9. Ethics Consultation on Certain Questions of Enrollment

Introduction

Recent Federal legislation, Public Law (P.L.) 104-262, the "Veterans Health Care Eligibility Reform Act of 1996," authorized a major revision of eligibility criteria that govern access to health care provided by the Veterans Health Administration (VHA). For the first time, all veterans receiving care in VHA will have equal eligibility for all health care services offered in a universal benefits package, whether these services are provided on an inpatient or outpatient basis. This change should foster more effective and efficient provision of services in the most appropriate care setting.

Another change mandated by P.L. 104-262 is that VHA must establish and operate a system of annual patient enrollment. The law gives an enrollment priority that closely follows, but does not replicate, current eligibility criteria. The law defines six priorities of eligible veterans who, if they seek care, shall be enrolled. In this report, these individuals are described as "mandatory" patients and applicants. The law defines a seventh priority of eligible veterans who, if they seek care, may be enrolled. They are described as "optional" patients and applicants. Beginning October 1, 1998, VHA will be permitted to provide care only to enrolled patients (with certain exceptions provided in the law; see Appendix A for pertinent points of current enrollment legislation).

In view of the significant changes brought about by P.L. 104-262, and of the future possibility that demand for VHA health care might exceed available resources to responsibly provide care, the VHA Bioethics Committee was charged with addressing the following ethical issues and questions related to enrollment:

1. Establish a model for ethical decision making about enrollment that is principle based.
2. Utilize this model to provide an ethical framework for making decisions regarding additional prioritization of veterans for enrollment within the priorities, and for possible disenrollment of already enrolled groups or individuals.
3. Is there an ethical obligation to maintain uniformity of enrollment and disenrollment prioritization criteria across the system?
4. What is the VHA obligation to the veterans who are difficult to reach for purposes of enrollment, e.g., the chronically mentally ill, the homeless? How far is VHA ethically obliged to go to locate these individuals, provide information about enrollment, and actually offer them a convenient mechanism for enrollment separate from mechanisms for all other groups?

In implementing enrollment, it is anticipated that conflicts between claims of some veterans for access to care and responsibilities of VHA to enrolled patients will arise. As a response to the charge, the committee presents a discussion that considers: a) moral values implicit in the law; b) who has legitimate access to VHA health care; c) what responsibilities VHA has to patients; and d) whether VHA may choose not to enroll some eligible veterans who seek care. The committee proposes a balance of claims and responsibilities that addresses these issues and that can guide VHA in complying with the legally required enrollment priorities in an ethical manner.

Response to the Charge

1. Establish a model for ethical decision making about enrollment that is principle based.

A "model" of decision-making based on principles is a presentation that: a) introduces the ethical values put into play by an action; b) identifies conflicts; c) justifies a hierarchy of values; d) poses discussions of the conflicts; and e) advises an ethically defensible course of action. The model developed in this report identifies principles and values of enrollment, and it clarifies ethical conflicts anticipated in the practice of enrollment. The model then stipulates a ranking of values that helps address the conflicts, followed by discussion and recommendations.

VHA faces a possible problem of having to deny enrollment to some eligible veterans who seek care. The two most general variables put into conflict in this problem are "individuals' access to care" and "responsibilities of providing care to enrolled patients." On the one hand, these variables converge in the mission to grant access to as many eligible veterans who seek care as for whom VHA can responsibly provide it. On the other hand, they possibly conflict in the realization that more eligible veterans might seek care than VHA can responsibly serve. *The committee stipulates that enrolled patients deserve responsible care.* Therefore, in a conflict between the values that justify providing access to eligible individuals and the values of providing care responsibly to enrolled patients, the committee thinks that latter values take precedence, and preserving them warrants denying access to some eligible individuals.

To outline such decision-making, the committee presents three guiding principles, two sets of values, and several criteria for attempting to resolve conflicts between the values.

- First, general ethical principles of justice, equality, and fairness express priorities that should be respected in considering individuals for enrollment and in responsibly providing care to all enrolled patients. These principles are the building blocks of subsequent values.

- Second, values that support enrolling individuals include loyalty, obedience to law, service-connection, and rescue. These values point toward, but do not finalize, who should be enrolled. They are mute on who should be denied enrollment.
- Third, values that indicate responsible provision of care include contract, continuity of care, security, beneficence, quality, fiscal integrity, equity, stewardship, and efficiency. They convey the contents of responsible care to enrolled patients.
- Fourth, some criteria for attempting to resolve conflicts between the values of granting access and the values of providing responsible care include need, non-abandonment, right, entitlement, merit, ability to pay, lottery, and first come/first served. These criteria are defined and briefly discussed in Appendix B.

Discussion

Moral "values" express prospects of action that are thought to be right, good, or desirable, e.g., that individuals should have access to health care or that providers should have responsibilities to patients. "Principles" express reasons for supporting some values, e.g., that access to health care is a matter of "justice" or that responsibilities to patients are matters of "fairness." "Ethical issues" arise when a course of action, such as enrollment, signals a possible conflict of values. An "ethical" response to issues consists in relating, ranking, and deciding between the pertinent values in order to make a coherent and plausible recommendation for bridging the conflict. In this report, the committee presents a model of ethical reasoning that concludes that eligible veterans who seek care should be enrolled and re-enrolled, unless at some point these actions threaten VHA's responsibilities to some other already enrolled patients.

In this context, "denial of enrollment" can encompass any of the following kinds of actions (not all of which are ethically justifiable): a) disenrollment of enrolled patients during an enrollment period; b) refusal of re-enrollment to enrolled patients at the time of annual enrollment; or c) refusal of enrollment to new applicants at the time of annual enrollment.

General Ethical Principles

Justice

Individual veterans are unique persons with differing claims to receive health care from VHA. In planning enrollment, VHA must rank individuals' claims, as well as its responsibilities in meeting them. Justice is the principle that most generally legitimates these rankings. Justice expresses the values that eligible veterans are ethically due to receive health care from VHA, and that VHA is ethically obligated to provide care responsibly. Distributive justice suggests criteria for limiting access if, and only if, all patients deserving of care cannot be responsibly cared for (see Appendix B).

Equality

Respect for justice yields another general ethical principle, equality. The ethical principle of equality expresses a value of access, that all eligible veterans who seek care should receive consideration. It also expresses values of providing care responsibly, i.e., all enrolled patients have access to a similar level and quality of care and that similar kinds of applicants be universally enrolled or universally not enrolled.

Fairness

Respect for equality yields a third general ethical principle, fairness. The ethical principle of fairness expresses the value that veterans' different claims, and VHA's several responsibilities, be consistently, not capriciously, considered. Regarding access, fairness is reflected in the distinction between optional and mandatory enrollees and in the higher ranking of mandatory patients. Regarding responsibilities, those of equity, stewardship, and efficiency exemplify fairness.

Justice, equality, and fairness by themselves do not determine what care is due, to whom care is due, or how to consistently prioritize for care. Additional, more concrete ethical values are necessary to help make those assessments. Nonetheless, respect for justice, equality, and

fairness underlie VHA's attempt to achieve an ethical enrollment process, and also legitimate the more concrete values to which this report now turns.

Values Justifying Access to Care

Loyalty

Loyalty supports enrolling eligible veterans who seek care. Veterans expressed loyalty to the United States by serving in the Armed Forces and risking unique harms. In return, eligible veterans may receive defined health care. The value of loyalty is marked by veterans' beliefs that promises will be kept, by VHA's making good on the promise of care, and by the commonly held trust that VHA will put the needs and interests of patients first.

In this context, claims of loyalty might be controversial because some veterans believe that they are eligible for care in VHA based on promises made to them during their time in the Armed Forces. While VHA will be able to provide care only according to the new enrollment criteria, the system should acknowledge that some veterans who cannot qualify for a mandatory enrollment category nonetheless truly believe that they have been promised lifelong access to care in VHA.

Obedience to Law

Because VHA is a part of the Federal government and provides health care largely with appropriations from Congress, compliance with Federal law is a governing value of VHA. VHA must follow congressional mandates and may not ignore or deviate from them. The force of this value is that VHA must follow the directions of P.L. 104-262 in enrolling eligible veterans who seek care, and that VHA may create "subpriorities" of patients within the legislated enrollment priorities. The value of obedience voices that VHA is obligated to apply the law, not that the law is in all parts ethically justifiable. VHA should seek relief from Congress with appropriate documentation if it encounters legal requirements that elude ethical justification.

Service-Connected Need

The value of service-connected need reflects the acknowledgment that the injuries, illnesses or disabilities of some veterans are caused or aggravated by military service. This value conveys two priorities at the heart of VHA's historical mission, that eligible veterans with service-connected disabilities have stronger claims to receive care than those without service-connected disabilities, and that eligible veterans with greater service-connected disability have stronger claims than those with lesser degrees of disability. Finally, the credibility of this value depends upon consistent application of disability rating regulations, as well as periodic assessment of determinations.

Rescue

The value of rescue addresses VHA's historical commitments of providing emergency care to veterans, health care to poor veterans, and back-up emergency health services during times of war and disasters. In these several contexts, rescue expresses the priority of meeting the needs of especially vulnerable individuals and communities. P.L. 104-262 acknowledges the value of rescue in saying that VHA may provide care for non-enrolled eligible veterans who have "compelling medical need."

Values of Providing Responsible Care

Contract

Contract is a central guiding value of providing responsible care. P.L. 104-262 gives VHA instructions for developing an enrollment contract. Contract conveys a binding agreement between identified parties. Contracts offered should be fulfilled, and contracts that cannot be fulfilled should not be offered. Contract also signals VHA's "fiduciary responsibilities." American law views health care providers as fiduciaries of patients. In the fiduciary relationship, a party with particular needs, interests, preferences, and vulnerabilities (e.g., an enrolled veteran) contracts with a party with the competence, power, and willingness to provide particular goods and/or to protect from

particular harms (e.g., VHA). Health care fiduciaries accept responsibilities for matters such as professional competency, advocacy, respect, truthtelling, confidentiality, and putting patients' interests first. Additionally, respect for the value of contract necessitates that veterans who seek care be informed of the details of enrollment, including possibilities of denial and disenrollment, and that they consent to be enrolled.

Claims of contract as a value should be distinguished from the legal definition of contract, which necessitates a mutuality of obligation on the part of the contracted parties and a legal recourse available in the event of non-performance on the part of any party. For example, after being enrolled, a veteran may pursue legal action against VHA for non-provision of necessary care. VHA, however, has no legal recourse to force an enrolled veteran to keep medical appointments, take prescribed medications, or comply with any medical recommendations.

Security

The value of security directs that enrolled patients not be disenrolled; that patients seeking re-enrollment be accommodated; and that applicants who seek care not be denied enrollment without good reasons. Disenrollment, meaning denial of care to enrolled veterans during an enrollment period, cannot be ethically justified and should not be done. All denials of enrollment or re-enrollment should be scheduled to take effect only at the end of an enrollment period. Furthermore, the only ethical justification for these denials is that retaining or accepting some individuals prevents VHA from meeting its responsibilities to enrolled patients with stronger claims to care. VHA should counsel denied individuals about access to other health care providers and assist them in receiving it.

Continuity of Care

Continuity of care is a professional value that conveys that VHA should not break therapeutic relations with current patients. Disenrollment during an enrollment period violates both professional

standards and patients' best interests. Some denials of enrollment and re-enrollment risk the same.

Beneficence

The value of beneficence expresses the priority of doing good in providing health care. The general goods that health care professionals should provide include preserving patients' lives, protecting against new harms, providing palliative care (end-of-life and otherwise), and promoting individual and collective health and well-being. VHA's mission emphasizes the specific good of providing rehabilitative care for veterans. Beneficence suggests doing all these goods. If all cannot be done, then beneficence requires VHA to prioritize them in accordance with the organization's mission, patients' expectations, professional and legal requirements, and limited resources.

Quality

The value of quality directs that VHA provide care according to professional standards, patients' expectations, and legal requirements. Quality expresses the priority that VHA remain a reliable health care provider, one worthy of trust by patients and professionals.

Fiscal Integrity

Fiscal integrity expresses the value that VHA receive a sufficient budget and stay within it. Possible negative consequences of violating fiscal integrity include postponement or non-provision of necessary care for enrolled patients.

Equity

The value of equity directs that patients have access to the same services regardless of their location in the system, and that enrollment be uniformly enacted throughout the system. The committee presumes that the 22 Veterans Integrated Service Networks (VISNs) will play a central role in enrollment. Equity expresses the priority that eligible veterans not be unfairly privileged or penalized by differences between levels of care or between enrollment practices among the VISNs.

Stewardship

Stewardship directs that VHA's fixed dollars be allocated adequately throughout the system to meet each VISN's different needs for providing care. Operationalization of this value requires knowledge of numbers of enrolled patients, their geographic distribution, and their diagnoses and typical costs. From an ethical standpoint, the decision about services that will be offered in the universal benefits package is a decision about stewardship of resources, because the contents of the package will define VHA's clinical commitments to enrolled patients, and the extent of the package will influence VHA's ability to meet all of its responsibilities. Stewardship additionally directs that VHA's fixed dollars be spent on patient care, education, research, and employment, and other activities that support and enhance the delivery of care.

Efficiency

The value of efficiency directs that dollars be spent as prudently as possible throughout the system. Some commitments of mission and quality include costs that cannot be repeatedly reduced. Efficiency should be continuously sought. It can be meaningfully measured, as controllable and non-controllable costs are distinguished, and as inefficient laws, policies and practices, excess capacity, replication of services, waste, and futile care are reduced.

2. Utilize this model to provide an ethical framework for making decisions regarding subprioritization of veterans for enrollment within the priorities, and for possible disenrollment of already enrolled groups or individuals.

Priorities and Subpriorities

Assumptions

There are several key points that shape the committee's reply to this part of the charge.

- The committee realizes that enrollment is a temporal, dynamic, and evolving process that will not conform exactly to a model of ethical decision-making. For example, the eligibility priority in

P.L. 104-262 is ethically significant, and the committee utilizes it in replying to this part of the charge. But the committee considered that in actually enrolling patients throughout the system, VHA probably, and for very good reasons, will initially enroll many individuals on a first come/first served basis, rather than try to schedule enrollment according to the legal eligibility priority. The general point here is that while discussion of a model of ethical values might appear static, the committee realizes that operationalization of enrollment is a complex process that requires applied ethical decision-making, not automatic referral to ethical formulae. Thus, this report's recommendations are forwarded as enrollment guidelines and timelined targets, not as initial necessary conditions.

- An enrollment system must be established by October 1, 1998. The committee presumes that VHA will gain valuable experience as the system becomes operational and will apply what is learned in meeting future needs. Therefore, the report includes discussion of ethical issues of enrollment before and after October 1998.
- The committee distinguishes mandatory and optional "current patients," and mandatory and optional "new applicants." Current patients are defined as eligible veterans who have received care from VHA in the three years preceding the first enrollment deadline. After that deadline, current patients are defined as enrolled veterans. New applicants are defined as eligible veterans who have not received care in the past three years and seek care before the first enrollment deadline. After that deadline, new applicants are defined as eligible veterans who are not enrolled and seek care.
- In developing its recommendations, the committee could not reach consensus on one point: the ethical legitimacy of creating subpriorities in the legally mandatory enrollment Priorities 5 and 6, and possibly denying enrollment to some new applicants in these two priorities. The discussion of broad ethical concerns about enrollment that emerged in consideration of these matters appears in Appendix C of this report.

Recommendations

The committee makes seven unanimous recommendations:

1. No enrolled patients should be disenrolled during a defined enrollment period.
2. Enrollment of all mandatory veterans who seek care should be always attempted.
3. No enrolled mandatory patient who seeks to have care continued at the time of annual enrollment should be denied re-enrollment.
4. Enrollment may be limited to mandatory eligible veterans who seek care. Optional eligible veterans may be denied enrollment or re-enrollment.
5. Denial of enrollment or re-enrollment of all optional eligible veterans should be strongly considered before denying any mandatory eligible veteran.
6. No eligible veteran who seeks care should be denied access if and when a VHA facility is the only local provider of particular medical services needed by an individual.
7. VHA must provide counseling regarding access to other health care providers and assistance in receiving it to any veteran denied enrollment or re-enrollment.

Discussion

As previously stated, VHA's patients deserve responsible care. The values presented as marking of this care may be read as an index of responsibilities to enrolled patients. Therefore, as a practical guideline, VHA may manage enrollment by enrolling and re-enrolling only as many individuals as can be responsibly cared for, and by denying enrollment and re-enrollment to some eligible veterans if, and only if, these denials are necessary to preserve responsibilities to enrolled patients.

The principle of justice gives two broad justifications for these claims. First, it is unjust to enrolled patients to admit or retain more

individuals than can be responsibly cared for. Second, it is unjust to applicants, even to deserving applicants, to admit them to a challenged system. Equality and fairness, as expressed through equity, stewardship, and fiscal integrity, send the same messages.

Therefore, considering enrollment through October 1, 1998:

- The values of contract, continuity of care, and security, reinforced by all the access values, warrant enrolling all legally mandatory current patients who seek care.
- P.L. 104-262 authorizes VHA to create subpriorities within the six mandatory priorities, and one purpose of creating subpriorities could be to establish criteria for denying enrollment to some mandatory individuals. However, the law requires VHA to accept all individuals in the first three priorities, as does the value of beneficence, reinforced by the access values of service-connection and rescue. The committee thus recommends against creating subpriorities within the first three mandatory priorities and enrolling all current patients and new applicants in these priorities who seek care.
- As previously mentioned, some criteria typically considered for restricting access include need, non-abandonment, right, entitlement, merit, ability to pay, lottery, and first come/first served. The committee recommends that VHA not utilize any of these criteria to create subpriorities in mandatory Priority 4, because the needs of these individuals are too great to refuse any of them enrollment. All Priority 4 current patients and new applicants should be enrolled.
- The committee could not reach consensus about creating subpriorities within Priorities 5-6. Members agreed that the reason for attempting this additional prioritization is that denial of enrollment of some of these mandatory new applicants might be necessary to preserve the provision of responsible care to already enrolled patients.
- Turning to optional current patients and new applicants, several ethical values combine to warrant enrolling all who seek care.

However, respect for the absolute priority of meeting responsibilities to current and future mandatory enrollees justifies at least considering not enrolling current optional patients, and more strongly considering not enrolling new optional applicants. Some current optional patients should be enrolled if they want to be, for example, individuals who are seriously ill, actively involved in ongoing treatment, or being evaluated for eligibility for a mandatory priority. Any optional individual who is enrolled should be fully and clearly informed of the possibility of future refusal of re-enrollment. Optional individuals who seek care and are denied enrollment or re-enrollment should be counseled by VHA regarding access to other health care providers and assisted by VHA in gaining that access.

Regarding enrollment after October 1, 1998:

- VHA should annually re-enroll all mandatory current patients who seek re-enrollment, as warranted by contract, continuity, security and equity, and reinforced by loyalty, service-connection, and rescue.
- VHA should annually enroll all new applicants in Priorities 1-4 who seek care.
- For reasons discussed above, the committee could not reach consensus about universally enrolling mandatory new applicants in Priorities 5-6.
- VHA should adopt an equitable stance toward re-enrolling current optional patients and enrolling optional applicants. In one scenario, VHA could re-enroll and enroll optional individuals and still meet its responsibilities to mandatory patients. In another scenario, optional individuals could be refused re-enrollment and enrollment because VHA could not meet its responsibilities to mandatory patients and also provide care to optional patients.

An Ethical Postscript

The guidance over time of this report's model for ethical decision

making can be plainly stated:

a. do not break therapeutic relationships during the time for which they are promised;

b. existing mandatory relationships (with some legal exceptions) take precedence over mandatory ones not yet established;

c. keep mandatory relationships that are begun, unless patients or legitimate surrogates discontinue them;

d. always preserve the values necessary for responsible provision of care;

e. do not begin, or do not promise to renew, optional therapeutic relationships;

f. always assist veterans denied enrollment or re-enrollment in making a successful transition to other providers in their communities.

The committee could not reach consensus on the following guideline:

g. do not begin some mandatory relationships that, once begun, would undermine the values necessary for responsible provision of care.

3. Is there an ethical obligation to maintain uniformity of enrollment and disenrollment prioritization criteria across the system?

The committee replies to this question in the positive. Recognizing that enrollment will initially be a temporal, dynamic, and evolving process, the committee recommends equity of access as a temporal target, not as an initial necessary condition.

Discussion

The principle of equity directs that enrollment and re-enrollment be uniformly enacted throughout the system. Equity expresses the absolute value that similarly needy eligible veterans not be privileged or penalized by geographic differences between enrollment practices in the

system. Such privileges and penalties would violate fairness, and render loyalty, rescue, contract, continuity, and security arbitrary and capricious. They would undermine VHA's fiscal integrity, stewardship of resources, and efficiency.

Prior to the first enrollment deadline, a plurality of enrollment strategies is tolerable as a necessary part of gaining experience, information and data, particularly data about the geographical distribution of mandatory and optional patients throughout the system. After the first deadline, however, VHA should identify a target date after which equitable enrollment is required systemwide. With prospective and capped budgets, VISNs have a real economic incentive to conduct enrollment in the most cost-effective manner. To counter this incentive with the value of realizing equitable enrollment, VHA should direct that each VISN may enroll only patients in priorities from which all VISN's are enrolling, and all VISNs must enroll patients in priorities from which any VISN is enrolling. VISNs should not receive funding-driven incentives to enroll less costly patients, or funding-driven penalties for enrolling more costly ones. Similarly, if VHA gains capacity to retain revenues from other payers, VISNs should not enroll lower priority paying patients ahead of higher priority patients covered solely by allocated funds. Finally, for VHA to reach equitable provision of care, all enrolled patients must have access to similar services, and similarly sick patients must be offered similar care.

The first major difficulty in realizing the value of equity could arise in facing the question of enrolling and re-enrolling optional veterans who seek care. Each VISN will be adequately funded to care for its mandatory enrollees. One VISN could conceivably realize the value of efficiency by bringing care for its mandatory patients in under budget, and then cite this value as justification for also enrolling optional veterans. However, another VISN, with different costs, could perform efficiently and bring its care for its mandatory patients in at budget, and then cite this value as justification for not also enrolling optional patients. Whether and how to permit similarly efficient VISNs with different costs of caring for mandatory patients to enroll optional patients is a question VHA could face in attempting system-wide equitable enrollment of optional veterans.

4. What is the VHA obligation to the veterans who are difficult to reach for purposes of enrollment, e.g., the chronically mentally ill, the homeless? How far is VHA ethically obliged to go to locate these individuals, provide information about enrollment, and actually offer them a convenient mechanism for enrollment separate from mechanisms for all other groups?

VHA has ethical responsibilities to reach out to these eligible veterans. Some chronically mentally ill and/or homeless veterans might have both greater need and less ability to initiate or complete an enrollment process without assistance. Many individuals might qualify as mandatory patients and, therefore, would have higher priority for enrollment than some more easily enrollable optional individuals.

VHA should utilize its own existing methods for locating these veterans, i.e., standdowns, Vet Center programs. Those individuals who qualify should be enrolled if they want to be. Impaired decision-making on the part of some of these veterans should be anticipated and provisions for attaining legitimate surrogate decision-makers planned.

Discussion

The values underlying this response include loyalty, service-connected need, and in some situations rescue and beneficence. Veterans, including currently vulnerable groups such as the chronically mentally ill and the homeless, expressed loyalty to the United States by serving in the Armed Forces and risking unique harms. The United States, through VHA, should stand loyal to these eligible veterans by providing necessary health care.

The illnesses suffered by these veterans, i.e., mental illness and illnesses and disabilities that contribute to homelessness, might have been resultant from or aggravated by military service. Veterans with service-connected disabilities have the strongest claims to receive health care from VHA. VHA has already recognized this special component of its mission by establishing outreach programs for mentally ill and homeless veterans. These programs should be strengthened as one effective means of better connecting with these veterans for purposes of enrollment.

Rescue expresses the value of meeting the needs of especially vulnerable individuals. Chronically mentally ill and homeless veterans are among the most vulnerable because of their continuous need for medical treatment and of the difficulties of sustaining their health while impoverished.

Lastly, beneficence expresses the value of doing good in providing health care. Strengthening outreach to enhance enrollment of these vulnerable veterans is consistent with another special component of VHA's mission, that of providing rehabilitative care for injured or disabled veterans, as well as with the general goods of preserving life, protecting against harm, and offering relief and respite from some of life's most threatening circumstances.

Appendix A: A Selective Summary of Current Enrollment Legislation

P.L. 104-262 requires VHA to enroll certain eligible veterans who seek care: mandatory patients within priorities. It permits VHA to enroll additional eligible veterans who seek care: optional patients. It designates annual enrollment as a necessary condition for providing and receiving health care with the following exceptions. Treatment without enrollment can occur for: 1) any service-connected (SC) veterans for treatment of a SC condition; 2) any condition of a SC veteran with 50% or greater disability; and 3) veterans released or discharged for a disability incurred or aggravated in the line of duty for the 12-month period following discharge or release from active duty.

The enrollment priorities are listed below in order of precedence. Priorities 1-6 correspond to "mandatory" patients. Priority 7 corresponds to "optional" patients.

1. Veterans with service connected (SC) disabilities rated 50% and above;
2. Veterans with SC disabilities rated 30% or 40%;
3. Former POWs, veterans with SC disabilities rated 10% or 20%, veterans discharged from Active Duty for compensable conditions, and veterans awarded special eligibility classification under Section

1151 (disability caused by or secondary to medical treatment provided by VHA);

4. Veterans who are in receipt of aid and attendance or housebound benefits and other veterans who are catastrophically disabled;
5. Non-SC veterans and 0% SC veterans unable to defray the expense of health care, including Medicaid recipients, VA pensioners, and veterans with incomes below established means test thresholds;
6. All other eligible veterans who are not required to make copayments for care including: WWI and Mexican Border War veterans, veterans receiving care for exposure to toxic substances or environmental hazards, and compensable 0% SC veterans who do not meet VA's means test;
7. Non-SC veterans and non-compensable 0% SC veterans able to defray the expense of health care (annual income and net worth above the means test thresholds), i.e., historical Category "C" patients.

Additional Pertinent Points

1. VHA is permitted to establish enrollment priorities within each one of these priority groups.
2. VHA is permitted to make enrollment exceptions to these priorities for "compelling medical reasons."
3. VHA must establish a system for enrollment by October 1, 1998.
4. VHA may not provide care to non-enrolled veterans after that date.

   There are three exceptions to this rule prohibiting care to non-enrolled veterans:

   a. veterans in need of care for a service-connected condition;
   b. veterans with disabilities rated 50%+ service-connected;
   c. veterans discharged or released from active duty for a 12-month period following separation for a compensable disability incurred or aggravated in the line of duty.

5. The law makes mention of four medical conditions: spinal cord dysfunction, blindness, amputations, and mental illness. VHA must provide "reasonable access to care and services for those specialized needs," and must retain at least current system-wide capacity to provide these services for patients who want them.
6. Regarding veterans suffering from exposure to ionizing radiation (IO), herbicides in Vietnam (HV), and toxic substances in the Gulf War (GW), specific, limited, required care is stipulated for each of these types of patients. Also, particular enrollment deadlines are given for HV veterans and GW veterans, and individuals in these groups who are enrolled before these deadlines must be continued in care after the deadlines.
7. The prioritizing of 0% SC veterans in need of care for non-SC illnesses, injuries, or conditions as "optional" weakens the access of a significant number of veterans for whom VHA previously was required to provide care.
8. Patients in Priority 7 must make a co-payment. Veterans in Priorities 6 and 7 may take a means test and move into Priority 5 if qualified.
9. VHA may design and provide a benefits package for all enrolled veterans that includes primary and preventive care, as well as care for illness, injury, or condition regardless of service connection.
10. The law expects VHA "to the extent feasible, [to] design, establish and manage health care programs in such a manner as to promote cost-effective delivery of health care services in the most clinically appropriate setting" (1706.a).
11. VHA may provide care "effective in any fiscal year only to the extent and in the amount provided in advance in appropriations Acts for such purposes" (1710.4).

Appendix B: Some Criteria for Restricting Access to Health Care

It is not clear whether all mandatory new applicants in Priorities 5-6 can always be enrolled. Distributive justice offers several criteria for deciding about limiting access to care: need, non-abandonment, right, entitlement, merit, ability to pay, lottery, first come/first served. To briefly consider the issues at stake, the committee defines and briefly discusses these criteria. One or more of them might serve as a basis for denying access to some mandatory new applicants in Priorities 5-6 if, and only if, such restriction of access is one necessary means of preserving responsibilities to enrolled patients. All of these criteria encapsulate decisional priorities, and each favors some priorities and discounts others. In the discussion each criterion is briefly explained and evaluated. None is urged as decisively preferable from an ethical standpoint.

Need

Need can refer to individuals' needs for particular medical treatments, and to their need for access to health care. The strength of need as a criterion for restricting access is that it prompts providers to identify and rank different generic needs. For example, VHA could decide that the need of all mandatory new applicants in Priorities 5-6 for access to health care ranks higher than some of the particular medical needs of any enrolled patients. This ranking of generic needs would warrant granting access to health care to all mandatory new applicants, but also limiting the medical treatments available to patients. Or, thinking in reverse, VHA could decide that provision of treatments for most medical needs of most enrolled patients ranks higher than the need of mandatory new applicants for access to health care. This ranking would warrant development of a "category of illness" that would govern admission of individuals into the system. In this way lies complexity, because adoption of a "category of illness" itself requires judgment. Should VHA prioritize less severe conditions and thereby more likely help a greater number of individuals who have comparatively less medical need? Or should VHA prioritize more severe

conditions and thereby more likely help fewer individuals who have comparatively greater medical need? These are only a few of the vexing questions VHA may encounter in trying to utilize need as a basis for denying access to some mandatory new applicants in Priorities 5-6.

Non-abandonment

Non-abandonment encapsulates the priority that institutional and clinical providers not discontinue the access of current patients. This criterion is therefore possibly not applicable in thinking about denying access to some mandatory new applicants in Priorities 5-6 because all of these veterans are applicants, not current patients. Denying some of them access would therefore not be abandonment. However, as all these veterans are "mandatory" new applicants, they may be plausibly said to have undeniable access to VHA, and if so, then denial would be abandonment. Notably, even if one of these two interpretations would be made, that would not settle which among all applicants with the same claim to access should be denied.

Right and Entitlement

Rights are human, moral, and legal powers possessed by citizens in societies. The power of rights is familiarly expressed in at least three ways: a) the right to be left alone in living one's life (non-interference); b) the right to receive some particular goods, for example, necessary medical care and access to health care (positive rights); and c) the right to be treated fairly in adjudication of conflicts of rights (due process). Entitlements are defined goods granted to particular populations by a legislature, e.g., Medicare for America's elderly and Medicaid for America's poor. While rights and entitlements are important, access to VHA health care is not granted as a right or an entitlement, but rather as a discretionary act of Congress. That fact stated, analogies to rights and entitlements might shed some light on the problem under discussion. Is the "mandatory" status of new applicants in Priorities 5-6 the functional equivalent of an unrestricted right or entitlement to access to VHA? If so, then VHA would probably need explicit approval from Congress to deny access to these mandatory new applicants.

However, if the "mandatory" status of these veterans is more like a restricted right or entitlement, i.e., one dependent upon available funding, then the restriction could count as a justification for denying access to some of them.

Merit

Merit indicates identified worthiness as a basis for restricting access to health care. The current eligibility reform directs VHA to restrict access according to particular recognized merits as described in the eligibility priorities and subpriorities. Therefore, a revised meritocracy would have to be developed and approved in order to deny some mandatory new applicants in Priorities 5-6.

Ability to Pay

Ability to pay signals restricting of access to health care according to a defined dollar amount of income, assets, and insurance. The provider decides the amount and requires individuals who want access to take a "means test." Applicants whose wealth exceeds the defined amount "pass" the means test, and their access is restricted by their ability to pay. Applicants whose wealth is less than the defined amount "fail" the means test, and access is granted to them because of their inability to pay. VHA currently utilizes ability to pay in defining who counts as a Priority 5 eligible veteran, and VHA could use this criterion as a basis for denying access to some mandatory new applicants in Priority 6.

Lottery

Lottery utilizes random selection from a defined group as a basis of restricting access. Lottery is impartial and it would allow VHA to bypass the decisional complexities surfaced by all the other criteria. However, there is strong feeling that it is inhumane to hand over to a lottery something as important in life as access to health care. It may be more preferable to take on difficult decisional complexities than to assign to mere chance the power of denial of access to some mandatory new applicants in Priorities 5-6.

First Come/First Served

To employ the criterion of first come/first served, a provider decides the number of patients that can be accepted for care, then grants access until that number is reached. First come/first served thus centers restriction of access in the choices of individuals to present or not present for care. Like lottery, first come/first served avoids decisional complexities encountered with the other criteria. Unlike lottery, however, first come/first served is not impartial, because individuals are differently informed about the availability of care and differently capable and disposed to come for care. VHA could accentuate the disadvantages that already hinder sicker and less sophisticated veterans by adopting first come/first served as the basis for denying access to some mandatory new applicants in Priorities 5-6.

Appendix C: Ethical Caveats of Enrollment

This appendix summarizes some additional concerns about enrollment that emerged in the committee's deliberation of possibly denying access to some mandatory new applicants in Priorities 5-6.

The committee frankly considered that VHA's future patient population may exceed the current level. The enrollment legislation heightens this possibility, and the prospect of significant increases in the numbers of patients in enrollment Priorities 2, 3, 5, and 6 should not be discounted. The impact of even small increases in the number of Priority 4 patients should be anticipated because Priority 4 figures to include individuals with high-cost health care needs. The prospect of more patients is likely because there are significant numbers of eligible veterans who are not current patients but who could legitimately apply for access to the mandatory priorities. Also, retrenchments by other public and private providers, combined with the attractiveness of VHA's universal benefits package, could motivate eligible veterans who are not current patients to seek enrollment. If VHA is inundated with mandatory applicants, enrollment legislation will have to be revisited and additional ethical consultation will be necessary.

As matters now stand, possible denial of enrollment to any mandatory applicant is complicated. The complication stems from P.L. 104-262. On the one hand, the law clearly identifies eligible veterans to whom VHA must provide care if they seek it. On the other hand, the law clearly holds that care be provided only to the extent and in the amount for which Congress appropriates funds. As this new way of granting access (i.e., enrollment) begins, the question arises: Can VHA refuse enrollment to mandatory eligible applicants based on the system's inability to pay? The committee does not know the answer to this question, but did discuss ways of avoiding it.

1. VHA could lower the income level in the means test, thereby limiting expansion of Priority 5, poor veterans.
2. VHA could offer a lean, scaled-down universal benefits package, thereby prospectively limiting costs of care.
3. VHA can improve operational efficiencies.

None of these options seems satisfactory. A stricter means test would further socially threaten the very veterans and their families already marginalized by poverty or low household incomes. A scaled-down universal benefits package would put quality of care at risk, and also quell the opportunity to legally provide the holistic care that VHA gained in eligibility reform. Efficiencies should be achieved, but 100% efficiency is always an ideal, and the trade-offs of efficiency with priorities of mission, quality, and equity always preclude realization of 100% efficiency.

The committee clarified that even if VHA at some point in the future may legally deny enrollment to some mandatory eligible applicants, the system's inability to pay is not a criterion for deciding which ones to deny. As noted above, the committee reached consensus that all applicants in Priorities 1-4 should be enrolled and all current patients in these priorities be re-enrolled if they want to be. If the numbers and needs of these patients overwhelm resources, VHA should report the situation to Congress. The committee concurred that there are obvious problems with denying access to any mandatory

applicants, for example, that some denied individuals will be sicker and/or poorer than others already enrolled, and that denying some mandatory applicants would at any given time create strong political backlash.

References

Brook RH, Kamberg CJ, McGlynn EA. "Health System Reform and Quality." *JAMA* 1996;276(6):476-480.

Bulger RC, Cassel CK. "Health Care Institutions," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:1046-1049.

Butler RN. "On Behalf of Older Women: Another Reason to Protect Medicare and Medicaid." *N Engl J Med* 1996;334(12):794-796.

Callahan D. "Bioethics," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:247-256.

Callahan D. "Controlling the Costs of Health Care for The Elderly: Fair Means and Foul." *N Engl J Med* 1996;335(10):744-746.

Campbell CS. "Utility," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:2509-2513.

Council on Ethical and Judicial Affairs, American Medical Association. "Ethical Issues in Health Care System Reform." *JAMA* 1994;272(13): 1056-1062.

Eddy DM. "Benefit Language: Criteria That Will Improve Quality While Reducing Cost." *JAMA* 1996;275(8):650-657.

Garland MJ, Greenlick MR. "Health Care Insurance," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:1051-1056.

Gin NE, Waitzkin H. "Health Policy: Politics and Health Care," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:1116-1121.

Gold MR, et al. "A National Survey of the Arrangements Managed-Care Plans Make with Physicians." *N Engl J Med* 1985;333(25):1678-1683.

Iglehart JK. "Health Policy Report: Politics and Public Health." *N Engl J Med* 1996;334(3):203-207.

Kassirer JP. "Our Ailing Public Hospitals: Cure Them or Close Them?" *N Engl J Med* 1995;333(20):1348-1349.

Kilner JF. "Health Care Resources, Allocation of," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:1067-1079.

Last JM, Parkinson, MD. "Health Officials and Their Responsibilities," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:1113-1116.

Levinsky NG. "Social, Institutional, and Economic Barriers to the Exercise of Patients' Rights." *N Engl J Med* 1996;334(8):532-535.

Mechanic D, Schlesinger M. "The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians." *JAMA* 1996;275(21):1693-1697.

Menzel PT. "Economic Concepts in Health Care," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:649-657.

Norton BG. "Future Generations, Obligations To," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:892-899.

Ogletree TW, "Responsibility," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:2300-2304.

Pawlson LG, Glover J. "Health Care Systems," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:1041-1045.

Schroeder SA. "The Medically Uninsured: Will They Always Be with Us?" *N Engl J Med* 1996;334(17):1130-1133.

Slote M, Quirk MJ, Solomon WD, et al. "Ethics," in Reich WT, editor-in-chief, *Encyclopedia of Bioethics*, Revised Edition. New York: Simon & Schuster MacMillan,1995:721-764.

Sterba JP. "Justice," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:1308-1315.

Weissman JW. "Uncompensated Hospital Care: Will It Be There If We Need It?" *JAMA* 1996;276(10):823-828.

Wellman C, Macklin R. "Rights," in *Encyclopedia of Bioethics*, Rev. Ed., Reich WT, editor-in-chief. New York: Macmillan/Simon & Schuster, 1995:2305-2316.

Weston B. "Patient Advocacy In The 1990s." *N Engl J Med* 1996;334(8):543-544.

Writers

Marsha Goodwin, R.N.-C, M.S.N. - Chairperson

Carol Babb, A.L.S.W.

Arthur R. Derse, M.D., J.D.

Gabriel Manasse, M.D.

Reginald Peniston, M.D.

Dorothy Rasinsky-Gregory, M.D., J.D.

James E. Reagan, Ph.D.