The VA Health System: A National Alternative?

by Theodore R. Marmor

Best Care Anywhere: Why VA Health Care Is Better than Yours
by Phillip Longman
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In 2007, as in 1993, acknowledging the need for reforming U.S. medical care resembles breathing: No one can escape it. But now, as one or two or three decades before, the obvious question is not whether problems exist, but whether there is a politically acceptable, administratively workable, and economically affordable policy at hand.

Phillip Longman's book, with the foreword by his journalistic sidekick Timothy Noah, claims to have *an* answer, if not *the* answer. It is the Department of Veterans Affairs (VA) arrangements, through the Veterans Health Administration (VHA), for the financing, organizing, and delivering of medical care to its clientele. Longman first outlined this bold, unexpected argument in a 2005 *Washington Monthly* article with the same title as his book: "Best Care Anywhere." "Ten years ago," he then claimed, "veterans hospitals were dangerous, dirty, and scandal ridden. ...Now they're producing the highest quality care in the country. Their turnaround points the way towards solving America's health-care crisis." Longman's book indisputably documents the amazing improvement in the reality and imagery of the VA medical system.

The book elaborates two separable themes. First, it is a fascinating case study of organizational change, the transformation noted above in the operation of the VA's nationwide medical care system. As such, it shows what is organizationally possible when leaders have both workable reform ideas and the levers of power to put them into practice. In that sense, Longman's work is a tribute to both the leaders and staff of the VA reform—Ken Kizer most prominently—and the VA's various constituents in Congress and interest groups for permitting this transformation to take place. Second, he claims, the VA presents a model for U.S. medical care reform. But that is quite another, controversial matter.

The central claims of the reform story are easy to state. With the help of electronic medical records across the VA system nationwide, it has been possible to greatly improve the quality of care. Whether the VA is better at that task than, say, Kaiser Permanente, will no doubt generate dispute in the medical journals. But that it does a better job than the disjoined care most Americans receive is not only plausible, but highly likely. Not only is the quality comparatively high, but the cost of the care given is modest by comparison with the rest of U.S. medicine. This is especially true for prescription drugs, where the VA uses its market muscle to purchase the products of Big Pharma at prices Medicare's congressional masters would be delirious to pay. And, in addition, eligible veterans face medical ailments without a glimmer of financial fear, with a range of benefits (and trivial cost sharing) that makes the rest of U.S. health insurance seem terribly restrictive.

Yet the obvious question is whether this remarkable reform story has all that much to offer our national debate over what to do about the cost, quality, and organizational complexity of medical care. Here one should acknowledge the moral zeal and the emotional intensity of the message Longman (and Noah) send.

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Both of them have painful personal stories of loss: deaths of spouses under circumstances that impel their widowers to press vigorously for change.

Longman's case for drawing overall reform lessons from the VA experience is earnest but somewhat naïve. First and most obvious, the story he tells is one of organizational innovation, not fundamental and long-standing performance. The prior experience of the VA could be used as a negative example of the "government medicine" that presidential candidates such as Rudolph Giuliani mock without attention to detail. That the VA story of the past decade or more is remarkable—and admirable—is to my mind undeniable. But that is not an example of system-wide reform on the scale of Canadian Medicare, the British National Health Service (NHS), or Germany's sickness fund arrangements. (In fairness, on the other hand, it is on a scale of a number of European nations and larger than most of the Canadian provinces, the administrative units of Canadian Medicare. And the VA experience is relevant to organizational innovation within the larger systems.)

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Second, the VA's interest-group and congressional support cannot easily be reproduced for any of the reform proposals likely to be sustained in American politics. The veterans have groups of supporters whose attention is fixed on the benefits, character, and durability of the VA's provision of care. Not only that, but the grounds for sustaining that care have a degree of social legitimacy that is precious: the notion of sacrifice of those wounded (or poor) who have served their country. While Medicare has its own contributory ethos, the dispute over deservingness—and the extent of care—is precisely what divides so many reform camps. Finally, the VA has the levers of control—ownership, purchasing power, and salaried personnel—that no proposed general reform would dare make. It is a part of a larger system, not a model of a system that Americans are likely to face as an alternative. That is a political prediction, not a normative claim.

Yet, as with all policy proposals, the expected value of a plan is its ideal form times the probability of that plan's being implemented. Valued that way, Longman's dream gets a grade of near-to-absolute zero. But, looked at another way, it is useful. It shows individual organizations what is possible under special circumstances. It can embolden organizational leaders with examples of change within a self-contained system. And it can offer examples to all of us of how much better medical care can be when the special circumstances of change are available. In that sense, Longman's book is a beacon of hope, if an unlikely proposal for universalizing the VA model.

There is a concluding observation that Longman's book prompts but does not discuss. His subtitle—"why VA health care is better than yours"—combines with the title's use of "best care anywhere" to reveal a provincialism that is quite general in U.S. health reform debates. This may be the result of Longman's editors, but the point remains: "Anywhere" means the United States, not the world, or even the world of industrial democracies that have had universal financing arrangements for decades. Yours, ours, America's—these descriptors betray an ethnocentric bias that starves our debate of useful perspectives. One need not claim that models are importable to realize that adaptation of the lessons of large, diverse democracies with universal financing of care within fiscal boundaries is a useful concept of our reform task. Longman is one of a new cadre of policy journalists—many of them graduates of the *Washington Monthly*—who combine sprightly writing with a confident stance as policy advocates. They produce useful, if limited, books.