Critics argue, however, that the VA system would become too small to provide quality care for them.

Alternatively, the scope of benefits to some or all veterans could be reduced. One approach would require veterans to rely more on the private health sector, either by ending the VA's provision of some services or by charging fees to some patients.

Some have proposed eliminating VA-operated acute care services or VA-operated nursing home care but financing the purchase of private services for veterans who are service-disabled or meet a means test. Such privatization would scale back or eliminate the costs of constructing and operating VA facilities, which are higher than in the private sector. Opponents object to the reduced access to care and increased out-of-pocket expenses for some non-service-disabled and non-poor veterans that could result.

Under the options that would retain the VA's provision of services but introduce cost-sharing, most veterans 65 or over who are not poor and not service-disabled could continue to use VA services only by paying for a portion of their care. Many such veterans would have Medicare coverage and, therefore, would be accustomed to copayments. Opponents argue, however, that cost-sharing would unfairly tax these veterans, especially those who served their country during war.

Savings to the VA under these options would range from $410 million to $3.3 billion in 1990 if fully implemented by that time. Since many affected veterans would be covered by Medicare or Medicaid, net federal savings under these latter options would be only about 30 to 40 percent of the VA savings, however.

CHAPTER I. INTRODUCTION

A significant increase in the demand for health care provided by the Veterans Administration (VA) is expected during the next decade. The probable pressure on the VA system will result from rapid growth in the veteran population age 65 and older, caused primarily by the aging of World War II and Korean War veterans. By 1990, the number of veterans 65 and older will be about 7.2 million--more than twice the number in 1980--and will include about 60 percent of the male population of that age. By the year 2000, the age-65-and-older veteran population will reach 9 million, although the total veteran population will probably be about 15 percent lower than in 1980 (see Figure 1). In addition, veterans age 75 and older will constitute an increasingly high percentage of elderly veterans--exceeding 40 percent of them by 2000--and will equal more than one-fifth of all veterans by 2010 (see Figure 2).

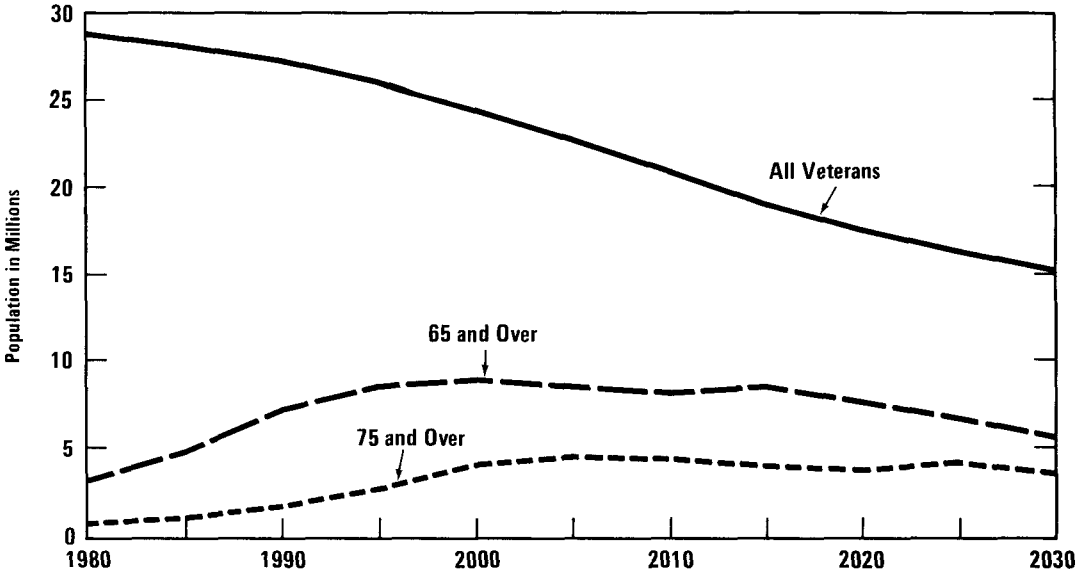
These population trends have important ramifications for the federal budget. The trends reflect the aging of the adult U.S. population combined with the fact that a high percentage of all men were in the armed services during World War II, most of whom will be over age 65 in the next few years. Since current law extends eligibility for VA health care to all veterans 65 and older, regardless of their financial status, the demand for VA health care services is likely to grow dramatically. Moreover, the fact that older veterans are more likely to be admitted to VA hospitals and nursing homes and stay longer than younger veterans will exacerbate these increased demands. If use rates remain the same and if funding for VA medical care keeps pace overall with requests for care--as it has in the past--VA medical care costs could double in real terms over the next decade.

Increases in VA medical care costs will not necessarily translate dollar for dollar into higher federal budget outlays, however. The VA system will absorb some of the costs that would otherwise be borne by Medicare and Medicaid, serving some veterans who also have Medicare or Medicaid coverage.

THE VA SYSTEM

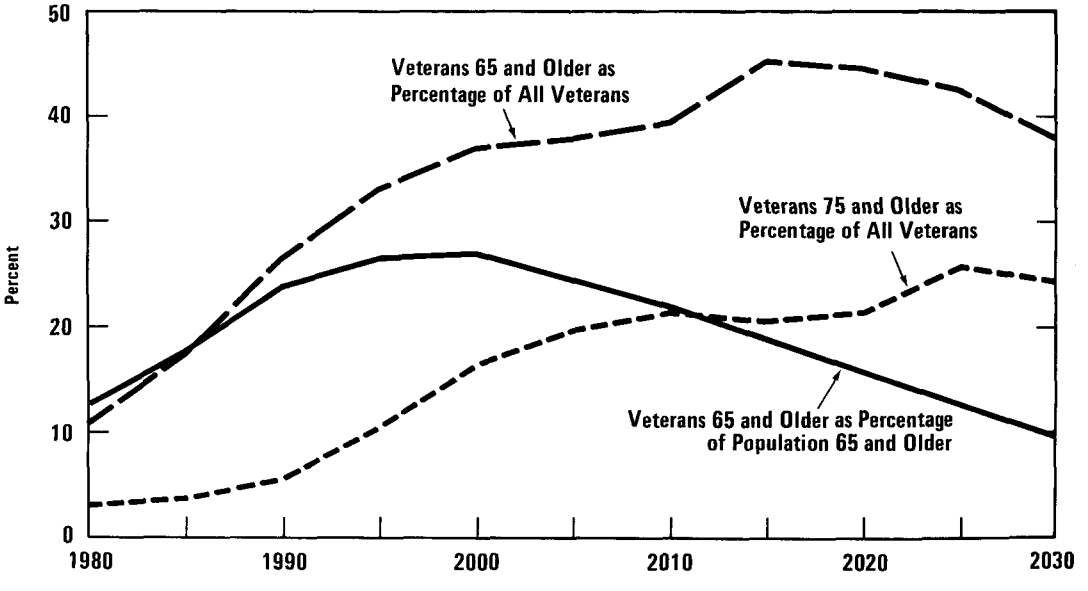
The VA health care system currently provides a broad spectrum of hospital, extended-care, and ambulatory services to eligible veterans. The

Figure 1.
Veteran Population Projections



SOURCE: Veterans Administration.

Figure 2.
Profiles of the Veteran Population Age 65 and Older



SOURCES: Veterans Administration; Social Security Administration.

bulk of the care is provided at 172 medical centers operated by the VA and located throughout the United States. The VA's outpatient clinics, nursing home units, and domiciliaries (residences or homes) are located at or near these hospital centers. The VA also provides for care in non-VA facilities when appropriate care is unavailable in VA facilities or is not economically feasible because of location.

While VA medical care is free or highly subsidized, access to it is limited by strict eligibility criteria and a priority system. The VA is required by law to provide health care services to eligible veterans only as resources permit, although veterans needing care have generally been served to date. When resources are limited, the VA serves veterans with service-connected disabilities first, and then other specified classes of veterans.

VA health care began mainly after World War I, when a hospital system for the treatment of veterans was established, and reached almost its current size in number of hospitals and types of services by 1970. (Before World War I, the federal government had provided national asylums or homes for indigent or disabled war veterans. 1/) By 1941, however, an extensive hospital and domiciliary (residence or home) system had been built. In 1946, the Congress established the Department of Medicine and Surgery within the VA and authorized a program affiliating VA hospitals with medical schools. Additional hospitals were built between 1946 and 1966--about 40 percent of today's total--with many near medical schools. In 1965, the development of the system was broadened when the VA nursing home care program was established.

THE VA MEDICAL CARE BUDGET

VA medical care is a significant item in the VA budget, but it is currently only about 1 percent of the federal budget and 0.2 percent of the gross national product. In fiscal year 1984, the VA will spend about $8.8 billion for medical care and related costs--approximately one-third of the VA's budget and 6 percent more than was spent in 1983. VA medical care is considered a discretionary rather than an entitlement portion of the federal

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1. The Congress authorized the U.S. Naval Home in Philadelphia in 1811 (Act of February 26, 1811) to be financed by deductions from seamen's pay. The Home was opened in 1833. In 1865, the Congress established several National Homes for Disabled Union Soldiers. For a more detailed discussion of the history of VA health care, see Barbara McClure, Medical Care Programs of the Veterans Administration, Congressional Research Service, report no. 83-99 EPW (May 1983), pp. 1-4.

budget; funding is fixed directly by the Congress, mainly through the annual appropriations process. Furthermore, outlays for the construction, alteration, or acquisition of any medical facility involving an expenditure of more than $2 million must be approved explicitly by Congressional committees.

Resources are allocated in the VA system each year primarily on the basis of uses and needs in the previous year. VA hospital medical directors track staff and bed supplies against local demand and submit plans to the VA Central Office each year for the coming year's budget. Local demographic and economic changes that should affect the demand for care are still monitored at the central office, however. Funds are distributed through the regional and local medical centers.

Current trends indicate that outlays for VA medical care, excluding construction costs, will total about $44.2 billion over the 1985 to 1989 period. 2/ Between 1985 and 1988, the VA plans to begin constructing 45 nursing home units and 12 domiciliaries, and renovate, replace, or improve other facilities, at a total cost of about $5.7 billion. 3/ Once the new facilities or units are in place, additional operating costs will be incurred.

THE POPULATION SERVED

Veterans eligible for VA medical care include those discharged from active service because of an illness or injury incurred or aggravated in the line of duty, other veterans with service-connected disabilities, former prisoners of war, veterans requesting care for illnesses related to exposure to Agent Orange in Vietnam, veterans age 65 or older, and others who are unable to pay for their medical care. 4/

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2. These estimates are CBO baseline budget projections designed to show what would happen to outlays if current legislation and spending policies were continued into the future. For spending programs requiring annual appropriations, the baseline projections assume that funding levels will change only with respect to specific programmatic assumptions and inflation. They do not take account of additional funds requested in the President's Budget for the pending fiscal year.

3. See Veterans Administration, FY 1984-1988 Five Year Medical Facility Construction Needs Assessment (June 1983).

4. Medical care in VA facilities can also be given to members of the Armed Forces, dependents or survivors of service-disabled veterans, or to other nonveterans for humane reasons or emergency care.

Access to care is determined through a system of priorities. Generally, priorities fall into three groups. Highest priority is given to veterans with service-connected injuries or illnesses, for the treatment of those conditions. 5/ Next, veterans with service-connected injuries or illnesses receive priority for hospital or nursing home care for the treatment of non-service-connected conditions. Finally, veterans without service-connected disabilities, who are age 65 or older or who are unable to defray the costs of care, receive treatment on a space-available basis. Few who apply are turned away, however, unless they are judged not to require medical care.

Only a small portion of the total veteran population is now served by the VA health care system. Less than three million veteran patients--roughly about 10 percent of the veteran population--use VA services during any year. Most veterans (about 75 to 80 percent) do not meet the eligibility criteria, and many of those eligible use community facilities instead, presumably because they prefer the non-VA facilities and have private or public health insurance to finance the costs. In contrast, a large proportion of the VA clientele have no health insurance. 6/ With almost universal eligibility for Medicare, only about 10 to 15 percent of veterans age 65 and older, all of whom are eligible, use the VA system for some type of health care in a given year. 7/

Although hospital and medical care were originally limited to those with service-connected disabilities, the majority of current VA patients --about 70 percent of hospital patients and two-thirds of VA-supported nursing-home patients--have no service-connected disabilities (see Figure 3). The World War Veterans' Act of 1924 broadened eligibility to include all

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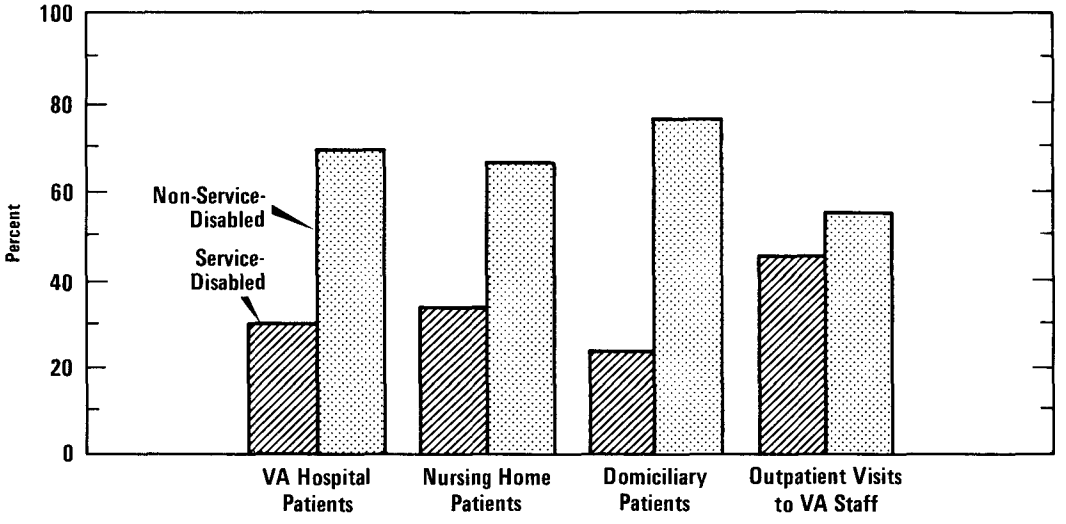
5. Priorities for care also take into account the medical need for care and the patient's current hospital status. Persons in need of emergency medical care or patients who are being readmitted to VA hospitals are treated first without regard to regular priorities. For a further detailing of priorities see Appendix A.

6. Results of the VA's 1979 Survey of Veterans indicate that 88 percent of hospitalized veterans receive care in non-VA hospitals and 92 percent of them have private or public insurance coverage for hospitalization compared to only 55 percent of those receiving care in VA hospitals. See Veterans Administration, 1979 National Survey of Veterans (December 1980), pp. 19, 26.

7. Ibid., p. 30. More recent estimates of older veterans who receive VA care are forthcoming in the VA's Survey of Aged Veterans.

Figure 3.
Profile of VA Patients in 1982 by Type of Care



SOURCE: Veterans Administration.

NOTE: Hospital data represent discharges, while data for nursing homes and domiciles were gathered by inpatient census.

veterans with diseases that had been granted presumptive service connection regardless of when the illnesses were contracted. Eventually, any war or peacetime veteran who signed an affidavit that he was unable to pay for medical care became eligible. In 1970, Congress enacted legislation that made all veterans age 65 or older eligible for free medical care regardless of financial need. These changes in eligibility were driven primarily by excess capacity in the VA system in the late 1940s and the 1960s. The expanded eligibility appears to have led to further growth in the system's capacity, however.

POLICY ISSUES

As the veteran population ages, producing greater demand for health care, VA medical programs are being scrutinized along several lines. Some in the Congress are concerned about growing costs and question whether future VA medical services should be provided in the same manner as today. Are VA facilities run as efficiently as possible? For example, where there exists a greater need for long-term care, some propose shifting underused hospital beds to nursing home care. In addition, non-VA facilities might play a larger role in accommodating the demand for medical care.

Other critics suggest that eligibility for VA care should be narrowed or that the scope of VA services should be reduced. Many believe that the VA's primary responsibility is to care for veterans with service-connected medical problems and that the system should not be expanded solely to provide care to other veterans, regardless of their financial needs. Some suggest that copayments be required of nonpoor veterans. Others contend that the VA should not operate a separate medical care system. 8/ They maintain that it is too costly and exacerbates the problem of unused capacity in public and private hospitals and nursing homes. The basic question is whether VA services could be integrated in some way with private services while still adequately serving veteran patients.

Another issue of importance is the impact of the aging veteran population on the federal budget in coming years. As more veterans reach age 65--and become eligible for both VA and Medicare benefits--total federal costs will rise. It is difficult to say how this will affect VA and Medicare costs without knowing the extent to which veterans will use each service. The proportion of Medicare enrollees who are eligible for VA health services will increase; if these persons use VA services at the same rate as those eligible for both do today, then Medicare outlays will grow more slowly than Medicare enrollment would suggest, while VA outlays will grow more rapidly. 9/ If the VA supplies substantially more care than today, then the total burden on federal programs may be less than it is today, since the government has more control over expenditures in VA facilities than in private facilities. On the other hand, the federal burden may increase if there is no cost-sharing to limit VA outlays per patient.

If the VA does not expand its services to meet the demands for care by elderly and non-service-disabled veterans, some of the lower VA costs will be offset by higher federal costs for Medicare and Medicaid. Because most of the VA's clientele are poor, this would also mean additional Medicaid costs to the states. In contrast, cutbacks in Medicare and Medicaid could

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8. See, for example, Cotton M. Lindsay, "Veterans Benefits and Services," in Eugene McAllister, ed., Agenda for Progress (The Heritage Foundation, 1981), pp. 294-301 and National Academy of Sciences, National Research Council, Health Care for American Veterans, Report of the Committee on Health-Care Resources in the Veterans Administration (May 1977), pp. 278-282.

9. It has been estimated that about 10 to 12 percent of veterans covered by Medicare use VA services. See Constance Horgan, Amy Taylor, and Gail Wilensky, "Aging Veterans: Will They Overwhelm the VA Medical System?" Health Affairs, vol. 2, no. 3 (Fall 1983), p. 83.

increase the burden on the VA beyond expectations under current law and practices. In addition, elderly veteran patients might experience significant increases in out-of-pocket medical expenses.

PLAN OF THE PAPER

This paper analyzes the problems facing the Veterans Administration's health care programs in meeting the needs of veterans 65 and over in coming years. Chapter II reviews the current VA health care services. Chapter III discusses the projected increase in demand for VA health care in future years, assuming current policies and practices are continued; the implications of these projections are discussed in Chapter IV. The last chapter analyzes some short- and long-range alternatives for VA health care, concentrating on options that would limit the federal financial commitment.

CHAPTER II. OVERVIEW OF VA HEALTH CARE SERVICES AND COSTS

The Veterans Administration provides hospital, nursing home, domiciliary, and ambulatory care to eligible veterans. The bulk of funded care is provided in VA-operated facilities; at the end of 1983, the VA was operating 172 hospital centers, 101 nursing home care units, 16 domiciliaries, and 226 outpatient clinics. 1/ Most institutional long-term care, however, is given in private and state-operated facilities. The VA contracts for nursing home care in over 3,000 community nursing homes and subsidizes care on a limited per diem basis at 48 state veterans' homes--hospitals, nursing homes, or domiciliaries established by the states for veterans. Non-institutional care is also provided for veterans through other programs run by the VA such as hospital-based home care, geriatric day care, and residential care programs.

ACUTE CARE SERVICES

VA-supported care for the acutely ill or life-threatened patient is provided mainly in VA hospitals, the primary source of VA medical care for veterans. VA hospitals are general medical hospitals, with surgery being performed at 136 of them and acute psychiatric care available at 128. During the last two years, approximately 81 percent of the VA's 80,000 hospital beds were occupied on an average day. While this is five percentage points higher than in short-stay community hospitals, a higher rate is to be expected since approximately 30 percent of VA beds now are devoted to psychiatric care, and almost 30 percent of the medical beds are used for extended-care patients, many of whom could be treated in other settings. 2/

Most VA medical centers are affiliated with educational institutions--medical, nursing, and dental schools. The affiliations are designed to enable the VA to maintain a high-caliber professional staff and to provide the opportunity for students in the health sciences to obtain necessary training. The VA also operates extensive medical research and manpower training programs.

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1. Domiciliaries are homes where food, clothing, and necessary medical services are provided to ambulatory veterans.

2. See American Hospital Association, Hospital Statistics, 1982 Edition, p. 12.

Bed Levels in VA Hospitals

The number of acute care beds operated by the VA declined over the last decade--from about 97,700 beds during 1973 to 79,900 during 1983. At the same time, the number of patients treated in hospitals rose by 30 percent. The decline in hospital beds resulted from several factors. Perhaps most important were a declining need for psychiatric hospital beds and a reduction in the average length of stay for VA patients. Both of these resulted primarily from serving more patients on an outpatient basis. Another factor has been a reduced demand for VA hospital services in many areas, caused by migration and the availability of more hospital beds in the private sector, leading to the closure of some hospital wards. Some VA hospitals, however, have maintained relatively high occupancy rates by keeping long-term patients in underutilized acute care beds, or by redesignating many such beds as "intermediate care" beds for chronically-ill patients.

Congressional concern that beds might be unavailable to needy veterans led to a recent law--P.L. 97-72--requiring the VA to operate at least 90,000 hospital and nursing home beds. The total for hospitals and nursing homes was 700 less than this mandate in 1982. Consequently, a further reduction in hospital beds will be possible only if the number of nursing home beds increases. In addition, the VA is required to have a sufficient number of beds in readiness to back up the Department of Defense in times of war (P.L. 97-174). 3/

Use of VA Hospitals

One standard measure of hospital use--the ratio of discharges to the size of the veteran population--shows only a slight increase in recent years. Frequency of use among the service-disabled population has been increasing, although the proportion of discharges of the service-disabled under age 65 has actually declined over the last several years. On the other hand, the proportion of elderly veterans receiving care has been declining (see Figure 4). These two groups comprise half of the patient load: in 1982, the service-disabled accounted for 30 percent of the discharges and veterans

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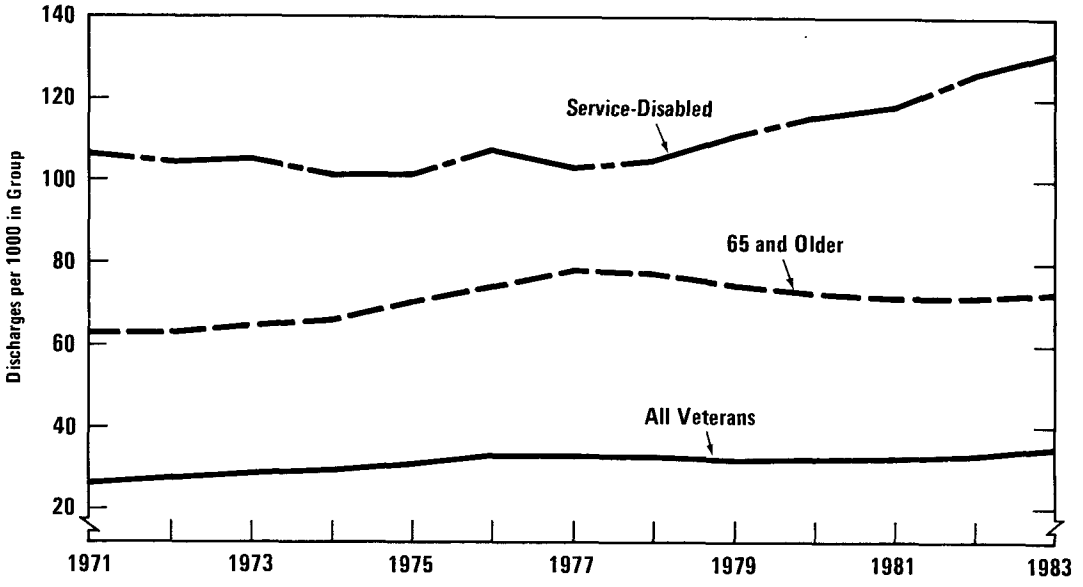
3. To meet the needs for emergency backup, the VA is required to have "jurisdiction" over 100,000 to 125,000 beds. Recently, the lack of skilled nurses together with a need to renovate wards have contributed to a decline in hospital beds. In addition, bed conversions would place beds temporarily out of operational--i.e., readiness--status and thus bring total beds below the minimum required level.

Figure 4.
VA Hospital Use, by Veteran Group, 1971-1983



SOURCE: Veterans Administration.

over 65 for 27 percent of them. Some overlap exists between the two groups, however, since about one-fourth of the service-disabled patients were 65 or older, so that only 23 percent of the discharges were service-disabled under age 65. Although the service-disabled patients received priority admittance to VA hospitals in 1982, about two-thirds of them were treated primarily for non-service-connected conditions.

LONG-TERM CARE SERVICES

Both institutional and non-institutional long-term care services are supported by the Veterans Administration. Institutional services include the operation of 101 nursing home units located near the hospitals at VA medical centers. Other institutional care is provided in community nursing homes, state veterans' homes, and VA domiciliaries. Non-institutional care consists of monitoring the health of patients in their own homes, in congregate homes, or at day care centers. Special programs have been initiated in recent years to support non-institutional care, such as hospital-based home care and geriatric day care. This latter group of programs is discussed in the next section under outpatient care.

Although the VA operates a large network of long-term care facilities, these support only a small proportion of the total number of veterans requiring such care. 4/ The majority of veterans receive care in private facilities.

Nursing Home Care

The VA pays for or subsidizes nursing home care in three types of settings. On a typical day in 1982, about 35 percent of VA-supported nursing home patients were in VA-owned and-operated nursing homes, about 39 percent were in community nursing homes under contract and the remaining 26 percent were resident in state-operated homes.

VA-supported nursing home patients have increased steadily over the last decade--from 0.4 for every 1,000 veterans in 1971 to 0.9 in 1982. (See Figure 5.) This is not the case for veterans 65 and older, however, probably because they have had increasing access to alternative non-VA sources of care. The VA also has exercised the option of placing more veterans in community nursing homes and more state homes during the period, so that VA beds were not required to keep pace with population growth.

VA Nursing Homes. VA nursing homes give skilled nursing care on a regular basis, for whatever period care is needed. Although the VA often places veterans in its nursing homes in states other than their state of residence--usually in adjacent states where beds are available--an average of 2,400 veterans were on the waiting list in 1982. 5/ That year the VA operated an average of 9,125 nursing home beds, up 20 percent since 1977. The average length of stay was 1.3 years in 1982, when 62 percent of resident patients were age 65 or older.

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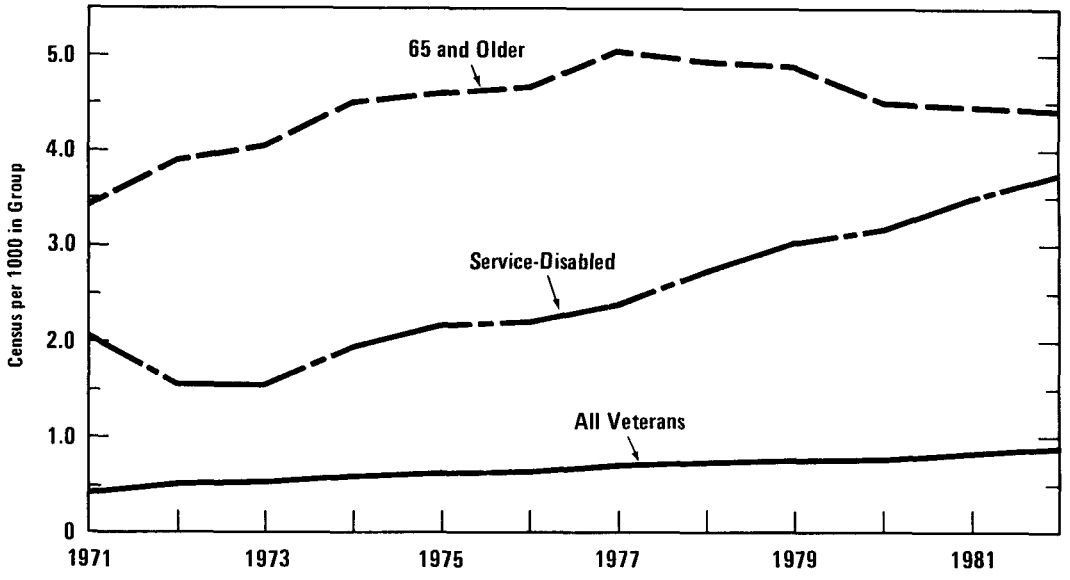
4. For example, studies of national surveys indicate less than 20 percent of all veterans receiving nursing home care are served under VA auspices. The VA currently estimates that it supports 12 to 16 percent of the total veteran nursing-home "market share." See Veterans Administration, Nursing Home Care Needs of Veterans in 1990, a Quantitative and Social Assessment (July 1982) and "Testimony of D. Earl Brown, Jr., M.D., before the Senate Veterans Affairs Committee," July 13, 1983.

5. While on the waiting lists, most of them probably receive care in VA-supported environments, however.

Figure 5.

VA-Supported Nursing Home Use, by Veteran Group, 1971-1982



SOURCE: Veterans Administration.

Community Nursing Homes. The VA also contracts for skilled or intermediate care at community nursing homes on a per diem basis. Care at VA expense, while unlimited in duration for treatment of service-connected disabilities, is limited to six months for the treatment of other conditions. On average, 9,525 veterans were cared for daily in community nursing homes in 1982--or about 1,000 more than in VA nursing homes. Twice as many veterans were treated in these homes partly because the average length of stay is shorter than in VA nursing homes. Almost 44 percent of the VA-supported patients in community nursing homes in 1982 had service-connected disabilities (see Table 1).

Since community nursing homes are more widely spread than VA homes, patients often have the advantage of being closer to their family and friends than if they were in VA nursing homes, but this system departs from the VA's traditional role of providing care in its own facilities. According to the VA, veterans placed in community nursing homes usually do not require the intense medical care available in VA nursing homes.

State Veterans' Homes. State veterans' homes are facilities established by a state for providing medical or residential care mainly to veterans. Two federal programs support the care of veterans in state veterans' homes. One is a per diem program whereby the VA assists the state in providing hospital, nursing home, or domiciliary care to veterans.

TABLE 1. VA EXTENDED CARE SERVICES: PATIENT SUMMARY

Type of Facility	1982 Annual Patient Census[a]	Percent Over 64	Percent Service-Connected[b]
Nursing Homes			
VA	8,573	62.4	36.1
Community	10,250	57.3	43.9
State Home	6,615	71.1	13.5
Domiciliaries			
VA	6,979	28.7	26.4
State Home	4,494	42.2	19.7

SOURCE: Veterans Administration, Extended Care Facilities Census Data: 1969 through 1978 (August 1979), updated for 1982.

a. The annual patient census is the number of patients resident on the day of the survey. It differs from the average daily census during the year.

b. "Service-Connected" refers to VA-supported patients who were determined to have incurred an injury or illness while in service.

VA financing is limited to 50 percent of the total costs of this care, which can be provided as long as necessary, at the state's discretion. In the other, a grant program, the VA pays up to 65 percent of costs to a state for constructing new domiciliary and nursing home facilities, or for expanding and remodeling existing facilities, provided at least 75 percent of the beds are used for veterans. Over 24,000 patients received VA-subsidized care in state homes in 1982. Providing care in state veterans' homes has long been regarded as cost-effective for the federal government because states share the cost. 6/

6. For an exposition of cost-saving in health care provided in state homes, see General Accounting Office, State Veterans' Homes: Opportunities To Reduce VA and State Costs And Improve Program Management, October 22, 1981.

State nursing home care has been provided to an increasing number of veterans in recent years--11,100 in 1982, compared to 8,600 in 1977. In 1982, about 6,428 were receiving care on an average day; they were about four years older, on average, than those in VA facilities.

State veterans' homes are a resource controlled by states rather than the VA. As a result, most states have two- to five-year state residency requirements for eligibility. Many states also require the veterans to have seen active-duty service during war periods, and some do not grant eligibility for care to spouses or dependents.

VA Domiciliaries

Domiciliaries are homes for disabled veterans, usually located at VA medical centers. They derive from legislation in 1865 that established Soldiers Homes for disabled veterans. Veterans placed in them must be chronically or permanently disabled and unable to work or support themselves. Often they require some monitoring of their health conditions, although not at the skilled nursing home level. In 1982, the VA provided domiciliary care for over 14,500 persons. On the census day, the average age of the patients was 59.6 years.

Receipt of VA domiciliary care in recent years has been on the decline--a daily census of 7,100 today as compared to 10,261 in 1973--because of both increased availability of VA nursing homes after 1964 and the changing mission of the domiciliaries. Domiciliaries serve more ambulatory patients now, rather than those requiring medical care in a sheltered environment.

OUTPATIENT CARE

The VA's outpatient clinical programs play a vital part in its health care system because they often represent a cost-effective alternative to hospitalization. It is for this reason that these programs have grown significantly over the past decade. Clinic services are used for pre- and post-hospitalization care, special medical exams, and qualifying exams for service-connected disability compensation or for disability pensions. For the aged, the outpatient clinics often serve as a means of controlling chronic diseases or conditions such as arthritis, hypertension, and diabetes. The VA operates 150 mental hygiene clinics and 60 day treatment centers for psychiatric patients.

The program has almost doubled in size, from about 9 million visits to VA staff in 1972 to about 15.9 million in 1982 (roughly five visits per patient.) An additional 1.9 million visits to non-VA physicians are funded on a fee-for-service basis by the VA. Current law allows such contracting out only in special circumstances.

Outpatient dental services and treatment are furnished by the VA mainly for veterans requiring care for a dental condition or disability that is service-connected. In 1982, about 150,000 cases were completed by VA staff and other dentists paid on a fee basis.

Hospital-Based Home Care

In this program, the VA aids patients with residual disabilities to remain in their own homes. Patients and their families are given the necessary instruction in routine nursing procedures under the supervision of a hospital-based treatment team. The teams include physicians, public health nurses, social workers, and rehabilitation therapists, as well as other specialists. The frequency of home visits is determined by the patient's needs and treatment plan. In 1982, teams at 30 hospitals served 6,500 patients, one-fifth of whom were terminally ill cancer patients.

Geriatric Day Care

Geriatric day care is a special type of outpatient care provided elderly veterans in place of institutionalization. Although several programs of this type operate in the community sector, it represents a new approach for the VA. Only a few model programs are in operation. Veterans can, however, participate in rehabilitation programs at community centers or outpatient clinics under VA auspices.

Geriatric Research

In addition, special Geriatric Research, Education, and Clinical Centers (GRECCs) have been established to support the growing number of elderly patients. GRECCs address problems specifically related to aging and the aged veteran. There are currently 8 centers, although 15 are authorized by legislation (P.L. 96-330). The GRECCs are located at VA medical centers and use the research and clinical activities of affiliated medical schools. One goal of the GRECC program is to develop new practitioners, teachers, and researchers in the field of geriatrics.

CURRENT COSTS OF CARE

The cost of VA medical care and related services is projected at $8.8 billion in 1984, a 16 percent increase over the $7.6 billion it cost in 1982. Inpatient care and outpatient services cost $6.5 billion in 1982, construction costs were $430 million, and other costs--including medical care for certain dependents and survivors of veterans, medical research, education, and training and associated administrative costs--were about $630 million.

Hospital care has made up the largest share of VA medical care outlays in the last decade. The fastest growing expenditures, however, have been for nursing home and outpatient care (see Table 2.)

TABLE 2. VA HEALTH CARE COSTS IN FISCAL YEARS 1973 AND 1982 (In millions of dollars)

Type of Service	1973	1982	Percent Increase
Medical and Hospital Services	2,352	6,522	177.3
Hospital Care	1,753	4,555	159.8
Nursing Home Care	107	478	346.7
Domiciliaries	57	106	86.0
Outpatient Care	435	1,383	217.9
Construction	95	429	351.6
Other Services	256	628	145.3
Total	**2,703**	**7,579**	**180.4**

SOURCE: The Budget of the United States Government, Appendix (Fiscal Years 1975, 1984) and Veterans Administration, Administrator of Veterans Affairs, Annual Report (1973, 1982).

Underlying the large increases in VA health care costs over the last decade have been significant increases in per diem costs and inflation. As in the private sector, medical care costs have risen dramatically over the last ten years within the VA system, driven by improved technology and equipment and by higher labor costs. Per diem hospital costs, for example, have increased from $58 in 1973 to $185 in 1982, or by 14 percent annually. Adjusted for general inflation, this means a 60 percent increase in real terms. Total costs per patient treated have risen only about two-thirds as fast over the same period because of higher turnover--that is, more patients have been treated with shorter lengths of stay per patient. In real terms, VA costs per patient treated have grown less than 4 percent per year during this period.

VA medical-care costs per patient cannot be directly compared to costs incurred in the private health care system. 7/ It is not certain, for example, whether actual costs for an episode of care in a VA hospital are significantly higher (or lower) than for the same care provided in community hospitals. 8/ Some types of care, however, such as nursing home care, can be secured at significantly lower per diem rates in private facilities than in VA facilities. Costs for care given in contracted community nursing homes average half of those in the VA's own nursing homes, although it is possible that patients in the latter tend to have illnesses that are more expensive to treat.

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7. See, for example, a discussion of the reasons for this problem in U.S. General Accounting Office, Results of VA's Medical Care Cost Comparison Studies Are Not Valid, Report to the Committee on Veterans Affairs, U.S. Senate (November 1982).

8. The VA claims that comparable costs in VA hospitals are about 8 percent less than those in private hospitals. Other studies suggest costs are higher in the VA system. See, for example, President's Private Sector Survey on Cost Control, Task Force Report on Privatization (July 1983), pp. 98-99.

CHAPTER III. FUTURE DEMANDS FOR HEALTH SERVICES

The use of VA health services is projected to increase significantly if current law and practices are continued. After 1990, an increasingly older clientele will make greater demands particularly upon nursing home care. Because the elderly also request VA health services at higher rates than younger veterans--for example, more hospital admissions and longer stays--the demands are likely to be greater for all types of health care in 1990 or 2000 than today.

These needs will vary across geographical regions, however. Although the demand by local areas is not discussed in detail below, adjusting to these differences will require much planning effort by the Congress and the VA.

HOSPITAL CARE

More acute care services would be needed in future years as the number of veterans age 65 and older increases. Estimating the level of demand on a daily basis requires making assumptions about hospital length of stay. The average length of stay (ALOS) in VA hospitals for patients of different age groups has decreased considerably during the last decade, although the decrease has been less in recent years. The following estimates of demand are made under two different assumptions: first, that the length of stay remains the same in coming years; and second, that it continues to decrease according to the trend of the past decade.

Assuming that the length of stay remains the same, the average number of patients on any day would rise from 64,900 in 1982 to about 95,000 in the year 2000 (see Table 3). Moreover, the projected increase in care for elderly veterans would not be offset by a decrease in the need for hospital care for veterans under age 65. Instead, the overall demand for hospital care would increase by as much as 26 percent by 1990, if current practices continue.

Assuming that the trend in reduced length of stay continues through 1990, however, fewer than 60,000 patients would be served daily at VA hospitals in that year. Although it seems realistic to assume that the average length of stay will decrease continuously--perhaps at a gradually slowing rate until 1990--it is not certain whether the degree or severity of illnesses among future patients will permit this trend to continue beyond

TABLE 3. PROJECTED DEMAND FOR VA HOSPITAL CARE IN 1990-2000 BY TYPE OF PATIENT (In thousands)

Type of Patient[a]	Number of Patients[b]		Number of Beds [c]			
			Assuming Current Length of Stay		Assuming Reduced Length of Stay	
	Total	Aged	Total	Aged	Total	Aged
			1990			
Medical and Surgical	50.9	30.1	60.0	35.4	43.5	24.8
Psychiatric	31.0	13.4	34.4	14.9	25.8	10.6
Total	**81.9**	**43.5**	**94.4**	**50.3**	**69.3**	**35.4**
			1995			
Medical and Surgical	56.0	37.8	65.9	44.5	47.4	31.1
Psychiatric	32.7	17.4	36.3	19.3	27.0	13.8
Total	**88.7**	**55.2**	**102.2**	**63.8**	**74.4**	**44.9**
			2000			
Medical and Surgical	59.5	43.1	70.0	50.7	50.2	35.5
Psychiatric	35.0	21.2	38.9	23.6	28.8	16.8
Total	**94.6**	**64.3**	**109.0**	**74.3**	**79.0**	**52.3**

SOURCE: Congressional Budget Office.

a. Patients are categorized by principal diagnosis. This may not always reflect the type of bed section from which a patient is discharged, but is likely to reflect the bed section for most of the stay.

b. Average number in residence on any day during the year.

c. Medical and surgical bed estimates are based on the average daily census assuming an 85 percent occupancy rate. Psychiatric bed estimates assume a 90 percent occupancy rate. These rates are those typically used for planning bed levels.

1990. Moreover, policies that decrease the length of stay would result in greater needs for outpatient care and nursing home care. 1/

Characteristics of Future Patients

After 1990, veterans 65 and older will constitute more than half of patients on an average day. In 1995, for example, 68 percent of medical and surgical patients, and 53 percent of psychiatric patients, will be 65 or older--double the proportions in 1982, assuming current practices and current ALOS levels.

Use of hospital care by the veteran population with service-connected disabilities, referred to as the service-disabled in this paper, would increase at least 3 percent overall by 1990. The number of requests for care from service-disabled veterans under age 65 would decline dramatically by 1990 (see Appendix C), assuming there is not another war. This expected decline in demand for care by younger veterans would be more than offset by the increased demand from older veterans with service-connected disabilities. Those over 65 will increase from about 25 percent of service-disabled patients to over 60 percent of them in 1990.

Number of Hospital Beds

More acute care beds would be needed to accommodate the projected increase in VA hospital patients if the average length of stay (ALOS) of VA patients remained the same. Under this assumption, the VA would need about 94,000 hospital beds by 1990--about 14,400 above its current operating level. The aged clientele alone would require 53 percent of the hospital beds, compared to 32 percent today. More than 100,000 beds would be needed after 1995 (see Table 3).

If average length of stay continued to decrease, however, the VA could meet the total hospitalization needs of veterans in 1990 with fewer hospital beds than currently in use. As already noted, the average length of stay of VA patients has decreased significantly over the last ten years and could continue to decrease in the future, although at a slower rate. The reductions in length of stay are caused primarily by improved diagnostic capabilities, higher staff-to-patient ratios, and substitution of outpatient

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1. The key assumptions for estimating VA-supported care in future years are described at the end of this chapter. Further details may be found in Appendix D.

visits for inpatient care. Assuming a continuing decrease in ALOS through 1990, the VA would need 10,800 fewer hospital beds, or a 14 percent reduction in current capacity. 2/ This net bed level would represent a 23 percent reduction in medical and surgical beds and a 9 percent increase in psychiatric care beds.

If the VA promotes further decreases in the average length of stay, it will also need to supply additional nursing home beds. Part of the reason for the past decrease in ALOS has been the availability of more nursing homes for better placement of some hospital patients.

The pattern or trend for hospital ALOS levels beyond 1990 is less certain, but significant reductions may not occur. Some continued decrease in length of stay could theoretically be achieved for each type of patient, since ALOS levels in private or community hospitals are considerably lower today for similar patient groups than those projected for VA patients in 1990. 3/ On the other hand, since patients over 65 will be in the majority in the VA hospital system in future years, the ALOS for the majority of patients will be longer than now. If the ALOS for these patients does not decrease, the overall ALOS may not decrease either.

NURSING HOME CARE

The demand for nursing home care will increase at least 40 percent by 1990, assuming that the veteran population requests and receives nursing home care at approximately the same rates as currently. Assuming current ALOS levels in VA hospitals, about 34,000 veteran patients would receive nursing home care in 1990 on an average day, compared to about 24,440 in 1982. Growth in demand would continue through the year 2000--up 73 percent by 1995 and up 107 percent by 2000. Part of the increased demand will come from an increase in the number of veterans age 85 and older, who form the highest-use group among veterans today. The demand for nursing home care should continue to grow through 2010, but start to diminish by 2020.

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2. The trend in ALOS values for different age groups of discharged patients since 1976 was used to derive the reduction in 1990 ALOS values. See Appendix D for further details.

3. U.S. Department of Health and Human Services, National Center for Health Statistics, Utilization of Short-Stay Hospitals: Annual Summary for the United States, 1980, Series 13, no. 64.

If current practices are continued, the VA would increase its own nursing home beds in proportion to the rising demand for VA-supported nursing home care. This would mean not only expansion of nursing home facilities, but also increases in professional staff and other associated resources. On the other hand, a continuation of policies designed to reduce VA-hospital length-of-stay levels, or promote better placement of hospital patients needing long-term care, would necessitate more nursing home care--for about 4,400 to 6,000 more patients in 1990--than if lengths of stay did not decline. 4/ In order to establish a baseline for these estimates, the rest of this section discusses the probable use of VA-supported care assuming that lengths of stay in VA hospitals do not decrease.

Characteristics of Future Nursing Home Patients

The nursing home population in future years would consist of more veterans over 65 than today, if current practices are continued. About 78 percent of VA patients in nursing homes would be age 65 or older in 1990 compared to about 62 percent in 1982 (see Table 4). The proportion will approach 90 percent by the year 2000, and could reach 100 percent in some state nursing homes.

About 45 percent of all VA-supported nursing home patients in 1990 would be veterans with service-connected disabilities, referred to as the service-disabled in this paper, of whom almost 90 percent will be 65 or older. If there is not another war, the service-disabled proportion would not change significantly by 2000, partly because there would be few new service-disabled veterans. After 2000, the service-disabled group, especially those under age 65, would decline rapidly.

Number of Nursing Home Beds

If the current pattern of placement of veterans in VA and non-VA nursing homes is maintained, the VA would increase its owned-and-operated nursing home beds significantly. By 1990, 12,500 VA nursing home beds would be needed--about 3,400 more VA nursing home beds than used on average in 1982, or a 37 percent increase (see Table 4). In later years, greater additions would be required--more than doubling the number of VA nursing home beds by 2000.

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4. These estimates are based in part on the VA's Multi-Level Care Survey. See Veterans Administration, Appropriate Placement of VA Hospital Inpatients, Health System Information Service, Report No. 81-7 (August 1981).

TABLE 4. PROJECTED DEMAND FOR SUMMARY OF NURSING HOME CARE IN 1990, 1995, AND 2000, ASSUMING CURRENT SERVICES AND UTILIZATION RATES, BY TYPE OF FACILITY a/

Type of Facility	Number of Patients b/ (thousands)	Percent of Patients Over 64	Number of Beds c/ (thousands)	Percent Change In Beds From 1982
		1990		
VA	11.9		12.5	
Community	13.3		13.3	
State	8.8		8.8	
Total	**34.0**	**78**	**34.7**	**38**
		1995		
VA	14.8		15.6	
Community	16.5		16.5	
State	11.0		11.0	
Total	**42.3**	**85**	**43.0**	**71**
		2000		
VA	17.8		18.8	
Community	19.7		19.7	
State	13.1		13.1	
Total	**50.5**	**89**	**51.5**	**105**

SOURCE: Congressional Budget Office

a. Estimates given in this table are based on the assumption that current law remains unchanged. In addition, the current use of hospitals and domiciliaries is presumed to continue with current length-of-stay averages.

b Average number on any one day.

c. The number of VA beds is derived by assuming a 95 percent occupancy rate. Estimates of beds in community and state nursing homes are equivalent to the patient counts.

If current patterns continue, the majority of VA-supported nursing home patients in future years will receive care in non-VA homes, as they do now. A minimum of 22,200 beds would be needed for VA patients at community nursing homes and state veterans homes by 1990. 5/

One caveat applicable to these estimates of demand concerns the current number of unmet requests for VA nursing home beds. The number who want VA care but do not actively seek it, or who request care but are not placed on any waiting list when rejected, cannot easily be estimated. About 2,400 veterans were on the waiting lists for VA nursing home care during any month in 1982, however, a figure comparable to 10 percent of those who were served. 6/ The VA could probably eliminate most of the backlog of waiting-list applicants by strategically placing its new VA nursing home beds where backlogs are consistently high.

OTHER VA HEALTH CARE

The VA plans to provide domiciliary care to an increasing number of aged veterans. Use of domiciliaries has declined over the years, although new interest in domiciliary placement of veterans suffering from brain disease and dementia could reverse the trend. If current use rates continue to decline, total demand for domiciliary care may be expected to increase only slightly by 1990 even under reduced hospital length-of-stay policies. About 500 to 1,000 additional VA and state domiciliary beds will be required over the next decade.

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5. A discussion of the availability of non-VA resources appears in Chapter IV. In addition, other factors enter into decisions to place veteran patients in VA versus non-VA facilities, such as how sick they are and how long the patients will need care, which are not reflected in these projections.

6. Although the exact number is unknown, most veterans are assumed to be supported by the VA in non-VA homes or in hospitals while they are still on the VA-nursing-home waiting list. Neither the age distribution nor service-disabled status of veterans on waiting lists for VA nursing homes is available. VA analysts believe that no service-disabled veterans stay on the waiting lists for any extended period and that turnover is generally 90 days or less for others. Veterans without service-connected disabilities are told to look elsewhere if their waiting time would be long.

Use of outpatient and noninstitutional care services is also expected to increase in future years. Currently, about three million veterans make 15.9 million outpatient visits to VA staff per year; about 18 percent of the visits are made by veterans age 65 or older. 7/ If this pattern continues, the number of outpatient visits to VA staff should exceed 16.8 million in 1990. Under policies to reduce hospital inpatient length of stay, outpatient visits to VA staff could increase to 18.6 million--an average increase of about 340,000 visits per year--or to about 21 million in 1990. 8/ VA analysts have noted that, historically, older patients make fewer outpatient visits than younger patients. Thus, some reduction in the total number of visits could be expected between 1990 and 2000. Based on current use rates and age distribution changes, less than 16.4 million VA-staff visits per year should be expected by the year 2000.

Outpatient care in future years may be accompanied by an increasing number of persons desiring hospital-based home care. The availability of this care will be limited, however, not only by the number of professional treatment teams, but also by the number of family members ready to provide the necessary patient care.

THE COSTS OF CARE

If the VA continues to follow current policies, the projected costs for providing major medical care would increase even after excluding the effects of inflation. The costs would vary under different policies affecting hospital length of stay, however. If no further reduction in length of stay occurs, then real hospital costs would be significantly greater than today. Under reduced length-of-stay policies, real hospital costs would rise less steeply, because fewer patients would be served daily.

Costs Under Current Length-of-Stay Policies

If current length-of-stay levels continue, the costs of providing VA hospital, nursing home, and domiciliary inpatient care in 1990 are projected

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7. See Veterans Administration, Department of Medicine and Surgery, The Aging Veteran Population: Factors Affecting Demand for VA Health Care (April 1981).

8. In this case, the number of outpatient visits is measured as a function of the average hospital length of stay and from the trend in the number of staff visits per year, rather than from age-specific use rates.

to total about $10.2 billion, or about $7.1 billion in 1982 dollars--a 42 percent increase in real costs (see Table 5). This increase reflects not only the aging of the veteran population, but also the future cost of technological improvements and patient intensity factors, which have increased health care expenditures substantially in the past. The cost of nursing home care will experience the most dramatic increase--about 50 percent in 1982 dollars.

The cost projections shown in Table 5 do not include the costs of constructing new facilities or resources such as nursing home beds. If the VA continues to provide nursing home care in future years as today, much new construction will be needed. The costs of constructing VA-operated nursing homes are likely to exceed $88,300 per bed for homes started in 1985--more than twice the costs incurred by some private builders. 9/ This means that the total costs of meeting the VA's share of operated beds through new construction would be more than $400 million between now and 1990, and more than $540 million between 1991 and 1995 ($280 million and $375 million in 1982 dollars, respectively).

Construction costs will be higher if state or community nursing home beds are not available for proportional increases in patients, and the VA chooses to meet demands for care by building additional VA facilities. Some reduction in nursing home construction costs could be obtained by converting hospital and domiciliary beds not in use, however. (See Chapter IV for a discussion of hospital resources.)

The costs of VA care provided in domiciliaries and outpatient clinics will depend a great deal on local policies toward placement of veterans in need of care. Under practices outlined earlier in this chapter, however, the VA can expect to spend about $130 to $140 million (in 1982 dollars) on VA and state domiciliary care per year from 1990 to 2000. About $2.4 billion, or $1.7 billion in 1982 dollars, would be spent on VA-staff outpatient visits for regular medical care in 1990. Ambulatory care in the 1995 to 2000 period would cost about $2.0 billion per year in 1982 dollars under current policies.

Costs Under Reduced-Length-of-Stay Policies

Under reduced-length-of-stay policies, real costs for VA health care in 1990 would rise by only 27 percent over 1982 costs, since hospital operating

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9. See, for example, President's Private Sector Survey on Cost Control, Task Force Report on Privatization (July 1983), p. 96.

TABLE 5. PROJECTED OPERATING COSTS FOR VA MEDICAL CARE IN 1982 AND FUTURE YEARS ASSUMING CURRENT POLICIES AND CURRENT AVERAGE LENGTH OF STAY (In billions of 1982 dollars)

Types of Care	Actual Cost 1982	Projected Cost a/ 1990	1995	2000
VA Hospital	4.38	6.28	7.23	8.26
Nursing Home	0.47	0.71	0.90	1.08
VA	0.28	0.41	0.52	0.62
Community	0.17	0.24	0.31	0.37
State	0.03	0.06	0.07	0.09
Domiciliary	0.10	0.13	0.14	0.14
VA	0.09	0.11	0.12	0.12
State	0.01	0.02	0.02	0.02
Outpatient	1.38	1.70	1.96	2.02
Other Costs b/	0.85	1.02	1.04	1.07
Total	**7.20**	**9.85**	**11.30**	**12.60**

SOURCE: Congressional Budget Office; Veterans Administration, Administrator for Veterans' Affairs, Annual Report 1982 (June 1983), Tables 12 and 13.

a. Costs include direct patient care, administrative, and support costs, but exclude construction costs and capital costs. The costs are based on the average per diem costs of care for VA patients.

b. These costs include the costs of other medically related programs--contract hospital care, medical care for dependents of service-disabled veterans, education and training, research, and miscellaneous administrative costs.

costs would increase only about 18 percent. There would be increases in the costs of providing other types of care--particularly nursing home care--however, since many patients now served in hospitals would be served elsewhere in the VA system. Nursing home care would cost about 68 percent more in real terms than in 1982 (see Table 6).

An additional requirement for providing care in future years will be an increase in outpatient facilities. Based on trends in the costs of new clinics or additional space in clinics, the VA estimates that it will cost $1.2 billion to provide 68 clinical additions or improvements between 1984 and 1988. If the trend in reduced average length of stay in VA hospitals were to continue, the VA might need 25 or more additional clinics, or expansions to existing clinics, costing about $440 million between 1985 and 1990.

SENSITIVITY OF ESTIMATES TO KEY ASSUMPTIONS

The estimates of future use of VA health care are sensitive to several assumptions. Key assumptions include the following:

- Age-specific use rates for veterans will not change significantly between now and 1990.
- The distribution of veteran patients by principal diagnosis will remain about the same within age groups.
- Adequate professional staff will be available.

Some of the estimates also assume that the average lengths of stay within age groups will continue to decline gradually through 1990, but then remain the same through 2000, whereas others assume no change from the current levels.

Use Rates

Rates of medical care use among veterans age 65 and older are critical in the projections discussed above. For example, any dramatic change in use rates among veterans age 65 to 74--about 80 percent of the age-65-and-older group in 1990--would have a large impact on estimates of demands and on the costs of continuing current VA policies for health care. Average use rates over the 1980-1982 period were employed because no dramatic change in these rates is expected. 10/

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10. See Appendix D for a discussion of these rates and Appendix E for an analysis of other factors.

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TABLE 6. PROJECTED OPERATING COSTS FOR VA MEDICAL CARE IN 1982 AND FUTURE YEARS UNDER REDUCED AVERAGE LENGTH OF STAY (In billions of 1982 dollars)

Type of Care	Actual Cost 1982	Projected Cost a/ 1990	1995	2000
VA Hospital	4.38	5.20	6.55	7.40
Nursing Home	0.47	0.79	0.98	1.17
VA	0.28	0.46	0.56	0.67
Community	0.17	0.27	0.34	0.40
State	0.03	0.07	0.08	0.10
Domiciliary	0.10	0.14	0.15	0.15
VA	0.09	0.12	0.13	0.13
State	0.01	0.02	0.02	0.02
Outpatient	1.38	2.00	2.40	2.60
Other Costs b/	0.85	1.03	1.05	1.07
Total	**7.20**	**9.15**	**11.15**	**12.30**

SOURCE: Congressional Budget Office; Veterans Administration, Administrator for Veterans' Affairs, Annual Report 1982 (June 1983), Tables 12 and 13.

a. Costs include direct patient care, administrative, and support costs, but exclude construction costs and capital costs. The costs are based on the average costs of care for VA patients.

b. These costs include the costs of other medically related programs--contract hospital care, medical care for dependents of service-disabled veterans, education and training, research, and miscellaneous administrative costs.

Benefit reductions that may occur in Medicaid and Medicare are unlikely to change the propensity among older veterans to use VA services. Although cuts already implemented in funding for Medicaid are being felt by a few veterans, the changes are not expected to have a major impact on VA health care because, historically, less than 4 percent of VA patients and 2 percent of veterans have depended on Medicaid for medical care. 11/

Similarly, increased cost-sharing under Medicare would probably have only a minor impact on out-of-pocket expenses of Medicare recipients, so their use of VA care would not change. Most Medicare enrollees have private insurance supplementing Medicare that would pay the increased cost-sharing, although some would see their private insurance premiums increase. 12/ Those without private coverage are already among the primary users of VA services. Some studies show that few veterans with private coverage in addition to Medicare opt for VA services and, hence, future use of VA services should remain about the same as today. 13/

Factors other than the age distribution of veterans were considered in this analysis. Theoretical models of the determinants of use of VA-supported nursing home care were tested, and some of the results are described in Appendix E. The results show that requests for care increase with the size of the population over age 84. The only other consistently significant factors in the regression analysis were the supplies of VA and non-VA nursing home beds in a given state, which were shown to have positive effects on the use of VA-supported care. This result indicates that increases in available nursing home care beds generate more requests for care. On the other hand, the level of beds can also be seen as a positive response to past demand for care.

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11. Veterans Administration, 1979 National Survey of Veterans, Research Monograph no. 14 (December 1980), pp. 42-43.

12. For an extended discussion of these cost-sharing effects for the general population, see Congressional Budget Office, Changing the Structure of Medicare Benefits: Issues and Options (March 1983).

13. See Constance Horgan, Amy Taylor, and Gail Wilensky, "Aging Veterans: Will They Overwhelm the VA Medical System?" Health Affairs, vol. 2, no. 3 (Fall 1983), p. 83.

Distribution by Patient Diagnoses

Currently more medical and surgical patients than psychiatric patients are treated in VA hospitals and nursing homes. A change in the demand for medical and surgical as against psychiatric care would change future requirements. For example, if cases of senile dementia per veteran age group were to increase significantly over the next decade, more beds for longer-stay patients would be needed.

Availability of Trained Staff

The assumption that it will be possible to maintain current staff-to-patient ratios rests on the ability of the VA to hire an adequate supply of trained professionals in the coming years. Recently enacted increases in pay levels together with liberal education benefits have not been sufficient as yet to end the shortage of skilled nurses in the VA system, however. If this shortage continues or increases, it could lead to reductions in the number of operable hospital and nursing home beds at VA facilities--which would limit the amount of care the VA could provide.

Average Length of Stay

The average length of stay reflects current decisions by individual staff physicians on admissions and discharges. This factor is important to assumptions about lengths of stay. VA hospitals operate a mixture of acute care and intermediate care (similar to extended care) beds, with about 3 percent of their patients staying for 100 days or longer. Any great change in the relative proportions of acute care and intermediate care patients would change the overall ALOS, resulting in a significant increase or decline in average bed requirements.

Likewise, an increase in the average length of stay of psychiatric patients would increase the estimate of bed requirements for care. The availability of outpatient clinical care is the most critical element in assessing the need for psychiatric beds. In other words, to continue current services but use fewer hospital beds--as assumed in the second set of estimates--would require an increase in the resources available for outpatient care to psychiatric patients.

CHAPTER IV. IMPLICATIONS OF FUTURE DEMAND FOR VA CARE

The previous chapter offered estimates of the number of VA medical care patients in 1990-2000 on the assumption that current policies will be continued. This chapter describes the main responsibilities facing the VA if it is to continue providing current levels of care. Other options available to the VA are discussed in the next chapter.

If current law and practices are continued, the VA would supply most of the necessary resources. In particular, it would need to construct large numbers of VA nursing home units.

NURSING HOME RESOURCES

To maintain the current mix of types of facilities, the VA could meet the probable demand for nursing home care by expanding its owned and operated facilities, contracting for care in community nursing homes, and providing grants to states for the care of veterans.

VA-Operated Nursing Homes

Maintaining current practices of serving veterans in VA facilities would mean constructing approximately 3,000 additional nursing home beds by 1990, and at least 9,400 more by the year 2000. These additional beds would represent a large and costly investment, plus additional operating costs. As indicated in Chapter III, new construction alone over the 1985-1990 period would cost $400 million.

The VA is planning to serve 40 percent of its supported nursing home patients in VA-operated beds by 1990--up from the 35 percent share today. Such an increase would imply 1,800 more beds than the above estimate, and a construction expenditure 50 percent greater for 1985 to 1990. 1/

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1. The VA has announced its latest construction plans in Veterans Administration, FY 1984-1988 Five Year Medical Facility Construction Needs Assessment (June 1983).

The VA would need even more nursing home beds than indicated above--perhaps double the additional amount previously estimated--if it progressively reduced hospital length of stay through 1990. Since it would need to place an additional 4,400 to 6,000 patients--who would receive care in VA hospitals for long stays under current length-of-stay policies--in nursing homes, the cost of supplying additional VA beds by 1990 would increase 100 percent. Alternatively, the VA could place more patients in community nursing homes, thereby lessening the impact on VA facilities.

Non-VA Nursing Homes

If the current mix of veterans placed in VA community and state home nursing homes is maintained, the VA will need to increase the amounts of contracted or subsidized care proportional to the expected increase in demand. On an average day in 1990, for example, the VA will need to contract for at least 13,300 beds in community nursing homes and subsidize care for 8,800 patients in state home nursing homes. The success of the VA in doing so could be limited by the lack of non-VA facility beds, however.

Availability of Community Nursing Home Resources. A crucial factor in continuing current policies will be the availability of sufficient community nursing home beds. The VA is currently using about 1 percent of them for veterans it supports--about a 10,250 census out of 1.4 million community beds. Many veterans who are not supported by the VA use community nursing homes, however, and this group will grow in step with those requesting VA care in future years, thereby competing for non-VA beds. 2/

Although the VA currently experiences no difficulty in contracting for community nursing home beds, some problems could develop in certain localities in the near future, partly as a result of differences in the objectives of state and local health planning agencies. Most likely, problems would arise in geographical areas where the demand for care by both nonveterans and veterans is increasing rapidly. Such areas generally have large veteran populations--for example, in southern California, the New York City area, and throughout Florida. The prospects in these areas may not necessarily be more alarming than in other geographic areas, however, because as aged veterans increase as a proportion of the total aged population, aged nonveterans, who also use nursing homes, will decline as a proportion of the aged population. But the size of the increased demand in these large population areas should not be ignored.

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2. See Veterans Administration, Nursing Home Care Needs, p. 44 and p. 53. According to the VA, non-VA-supported care will be needed by over 250,000 veterans by 1990.

One main concern is whether certificate-of-need (CON) review and state Medicaid reimbursement policies will limit the number of community nursing home beds available to the VA. In an effort to restrain unnecessary growth in health care facilities, the Congress passed laws requiring states and local planning agencies to review applications for new construction. One effect of this policy may have been to reduce the growth of the nursing home bed supply, primarily because requests for new nursing home construction have been rejected by planning commissions relatively more often than requests for other types of facilities. This does not mean that CON reviews inevitably have a negative impact on nursing home growth. 3/ CON review may serve to encourage bed construction in relatively underserved areas, for example, when the state has designated the proposed area for construction as one with identified need. Moreover, many denied projects prevented expansions as a way of controlling the quality of care in the local market.

The VA may also have less flexibility in obtaining the necessary beds for VA-supported patients than in past years, if states continue to control the growth of nursing home beds through rate-setting or Medicaid reimbursement policies. If private operators of nursing homes consider reimbursement rates low, they may not expand their nursing homes to meet the probable demands from poor patients--including those supported by the VA.

In order to ensure available beds, the VA would need to coordinate its planning efforts more closely with state or local agencies. The VA is outside the CON review process, however, so that little coordination currently exists between the VA's and the community's construction efforts. As a result, the VA's resource planning in recent years has not always complemented state or local construction efforts and vice versa. In particular, local agencies may lack incentives to allow expansion in community nursing home beds, even though beds would be used for VA-contracted care, if they believe alternative sources of care--such as home health care or residential care--will be available. 4/ Lack of coordination can produce other problems--for example, some residential areas are currently reporting an oversupply of nursing home beds. 5/

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3. See Judith Feder and William Scanlon, "Regulating the Bed Supply in Nursing Homes," Milbank Memorial Fund Quarterly, vol. 58 (Winter 1980), pp. 54-88.

4. In New York state, for example, the State Health Planning Agency's 1982 report suggested that alternatives to institutionalized care would be relied upon more heavily than in the past and that requests for new nursing homes would be screened against this alternative.

5. An example of oversupply of beds is discussed in General Accounting Office, State Veterans' Homes: Opportunities to Reduce VA and State

Availability of State Home Resources. To complete the mix of nursing home resources in 1990 to 2000, the estimates have assumed that more beds would be available in state veterans' nursing homes. This could come about in two ways. First, the number of beds could be expanded. Second, because veterans do not always use 100 percent of the bed supply in such homes, the states could supply more beds to veterans by reserving fewer beds for nonveterans such as spouses, widows, or dependents of veterans after 1990. Since the states make these decisions, however, the VA could find that there were insufficient beds in state homes to continue the current mix.

HOSPITAL CARE RESOURCES

Depending upon length-of-stay policies in future years, the need for greater hospital resources could be limited to increased staff and new equipment or, on the other hand, could require extensive renovation of some hospital centers. Although the VA currently has the physical capacity for over 94,000 beds--enough to meet the demand by 1990 even if the average length of stay declines no further--it does not have all these beds staffed and in operation. Therefore, some construction costs would be incurred--to bring closed wards up to standards, for example. Moreover, many VA hospitals are now over 30 years old and some of them will probably require replacement by 1990. In the absence of another war or major buildup of armed forces, the VA could probably accommodate both elderly and non-elderly patients with fewer beds than it currently operates. This would result from two main factors: the likely reduction in the average length of stay for all patients and the increased placement of long-stay patients in nursing homes or domiciliaries. 6/ Additional hospital beds might be needed in a few areas, however.

The level of hospital resources needed after 1990 will depend on how the VA meets requests for care between now and 1990. If it increases hospital bed capacity instead of reducing length of stay, some additional beds--such as those projected earlier--would be needed by 2000. These

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5. (Continued)
Costs, p. 56. The Minneapolis-St. Paul local health planning agency recommended in 1981 that the VA limit the number of nursing home beds in its new hospital to 40 instead of the 120 under construction in 1983. The state had already opened a 250-bed state nursing home in 1981 and was planning to construct another 250-bed unit in 1983.

6. See Chapter III for an assessment of the number of hospital beds likely to be needed by the VA in future years.

extra resources could be expensive, costing the VA from $1.4 billion ($100,000 per bed) to $2.9 billion ($200,000 per bed) by 1990 for modernized or replaced hospital beds. If ALOS continues to fall until 1990, the number of beds needed in 2000 would equal the 1983 level.

Geographic Variations in Hospital Resources

Increases in the number of beds in certain areas and decreases in other areas may be an appropriate way for the VA to deal with geographical variations in demand. 7/ The veteran population in many states is declining (see Appendix B); moreover, in many states with declining numbers of veterans, capacity utilization is already low. One way to deal with such problems would be to shift resources among states or medical districts to the greatest extent possible. This might mean closing some hospitals and reassigning staff, which would require the smallest net addition to national VA hospital resources.

Another way to deal with variations in expected use would be to contract for more hospital care in community hospitals in future years. Contracting for hospital care could be done routinely for certain types of patients or patient treatments, for example. Increases in demands in local areas where large numbers of eligible veterans reside could be met by private hospitals on a reimbursement or fee basis, thereby avoiding major requirements for additional VA-operated facilities. Currently, this contract care is provided only when care is unavailable at VA or government hospitals or less economical because of location.

Change in Hospital Patient Mix

Changes in the types of conditions presented to VA hospitals after 1990 or 1995 may result in a need for a different resource mix. For example, patients over 65 experience different chronic conditions than younger patients, so that specialists in gerontology may be required more often than specialists experienced in combat-related injuries. Another possibility would be the need for more psychiatric services within the VA medical centers as a result of having to provide more acute psychiatric care to veterans age 65 and older.

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7. According to the VA, future needs may require as many as 1,500 additional hospital beds in the state of Florida, for example. See Veterans Administration, A Thirty Year Study of the Needs of Veterans in Florida, draft report (December 1982).

OUTPATIENT CARE

Since outpatient care has been one of the fastest growing services in recent years, more clinics, especially in areas not previously served, may be needed in order to continue current policies. Outpatient services to veterans provide screening of veterans for inpatient care as well as clinical care that obviates the need for inpatient care. The VA uses general guidelines for expansions per eligible veteran, but further clinical expansion might be necessary to reduce the average hospital length of stay--in part to provide more psychiatric care on an outpatient basis.

CHAPTER V. OPTIONS

The options covered in this chapter represent ways the VA might respond to the aging of the veteran population in coming years. They are discussed in terms of three broad but not mutually exclusive strategies:

- Continue current policies and services in VA facilities, but use resources more efficiently;
- Increase the share of nursing home care provided in non-VA facilities under contract or per-diem agreements; and
- Restrict eligibility for VA medical care or reduce the scope of VA benefits.

The estimated savings for each option are measured against a baseline projection of costs under current practices, assuming that the average length of stay in VA hospitals does not decrease.

PROVIDE CURRENT SERVICES MORE EFFICIENTLY

One broad strategy for handling the expected demands for care in future years would be to implement more efficient delivery mechanisms. Since the main increase in resources in future years would be additional nursing home beds, all except one of the options discussed in this section are concerned with more efficient and cost-effective means for providing this type of care. The options, which are not mutually exclusive, are:

- Converting more acute care beds to extended care;
- Changing the mission of some VA hospitals;
- Shifting more patients from institutional care to hospital-based home care, combined with greater use of outpatient clinics and day care services; and
- Requiring reimbursement for medical care from public and private third-party insurers.

In general, the options discussed in this section of the paper would require Congressional approval or enactment of major legislation.

Converting More Acute Care Beds to Extended Care

The VA could shift more of its underutilized acute care resources to long-term care and thereby reduce the large-scale construction of nursing homes. In recent years, the VA has concentrated efforts to improve efficiency on shifting hospital resources among hospital bed sections--from medical and surgical to intermediate care, for example. There are indications that the VA plans to expand its efforts by converting some underutilized hospital beds to nursing home care. Only a few such conversions have taken place or been announced to date, however. Instead, the emphasis has been on constructing more VA nursing home beds.

The availability of beds for conversion is indicated by two main factors. First, almost 20 percent of VA hospital beds are empty on an average day, and one-fifth of the hospitals have more than 25 percent of their beds empty. VA and community hospital planners use 85 percent as a target occupancy rate, which would imply more than 3,700 excess beds in VA hospitals. Second, this estimate of excess beds should be augmented by the number of long-term patients who remain in hospital beds longer than necessary. An estimated 20 percent of current VA hospital patients could be placed in nursing homes or domiciliaries or become clinical outpatients if adequate facilities were available, freeing about 13,000 of today's VA hospital beds for long-term care. 1/

In addition, the number of hospital beds available for conversion will grow if average length of stay continues to decline. The total number of VA acute care beds not in demand nationally after 1990 is expected to be almost 11,000, although the proportion of excess beds would vary among medical districts. In many geographical areas, this source alone would eliminate the need for constructing additional nursing home beds between 1985 and 1990.

This option could be implemented in one of two ways. A maximum number of conversions could be made right away if the Congress relaxed the minimum bed restriction on total hospital and nursing home beds. Other-

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1. Results of the Multi-Level Care Survey, a VA facility survey conducted each year, indicate that 23 percent of hospital patients could be discharged on the census day instead of remaining, if sufficient nursing home, outpatient, and domiciliary care were available. About 40 percent of these patients could be placed in nursing homes and 40 percent on outpatient care. See Veterans Administration, Appropriate Placement of VA Hospital Inpatients, Health System Information Service, Report No. 81-7 (August 1981).

wise, conversions could be tied to the rate of new construction so that the minimum would be maintained. In either case, conversion of most beds under this option could begin according to the schedule for nursing home bed construction under the current five-year VA construction plan (1984-1988). 2/ The VA could convert over 3,000 beds between 1985 and 1990, expanding to 10,000 beds before 2000. This option would not completely eliminate the need for new nursing homes in the VA system by 1990, but would reduce the amount of planned construction by about 80 percent.

A policy of hospital bed conversion would have important advantages. First, bed conversions could be made at less than half the cost of new construction, on average. 3/ Second, this would reduce the excess supply of hospital beds, which is greater in some areas than in others. Since some hospital wards would be closed and less medical staff required, operating costs would be significantly lower.

On the other hand, during conversion hospital beds would not be available for either hospital or nursing home care. VA services in some locations, perhaps in smaller hospitals, might be temporarily interrupted.

Savings under this option, although difficult to estimate because locations of underutilized beds are widely distributed geographically, would be about $600 million over the 1985-1990 period. This estimate is based on past construction costs for converting beds, inflated by the medical-construction price index. It allows for the differences in operating costs of nursing homes and hospitals.

Changing the Missions of Some VA Hospitals

Some VA hospitals--those with low demand for care--could be converted entirely to nursing homes. In medical districts under the lowest pressure--for example, less than 20 applications per bed annually--more

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2. The length of time required to complete bed conversions, as well as the costs of conversion, would depend in part upon the preconversion conditions of the facilities; older facilities would require longer conversion times and cost more.

3. Beds in relatively new hospitals could be converted at 10 percent of the cost for new construction, but in older hospitals the need for renovation would raise costs to 50 or 60 percent of new construction. Many factors are involved in conversion, such as changing room size and adding amenities like bathrooms or sinks.

than 2,200 hospital beds could be converted to nursing home beds by 1990 by changing the missions of several hospitals to nursing home units.

In states or localities where demand for nursing home care is steadily rising, some VA hospitals might be better used in that function. Since not all hospitals within a medical district would be changed to nursing homes, VA acute care would still be available to veterans served by the current system.

Opponents argue that this option could greatly inconvenience some veterans in localities where hospitals were converted, especially at a time when cutbacks in Medicare coverage may reduce access to care for some veterans.

The option would save about $350 million between 1985 and 1990, based on the same assumptions about construction costs and operating costs as in the previous option. The estimate includes increased but comparatively small costs for transporting veteran patients in need of special acute care services to VA hospitals with those services.

Shifting Resources to Outpatient Care

Over the last decade, a shifting of medical care delivery from inpatient services to outpatient services has improved the overall efficiency of VA operations. This trend began about 1973, when non-service-disabled veterans became eligible for outpatient care whenever it would obviate the need for inpatient hospital care, and continued as more outpatient clinics were established. A further shifting of staff and other resources to outpatient care could reduce the need for increased inpatient services, particularly hospital services, over the next decade.

In essence, this option implies more cost-effective delivery of health care while providing the same quality of care. Some opponents suggest, however, that increased emphasis on outpatient care might keep patients out of hospitals who really need acute care--including intensive observation and evaluation--and that many would in fact be hospitalized even after several outpatient visits.

The VA could shift more psychiatric care to outpatient settings. According to its annual patient survey, more than 20 percent of psychiatric patients could be discharged to other than hospital settings; approximately 40 percent of these patients could be discharged to outpatient care. Reducing stays of psychiatric patients in hospitals by 30 days for approximately 8 percent (40 percent of the 20 percent) of patients through revised

criteria for placement would save $80 million per year by 1990. 4/ Some would oppose an emphasis on outpatient psychiatric care, however, because of concern that some mental patients might be released from hospitals too early.

Another way to shift medical services away from institutional care would be to provide more care in the veteran's home. Many VA hospital patients could benefit from hospital-based home care (HBHC), in which members of special treatment teams--including a doctor, nurse, and social worker--make home visits providing medicine and therapeutic services as well as diagnostic services to chronically ill patients. An increasingly older veteran clientele is likely to generate more cases of cancer, stroke, and heart disease, which the HBHC program is designed to treat. Those who oppose an emphasis on home care maintain that patients might receive inadequate care in emergency situations at home and would have to be transported back to hospitals--a situation more likely to occur with these patients than others.

This option could yield savings in 1990 of at least $3,000 per patient shifted from a VA hospital to HBHC, assuming that 12 or more days of hospital stay could be prevented. It could, on the other hand, stimulate requests for HBHC from those who do not at present use the VA system. The VA might avoid this outcome, however, if it carefully screened such applicants and extended service only to cases that would most likely be hospitalized in the absence of home care (or restricted HBHC to certain types of discharged VA hospital patients).

Requiring Reimbursement from Public and Private Insurers

About 35 percent of VA system users have private health coverage, but the VA does not currently collect payment from the insurers for their hospital care. If it did, it would still absorb a portion of the costs. Deductibles and coinsurance amounts required by these policies would not be paid by veterans receiving hospital care under VA auspices, so VA costs would be reduced only by the average reimbursements from third parties.

Proponents favor this option because it would cut federal costs and eliminate the advantage that now accrues to private insurers when veterans choose to use the VA system rather than the community health care system. Others would oppose its implementation because they believe increases in

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4. Some additional costs for outpatient clinic improvement or expansion of service at some medical centers might be required, but such adjustments would be small compared to current plans for 1990.

insurers' costs would be passed on in higher premiums to the insured or their employers--which could lead to reductions in coverage. Legislation would be required in order to implement this option, so that private insurers could not prohibit reimbursement to the VA. 5/ Some question has been raised as to the constitutionality of such legislation. 6/

Based on average patient costs, savings to the VA under this option would exceed $3.0 billion in 1990, reducing annual direct medical care costs by 25 percent. Since about one-fifth of those privately insured also have Medicare coverage, total federal savings would be reduced by 15 percent that year, assuming 80 percent of reasonable hospitalization costs were paid. 7/ In addition, administrative costs could be large--about $50 million in the first year, and $20 million thereafter.

INCREASE SERVICES IN NON-VA NURSING HOMES

As an alternative to expanding VA-operated facilities, more veterans could be accommodated in nonfederal nursing homes. This would lower total costs for VA medical care because the VA pays considerably less for contract care on a per diem basis than for care in its own facilities. It could, however, shift considerable costs to state governments since the VA pays less than 30 percent of the total costs for care in state facilities.

More veterans could be placed in contract community nursing homes or state veterans' nursing homes--for example, whenever it was determined that closer proximity to a VA hospital, or the specialized skilled care offered only in a VA nursing home, was not a requirement for the patient--thereby avoiding a costly buildup of VA facilities. Avoiding such a buildup is especially important in a time of fiscal stringency like the

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5. The VA can collect for certain non-service-disabled veteran patients who are eligible for worker's compensation or other private payments in cases of work-related injuries or illnesses, unless the private insurance policies strictly forbid payment for VA services. For a recent discussion and recommendation of a similar option, see President's Private Sector Survey on Cost Control, Report on Federal Hospital Management (Spring-Fall 1983), pp. 224-231.

6. For a discussion of regulating the practices of private insurers, see Congressional Budget Office, Options For Change In Military Medical Care (March 1984).

7. See 1979 Survey of Veterans, pp. 26-27.

present. Shifting the growth in nursing home facilities to the nonfederal sector would be advantageous because there will be increased demand for such care among the nonveteran elderly after 2010 or 2020, which would offset the probable decline in demand from elderly veterans. In addition, this approach would allow more space within VA facilities to be used by the service-disabled and others most in need of specialized VA medical care.

One main drawback to this strategy is the possibility that states might refuse to accommodate the VA by expanding their facilities, or that they might reduce the quality of care. Although the VA would pay some of the ongoing costs for care of veterans and up to 65 percent of the costs for construction or renovation of state-operated facilities, state obligations would still increase substantially. 8/ Since states are already experiencing tight budget constraints in Medicaid funding, they might be slow to increase state home capacities. Alternatively, they might cut the staffs, resulting in lower quality care in some areas. Such cuts would be limited by the fact that the VA would still maintain some control over the standards for care in the contracted facilities.

A second drawback is that, since the VA would no longer control the building of facilities, supply might lag behind the mounting demand. This could happen in areas where policies set up by local health planning agencies tended to restrict growth in new nursing home construction. Also, some patients might have to be placed in community nursing homes farther away from their families than are the VA facilities. This could happen if they were rejected by private operators as being too sick or costly to be served in nearby institutions at VA contract rates.

Placing More Veterans in Community Nursing Homes

Veterans requiring nursing home care could be placed in community nursing homes unless beds in such facilities were unavailable, less economical, or would not provide the required medical care to veteran patients. About 30 percent of VA nursing home patients are now returned to their homes after stays of six months or less, so a careful screening of patients discharged from hospitals would allow the VA to place many of them in

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8. States could pass along some of the increased costs to veterans, although most states charge for care on a means-tested basis. Increases in per diem rates paid by the VA, such as the one mandated in Public Law 98-160, might prevent increases in cost-sharing to veterans.

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community nursing homes. 9/ Moreover, since the rates the VA pays at community nursing homes under contract generally are higher than those paid for Medicaid patients, the VA would have no trouble securing beds for veteran patients. The average length of stay in VA nursing homes would probably increase as a result of this option, but fewer VA nursing home beds would be required.

In addition to the general arguments against this option discussed earlier, some analysts suggest that more VA contracting in the private sector could push Medicaid patients out, or cause Medicaid patients to have to wait longer for available beds. This could happen if the VA paid far above the Medicaid reimbursement rates, but that is not the case at present. Moreover, private operators would probably continue to expand their facilities to accommodate poor patients, provided that Medicaid reimbursement was sufficient to cover their costs.

The VA could place patients under contract for less than half the per diem cost of care in VA nursing homes. About $140 million could be saved in 1990 by placing short-stay patients in community nursing homes. (This cost estimate assumes closure of VA-operated beds that would have served patients being treated in non-VA facilities. Savings would exceed $180 million if an equivalent number of beds were not constructed in 1985-1990.)

Providing Larger Grants to States for Construction

This option would extend the previous one by modifying the mechanism to reimburse states for the costs of constructing or expanding nursing homes. Specifically, the VA could pay a larger share of initial construction or expansion costs--possibly a maximum of 75 percent of costs instead of the current 65 percent.

The main advantage of this option is that, in the long run, savings in operating costs would more than offset the increased grants. It would also provide more nursing home care for nonveterans. Because of mandated limits on funding in state homes, the average per diem cost to the VA is less than $17 per patient and the VA eventually pays only about 30 percent of the total cost of care. Up to 25 percent of the nursing home beds could be used for nonveterans--spouses, dependents, or survivors of veterans.

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9. These patients tend to be younger than the average VA nursing home patient, however. Short-stay patient data were supplied by the Veterans Administration, Division of Reports and Statistics.

The net savings under this proposal are difficult to assess, since the number of states that would request higher grants because of an incremental increase in the proportion of costs paid by the federal government is not known, while those that would have applied anyway would still receive the higher percentage reimbursement. Since 24 states have no state nursing homes for veterans, some increase in construction could be expected, although this might not yield savings in operating costs large enough to offset completely the higher outlays for all grants. For every $5 million grant for construction or expansion in 1985 that would not have occurred under the current program, the VA could expect significant savings in operating costs after five years--about $1.9 million per year, assuming a 60-bed unit was constructed with the grant. If state facilities replaced plans for VA facility construction, savings of 25 percent of construction costs would also accrue, since the federal government would reimburse the states for only 75 percent of the construction costs.

RESTRICT ELIGIBILITY OR REDUCE SCOPE OF BENEFITS

Future demands for VA health care could be more easily met if fewer veterans were eligible. For example, if only service-disabled and poor veterans were accepted, present resources would be sufficient to meet the probable demand. If eligiblity was not restricted, either the VA's resources would have to be expanded (as discussed in Chapter IV) or the scope of VA benefits would have to be reduced.

By restricting eligibility and/or reducing the scope of benefits, the VA could avoid a buildup of facilities beyond what will be needed after the year 2010 or 2015. It would also reduce its overall costs.

This approach would represent a significant departure from the current policy of providing medical care to all of the nation's veterans. It would exclude many war veterans who are not defined as poor, or who have no service-connected disabilities, or who have other means of obtaining medical care. Reducing the scope of benefits could mean that less than a comprehensive set of services would be available, or that veterans would pay some of the costs.

This section first discusses options for restricting eligibility--limiting VA-assisted care to the service-disabled and to poor veterans. It then turns to ways to cut the scope of VA benefits--eliminating acute care services, for example. Finally, cost-sharing arrangements are examined. All of the options in this section of the paper would require explicit Congressional approval through legislative action before they could be implemented.

Limiting Eligibility to Only the Service-Disabled and Poor

Under current law and practices, the VA gives inpatient care to veterans without service-connected injuries or illnesses on a space-available basis, although priority goes to the service-disabled. Considerable savings could be achieved by denying VA-supported hospital or nursing home care to veterans without service-connected disabilities, unless they were unable to defray the costs of their care.

The VA could apply the restriction to all types of care currently provided in the system or only to hospital care. The broader restriction would yield more savings. Limiting it to hospital care would mitigate the impact, since many veterans would have access to private hospital care, which is much more extensively covered by insurance than nursing home care.

About one-fourth of the expected VA clientele would be affected by the broader approach, assuming that the strongest impact would be on VA patients over 65, most of whom have no service-connected condition. In addition, some veterans under age 65 who are currently eligible for VA care would no longer meet a strict test of poverty and/or inability to defray the costs of their care. The test of poverty might be based on receipt of means-tested benefits such as veterans' pensions or food stamps, or might be linked directly to income and assets.

Proponents are in favor of this option primarily because they believe that the VA's primary responsibility is to provide care to the service-disabled, and that VA resources should not be expanded solely to meet the needs of the non-service-disabled. One drawback to this approach is its possible side effects on the VA medical system, however. If the VA served significantly fewer veterans, it might have to scale back its medical school affiliations and, as a result, no longer be able to provide quality care to some service-disabled veterans. A reduction in size might also hinder the VA in maintaining enough reserve capacity for military needs in time of war or national emergency.

After 1990, savings per year would amount to at least $3.5 billion under the broader restriction, and $2.6 billion under the alternative option. These estimates assume no increase in utilization rates among service-disabled veterans, and no increase in poverty among veterans over 65.

The restrictions could be tightened even further by eliminating eligibility for nonpoor veterans with service-connected disabilities who are less

than 50 percent disabled. 10/ Proponents believe that the additional persons affected by this change would be those who primarily require care of non-service-connected conditions and who could be treated similarly to non-service-disabled veterans. Opponents believe that free medical care is an important part of compensation to these veterans, some of whom may have suffered combat-related impairments.

Reducing the Scope of VA Benefits

If the VA wanted to restrict eligibility less but still reduce costs, it could cut back on specific benefits to some or all veterans. Examples of this approach analyzed here are:

- o No longer providing VA-operated acute care services;
- o No longer providing VA-operated nursing home care; or
- o Requiring cost-sharing for VA medical care provided to nonservice-disabled veterans.

The first two options would involve an increased use of private health care services only a portion of which would be paid for by the federal government, while the third would raise costs paid by beneficiaries using the VA health system.

Some proponents favor the first two options because they believe the private health care system to be more efficient; others focus on the savings in VA medical care costs that all these could achieve. Opponents argue against reducing access to both general and specialized medical care for veterans.

No Longer Provide VA-Operated Acute Care Services. Acute care services operated by the VA could be dismantled by 1990. This would mean that all veterans would be served in non-VA hospitals. This general approach has been proposed by several analysts in recent years, mainly as a way of avoiding costly renovation or replacement of very old VA hospitals. For example, in this option the VA would continue to assist poor veterans and those with service-connected disabilities in obtaining care in private hospitals on a contract or fee-for-service basis or through reimbursement procedures.

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10. Service-connected disabilities are rated between 0 and 100 percent, reflecting the degree of total disability or impairment and the estimated reduction in earning capacity.

Proponents believe this would eliminate costly duplication in the VA and community hospital systems that results in excess beds in some areas. On the other hand, it would sever the strong affiliation between the VA and the nation's medical schools, which might dislocate part of the medical education and training system or lower its quality. Opponents believe veterans would also suffer from the loss of a system that serves them with priority; they believe only a VA-operated hospital can provide quality care for service-disabled. In addition, some chronic psychiatric patients, who tend not to be served well outside VA or state systems, could be adversely affected.

Proponents, in turn, argue that veterans would have access to care through Medicare and Medicaid, which provide enough benefits to cover most of the costs of hospital care for both elderly and disabled persons. Medicare's catastrophic coverage, however, which provides assistance for lengthy episodes, is limited, and some elderly veterans would face substantial increases in their out-of-pocket costs.

Savings in VA operating costs under this option would exceed $2.6 billion in 1990. But about 55 percent of the savings would be shifted as costs to Medicare, so that net federal savings would be only about $1.2 billion in 1990. Savings in construction costs would be large--as much as $600 million per year, if implemented by 1990.

Variations of this option could broaden it or narrow it. For example, savings would be increased if the VA only paid for those treated for service-connected conditions. 11/ Others would either pay for their own care or be supported by Medicare, Medicaid, or their own private insurance. Alternatively, the savings would be less if VA eliminated just one particular type of care--such as surgical care--rather than all hospital care.

No Longer Provide VA-Operated Nursing Homes. This option would limit VA-assisted nursing home care to that provided in non-VA facilities. 12/ The current rules for eligibility for VA care in non-VA facilities would be maintained under this option. This would mean that most veterans requiring nursing home care would be assisted by the VA for a maximum of six months, unless care was given in state veterans homes.

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11. See Cotton M. Lindsay, "Veterans Benefits and Services," in Agenda for Progress (The Heritage Foundation), p. 298.

12. This option, combined with an earlier one to increase use of non-VA facilities, is similar to one proposed in President's Private Sector Survey on Cost Control, Task Force Report on Privatization, p. 114.

Veterans with service-connected disabilities could, however, remain in non-VA homes at VA expense for as long as required.

Important efficiencies might be achieved by this approach. Some analysts believe that VA-operated nursing homes are more expensive to run than necessary, particularly as compared to community nursing homes. The costs of building new VA homes have also been two to three times greater than the costs of private operators. Costs for the limited VA care would be half or less of the current operating costs per patient in VA-operated homes. In addition, VA-operated homes could be sold or leased to private operators, thereby generating revenues in the near term and becoming a source of care for nonveterans in later years. Finally, some believe that the efficiency of the health care system would be enhanced by integrating VA resources with those of private or community operators.

Others oppose this approach, however, because the VA would lose control over nursing home operations and, in some cases, the decision for placement of a veteran in a particular nursing home. Moreover, the VA's limited influence on the availability of community nursing home beds could lead to limitations in access.

Savings under this option would be at least $410 million per year, if implemented by 1990. Additional savings would accrue from not constructing new VA nursing home units, as described earlier in this chapter.

Institute Cost-Sharing Arrangements. Instead of providing totally free hospital and nursing home care to veterans without service-connected conditions, the VA could institute cost-sharing arrangements for them. The majority of veterans today receive medical care outside of the VA system, and hence are accustomed to cost-sharing; under Medicare and many private health insurance plans, some cost-sharing arrangement--usually including deductible and coinsurance amounts--is required for stays in hospitals or nursing homes.

Veterans tend to have higher family incomes than nonveterans, and their ability to share in the costs of medical care is likely to be at least as great as that of nonveterans. Opponents argue, however, that free VA medical care is owed to veterans because of their military service, regardless of their financial status.

Two cost-sharing arrangements for veterans without service-connected disabilities are discussed below:

- Copayments for hospital care similar to those under Medicare; and
- Fee charges on a scale related to income.

Copayments similar to those required under Medicare would provide savings to the VA system and reduce the potential demand for care in VA hospitals. The deductible charged for any hospital stay up to 60 days in length could be set at about $356 in 1984. Coinsurance on days 61 through 90 could be $89 per day. 13/ Also, copayments equivalent to those under Medicare could be set for outpatient care received at VA medical centers or at VA expense.

Establishing deductibles and coinsurance amounts for non-service-connected veterans who are not poor would be a way of containing increases in VA health care costs, and also of decreasing some veterans' preference for VA care over care in private hospitals. More than half of the veterans eligible for care in the VA system are eligible for Medicare. Copayments would also help ensure that the VA-operated services would always be adequate to meet the needs of veterans with service-connected disabilities, as the demand for VA health services increased with the aging of the veteran population.

Opponents hold that the VA is obligated to provide free medical care for veterans without service-connected disabilities, particularly war veterans and those age 65 or older. Just as Veterans' Compensation and Pension payments are entitlements for certain veterans, they believe VA medical care should also be considered an entitlement.

If implemented in 1985, cumulative savings through 1990 would be about $1.8 billion, net of administrative costs. Part of the savings would come from reduced use of VA services by those having to pay, and part would stem from direct payments by patients who would continue to use VA care. 14/ Medicare costs could rise as much as $150 million over the same period from those leaving the VA system, however.

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13. In this option, coinsurance payments would not be required for days of hospital stays over 90. This would represent more extensive benefits than now provided under Medicare, however.

14. Data from the National Survey of Veterans (1979) indicate that 41 percent of non-service-connected veterans hospitalized at VA centers in 1978 had no insurance coverage. In addition, based on estimates of use in 1990 described in Appendix C, about two-thirds of veteran patients would be excluded from this option. Also, approximately one-third of those affected would presumably leave the VA system since they would probably have sufficient private insurance coverage.

Fees could be charged for hospital or nursing care, in relation to income. Again, only the non-service-disabled veteran would be affected by this option.

One possible scheme for charging fees is the following. A hospital episode of short duration would be the basis for all other fees, and the VA would charge for nursing home and outpatient care services on a proportionate level. 15/ For example, a short hospital stay (99 days or less) could cost a veteran $100 per month if he has $1,000 or more in annual income above the VA pension level--about $6,980 in 1983 for a veteran with one dependent. For each additional $1,000 of income above this level, an additional $100 per month would be charged, with total charges constrained to one-half the costs of care. Similarly, base fees could be set at a $12 charge for an outpatient visit and $25 per day for a resident in a VA-supported nursing home, after the first month of care; incremental amounts could be one-fourth of the base fee for each type of care up to one-half the costs of care.

One important advantage of this option compared with the copayment method is that it makes allowance for those veteran patients who are nearly poor or who may be temporarily without their usual incomes. Most opponents would object to this form of cost-sharing, however, because it would expose veterans to a more rigid means test than today. They also suggest that most VA clientele are poor or nearly poor and therefore should not be charged for care.

Savings under this option would be significantly lower than under the copayment system, because only about one-fourth of those affected would pay the maximum charges. Hence, outlays for hospital and other types of care would be reduced only about 6 percent, or $600 million in 1990, if the option were fully implemented by then.

If the VA wanted to restrict free care to a greater degree, it could subject veterans with service-connected disabilities rated below 50 percent to this cost-sharing arrangement. Although some would oppose requiring payments from service-disabled veterans, even those with lesser impairments, most such patients come to the VA for treatment of non-service-connected problems and should, proponents say, be treated similarly to non-service-disabled veterans.

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15. Alternatively, fees could be set according to treatments given, or on a diagnostic-related group basis. Data are not currently available, however, to estimate the impact of these alternatives.

APPENDIXES

APPENDIX A. RECENT LAWS AND PRIORITY-SETTING REGULATIONS FOR VA HEALTH CARE

RECENT LAWS

Many changes in the laws governing VA health care have been enacted during the last five years. This appendix describes some of the more important legislation.

VA Health Care Amendments of 1980 (Public Law 96-330)

The focus of this legislation was on improvements in the management and quality of care provided in the VA health care system. Among the law's provisions are:

- Authority and guidelines for 15 geriatric research, education, and clinical centers (GRECCs) at VA medical facilities;
- Improved standards for presumption of the inability to pay medical expenses for VA care;
- Permanent special pay authority for health care professionals employed by the VA; and
- A scholarship program for medical school students.

Veterans Health Care, Training, and Small Business Loan Act of 1981 (Public Law 97-72)

This law contains several health care provisions. It:

- Provides for priority hospital and outpatient care for veterans exposed to dioxin or other toxic substances in Vietnam, and for other veterans exposed to ionizing radiation;
- Requires the VA to operate and maintain no less than 90,000 hospital and nursing home beds;

- o Expands the scope of the VA's Agent Orange Study authorized under an earlier law (Public Law 96-151) to include an evaluation of the defoliant's impact on human beings;

- o Provides that the VA be reimbursed by specified insurers for care provided veterans without service-connected disabilities who have been disabled at work or in an automobile accident or as a result of crime; and

- o Extends through September 1984 the Vietnam-era readjustment counseling centers.

VA and DoD Health Resources Sharing and Emergency Operations Act (Public Law 97-174)

This law, enacted in 1982, establishes authority to provide sharing of medical resources between the VA and the Department of Defense. It also requires the VA to act as emergency backup by providing medical care to active duty Armed Forces personnel during a period of war or national emergency declared by the Congress or the President.

Veterans Administration Health-Care Programs Improvement and Extension Act of 1982 (Public Law 97-251)

This law grants the VA Administrator authority to increase the pay rates for nurses and other health care personnel, extends eligibility to participate in the Health Professional Scholarship program to full-time VA employees, extends authority for grants to states for state home construction, and reinstates eligibility for VA medical care for certain dependents and survivors of service-disabled veterans.

Veterans' Health Care Amendments of 1983 (Public Law 98-160)

A major provision of this law increases the per-diem rates paid for veterans in state veterans' homes. The percentage increase for state veterans' nursing homes is greater than that for state domiciliary care or hospitals--40 percent versus 15 percent--so that states may have an incentive to provide more nursing home care.

In addition, this law:

- Requires the Administrator to establish an advisory committee on women veterans and to ensure available gender-specific health care to female veterans eligible for VA health care;

- Authorizes the Administrator to make special appointments and to adjust pay scales for certain medical personnel;

- Extends authority for the preventive health services pilot program through 1988; and

- Authorizes the Administrator to refer eligible veterans to community residential care.

PRIORITIES FOR VA HEALTH CARE

Generally, veterans with service-connected disabilities receive first priority for admissions to VA medical facilities. Moreover, veterans requiring treatment of their service-connected conditions are admitted before veterans with such conditions requiring treatment of non-service-connected problems. Veterans requiring emergency hospital care or being readmitted to continue treatment are not subject to the priority scheme, however.

Hospital Care

Veterans are admitted to VA hospitals according to the following set of priorities:

- Veterans in need of hospitalization because of injuries or disease incurred or aggravated in the line of duty have top priority for admission for treatment of their service-connected injuries or illnesses.

- Veterans who were discharged or retired for disability incurred or aggravated in the line of duty, or who are receiving compensation, or who would be eligible to receive compensation except for receipt of retirement pay, are admitted for treatment of ailments not connected with their service, as beds are available.

- Finally, veterans who were not discharged or retired for disability or are not receiving compensation, and who apply for treatment of a non-service-connected disability, may be admitted to a VA hospital if they are unable to defray the cost of hospital care

elsewhere and if beds are available. The "inability to pay" requirement does not apply to any veteran who: (1) is 65 years of age or older; (2) is receiving a VA pension; (3) is eligible for Medicaid; (4) is rated service-connected disabled; (5) is a former prisoner of war; or (6) requests medical services in connection with exposure to dioxin or other toxic substances in herbicides or defoliants (such as Agent Orange) used for military purposes in Vietnam, between August 5, 1964 through May 7, 1975; or requests medical services in connection with exposure to ionizing radiation from the detonation of a nuclear device as a result of participation in the test of such a device or the American occupation of Hiroshima or Nagasaki, Japan, between September 11, 1945, and July 1, 1946 (P.L. 97-72).

VA Nursing Home Care

Veterans may be admitted to VA nursing home care units according to the following priorities:

- First, veterans receiving hospital or domiciliary care in VA facilities when transfer is required for service-connected or adjunct disabilities and persons being furnished care in Armed Forces hospitals who will require a protracted period of nursing home care upon release therefrom, and will become veterans on discharge from active military service.

- Second, veterans not hospitalized or domiciled by the VA who require nursing home care for service-connected or adjunct disabilities.

- Third, veterans with a service-connected disability who are receiving VA hospital care and require nursing home care for non-service-connected disabilities.

- Fourth, veterans with a service-connected disability not hospitalized by the VA who require nursing home care for non-service-connected disabilities.

- Fifth, veterans receiving hospital or domiciliary care in VA facilities whose transfer is required for non-service-connected disabilities.

- Sixth, veterans not hospitalized or domiciled by the VA who require nursing home care for non-service-connected disabilities.

Outpatient Treatment

The following veterans are eligible for outpatient care:

- Any veteran, for a service-connected disability;
- Any veteran with a service-connected disability rated at 50 percent or more, for any medical condition;
- Any veteran of World War I, the Mexican Border period, or the Spanish-American War; any veteran in receipt of aid and attendance or housebound benefits; or any former prisoner of war, for any medical condition;
- Certain disabled veterans entitled to or receiving vocational rehabilitation training, for any condition requiring medical care to enable the veteran to begin, continue, or return to such training;
- Any veteran eligible for hospitalization when outpatient services are reasonably necessary in preparation for, or, to the extent facilities are available, to obviate the need for hospital admission; and
- Any veteran who has been granted hospital care when outpatient services are reasonably necessary to complete treatment related to such hospital care.

Outpatient dental services and treatment, and related dental appliances, are generally furnished by the VA only for a dental condition or disability that is service-connected. Veterans are eligible for dental care as follows:

- Veterans whose dental conditions or disabilities are service-connected and compensable;
- Veterans whose dental conditions or disabilities are service-connected but not compensable and which are shown to have been in existence at the time of discharge or release from active service must apply to the VA for outpatient dental care for the service-connected dental condition within 90 days of separation;
- Veterans with service-connected noncompensable dental conditions resulting from combat wounds or service injuries, and former prisoners of war with service-connected noncompensable dental conditions;

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- Veterans who were prisoners of war for six months or more, and certain veterans who are receiving disability compensation at the 100 percent rate for service-connected conditions;

- Veterans whose non-service-connected dental conditions are determined by the VA to be associated with or aggravating a service-connected condition;

- Disabled veterans training under the Vocational Rehabilitation Act, who may apply for this type of treatment as needed; and

- Veterans with a non-service-connected dental condition or disability for which treatment was begun while receiving hospital care at VA expense when it is professionally determined to be reasonably necessary to complete such dental treatment on an outpatient basis.

APPENDIX B. PROJECTIONS OF THE VETERAN POPULATION

The veteran population will steadily decline over the next 50 years, assuming that there is no war or major buildup of the armed services. Currently there are about 28.3 million living veterans, approximately 14 percent of whom are age 65 or older. There will be about 14 percent fewer veterans by the year 2000, and 47 percent fewer by the year 2030. The number of veterans is declining primarily because of the aging and death of the large World War II cohort, which is not offset by the number of persons leaving the active forces in peacetime. Although the total number of veterans will steadily decline, the veteran population age 65 and older is expected to grow in proportion to about three times its current percentage by 2000 before declining by the year 2030.

AGE DISTRIBUTION

The veteran population age 65 and over in the United States and Puerto Rico will increase rapidly over the next 20 years before declining, according to the Veterans Administration's estimates. It will reach 4.8 million by 1985 and 7.2 million by 1990 (see Table B-1), when it will include more than 60 percent of the male population 65 and older. By the year 2000, it will reach almost 9 million and make up 37 percent of the veteran population. It will begin to decline by the year 2010 and be less than its 1990 size by the year 2030.

A finer breakdown of estimates shows the rise and fall in the number of veterans of specific age groups, as well as the increase in the population age 65 and over. As shown in Table B-2, veterans 65 and over increase rapidly (as a result of aging World War II and Korean War veterans), while the number of veterans under age 65 declines rapidly, caused primarily by low numbers of new veterans. Another trend in the population projections is the steady increase for at least 20 years in the veteran population age 85 and older, after a temporary decline in this group between now and 1990. This latter trend will establish a group of veterans with high use rates for long-term-care services in future years.

THE NUMBER OF SERVICE-DISABLED VETERANS

The number of service-disabled veterans receiving compensation payments is expected to decrease continuously through 1990 according to CBO

TABLE B-1. ESTIMATES AND PROJECTIONS OF THE VETERAN POPULATION IN THE UNITED STATES AND PUERTO RICO, SELECTED YEARS BETWEEN 1980 AND 2030 (In thousands)

In March of Year	All Veterans	Veterans 65 and Over	Percent 65 and Over
1980	28,640	3,036	10.6
1985	28,014	4,833	17.3
1990	27,064	7,155	26.4
1995	25,802	8,516	33.0
2000	24,259	8,974	37.0
2010	20,710	8,125	39.2
2020	17,461	7,771	44.5
2030	15,086	5,716	37.9

SOURCE: Veterans Administration, May 1983.

TABLE B-2. ESTIMATES AND PROJECTIONS OF VETERANS IN THE UNITED STATES AND PUERTO RICO, BY AGE GROUPS AND SELECTED YEARS BETWEEN 1983 AND 2030 (In thousands)

Age Groups	1983	1990	2000	2010	2020	2030
Total	**28,304**	**27,064**	**24,259**	**20,710**	**17,461**	**15,086**
Under Age 65	24,341	19,909	15,285	12,585	9,690	9,370
Age 65 and Over	3,963	7,155	8,974	8,125	7,771	5,716
65-74	3,031	5,621	5,007	3,723	4,053	2,065
75-84	657	1,326	3,451	3,020	2,351	2,476
85 and Over	276	208	516	1,383	1,367	1,175

SOURCE: Veterans Administration, May 1983.

estimates. From 2.27 million in 1983, it is expected to decline to about 2.10 million by 1990, assuming there is not another war. Almost 60 percent of them--about 1.2 million veterans--will be age 65 or older, compared to about one-fifth now.

An uncertainty in estimating the number of veterans with service-connected disabilities in future years is caused by the status of veterans suffering from the effects of exposure to Agent Orange in Vietnam. Legislation now before the Congress would extend compensation to these veterans on the assumption that certain conditions or illnesses were caused by exposure to herbicides or defoliants while in service. 1/ The number of Vietnam-era veterans who will become eligible for disability compensation if the legislation is enacted is not known, but they would be among the 2.9 million who served in the Vietnam theater. Only about 97,500 veterans had entered a special registry for Agent-Orange-related problems by the end of 1982, however.

GEOGRAPHIC DISTRIBUTION OF VETERANS

Since the geographic location of a group of veterans will often determine the location of VA health care facilities and therefore the type of services available to them, it is important to note areas where great increases in the over-64 veteran population are expected by 1990. The distribution of the veteran population in the United States currently is roughly like the distribution of nonveterans. The same is true of the over-64 veteran population. By 1990, however, some variations in this relationship may be expected as a result of declines in the total veteran population and increases in the population age 65 and older.

Eight states--California, New York, Texas, Pennsylvania, Ohio, Illinois, Florida, and Michigan--have the largest veteran populations, and together contain almost half of the U.S. veteran population. Each of these states has more than one million veterans (see Table B-3). They also currently have high percentages of veterans in the World War II cohort, which indicates a "graying" of their veteran populations. By 1990, the total veteran population will have decreased in all these states, with the exception of Florida and Texas, where the populations should increase, primarily because of migration. The over-64 veteran population, however, will increase in each of these states to twice or more its 1980 size.

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1. This legislation is currently represented in the 98th Congress by S. 1651 and H.R. 1961 reported by the Senate and House Committees on Veterans' Affairs, respectively.

TABLE B-3. 1980 VETERAN POPULATION IN THE UNITED STATES AND PUERTO RICO AND SELECTED STATES

State	Veteran Population		Veterans 65 and Over	
	Thousands	Percent	Thousands	Percent
United States	28,640	100.0	3,036	100.0
High Density States				
California	3,097	10.8	335	11.0
New York	2,048	7.2	251	8.3
Texas	1,716	6.0	172	5.7
Pennsylvania	1,618	5.6	172	5.7
Ohio	1,406	4.9	130	4.3
Illinois	1,391	4.9	142	4.7
Florida	1,352	4.7	232	7.6
Michigan	1,134	4.0	93	3.1
Low Density States				
Alaska	55	0.2	2	0.1
Vermont	63	0.2	7	0.2
Wyoming	65	0.2	5	0.2
North Dakota	72	0.3	7	0.2
South Dakota	82	0.3	9	0.3

SOURCE: Veterans Administration, May 1983.

The state of Florida can be singled out as having the greatest expected increase in its total veteran population. By 1990, its veteran population will be 152,000 greater than in 1980; its over-64 veterans will have increased by 303,000--more than 130 percent--and will constitute a higher percentage of Florida's veteran population than in 1980. In contrast, while New York's over-64 veteran population will almost double by 1990, it will constitute a smaller proportion of the national population in that category than it did in 1980 (see Table B-4).

Although the size of the veteran population is relatively small in some states--including Alaska, Vermont, Wyoming, North Dakota, and South Dakota, for example--the number age 65 and over will more than double over the next ten years. This may imply that some additional VA resources will be needed in these areas before 1990, although the amount will be relatively small.

TABLE B-4. 1990 PROJECTIONS OF THE VETERAN POPULATION IN THE UNITED STATES AND PUERTO RICO AND SELECTED STATES

	All Veterans				Veterans 65 and Over			
		Percent of	Change Since 1980			Percent of	Change Since 1980	
	Thousands	Total	Thousands	Percent	Thousands	Total	Thousands	Percent
United States Total	**27,064**	**100.0**	**-1,576**	**-5.5**	**7,155**	**100.0**	**4,119**	**135.7**
California	2,791	10.3	-306	-9.9	735	10.3	400	119.4
New York	1,704	6.3	-344	-16.8	493	6.9	242	96.4
Texas	1,742	6.4	+26	1.5	416	5.8	244	141.9
Florida	1,504	5.5	+152	11.2	535	7.5	303	130.6
Pennsylvania	1,487	5.5	-131	-8.1	433	6.1	261	151.7
Ohio	1,288	4.7	-118	-8.4	334	4.7	204	156.9
Illinois	1,214	4.5	-177	-12.7	320	4.5	178	125.4
Michigan	1,042	3.9	-92	-8.1	253	3.5	160	172.0
Alaska	43	0.2	-12	-21.8	5	0.07	3	150.0
Vermont	64	0.2	+1	1.6	15	0.21	8	114.3
North Dakota	64	0.2	-8	-11.1	14	0.20	7	100.0
Wyoming	68	0.3	+3	4.6	12	0.17	7	140.0
South Dakota	76	0.3	-6	-7.3	19	0.27	10	111.1

SOURCE: Veterans Administration.

APPENDIX C. USE OF VA HEALTH CARE BY SERVICE-DISABLED VETERANS

This appendix presents estimates of the future demand for institutional health care provided through the Veterans Administration to service-disabled veterans. These veterans are given first priority in the VA health care system.

HOSPITAL AND NURSING HOME USE IN 1990

The demand for hospital care for service-disabled veterans will increase by 1990, assuming current trends in the provision of care continue, as the veteran population ages. If hospital use rates remain the same among service-disabled patients within the age groups under 65 and 65 or older, then a 2.5 percent increase in hospital use by service-disabled patients can be expected--about 8,000 more than in 1982 (see Table C-1). However, use rates among this group steadily increased in the 1977-1982 period; if the same trend continues, a 50 percent increase in service-disabled patients can be expected, as shown in the totals of Table C-1. This change would be due primarily to increasing numbers of service-disabled veterans age 65 and older.

Since service-disabled veterans receive more VA hospital care for non-service-connected than for service-connected conditions, it is apparent that most care provided by the VA would not be service-related after 1990. Assuming average use rates by category of treatment, and average lengths of stay in VA hospitals, demand for treatment of service-connected conditions by service-disabled veterans 65 and over will double by 1990, while demand by veterans under 65 will decrease by more than 40 percent. If current trends continue, the service-disabled will need between 35 and 45 percent of VA hospital beds in 1990, on average--up from about 30 percent in 1982.

Nursing home care provided to the service-disabled after 1990 will also increase as that group ages. If current trends continue, service-disabled veterans will represent about 45 percent of VA-supported patients in nursing homes in 1990, rather than 35 percent as now.

TABLE C-1. VA HOSPITAL DISCHARGES OF VETERANS WITH SERVICE-CONNECTED DISABILITIES, BY TREATMENT TYPE AND AGE GROUP, 1982 AND 1990 (In thousands)

Treatment Type and Age Group	1982 Discharges	Projected 1990 Discharges: Based on 1980-1982 Average	Projected 1990 Discharges: Based on 1977-1982 Trend
Service-Connected Conditions			
Under age 65	85.7	41.3	49.2
65 and over	16.9	46.0	50.9
Non-Service-Connected Conditions			
Under age 65	143.4	64.5	117.3
65 and over	64.0	166.0	240.5
Total	310.1	317.8	457.9

SOURCE: Veterans Administration data and CBO estimates.

NOTE: These data include approximately 20,000 patients with 0-percent disability ratings in 1982 and therefore are not strictly compatible with other discharge data used in the text.

Unless there is another war, the service-disabled population will decline steadily after 1990, and by 2000 relatively few VA patients under age 65 with service-connected conditions will require VA hospital or nursing home care.

CURRENT APPLICATIONS FOR CARE

The application rate for veterans with service-connected disabilities is much higher than that for non-service-disabled veterans--about six times

greater in 1982. Approximately 940,120 service-disabled veterans applied for VA medical care in 1982, a rate of 41.3 percent, compared to 7.0 percent for other veterans. 1/ That the service-disabled would apply more readily for VA benefits comes as no surprise, since they have first priority. VA hospitals also have traditionally specialized in procedures for treating combat-related medical problems.

Application pressure varies among medical districts. For all veterans, applications per bed now average about 34 per year. In 1982, the rate ranged from 16.7 in Medical District 4 (New Jersey and Pennsylvania) to 65.2 in District 25 (Texas, Arizona, and New Mexico). For veterans with service-connected disabilities, applications averaged 12 per bed and ranged from 4.0 in District 15 (counties in Indiana and Illinois) to 32.4 in District 25. (See Table C-2 for the rates computed through July 1982).

The variation in the number of applications per bed reflects mainly the number of beds available. In districts of similar population size, application pressure varies almost inversely with the number of beds. For example, in districts with 90,000 to 95,000 veterans, the number of applications per bed ranged from 30 to 54 during 1982 (through July), and corresponding hospital beds from 3,020 to 1,720. Without taking account of possible differences in case mix, beds appear to be inappropriately distributed.

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1. These data are also supported by the 1979 National Survey of Veterans data. In response to questions about use of VA hospital and outpatient services, participation rates for veterans with service-connected disabilities were 33 and 36 percent for hospital and outpatient care, respectively, whereas rates for those with nonservice-connected disabilities were almost 10 and 7 percent, respectively.

TABLE C-2. APPLICATIONS FOR VA CARE BY MEDICAL DISTRICTS, FISCAL YEAR 1982 (THROUGH JULY)

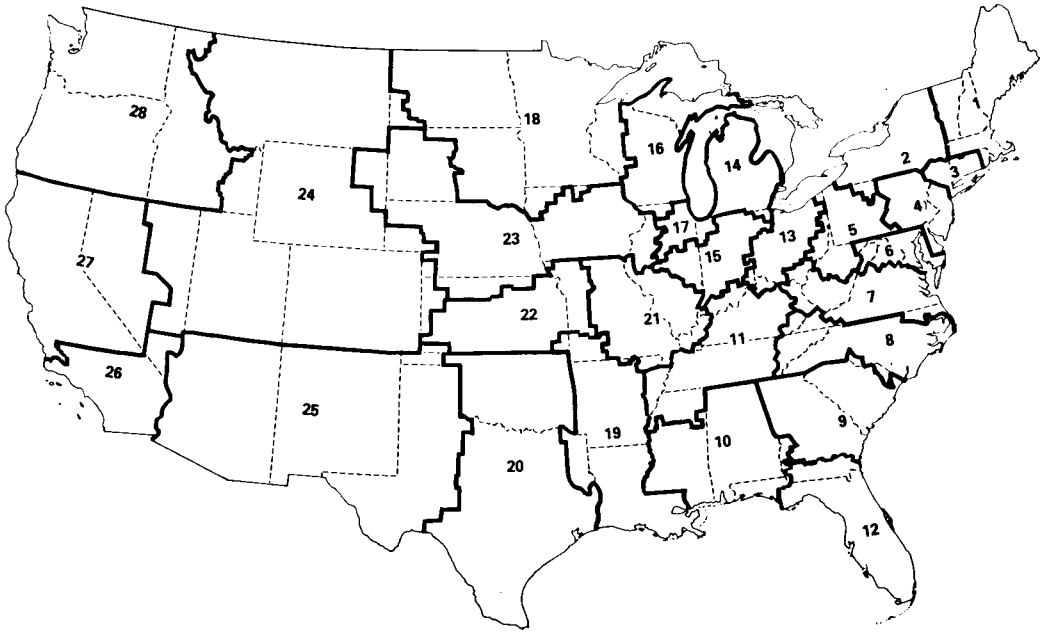
Medical District a/	Applications (thousands)		Hospital Beds	Applications per Bed	
	Total	Service-Connected Disabilities		Total	Service-Connected Disabilities
Total	**2,262**	**767.3**	**80,129**	**28.2**	**9.6**
1	68	27.1	4,355	15.6	6.2
2	62	23.2	3,040	20.5	7.6
3	235	92.8	6,278	37.4	14.8
4	70	25.5	5,057	13.9	5.0
5	31	12.4	2,158	14.3	5.7
6	56	11.1	2,440	23.0	4.6
7	57	20.8	2,184	26.2	9.5
8	65	22.2	2,602	25.0	8.5
9	90	20.5	2,497	36.0	8.2
10	74	27.0	3,216	23.0	8.4
11	81	23.4	3,128	25.8	7.5
12	129	59.4	2,833	45.5	21.0
13	91	29.0	3,025	30.0	9.6
14	49	17.3	1,872	26.1	9.2
15	34	7.3	2,241	15.3	3.3
16	35	9.0	2,046	17.1	4.4
17	97	15.8	3,293	29.3	4.8
18	40	12.2	2,031	19.5	6.0
19	95	27.3	2,664	35.8	10.2
20	182	64.6	5,108	35.6	12.6
21	56	18.9	1,547	36.0	12.2
22	40	9.5	1,790	22.2	5.3
23	52	13.7	2,318	22.3	5.9
24	55	20.6	1,873	29.3	11.0
25	93	46.4	1,719	54.3	27.0
26	146	45.1	3,939	37.0	11.4
27	111	42.3	2,557	43.4	16.5
28	68	23.1	2,316	29.2	10.0

SOURCE: Veterans Administration, Summary of Medical Programs (July 1982).

a. Medical districts are designated planning and reporting areas for the Veterans Administration. Each district contains several medical centers within counties of one or more states (usually adjacent states). See Figure C.

Figure C.

Veterans Administration Medical Districts



APPENDIX D. METHODOLOGY FOR DETERMINING THE DEMAND FOR VA HEALTH CARE IN 1990

The demand for VA health care in 1990 will reflect the current trend in use of VA care by the veteran population, most of whom use private or non-VA medical services. The methodology used here is based on empirical analyses of the past demand for medical care, which show that demand for and use of medical services increase significantly with age. 1/

THE DEMAND FOR HOSPITAL CARE

The probable demand for VA hospital care in future years was based on projections of the number of patients using VA hospitals in those years. These were derived by multiplying age-specific projections of the veteran population by estimated use rates for future years. Then an average daily census was calculated. The methodology is summarized below for the 1990 projection.

1. Current hospital discharge rates were computed for specific five-year and ten-year age groups for each year 1980, 1981, and 1982. The average discharge rates per year for each age group were derived.

   (Rates = Discharges / Population)

2. Two sets of average-length-of-stay (ALOS) values were computed: first, the average over the years 1980-1982; and second, the trend in ALOS since 1977 projected to 1990, adjusted to exclude reductions of more than 30 percent below the average 1980-1982 levels. ALOS values were days of stay per hospital admission.

3. Using the rates derived in step 1 above and VA veteran-population projections, 1990 discharges were projected for each age group.

   (1990 Discharges = Rates x Projected Population)

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1. See, for example, a survey of models in William J. Scanlon, "Nursing Home Utilization Patterns: Implications for Policy," Journal of Health Politics, Policy, and Law (Winter 1980), pp. 619-41 and Veterans Administration, VA/GAO Bed Requirements Projection Model, Summary of Current Computer Programs, draft report (October 1982).

4. The 1990 hospital daily census was calculated by multiplying the 1990 discharges by the expected number of days of stay and then dividing by the number of days in a year.

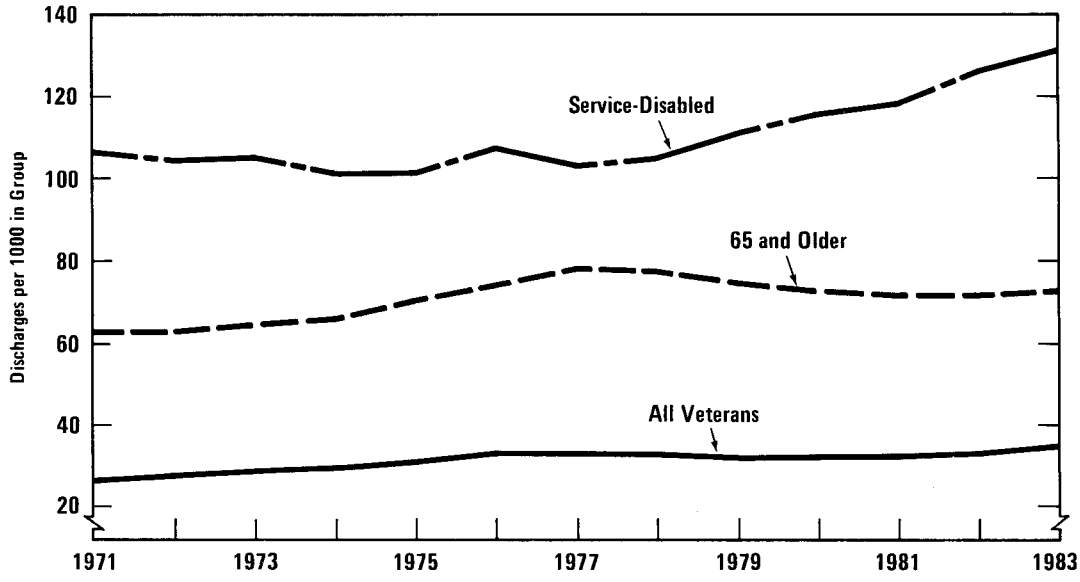
   (Census = 1990 Discharges x ALOS / 365)

Two sets of estimates were derived, based on different ALOS, in order to show the range in probable demand for VA hospital care.

One assumption in the methodology is that use will not change significantly between now and 1990, particularly not for veterans of similar ages. While overall VA hospital discharge rates have been slowly increasing in recent years, they have not changed significantly over the last several years, although rates among veterans over 64 have been declining. Figure D and Table D-1 show the trend in use rates per 1,000 veterans by category over the 1971 to 1982 period.

Figure D.

VA Hospital Use, by Veteran Group, 1971-1983



SOURCE: Veterans Administration.

TABLE D-1. VA-HOSPITAL DISCHARGE RATES FOR SELECTED FISCAL YEARS, 1971-1983

Year	Discharges per Thousand Population		
	Total Veterans	Veterans Over 64	Service-Disabled Veterans
1971	26.82	62.49	106.84
1973	29.12	64.39	105.08
1975	31.41	70.24	101.84
1977	33.25	77.91	103.63
1979	32.43	74.65	111.07
1980	32.60	72.89	115.85
1981	33.04	71.58	118.16
1982	33.61	71.55	126.09
1983	35.25	72.72	131.61

SOURCE: Congressional Budget Office calculations based on unpublished Veterans Administration data (with provisional population estimates for years prior to 1977 as of March 1984); and Veterans Administration, Trend Data 1956-1980 (February 1981).

Use rates differ, however, among age groups and by patient type. About 80 percent of discharged VA hospital patients are classified as medical or sugical patients, and the rest are classified as psychiatric patients. Table D-2 shows average discharge rates in 1980-1983 for different types of patients. Percentage differences between the 1982 rates and the 1980-1982 averages are shown in parentheses--a negative value implies declining use among veterans in the specific age group. Although fluctuations in use have occurred for some age groups over the last three years, the average rates can be used to project the number of veteran patient discharges in 1990 by age group. This follows because projecting a constant rate of growth in use rates implies near-average 1980-1982 rates through 1990.

The daily demand for care by veterans was determined next, based on the projected average lengths of stay (ALOS) in VA hospitals in 1990. The 1980-82 ALOS are shown in Table D-2. These values were used to determine the average daily census for medical and surgical patients in 1990. Two sets

TABLE D-2. AVERAGE 1980-1982 VA HOSPITAL DISCHARGE RATES AMONG VETERANS OF SELECTED AGE GROUPS, BY TYPE OF PATIENT

Age Group	Type of Patient a/					
	Medical and Surgical		Psychotic		Other Psychiatric	
Under 25	12.96	(-2.5) b/	6.06	(-9.4)	5.29	(-1.3)
25-34	10.06	(3.1)	5.06	(5.0)	6.57	(9.7)
35-44	8.51	(1.4)	2.45	(8.3)	4.40	(5.5)
45-54	17.69	(-2.1)	1.94	(1.7)	4.40	(-8.1)
55-64	38.19	(0.0)	1.94	(3.5)	4.13	(-9.7)
65-74	59.30	(0.7)	1.85	(4.9)	3.01	(-13.5)
75-84	68.05	(0.5)	2.24	(15.8)	2.34	(-16.7)
85 and older	130.43	(-2.9)	4.91	(9.8)	5.03	(-14.3)
Total	**25.53**	**(2.8)**	**2.72**	**(2.2)**	**4.57**	**(-3.0)**

SOURCE: Veterans Administration data.

a. Type is determined by the primary hospital treatment received by patients prior to discharge.

b. Values in parentheses show the percentage differences between 1982 rates and the average 1980-1982 rates.

of ALOS were projected (Table D-3), one based on average lengths of stay of VA medical and surgical patients in 1980-1982, the other based on the downward trend observed in ALOS in 1977-1982. 2/ The latter implies an

2. For discussions on reduced lengths of stay among VA hospital patients, see Congressional Budget Office, Projected Acute-Care Bed Needs of

TABLE D-3. PROJECTED LENGTHS OF STAY OF MEDICAL AND SURGICAL PATIENTS IN 1990 IN VA HOSPITALS

Age Group	Average 1980-1982	Percent Reduction Based on 1977-1982 Trend
Under 20	18.47	0
20-24	11.17	0
25-29	10.83	20
30-34	12.20	26
35-39	13.60	45
40-44	16.50	11
45-49	16.97	31
50-54	18.80	28
55-59	19.57	13
60-64	19.50	33
65-69	21.60	32
70-74	24.17	34
75-79	27.50	39
80-84	30.63	44
85 and over	33.13	57
Total	20.13	24

SOURCE: Congressional Budget Office calculations based on Veterans Administration data.

overall 24 percent reduction in ALOS by 1990. The ALOS reduction for any specific age group was not allowed to exceed 30 percent, since in practice any greater reduction would be difficult if not impossible to obtain. For example, lengths of stay could not be expected to be less than those currently experienced in private short-stay hospitals.

The ALOS values for psychotic and psychiatric patients were derived in the same way. Then the ALOS were multiplied by discharges to give average patient days per year, which in turn provided the projected average daily census.

NURSING HOME CARE

The demand for nursing home care in future years can be estimated in a manner similar to that used for hospital care. Since average length of stay in nursing homes is longer than in hospitals--typically a year--the future demand was projected from the average current census. 3/

By examining the age-specific census over the 1980 to 1982 period and dividing this by the population estimates in each of those years, then computing the average over these ratios, average use rates for nursing home care were obtained. These rates were multiplied by the projected 1990 (1995, 2000) population levels for different age groups to yield the probable 1990 (1995, 2000) census. Table D-4 shows the result of this algorithm: approximately 34,200 patients would be supported on an average daily basis in 1990, representing a 40 percent increase over current demand. Also shown in Table D-4 is the result of assuming that the trend established since 1977 will continue into the future, yielding approximately 30,000 patients daily in VA-supported nursing home care--a 23 percent increase in demand. The trend projection may have a downward bias if it reflects a past shortage

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2. (Continued)
Veterans Administration Hospitals, staff working paper (April 1977) and, "Veterans Administration Health Care: Planning for 1990," interim report (February 1983).

3. Nationally, the demand for nursing home care has been on the rise. Between 1969 and 1977, among the civilian population, an increase in the amount of nursing home use has been observed. This result is based on data extrapolated from the 1969, 1973-1974, and 1977 National Nursing Home Surveys. See, for example, a selection of use patterns in Veterans Administration, Nursing Home Care Needs of Veterans in 1990, A Quantitative and Social Assessment (July 1982).

TABLE D-4. PROJECTED NURSING HOME CARE IN 1990: USE RATES AND CENSUS

Age Group	Average 1980-1982 Use Rates	1990 Census	Trend Use Rates	1990 Census
Under 35	.041	119	.084	242
35-54	.182	1,927	.181	1,920
55-64	.868	5,573	1.226	7,875
65-74	2.500	14,055	2.217	12,462
75-84	6.637	8,801	2.118	2,808
85 or older	17.982	3,740	22.518	4,684
Total		**34,215**		**29,990**

SOURCE: Congressional Budget Office.

of VA-operated beds, and therefore this was not considered the best approach for the long-range estimates.

CONCLUSION

The methodology described here seems appropriate for many reasons. Studies of the demand for nursing home care in the private sector have almost universally included age distribution, particularly of the elderly population, among the determinants of the overall demand for care. 4/

4. See, for example, a survey of previous studies in William Scanlon, "Nursing Home Utilization Patterns: Implications for Policy," Journal of Health Politics, Policy, and Law (Winter 1980) vol. 4, pp. 619-41, and William J. Scanlon, "A Theory of the Nursing Home Market," Inquiry 17 (Spring 1980), pp. 25-41.

Moreover, among the factors assumed to affect demand, only the size and age distribution of the veteran population is expected to change dramatically by 1990. The bed supply--which is determined administratively--was assumed to accommodate the demand.

A weakness in this approach is that environmental factors that determine the proportion of veterans who prefer VA care could change. For example, the cost of care to veterans served outside the VA system could increase significantly, causing them to want more VA care. For this reason it is necessary to examine the influence of all variables, including age, that could have an effect on the demand for VA care in 1990 and beyond. That topic is the subject of Appendix E.

APPENDIX E. REGRESSION MODELS OF DEMAND FOR VA CARE

This appendix describes the regression models that were used to examine the effects of social and economic factors on the probable demand for VA-supported nursing home care (NHC) by veterans 65 and over.

OVERVIEW

Few recent studies have actually dealt with the demand for VA hospital or nursing home care. Those that did have tested individual motivations for VA use, such as the extent of coverage by public or private insurance for medical care costs and the veteran's preference for community hospital or private nursing home care. 1/ These studies have not, however, been able to explain aggregate demand for VA health care.

The results of this analysis show that a few variables associated theoretically with the demand for care can help to explain the aggregate use of NHC by veterans 65 and over. Consistently included among the significant variables is the percentage of the veterans 65 and over who are over age 84. This result indicates that NHC is sensitive to, and increases with, the size of the very old veteran population, which has been shown to have the highest use rate among veterans. Also, the number of nursing home beds operated by the VA in a state or jurisdiction per veteran 65 and over was shown to affect positively NHC use among those veterans, although not as greatly as the total level of non-VA NHC beds in an area. Such findings often imply that available beds act as an inducement to requests for NHC. Eligibility variables such as the percentages of VA pensioners and service-disabled veterans in the population were not consistently observed to affect demand among veterans 65 and over.

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1. See, for example, Veterans Administration, Nursing Home Care Needs of Veterans in 1990: A Quantitative and Social Assessment (July 1982) and William Frank Page, "Why Veterans Choose Veterans Administration Hospitalization: A Multivariate Model," Medical Care, vol. 20 (March 1982).

METHODOLOGY

The model discussed below attempts to measure the relative impact of demographic and social characteristics, income, health, eligibility, and other access factors on nursing home care demand. The demand for care is represented in the regressions by a use variable: the proportion of veterans 65 and over receiving VA-supported nursing home care. 2/ This variable is the dependent variable in all the regressions presented below.

Unlike the nursing home market in the private sector, the VA-supported NHC system does not require substantial payments by the recipients of care. In VA-operated nursing homes, no charges are made to patients; those already receiving VA pensions for non-service-connected disabilities may, however, receive a reduced pension while being treated in a VA facility if they stay more than three months. For a limited period only--six months or less depending on the veteran's needs--community nursing homes under VA auspices are free to the veteran without service-connected conditions. Care subsidized by the VA in state veterans' homes may result in some costs (a small portion of total costs) to the veteran in some states.

Since most VA-supported care carries little or no cost to veterans compared to those they would incur in non-VA homes as private paying patients, no price equation was estimated for this analysis. Instead, a cost-differential variable was included in the demand equations to test for high NHC use in areas where private costs were high relative to family income.

The regression equations take linear forms where:

Demand = f (Demographic and Social Variables, Eligibility, Income, Health Status, Alternatives to VA Care, Availability of Beds)

All the models tested were cross-sectional, with the unit of observation being veterans residing in the state. 3/ The broad categories of

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2. Although there is a waiting list for nursing home care in VA-operated facilities, many of those on the list are already being served in non-VA facilities under VA auspices and would, therefore, be included in the overall nursing home census used here.

3. Adjustments were made to the nursing home census data for each year to prevent the dependent variable from reflecting temporary migrations to a state only for nursing home care.

explanatory variables are described in detail in Table E-1. They include the percentage of veterans 65 and older who are over age 84, the percentage with means-tested VA pensions--a proxy for the proportion of local veterans who are poor or near poor--and a morbidity or illness rating for all persons in the state age 65 and over.

Several adjustments were made to the theoretical variables in order to work with either the most appropriate or the best available data. For example, the civilian population and veteran race variables were measured for each state in a single year--typically 1980, the year of the last census, which provides the most accurate information. The morbidity variable was available only for 1976. In addition, for lack of a complete set of data, Alaska, Hawaii, and Puerto Rico were excluded from the analysis, although the District of Columbia was included. Models for separate years, 1978 and 1982, were examined and it was determined that the regression coefficients remain stable across years. Thus, pooled data were used to provide a greater degree of precision in the coefficient estimates.

REGRESSION RESULTS

The analysis indicates that a few independent factors can help predict the probable demand for VA-supported nursing home care. The significant results are described below and in Table E-2.

Age Variables

The results indicate that age plays an important role in determining nursing home care. Two age variables were entered into the regressions: the percentage of veterans age 65 and older who are over age 84; and the percentage of the state population who are over 64.

The percentage of veterans age 65 and older who are over age 84 was found to be significant, with a positive coefficient, in all regressions. The result is not surprising, since national data indicate that veterans with the highest NHC use rate are among this group. Specifically, a 10 percent increase in the proportion of aged in this group would imply a 7 percent increase in the demand for NHC.

The second age variable--for the civilian population--was used to represent offsetting effects of the supply of non-VA NHC beds and could be excluded from equations lacking the non-VA bed variable. When included, the percentage of civilians age 65 and older entered the regressions with a

TABLE E-1. EXPLANATORY VARIABLES INCLUDED IN THE CROSS-SECTIONAL MODELS

Variable	Description
P85	Percentage of veterans age 65 and over who are age 85 or older
NWHITE	Percentage of veterans age 65 and over who are nonwhite
MSTAT	Percentage of veterans who are married and living with their spouses
PSC	Percentage of veterans age 65 and over with service-connected disabilities
PPEN	Percentage of veterans age 65 and over receiving VA pensions
CIVAGED	Percentage of civilian population age 65 or older
MORB	The ratio of average days of bed disability among persons age 65 or over in the state to the national average days of bed disability for persons 65 or older
NCOST	One minus the ratio of per diem cost of community nursing home care to the daily median family income
ALTB	Number of personal care home (non-VA and not with skilled or intermediate nursing care) beds and non-VA domiciliary beds per veteran age 65 or over
NVABEDS	Number of non-VA nursing home (skilled and intermediate care) beds per veteran age 65 or over
VABEDS	Number of VA nursing home beds per veteran age 65 or over
PSYB	Number of VA psychiatric hospital beds per veteran age 65 or over
UBEDS	Percentage of beds in VA nursing homes that are unfilled
MEDIC	Dummy variable = 1 for states with ICF coverage for the medically needy under Medicaid
NOBED	Dummy variable = 1 for a state having no VA-operated nursing beds

TABLE E-2. RESULTS OF REGRESSIONS ON VA-SUPPORTED NURSING HOME USE

Variable a/	Mean	All Variables Included		Bed-Level Variables Omitted	
		Coefficient b/	Elasticity	Coefficient b/	Elasticity
P85	.073	.059*	.740	.057*	.716
NWHITE	.077	.001	.012	.001	.012
MSTAT	.715	.0005	.059	.002	.255
PSC	.124	.0003	.006	.005	.108
PPEN	.156	.002	.047	.015*	.395
CIVAGED	.118	.032	.646		
MORB	1.016	-.0001	-.019	-.006*	-.998
NCOST	.302	-.002	-.086	.001	.028
ALTB	.084	.003	.050		
NBEDS					
NVABEDS	.434	.009*	.645		
VABEDS	.003	.587*	.303		
PSYB	.009	-.118*	-.182		
UBEDS	.062	-.0002	-.002		
MEDIC	.490	-.0007	-.060	-.0006	-.052
NOBED	.112	.002*	.044		
Constant		-.007		.003	
R^2		.415		.260	
Standard Error		.003		.003	
F value		3.872		3.904	
Degrees of Freedom		(15,82)		(8,89)	
Dependent Variable = VA-supported nursing-home-care census per aged veteran.					
mean =	.0058				

a. The combined two-year observations (1978, 1982) of variables were used in these regressions. Table E-1 contains descriptions of these variables.

b. Significance at the 0.10 level is indicated with asterisks beside the coefficient of the variable.

positive coefficient, although it was not always significant. This result may imply a somewhat greater reliance on VA resources in areas where the civilian population age 65 and over is large.

Medicaid Coverage Variable

A variable to measure Medicaid coverage was included in the analysis mainly to determine if a major non-VA policy, such as broad Medicaid coverage, could affect requests for VA care. This test is important, since more than half of care in nursing homes is assisted through the Medicaid program so that significant cutbacks in coverage could presumably increase dependence on the VA.

The specification is a dummy variable indicating whether the state provides coverage to the medically needy and allows intermediate care facility services (ICF) benefits--an option under state Medicaid programs. (All state programs had ICF coverage in 1982, however.) This variable is consistently negative, but insignificant, in all the regressions. Consequently, while Medicaid coverage in a state may lower the demand for VA-supported nursing home care, its effect is not sufficiently strong to be captured here.

Availability of NHC Beds

The availability of VA and non-VA nursing home beds both have positive effects on the VA-supported nursing home census. In other words, a large supply of beds in an area produces a higher likelihood of veterans being in nursing homes. The unfilled VA-bed variable is not significant in the regressions, however, indicating that the readiness of a VA-operated bed is not a determining factor for the extent of VA-supported care. Moreover, the absence of VA nursing homes in a state was shown to have a positive and significant effect on VA-supported care--an effect implying that VA-supported care is either readily available or not greatly needed in areas without a VA-operated NHC facility.

The bed-level variable for non-VA nursing homes turned out to be the most significant variable in the regressions. It had the highest simple correlation with the dependent variable and entered all regressions with a significant positive coefficient. This variable generally represents the past response to accumulated demand for NHC in a state. The 0.64 elasticity shows that a 10 percent increase in non-VA NHC beds per veteran age 65 or over is related to a 6 percent increase in the proportion of such veterans requesting NHC. According to the results, this impact would be twice that expected from a 10 percent increase in VA NHC beds in a state.

The number of psychiatric beds per elderly veteran is significant in the regressions, with a negative coefficient. This result comes as no surprise since the decline in VA psychiatric hospital beds has often been attributed to increased alternatives to long-term hospital care, namely nursing home care.

A comparison of regressions with and without the bed-level variables indicates the importance of these variables in explaining the cross-sectional variance in nursing home use. Almost half of the explained variance is due to variables representing available beds. The reader should note that these variables are not essentially supply-side variables in the true market sense, however, because no consumer price is associated with the VA-supported bed supply.

Other Variables

Although the positive or negative signs of most coefficients in the regression appear to be theoretically correct, a few significant exceptions appear in the regressions. For example, the negative sign on the morbidity coefficient implies that having more sickly persons over 64 in a state is associated with a lower VA-supported census. The opposite effect would be expected. Having more sickly over-64 patients in a state may result in greater utilization of hospitals rather than nursing homes, however, which could not be tested here. In addition, some regional effects may be masked by the morbidity variable, since a high number of days of disability is frequently observed in the southern states, where there are also fewer NHC beds per veteran. In other regressions, a dummy variable set to one for states in the south region was substituted for the morbidity variable; the results were as expected--a significant negative coefficient and little change in the other variable coefficients.

The service-connected and pension variables are probably among the more important variables not shown to be significant in many of the regressions. 4/ This result probably denotes their lesser importance than the age factor among veterans 65 and over eligible for VA care. The pension variable sometimes entered regressions with a significant positive coefficient, however. This suggests that an increase in the number of low-income veterans over 64 might result in a small increase in NHC use.

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4. See William Page, "Why Veterans Choose Veterans Administration Hospitalization," for an estimate of the impact of these variables on VA hospital utilization.