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Failure to Provide

Healthcare at the Veterans Administration

Ronald Hamowy

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Executive Summary

Prior to World War I, the federal government effectively provided no hospital or medical care to veterans other than extending domiciliary care to a few veterans disabled while in service. With American entry into World War I, however, it was decided to extend the treatment accorded members of the armed forces who were receiving hospital care after they had been mustered out. As a consequence the Veterans Bureau was created in 1921. In 1930 a new agency, the Veterans Administration (VA), took over responsibility for all veterans' affairs. Following World War II and the passage of a comprehensive GI Bill that included generous medical and hospital care for returning soldiers, the VA rapidly expanded to the point whereby it established itself as the largest supplier of health care in the nation. For most of the period since the end of World War II these medical facilities were plagued by waste, poor management, and negligence. While it is true that conditions at VA facilities have improved since the late 1980s, they still lag behind those that obtain at the nation's voluntary hospitals. The shift from inpatient to ambulatory care, an increase in chronic care needs in an aging population, and increases in the demand for medical services as a result of the most recent Middle Eastern conflicts clearly undermines the reason originally put forward to operate a direct health care system. However, given the pressures put upon Congress by the American Legion and other veterans groups, it is unlikely that the United States will follow the lead of the governments of Australia, Canada, and the United Kingdom and close or convert their hospitals to other uses and integrate the treatment of veterans into the general heath-care system.[1]

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Prior to World War I, the federal government effectively provided no hospital or medical care to veterans other than extending domiciliary care, including incidental medical care, to a few disabled veterans.[2] The traditional method of dealing with those who had served in the military following the Civil War and prior to the First World War was to award them pensions, although, even then, earlier legislation limited pensions to soldiers or the widows of soldiers who had been disabled or killed in the line of duty. However, during the presidential campaign of 1878, Rutherford B. Hayes had pledged to liberalize existing pension legislation if elected.[3] Under the Republican presidents who succeeded Hayes, the terms and amounts of these pensions escalated to the point where the Pension Bureau's expenditures in 1883 were as great as the federal government's entire pre-Civil War budget. The Republican Party consistently supported a generous pension scheme for political purposes.[4] Indeed, by 1893 no less than 41.5 percent of the federal government's income was spent on veterans' benefits. In 1900, thirty-five years following the end of the Civil War, of the 1,000,000 surviving veterans of the conflict, more than 74 percent were receiving military pensions.[5]

The issue of providing medical and hospital care to veterans had been considered both after the Civil War and after the Spanish-American War but had never been instituted except on an incidental basis. However, following American entry into World War I, the question was once again raised, and it was determined that a comprehensive system of medical and hospital care directly administered by the government would constitute the most efficient and least traumatic mechanism for continuing the care veterans had received while on active duty. As a result, in October 1917, Congress enacted legislation providing that injured military personnel were eligible to receive medical, surgical, and hospital services through facilities operated by the United States government. In addition, the Democratic Party under President Woodrow Wilson, not wishing to appear less generous to veterans than were Republicans, also instituted a system of support for the dependents of members of the armed forces during service, and compensation and vocational rehabilitation for disabled veterans. The task of performing the necessary physical examinations by which disability was to be determined and of providing hospital facilities and treatment first fell to the Public Health Service but, under the terms of the Sweet bill of 1921, these duties were transferred to the newly created Veterans Bureau.

So rife with corruption was the Bureau under its first and only director, Colonel Charles R. Forbes,[6] that in 1930 it was abolished and replaced with a new agency, the Veterans Administration (VA), which was given responsibility for all veterans affairs. While President Franklin Roosevelt was forced to introduce cuts in the overall benefits accorded to veterans as a result of the Depression, net hospital operating costs continued to rise between 1930 and American entry into World War II, from $28.5 million to more than $55 million.[7] Indeed, demand for hospital services rose steadily during the decade, largely due to an increase in the incidence of tuberculosis. However, veterans being treated for neuropsychiatric conditions continued to comprise the largest proportion of patients.[8]

The American Legion Speaks for World War II Veterans

With America's entry in World War II, the American Legion[9] embarked on a campaign to extend to returning veterans the same benefits earlier accorded veterans of the First World War, a campaign that increased in intensity in late 1943 as German forces were retreating before the Allies in central Italy. The Legion's lobbyists were soon joined by William Randolph Hearst, who was prepared to put all the resources of his publishing empire behind a generous benefit scheme.[10] The Legion's first salvo concerned a bill that would have provided a mustering-out payment of up to $500 to discharged veterans. Hearings on the bill were conducted before the House Committee on Military Affairs, chaired by Representative Andrew Jackson May of Kentucky in late 1943. The House speaker, Sam Rayburn of Texas, and the majority leader, John McCormack of Massachusetts, had charged May to write a bill providing a veteran bonus, but May refused to report the bill out of committee before he returned to his home in Kentucky for the Christmas holidays. May's actions were a public relations disaster,[11] and he was forced to act expeditiously as soon as Congress reconvened in January 1944. May's bill, with the bonus reduced to a maximum of $300, was duly passed by the end of the month. However, enactment of this legislation did not remove the pressure for passage of a far more comprehensive package of benefits, including medical and hospital care. The Legion had crafted an omnibus bill, originally titled The Bill of Rights for GI Joe and Jane, which provided an extravagant array of benefits for returning veterans, and it was successful in getting Congressman John E. Rankin, chairman of the Committee on World War Veterans' Legislation, to introduce the bill into the House on January 10, 1944. On the following day, Bennett Champ Clark of Missouri, one of the founders of the American Legion in 1919, introduced a companion bill in the Senate.

Competing with the Legion bill were a large number of other measures relating to returning veterans, including one that had been prepared by the National Resources Planning Board (NRPB), which was headed by Frederic A. Delano, the president's uncle. The president had charged the NRPB with postwar planning, including veterans' concerns, and had drafted a proposal that would have provided one year of vocational training for all veterans and a college education for a select few who could meet certain strict qualifications.[12] This was hardly a comprehensive measure, but the administration attempted to create the impression that it had given prolonged thought to the question of returning veterans. In July 1943, Roosevelt, in one of his fireside chats, told the nation:

> While concentrating on military victory, we are not neglecting the planning of things to come, the freedoms which we know will make for more decency and greater democracy in the world. Among many other things we are, today, laying plans for the return to civilian life of our gallant men and women in the armed services. They must not be demobilized into an environment of inflation and unemployment, to a place on the bread line or on a corner selling apples. We must, this time, have plans ready—instead of waiting to do a hasty, insufficient, and ill-considered job at the last minute.[13]

Nothing could have been further from the truth. What Roosevelt did in fact suggest to Congress in June 1943 was that, at the end of hostilities, the government would underwrite the costs of one year's vocational training and would permit servicemen to remain on furlough in the military for up to three months while they sought civilian jobs.[14]

Without serious competition, the American Legion proposal quickly gained headway, aided by the Hearst newspapers and a string of horror stories, which the Legion publicized, of badly in-

jured servicemen discharged without a penny and denied benefits while the VA adjudicated their disability claims.[15] So popular was the measure in the Senate that no fewer than eighty-one senators sponsored it, thus assuring the bill's passage in that chamber even before it reached the Senate floor. However, things did not go quite as smoothly in the House. Among the bill's more controversial provisions were those relating to education. The bill stipulated that the government would underwrite an educational allowance plus all educational expenses in established colleges and universities for up to four years.[16] The nation's labor unions, who viewed a workforce increased by so many millions of discharged men with alarm and feared for the future of the closed shop, strongly supported the GI Bill's educational features; however, many educators thought the proposals a threat to higher education standards. No less contentious was the large-scale bureaucracy that would be needed to administer a package of veterans' benefits as munificent as those proposed. President Roosevelt, in his State of the Union message of January 1944, had called not only for massive tax increases and for his "Economic Bill of Rights," but for a national service program that would apply to all adults, in effect conscripting all Americans, with the federal government as the nation's sole employer.[17] A number of congressmen were understandably appalled by Roosevelt's suggestions, which smacked more of the policies of the fascist regimes with whom Americans were then engaged in battle than of traditional notions of a free society.[18] Against this backdrop, some representatives were apprehensive lest a bloated VA act as the vanguard of a postwar federal government that intruded into every aspect of social life.

By far the most serious threat to passage, however, was the bill's provisions regarding unemployment compensation. The bill authorized a readjustment allowance to each veteran of $20 per week for up to fifty-two weeks (the so-called 52-20 Club), while seeking employment. Some critics regarded the program as yet another welfare giveaway that would encourage indolence among able-bodied veterans while at the same time depriving the wounded and disabled of much-needed funds. Thus, an officer of the Disabled American Veterans wrote of the provision: "The lazy and 'chiseley' types of veterans would get the most benefits, whereas the most resourceful, industrious and conscientious veterans would get the least."[19] Significantly, John Rankin,[20] who chaired the House committee considering the bill, also had grave reservations about its unemployment compensation provisions. Rankin, and a few other congressmen who were less vocal in their views, had concluded that since the same benefits would be extended to all veterans regardless of race, the effect would be that taxpayers would end up supporting large numbers of shiftless blacks. Rankin noted:

> I see the most violent discrimination against that strong, virile, patriotic, determined man who goes into the Army to fight for his country and comes back and says, "I don't want anything. I am going back and going to work and that is what the rest of you ought to do." . . . At the same time, I see a tremendous inducement to certain elements to try to get employment compensation. It is going to be very easy . . . to induce these people to get on federal relief, what we call unemployment compensation, rather than getting back into active employment.[21]

Despite Rankin's reservations, however, he was forced to report the bill out of committee. The American Legion had applied intense pressure on the other members of the committee who then compelled Rankin to present the bill to the full House in April. After prolonged debate in the House, the bill finally passed that chamber unanimously in May 1944 and was signed into law on June 22, 1944, as the Servicemen's Readjustment Act.

Extending the same medical benefits to the veterans of the Second World War as had been ac-

corded to the veterans of World War I quadrupled the potential eligible population for benefits, from 5,000,000 to 20,000,000 veterans. Negotiations while the House considered the GI Bill had already included providing $500 million for new hospital construction.[22] New facilities, which had been authorized to accommodate new users as a consequence of this expansion of the VA program, required a substantial increase in the number of medical personnel. At the same time, the VA sought to raise the quality and variety of facilities and the quality of care. While the medical care accorded soldiers on the battlefield was generally regarded as commendable, there had been a large number of complaints about the level of care at VA hospitals. Not only was the American Legion vocal in its protests, but a series of articles in the public press criticized the Veterans Administration for shoddy medical treatment in VA facilities. In March and April of 1945, *Cosmopolitan* magazine ran a series by Albert Q. Maisel, which accused the VA of allowing veterans admitted to VA hospitals to suffer needlessly and, "all too often," to die needlessly.[23] Overcrowding and overworked doctors were held largely responsible for these conditions, but much criticism was directed at the Veterans Administration administrator, Frank T. Hines, who had served in that position since succeeding Charles Forbes in 1923. In August 1945, President Truman accepted Hines's resignation and appointed General Omar N. Bradley as administrator.

Bradley took charge of an agency that had 65,000 civilian employees, the largest in the federal bureaucracy, which was mandated to extend benefits to 43 percent of the adult male population.[24] Within two years, the VA workforce had increased to more than 200,000 and its budget had grown by a factor of ten, from $744,000,000 in 1944 to $7,470,000,000. But despite Bradley's eager attempts to provide veterans the benefits stipulated in the GI Bill, John Stelle (one-time governor of Illinois), national commander of the American Legion, charged the Veterans Administration with an "unbalanced diet of promises," including the slow pace of new hospital construction and the fact that the VA was contracting out medical care to private hospitals.[25] In addition, a whole series of complaints from Legion officials regarding problems at specific hospitals was forwarded to the Veterans Administration concerning a wide range of issues, among them the availability of army or navy medical records on new claims and the lack of space for Legion representatives at VA stations. Even more aggravating, Bradley was considering a new policy that called for suspending VA hospitalization privileges for all veterans who had not been injured in the war, as long as any beds were still needed by those with combat-related disabilities. Those opposed to this policy argued that it was brutally shortsighted since even soldiers without combat-connected disabilities might later become seriously ill as a result of the stresses of combat and that these veterans were as much entitled to hospitalization as were veterans wounded or disabled in battle.

To the complaints leveled against the VA, the Legion received no reply. As a consequence, in February 1946, Stelle held a press conference in Washington at which he effectively called for Bradley's ouster, arguing that "what we need in charge of the VA is a seasoned businessman, not a soldier, however good a soldier he may be."[26] Congressman Rankin, chairman of the House Committee on Veterans Affairs, reacted to Stelle's comment with the claim that "it sounds like communism to me," to which Stelle pointed out that a new VA hospital was being built in Tupelo, Mississippi, Rankin's home state. Stelle further charged that between 300,000 and 500,000 veterans who were suffering from war-connected disabilities had received no benefits because the Veterans Administration had not retained their medical records. Criticism continued throughout the summer and fall of 1946 until, finally, at the Legion's annual convention in San Francisco late that year, General Bradley was compelled to conclude his speech be-

fore the assembled legionnaires with these words: "What we have been able to accomplish during this year in the Veterans Administration has been achieved not because of, but in spite of, your national commander."[27] At the same meeting, Paul H. Griffith of Pennsylvania was elected to replace Stelle as national commander.

Despite complaints from veterans' groups that the VA was simply not doing enough for those who had fought for their country, the VA continued to expand. By November 1949 the agency was operating under the authority accorded it by more than 300 laws, providing benefits to nearly 19,000,000 living veterans and to dependents of deceased veterans.[28] Among the benefits that it administered were disability compensation, pensions, vocational rehabilitation and education, the guaranty of home and farm loans and loans for businesses, readjustment allowances for unemployed veterans, life insurance, death and burial expenses, adjusted compensation, emergency officers' retirement pay, and, not least, an extensive system of hospital and outpatient treatment and domiciliary care in the United States.[29] By the end of the 1950 fiscal year, it was operating 136 hospitals, comprising 18 dedicated to the care of tuberculosis, 34 specializing in neuropsychiatric problems, and 84 for general medical and surgical needs. Its facilities boasted 106,287 operating beds, and over the course of the preceding twelve months almost 600,000 patients had been admitted for treatment to VA hospitals. The agency's hospital, medical, and domiciliary programs employed approximately 120,000 employees, including almost 4,000 full-time physicians, 4,375 part-time physicians, about 1,000 dentists, and more than 13,000 nurses. Approximately 2,000,000 veterans were given treatment in outpatient clinics and a further 500,000 in dental clinics.[30] Not only was the Veterans Administration medical program by far the most extensive in the country, but it was larger and more comprehensive than that of many nations with national health-care schemes.

During the fifteen years following World War II, there was a steady expansion in hospital facilities. Table 1 indicates the average daily patient load and the average number of operating beds in facilities under Veterans Administration control for the 1930s, 1940s, and 1950s.

The conflict between the American Legion and General Bradley was not the only political struggle the Legion found itself fighting in the years immediately following the end of World War II. While much of the nation's military establishment was rapidly dismantled at the end of the war,[31] a substantial portion of the government's civilian arm, grown to massive proportions by the war, remained. In 1940, the last full year of peace, the federal government had just more than 1,000,000 employees and spent approximately $9 billion. By 1947, these numbers had grown to 2,100,00 employees and to expenditures of more than $39 billion. In that year the executive branch was a bureaucratic labyrinth comprising 1,816 components, including 9 departments, 104 bureaus, 12 sections, 108 services, 51 branches, 460 offices, 631 divisions, 19 administrations, 6 agencies, 16 areas, 40 boards, 6 commands, 20 commissions, 19 corporations, 5 groups, 10 headquarters, 20 units, 3 authorities, and an additional 263 miscellaneous and functionally designated parts.[32] So complex was the administrative arm of the national government that even Franklin D. Roosevelt, whose policies routinely called for further extensions of the federal bureaucracy, wrote as early as 1937:

> The Executive structure of the Government is sadly out of date. I am not the first President to report to the Congress that antiquated machinery stands in the way of effective administration and of adequate control by the Congress. . . . Neither the President nor Congress can exercise effective supervision and direction over such a chaos of establishments, nor can overlapping, duplication, and contradictory policies be avoided.[33]

Table 1. Average Daily Veteran Patient Load in VA and Non-VA Hospitals, and Average Number of Operating Beds in VA Hospitals, 1931–1960

	Average Daily Patient Load			
Fiscal Year	Total	VA Hospitals	Non-VA Hospitals	Operating Beds, VA Hospitals
1931	32,949	24,398	8,553	24,255
1932	42,606	32,568	10,038	28,278
1933	42,129	33,649	8,480	31,192
1934	36,583	35,220	1,363	39,456
1935	41,333	39,030	2,303	43,017
1936	43,524	40,972	2,552	44,521
1937	44,879	41,939	2,940	45,905
1938	48,973	45,639	3,334	49,451
1939	52,763	49,147	3,616	53,077
1940	56,251	52,409	3,842	56,429
1941	58,423	54,582	3,841	60,245
1942	57,927	54,636	3,291	60,952
1943	56,147	53,470	2,677	61,103
1944	61,332	58,338	2,994	65,972
1945	68,260	64,317	3,943	73,777
1946	78,586	71,493	7,073	80,927
1947	98,248	85,715	12,533	96,451
1948	105,882	92,891	12,991	102,854
1949	106,985	94,539	12,446	103,854
1950	108,038	96,643	11,395	106,012
1951	104,391	96,305	8,086	107,568
1952	105,110	98,024	7,086	109,790
1953	104,482	97,975	6,507	108,967
1954	108,944	103,491	5,453	114,244
1955	110,733	106,682	4,051	117,643
1956	113,458	111,205	3,253	120,649
1957	114,325	111,265	3,060	121,144
1958	114,581	111,599	2,982	121,201
1959	114,103	111,050	3,053	120,489
1960	114,356	111,408	2,948	120,257

SOURCE: Administrator of Veterans Affairs. 1963. Annual Report, 1963. Washington, D.C.: Government Printing Office: 194 (Table 4).

The Hoover Commission

In response to such complaints, in July 1947—in one of its periodic obeisances to efficiency—Congress unanimously voted to establish a blue-ribbon Commission on Organization of the Executive Branch, whose purpose was to recommend ways to economize and streamline the federal government.[34] Herbert Hoover, who was reputed to be a brilliant organizational tactician, was appointed its chairman, while its membership included: Dean Acheson, soon to be secretary of state; Arthur Fleming, formerly civil service commissioner; James Forrestal, former secretary of Defense; senators John McClellan of Arkansas and George D. Aiken of Vermont; and Joseph P. Kennedy, formerly ambassador to Great Britain. The commission proceeded to hire more than 300 consultants whose area of expertise was government activity, and these experts were, in turn, assisted by professional research and management firms. The result of this was a mammoth report issued in twenty-four parts between January and June 1949. Among its many recommendations was a complete reform of the Veterans Administration. The report pointed out that VA rules were contained in no less that 88 manuals, 665 technical bulletins, and more than 400 circulars. The commission's investigation of the VA uncovered a staggering amount of waste. As examples, the report cited the fact that, as of June 1948, the VA was handling almost 7,000,000 life-insurance policies with a face value of $40 billion, to which more than 15,000 employees were assigned, handling an average rate of 450 policies apiece. The commission observed that a comparable private insurance company had an average workload of almost 1,800 policies per employee. And while private companies were able to process almost all their death claims within fifteen days of notification, it took the Veterans Administration eighty days.[35] Nor did its handling of veterans' educational benefits fare any better. The commission concluded that the VA often paid the highest possible fees for tuition and equipment, despite the poor quality and usefulness of many schools that veterans attended, and was habitually clumsy in handling subsistence allowances to student veterans. Despite these inefficiencies, however, the focus of the commission's complaints centered on the federal government's medical programs, the largest and most comprehensive of which was that administered by the VA.

The report pointed out that the federal government undertook the medical care of some 24,000,000 people, about one-sixth of the nation's population, of which approximately 18,000,000 were veterans. Other groups included members of the armed forces and their dependents, government employees, and merchant seamen. Medical care was handled by some forty government agencies, spending about $2 billion in 1949, a figure ten times as large as in 1940. The report went on to note:

> These agencies, obtain funds and build hospitals with little knowledge of, and no regard for, the needs of the others. On June 30, 1948, there were only 155,000 patients in government hospitals having a capacity of 255,000. Yet the agencies, led by the Veterans Administration, are now planning to build over $1 billion worth of new hospitals.
>
> Aside from waste of money and materials, the most serious question is where they will find the doctors to man their hospitals. Already the Veterans Administration has had to close 5,600 beds for lack of medical manpower to service them. And there is talk of a draft to provide enough doctors for the armed forces. Meantime, the competing federal services unnecessarily drain doctors from private practice, and the country is now dreadfully short of doctors.[36]

Among the particulars specified in the report were the facts that: the Army had just completed a

$37 million hospital in Honolulu, despite the fact that the Navy had a comparable hospital in the same area adequate to care "for all military personnel" of all three services; it would be possible to close four large Army and Air Force hospitals in the New York City area without reducing the level of care given patients, yet, despite this, the VA was in the process of building new hospital facilities with construction costs of more than $100 million; VA facilities for treating tubercular and neuropsychiatric patients, accounting for 60 percent of all VA beds, were inefficient and suffered from a chronic shortage of trained personnel; and the length of stay of patients suffering from similar diseases was three times as long in VA hospitals as in comparable voluntary hospitals.[37]

The commission found that construction costs of government hospitals, almost all of which were built by and for the Veterans Administration, ran from $20,000 to over $50,000 per bed, compared to about $16,000 per bed for voluntary hospitals. More important, it observed that while the VA was authorized to hospitalize veterans with non-service-connected disabilities only if beds were available, over 100,000 hospital beds had been built or authorized that could serve no purpose other than to provide for non-service-connected cases.[38] Building hospitals far in excess of what was needed to undertake the care of veterans with service-connected diseases or injuries was the method by which the VA was able to extend medical care to other veterans. As a solution to this problem, in what must constitute one of the strangest recommendations of a panel ostensibly opposed to the creation of even larger bureaucratic entities and to the expansion of federal power, the commission proposed that Congress create a united medical administration that would take over the Public Health Service, all Veterans' Administration hospitals and medical services, and all general hospitals of the armed forces located in the continental United States.[39]

The American Legion, predictably, strongly opposed the commission's proposals. The organization's reaction to establishing any committee whose function was to recommend economies in the Veterans Administration was highly negative inasmuch as this raised the specter of a reduction in veterans' benefits, as had occurred for a brief period in 1933. However, the Legion was especially upset over the suggestion that the VA be dismembered and that a new super-agency take over its medical responsibilities. As one Legion executive put it:

> The major benefit programs for veterans are so dependent upon and integrated with the medical, hospital, and domiciliary care programs as to preclude separation from the VA without disastrous effects on the efficient administration of veterans' benefits.[40]

In May 1949 the Legion's national executive committee went on record as being unalterably opposed to the commission's recommendations and especially to the creation of a united medical administration, and this was affirmed at the Legion's national convention in Philadelphia later that year.[41] The Veterans Administration, since its establishment in 1930 as the successor agency to the Veterans Bureau, had—for most of its history—been extremely responsive to the wishes of the American Legion, which was instrumental not only in running the VA but in shaping the legislation governing it. The proposal that several of the VA's most important functions be hived off constituted a grave threat to this relationship.[42] Not only did the Legion attack the notion that the VA should be split up, but it was able to enlist the support of several influential congressmen in its criticism of portions of the Hoover report. Thus in January 1949, House majority leader John W. McCormack of Massachusetts issued a statement opposing any division of authority in administering the affairs of veterans, maintaining that "the Hoover Commission had failed to recognize that the VA was already set up on the one basis on which veterans' affairs could be handled with the greatest dispatch and the least cost."[43]

Additionally, it appeared that the Hoover Commission's recommendations might be used as an "excuse" to trim expenditures of veterans' benefits. In March 1950 the VA's administrator, General Carl Raymond Gray Jr., ordered a reduction of 7,800 personnel,[44] after President Truman, in a series of budget messages, had suggested that only veterans with service-connected disabilities should receive medical treatment at government expense.[45] The American Legion's position, on the otherhand, was that military service in time of war conferred on veterans a distinct status that warranted their receiving special benefits not accorded other citizens, among them treatment for all illnesses and disabilities, whether service connected or not. As the director of the Legion's Rehabilitation Division observed: "It is our belief that the government created a special class when it selected millions of young Americans for service."[46] These illnesses, the Legion maintained, were not merely trivial ailments but often serious. A member of the Legion's National Executive Committee gave voice to the Legion's position: "We feel," he commented, "that a veteran, even with a non-service-connected disability, is entitled to a little extra treatment from the government he fought to uphold, provided he needs such treatment."[47] The Legion declared that ongoing medical care for veterans did not fall under the category of "special interests"—a term that the Legion strongly condemned—but rather was a "special social need."[48]

Despite the support accorded the Hoover Commission by Americans familiar with its findings,[49] in the end, few of its recommendations were enacted, despite extensive support. In late 1949 it appeared that the Legion would be unsuccessful in its attempts to block legislation dismembering the Veterans Administration and creating a united medical administration. To encourage Congress to enact the necessary reforms recommended in the commission report, a group of prominent citizens launched the Citizens Committee for the Reorganization of the Executive Branch under the chairmanship of Robert L. Johnson, president of Temple University. Among its members were two former vice presidents, Charles G. Dawes and John Nance Garner; a former Supreme Court justice, Owen J. Roberts; and a large number of former Cabinet members, senators, congressmen, and governors. In addition to these political luminaries, the committee boasted more than forty college and university presidents; fifty publishers, editors, and writers; and the leaders of farm, professional, business, labor, and women's organizations.[50]

Nor was the Citizens Committee alone in pushing for support of the Hoover Commission reforms. The Tax Foundation, a policy research organization founded in 1937 to monitor government fiscal policy, gave strong support to implementing the Hoover recommendations and, in October 1949, urged that the VA be authorized to investigate the ability of patients to pay for medical treatment for non-service-connected disabilities.[51] Against these organizations, the Legion engaged in a national campaign to familiarize the public with its concerns and issued a series of papers outlining its reservations. In March 1949 Legion officials testified before the House Committee on Expenditures in the Executive Departments (on H.R. 5182), which was examining the proposal to merge the federal government's medical services. A new united medical administration, the Legion contended, would be unworkable since it called for a mix of medical treatments: veteran (civilian), military (highly specialized), and public health (preventative and research). Equally important, under the plan a veteran would not only lose his "right" to exclusive hospitalization but "his identity as a veteran," thus disassociating him from his service to his country.[52]

Legion executives, both at the House hearings and at the Senate hearings the following month, received less than cordial receptions, and it appeared that Congress would proceed with creating a united medical administration that year. In addition, President Truman, on the Bureau of the Budget's recom-

mendation, immediately altered the VA's hospital construction program by canceling earlier authorization for the building of twenty-four hospitals and ordering a reduction in the size of fourteen additional hospitals, with a savings in construction costs of approximately $279 million.[53]

However, almost providentially, foreign affairs intervened to delay consideration of any executive reorganization. In June 1950 the Korean peninsula erupted into warfare, and President Truman, eager to halt the advance of forces hostile to American interests, dispatched American troops to the region. The law then governing veterans' benefits placed veterans of the Korean conflict in a somewhat anomalous position inasmuch as they were not legally regarded as entitled to wartime benefits.[54] The American Legion engaged in intense lobbying effort to alter this,[55] and, as a result, Congress enacted Public Law 28 in May 1951, whereby veterans of the Korean War were granted entitlement to the same benefits, including medical, hospital, and domiciliary care, as were veterans of World War II. Having now expanded the number of veterans entitled to medical care, the Legion once again turned its attention to campaigning against the Hoover Commission recommendations and to agitating for additional beds and physicians at VA facilities. In March 1952 the Legion initiated a new public relations campaign to oppose legislation inspired by the Hoover report. The Legion was particularly troubled by a Senate bill, S. 1140, then being considered to create a new cabinet-level position, the Department of Health, which would consolidate the Public Health Service, the VA's Department of Medicine and Surgery (including all VA hospitals and outpatient services), and all general hospitals of the army, navy, and air force in the United States and the Canal Zone. This, of course, simply amounted to establishing the united medical administration under another name, which the Legion had so tirelessly fought. Not only was the Legion fighting the dismemberment of the Veterans Administration, but it found it had to contend with efforts by economizing congressmen to cut appropriations to the VA. The Legion's news releases decried the "senseless cuts [that] would disastrously cripple VA service and add a tremendous load upon American Legion workers . . . [and] would cause much injustice to hospitalized veterans."[56] Fortunately, the Legion had a friend in Congress in the form of Representative John Rankin, who chaired the Committee on Veterans Affairs. Rankin, who was in a position to kill any bill simply by refusing to give it a hearing, allied himself with the Legion against the Hoover recommendations and thus was able to ensure the continued integrity of the VA. In addition, in June 1952 the Senate restored most of the VA's 1953 operating funds, earlier cut by the House, thus averting a reduction in medical and hospital personnel and allowing the completion of twenty-one hospitals then in the process of being built.[57] And in the following year, the Legion was again successful in getting the House to reverse itself, this time restoring an earlier cut of $279 million in appropriations to the VA that the Bureau of the Budget had recommended.[58]

A Second Hoover Commission Finds Gross Waste

Having succeeded in blocking attempts to reorganize the federal government's bureaucracy responsible for administrating veterans' benefits during the Truman presidency, the Legion found itself faced with similar problems under President Eisenhower. The Republicans who controlled the Eighty-third Congress—the first, other than a brief period between 1946 and 1948, that the party had controlled for two decades—sought to reduce the spectacular amount of waste and inefficiency that had come to light with the first Hoover Commission reports. In this they were joined by a Republican president who was anxious to reorganize the executive branch to make it more responsive to aggressive management. At the open-

ing of the Eighty-third Congress, Congressman Clarence Brown, Republican from Ohio and one of the sponsors of the bill creating the first Hoover Commission, and Senator Homer Ferguson, Republican from Michigan, introduced a measure calling for the establishment of a new commission that would identify reductions in spending and the elimination of services in the executive branch.[59] Once again, Herbert Hoover was appointed chairman;[60] among the other members were Herbert Brownell, the attorney general; James A. Farley, who had been a close political crony of Franklin Roosevelt; senators Homer Ferguson and John McClellan of Arkansas; and Congressman Brown.

Once more, the commission took aim at the enormous waste in medical and hospital services provided by a variety of federal agencies, particularly the Veterans Administration.[61] It pointed out that a total absence of coordination between the federal government's military and civilian medical services was responsible for a huge excess of hospital beds and contributed to a chronic shortage of medical personnel. Thus, with reference to the San Francisco Bay Area, the commission found that four separate agencies operated sixteen hospitals. Of the 11,565 beds available in these facilities, 5,233, or 45 percent, were unoccupied at the time the commission made its survey. And with specific reference to VA facilities in the area, the figure was actually 81 percent! Similar problems were discovered in New York City and Norfolk, Virginia. Among the twelve federally operated hospitals in the New York area, 3,010 of a total of 12,841 beds, or 25 percent, were found to be unoccupied, with the figure at VA hospitals standing at 86 percent. In Norfolk, 1,659 out of 3,971 beds, or 42 percent, were unoccupied, with the VA figure once again far surpassing those for the other federal agencies at 85 percent.[62] Despite such excess capacity, the VA's hospital construction program was adding new facilities daily. In mid-1951, the total number of beds in VA hospitals was 115,945, of which 11,554, or 10 percent, were unoccupied. By 1954, the number of unoccupied beds had increased to 14 percent of the total, during which time the VA had spent $375 million on added hospital facilities.[63]

Not only were large numbers of VA hospital beds standing empty, but patients admitted to these facilities were hospitalized for much longer periods than was the case at civilian voluntary hospitals. One small example: the average stay for tonsillectomies at voluntary hospitals was 1.4 days while at VA hospitals it was 8 days.[64] The General Accounting Office concluded that these longer periods of hospitalization were in large part accounted for by the absence of cost to patients and a tendency on the part of hospitals with light patient loads to continue care "beyond necessary limits."[65] Indeed, the whole VA hospital program was riddled with inefficiencies. Not only were there an inadequate number of patients for the number of hospital beds available, but the size and location of these hospitals made little economic sense, having been determined for political rather than economic reasons.[66]

The major problem with the VA medical and hospital program, the commission found, centered not so much on the care provided the 3,500,000 veterans with service-connected disabilities, but rather on the 21,000,000 other veterans who were able to receive hospitalization for illnesses or disabilities unconnected to their military service provided that they stipulated they were unable to pay for such services. When in 1923 Congress had authorized the extension of medical benefits to veterans with non-service-connected disabilities who were unable to pay for medical services, the commission observed, it operated on the assumption that this would involve no additional costs. In fact, the construction of new hospital beds for the care of such cases had totaled more than $1 billion by 1954, and the costs of such care was running at the rate of $500 million per year.[67] While providing medical and hospital care to veterans admitted for non-service-connected disabilities was to

be limited to those unable to pay, apparently no effort was made to determine whether prospective patients were in fact indigent. Rather, the VA was prohibited from challenging statements made by prospective patients about their inability to pay, and when a bill incorporating a provision for verifying inability to pay was introduced in Congress in 1953, it failed.[68] The commission found that all of the 369,000 veterans receiving non-service-connected care in 1954 did not have to pay for it and quoted a 1952 General Accounting Office study that found that out of a sample of 336 cases of veterans with annual incomes of over $4,000 and receiving hospitalization, one had an annual income of $50,000, at least four had assets of between $100,000 and $500,000, and twenty-five had assets of more than $20,000.[69] The commission further noted:

> The Veterans' Administration has found it difficult even to collect on the health-insurance policies of veterans treated for non-service-connected disabilities. Frequently these contracts provide that the insurance company need make no payment for treatment received in veterans' hospitals. As a result, these companies refuse to reimburse the Veterans' Administration on the ground that the veteran has had no personal loss. In such circumstances, the Veterans' Administration does not even bill the company. In 1954, the administration billed insurance companies for $15,000,000, but collected only $3,300,000.[70]

The commission was alarmed that the prevailing situation, whereby responsibility for the medical care of more than 21,000,000 Americans was placed in the hands of the federal government, was a giant first step in undermining the notion of private responsibility for one's medical treatment and thereby paved the way for instituting a national system of socialized medicine.[71] As a result of these findings, the commission strongly urged that the financial status of veterans admitted to VA facilities with non-service-connected ailments be verified and that they be made to pay for any services if they were found to be financially able to do so. In instances where the veteran was incapable of paying, the commission proposed that he be made to sign a note of obligation for the costs of service, payable in the future.[72] The report concluded:

> The Commission's recommendations recognize that the American public is willing to give some preferment to any veteran. However, it would require that veterans take responsibility for their own care when their disabilities are not service-connected. Thus, while the Government is the agent of the people in granting a special privilege for specified causes, there should be no assumption of the right of any group of citizens to receive such care at the expense of all the citizens.[73]

As had been the case with the first Hoover Commission, the American Legion found itself in the forefront of those groups with a vested interest in maintaining the inefficiencies of the government's medical programs. Among the commission's recommendations was that twenty veterans' hospitals be closed immediately and that no new VA hospitals, other than those then under construction, be built.

The Legion's response was to label the commission's findings both "misinformed and uninformed" and to assail its purely "dollars and sense" approach to the health of those who fought for their country.[74] In any event, the Legion need not have worried. By the time the commission submitted its recommendations, Congress had lost interest in reform, especially in those areas that threatened traditional congressional policy. Indeed, inasmuch as the Democrats had recaptured both houses in the 1956 elections, no incentive existed to undo programs that were regarded as the private preserve of certain powerful congressmen.[75] The effect was that the movement for re-

form simply wound down to a stop and the Veterans Administration continued to operate in much the same way as it had prior to the convening of the first Hoover Commission seven years earlier.

The Department of Medicine and Surgery: Training Physicians

The Hoover Commission reports notwithstanding, the Veterans Administration medical programs continued their expansion throughout the 1950s. One of the problems it sought to address was the poor quality of medical treatment offered at its facilities. A continuing complaint leveled at the Veterans Administration from its inception through World War II was the poor quality of the medical care offered. In an effort to remedy this, General Omar Bradley, upon being appointed administrator of the VA in 1945, began affiliating the various Veterans Administration hospitals with the nation's medical resources. Toward this end, in 1946, Congress established the Department of Medicine and Surgery within the VA with the purpose of creating a separate VA medical staff capable of participating in the graduate training of physicians. At the same time, the VA was encouraged to call upon the expertise of the nation's medical faculties in treating its patients. As a consequence, a large number of new VA hospitals were constructed near the nation's medical schools. By 1959, nearly half of the VA's 171 hospitals were associated with teaching institutions.[76]

The various medical schools were expected to take a large measure of responsibility for the quality of medical care in these new hospitals, while the VA supervised operations. This plan required that the VA's physicians, dentists, and nurses cease being subject to the restrictions of the Civil Service, a reform undertaken by Congress concurrent with the establishment of the Department of Medicine and Surgery. At the start of fiscal year 1946, 1,700 of the VA's 2,300 physicians were on active military duty. At the close of the year, however, of the more than 4,000 full-time staff physicians employed by the Veterans Administration, only about 400 were still in active military service,[77] and by 1950 all full-time VA physicians were civilian employees. The new medical program inaugurated a residency-training program at a number of VA hospitals, which allowed medical schools to help treat patients and at the same time alleviate the VA's shortage of physicians. The VA's residency program became increasingly important over the following years as larger and larger numbers of the nation's physicians were trained in VA hospitals.[78] Indeed, by 1957, fully 12 percent of all medical residents in the United States were working at VA facilities. In addition, some sixty-one medical schools had assigned their students as clinical clerks to VA hospitals. These trends were accelerated by passage of Public Law 89-785 in November 1966, which provided statutory recognition of the VA's program of training and education and authorized the VA to increase its contacts with the country's medical schools. Medical and dental students and graduates were not the only groups to undergo training in VA facilities. Pharmacists, nurses, social workers, dietitians, and a host of other health workers were provided training facilities within the VA's medical program. Over the next few years, the VA entered into affiliations with dental schools, nursing schools, schools of social work, and departments of psychology. In the aftermath of the 1966 legislation, the VA's medical manpower training functions were greatly expanded and intensified; as a result, the total number of trainees in VA medical facilities increased sharply, from approximately 23,600 in 1966 to 37,900 in 1969.[79]

In addition to acting as a huge training ground for future medical personnel, the VA attempted to integrate its clinical and research programs with those of the country's medical schools in the hope that an "environment of academic medicine" would increase the quality of care that veterans were offered. Efforts to provide better medical treatment

at veterans' facilities by aligning its standards with those prevailing in civilian hospitals had been made in the past, with little result. As far back as 1925, the Veterans' Bureau had arranged with the American College of Surgeons to undertake a survey of the bureau's hospitals with the intent of raising their standards to those recommended by the college.[80]

However, widespread criticism of the quality of medical care accorded veterans continued through the 1930s and 1940s. Complaints during this period were most often directed at the quality of medical facilities and at the poor qualifications of VA personnel. These concerns were in part addressed in 1946, with the creation of the Department of Medicine and Surgery and the severing of the VA's medical staff from the Civil Service, which had the effect of almost immediately elevating the level of competence in VA facilities. Freed from the regulations, salary scales, and bureaucratic requirements set out for all government employees, VA medical personnel could now be integrated with the nation's medical workforce who were held to the higher standards of the nation's voluntary hospitals. This was especially true as more and more VA hospitals became affiliated with medical schools.[81] At the same time, appropriations for the construction of hospitals and other facilities and the hiring of better-trained staff were substantially increased. The long-run effect of these changes was to advance the quality of medical care in many VA hospitals. Despite improvement in the VA's training facilities, however, complaints about poor care continued. Numerous articles in newspapers and magazines reported horror stories about careless and inadequate treatment at VA medical facilities.

In 1970 the *Los Angeles Times* carried a series of articles decrying the level of care offered at the nation's VA hospitals.[82] In 1982 and again in 1993, the General Accounting Office complained that the VA was extending inconsistent, and often poor, care to female veterans, which at that time comprised over 4 percent of the veteran population.[83]

Inpatient versus Outpatient Care

A secondary effect of substantially increased budgets, which came in the wake of World War II, was an underutilization of expensive specialized medical facilities in many VA hospitals, leading to a large-scale waste of resources.[84] This misallocation was in part due to the distribution of VA resources between inpatient and outpatient facilities. When the veterans health care system was originally established, emphasis was placed on inpatient care, and ambulatory services were regarded as a secondary adjunct. The relation between inpatient and outpatient services in the VA are, in fact, the inverse of what they are in civilian medical practice, where the overwhelming proportion of one's medical care occurs in doctors' offices. Since the VA was originally designed to deal almost exclusively with hospitalized patients, little was originally done to develop an extensive network of outpatient clinics to provide ambulatory care. Consequently, when outpatient services began to be extended to veterans on a regular basis, facilities were comparatively scarce. Even as late as 1976 most outpatient clinics were located in existing VA hospitals, and there were therefore too few locations at which such care was conveniently available.[85] Indeed, with only 214 clinics in the whole of the United States, most veterans lived too far from a clinic to take advantage of any outpatient care offered by the VA. The effect of this uneconomic distribution between inpatient and outpatient resources was (and continues to be) to hospitalize ailing veterans who should, more properly, be treated as outpatients, especially at hospitals that would otherwise be underutilized.[86]

The situation was exacerbated in August 1973 with passage of legislation that extended outpatient benefits to veterans without service-connected disabilities if such care would obviate the need for hospitalization. Prior to that time, outpatient care, other than that connected with pre- or post-hospitalization, had been confined to veterans

under treatment for service-connected disabilities. The effect of this change was to immediately increase the demand for ambulatory care. In fiscal year 1973 the VA reported 10,900,000 visits, while in the following year the number jumped by 13 percent, to 12,300,000 visits.[87] It is clear from these data that the removal of restrictions on who could be treated at outpatient facilities led to an even greater increase in the already substantial growth of outpatient visits. As a consequence, Congress soon chose to constrain the rate of increase by mandating a queuing system based on a series of priorities and at the same time limited the VA's option to contract with private facilities "only when the VA or other government facilities are not capable of furnishing economic care because of geographical inaccessibility or cannot furnish the care or services required."[88]

The National Academy of Sciences (NAS), in its study of the VA's medical facilities, conducted a survey of outpatients in 1975 and found that no less than 67 percent of the sample reported that they considered the VA their usual source of outpatient care. Indeed, only 17 percent claimed to have a private physician.[89] In light of this and inasmuch as the number and geographical distribution of outpatient clinics militated against widespread usage, the authors of the NAS report predicted that the principal consequence of the new law would be a further misallocation of medical resources as more and more patients were hospitalized unnecessarily.[90] This, in fact, appears to have occurred.[91]

The propensity of the VA to underutilize its facilities, particularly by assigning patients in need of long-term care to acute-care facilities,[92] had substantially added to the costs of its medical program.

Pressures from Congress to rationalize its program encouraged the VA in 1965 to establish a new category of medical care—nursing-home care. Nursing-home care also served to provide a more intensive level of care than was available in the VA's domiciliary program, where enrollments had been declining. The average daily member load in VA domiciliaries, which had stood at over 26,500 in 1959, had shrunk to just over 20,000 in 1968, although the numbers of patients needing some level of long-term care remained constant. Congress enacted legislation authorizing the establishment of a nursing-care program in 1964,[93] and the VA complied with the installation of 1,000 nursing beds at twenty-seven of its hospitals.[94] These facilities were designed to accommodate veterans who were diagnosed as too physically disabled for domiciliary living but not ill enough to warrant care in acute medical wards. By the end of fiscal year 1975, the VA was operating almost 27,000 long-term care beds, constituting more than 24 percent of the 112,000 beds operated in VA facilities, but even then the actual number of long-term care patients was substantially greater.[95] The quality of care in the VA nursing-care units does not seem to have been particularly good, although there is some evidence that it has improved somewhat over the course of the last twenty-five years. The National Academy of Science study undertaken in 1975 found that no less than 69 percent of the patients in nursing-care facilities received less than adequate care.[96] By the late 1990s, nursing-home care had become one of the most important aspects of the VA's medical program, especially in light of the substantial decrease in total operating beds. Currently, of a total of 52,000 operating beds throughout the VA system, 15,000 are nursing-home beds.[97]

Changing Demographics

The shift toward extended care followed demographic changes in the veteran population. By 1965, twenty years after the end of World War II, the average age of veterans was 45.8. As these ex-servicemen grew older, one would have expected that their use of the Veterans Administration's medical facilities would have increased as their need for medical care grew. However, the introduction of Medicare in 1965 initially led

large numbers of veterans entitled to the use of VA facilities to continue in private care. While the average age of veterans treated in VA facilities barely changed in the ten years following the introduction of Medicare, over the next decade there was a fairly constant decline in the proportion of patients sixty-five years old and over. In 1965, 33 percent of the patients in VA medical facilities were over the age of sixty-five, while in 1974 it had dropped to 23.8 percent. Conversely, the number of patients under thirty-five increased from 7.1 percent to 11.7 percent. Table 2 shows data compiled by the VA from periodic censuses of inpatients in VA hospitals.[98]

Another factor contributing to this reversal in the average age of VA patients during this period was the passage, in March 1966, of the Veterans Readjustment Benefits Act, which extended VA benefits, including non-service-connected hospitalization, to veterans serving after January 1, 1955.[99] The post-Korean GI Bill, which became effective in June 1966, had the effect of adding approximately 3,000,000 more veterans to the VA's medical program. In the following year, Congress enacted yet another piece of legislation extending all veterans benefits to Vietnam War veterans serving between August 5, 1964 (later adjusted to February 28, 1961) and, as was later determined, May 7, 1975. A major difference between Vietnam-era veterans and those of earlier wars was the larger percentage of disabled military personnel that emerged from the battlefield,[100] which led to increased usage of VA medical facilities by younger veterans.[101] The trend toward younger patients proved short-lived, however, and in 1974 the average age of veterans discharged from VA hospitals once again began to increase. In 1997, only 3 percent of veterans discharged from the VA's medical facilities were under thirty-five years of age, while over 43 percent were sixty-five years old or over. This appears to have remained constant with respect to those over sixty-five. The latest figures available show that in 2007 appropriately 42.7 percent of the 7,340,000 enrollees for VA health care services were sixty-five years old or older, while 13.9 percent were thirty-five years old or younger.[102] This compares to 45.0 percent and 15.0 percent of the 3,643,000 enrollees in 1999.[103]

As a response to the increase in the median age of American veterans, the VA established an Office of Assistant Chief Medical Director for Extended Care in September 1975 and instituted several

Table 2. Average Age of VA Patients and Percentages of Those Under 35 and Over 65, 1965–1974

	Total Average		Under 35 Years Old		65 Years Old and Over	
Census Date	Number	Age	Number	Percent	Number	Percent
October 27, 1965	107,295	54.3	7,558	7.1	35,408	33.0
November 30, 1966	104,870	53.7	8,495	8.1	30,870	29.4
November 30, 1967	98,390	53.8	8,085	8.2	27,545	28.0
November 26, 1968	90,930	53.9	7,765	8.5	23,940	26.3
October 15, 1969	87,545	54.3	7,985	9.1	22,276	25.4
October 14, 1970	85,550	53.6	9,018	10.5	20,247	23.7
October 20, 1971	81,150	54.3	8,813	10.9	20,196	24.9
October 18, 1972	83,425	53.7	9,617	11.5	19,351	23.2
October 3, 1973	82,485	54.1	9,679	11.7	19,710	23.9
October 2, 1974	80,715	54.5	9,435	11.7	19,216	23.8

Source: Administrators of Veterans Affairs. 1975. Annual Report, 1974. Washington, D.C.: Government Printing Office: 20.

new medical programs. These included hospital-based home care, which provided chronically ill veterans with hospital-based treatment in their own homes, and residential care, a more ambitious program in which the VA arranged for the provision of room, board, personal care, and general medical treatment to veterans incapable of living independently but who were judged not to require either hospital or nursing-home care. In addition, the Geriatric Research, Education and Clinical Centers (GRECC) program was created to centralize the study of the health care requirements of aging veterans and to undertake original research in gerontology within the VA clinical system. The Personal Care Home Program, under which a veteran paid for his care (usually out of a combination of VA pension, supplemental security income, and Social Security disability payments), appears to have been particularly successful, and in June 1978 the General Accounting Office, in a study of the Personal Care Home Program (renamed the Residential Care Program in 1980), concluded that the program was a cost-effective alternative to hospitalization and recommended that it be expanded.[104] Finally, a contract program (titled Community Nursing Home Care) was established with the goal of helping veterans who required skilled or intermediate nursing care. Toward this end, a large number of community nursing homes were established throughout the United States. Veterans with service-connected disabilities were eligible for indefinite placement in these facilities, while veterans whose disabilities were non-service-connected were limited to a six-month stay.

In addition to these new programs, the VA was forced to completely revise its approach to health care in light of the aging veteran population. Despite the fact that they were covered by Medicare, larger and larger numbers of older veterans were turning to the VA to cover the costs of extended care inasmuch as Medicare did not cover long-term nursing home charges.[105] The result was that the demand for nursing home care increased while the demand for VA acute medical and surgical care, obtainable under Medicare, decreased. Between 1971 and 1995, the average daily workload in VA hospitals dropped by 56 percent while demand for nursing home and outpatient care increased.[106] By 2008 over almost 80 percent of all veterans had some form of public or private health insurance sufficient to meet their acute-care needs.[107] The 10 percent who were without insurance relied on public hospitals and clinics, particularly VA facilities, for medical care, including—when geographically available—outpatient care.[108] The reduction in the VA's hospital workload was not reflected in a decrease in the VA's medical budget, in part because the costs per average patient day and per hospital inpatient increased substantially over this period, as shown in Table 3.

While these changes were occurring, Congress enacted the Veterans Health Care Expansion Act of 1973,[109] whose provisions included authorization that the VA undertake to furnish medical care to the spouse or child of a veteran who either has a total and permanent service-connected disability or has died as a consequence of a service-connected disability. The law was later amended so that, beginning in 1980, eligibility was extended to the surviving spouse or child of a member of the armed forces who died while on active duty. The program, known as the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA), was designed to offer the same benefits that the Department of Defense extended to families of members of the armed services.[110] The program was fully implemented during fiscal year 1975 with somewhat over 80,000 applications representing more than 150,000 persons approved.[111] It is interesting that few of the services, either inpatient or ambulatory, to which the beneficiaries were entitled were performed at VA facilities. Instead, and more sensibly, the VA acted as a health insurer, underwriting the costs of approved medical treatment by private physicians and hospitals. Over $17 million was expended on the

Table 3. Cost Per Average Patient Day and Total Cost Per Hospital Inpatient*: Fiscal Years 1975–1984

	Cost Per Hospital Inpatient			
Fiscal Year	Per Diem Amount	Index (1975 = 100)	Amount	Index (1975 = 100)
1975	$75.71	100	$1,984	100
1976	87.86	116	2,135	108
1977	103.27	136	2,346	118
1978	119.10	157	2,583	130
1979	133.82	177	2,772	140
1980	154.00	203	3,077	155
1981**	166.05	219	3,222	162
1982	190.36	251	3,629	183
1983	206.89	273	3,833	193
1984	220.49	291	3,947	199

NOTES: *Includes physicians' fees, medications, and all other direct costs plus administrative costs and assets acquisitions. **Beginning in 1981, data are calculated on the basis of obligations rather than costs.
Source: Administrator of Veterans Affairs. 1985. *Annual Report, 1984*. Washington, D.C.: Government Printing Office: 56.

program in its first year of operation, with a total of somewhat over $830 million by 2008, treating approximately 310,000 enrollees.[112] Studies conducted by the VA itself indicated that contracting out for medical services was more cost-effective than was providing the services directly.

Establishing a Means Test for Medical Care

Every attempt to reduce funding for the VA's medical care programs was met by sustained and vigorous opposition by the American Legion and other veterans' groups. The Legion's Medical Affairs Committee was one of the most powerful lobbies in Washington and consistently fought for more generous funding and against all attempts to put pressure on the VA's budget in order to decrease inefficiencies.[113] It was therefore in the face of considerable opposition from veterans groups that the Reagan administration had, during the early and mid-1980s, several times proposed that a means test be established for certain classes of VA medical care. In 1985, Congress began debating the inclusion of a means test and third-party reimbursement, to which the American Legion strenuously protested. The Legion maintained that inasmuch as the largest number of VA patients were elderly and comparatively poor, the cost of screening claimants would prove more costly than any savings to the VA. With respect to third-party reimbursements, through which the government sought to recoup a portion of health-care costs from private insurance companies that insured health-care claimants, the Legion argued that the government was morally and legally bound to care for those who had contributed a portion of their lives to their country and that "cost sharing" violated this obligation. The Legion was further concerned that any third-party reimbursement scheme would ultimately lead the VA to steering veterans to private-sector hospitals, thus eroding the special medical status of accorded veterans.[114]

In any event, Congress overruled the Legion's objections, passing the Veterans Health-Care Amendments in April 1986.[115] The act granted statutory authority to Veterans Affairs to bill third-party health insurance carriers for medical care provided to veterans for treatment of their non-service-connected disabilities, established a means

test for VA medical treatment of non-service-connected disabilities, and authorized the VA to charge veterans earning more than $20,000 per year. The law established three categories of veteran eligibility for medical care, depending on whether the veteran seeking treatment was suffering from a service-connected disability and, in the case of non-service-connected disabilities, on the applicant's income. All veterans falling under Category A received priority admission to VA facilities, whether for hospital or nursing home care. These included (1) veterans with service-connected disabilities, (2) those who were in receipt of a VA pension, (3) those eligible for Medicaid, (4) former POWs, and (5) veterans whose incomes were below a certain specified amount. Category B and Category C veterans were those with non-service-connected disabilities, with a means test determining to which category one belonged. Those in Category C were obligated to reimburse the VA for a portion of the expenses incurred in their treatment, either directly or through their medical insurance. This marks the first time the VA established a means test for medical treatment. While those veterans with incomes in excess of the means-test levels continued to be eligible for both inpatient and outpatient care if the resources were available, they now had to agree to a co-payment.[116] The Legion complained bitterly that these provisions were "insulting" and amounted to disenfranchising veterans and immediately called for the establishment of a team to gather data on its operation. "Project Concern," as this group was known, soon released a series of case histories detailing the "abuses" of the law by VA personnel and the horrors to which some veterans were subjected as a consequence of these provisions. Finally, in September 1986, the Legion authorized "litigation to challenge and clarify VA policies on Public Law 99-272."[117] Notwithstanding the Legion's objections, the existence of a means test for veterans suffering from non-service ailments continued even after Congress revised the eligibility requirements for VA medical treatment in 1996.

While veterans groups were unsuccessful in preventing the introduction of a means test, they did finally prevail on Congress to elevate the Veterans Administration to Cabinet status. President Reagan had issued a statement in support of a Department of Veterans Affairs while the House was considering the matter in the fall of 1987. A bill, which had almost 200 sponsors, soon cleared the House Committee on Government Operations, and the full House passed it in December by a vote of 399 to 17. Senate hearings before the Committee on Governmental Affairs, under the chairmanship of Senator John Glenn of Ohio, were held on a similar measure in March of the following year. The motives behind the bill were, predictably, purely political. The Senate bill had sixty-five cosponsors, and the witnesses appearing before Senator Glenn's Committee gave overwhelming support to the proposal, the arguments favoring the change couched in the most fatuous language. In almost 400 pages of testimony, there is not one substantive argument put forward for raising the Veterans Administration to a Cabinet department other than references to "the nation's debt" to its veterans. The testimony of Senator Strom Thurmond of South Carolina was typical:

> In recognition of the contributions to freedom and liberty made by servicemen and women, our Government has placed a high priority on the welfare of its veterans. It is the highest obligation of citizenship to defend this Nation in time of need and this obligation creates an equal responsibility on the part of our Nation to care for the men and women who have worn the uniform. It would be more appropriate for the principal Federal agency charged with providing benefits and services to veterans, and their dependents and survivors, to have Cabinet-

level status. The honor and respect due our veterans requires no less.[118]

Only Senator Alan Simpson of Wyoming expressed reservations about the proposed Department of Veterans Affairs, pointing out that American veterans were extremely well-treated and that the proliferation of political appointments that would follow creation of a Cabinet-level department was unnecessary. At the same time, Simpson urged that the Senate bill be amended to allow judicial review of the VA's Board of Veterans Appeals decisions,[119] a provision the American Legion firmly opposed. After much lobbying, the Legion was able to prevail on Senator Glenn to quash the judicial review provisions in Committee, where it was approved for action on the Senate floor in April. The bill passed the full Senate in July. The Legion was ecstatic, and its national commander remarked that Congress had at last "ignored the bankrupt bleatings of a few who would deny veterans their earned place in the executive branch."[120] In October 1988 President Reagan signed the new act,[121] and on March 15, 1989, the Veterans Administration became the Department of Veterans Affairs with Edward J. Derwinski, at the time VA administrator, appointed Secretary of Veterans Affairs. Among the three main divisions in which the new department was divided, the most important was the Veterans Health Administration (VHA), which inherited the functions of the Veterans Health Services and Research Administration.

Non-Service Related Health Care (Substance Abuse and Homelessness)

When the Veterans Bureau was initially established in 1924, its primary mission had been to treat veterans of World War I, particularly those with service-connected disabilities such as blindness, paralysis, and loss of limbs. Since that time the VA's medical services have become the largest in the nation, with an annual budget of over $42 billion and a vast physical plant, including 153 hospitals, 819 ambulatory and community-based clinics, 135 nursing care units, 49 domiciliary sites, and 232 readjustment counseling centers. In fiscal year 2008, over 7,900,000 veterans were enrolled in Department of Veterans Affairs medical programs and 5,577,000 patients received medical treatment. Its facilities are affiliated with 107 of the nation's 130 allopathic and 15 of its 25 osteopathic medical schools, and 56 dental schools. In addition, its training facilities accommodate over 34,000 medical residents a year.

In spite of its history of treating discharged military personnel for disabilities obtained while in service, the VA's medical facilities have, since World War II, increasingly become the treatment facility of choice for poorer veterans whose medical problems are unconnected with their military service. In fiscal year 2008 the number of enrollees in the VA medical system who had some form of service-connected disability (including those who had service-connected disabilities but were treated for conditions unrelated to their disability) was slightly over 34 percent. The remaining 66 percent of the patients treated had no service-connected disability.[122]

In 2008 over 52 percent of all patients enrolled in the VA health system were also covered by some level of Medicare, and of these over two-thirds had Medicare Part B (supplemental) coverage. In addition, over 7.7 percent were covered by Medicaid.[123]

An extensive study undertaken in 1994 found that 23.3 percent of all patients were hospitalized for psychiatric disorders, which accounted for almost 43 percent of bed days in VA facilities.[124] Doubtless this number has increased in light of the large number of psychiatric disorders associated with service in Iraq and Afghanistan.[125] In addition, alcohol and drug dependence played and continue to play a major role in the list of disorders presented by veterans seeking medical treatment. The National Survey on Drug Use and

Health, published in November 2005, found that no less than 200,000 veterans had to be hospitalized or placed in a rehabilitation facility over the preceding twelve months for some kind of substance abuse.[126] A General Accounting Office study done in 1995 found that in fiscal year 1995 almost 25 percent of all VA patients discharged from inpatient settings had been diagnosed as having alcohol or drug abuse problems. The VA then estimated that it spent $2 billion, about 12 percent of its total health-care budget, treating veterans with substance abuse disorders.[127] That alcohol and drug dependence are so prominent among veterans who make use of the VA's medical facilities is a reflection not only of veteran demographics but of the role played by the Vietnam and Iraq wars. In addition to setting up treatment centers for substance dependence, the VA found it necessary to deal with the large number of homeless veterans throughout the country following these conflicts. In 1987 the Veterans Administration launched a program that sought to offer treatment for these veterans.

Current estimates indicate that about one-third of the adult homeless population have served in the military and that up to 130,000 veterans live on the streets or in shelters, while approximately twice that number are homeless at some point during the year.[128] Most of this population are Vietnam War veterans, and while the Department of Veterans Affairs claims that they can discover no link between combat exposure and service in Vietnam, impressionistic evidence seems to suggest that the mental conditions that give rise to homelessness are yet another legacy of that dreadful war.

The federal government began addressing the problem of homeless veterans in the late 1980s, for the most part funded through the Veterans Health Administration programs, among them the Health Care for Homeless Veterans and Domiciliary Care for Homeless Veterans. The Health Care for Homeless Veterans (HCHV) system supplies physical and psychiatric support through 132 distinct sites while the Domiciliary Care for Homeless Veterans (DCHV) program provides medical services through 38 medical centers and has 1,950 beds available.[129] The budgets of these two programs have increased substantially over the course of the last twenty years. The budget for the HCHV program, which was slightly less than $13 million in 1888, reached $36 million in 1998, and over $80 million in 2009. Expenditures on the DCHV program increased from $15 million in 1988 to $38 million in 1998 and more than $98 million in 2009.[130]

The Department of Veterans Affairs

The transformation in the VA's structure in the last five years has been dramatic. In the words of a high-ranking official in the Department of Veterans Affairs, the Veterans Health Administration (VHA) has, since the mid-1990s, sought to transform itself from a disease-oriented, hospital-based health care system to a system that is "patient-oriented, prevention-oriented, community-based, and which has universal primary care at its foundation."[131] In keeping with this, major changes were made to the VHA's organizational structure in late 1995. Prior to its reorganization, the VHA's numerous medical facilities throughout the United States were under the authority of an associate chief medical director for operations, who provided operational direction and supervision of four geographical regions, each of which was headed by a regional director who supervised the operation of the approximately thirty-five to forty-five medical care facilities within his region. In place of this schema, the VHA has restructured its facilities into twenty-four service delivery networks, called Veterans Integrated Service Networks (VISNs), thus integrating services within and among medical centers. Each VISN was designed to form a fully integrated health care system providing a whole range of health care services to patients residing in

a particular geographic area. Emphasis has shifted from inpatient hospital care to primary care in a great number of community-based clinics and has expanded evening and weekend hours.[132]

As a consequence of the shift in veteran demographics and the VHA's restructuring, veterans' medical facilities underwent a series of changes in the late 1990s. Among them:

- Between fiscal year 1994 and fiscal year 1998, more than 52 percent of all hospital beds in FHA facilities were closed.
- The number of bed days of care per 1,000 patients declined by more than 62 percent nationally from October 1995 to September 1998, from 3,530 to 1,333.
- Inpatient admissions declined by 31 percent since fiscal year 1994.
- The number of ambulatory care visits has increased by almost ten million, a 35.4 percent increase between fiscal year 1994 and fiscal year 1998.
- Between 1995 and fiscal year 1998, ambulatory surgeries increased from approximately 35 percent of all surgeries performed to about 92 percent.[133]

In 1996 Congress passed the Veterans' Health Care Eligibility Reform Act, which completely restructured the VA health care system and established a patient enrollment classification. The effect of this legislation was to serve all veterans who enrolled in the system, in addition to those veterans who suffered from service-connected disabilities and those who were indigent. In addition, the Veterans Millennium Health Care and Benefits Act of 1999 had the effect of increasing demand for primary care through the creation of 600 community-based outpatient clinics. Since that time the growth in demand for VA medical services has dramatically increased, almost doubling in the ten years since 1999. One effect of this increase in enrollment was enormously long waiting times veterans had to endure before being incorporated into the VA health care system, largely as a consequence of poor or nonexistent communication between the Department of Defense's medical division and the Veterans Health Administration. So serious had this problem become that in May 2001 President George W. Bush appointed a committee under the joint chairmanship of Dr. Gail R. Wilensky and one-time Congressman John Paul Hammerschmidt (Republican from Arkansas)[134] to investigate conditions at the agency and to make recommendations to improve the medical services extended to veterans. The report, submitted two years later, noted, among other things, that there existed almost no coordination between the VA and the Department of Defense respecting medical information about VA beneficiaries. One effect of this was that "as of January 1, 2003, more than 236,000 enrolled veterans were on waiting lists of more than six months for a first appointment or for an initial follow-up for heath care from the VA."[135]

This appears to have been an ongoing problem. Another congressional commission had addressed it in 1991,[136] and the Congressional Commission on Service Members and Veterans Transition Assistance had considered it in 1998.[137] All three commissions made similar recommendations regarding the need for greater coordination between the Department of Defense's medical division and the VA, but they lacked specificity. One example of these commissions' empty recommendations is made in the 2001 commission's *Final Report:* "Leaders must establish organizational cultures and mechanisms that support collaboration, improve sharing, and coordinate management and oversight of health care resources and services, with clear accountability of results."[138] However, nothing appears to have changed. In 2005, 18 percent of service-connected veterans waited more than thirty days to see a physician.[139] This condition persisted into 2007, despite the VA's claim that this was not longer true.[140]

In October 1996, Congress enacted new legislation providing that the VA institute an annual enrollment system based on seven specified priority categories.[141] After October 1998, treatment by the VA, either inpatient or outpatient, was confined to those enrolled in the system. Priority was given, in order, to: (1) those veterans with service-connected disabilities who were rated at least 50 percent disabled, (2) those with lesser disabilities whose ailments were service-connected, (3) former POWs, and (4) veterans who were determined to be "catastrophically disabled." These groups were followed by: (5) veterans who were determined to be unable to defray the costs of needed care, that is, veterans with incomes below the means-test threshold (at the time $22,351 for single veterans and $26,824 for veterans with one dependent). The final categories included: (6) all other veterans not obligated to make copayments for their treatment,[142] and (7) veterans without service-connected disabilities who agreed to make copayments for their treatment. In fiscal year 1999, 43 percent of VA users fell within category five, with incomes below the means-test threshold (approximately 1,400,000 enrollees out of a total 4,000,000).[143] Between its inception and 2002, the VA elected to enroll all eligible veterans. However, in January 2003 the Secretary of Veterans Affairs no longer enrolled higher income veterans who had not previously been enrolled.[144] As a consequence, as the number of veterans has increased, the number of enrollees has climbed at a slower rate.

While these reforms reduced the amount of waste and mismanagement that had been endemic to the VA since its founding, in no way did they eliminate the problems. While the gap in length-of-stay in VA hospitals compared to other hospitals was appreciably reduced, it still remained significant throughout the late 1990s. The percentage difference in average length of stay of all VA patients relative to those in other hospitals in 1999 was 17.0 percent, ranging from 5.5 percent longer for kidney and urinary tract infections to 28.8 percent longer in cases of cardiac atherosclerosis.[145] The improvements that did occur were largely the result of better quality control, more economical use of VA facilities, and greater reliance on electronic recordkeeping. However, despite these changes, conditions again deteriorated after the government decided to intervene in Iraq in 1991 and again in 2003 and in Afghanistan in October 2001, thus substantially increasing the number of veterans needing medical care.[146]

Conclusion

There is no question that the conflicts in Iraq and Afghanistan will continue to substantially increase the costs of the VA health services' operations. A study undertaken in 2007 by Linda Bilmes of Harvard University[147] concludes that the lifetime costs of providing disability benefits and medical care to the veterans of these two wars, depending on the length of time the U.S. commits troops to these areas, will amount to between $350 and $700 billion. This is largely the result of the fact that the ratio of troops wounded to those killed is far greater than in previous conflicts. While this ratio in the Vietnam and Korean wars was two injured for every fatality, in Afghanistan and Iraq the ratio is sixteen to one.[148]

The shift from inpatient to ambulatory care, an increase in chronic care needs in an aging population, and increases in the demand for medical services as a result of the most recent Middle Eastern conflicts clearly undermines the reasons originally put forward for the government to operate a direct delivery health-care system. The rationale for constructing this immense health-care edifice was extremely weak to begin with, but in light of the change in demand from acute to long-term treatment and from hospital to outpatient care, the arguments supporting a direct delivery system are practically nonexistent. It is obviously impractical for the Veterans Health Administration to duplicate the outpatient facilities available

to non-veterans throughout the country, and unless they were to attempt some such duplication, VHA outpatient facilities would of necessity remain geographically inaccessible to the majority of potential users. An aging and declining veteran population has led the governments of Australia, Canada, and the United Kingdom to close or convert their veterans' hospitals to other uses and to integrate the treatment of veterans into their general health-care systems.[149] Surely this policy makes equal sense in the United States. At the very least, the Department of Veterans Affairs could subsidize the treatment of qualified veterans who consulted physicians or were hospitalized on a fee-for-service basis, as they do with respect to those covered by CHAMPVA. However, except in very limited circumstances, this policy is currently against the law and is unlikely to be instituted inasmuch as most of the DVA's health care budget is spent on maintaining its direct delivery infrastructure.[150] "Solutions" such as allowing veterans' dependents to use the VA's excess hospital capacity or converting acute-care hospitals into nursing homes undermines the whole purpose of the VA's medical programs and would pit government health care against private health care in direct competition. What direction these programs will eventually take remains an open question.

Appendix

Table 1. Number and Median Age of Veterans: Fiscal Years 1969–2008 (in thousands)

		Under 35		Over 65		
Year	Total	Number	Percent	Number	Percent	Median Age
1969	26,925	6,224	23.1	2,024	7.5	44.3
1970	27,647	6,666	24.1	1,996	7.2	44.4
1971	28,288	7,110	25.1	1,993	7.0	44.5
1972	28,804	7,455	25.9	2,025	7.0	44.7
1973	29,073	7,505	25.8	2,076	7.1	45.0
1974	29,265	7,510	25.7	2,125	7.3	45.5
1975	29,459	7,520	25.5	2,202	7.5	45.9
1976	29,607	7,463	25.2	2,294	7.7	46.3
1977	29,844	7,487	25.1	2,374	8.0	46.5
1978	29,984	7,283	24.3	2,540	8.5	47.0
1979	30,072	7,054	23.5	2,757	9.1	47.5
1980	30,118	6,750	22.4	3,011	10.0	48.0
1981	30,083	6,239	20.7	3,320	11.0	48.0
1982	28,522	5,312	18.6	3,506	12.3	50.8
1983	28,202	4,370	15.5	4,175	14.8	51.8
1984	28,027	3,906	13.9	4,618	16.5	52.3
1985	27,839	3,569	12.8	5,040	18.1	52.9
1986	27,382	3,400	12.4	5,507	20.1	53.4
1987	27,469	3,205	11.6	5,986	21.8	53.9
1988	27,279	3,061	11.2	6,431	23.6	54.4

Table 1. Number and Median Age of Veterans: Fiscal Years 1969–2008 (in thousands)

		Under 35		Over 65		
Year	Total	Number	Percent	Number	Percent	Median Age
1989	27,105	2,899	10.7	6,888	25.4	54.9
1990	26,885	2,759	10.3	7,283	27.1	55.3
1991	26,629	2,590	9.7	7,645	28.7	55.7
1992	26,838	2,641	9.8	8,035	29.9	56.0
1993	26,655	2,689	10.1	8,354	31.3	56.3
1994	26,365	2,555	9.7	8,542	32.4	56.7
1995	26,067	2,400	9.2	8,750	33.6	57.1
1996	25,881	2,309	8.9	8,994	34.8	57.4
1997	25,551	2,193	8.6	9,149	35.8	57.7
1998	26,267	2,064	7.9	9,258	35.2	56.5
1999	25,947	1,914	7.4	9,619	37.1	57.1
2000	25,498	2,212	8.7	9,531	37.4	57.4
2001	25,038	2,105	8.4	9,409	37.6	57.7
2002	24,570	2,213	8.6	9,269	37.7	58.0
2003	24,098	2,116	8.8	9,107	37.8	58.3
2004	23,625	2,007	8.5	8,938	37.8	58.6
2005	23,150	1,866	8.1	9,761	37.8	59.1
2006	23,977	1,949	8.1	9,200	38.4	60.0
2007	23,816	1,900	8.0	9,302	39.1	60.0
2008	23,400					61.0

SOURCE: Annual Reports. Various years.

Table 2. Veteran Enrollees, Total Medical Expenditures, and Expenditures Per Enrollee; Veterans Receiving Care, Total Medical Expenditures, and Expenditures Per Patient: FY2002–2009

Year	Total Expenditures (million $)	Enrollees (thousands)	Expenditures Per Enrollee	Veterans Receiving Care (thousands)	Expenditure Per Veteran Receiving Care
2002	21,916	6,882	3,184	4,246	5,160
2003	24,361	7,187	3,290	4,544	5,361
2004	26,845	7,732	3,517	4,742	5,661
2005	29,689	7,745	3,833	5,308	5,593
2006	29,340	7,872	3,727	5,466	5,368
2007	33,999	7,833	3,340	5,479	6,205
2008	37,201	7,835	4,748	5,577	6,670
2009	42,000	8,317	5,050	5,929	7,084

SOURCE: Congressional Research Office. Various Years. Veterans Medical Care Funding. Washington, D.C.: Congressional Research Service.

Notes

1. This essay draws on sections of a previously published monograph on the history of government involvement in public health: *Government and Public Health in America.* 2007. Northampton, Mass.: Edward Elgar.

2. For a brief history of federal efforts to provide domiciliary care for veterans, see Ijams, Col. G. E. 1935. History of Medical and Domiciliary Care of Veterans. *The Military Surgeon* 76 (March): 113–133; and *History of the National Home for Disabled Volunteer Soldiers.* 1875. Dayton, Ohio: United Brethren Printing Establishment: 17–50. Kelly, P. J. 1997. *Creating a National Home: Building the Veterans' Welfare State, 1860–1900.* Cambridge, Mass.: Harvard University Press. Offers a sociological analysis of the role played by American soldiers' homes in creating a new form of citizenship—martial citizenship—at the point where the welfare state conjoined with a warfare state.

3. Federal pensions awarded to Civil War veterans and their dependents were already among the most generous in the world, thanks to a series of prodigal Republican administrations. When, in 1887, Congress passed a bill that would have extended pensions to any person who had served at least three months in any war in which the United States had been engaged and who were incapable of "procuring subsistence by daily labor," President Grover Cleveland, a Democrat, in vetoing the bill, noted that Civil War soldiers, in their pay, bounty, pension provisions, and preference for public employment, had "received such compensation for military service as has never been received before since mankind first went to war." *Congressional Record* (1887). 49th Cong., 2d sess. vol. 18, pt. 2, 1638. Quoted in Weber, G. A. and L. F. Schmeckebier. 1934. *The Veterans Administration: Its History, Activities, and Organization.* Washington, D.C.: The Brookings Institution: 42–43.

4. The number of Union veterans surviving the Civil War was close to 2,000,000, and they and their dependents represented a substantial block of voters to which the Republican Party was particularly attentive.

5. Skocpol, T. 1992. *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States.* Cambridge, Mass.: Belknap Press of Harvard University Press: 109.

6. On Forbes, see Severo, R. and L. Mumford. 1989. *Wages of War: When American Soldiers Came Home, from Valley Forge to Vietnam.* New York: Simon and Schuster: 247–257.

7. Dillingham, W. P. 1952. *Federal Aid to Veterans: 1917–1941.* Gainesville, Fla.: University of Florida Press: 65. Net hospital operating costs refer solely to the costs of hospital operation and do not include, among others, the costs of outpatient care, dental care, and hospital construction.

8. The number of hospital beds occupied increased from slightly over 30,000 in 1930 to 58,000 at the outbreak of war eleven years later. Dillingham, *Federal Aid to Veterans*.

9. Congress chartered the American Legion in September 1919, and the Legion held its first convention in Minneapolis in November of that year, with the goal of advancing the interests of veterans. The Legion quickly became the primary spokesman for those who had served in the military. Among its ongoing concerns was maintaining an inflexible opposition to any type of "anti-Americanism," which the Legion associated with all manner of "left wing" causes, among them opposition to higher military appropriations and to universal military service. The Legion quickly set up a Committee on Americanism, still active, to root out "Bolshevism," pacifism, and other "alien" influences from American life. For a history of the Legion, see Rumer, T. A. 1990. *The American Legion: An Official History, 1919–1989.* New York: M. Evans & Co.

10. The Hearst organization quickly assigned three full-time reporters to the project. Rumer, *The American Legion*, 245. Hearst was strongly opposed to Roosevelt's postwar international designs and apparently thought that if Congress could be persuaded to set up an elaborate benefits program for returning veterans, members would be less likely to appropriate funds for economic assistance to liberated countries. See Bennett, M. J. 1996. *When Dreams Came True: The GI Bill and the Making of Modern America.* Washington, D.C.: Brassey's: 77.

11. According to one Gallup poll, over 81 percent of Americans favored granting a bonus to returning veterans. Bennett, *When Dreams Came True*, 78.

12. In January 1942, President Roosevelt ordered the NRPB to prepare a document that would create new "freedoms" applicable to all Americans to be added to the Bill of Rights, including the "right" to fair pay, the "right" to adequate food, a "decent home," "adequate medical care," to "rest, recreation, and adventure," to "adequate protection from the economic fears of old age, sickness, accident, and unemployment," and the right to a "good" education. Graham, Jr., O. L. and M. Robinson Wander, eds. 1985. *Franklin D. Roosevelt: His Life and Times.* Boston: G. K. Hall & Co.: *s.v.* "Planning." The NRPB, with Roosevelt's help, did in fact draft such a document, which Roosevelt later used in his 1944 State of the Union address, outlining a new economic Bill of Rights that was to be achieved through government. See Goodwin, D. K. 1994. *No Ordinary Time: Franklin and Eleanor Roosevelt: The Home Front in World War II.* New York: Simon & Schuster: 485–486; and Freidel, F. 1990. *Franklin D. Roosevelt: Rendezvous with Des-*

tiny. Boston: Little, Brown and Co.: 500. In response to further prompting from the president, the NRPM put forward yet a more ambitious proposal in March 1943. Fearful of being outdone by Britain's Beveridge Report, the NRPB developed a comprehensive plan for extensive cradle-to-grave social security measures, most of which would be under the control of the federal government. Bennett, *When Dreams Came True*, 82–83, 87.

13. Radio broadcast of July 28, 1943. "First Crack in the Axis." Quoted in Bennett, *When Dreams Came True*, 88.

14. The original scheme provided that they be forced to remain in the military until they could be reabsorbed into civilian life. See Bennett, *When Dreams Came True,* 85–86.

15. The Hearst papers consistently placed passage of a veterans' bill alongside Roosevelt's international concerns, particularly the president's support for appropriations for the United Nations Relief and Rehabilitation Administration. Bennett describes one cartoon that ran in all the Heart newspapers on December 29, 1943. "Under the title 'Merely Our Son' is shown a disabled veteran, with one foot gone, supporting himself on crutches and looking into a store window with a sign, 'Ye New Deal Globaloney Shoppe: Goodies for Good Neighbors.'" *When Dreams Came True*, 101.

16. Indeed, the measure provided the most comprehensive package of benefits ever offered to veterans of any country. Among its other provisions were those that extended medical and hospital care, readjustment allowances and compensation for temporary unemployment, home loan guarantees, vocational and on-the-job training, and loans for farming and small businesses.

17. "National service," the president observed, "has proven to be a unifying moral force—based on an equal and comprehensive legal obligation of all people in a nation at war." "Annual Address to Congress, January 11, 1944." In J.B.S. Hardman, *Rendezvous with Destiny.* New York: The Dryden Press: 230. The president's wife had been a longtime advocate of national service. In March 1942, after having attended a White House conference on manpower needs, she announced: "I've come to one clear decision, namely that all of us—men in the services and women at home—should be drafted and told what is the job we are to do. So long as we are left to volunteer we are bound to waste our capacities and do things that are not necessary." *My Day*. [Eleanor Roosevelt's daily newspaper column.] March 10, 1942. Quoted in Goodwin, *No Ordinary Time*, 331.

18. Perhaps nothing better reflects the totalitarian instincts shared by many during World War II than the fact that a large number of educated Americans embraced Roosevelt's proposals. Thus, the *New York Times* editorialized that a national service act was both fair and proper and "in the spirit of democracy." January 12, 1944, 22.

19. Quoted in Bennett, *When Dreams Came True,* 148.

20. Even in an age of racism and open bigotry, Rankin stood out. He regarded communism as a creature of international Jewry and viewed blacks as subhuman and incapable of caring for themselves. One of the leading supporters of the House Un-American Activities Committee, Rankin responded to Walter Winchell's reservations about the committee's work by referring to Winchell as "a little slime-mongering kike." Rankin served sixteen terms in Congress, representing the white population of his district in Mississippi. His supposed distrust of government control of the means of production apparently did not extend to the generation and distribution of electric power inasmuch as he coauthored the bill creating the Tennessee Valley Authority.

21. Quoted in Bennett, *When Dreams Came True*, 150.

22. Bennett, *When Dreams Came True*, 148.

23. Maisel's article was reprinted in *Reader's Digest* in April 1945. See Severo and Milford, *The Wages of War*. 304–305. Maisel's article was especially critical of the VA hospitals at Castle Point, New York, and Dayton, Ohio. The April 1945 issue of *Harpers* also ran a critical article, detailing the bureaucratic maze that veterans just entering civilian life were forced to thread before receiving benefits.

24. Severo and Milford, *The Wages of War*, 306.

25. The Legion was concerned that placing veterans in private hospitals would become more common, thus "diminishing the medical professionalism of the VA" and "hindering the special medical and neuropsychological needs of veterans." Rumer, *The American Legion*, 264.

26. See *The New York Times*, February 2, 1946. The statement is quoted in Rumer, *The American Legion*, 265. The acrimony between Bradley and Stelle was compounded by the fact that the VA had disregarded Stelle's suggestion that a new VA hospital be constructed in Decatur, Illinois, Stelle's hometown. Fearful that he had overstepped the bounds of legitimate criticism of the Veterans Administration and would lose support among his own legionnaires, Stelle later denied that his intent was to recommend that Bradley be replaced as administrator.

27. Rumer, *The American Legion*, 268.

28. It was estimated that the number of living veterans, together with their dependents, amounted to almost 40 percent of the population of the United States.

29. This list of VA programs appears in Rumer, *The American Legion*, 310–311.

30. These data come from the Veterans Administration. *Annual Report, 1950.* 1951. Washington, D.C.: Government Printing Office: *passim*.

31. Within a few weeks of Japan's surrender in August 1945, members of the armed forces were being discharged at the rate of 100,000 per month. By the end of 1946, 9,000,000 of the 12,000,000 soldiers and sailors on active duty had been mustered out, and by 1948 the army had been reduced from its high of 8,000,000 to 550,000. Bennett, *When Dreams Came True*, 5.

32. Supplement on "Big Government: Can It Be Managed Efficiently? [A Digest of the Reports of the Commission on Organization of the Executive Branch of Government]."1949. *Fortune* (May): Supplement, 4.

33. Quoted in *Fortune,* Supplement, 2.

34. It should be underscored that the commission's mandate was not to recommend ways in which the federal government's powers could be curtailed but rather to deal exclusively with questions of organization and procedure. The sheer amount of government intrusion was not at issue and was scrupulously avoided by the commission's membership.

35. "Digest," *Fortune*, Supplement, 23.

36. "Digest," *Fortune,* Supplement, 21.

37. Gervasi, F. 1949. *Big Government: The Meaning and Purpose of the Hoover Commission Report.* Westport, Conn.: Greenwood Press: 177–178.

38. "Digest," *Fortune*, Supplement, 22.

39. "Digest," *Fortune*, Supplement, 22. Details of the proposed UMA can be found in Gervasi, *Big Government*, 176–190.

40. Ralph Godwin, who served on the National Executive Committee, quoted in Rumer, *The American Legion*, 313.

41. Rumer, *The American Legion*, 309.

42. In addition to recommending that the VA's medical functions be transferred to a new united medical administration, the Hoover Commission also proposed that a new government corporation be established to administer veterans' insurance.

43. Quoted in Rumer, *The American Legion,* 310.

44. The ostensible reason for this reduction was the fact that Congress had ordered a pay increase for federal employees but had failed to appropriate sufficient additional funds to the VA to offset these additional expenses.

45. Under the Reorganization Acts of 1945 and 1949, which granted to President Truman reorganizational authority for the executive branch, Truman submitted a series of Reorganization Plans to the House Committee on Expenditures, one of which—Number 27—called for the creation of a cabinet-level agency, the Department of Health, Education, and Security, which would have taken over responsibility for veterans' affairs. The Legion feared that creating such an agency, whether or not a united medical administration was established, would almost certainly lead to weakening the Legion's influence and to de-emphasizing the importance of veterans' benefits and their eventual loss.

46. Quoted in Rumer, *The American Legion*, 315.

47. Quoted in Rumer, *The American Legion,* 313.

48. The Hoover Commission Report noted that the "VA has the advantage, from the viewpoint of the veterans' groups, of being deliberately designed to aid veterans as a special class." Gervasi, *Big Government,* 181.

49. A Gallup poll taken in March 1950 found that only 31 percent of those polled were familiar with the details of the Hoover Report. Among those, however, more than 92 percent supported the recommendations. Even among the 69 percent who were uninformed about the Report's specific proposals, an overwhelming number supported the commission's stated goals: to reduce the amount of the federal government's waste and increase its efficiency. Rumer, *The American Legion,* 315.

50. Hoover, H. 1949. The Reform of Government: The Burden Now Shifts from the Commission to the New Citizens Committee. *Fortune* (May): 73.

51. Rumer, *The American Legion*, 318.

52. Rumer, *The American Legion*, 323.

53. Gervasi, *Big Government*, 186.

54. It had never been the case that veterans whose service was limited to peacetime received the same benefits as those who served in time of war. See *The Historical Development of Veterans' Benefits*, *passim.* This was to change when the draft officially ended on December 31, 1972, after which benefits were extended to all veterans by a series of Congressional acts.

55. The American Legion, in lobbying for an extension of benefits to veterans of the Korean conflict, had publicized several stories of Korean War veterans who had been refused hospital treatment at VA facilities for ailments that were service-related. One such case, reputed to have occurred on May 9, 1951, involved a twenty-one-year-old Korean War veteran who sought to be admitted to the VA hospital in Tucson, Arizona, but was refused admission since he was regarded as "a peacetime soldier," no formal declaration of war having been made by Congress. "Under the present setup," the director of the Tucson hospital is reputed to have said, "no returned veteran from Korea is eligible for hospital benefits unless he had been discharged from the service because of a duty disability." The effect of such propaganda

was quick passage of legislation extending benefits to Korean War veterans, which passed Congress on May 11. Rumer, *The American Legion*, 347–348.

56. Quoted in Rumer, *The American Legion*, 350–351.

57. Rumer, *The American Legion*, 353.

58. Rumer, *The American Legion*, 355. The Legion had coined the term "slide rule hospital care" to refer to the type of economic calculation of costs undertaken by the Hoover Commission and the Bureau of the Budget. Such calculations, they maintained, showed little appreciation for the "human" side of the needs of disabled veterans.

59. Arnold, P. E. 1986. *Making the Managerial Presidency: Comprehensive Reorganization Planning, 1905–1980.* Princeton, N.J.: Princeton University Press: 167–168.

60. By this point in his career, Hoover's sense of self-importance had grown to the point where he demanded the kind of deference he had been denied since Roosevelt's election victory in 1932. He insisted that Eishenhower personally name him as chairman, and he was given a crucial voice in recommending the other commissioners. Arnold, *Making the Managerial Presidency*, 169–170.

61. The commission created a series of investigative committees, among them a Task Force on Medical Services, under the chairmanship of Dr. Theodore G. Klumpp, president of Winthrop Laboratories, at the time one of the country's largest pharmaceutical firms. The task force was authorized to study the more than sixty federal agencies then operating in the medical and health areas and make appropriate recommendations.

62. MacNeil, N. and H. W. Metz. 1956. *The Hoover Report, 1953–1955: What It Means to You as Citizen and Taxpayer.* (New York: The Macmillan Co.: 178–179.

63. MacNeil and Metz, *The Hoover Report*, 179.

64. This reached the extreme of 16.1 days in army hospitals. MacNeil and Metz, *The Hoover Report*, 180.

65. Commission on Organization of the Executive Branch of the Government. 1955. *Federal Medical Services, A Report to the Congress, February, 1955*. Washington, D.C.: Government Printing Office: 19.

66. MacNeil and Metz, *The Hoover Report*, 183.

67. MacNeil and Metz, *The Hoover Report*, 184.

68. Citizens Committee for the Hoover Report. 1955. *Digests and Analyses of the Nineteen Hoover Commission Reports.* Washington, D.C.: Citizens Committee for the Hoover Report: 24.

69. Citizens Committee for the Hoover Report, *Digests and Analyses*, 24.

70. MacNeil and Metz, *The Hoover Report*, 184–185.

71. MacNeil and Metz, *The Hoover Report*, 192–193. The figures are impressive. In 1954, the federal government employed 10 percent of the nation's active physicians, 9 percent of its active dentists, and 6 percent of its active graduate nurses. Thirteen percent of all hospital beds were in federal hospitals, which admitted 7 percent of the nation's hospital patients. Citizens Committee for the Hoover Report, *Digests and Analyses,* 22.

72. Citizens Committee for the Hoover Report, *Digests and Analyses,* 25.

73. MacNeil and Metz, *The Hoover Report,* 193.

74. Rumer, *The American Legion,* 377.

75. Arnold, *Making the Managerial Presidency,* 200.

76. Shonick, W. 1995. *Government and Health Services: Government's Role in the Development of U.S. Health Services, 1930–1980.* New York: Oxford University Press: 148.

77. Administrator of Veterans Affairs. 1947. *Annual Report, 1946.* Washington, D.C.: Government Printing Office: 3. This change in the status of the VA's professional employees, while welcomed by the medical profession, was criticized for not going far enough since it did not remove from the Civil Service system the host of auxiliary personnel, including clinical psychologists, dietitians, physical and occupational therapists, social workers, and laboratory and x-ray technicians of various types. See Kracke, R. R. 1950. The Medical Care of the Veteran. *Journal of the American Medical Association* 143 (15): 1323.

78. In 1953 the number of medical residents and interns working in VA facilities was 2,014 and 80, respectively. By 1972 this had increased to 5,366 and 771. Veterans Administration, various *Annual Reports*.

79. Administrator of Veterans Affairs. 1970. *Annual Report, 1969.* Washington, D.C.: Government Printing Office: 42–44. With particular regard to nursing, the number of nursing trainees increased from 6,238 in 1966 to 14,191 in 1969, at which time the VA acted as a training ground to over 20 percent of all nurses enrolled full-time in graduate study.

80. House Committee on Veterans Affairs. 1967. *Medical Care of Veterans* [90th Cong., 1st sess. Committee Print No. 4]. Washington, D.C.: Government Printing Office: 332.

81. The affiliation served the interests both of the VA and the nation's medical schools. The VA sought to acquire qualified physicians in order to deal with the major increase in its patient load as a consequence of World War II. The medical schools were equally desirous of expanding residency training to accommodate the increased postwar demand from the large number of physicians who had entered the military during the war without having had specialty training. Committee on Health-Care Resources in the Veterans' Administra-

tion, Assembly of Life Sciences, National Research Council. 1977. *Health Care for American Veterans.* Washington, D.C.: National Academy of Sciences: 242.

82. See, among others, Cranston Assails VA Hospitals' Lack of Care: Tragic Conditions Held Result of False Economy Measures by Government. *Los Angeles Times*, January 10, 1970; New VA Facilities (editorial), *Los Angeles Times,* January 26, 1970; Improving Veterans' Medical Care (editorial), *Los Angeles Times*, August 29, 1970; Two Doctors Hit Care at Veterans Hospital Here, *Los Angeles Times,* August 29, 1970.

83. VA Hospitals Provide Inadequate Care to Women, Study Says. *Washington Post*. June 24, 1993. At one point there even existed a Web site, the Veterans Alliance for Competent Medical Care, created by critical veterans, for lodging complaints against the health care treatment accorded by the VA. See also vawatch.org. Accessed October 10, 2009.

84. National Research Council, *Health Care for American Veterans*, 271.

85. In February 1976, the VA was operating a total of 214 multipurpose outpatient clinics, and most were in the VA's 171 hospitals. Only 32 hospitals had geographically separated multipurpose satellite outpatient clinics. National Research Council, *Health Care for American Veterans*, 114.

86. National Research Council, *Health Care for American Veterans,* 115. The report goes on to note that "Because most outpatient clinics are part of a hospital, and because average daily patient census is the prime 'workload' indicator used to determine a hospital's budget, there are strong indications that utilization of outpatient facilities is correlated with a hospital's inpatient admission and retention policies more closely than with the medical needs of the patients who apply for care" (115).

87. Administrator of Veterans Affairs. 1974. *Annual Report, 1974.* Washington, D.C.: Government Printing Office: 13.

88. Public Law 94-581, the Veterans Omnibus Health Care Act of 1976. 1977. Administrator of Veterans Affairs, *Annual Report, 1977.* Washington, D.C.: Government Printing Office: 7.

89. National Research Council, *Health Care for American Veterans*, 118. Approximately 69 percent of the outpatients were unemployed and only 21 percent were employed full-time.

90. National Resource Council, *Health Care for American Veterans,* 116.

91. The number of outpatients treated increased by 4.48 percent between 1977 and 1982, while during the same period the number of patients admitted to VA hospitals increased by 5.45 percent.

92. The Report of the National Academy of Sciences' Committee on Health-Care Resources in the Veterans' Administration, prepared in 1977, concluded that "about half the patients in acute medical beds, one-third of the patients in surgical beds, and well over half the patients in psychiatric beds do not require—and are not receiving—the acute care services associated with these types of beds." National Research Council, *Health Care for American Veterans*, 271.

93. Public Law 88-450. Earlier in 1964 the president had called on the VA to develop a nursing-care program.

94. At the same time, the VA instituted a reimbursement program to state and private nursing homes for nursing bed care provided to eligible veterans. Administrator of Veterans Affairs. 1966. *Annual Report, 1965.* Washington, D.C.: Government Printing Office: 30–31.

95. According to the Committee on Health Care Resources, it was likely that at least 10,000 more patients who at the time were in VA general and psychiatric hospitals would have been more appropriately placed in nursing-home care beds. National Research Council, *Health Care for American Veterans*, 209. "Long-term care beds" here include those patients held in "intermediate care" facilities, that is, facilities that accommodated patients who required more care than would be available in a nursing home but less than in an acute-care hospital.

96. National Research Council, *Health Care for American Veterans,* 216. According to the same study, the quality of care in the VA's intermediate care facilities was substantially worse, with 100 percent of the patients receiving inadequate care.

97. Department of Veterans Affairs. Facts about VA Health Care Facilities: Inpatient Capacity. Retrieved October 8, 2009 from http://www.pandemicflu.va.gov/docs/AppxA3_HealthCare.pdf.

98. These annual hospital censuses were based on a 20 percent sample of the VA hospital population. Administrator of Veterans Affairs. 1975. *Annual Report, 1974.* Washington, D.C.: Government Printing Office: 20.

99. Public Law 89-358. March 3, 1966.

100. Office of Public Affairs, Department of Veterans Affairs. No date. *VA History in Brief.* Washington, D.C.: Office of Public Affairs: 19.

101. The average age of American veterans, however, continued to increase.

102. Department of Veterans Affairs, Veterans Health Administration. 2009. *2008 Survey of Veteran Enrollees' Health and Reliance upon VA.* Washington, D.C.: Department of Veterans Affairs: 11. Once the Veterans Health Administration instituted a program of prior enrollment for health-care services, published statistics for the enrolled population show

the number of veterans forty-five years old or younger and those sixty-five or older.

103. Department of Veterans Affairs, Veterans Health Administration. 2004. *2003 Survey of Veteran Enrollee's Health and Reliance upon VA.* Washington, D.C.: Department of Veterans Affairs: 2. Appendix 1 shows the aging of the veteran population over the last fifty years.

104. Administrator of Veterans Affairs. 1979. *Annual Report, 1978.* Washington, D.C.: Government Printing Office: 13.

105. Nor did Medicare provide the costs of inpatient psychiatric care nor, at the time, any of the costs of prescription drugs. The effect was that a large proportion of Medicare-eligible veterans with lower incomes made use of VA facilities. See General Accounting Office. 1994. Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans. *Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives* (GAO/HEHS-95-13): 2.

106. Veterans' Health Care: Challenges for the Future. Statement of David P. Baine, Director, Health, Education, and Human Services Division. 1996. General Accounting Office: Testimony before the Subcommittee on Hospitals and Health Care, Committee on Veterans Affairs, House of Representatives (GAO/T-HEHS-96-172): 1–2.

107. Medicaid coverage, 8 percent; Medicare coverage, 53 percent; private insurance coverage, 32 percent. *2008 Survey of Veteran Enrollees' Health and Reliance Upon VA*, 23.

108. It appears that the VA was at one point also treating a not insignificant number of people ineligible for VA medical care. In a study conducted by the comptroller general for Senator William Proxmire's office it was found that during a twenty-seven-month period prior to January 1980, the Veterans Administration attempted to collect $15,000,000 from persons who had received medical treatment but who were ineligible for such benefits. Of this amount only $1,200,000 was in fact recovered and an additional $6,500,000 was written off as uncollectible. General Accounting Office. 1981. Cost of VA Medical Care to Ineligible Persons Is High and Difficult to Recover. Report to the Honorable William Proxmire, United States Senate [July 2, 1981]. HRD-81-77.

109. Public Law 93-82. September 1973.

110. The Department of Defense program, the Civilian Health and Medical Program, was known by its acronym—CHAMPUS.

111. Administrator of Veterans Affairs. 1976. *Annual Report, 1975.* Washington, D.C.: Government Printing Office: 13.

112. Congressional Research Service. 2008. *Health Care for Dependents and Survivors of Veterans.* Washington, D.C.; Government Printing Office: 2.

113. See Rumer, *The American Legion, passim,* but esp. 504–535. Additionally, in the spring of 1987, the Legion was able to prevail on Congress and the president to enact a permanent GI Bill—the so-called Montgomery GI Bill, named after the Democratic representative from Mississippi, G. V. Montgomery, who had worked tirelessly for its passage—which granted to all veterans, whether or not they had volunteered for military service and whether they had served in combat or not, the benefits accorded the first beneficiaries of the GI Bill.

114. Rumer, *The American Legion*, 506–508.

115. Public Law 99-272.

116. Administrator of Veterans Affairs. 1988. *Annual Report, 1987.* Washington, D.C.: Government Printing Office: 16–17. Fiscal year 1987 was the first year in which means-test data were collected on all outpatients, inpatients, and applicants for medical care. VA statistics show that 95.5 percent of its medical workload consisted of Category A veterans, while categories B and C each comprised 2.5 percent of the workload.

117. Quoted in Rumer, *The American Veterans,* 518.

118. Senate Committee on Governmental Affairs. 1988. *Proposals to Elevate the Veterans' Administration to Cabinet-Level Status*. 100th Cong., 1st and 2d sess. December 9, 1987, and March 15, 28, 1988 [S. Hrg. 100-670]: 9.

119. Senate Committee on Governmental Affairs, *Proposals to Elevate the Veterans Administration*, 105–109.

120. Quoted in Rumer, *The American Legion*, 526.

121. Public Law 100-527. October 25, 1988.

122. *2008 Survey of Veterans Enrollees' Health and Reliance Upon VA*, 12.

123. *2008 Survey*, 24.

124. Ashton, C. M., N. J. Petersen, N. P. Wray, and H. Jen Yu. The Veterans Affairs Medical Care System Hospital and Clinic Utilization Statistics for 1994. 1998. *Medical Care* 36 (January): 797.

125. See, for example, Veterans Reporting Mental Distress. *Washington Post* (March 1, 2006): A01

126. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2005. *National Survey on Drug Use and Health (the NSDUH Report).* Washington, D.C.: Government Printing Office.

127. General Accounting Office. 1997. Substance Abuse Treatment: VA Programs Serve Psychologically and Economically Disadvantaged Veterans. *Report to the Chairman, Committee on Veterans Affairs, United States Senate*. HEHS 97-6.

128. Department of Veterans Affairs. *Overview of Homelessness.* Retrieved on October 27, 2009 from http://

www1.va.gov/homeless/page.cfm?pg=1. The Department estimates that "the number of homeless male and female Vietnam era Veterans is greater than the number of service persons who died during that war—and a small number of Desert Storm veterans are also appearing in the homeless population." About 45 percent are estimated to be suffering from mental illness, and (with considerable overlap) slightly more than 70 percent suffer from alcohol or other drug abuse problems. Roughly 56 percent are black or Hispanic. These figures have shown no change for the past ten years. *USA Today* reported in 2008 that 25 percent of all those homeless in America were veterans, compared to 11 percent of the population. Homeless Vets Reveal a Hidden Cost of War. 2008. *USA Today* (January 18): 11A.

129. Congressional Research Service. 2009. *Veterans and Homelessness.* Washington, D.C.: Government Printing Office: 16–17.

130. Congressional Research Service, *Veterans and Homelessness.*, 13–14.

131. House Subcommittee on Health, Committee on Veterans Affairs. 1999. Statement of Thomas L. Garthwaite, M.D., Deputy Under Secretary for Health, Department of Veterans Affairs. In *VHA Capital Asset Management.* 106th Cong., 1st sess. March 10, 1999.

132. The VHA's restructuring is discussed in great detail in Kizer, K. W. 1995. *Vision for Change: A Plan to Restructure the Veterans Health Administration.* Washington, D.C.: Government Printing Office.

133. These data are taken from the testimony of Thomas L. Garthwaite, Deputy Under Secretary for Health, Department of Veterans Health, before the House Subcommittee on Health, Committee on Veterans Affairs.

134. Bush originally appointed Congressman Gerald B. Solomon (Republican from New York) as co-chair, but Solomon died while the commission was still in session.

135. President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. 2003. *Final Report.* Washington D.C.: Government Printing Office: p. 1.

136. See the *Report of the Commission on the Future of Structure of Veterans Health Care.* 1991. Washington, D.C.: Government Printing Office.

137. See the *Health Care Advisory Group Report* to the Congressional Commission on Service Members and Veterans Transition Assistance. 1999. Washington, D.C.: Government Printing Office.

138. "President's Task Force to Improve Health Care Delivery to Our Nation's Veterans, *Final Report* (2003), p. 6.

139. Statement of Belinda J. Finn, Assistant Inspector General for Auditing, Department of Veterans Affairs. 2007. Outpatient Waiting Times. *Joint Hearing before the Subcommittee on Health and the Subcommittee on Oversight and Investigations of the Committee on Veterans Affairs, U.S. House of Representatives.* 110th Cong., 1st sess. December 12, 2007: 15.

140. The Inspector General's office contended "that the VHA cannot support its assumption that patient preference caused our findings. We find it contradictory that the VHA agreed with our 2005 report but disagreed with our follow-up audit. We used the same methodology and found a continuation of the same problems, problems that could have been resolved had VHA implemented our recommendations" (15).

141. Currently there are eight priority groups:

1. (a) Veterans with service-connected disabilities rated 50 percent or more disabling or (b) unemployable veterans with service-connected disabilities

2. Veterans with service-connected disabilities rated 30 to 40 percent disabling

3. (a) Veterans who were former POWS, (b) veterans awarded a Purple Heart, (c) veterans whose discharge was the result of a disability that was incurred and aggravated in the line of duty, (d) veterans with service-connected disabilities rated 10 to 20 percent, or (e) veterans awarded special eligibility by virtue of being disabled by treatment or vocational rehabilitation

4. (a) Veterans who are receiving aid and attendance or household benefits from VA or (b) veterans whom the VA have determined to be catastrophically disabled

5. Non-service-connected veterans and non-compensable service-connected veterans rated 0 percent disabled whose annual income and net worth are below the VA established thresholds, (b) veterans receiving VA pension benefits, or (c) veterans eligible for Medicaid programs

6. (a) World War I veterans; (b) Mexican Border War veterans; (c) compensable 0 percent service-connected veterans; or (d) veterans solely seeking care for disorders associated with (1) exposure to herbicide while serving in Vietnam, (2) exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki, (3) service in the Gulf War, (4) illness possibly related to participation in Project 112/SHAD [chemical and biological tests conducted by the Department of Defense], or (5) service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, are eligible for VA health care for two years following discharge from military service for combat related conditions

7. Veterans with income and/or net worth above the VA income threshold and income below the geographic income threshold who agree to pay copays

Subpriority a: Non-compensable 0 percent service-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date

Subpriority c: Non-service-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date

Subpriority e: Non-compensable 0 percent service-connected veterans not included in Subpriority a above

Subpriority g: Non-service-connected veterans not included in Subpriority c above.

8. Veterans with income and/or net worth above the VA income threshold and the geographic income threshold who agree to pay copays

Subpriority a: Non-compensable 0 percent service-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date

Subpriority c: Non-service-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date

Subpriority e: Non-compensable 0 percent service-connected veterans applying for enrollment after January 16, 2003

Subpriority g: Non-service-connected veterans applying for enrollment after January 16, 2003

142. These include World War I and Mexican border veterans, veterans receiving care for disorders associated with exposure to toxic substances or environmental hazards while in service, and compensable 0 percent service-connected veterans.

143. General Accounting Office. 1999. VA Health Care: Progress and Challenges in Providing Care to Veterans and the statement of Stephen P. Backhus, Director, Veterans' Affairs and Military Health Care Issues. Testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives. [July 15, 1999] (GAO/T-HEHS-99-158): 6.

144. Accessing the Impact of Public Law 104–262, the Veterans' Health Care Eligibility Reform Act of 1996. Retrieved on October 28, 2009, from http://veterans.house.gov/democratic/budget/impact.htm.

145. Rosenthal, G.E., P. J. Kaboli, and M. J. Barnett. 2003. Differences in Length of Stay in Veterans Health Administration and Other United States Hospitals: Is the Gap Closing? *Medical Care* 41 (August): 890. See also Wolinsky, F. D., R. M. Coe, and R. R. Mosely II. 1987. Length of Stay in the VA: Long-Term Care in Short-Term Hospitals. *Medical Care* 25 (March): 250–253; J. L. Rogers, J. Feinglass, et al. 1989. Longer Hospitalization at Veterans Administration Hospitals Than Private Hospitals. *Medical Care* 27 (October): 928–936; C. B. Smith, R. L. Goldman, et al. 1996. Overutilization of Acute-Care Beds in Veterans Affairs Hospitals. *Medical Care* 34 (January): 85–96.

146. By 2006, the number of new veterans as a consequence of the Aghan and Iraq wars was about 550,000. How Veterans' Hospitals Became the Best in Health Care. 2006. *Time* (August 27): 36.

147. Bilmes, L. 2001. Soldiers Returning from Iraq and Afghanistan: The Long-Term Costs of Providing Veterans Medical Care and Disability Benefits. Kennedy School of Government, Harvard University, Faculty Research Working Paper RWP07-001.

148. Quoted in Schram, M. 2008. *Vets under Siege: How America Deceives and Dishonors Those Who Fight Our Battles.* New York: Thomas Dunne Books: 267. See also Stiglitz, J. E. and L. J. Bilmes. 2008. *The Three Trillion Dollar War: The True Cost of the Iraq Conflict.* New York: W. W. Norton. Chap. 3, The True Cost of Caring for Our Veterans: 61–90.

149. General Accounting Office. 1996. Veterans' Health Care: Challenges for the Future. Testimony of David P. Baine, Director, Health Care Delivery and Quality Issues of the GAO to the Subcommittee on Hospitals and Health Car, House Committee on Veterans' Affairs. [27 June 1996] (GAO/T-HEHS-96-172): 15–16.

150. General Accounting Office, Veterans Health Care: Challenges for the Future, 16. In a meeting on August 6, 2009, President Obama assured the American Legion's national commander that his heath care proposals did not include absorbing the Veterans Health Administration into some national system but would remain essentially as is. The American Legion had been fearful that the president's recommendations would call for either diluting or abolishing the Department of Veterans Affairs' health-care provisions and sought reassurances from the president that medical care for veterans would continue to be provided by a separate agency.

About the Author

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