Medical Demand Chain Performance and Treatment Service Levels for Wounded Military Personnel: Supply Chain Problem or Systemic Bureaucratic Inefficiency?

Abstract

In light of the 2014 VA crisis, this paper began as an outsider's perspective of how the Department of Veterans Affairs could reduce patient wait times and streamline its processes through private sector supply chain management. As our research progressed, however, it became increasingly apparent that there were systemic inefficiencies in the VA system that existed well before the issues at the Phoenix facility were made public. This paper details some of the history of that mismanagement during troop demobilization and continuing care of veterans. We conclude by highlighting possible solutions from commissioned studies about the crisis, as well as our own recommendations in improving overall VA management.

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1. Introduction

Imagine being a Vietnam veteran, having answered your country's call to service, earning the Medal of Honor, and needing to organize your affairs in order to move to a new city for another job. One of these chores requires going to the local Veterans Affairs office in order to update your new address, only to be stymied by an extraordinary bureaucracy.

Such was the story of Bob Kerrey, former senator from Nebraska, who experienced firsthand the morass of government red tape for even a simple request. In a somewhat humorous anecdote, Kerry has told the story of changing his address with Veterans Affairs, only to be given a literal runaround. Upon calling the office, he was told he would need to physically come in to fill out any necessary paperwork. Arriving at the New York office, Kerry was directed to a set of desks, labeled A, B, and C. He went to Desk A, only to be directed to Desk C, where no one was currently working. Sitting himself in front of Desk C, Kerry waited and waited, only never to be helped. The supervisor was also of no help and told Kerry to come back another time. Ultimately, the simple matter of changing his address took twelve days. Conversely, Kerry's change of address at his commercial bank was done over the phone in ten minutes [1].

While the above story is a simple illustration of the public sector versus the efficiency of the private sector, providing for a funny story to tell at parties, the gross inefficiency and backlog of those veterans needing critical medical care is not. Spring 2014 was plagued by myriad news reports of long wait periods and quality of care issues for military personnel seeking medical care through the United States's system of

Veterans Administration (VA) hospitals. Even a year after the VA crisis became known, hundreds of thousands of veterans' health care applications were still pending, with some news reports suggesting vets may have died during the waiting period [2].

This paper explores the accompanying controversy and scandal related to the Veterans Administration delivery of medical care to wounded military personnel during that year, examining the response process from a supply chain perspective. The delivery of care is represented as the final link in the military's demand chain. This chain begins with its personnel being deployed to overseas combat theaters or having reached retirement age, applying for VA benefits or future medical care. In the wake of the news stories, audits have been conducted on procedures, response times, and levels of medical care extended to wounded military personnel. [3].

Viewing the VA system as a supply chain, it begins with service personnel entering the system as new recruits, adding training and skill sets to the individual and providing medical care during this time (and ultimately, further medical care upon retirement). Private companies typically seek to streamline their supply chain or demand chain operations in order to improve performance and reduce cost. These strategic changes are pursued and implemented with the intent to benefit both the organization and its customers. As demand for the product or services of private organizations increases, it is typical for such entities to increase their productive capacities where possible. However, given entrenched bureaucracies and the glacial pace of public sector adaptability, these efficiency gains are rarely seen or pursued by government entities.

Former Secretary of Defense Robert Gates, who served in that position under both Presidents George W. Bush and Barack Obama, has written that, "at the outset of the

Afghan and Iraq wars, neither Defense nor VA [Veterans' Affairs] ever conceived of, much less planned for, the huge number of wounded young men and women…who would come pouring into the system in the years ahead" [4].

In essence, this is the central thesis of this paper. In his memoirs, Gates stated, "Many of our troops would not have survived their wounds in previous wars, but extraordinary medical advances and the skills of those treating the wounded meant that a large number with complex injuries" would now be absorbed into VA care [5]. It is not a stretch to assume that severe combat injuries during the World Wars, Korea, and perhaps Vietnam inflicted a higher mortality rate for troops in combat. However, advanced medical treatment in combat theaters in Afghanistan and Iraq have most certainly increased the lifespan of those discharged from active duty. Much like the increased statistical life expectancy enjoyed by everyone with advances in modern medicine, the federal government's Social Security and Medicare programs are facing similar overwhelming demands.

2. History of Veterans' Support in the United States

The VA itself reports that the United States has one of the "most comprehensive systems" for supporting its veterans than any other country. Notably, its heritage can be traced back to 1636. In the early-17th century, "the Pilgrims of Plymouth Colony were at war with the Pequot Indians," leading its settlers to pass legislation which stated that "disabled soldiers would be supported by the colony" [6].

This laudable commitment to the nation's veterans has not wavered in intent with the passage of time. The Continental Congress of 1776 incentivized enlistments during the Revolutionary War by promising pensions to combat-wounded soldiers. On the eve

of the War of 1812, "the federal government authorized the first domiciliary and medical facility for veterans." In the later 1800s, the veteran's assistance program was expanded to include benefits and pensions for veterans as well as their widows and dependents. This was notably done with the signing of the Arrears Act of 1879 by President Rutherford B. Hayes, which provided pensions to disabled soldiers of the Union Army and to dependents of those soldiers killed in action. This legislation resulted in pension payments that became one of the largest government expenditures of budgets in the Gilded Age, handing Republicans an excuse to impose high tariffs on imports [7]. With war raging in Europe in 1917, "Congress established an expanded system of veterans' benefits, including programs for disability compensation, insurance for service personnel and veterans, and vocational rehabilitation for the disabled" [8].

In his 1929 State of the Union message, President Herbert Hoover proposed consolidating all of the agencies responsible for administering veterans' benefits. "I am convinced that we will gain in efficiency, economy, and more uniform administration and better definition of national policies if the Pension Bureau, the National Home for Volunteer Soldiers, and the Veterans' Bureau are brought together under a single agency" [9]. Hoover signed the executive order establishing the VA on July 21, 1930 [10].

3. The 2014 VA Crisis Becomes Public

CNN reported on April 23, 2014, that "at least forty United States veterans died" while waiting for care at the Veterans Affairs Health Care facilities in Phoenix, Arizona [11]. A later internal VA audit found that more than 120,000 veterans were either left waiting for ninety days or never received care altogether. The findings also reported that schedulers made "unofficial lists" and/or violated standard operating procedures in order

to falsify wait times [12]. This scandal was not only limited to the Phoenix office. The VA Inspector General's (IG) report found 31,000 inquiries from veterans at the Philadelphia office took longer than 312 days for a response, but by procedure, should have been answered within five days [13].

More unsettling, Kelly Beaucar Vlahos of *Fox News*, writes, "Perhaps even worse, claim dates were manipulated to hide delays, $2.2 million in improper payments were made because of duplicate records, 22,000 pieces of returned mail went ignored and some 16,600 documents involving patient records dating back to 2011 were never scanned into the system." In response to the Philadelphia IG report, the VA's official in charge (benefits), Allison Hickey, replied, "this is a last year thing" [14].

In April 2015, a congressional committee chaired by Representative Jeff Miller, Republican of Florida, questioned the progress on the construction of the VA's new facility in Denver. The project was behind schedule and the cost-to-date of $1.7 billion had exceeded the planned budget. The contract specialist, Adelino Gorospe, had been fired for issuing cost warnings; however, the VA's construction executive, Glenn Haggstrom, was allowed to retire with full benefits [15].

Chris Porter, blogger for the VA, reported on June 25, 2014, claimed that it was common knowledge that the VA system was overwhelmed. While the VA may have planned for the needs of aging Vietnam veterans, the recent Afghan and Iraq wars have found the VA struggling to handle the volume of young veterans requiring treatment for combat injuries and post-traumatic stress, requiring more extensive and longer treatment plans [16].

Moreover, not all problems concern medical treatment. According to news reports published in late-2015, "Diana Rubens, the VA executive in charge of the nearly 60 offices that process disability benefits compensation claims, collected almost $60,000 in bonuses while presiding over a near seven-fold increase in backlogged claims." Incredibly, at the St. Louis VA Medical Center, it was discovered that "more than 1,800 patients were possibly exposed to HIV and Hepatitis" stemming from unsanitary dental instruments [17]. Furthermore, reports indicated that the backlog of new and reopened disability claims at Veterans Affairs facilities was over 711,000, down from nearly 1 million earlier that year [18]. Such examples of poor service and long waits involve several other state VA locations. The outrage over allegations of poor care and long wait times ultimately resulted in the resignation of VA Secretary Eric Shinseki.

A subsequent investigational report in early-2015 detailed the results of an investigation into the Phoenix location's urology department. The report found that the issues of the previous year had not changed. Over three thousand urology patients had not received prompt care, with 23 percent of those patients having incomplete records [19]. Additionally, there have been allegations among employees of ongoing retaliation against whistleblowers [20]. A summary of a report disclosed in mid-2015 stated that the VA healthcare network faces "a significant leadership crisis within VA as well as staffing shortages, a demoralized workforce, inconsistent care throughout," as well as an "`unsustainable trajectory of capital costs.'" [21].

4. The VA's Production Load

Clearly, the potential demand for VA benefits, represented by the population eligible for its services, has increased with each additional declared and undeclared

conflict. As shown in Table 1, roughly 20 million veterans are eligible or currently receiving VA treatment. Statistically, as time passes from a given conflict, natural causes will release some of the pressure on the timely provision of medical care. While the backlog of VA claims has fallen since the publicity of the crisis (described below), it is a fair question to ask whether or not the reduction has been due to improved accessibility or the passage of time. For example, with respect to World War II, 1.2 million veterans would have been eligible for benefits in 2014. Statistics for 2017 show this number reduced by half [22].

Table 1. Surviving Veterans

Category	**Estimated Use**
World War II	0.6 million
Korean Conflict	1.5 million
Vietnam Era	6.7 million
Peacetime Only	4.5 million
Gulf War	7.1 million

However, health care eligibility is not simply a matter of having served in the armed forces. The VA categorizes such eligibility in terms of eight priority groups, briefly summarized in Table 2 [23].

Table 2. VA Priority Groups

Priority Group	Eligible Veterans
1	50 percent or greater disabled; unemployable due to disability; Medal of Honor recipients
2	30 to 40 percent disabled
3	former POWs; Purple Heart recipients; discharge due to disability; 10-20 percent disabled; other special eligibility classification
4	housebound benefits from VA; catastrophically disabled
5	0 percent disabled and an annual income below geographically-adjusted limit; recipients of VA pension benefits; eligibility for Medicaid
6	0 percent disability; radiation exposure from occupation of Hiroshima and Nagasaki; Project 112/SHAD participants; World War I; Vietnam service between Jan. 9, 1962-May 7, 1975; Persian Gulf War service between Aug. 2, 1990-Nov. 11, 1998; active duty at Camp Lejeune (minimum 30 days) between Aug. 1, 1953-Dec. 31, 1987; enrollees serving in combat theater after Nov. 11, 1998 and those discharged after Jan. 28, 2003 (5-year eligibility post-discharge)
7	gross income below geographically-adjusted limit and agree to copayments
8	gross income above geographically-adjusted limits and agree to copayments

Veterans wishing to determine their eligibility can fill out a survey of questions using the VA Health Benefits Explorer [http://hbexplorer.vacloud.us/]. Participants answer a couple of basic questions concerning service and discharge status (an answer of "other than honorable discharge" will end the survey and encourage applicants to seek eligibility through another source). Afterward, new decision tree questions arise based on the prior questions' responses. Some of these decision tree questions are related to the eligibility characterizations described in Table 2. After about a dozen or so questions, applicants are given a list of possible benefits and copay requirements before being encouraged to apply formally online.

Point of fact, all veterans are eligible for VA benefits upon reaching the age of 65 (receipt of benefits, however, is dependent upon qualification in the eight priority groups described above). Those who enter before that age are most likely being treated for service-related injuries [24]. The demand on VA services can reasonably be forecasted based upon the number of service personnel per conflict. This is similar to production planning forecasting techniques utilized in industry to anticipate future demand and to adjust capacity to service that demand. What the VA *cannot* forecast with any accuracy is the probability of future conflicts and the number or severity of injuries from those conflicts. Given the time to gain approval, funding, permitting, and construction time for new facilities, agile response within the VA system is virtually impossible to guarantee. As noted above, it has been suggested that the VA would be better able to respond to short-term fluctuations in demand by utilizing a similar strategy employed in industry: outsourcing. Creating duplicate service presently available from the private sector at similar or lower cost is simply not efficient. Outsourcing of procedures routinely

performed in the private sector would allow the VA to focus on the more intensive large-scale injuries typical of those being incurred in the nation's recent wars in the Middle East. By default, the VA establishes a core competency. In April 2017, President Donald Trump signed the Veterans Choice Improvement Act. This law provides for continued access to medical services that either a) veterans need for specific instances of care, and/or b) prevents burdensome travel for veterans traveling to VA facilities [25]. However, the Veterans Choice Program is a temporary program that expires once all funds have been expended.

Of course, shortages in wartime are certainly nothing new. As it turns out, neither is the slow pace of bureaucracy when it comes to returning soldiers. Regarding this latter point, the United States had been fortunate for the most part in terms of foreign deployment. The Revolutionary War, the War of 1812, and the Civil War were all solely fought on American soil. The forgotten conflict of the Tripolitan War, where the Navy and Marines were sent to North Africa, deployed only a handful of personnel. The Mexican War was a boundary dispute and ultimate land grab by the James K. Polk Administration.

The Spanish-American War of 1898 was the country's first truly foreign war, and its conclusion saw many of the same difficulties described above. After the destruction of the USS *Maine* in Havana harbor on the evening of February 15, 1898, the Americans were rallied for war. While an American inquiry one month later found that a submarine mine was used to destroy the *Maine*, a Spanish inquiry found that the ship had suffered an internal explosion. Regardless, Congress passed a joint resolution in April calling for Spain to withdraw from Cuba lest face military action. President William McKinley, no

doubt influenced by American outrage, signed the resolution. Shortly thereafter, Spain broke diplomatic relations with the United States and declared war. While popular opinion now holds that Spain was likely correct in its conclusion about the *Maine*, it was in no condition to fight the United States so far away from friendly European ports and without the backing of any major allies. Cuba, Puerto Rico, and Manila would all soon become part of the conflict that was over in a matter of months [26].

How this all relates to the central theme of this paper was what occurred during demobilization from that conflict. On or just after the surrender of Spanish forces at Santiago de Cuba, an outbreak of yellow fever plagued the American troops of the Fifth Army Corps. One of the steps taken by the commanders was to limit the overcrowding that might occur during transport and bivouacking. If there were no new cases of yellow fever after a five-day period, units were to be evacuated to the United States. With troop morale plummeting, the Fifth Army was sent to Montauk Point on Long Island, at Camp Wikoff. Government inefficiency combined with the necessity of providing for the returning troops created unsuitable conditions for the returning soldiers [27].

Given that the troops needed to be moved from the theater before entire units collapsed from disease, there was not enough lead-time to prepare for the new camp's construction. Located in a relatively small-populated area of Long Island, Camp Wikoff was in no way prepared for the arriving soldiers. This isolated site resulted in labor shortages, and, combined with only one rail line and unnavigable roads overwhelmed the resources of the area. Interestingly enough, much like the VA scandal described above, press reports describing the inadequacy of Camp Wikoff caused both the government and the public to take notice. President McKinley and Secretary of War Russell Alger both

visited the site to ensure that services to the area were improving. Ultimately, 20,000 soldiers moved through Camp Wikoff during a period of two months of demobilization. Of this number, 257 died from disease. By comparison, although still worthy of note, 514 soldiers met a similar fate while stationed in Cuba (and during a shorter time span) [28]. Hence while the demobilization and quarantining of troops at Camp Wikoff almost certainly lowered the mortality rate of the soldiers returning from the war, poor planning and overcapacity could not mitigate those losses entirely. Sometime later, during the Woodrow Wilson Administration, unnecessary troop movements at the denouement of World War I perhaps led to thousands of preventable deaths. American soldiers at camp and in troop transports were tightly clustered together, quickly spreading the deadly Spanish Flu between themselves. During October 1918, when the President discussed halting troop transports as the virus raged in Europe, Army Chief of Staff General Peyton March assured Wilson that the soldiers were carefully examined before shipping out. It was later estimated that six percent of those en route to Europe died of the flu. This was especially senseless in that an armistice was signed one month later [29]. Historically then, American soldiers have needlessly been put at risk during both mobilization and demobilization.

Demobilization and combat troops returning from the wars in Afghanistan and Iraq have led to similar problems. Former Defense Secretary Robert Gates, who served under both George W. Bush and Barack Obama, best describes the problem with government procurement, which is worth quoting at length:

> The military departments develop their budgets on a five-year basis, and most procurement programs take many years—if not decades—from decision to delivery. As a result, budgets and programs are locked in for years at a time, and all the bureaucratic wiles of each military department are dedicated to keeping

> those programs intact and funded. They are joined in those efforts by the companies that build the equipment, the Washington lobbyists that those companies hire, and the members of Congress in whose states or districts those factories are located. Any threats to those long-term programs are not welcome. Even if we are at war [30].

Gates also stated, "The Department of Defense is structured to plan and prepare for war but not to fight one" [31]. Given past experiences, perhaps the same can be said of force demobilization.

5. Conclusion

A 2018 RAND Corporation study noted that VA-provided care was considered good [32]. Perhaps the problem is gaining access to VA care. Anticipating the exact time of a military conflict is difficult to predict, as well as its duration or intensity. Are there indicators of a looming surge in demand that could be relied upon to plan for additional capacity? The Cold War led to a history of foreign proxy engagements, most small in deployment and many within the train and support category. However, congressional authorization of an overseas action (such as George H. W. Bush's Operation Desert Shield) or a presidential action through the 1973 War Powers Act, could act as a "trigger" sign of likely greater demand for VA services. These indicators would be treated as precursors for review of current capacity and, if necessary, initiate the planning process of identifying alternate paths to patient service requirements. For example, when manufacturers launch new products, initial demand is often high and hard to predict. Demand then reaches a steady-state after the early adoption period.

As stated above, the lead time for the proposal of additional facilities, approval of funds, review of bids, and actual construction time render any necessary increase of VA support facilities too little too late. The VA must sustain an alternate care delivery

process to utilize outside care facilities that can be engaged when demand for conflict care exceeds the service capability within the VA system. Alternately, the VA could develop a core competency review to decide which type of injuries and their volume it is capable of accommodating. All other procedures would then be outsourced to the private sector, where labor costs might also be lower due to the possibility of no union protection. Private sector companies are motivated to produce products for which they have a competitive advantage. Such rationale should extend to the VA in that routine and repetitive procedures should be regularly outsourced, allowing it to retain the catastrophic injuries in-house, constantly developing the medical staff and facilities to support such injuries.

A persistent problem cited in the news was the wait time for individuals to have their case reviewed within the VA system. Here again, this administrative procedure could be outsourced to a private party where upon approval, the patient is referred to either a private or VA facility determined by type and extent of injury. A concern is that third-party providers for government contracts tend to become bureaucratic themselves. Case denials could be challenged through an appeal process.

Interestingly enough, the federal government's Congressional Budget Office (CBO) has looked at changing the VA health care structure not necessarily for its own sake, but as a means of deficit reduction. As noted above, the VA's priority groups range from 1 through 8, with Group 1 the highest priority to Group 8 being the least priority (and having means to purchase their own care more easily). The CBO estimates that by ending enrollment in Groups 7 and 8, the federal government would save roughly $57 billion over the next nine years by removing two million veterans from the rolls.

Ironically, those veterans over the age of 65 (estimated to be half of Groups 7 and 8) and those below the income threshold would have to get health insurance through either Medicare or Medicaid, increasing spending from those sources to $29 billion. Ultimately, this would leave a net effect of $28 billion in deficit reduction [33].

While reform is sometimes not without an implicit cost, such a move by the federal government would necessitate breaking a promise it has long made to those who have signed up for military service. By reducing the load of the demand chain—assuming no other conflicts for the foreseeable future—as well as the inevitable passing of survivors from World War II and the Korean conflict, pressure on VA services will diminish greatly in the near future.

With respect to the supply chain for the acquisition of equipment and clinical supplies, the Commission on Care study noted that the VHA spent approximately $3.4 billion in the acquisition of equipment and clinical supplies. As a comparison, the study cited cost savings for private health care facilities in the hundreds of millions of dollars from modernizing their supply chains, an effort that could be duplicated by the VHA with strong, consistent executive leadership [34].

However, when the VA crisis became known in 2014, culminating in the resignation of VA Secretary General Eric Shinseki, there have been three secretaries in the past five years. Such turnover for the leadership of a tremendous bureaucracy is quite extraordinary and would deprive any organization of needed stability. While cabinet secretaries serve at the pleasure of the President, perhaps this is another post in the executive branch that should transcend partisanship selection and changes in the presidency. For example, the chairman of the Federal Reserve serves a renewable four-

year term that straddles two presidential terms, meaning the incoming President must live with the current Fed chair for at least a year (or sometimes as many as three years as was the case with Bill Clinton in his first term). Alan Greenspan, originally appointed by Republican Ronald Reagan in 1987, was seen by his contemporaries as a fine steward of the national economy. When Democrat Bill Clinton had the opportunity to name a new Fed chair, he chose to continue Greenspan's chairmanship for another four years. In the executive branch itself, the FBI director now serves a 10-year term, clearly longer than two presidential terms. While the FBI director can still be removed by a sitting President (witness President Donald Trump's firing of James Comey in May 2017), President Barack Obama wanted Robert Mueller to remain in that role after 2011 due to ongoing national security threats. Such an extension also required the approval of Congress [35].

We recommend a similar staggered term-length structure for the VA secretary. After all, such a position is typically not known for a partisan bent, nor for being primary to implementing the policy prescriptions of a new President. A proven, field-tested manager of a large agency overseeing an institution of 366,000 employees with an annual budget of nearly $200 billion ($110 billion mandatory spending plus $86 billion in discretionary spending) is necessary to ensure the long-term viability of the organization and the care of its patient load [36].

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