THIRD EDITION

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BEST CARE ANYWHERE

WHY VA HEALTH CARE WOULD WORK BETTER FOR EVERYONE

PHILLIP LONGMAN

An Excerpt From

Best Care Anywhere: Why VA Health Care Would Work Better for Everyone, Third Edition

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PREFACE TO THE THIRD EDITION

After Obamacare

The cause of health-care reform has taken great leaps since the last edition of *Best Care Anywhere* went to press in late 2009. Yet we seem farther away than ever from achieving resolution to our health-care crisis.

After a prolonged and rancorous debate, the nation passed the landmark legislation known inevitably as "Obamacare." Today, progressives continue to grieve its compromises. Conservatives, energized and empowered by populist suspicions and resentments of the bill, have meanwhile set furiously to work on its repeal in the courts and Congress.

Adding to the sense that passage of Obamacare has done little to resolve our health-care crisis, federal health-care spending—or more precisely, political brinksmanship over how to control it—has become the major cause of the nation's long-term deficits, which now have compounded sufficiently to earn the United States its first-ever credit-rating downgrade. Responding to this reality check, mainstream opinion now holds that one way or another the nation must soon take strong action to rein in entitlement spending; and the largest drivers by far are Medicare and Medicaid.

Even a progressive Democratic president, whose signature

legislative accomplishment was to attack the problem of the uninsured, has signaled that he'd go along with raising the Medicare retirement age to 67.[1] Meanwhile, at a time of high unemployment and a burgeoning growth in the numbers of low- and moderate-income elders, the Republican Party has voted to end Medicare as we know it and so far lived to tell about it.

With lightning speed, the politics of health care are shifting in ways that were unimaginable only a year ago. Yet while it is a moment of unnerving divisiveness, it is also a moment that vastly expands the realm of the politically possible. Ideas for solving the mounting health-care crisis that once seemed too bold and unfamiliar to be politically viable, including the policy prescription contained in *Best Care Anywhere*, now have new currency, if only because of the exhaustion of plausible alternatives.

This is far different from the climate of opinion that existed when *Best Care Anywhere* first appeared in January 2007. That same month, for example, the *Washington Post* began an exposé on problems at Walter Reed Army Medical Center in Washington DC—a series for which it later won the Pulitzer Prize. The facility is a U.S. Army hospital, and as its name indicates, it is run by the Department of Defense, not by the separate cabinet agency—the Department of Veterans Affairs (VA)—whose virtues I had described in my book. Nonetheless, this distinction was lost in much of the reporting on the scandal, leaving many Americans with the impression that the VA was neglecting grievously wounded warriors. As media and congressional investigations mounted, my first publisher and editor pretty well gave up on the book, as they later told me.

Meanwhile, I endured blogosphere ridicule for having written one of the worst-timed books in years.

Slowly, by word of mouth, the book and its paradoxical message did, however, begin to gain some influence behind the scenes. For example, in an odd loop-the-loop, when reporters around the country started visiting their local VA hospitals looking for scandalous conditions like those described by the *Post* at Walter Reed, they often came away as impressed as I had been in researching the book. The VA received an unexpected burst of positive coverage, in which *Best Care Anywhere* was often cited. That coverage has continued to build; by now, most organs of the mainstream media have weighed in with stories extolling the virtues of the VA's model of care, including *Fortune*, CBS News, the *Wall Street Journal,* and *USA Today*.

And, to be sure, some people in high places also became aware of the quality revolution at the VA that I had described. For example, in the spring of 2007, I was twice summoned to brief the health-care staff of the leading Democratic presidential candidate at the time, Hillary Clinton. Afterward, her standard speech on health-care quality came to include two paragraphs on the transformation of the nation's long-tarnished veterans' health-care system and its lessons for improving quality in health care generally.

Through a well-placed friend and colleague, a copy of the book was also slipped to candidate Barack Obama before he boarded a long flight to Hawaii. Whether he read it, I do not know, but he, too, began making positive references to the VA in his health-care addresses. Peter Orszag, then director of the Congressional Budget Office (CBO) and later Obama's head of the Office of Management and Budget, began order-

ing up studies from his staff on the lessons of the VA's quality performance.

Interest stirred in some Republican circles as well. Michael Cannon, director of health policy studies at the libertarian Cato Institute, took exception to the idea that the VA—the nation's one undeniable example of fully socialized medicine—should stand as a model of twenty-first-century health reform. But he acknowledged the VA's emergence as a quality leader in health care and wrote thoughtfully for the *National Review* about how the agency's performance might be replicated in the private sector.[2]

The number of speaking invitations at Yale, the University of Pennsylvania (Wharton School of Business), and other universities, as well as increasing sales to university bookstores, also signaled a growing academic interest. Through the initiative of academics in Beijing University, the book was also translated into Chinese. (As the United States's prime creditor, China is particularly interested these days to learn if a model exists, such as a civilian version of the VA, for containing the spiraling cost of the U.S. health-care system, because otherwise, China worries, we won't be able to repay our mounting debts.)

Interest in the book also began to spread among the larger veterans' community. Organizations such as the American Legion are often heard in the media and in Congress complaining about the VA's shortfalls, as is their role. They are particularly upset, and rightly so, about how difficult it can be for veterans to establish eligibility for VA care. But they are also tenacious in their advocacy for the VA and its ongoing quality revolution in ways that offer fascinating soundings into the deeper currents of American health-care politics.

During the summer of 2009, I had the great honor of addressing a large audience of American Legion officials at their annual convention in Louisville, Kentucky. Looking back at me was an assemblage of many middle-aged and older vets, mostly drawn from small-town, Red-State America. Steeped in patriotic traditions and bedecked with its symbols, they spontaneously stood and cheered when I suggested that they tell their neighbors about today's VA—and about the ability of "socialized medicine" to deliver the "Best Care Anywhere."

Yet it is fair to say that outside of the very different worlds of health-care policy wonks and veteran service organizations, the VA's reputation remains mixed at best. This divided reputation is partly due to the VA's long history, particularly during the Vietnam era, as a deeply troubled institution. That legacy still affects its image. Many Americans simply have not heard of the VA's quality transformation, and even when they have, they remain skeptical because of their generally dim view of government.

The VA's mixed reputation is also partly due to the fact that its mistakes tend to become national news. Medical errors are demonstrably less common in the VA than elsewhere in the health-care sector, and study after study demonstrates the VA's superior quality of care and high rates of patient satisfaction. Many of the ideas most often discussed by today's experts for improving the quality of U.S. health care—from deploying integrated electronic medical records to adhering to quality metrics based on hard science—were pioneered by the VA as far back as two decades ago. But because of the public nature of the VA, and because the VA systematically looks for and reports its mistakes, its errors are much more likely to come to public attention, through congressional hearings,

press reports, and investigations by veterans advocacy groups and the VA's own inspector general. The cumulative effect on the average news consumer can be an impression that the VA is limping along from one scandal to the next, even as its patients and health-care quality experts applaud its quality, safety, and cost-effectiveness.

Reflecting this mixed reputation, when the Obama Administration set to work selling the legislation that became the Patient Protection and Affordable Healthcare Act of 2010, or "Obamacare," political operatives in the White House were careful to freeze the VA out of their public deliberations. The concern, I'm told by multiple sources, was to avoid giving the public the impression that anything like a civilian VA was under contemplation. This was true even though the tangible example of the VA's quality and cost performance was one big reason why many health experts were able to give at least qualified endorsements to Obamacare. The story of the VA's remarkable turnaround allowed for at least the possibility of what would otherwise seem absurd: that it just might be possible to expand access to health care for tens of millions of uninsured Americans, as Obamacare promises to do, while at the same time saving money and improving quality. If the rest of the U.S. health-care system could become as efficient in the production of high-quality medicine as the VA, then it would indeed become possible to expand coverage, improve quality, and reduce cost at the same time.

The decision by the champions of Obamacare to ignore or downplay the VA's example may well have been politically necessary at the time. I say this not just because of the VA's mixed reputation, but also because the country's political system was

then still caught up in a protracted debate that for the most part willfully ignored reform of the actual practice of medicine. Almost all the public arguments about health care over the last generation have really been about health care *insurance*—who should get it, and who should pay for it. Until very recently, the country was just not ready to talk seriously about fundamental reform of the health-care delivery system itself.

When *Best Care Anywhere* was first published, for example, a Republican White House was arguing that unsustainable health-care inflation could only be checked if Americans came to "have more skin in the game," that is, to pay more of the cost of their health care out of their own pockets. Measures such as health savings accounts and high-deductible insurance plans were supposed to encourage patients to do more comparison shopping and haggling with their doctors and therefore create more market discipline within the existing system. Essentially, this remains the Republican position on health care.

The most recent example is the budget proposal introduced by Rep. Paul Ryan in 2011 (for which all but five Republicans in the House have voted) that would transform Medicare into a much less generous voucher program. Under the Ryan plan, each senior would receive only a fixed amount of money (about $8,000 on average in 2022) to spend on private health-care insurance each year, regardless of what his or her health-care needs and costs might actually be (which, given current rates of health-care inflation, will be astronomical going forward). The CBO estimates that under the plan, seniors would pay about 68 percent of their health-care costs out of their own pockets in 2030, as compared to 25 to 30 percent under traditional Medicare.[3]

Meanwhile, the dominant idea for health-care reform among centrist Democrats became the "individual mandate" at the heart of Obamacare. Assuming it survives Supreme Court scrutiny and Republican rule, this mandate will require, starting in 2014, that all Americans who are not already covered by health insurance purchase a policy from a private insurance company, either directly or through government-created market "exchanges"; those who cannot afford the premiums are to get subsidies.

The individual mandate would, by fiat, end, or at least substantially reduce, the ranks of the uninsured. By enlarging the pool of Americans contributing to the cost of their own health care, and by offering subsidies to those of modest means, the measure could also reduce, at least for some people, the cost of buying comprehensive health coverage on the individual market. The individual mandate also carries with it a provision that will end discrimination against people with pre-existing conditions. What the individual mandate will not do, however, is create any measures or incentives to improve the quality, safety, or cost of health care itself, including, most notably, the vast amounts of unnecessary surgery, redundant testing, and other forms of overtreatment and mistreatment that mark the U.S. health system.

Lest you think that is no big deal, numerous studies now confirm that about a *third* of all health-care spending is pure waste, or worse, mostly in the form of unnecessary and often harmful care—amounting to some $700 billion a year.[4] Meanwhile, estimates by the Institute of Medicine (IOM) put the number of people killed by medical errors in American hospitals as high as 98,000 a year. Even the IOM's most conservative estimates rank hospital medical errors as a bigger

cause of death than motor vehicle accidents, breast cancer, or AIDS.[5] Adding to these unnecessary deaths are hospital-acquired infections, few of which are counted as "errors," but nearly all of which are preventable. The result is the death of approximately another 100,000 Americans each year.[6] Though there are other provisions buried deep within the Affordable Care Act that might eventually lead to improvements in the practice of medicine, they are, as we shall see, indirect at best while also being highly vulnerable to being defunded or repealed.

Further to the Left are people who have argued, and still argue, that health-care reform simply entails creation of a "single-payer system," specifically a policy that would extend Medicare-like insurance coverage to everyone. Short of that policy, the progressive cry has been for a "public option" that would give at least some Americans the opportunity to purchase government-provided health *insurance*, though not government-provided health *care*.

Those who argue for this approach have been largely silent, however, about how to rationalize the health-care delivery system itself, as opposed to its paperwork, and thus their solution is grossly inadequate to the problem. While they are able to point to considerable administrative costs that would be reduced if all the redundant bureaucracy and marketing costs of private insurance companies were replaced by a single government program, the savings involved would be modest compared to the challenge we face.[7]

Given this spectrum of opinion, the VA model's advantages in the hands-on delivery of health care have hardly been part of the national debate. Many insiders have said that this low profile was necessary. Political logic dictated, they have argued,

that first we insure the uninsured, and later we worry about what that entails—that is, what protocols of health care will be followed for different conditions, and how to ensure their effective delivery. Less charitably, future historians may look back at the terms of our recent health-care debate and view them as part of a larger, darker cultural phenomenon of our time.

An odd feature of American life in the last few decades has been the tendency, especially among the "best and brightest," to focus not on hands-on production, whether it be of automobiles, homes, or health care, but on "derivatives" of production—the manipulation of symbols that has become the essence of finance, from securitized auto loans and subprime mortgages to high-deductible or "public-option" health insurance policies. Yet we have now reached the moment when continuing the conflation of finance with production—and particularly of health-care finance with health care itself—has played out about as far as it can.

After decades of denial, here is the fiscal reality the United States now faces. Just the projected increase in the cost of Medicare and Medicaid over the next twenty years is equivalent to doubling the Pentagon's current budget, and there is no end in sight after that. We wouldn't even face a structural deficit, much less have to endure downgrading of the nation's credit rating, were it not for the soaring cost of health care. By contrast, Social Security will rise only gradually, from 4.8 percent of GDP to 6.1 percent in 2035, and then taper off as the large baby boom generation passes.[8] Meanwhile, according to the same CBO projection, all other government programs—the military, the courts, farm subsidies, Amtrak, unemployment insurance, infrastructure spending, education, and others—are on course to *shrink* dramatically as a share of the

economy, from 12.3 percent of GDP in 2011 to 8.5 percent in 2035.[9] As others have observed, the federal government is not so gradually being transformed into a giant—and insolvent—health insurance company.

This reality explains why both parties, despite their deep differences, have proposed cuts in Medicare so drastic that they would have been politically suicidal a decade ago. The Democrats may decry Republican attempts to "end Medicare as we know it," but in their own way they are bent on doing the same thing. "With an aging population and rising health care costs, we are spending too fast to sustain the program," the president told a joint session of Congress in 2011. As part of his deficit reduction plan, he has proposed $248 billion in Medicare savings over the next ten years.[10] These include higher co-pays for many beneficiaries and steep cuts in payments to providers—as much as 30 percent for physicians starting in 2012.[11] If you think Obama and the Democrats are bluffing, consider that "Obamacare" comes with hundreds of millions in Medicare cuts and includes a mechanism that could cut vastly more. The president has since signaled that he would be willing to support even more cuts in Medicare, provided that taxes on the rich are raised at the same time.

Why are both parties declaring war on Medicare when both know that it could lead to their own political annihilation? The reason is simple. Sure, both Democrats and Republicans fear the wrath of the AARP and the exploding ranks of hard-pressed seniors—to say nothing of lobbies like the American Hospital Association. But Medicare's relentless squeeze on the budget seems to party leaders to give them no choice but to attack the program's spending regardless of the political cost. Medicare's ever-expanding claims on the

Treasury threatens to crowd out nearly every other priority on either party's agenda, from bullet trains and decent public schools, to, yes, avoiding future tax increases and draconian cuts in the military.

Underscoring how desperate the situation has become, both parties are incurring these risks without either of them having a plan likely to produce anything but more pain for themselves and the public. Turning Medicare into a voucher program, for example, surely would save the government money. But the primary effect would be to shift health-care cost away from government and on to seriously ill individuals and their families. Nor would the plan do anything to improve the appallingly poor quality of health care received by Medicare beneficiaries. According to a study conducted by Medicare's Office of Inspector General, every month 15,000 Medicare beneficiaries are victims of medical errors that contribute to their death.[12] Another 8,000 a year do not survive hospital-acquired bloodstream infections,[13] which the VA and other well-managed health-care systems have shown are largely preventable.[14] It's hard to see how forcing Medicare patients to have more "skin in the game" will save them from being victimized by sloppy, dangerous, money-driven medicine, except by pricing more seniors out of access to infectious hospitals and the often fatal reach of money-chasing doctors.

Raising the Medicare retirement age to age 67, as Obama has hinted he is considering and as many Republicans support as well, might at first seem to be a reasonable adjustment. Since we are all living much longer, so goes the common thought, we can afford to wait longer to become entitled to Medicare. But the premise is false. For fully half of the U.S. population (specifically the poor and working-class Americans with

earnings at or below the median), life expectancy at 65 is virtually unchanged since the 1970s.[15] In many parts of the country, including much of the South, life expectancy at birth for black males is not yet even 65, and in places it is as low as 59.[16]

As with plans to "voucherize" Medicare, the primary effect of increasing the Medicare retirement age would be to shift the cost onto needy individuals while also leading to worse health outcomes. Nor in the grander scheme of things would the proposal save the government much money, since most Medicare spending is concentrated on people well over age 67, and since many of the people who would be cut from the Medicare rolls would wind up on Medicaid or qualifying for other means-tested government subsidies. The Kaiser Family Foundation estimates that if the proposal were fully in effect in 2014 it would generate only about $5.7 billion in net federal savings but impose twice as much cost ($11.4 billion) on individuals, employers, and states.[17]

Then we have the proposal generally most favored by mainstream Democrats: cutting back on reimbursement rates for Medicare providers. To be sure, reimbursement rates need to be adjusted; Medicare pays far too much for many procedures of dubious value. Overpaying cardiologists relative to other providers, for example, creates too many cardiologists and not enough family doctors. And in the process, it also generates egregious rates of unnecessary and often harmful heart operations, such as a million stents a year placed in patients whose heart conditions would be better treated with drugs, as has been scientifically established for years.[18] By overpaying radiologists, Medicare fuels the unconscionable overuse of redundant scans that have little or no medical value and that expose individuals to dangerous levels of radiation.[19] But

experience has shown that cutting back reimbursement rates doesn't necessarily save money, let alone improve quality, so long as profit-maximizing providers remain free to game the system.

For example, after Medicare began restricting, beginning in the in mid-1980s, the amount it would pay for specific procedures, many providers responded simply by "making it up on volume," that is by increasing the number of unnecessary tests and surgeries they performed. Often this takes the form of "upcoding"—the now massive phenomenon in which doctors diagnose patients as being sicker than they actually are so as to make more money on treating each one.[20] Simply cutting prices in regions where Medicare spending is high due to overtreatment "will only cause providers in those regions to deliver more services," notes Dr. Elliott S. Fisher, director of the Center for Health Policy Research at Dartmouth Medical School.[21] Worse, cutting reimbursement rates, particularly if done crudely across the board, will create shortages of doctors who are willing to accept Medicare patients, and especially of vitally needed primary care doctors who are already poorly compensated and in short supply.

At this point, defenders of "Obamacare" will be quick to assert that they have engineered solutions to these problems: First they will point out that the Affordable Care Act creates a so-called Independent Payment Advisory Board (IPAB), which is designed to be the new mechanism for determining how much Medicare will pay for different procedures. In theory, the board could end the grip that high-paid specialists like cardiologists and radiologists have over the process now and could direct more resources to primary care physicians. But Republicans are gunning to kill the board with the usual

talk of "death panels," and more than a few Democrats are also conspiring to snuff it out.[22] Even if it survives, there is a high probability that it will be captured by specialists and their allies among medical device manufacturers. Moreover, the bottom-line mission of the new board is not to improve the quality of care paid for by Medicare, but to keep the per capita growth in Medicare spending far below its historical average. Starting in 2015, Congress must either accept IPAB's recommendations or come up with equivalent cuts of its own. Given the magnitude of the cuts that would be required in the absence of vast improvements in the overall efficiency of the U.S. health-care system, there is a serious possibility of creating severe shortages of physicians who will take Medicare patients.

But not to worry, say defenders of Obamacare; we've got a plan for that, too. Enter "accountable care organizations" (ACO). Just what are they? It's hard to say, since the language of the bill on this subject is so vague. An essential feature though, is that an ACO is an institution that contracts with Medicare to serve a specific population and promises to deliver specific quality metrics, such as keeping its infection rates down or offering primary care services to patients. In return, it receives the right to retain a large share of any resulting savings.

So far, ACO pilot programs have proven disappointing, producing little if any savings.[23] And there are good reasons to believe that most ACOs will never deliver the quality and cost effectiveness of a truly integrated, nonprofit health-care system like the Mayo Clinic or the VA. Under the merged regulations, there is nothing to prevent ACOs from being just loose networks of colluding, profit-driven, fee-for-service providers

who go through the motions of pursuing quality.[24] Even stalwart defenders of ACOs now acknowledge their large potential for abuse. As Donald Berwick, the former administrator for the Centers of Medicare and Medicaid Services, recently told a forum at the Brookings Institution: "There will be parties out there who want to repackage what they do and call it an ACO."

Berwick went on to warn, as have many others, that many ACOs are likely be effective monopolies in their local markets, given the massive consolidation already going on in the health-care industry. This means they will be tempted to abuse their market power, for example, by raising their rates for non-Medicare patients. This "would ultimately undermine any short-term savings achieved by Medicare," notes Merrill Goozner of the *Fiscal Times*, "since increases in a region's top line health care tab would eventually force Medicare to raise its own rates."[25]

Even if all these and other pitfalls of ACOs are avoided, there still remains an objection that no one can rebut. Any benefit ACOs might bring will at best be only gradual. Unless a more immediate and certain reform is applied, most of the Medicare population will continue to be treated—for years, if not decades to come—by a system that remains deeply fragmented, wasteful, and dangerous, fee-for-service care, the cost of which everyone now agrees is unsustainable. We can and must do better.

There is a better way. It starts with a question we should have been asking more forcefully all along: Why is the practice of medicine in the United States so widely and spectacularly wasteful, dangerous, and corrupt, and what hands-on, proven models do we have for fixing it?

In updating the statistics for this edition, I have been reminded again and again of the continuing breakdown of day-to-day medical practice in the United States: the extraordinary levels of unnecessary and often harmful treatments; the high rates of medical errors and of preventable hospital infections; the neglect of prevention, of primary care, of patient safety, of coordination among specialists, of basic research on what works and what doesn't, of investment in simple health information technology for purposes beyond billing.

It all brings to mind a concept that encapsulates all these and other baleful trends in our health-care delivery system: iatrogenesis. The term, derived from the ancient Greek, refers to death and suffering caused by poor medical treatment or advice. Today, iatrogenesis includes unnecessary surgery, medical errors, hospital-acquired infections, and the prescribing of unsafe drugs or unsafe combinations of drugs. According to an estimate published in the *Journal of the American Medical Association*, such iatrogenic practices minimally kill 225,000 Americans per year. This makes contact with the American health system the third-largest cause of death in the United States, following all heart disease and all cancers.[26]

Moreover, a fair accounting of iatrogenic medicine must also include the less quantifiable but nonetheless undeniable illness and suffering induced by wasteful spending on health care itself, whether that spending is borne by individuals or society as a whole. As previously mentioned, numerous studies confirm that the United States spends about $700 billion a year on unnecessary and often harmful care. That's $56 billion more than total federal spending in 2009 for Social

Security, a program that, along with many others, may well wind up being cut due to the soaring cost of health care, much of which isn't needed and is often lethal.

A nation spending that much on wasteful medical procedures is also a nation that necessarily spends less than it otherwise could on reducing the major social and economic determinants of illness. These include unemployment, lack of education, pollution, addiction, poor nutrition, and strains between work and family life. It's also a nation in which the majority of citizens must accept falling or stagnant real wages, as the cost of premiums for private health-care insurance vastly outstrips, year after year, even the substantial improvements the United States has made in worker productivity. We work harder and smarter, but have less take-home pay, due overwhelmingly to the rising cost of health care. Whether today's U.S. health-care system is, on balance, iatrogenic—that is, contributing, directly and indirectly, to more illness than it cures—cannot be conclusively demonstrated. But it is at least a possibility, and one that becomes increasingly certain given current trends.

So the moment comes when we must move beyond the realm of mere health-care finance and be as empirical as we can about what does and does not work in the delivery of health care and promotion of public health. The VA system is hardly a perfect model for a delivery system reform, and replicating its performance in the private sector presents many challenges. Yet its comparative effectiveness should be examined and explained if we are to have any hope of building a health-care system that is not itself a major cause of death, suffering, impoverishment, and national decline.

By all rights, after all, the VA should offer the worst care

anywhere: it's a gigantic, unionized bureaucracy, micromanaged by Congress and political appointees, and beset by an uncertain budget, an aging infrastructure, and a legacy of scandal. That it nonetheless now outperforms the rest of the U.S. health-care system, on metrics ranging from patient satisfaction to cost-effectiveness and the use of evidence-based medicine, suggests that much of what we think we know about health care simply isn't true.

The VA's long-term relationship with its patients, it turns out, more than makes up for its built-in institutional liabilities, as do other key features that we ignore at our peril, such as its being staffed by salaried, medical professionals who, by self-selection, are not "in it for the money." I offer this third edition of *Best Care Anywhere* in the belief that the moment is finally upon us when, due to the extremity of our economic and fiscal challenges and the exhaustion of alternative approaches, acting on the lessons of the VA is becoming not just a national necessity but also politically possible.

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Washington DC

ONE

Best Care Anywhere

When you read "veterans hospital," what comes to mind? Maybe you recall the headlines about the three decomposed bodies found near a veterans medical center in Salem, Virginia, in the early 1990s. Two turned out to be the remains of patients who had wandered off months before. The other patient had been resting in place for more than fifteen years. The Department of Veterans Affairs admitted that its search for the missing patients had been "cursory."[1]

Or maybe you recall images from movies like *Born on the Fourth of July*, in which Tom Cruise plays an injured Vietnam vet who becomes radicalized by his shabby treatment in a crumbling, rat-infested veterans hospital in the Bronx. Sample dialogue: "This place is a fuckin' slum!"

By the mid-1990s, the reputation of veterans hospitals had sunk so low that conservatives routinely used their example as a kind of reductio ad absurdum critique of any move toward "socialized medicine." Here, for instance, is Jarret B. Wolistein, a right-wing activist and author, railing against the Clinton health-care plan in 1994: "To see the future of health care in America for you and your children under Clinton's plan," Wolistein warned, "just visit any Veterans Administration

hospital. You'll find filthy conditions, shortages of everything, and treatment bordering on barbarism."[2]

Former congressman and one-time attorney for the Department of Veterans Affairs, Robert E. Bauman, made the same point in 1994, in a long and well-documented policy brief for the libertarian Cato Institute. "The history of the [VA] provides cautionary and distressing lessons about how government subsidizes, dictates, and rations health care when it controls a national medical monopoly."[3]

And so it goes today. If the debate is over health-care reform, it won't be long before some free-market conservative will jump up and say that the sorry shape of the nation's veterans hospitals just proves what happens when government gets into the health-care business. In 2009, the organizers of the Tea Party took it up again on their Web site: "LOOK AT THE VETERANS HOSPITALS AND ALL THE PROBLEMS OUR VETS HAVE EXPERIENCED. WE MUST KEEP THE FEDERAL GOVERNMENT OUT OF HEALTHCARE."

Yet here's a curious fact that few conservatives or liberals know. Who do you think receives better health care? Medicare patients who are free to pick their own doctors and specialists? Or aging veterans stuck in those presumably filthy VA hospitals, with their antiquated equipment, uncaring administrators, and incompetent staff?

An answer came in 2003, when the prestigious *New England Journal of Medicine* published a study that used eleven measures of quality to compare veterans health facilities with fee-for-service Medicare. In all eleven measures, the quality of care in veterans facilities proved to be "significantly better."[4]

Here is another curious fact. The *Annals of Internal Medicine* in 2004 published a study that compared veterans health

facilities with commercial managed care systems in their treatment of diabetes patients. In seven out of seven measures of quality, the VA provided better care.[5] A RAND Corporation study published in the same journal concluded that the VA outperforms all other sectors of American health care in 294 measures of quality.[6]

Or consider this: In 2006, a study comparing the life expectancy of elderly patients in the care of the veterans health system with elderly patients enrolled in the Medicare Advantage Program showed that the mortality rates were "significantly higher" among the latter. The study found that the average male patient had a 40 percent decreased risk of death over the next two years if he was cared for by the VA rather than through the Medicare Advantage program. For women, chances of dying in the next two years were 24 percent less at the VA.[7]

It gets stranger: In 2007, the *Milbank Quarterly* published a study showing the VA outperforming Medicare, Medicaid, and commercial health care in key quality indicators, including diabetic care, control of hypertension, and preventive care such as mammography. The disparities are often stunning. For example, the VA successfully treats its patients with high blood pressure in 77 percent of cases, while the commercial health-care success rate is just 67 percent.[8]

And low-tech medicine is not the only arena where the VA excels. In the late 1990s, the VA adopted a National Surgical Quality Improvement Program that was soon imitated by private-sector surgeons, but with less than perfect results. In 2009, for example, the *Journal of Surgical Research* published a study of outcomes of coronary surgery at a VA hospital versus other hospitals. Even though the VA patients were con-

siderably sicker on average, suffering nearly twice the rate of myocardial infarction, for example, their mortality rate after surgery was barely half that of those treated outside the VA system.[9]

The most recent data point comes from a study of cancer care published in 2011 in the *Annals of Internal Medicine*. It compared the treatment of older male veterans in the VA with that received by older men under traditional, fee-for-service Medicare. It found the VA offered care that was as good and often better, with the VA particularly exceeding in diagnosing colorectal cancers at earlier stages and at adhering to recommended treatments, including surgery for colon cancer, chemotherapy for lymphoma, and bisphosphonates for myeloma.[10]

According to Nancy Keating, an associate professor of health care policy at Harvard Medical School and the lead author of the study, several factors account for these results. Care at the VA "is much better coordinated than most other settings," she explains. The VA also "has a good, integrated medical record. Their doctors all work together and communicate more effectively. There are no incentives for the overuse of cancer treatments because [VA] physicians are not rewarded financially for prescribing more drugs or procedures."[11]

In an editorial accompanying the study, the *Annals* surveyed these and other demonstrations of the VA's superior care, as well as the ongoing efforts to repeal "Obamacare," and argued that the true "public option" should be giving all Americans access to the VA model of care. "Despite the clamor of special interests, corporate lobbying, and the particular American distaste for government-run institutions,

the public option may yet find its voice in the latest round of accomplishments demonstrated by the [VA]," the highly prestigious journal predicted. "Thanks to proposals to repeal the historic Patient Protection and Affordable Care Act, it is ironic that the moment for reconsideration has returned—and with it, the opportunity to celebrate more vociferously the triumphs of the country's largest integrated and publicly funded health care network."[12]

Or consider what veterans themselves think. Sure, it's not hard to find vets who complain about difficulties in establishing eligibility. Many are rightly outraged that the Bush administration decided in 2003 to deny previously promised health-care benefits to veterans who don't have service-related illnesses or who can't meet a strict means test. Yet these grievances are about access to the system, not about the quality of care. Veterans groups tenaciously defend the VA health-care system and applaud its turnaround. "The quality of care is outstanding," says Peter Gayton, deputy director for veterans affairs and rehabilitation at the American Legion. The Legion lists among its top legislative priorities a bill that would entitle veterans to trade in their Medicare benefits for treatment by the VA. Its annual survey of deficiencies at the various VA facilities (and of course they exist and often create headlines) is put into context by the publication's title: *A System Worth Saving*.

The VA also consistently receives extremely high satisfaction ratings, as measured by the American Consumer Satisfaction Index compiled by the University of Michigan. In 2009, 88 percent of VA patients expressed satisfaction with the care they received. The last time Medicare was compared

in the same survey, in 2006, it scored in the low seventies. Private health insurance companies consistently score worse.[13]

Perhaps the surest measure of the VA's performance is the number of vets who are voting with their feet: despite tightened eligibility rules and the declining population of veterans, the number of patients enrolled by the VA increased from 3.3 million in 2000 to 5.3 million in 2010.

Outside experts agree that the VA has become an industry leader in safety and quality. Dr. Donald M. Berwick, president of the Institute for Healthcare Improvement and one of the nation's top health-care quality experts, praises the VA's information technology and use of electronic medical records as "spectacular." The venerable Institute of Medicine notes that the VA's "integrated health information system, including its framework for using performance measures to improve quality, is considered one of the best in the nation." The *Journal of the American Medical Association* (*JAMA*) noted in 2005 that the VA's health-care system has "quickly emerged as a bright star in the constellation of safety practice."[14] Another study published in *JAMA* finds that the VA is also distinguished by its ability to overcome racial disparities in health care by doing a much better job than other health-care providers in keeping African-American patients alive.[15]

In 2007, the prestigious British medical journal *BMJ* noted that while "long derided as a US example of failed Soviet-style central planning," the VA "has recently emerged as a widely recognized leader in quality improvement and information technology. At present, the Veterans Health Administration offers more equitable care, of higher quality, at comparable or lower cost than private-sector alternatives."[16]

The Honda of Health Care

Stranger still, all the while that the VA has been winning these encomiums, it has tightly contained its cost per patient. Even as inflation in the rest of the U.S. health-care sector has been running in double digits, the VA is not only raising the quality, safety, and effectiveness of the care it provides, but also controlling costs. As Harvard's John F. Kennedy School of Government gushed, in awarding the VA a top prize in 2006 for innovation in government: "While the costs of healthcare continue to soar for most Americans, the VA is reducing costs, reducing errors, and becoming the model for what modern health care management and delivery should look like."[17]

Precise comparisons of year-to-year costs per patient are difficult, since the mix of patients changes over time with changes in eligibility rules and with the amount of combat American forces face. In addition, many people enrolled with the VA also receive health care elsewhere, so only estimated comparisons are possible between the VA's cost efficiency and that of other providers. But here's a suggestive statistic: After adjusting for the changing mix of patients, the Congressional Budget Office estimates that the VA's spending per enrollee grew by 1.7 percent in real terms from 1999 to 2005. Compare that 1.7 percent with Medicare's real rate of growth of 29.4 percent in cost per capita over that same period.[18]

Or consider this measure of the VA's medical efficiency: Veterans enrolled in its health-care system are, as a group, far older, sicker, poorer, and more prone to mental illness, homelessness, and substance abuse than the population as a whole. Half of all VA enrollees are over age sixty-five. More than a third smoke. One in five veterans has diabetes, com-

pared with one in fourteen U.S. residents in general. Name any chronic disease—Alzheimer's, cancer, congestive heart failure, sclerosis of the liver—and a much higher percentage of veterans have it than do Americans in general. In recent years, the VA has also had to invest massively to meet the needs of recent combat vets suffering from traumatic brain injury, post-traumatic stress syndrome, and an extraordinary level of other mental health needs. It has had to do so even while caring for Vietnam-era veterans who are more and more beset not only with the normal chronic conditions of age, but with delayed complications now linked to exposure to Agent Orange, such as type II diabetes. Yet from 2002 to 2007, a period of intense combat for U.S. forces, during which the VA generally excluded new enrollments by vets lacking service-related disabilities, the VA's spending per patient rose no faster than Medicare's.[19] One study done before the wars started asked: "What would it cost to provide the same healthcare benefits as the VA using Medicare as the surrogate payor?" The answer that came back was that Medicare would cost 21 percent more.[20]

You might well think that the untold story here is that the VA engages in rationing. And indeed, according to a RAND study published in the *New England Journal of Medicine* in 2006, VA patients received only about 67 percent of the care that experts believe they should get. But before you say, "I knew there was a catch," consider this: the same study found that the U.S. health-care system as a whole delivers only 54.9 percent of the treatments recommended by evidence-based medicine.[21]

Because the VA lacks any financial incentive to engage in overtreatment, it saves money by avoiding unnecessary

surgery and redundant testing. But "rationing" is hardly the right word to explain the VA's cost-effectiveness. Instead, Americans who *don't* use the VA stand the greatest risk of receiving inappropriate care, ranging from doctors who fail to prescribe routine preventive measures such as flu vaccines or medicine to control hypertension to vast amounts of overtreatment. According to the same study, even Americans with $50,000 or more in family income receive lower-quality health care than do VA patients in general.[22]

What a concept! Cost containment and quality improvement go hand in hand in many industries, but in health care this combination is virtually unheard of. If the VA were a car company, it would be Honda. Today's VA produces the equivalent of well-engineered, efficient, reliable, reasonably priced cars with few defects and great safety records, using proven scientific techniques and a culture of continuously improving quality control. By contrast, if America's most prestigious hospitals were auto companies, most would build cars like Alfa Romeos or Renaults—classy to look at, and often very innovative, but unsafe, inefficient, temperamental, ridiculously expensive, and an unwise choice of transportation in situations where your life actually depends on their not breaking down.

Take-Home Lessons

If this contrast gives you cognitive dissonance, it should. The VA, after all, is a massive bureaucracy headquartered in Washington. Its medical division alone, known as the Veterans Health Administration (VHA), employs more than 247,000 workers represented by five different unions. Even

many of its doctors are organized into bargaining units. It's micromanaged by Congress and political appointees. The VA is the last place most people, including myself, would expect to find true innovation in technology or human organization, let alone a world-class exemplar of best practices in health care. As one British health-care researcher puts it with typical English understatement: "It may be somewhat ironic, to both Americans and non-Americans, that through the VHA the United States has implemented a model of integrated public-sector health care that appears, on balance, to work quite well. And therein lies perhaps the most potent message of the VHA story."[23]

The VA's performance is particularly difficult for conservatives to process. Back in 2004, when the Bush administration pushed for greater use of information technology in health care as a means of improving quality and holding down costs, it wound up choosing not some well-endowed, prestigious private hospital as the place to showcase the potential, but the Baltimore VA Medical Center. That's because, despite the administration's overall faith in market forces, it could find no private-sector hospital that could begin to match the VA's use of electronic medical records. Astonishingly, twenty years after the digital revolution, only 1.5 percent of hospitals today have integrated IT systems like the VA uses, and those that do often find their commercial software programs to be buggy and inadequate.[24] "I know the veterans who are here are going to be proud to hear that the Veterans Administration is on the leading edge of change," Bush found himself exclaiming in his remarks at the Baltimore VA Medical Center.[25] If Bush found it strange or disorienting to be saying this about the largest actual example of socialized medicine in the United

States, he didn't express any curiosity about how and why it might be true.

Which is regrettable. Because the story of how and why the VA became the benchmark for quality medicine in the United States suggests that vast swaths of what we think we know about health, health care, and medical economics are just wrong.

It's natural to believe, for example, as I long did, that more competition and consumer choice in health care will lead to greater quality and lower costs, because in almost every other realm it does. That's why conservatives in general have pushed for individual "health savings accounts" and high-deductible insurance plans. Together, these measures are supposed to encourage patients to do more comparison shopping, therefore creating more market discipline in the system.

But when it comes to health care, it's a government bureaucracy that's setting the standard for best practices while controlling costs, and it's the private sector that's lagging in quality and cost-effectiveness. That unexpected reality needs examining if we're to have any hope of understanding what's wrong with America's health-care system and how to fix it.

It turns out that precisely because the VA is a big, government-run system that has nearly a lifetime relationship with its patients, it has incentives for investing in prevention and effective treatment that are lacking in private-sector medicine, including that which is underwritten by Medicare and Medicaid. As we'll see, these incentives became particularly sharp beginning at the VA's lowest moment in the late 1970s. Even as the VA faced severe budget cuts and loss of political support, the large numbers of World War II and Korean War veterans it served were then beginning to experience

the infirmities of old age. VA doctors in that era found themselves dealing more and more with aging patients beset by chronic conditions such as hypertension, diabetes, and cancer, and they had to find a way to manage these diseases with dwindling resources. The happy, if unexpected, result was an explosion of organizational and technological innovation, most of it started by individual VA doctors acting on their own, that the private sector still cannot match.

During the period of the VA's transformation, chronic illnesses still affected a comparatively small share of the population as a whole but are now becoming widespread as the baby boom generation ages and as increasing numbers of younger Americans experience the consequences of obesity and sedentary lifestyle. The increase in chronic illnesses gives the story of the VA's turnaround a growing relevancy. Some 20 years ahead of their time, VA doctors felt compelled to begin developing a new, highly effective model of care stressing prevention as well as safe and effective management of chronic disease. Today, the continuing improvement of this model, which is based largely on the skillful use of information technology in both treatment and medical research, has propelled the VA into the vanguard of twenty-first-century medicine. The purpose of this book is to explain the VA's unexpected triumph and to show how to make its benefits available to all Americans.

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