

CC: Molly Brostrom
~~HEALTH~~

Health Policy Report

REFORM OF THE VETERANS AFFAIRS HEALTH CARE SYSTEM

JOHN K. IGLEHART

THE Department of Veterans Affairs has embarked on the reformation of its often-criticized health care system, an insular system that Congress has protected from the tumultuous forces that are reshaping other parts of American medicine. The department is decentralizing, reducing its inpatient capacity, reallocating resources to ambulatory care, and simplifying the convoluted method Congress designed to determine which veterans are eligible to receive medical services. These changes, which are shaking the rigid foundations of the Veterans Affairs system, are the subject of this report. They represent, in many respects, an attempt to transform the department's vast medical system along the lines of managed care. Although the proposed changes have unsettled the veterans' service organizations, Congress has been largely supportive. The acquiescence of Congress is surprising, since the reforms, if fully implemented, would mean a loss of jobs in Veterans Affairs facilities, the consolidation and perhaps closure of some medical facilities, and a departure from the pork-barrel politics that have long dominated the department's expenditure of its health care resources.

The Department of Veterans Affairs is an anomaly in a capitalist country where the majority of people are covered by employer-based private health insurance rather than through a government program. It is a tax-financed agency that delivers care directly through salaried physicians and government-owned facilities and that relies on an annual federal appropriation for its money. It has 191,000 full-time-equivalent employees, the third largest work force among federal agencies, although that number is 9000 less than it was one year ago.

Originally, the system was not intended to be the primary provider of medical services for most veterans. Rather, it was established to treat veterans with war-related injuries and to help rehabilitate soldiers with service-connected disabilities such as blindness, paralysis, and loss of limbs. About 465,000 of the nation's 26.2 million veterans have service-connected disabilities that diminish their functioning by at least 50 percent. They are eligible to receive comprehensive medical care through the Veterans Affairs medical centers. Of remaining veterans, fewer than 10 percent currently use Veterans Affairs facilities for medical

care. The General Accounting Office estimated that, in 1990, 9 of every 10 veterans had insurance coverage other than that offered by the department.¹

THE VETERANS AFFAIRS SYSTEM AS SAFETY NET

Despite its roots as a system designed to treat soldiers with war injuries, the services of the Department of Veterans Affairs have increasingly been used by poor veterans with medical conditions unrelated to military service. As a result, the Veterans Affairs system has become a vital, if uncoordinated, component of the array of private and public programs that make up the United States' pluralistic health care maze.² In fiscal 1995, only about 12 percent of the patients treated in Veterans Affairs hospitals received treatment for service-connected conditions. Another 28 percent had service-connected disabilities but were treated for conditions not related to those problems. The remainder, 59 percent of the patients treated, had no service-connected conditions; most of these patients were poor.³

The most prevalent disorders among patients discharged from Veterans Affairs medical centers, and the percentage of total discharges each represents, are as follows: alcohol dependence syndrome (7.8 percent), schizophrenic disorders (3.9 percent), various forms of chronic ischemic heart disease (2.8 percent), drug dependence (2.6 percent), affective psychoses (2.5 percent), heart failure (2.4 percent), adjustment reaction (2.4 percent), respiratory and chest symptoms (1.9 percent), diabetes (1.9 percent), and cardiac arrhythmias (1.8 percent).

The Department of Veterans Affairs fulfills its role as safety-net provider for veterans without service-connected conditions only to the extent that space and resources are available after those with service-connected disabilities or injuries are treated. Historically, the department's budgets have been adequate to meet the demands of veterans seeking care for conditions not related to military service, but it has, at times, rationed the care provided by some types of specialists. The Department of Veterans Affairs operates 173 hospitals, 401 ambulatory care clinics, 133 nursing homes, 39 residences, and 205 readjustment-counseling centers. The direct provision of care consumes most of its health budget, but the department also performs several other important tasks.^{4,5} It funds some 8900 residency-training positions sponsored by 105 medical schools that are affiliated with Veterans Affairs medical centers; it has active biomedical, rehabilitation, and health-services research programs with an aggregate budget of about \$1.1 billion; and at the direction of Congress, it has become active in responding to national emergencies, providing medical care at the scene of major disasters.

Unlike other industrialized nations that care for

veterans along with everyone else through universal health insurance systems, the United States has organized the Department of Veterans Affairs to operate as a separate system. Most countries that previously operated separate systems for veterans (examples include Australia, Canada, Finland, and the United Kingdom) abandoned them when they adopted universal health insurance plans.⁶ Eleven years ago, I wrote that the Veterans Affairs (then the Veterans Administration) system was moving into a period of greater uncertainty than it had previously encountered.⁷ But since then, it has endured remarkably well, because most politicians bend over backward to protect it. One skeptic, Senator Alan K. Simpson (R-Wyo.), who is chairman of the Senate Veterans Affairs Committee but is retiring at the end of the 104th Congress, has referred to this attitude as "veteran-o-mania."⁸ Time and again, politicians of every stripe have reaffirmed their belief — reinforced by the veterans' lobby — that veterans are served better medically through a separate system. Most recently, when the Clinton administration had an opportunity to consider whether to integrate the care provided by the Veterans Affairs medical centers into a reformed health care system, its ill-fated reform plans called for maintaining the independence of the department, reconfiguring the care it provides as a series of managed-care plans and "greatly expand[ing] the number of veterans entitled to free, comprehensive health care services."⁹

THE DEPARTMENT'S REFORM PLAN

As a part of government-wide efforts to shrink the federal government and reduce the budget deficit, the department, both before and after the demise of the Clinton administration's health care reform plan, devoted considerable attention to examining its operations and structure. On the basis of these discussions and armed with a mandate from the administration to reengineer the department's medical system, its undersecretary for health, Dr. Kenneth W. Kizer, introduced "Vision for Change: A Plan to Restructure the Veterans Health Administration" in March 1995.¹⁰ The plan calls for the restructuring of the 950 Veterans Affairs facilities and its work force of 191,000 into 22 "veterans integrated service networks" (VISNs). At the same time, the department reduced the size of its headquarters staff by 25 percent (eliminating some 200 positions) and delegated much of the system's operational authority to the VISN directors. Seven of these network directors were recruited from outside the department, an unusual step for an organization that usually promotes from within:

The VISN directors were charged with creating a continuum of care through the more effective integration of the department's resources and contracts with private providers. The network directors, with

their small administrative staffs, will serve as shock troops in the implementation of another one of Kizer's ambitious designs — converting the Veterans Affairs system, "as rapidly as possible,"¹¹ from a hospital-based, specialty-focused health care system to one that is rooted in primary care delivered in outpatient settings. In the past several years, the department has reduced its total number of acute care and long-term care beds by 2294 (from 53,082 to 50,788), pared its inpatient staff by 3436 full-time-equivalent positions, and increased the number of visits to its outpatient clinics by 2.4 million (9.2 percent). The department, however, has never closed a hospital because of declining use.

Kizer, a former director of California's State Department of Health and a specialist in emergency medicine, envisions a Veterans Affairs system that would resemble a managed-care plan like Kaiser Permanente's, with which he is very familiar. Kizer's reform plan would place greater emphasis on case management, primary care, and preventive services. It would also create an enrollment system through which veterans could be declared eligible and assigned to primary care physicians. And it would make physicians more accountable by monitoring more closely the quality of the care they deliver. Describing the changes, Kizer recently wrote: "This reorganization will shift the Veterans Health Administration from a collage of independent and often competing facilities to a system of interdependent and interlocking networks of care focused on aligning resources with local needs."¹²

REFORM OF ELIGIBILITY REQUIREMENTS

The department, with the support of Congress, also plans to overhaul the complicated process by which veterans are declared eligible to receive its medical services. Congress has debated eligibility reform for the better part of a decade without success.¹³ In a letter dated May 10, 1996, to Senator Jay Rockefeller of West Virginia, the ranking Democrat on the Senate Veterans Affairs Committee, Kizer was particularly critical of the department's process of determining eligibility.

Under the current system there are different rules for hospital care, outpatient care and long term care depending on each particular veteran's service-connected status and income level. This sets the stage for disjointed, fragmented and discontinuous care. . . . The eligibility rules are the epitome of mindless bureaucracy, and our physicians should be applauded for finding ways around such rules so that they can take care of real people with real medical problems that don't follow these biologically arbitrary eligibility provisions.

The full House and the Senate Veterans Affairs Committee have approved eligibility-reform bills that, as a report by the House Veterans Affairs Committee explained, would substitute

a single uniform eligibility standard for the complex array of standards governing access to [Veterans Affairs] hospital and outpatient care. While the new standard is a simple one, more importantly, it would employ a clinically appropriate "need for care" test, thereby ensuring that medical judgment rather than legal criteria will determine when care will be provided and the level at which that care will be furnished.¹⁴

The legislation would also authorize, though not require, the department to contract with community providers for hospital care and medical services when Veterans Affairs facilities "cannot furnish such care and services economically."¹⁴

NEW PAYMENT METHODS

The department also plans to transform the way in which its medical facilities are funded. Historically, Veterans Affairs medical centers have been funded according to their past costs, with incremental increases every year. Such support encouraged administrators to keep their costs high without regard to how many veterans they served. Starting in fiscal 1997, the department plans to base funding on the number of veterans each facility serves; thus, it will no longer support facilities through an institutional grant of monies.

Unless adjustments are made by Congress, this new funding approach could shift hundreds of millions of dollars from the Veterans Affairs medical centers in Chicago, Boston, and New York, which have more inpatient capacity than they need and where the numbers of veterans are declining, to cities in the Sunbelt, where an increasing number of veterans live. Republican senators John McCain of Arizona and Phil Gramm of Texas have been particularly aggressive advocates of redirecting the department's funds because of the obvious benefit that would redound to their states. However, a per capita payment approach is a major source of concern for the Paralyzed Veterans of America (PVA), whose members rely heavily on medical care from the department. Gordon H. Mansfield, executive director of the PVA, which has a reputation as the most sophisticated of the veterans' service organizations, testified last June 27 before the House Veterans Affairs Subcommittee on Hospitals and Health Care:

This allocation system will not work well for [Veterans Affairs] users with spinal cord injury. Even the high-end capitation rate we are hearing proposed does not meet the costs per bed of many [spinal cord injury] centers. . . . The planned allocation system will give hospital directors an incentive to either underserve or transfer these patients to cheaper providers.

THE POLITICS OF CHANGE

Whereas efforts to reduce the size of government and its budget deficit increasingly weigh on the Department of Veterans Affairs, the currents of political

change ebb and flow, depending on the intensity of feeling surrounding any given issue and the willingness of Congress to intervene. Reform is a work in progress with bipartisan support, although it is well to remember that previous efforts at reform ultimately met with failure because of congressional opposition. In 1989, for example, Veterans Affairs Secretary Edwin J. Derwinski called for a sweeping review of the agency's medical mission, establishing the Commission on the Future Structure of Veterans Health Care. Its recommendations¹⁵ were shelved, and in 1991 Derwinski was forced from his position by the veterans' lobby because of a proposal to open several underutilized Veterans Affairs medical facilities experimentally to nonveterans.

The surprise thus far, given that the Veterans Affairs medical system has long been a protectorate of Congress,⁷ is that both the House and Senate Veterans Affairs committees have been quietly supportive of Kizer's initiatives for change. The department's reform plan was submitted to Congress on March 17, 1995, for the required 90-day review. Congress completed its review on September 5, 1995, without changing the plan.

I recently conducted separate interviews with six congressional staff members, all of whom asked to remain anonymous. They reported being impressed with Kizer's deftness in pursuing reform and noted the absence of a united opposition to his plan, such as history would suggest the veterans' service organizations might mount. They conceded that veterans' groups were nervous, but they said that many legislators, like the Department of Veterans Affairs itself, were seeking to persuade the veterans' groups that their interests would be best served by accepting incremental change rather than resisting any change at all. They also said that Kizer, as the leading agent of change, had deflected criticism from legislators who have given the department a relatively free hand to pursue reform. One staff member put it this way:

Kizer is heading us in directions the Veterans Affairs system needed to go, without a great deal of political ire. We're all playing this game by, in essence, saying, "Ken, do it. But don't paint a legislator into a corner and don't force us to highlight these changes." Neither committee has invited vivid testimony on the consolidation of Veterans Affairs facilities and the staff reductions that have begun.

Although legislators have allowed the department's reform plan to proceed, other congressional actions illustrate their reluctance, and that of the administration, to give clear definition to the agency's future. Congressional Republicans, wielding their scalpels shortly after taking control of Congress, adopted a budget resolution in July 1995 that would have essentially frozen health spending by the department for the next seven years at the 1995 level — \$16.2 billion per year. The budget resolution

serves as a guide, not a binding requirement in congressional decision making. At about the same time, the Clinton administration put forward spending projections that called for ever greater reductions in medical spending by the department over the next seven years, even though the Veterans Affairs Secretary, Jesse Brown, testified that such reduced expenditures would "devastate" the department.¹⁶

In the end, Congress rejected the flat funding level recommended by its budget panels and appropriated \$16.6 billion for the Veterans Affairs health system in fiscal 1996. For fiscal 1997, the administration, influenced in large part by the coming election, proposed a medical budget of \$17 billion for the department. In response, Congress, sensitive to the same election-year issues, provided an appropriation of a similar amount to finance Veterans Affairs medical operations in the new fiscal year.

Another illustration of the administration's political sensitivity in dealing with veterans is the insistence of the White House that the department proceed with its plans to construct a new hospital at Travis Air Force Base in Fairfield, California — a politically crucial state — to replace a Veterans Affairs hospital in nearby Martinez that was closed in 1991 because of concern about its safety after an earthquake. In a recent report, the General Accounting Office said the project was "unnecessary," and it spelled out why:

We found that significant changes have occurred in the health care marketplace and in the way [Veterans Affairs] delivers health care in the 4 years since the project was planned, but [Veterans Affairs] plans have not been revised accordingly. These changes alone have resulted in 3300 unused hospital beds in northern California hospitals, including beds in [Veterans Affairs], Air Force, and community hospitals. In addition, the veteran population in the service area is expected to drop by about 25 percent between 1995 and 2010. We also found that [Veterans Affairs] has not considered the likely negative effects the additional beds could have on other hospitals in northern California, particularly those community hospitals in the Solano County area surrounding Travis Air Force Base that have occupancy rates of around 40 percent.¹⁷

CHICAGO AS A TEST CASE

The department's new vision and the political realities with which it must deal have begun to collide as the agency moves to consolidate the management of some of its medical centers and other facilities that operate in the same geographic areas. It has done so now in 15 different locations without substantial opposition. The department has also closed down several small medical and surgery programs because of their low patient volumes or questionable quality and has laid off physicians, dentists, and nurses for the first time without serious repercussions. But in its first effort to consolidate the operations of several of its major medical centers, in

Chicago, the department has run into strong opposition. It operates four large Veterans Affairs medical centers in the metropolitan Chicago area, two of which are six miles apart in the downtown area. The department has consolidated the management of two of its downtown medical centers — Lakeside, which is affiliated with Northwestern University Medical School, and West Side, which is affiliated with the University of Illinois College of Medicine. The decision was made by Dr. Joan E. Cummings, the VISN director for the region, with the approval of the department's secretary, Jesse Brown, who comes from Chicago.

After the decision was announced last spring, the University of Illinois College of Medicine and its dean, Dr. Gerald S. Moss, launched a full-scale attack on the department's plans to consolidate the operations of Lakeside and West Side, the latter of which is an integral part of the school's training program. The Veterans Affairs hospital supports some 120 residents and their physician supervisors. Led by Moss, the school has enlisted the city's congressional delegation, the state's two senators, the veterans' service organizations, and state, county, and local officials to oppose the plans. The school fears that the department's real goal is to close the medical and surgical services at West Side Veterans Affairs Medical Center and move veterans in need of such care to Lakeside. At the same time, the University of Illinois believes, the department plans to convert its West Side medical center to an ambulatory care facility.

In an interview, Cummings said the department has no such immediate plans, but she did concede that, given shrinking resources, the agency must take steps to rationalize its expenditures. "We will have \$860 million available to fund medical programs in this VISN," she stated, "but some \$40 million less will be available next year" because congressional appropriations are not expected to grow and because changing flows of funds will divert monies to other geographic areas where more veterans reside. For the moment, Cummings has responded to the strong opposition from the University of Illinois by creating a task force that will study in greater depth the options available to the department if it must reduce its clinical capacity in greater Chicago.

Chicago is only the first metropolitan area where the department's plans to consolidate and possibly close facilities have provoked conflict. Kizer said in an interview:

There are more [Veterans Affairs] medical centers in the Northeast than the current patient population would suggest is necessary. VISN directors responsible for Boston and New York will have to take a hard look at what the [department] can afford, how many physicians, particularly specialists, they can train and employ and how they should close the gap between the shrinking resources available and the needs of patients.

In the course of reconfiguring the Veterans Affairs medical system, the agency plans to examine its commitment to graduate medical education and the training of some 45 other categories of allied professionals. The department formed a Residency Realignment Review Committee, chaired by Dr. Robert G. Petersdorf, to make recommendations. The committee recently recommended that the number of residency-training positions supported by the department be "rolled back" to the number funded in 1987.¹⁸ The department accepted this recommendation and will eliminate 250 training positions in non-primary care specialties over the next three years. It will also change 750 others from specialty to primary care training positions, as the advisory committee recommended. This shift will increase the proportion of primary care positions from 34 percent of all residencies supported by the Department of Veterans Affairs in 1987 to 49 percent by the end of 2000. The department also recently convened a group of experts, chaired by Dr. George W. Rutherford of the University of California, to review the agency's health research programs. Among the conclusions in its report was that the department's research program should be more sharply focused on the needs of veterans.¹⁹

CONCLUSIONS

In the coming years, Congress will repeatedly face the questions of how generous it should be in providing medical care to veterans, particularly those who are poor but who suffered no wartime injuries, and whether it should maintain a separate health care system in the face of excessive capacity in the private sector. Despite the concern of the PVA, the commitment of Congress to veterans with serious injuries connected with their service has so far been steadfast.

Beyond this issue looms an even larger one: will Congress allow the Department of Veterans Affairs to modernize its operations, on the basis not of historical funding patterns and politics but according to what the agency believes will best serve veterans? The subject was touched on at a hearing on March 8, 1996. Senator Christopher (Kit) Bond of Missouri, a Republican who chairs the Senate Appropriations Subcommittee on Veterans Affairs, the Depart-

ment of Housing and Urban Development, and Independent Agencies asked Kizer whether the new VISN directors "will have the authority and the backing of the [Department of Veterans Affairs] to direct resources away from underutilized facilities, to change missions, to close facilities." Kizer responded: "The more important question is, Will Congress allow us to do these things?"

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Implementing Change in Veterans Healthcare

Why is the VA embarking on a journey to change healthcare services for veterans?

In general --

- *Private-sector care systems rapidly moving to more modern delivery modes*
 - Strong, continuing growth in primary and managed-care systems
 - Improved business operations
- *Physician and other practitioners changing practice patterns*
 - More ambulatory care; falling hospital stays
 - New techniques, new tests, new ways to discover and treat illness and disease
- *Consumerism in American healthcare driving demand for improvements in access to care*
 - Americans demanding better, more convenient, and more efficient care

* * *

- *The Veterans healthcare system was "locked" into 1960's style delivery mechanisms--*
 - Very large, impersonal hospitals, often located in central cities, hard to reach
 - Care was hospital-focused, not patient-focused -- long stays in hospital often far from home
 - VA programs were "institutional" in character -- Vets forced to seek help from VA, rather than VA reaching out to vets
- *No rigorous review of basic assumptions concerning VA's care of veterans*
 - Vets aging -- dominated by World War II and Korean groups
 - Vets needs are changing -- greater needs for primary and long-term, home and nursing care
 - Vets special care needs -- spinal cord injured, sight impaired, mental health disorders, Persian Gulf vets, Vietnam vets, etc., needed fresh new look at VA programs for these special groups

- *VA organizational structure essentially unchanged since the early post-war years*
 - Dominated by VA hospitals, limited in services to Congressional authorization levels
 - VA Central Office was prime example of "stove pipe" management -- ineffectual planning and goal setting; multiple programs in competition for resources

* * *

I appointed Ken Kizer, MD, of California, to the position of Under Secretary for Health, in the fall of 1994. Ken's nomination was confirmed unanimously by the Senate.

- Ken, a former director of public health at the state level and a recognized expert in community and public health issues, hit the ground running at VA.

Early on, Ken published *Vision for Change*, his blueprint for restructuring VA healthcare services.

- New key teams are in place at VA, both in Headquarters and in the field
- VA field activities restructured into 22 dynamic networks, *called "Veterans Integrated Service Networks,"* headed by a balanced and diversified group of seasoned healthcare executives.
- Headquarters now functioning in "product lines" to support field structure and to coordinate larger issues across networks.
- VA taking a refreshed look at relationships between VA and schools of health professions/medical schools to confirm that VA is getting back for veterans what it is investing in medical and health-careers education -- also looking at VA research programs to ensure focus is on veterans
- Ken has recently published his *Prescription for Change*, both reporting progress against his and Secretary Brown's goals, and further leading the way for change in veterans healthcare.

* * *

As we push forward to gain the best healthcare for America's veterans, Ken is focused on addressing these many long-standing VA problems. He and Jesse are leading the Veterans Health Administration toward these many challenges, and I fully support -- and urge veterans organizations to continue to back -- these long-needed changes.

U.S. Boldly Reshaping the Way Veterans Get Medical Care

By Bill McAllister
Washington Post Staff Writer

WALLA WALLA, Wash.—The last time officials in the nation's capital talked about closing a veterans hospital, they targeted this town's under-used, 119-bed facility.

The closing sailed through Congress until Rep. Thomas S. Foley (D-Wash.), then House majority leader, had second thoughts. He tacked a floor amendment onto a veterans bill that killed the plan.

Nine years later, officials at the Department of Veterans Affairs are again talking of closing VA hospitals. This time Foley, who became House speaker before his defeat two years ago, is no longer in Congress to protect the hospital.

But that may not matter. For here, in a state that is regarded as a pioneer in cutting medical costs, VA officials have begun a bold effort to reshape the way roughly 3 million veterans receive free medical care from the federal government. In the process they hope not only to save a small hospital that almost surely would be back on the chopping block, but to chart a new direction for the VA's 170 other hospitals.

"Walla Walla has changed more than any of my other facilities," said Barry Bell, supervisor of the eight VA hospitals in the Pacific Northwest. "It's my most ideal [facility]."

The switch—from a hospital-based inpatient care to an outpatient care regime modeled after private medical practices—has stunned workers here. "I never thought I'd see change like this—especially in the VA," said longtime nursing supervisor Angie Stevenson, expressing an amazement that is widespread within the staff of 317 VA workers here.

Faced with certainty of severe budget restraints and a realization that the VA's hospital-based medical system is out of date, the Walla Walla hospital three years ago began the change to outpatient care.

Private medicine long ago moved to providing much care on an outpatient basis, but many VA hospitals have been reluctant to follow, confident that a friendly Congress and sympathetic veterans groups would protect the VA approach.

That philosophy began to change in the VA's central office after a reexamination of the VA's hospital system that was a response to the Clinton administration's ill-fated health care initiative. Veterans Affairs Secretary Jesse Brown came away from that investigation convinced that the system had to change to save itself.

When former California state health director Kenneth W. Kizer took over as the department's undersecretary of health in September 1994, the change accelerated. Kizer has told Congress that since 80 percent of care can be delivered on an outpatient basis, it makes sense to expand outpatient facilities. According to Kizer, big hospitals are out of step with American medicine and a political system that, as one senator put it recently, liked to view big veterans hospitals as political trophies.

Under the old system, in Walla Walla and elsewhere, whenever VA doctors had questions about a veteran's health they could not quickly resolve, they put the patient in the hospital overnight and let the VA staff run a battery of costly tests. Today the odds are against any of the 7,600 veterans who are served by Walla Walla being hospitalized.

That's not because few of the remaining 41 medical beds here are full. Most nights, two-thirds of them are empty in the three-story hospital building here.

But most patients are being treated on an outpatient basis. Now, the chances are that a veteran's individual doctor will have a much better knowledge of his patient's

health than any VA physician would have had under the old system. And that makes hospitalization less likely, the staff says.

To make the new system work, doctors and nurses were reassigned from the hospital to an adjoining, remodeled outpatient facility. It was radical thinking for the hospital and more than four physicians could take—two of whom resigned and two of whom transferred.

But officials here say the switch to outpatient care has worked. "The change has been phenomenal—and it has been for good," said medical center director George Marnell, who arrived here from Denver in the midst of the transition.

The hospital also radically changed its surgical program. Shortly before Marnell arrived, Washington VA officials decided Walla Walla's two surgeons were performing too few operations to remain up to speed and felt it would be better—and safer—for veterans to undergo surgery at the public hospital here or at larger VA hospitals in Portland and Seattle. Now the Walla Walla VA pays local surgeons and the local hospital for any work they perform on veterans under a cost-sharing agreement.

VA officials say the new direction put Walla Walla on the cutting edge of VA medicine. It is a change that other, larger VA hospitals are expected to adopt in the coming years as the department decentralizes its control and forces regional administrators to deal more realistically with federal budget cuts, a dwindling veteran popu-

lation and the high costs of maintaining big hospitals in the same area.

VA hospitals across the nation are downsizing and beginning to shift to outpatient care. In the past 18 months, the system has closed 4,664 hospital beds and hopes to close another 2,000 to 3,000 more this year. That is the equivalent of closing about 30 community hospitals, a move that Kizer says is vital to freeing up funds to provide for the expanded outpatient care.

Patients have been delighted, officials said. As Marnell put it, "The patients like our kind of private practice."

The 7,600 patients the hospital served last year is the largest number of veterans the facility has seen in its 74 years, and Marnell is confident that more of the estimated 45,000 veterans living around Walla Walla will start coming to the VA once they learn of the services there.

Equally important, the smaller VA staff has few complaints. In what one called "the old VA," patients were shuffled among medical clinics and had little contact with individual doctors or nurses. "We didn't know the patients and they didn't know us," said Karen Cole, a nurse here for 30 years.

Today, the veterans from rural Washington, Oregon and Idaho who come to Walla Walla are assigned to one of the four primary medical care teams. The veterans are given color coded cards identifying their teams and are told to call when they have a medical problem.

Doctors and nurses no longer frantically comb each patient's military record for proof that a particular ailment can be linked to active duty injuries. Under new,

liberalized VA health care rules, the hospital's primary focus is on the veteran's health, not his active-duty health record.

So far, despite the larger number of patients, Walla Walla's Marnell said the hospital has stayed within its budget, funding the outpatient care with dollars diverted from inpatient care.

The switch troubles some in Congress who fear that the VA's overall costs will begin to rise as the department cares for more veterans. But Kizer said outpatient care is the only logical approach and is urging Congress to let the VA keep more of the insurance dollars it collects from veterans with private insurance to offset any increased costs. As for the 100 outpatient service facilities he wants to add, Kizer said, "I'm confident we can do it with existing resources."

Many old-time VA workers at the Walla Walla facility believe the change put the local hospital where it should have been all along. "We're a more viable [medical] choice for people now; we weren't 10 years ago," said Mirjana Murtonick, who has worked at the hospital for 23 years.

Tami Coleman, a nurse for 14 years here, said, "There was no rhyme or reason to the way it used to be. . . . The patients often looked lost. They didn't have a sense of belonging. . . . They'd have to walk over the entire compound for tests and lab work."

The change has dramatically cut waiting times for appointments, a major gripe at many VA hospitals. "You get in, you get out. You don't have to wait hours to be treated," said Gary Colwell, a Navy veteran.

"They're a lot more courteous," said James Carroll, a Korean War veteran who traveled for four hours from Idaho for a checkup. "I don't have any insurance. These people have been a life-saver for me."

Not every member of Congress has signed off on the VA's new direction. "I'm telling you that the rank and file [veteran] doesn't know what is going on," Rep. Rodney P. Frelinghuysen (R-N.J.) complained at a recent meeting of the House Appropriations subcommittee that oversees the VA budget. Veterans in his southern New Jersey district were unaware of the serious implications of the new program for their hospitals, he said.

In Chicago, plans to turn one of four VA hospitals to an outpatient facility have alarmed one of the city's medical schools and members of the Illinois delegation. The move would have a "devastating effect" on the University of Illinois, which uses the VA Lakeside hospital to train its medical students, according to a joint letter Sens. Paul Simon (D) and Carol Moseley-Braun (D) and Rep. Cardiss Collins (D) recently sent to Congress.

To reduce such complaints, the VA has reorganized its hospitals into 22 regional districts, called Veterans Integrated Service Networks. Each VISN (pronounced vision) will control the budgets of all hospitals in its region. Washington policy makers hope this will reduce costs by eliminating duplicated programs and make the changes—and closings—more politically acceptable.

That doesn't mean the VA hospital itself has a secure future. If the VA can purchase beds in a local hospital cheaper than it can maintain them here, then that's what the VA will do, said Bell, the VISN director for the Pacific Northwest.

With VA officials predicting the department will have to drop 10,000 positions in the next two years, attention is certain to turn to the VA's small, rural hospitals.

Many workers here in Walla Walla say they know that the VA's new philosophy may have placed a question mark over their hospital's future. Are they worried about their jobs? "I'm not any more insecure. I would be in the private sector," said nurse Murtonick.

Mojave Caught in Dispute Over Man's Relationship With the Desert

By William Claiborne
Washington Post Staff Writer

IVANPAH, Calif.—Across a dry, barren lake north of this desert hamlet, open-pit mining has left a range of mountains permanently disfigured. Further south, a swath of sandy scrub land is being readied for a low-level nuclear waste dump. And to the west, the world's largest landfill may soon be built just outside a popular national park to dispose of trainloads of municipal refuse.

The Southwest deserts, an underappreciated but vital natural resource, are under relentless assault from encroaching development. The Sonoran Desert in central Arizona is vanishing at the rate of an acre an hour. The Great Basin Desert in northern Nevada and Utah has been permanently scarred by massive strip mining. Western Nevada's Amargosa Desert has been polluted by radioactivity from a leaky nuclear waste dump shut down in 1993.

But few deserts have faced quite the onslaught of man and development as the majestic and austere Mojave Desert, which straddles three states and hides beneath its surface a vast array of minerals, including gold, silver and others used in space-age metals.

"This is a spectacularly beautiful desert, but it's also very exploitable," said Jerry Freeman, a former miner who bemoaned the deterioration of the desert in the last 10 years. "Some degree of regulation has to happen. This isn't the Wild West anymore. It's the 20th century, and the Mojave could be permanently ruined very quickly." Although a 1994 act of Congress assured that the Mojave Desert would be protected under strict National Park Service rules, residents and environmentalists remain locked in a bitter battle over its future, as dune buggies, dumps, cheap housing developments and casinos encroach ever deeper into it.

Environmentalists and their allies say the next few years will be crucial as the fast-growing population of the West, and resultant development, wears away at the deserts, posing a threat to their continued survival as habitats of a unique life system of flora and fauna. These groups have fought hard to see much of the Mojave given national park sanctity to preserve its ascetic scenic wonders.

"For a long time the Mojave was just a place to take your old bed and toss it. Now it can be something of value—a real draw for people who appreciate the beauty of deserts,"

said Willis Herron, who owns two small motels and restaurants in Baker, in the heart of the Mojave outside of protected areas, and envisions a boom in ecological tourism that would enhance the desert and not degrade it.

But many other residents—and businesses that could profit from unfettered development—say the deserts have never been the pristine place environmentalists envision, at least not since railroad surveyors, gold and silver prospectors, Army expeditions, homesteaders and ranchers started coming here in the middle of the last century. They want to escape from an intrusive federal government that already has placed millions of acres of land under draconian restrictions against mining, cattle-grazing and off-road recreational motoring.

"This area isn't pristine. Everywhere you go in the Mojave there are signs of man's activity—thousands of miles of primitive roads, abandoned mines, ghost towns, abandoned ranches," said Dennis Casebier, the Mojave's unofficial historian, who runs a heritage association in the tiny desert village of Goffs. "We see that as proof of a relationship between man and the desert that should be allowed to continue. We don't want to end a relationship for the sake of desert tortoises that we don't believe are endangered anyway."

The dispute mirrors many other land-use battles going on in the West that have revealed a deep vein of mistrust of the government. It is also a reflection of newly emerging public attitudes toward deserts and their natural wonders.

Historically, the vast deserts of the southwestern United States have been regarded by most who encountered them as inhospitable wastelands undeserving of environmental respect because of their blazing desolation and seeming barrenness.

Indeed, when viewed only from the interstate highways that traverse the desert, the bleak land seems unworthy of the kind of reverence that is accorded the majestic mountains of the Continental Divide or the verdant, pristine forests of the Pacific Northwest.

It is only at close range, along the narrow, uncharted dirt roads that crisscross the desert far removed from the speeding highway traffic, where a highly diverse ecosystem of Joshua trees and desert lilies, jack rabbits, coyotes, burrowing owls and

desert tortoises—and its vulnerability to human despoilment—is visible.

Remote, sparsely populated, water-deprived, and with temperatures that can reach 130 degrees or more, the Mojave had long been the forgotten one-third of California, attracting a handful of eccentric gold prospec-

tors, struggling cattle ranchers and desert-lovers who live here in self-imposed isolation.

That is, until a few persistent environmentalists and legislators, battling for 10 years in Congress to stop the strip mining, dumping, overgrazing and other development,

managed to enact the 1994 California Desert Protection Act, which led to the largest U.S. parks and wilderness designation outside of Alaska.

Passed by one vote on the last day of the outgoing Democratic-controlled Congress, the desert act extended National Park Service protection over 9.2 million acres of the Mojave, stretching from the Sierra Nevada in central California to the Mexican border, an area almost the size of Massachusetts, Connecticut and Rhode Island combined.

The law set up 69 new wilderness areas, upgraded the Death Valley and Joshua Tree national monuments to national parks, giving them greater protection, and created a new 1.4 million-acre Mojave National Preserve. The preserve, the crown jewel of the legislation, was formed from land until then under the federal Bureau of Land Management, which had loosely supervised mining, ranching, and other activities and which environmentalists had accused of being in the pocket of mining and development interests. Now, the far more restrictive National Park Service, which is committed to protecting the desert from development, exploitation and ecological damage, was to take over.

But almost immediately, the new law got bogged down in budget politics. Rep. Jerry Lewis (R-Calif.), who represents the Mojave district and had opposed the law's enactment, persuaded the new Republican majority in Congress last year to withhold Park Service funding for the management of the new preserve, effectively leaving it under the old, less restrictive rules of the Bureau of Land Management.

Only last month, with the approval of the federal budget bill, was the funding authorized and the Park Service given undisputed control of the Mojave Preserve. But Lewis and many of his constituents in the East Mojave are pledging to continue their battle for looser regulation. "The White House wants to use it to demonstrate their purity on environmental issues," Lewis said, "but what is lost in the process is the people who live there."

Sen. Dianne Feinstein (D-Calif.), who fought to win approval of the Desert Protection Act, said she recognizes some of the conflicting claims to the desert and is open to some compromise—except for allowing open-pit mining. There are no legally operating mines in the preserve area, although several companies have claims and are seeking to begin operations. However, numerous mines are operating outside the preserve area.

"I'm prepared for a continued onslaught, but what I would like to do is get at the basis of what these people want and how they can be accommodated. I do agree that the Park Service can be unduly rigid at times," Feinstein said.

Environmentalists and some government officials want the Park Service to move quickly to stop what they see as a marked deterioration of the desert during the two-year funding stalemate. Norman J. Riedy, a desert advocate with the Wilderness Society, said that for the last two years the Park Service had only a skeleton crew of rangers in the East Mojave to fend off illegal mining, off-road vehicle use, overgrazing by cattle, illegal trash and toxic waste dumping and other abuses.

"Our perspective is that it should be closed off to that kind of destruction, and the Park Service is the only agency equipped to do that," Riedy said.

Deputy Interior Secretary John Garamendi noted that virtually every new national park, including Yosemite and Yellowstone, initially sparked local opposition. But he said he expects the controversy over the Mojave to die down as the economic benefits of increased, but carefully managed, tourism become apparent.

Casebier said the Park Service may be able to protect the Mojave's ecology, but it cannot preserve a century-old way of life in a museum case. "That way of life is part of the character of the desert. Why do they want to destroy it?" he asked.

The same complaint was voiced in numerous interviews throughout the back country of the East Mojave, with many people accusing those pushing for greater desert protection of being city-based "elitists" who are more interested in political power than in the desert.

"The key to this dispute is access. Are we going to allow people to use the desert like it's been used for hundreds of years, or are we going to let the Park Service turn it into some kind of sanitized Disneyland experience," said Ron Schiller, a hunter whose High Desert Multiple Use Coalition leads the fight against restrictions in the Mojave.

William Claypool, who grew up around Needles, on the Colorado River, and whose grandfather was a miner in the desert in the 1870s, angrily criticized what he called "armchair elitists" and "Sierra Club people from San Francisco" for "whipping up hysteria over a few garbage dumps and getting this whole desert closed off."