

Military Health Care at a Crossroads

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The certainty that federal health care will be different, and the equal uncertainty about when and how the systems will evolve, were major topics at the recent AMSUS annual meeting. The Veterans Health Administration (VHA) and Military Health System (MHS) are in the midst of major transformations, although they are at very different points in the process and the final outcomes are yet unknown. This editorial, written at the end of 2019, will review some of the highlights of a discussion that is sure to continue in 2020 and beyond.

Almost everyone in the VA and many of the public can pinpoint the exact place (and time) the VHA's upheaval began: Phoenix, Arizona, in 2014. "The attack on our system," as VHA Executive in Charge Richard A. Stone, MD, described it at AMSUS, happened because "we were just too slow a bureaucracy," he explained.¹ "We can debate how many veterans died while waiting for care, but the answer is that 1 was too many and it had to be fixed. We had to become a more agile organization."

The US Department of Veterans Affairs (VA) response to the media firestorm and congressional outrage was uncharacteristically swift and sweeping. Both the VA Secretary and Deputy Under Secretary of Health were removed, as were many others in leadership at Phoenix and elsewhere. The VA faced an existential crisis as many loud voices called for dismantling the entire system in the wake of its perceived inability or unwillingness to care for those it was legally mandated to serve.² The Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 and its successor the VA Mission Act of 2018 dramatically expanded veterans' access to covered health care from non-VA health care providers (HCPs).

Debate continues in the veteran community and the wider society about whether this expansion constitutes an abandonment of a health care system dedicated to veterans and their unique health problems or a commitment to deliver the most efficient and high-quality care

to veterans that can be obtained.³⁻⁵ Many see this as a crossroads for the VA. Still, even if the VA will continue to exist, the question remains: in what form?

The increased use of private sector HCPs has wrought significant and long-lasting modifications to the traditional VA organization. In fiscal year (FY) 2017, the VA paid for care that non-VA HCPs provided for 24% of patients.⁶ Veterans with higher service-connected disability ratings and aged > 65 years were more likely to rely on the VA for care than were less disabled and younger patients.⁶ The Mission Act is expected to increase the VA expenditures by nearly \$19 billion between FY 2019 and FY 2023, with the bulk of the patients still going to the VHA for their care.⁶ Stakeholders from unions to politicians are concerned that every dollar spent on community care is one less they can spend in VA institutions. It is unclear to what degree this concern will be actualized, as smaller hospitals and those in rural areas have always had contact with the private sector to obtain the specialty care veterans needed that the VA could not provide.

Compounding these trends is the VA's ongoing staffing challenges. To meet the demand and eliminate wait times between September 2014 and September 2018, the VHA grew its workforce by > 40,000 individuals, a 13% growth rate. In FY 2019 alone, the VHA hired 28,000 new employees. And yet despite the rapid growth, a lower than average turnover rate, and relatively high employee satisfaction measures (at least when compared with those of other federal employees), the VHA still has 43,000 vacancies.^{7,8}

Which brings us to the very different set of challenges facing the Defense Health Agency (DHA). In an era of ballooning military budgets the DHA is being asked to "transform the MHS into an integrated readiness and health system, eliminate redundancies, and create a common high-quality experience for our beneficiaries."⁹ The seeds of change were tucked

into the National Defense Authorization Act (NDAA) of 2017, and their ramifications are only now becoming apparent. Among the most consequential of these changes are transfer of the management of hundreds of MHS hospitals and clinics from the medical services of the Army, Navy, and Air Force to the DHA.

“If we don’t shape our future, others will step in and do it for us,” Tom McCaffrey, Assistant Secretary of Defense for Health Affairs explained at AMSUS.¹⁰ In October 2019, DoD transitioned the first group of facilities to the DHA, and the remainder will change management by the end of 2022. In the next step of the process, facilities will be combined—along with TRICARE providers—in 21 geographically based “markets” to streamline management and avoid “redundancies.”

Lost in the bland language, though, is the scale of the contemplated changes. Although the exact shape of the changes have not been finalized, up to 18,000 MHS health care providers—civilian or uniformed—may be eliminated as DHA relies more heavily on TRICARE providers.¹¹ Not even the future of the Uniformed Service University for the Health Sciences and its leadership training and health care research are guaranteed.¹² The ominous possibility that the nation could lose its only military medical school has raised alarm among medical educators. They fear that the country may sacrifice its ability to train physicians with the highly skilled specialties needed on the battlefield and the familiarity with military culture that enables doctors in uniform to relate to the problems of active-duty families and retired service members.¹²

VHA and MHS colleagues are undergoing a similar organizational transition with all the trepidation and expectation that accompanies the turning of an enormous ship in stormy seas. In the midst of these major institutional transformations, VHA and MHS need to band together if the unique specialty of military and VA medicine is to survive. Unless these unprecedented changes can establish a new spirit of solidarity to 2 often separate partners in one

mission to care for those who serve, we may well be asking in the next few years, “Where have all the federal practitioners gone?”

Disclaimer

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