The Veterans Health Administration

A Preliminary Analysis of the Influence of *The Independent Budget* and Bureaucratic Performance on Funding Trends

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Introduction

The Veterans Health Administration (VHA), housed within the Department of Veterans Affairs (VA), is the largest integrated health system in the United States (Perlin et al. 2004). Currently 7.9 million of 23.5 million U.S. veterans are enrolled in the VA health system. In recent years VHA has faced an increase in demand for health care services, which, accompanied with the rising cost of delivering such services, has driven significant growth in the VA budget (CBO 2005).

VA's budget, as a discretionary program, is vulnerable to substantial political influence and competition from discretionary federal programs and priorities, inviting the question: To what extent do veterans' service organizations (VSOs) affect the allocation of money to the VA medical care budget? This article analyzes VHA medical care funding levels over the past ten years in light of the participation of VSOs in committee hearings, the reliance of lawmakers on *The Independent Budget* (*IB*), and the impact of new performance-based management initiatives on budget outcomes. Ultimately, this article reveals the highly political nature of the VHA budget and the influential role of VSOs in funding outcomes.

The methodology used to reach this conclusion involved several com-

ponents. Testimony given during budget hearings held by the U.S. House and Senate Committees on Veterans Affairs were analyzed to determine: (1) the ratio of VSOs participating as witnesses in the hearings; and (2) the number of references to the *IB*, which is a comprehensive budget and policy document produced by a coalition of four congressionally chartered VSOs that present budget and policy recommendations on programs administered by VA and the Department of Labor (AMVETS et al. 2007).

In order to analyze VHA funding trends and the *IB*'s influence on those trends, the VHA Medical Care component of the discretionary funds appropriated to VA are compared to the President's Budget Requests and the *IB*'s requests from FY 1999 through FY 2008. Furthermore, qualitative data are presented to more fully understand the impact of both the *IB* and VSOs on the budget decision-making process. The statements of several policymakers, taken from budget hearing testimony, provide a preliminary picture of the extent to which such policymakers rely on and use the information presented in the *IB* in their decision processes. Finally, performance data from VA were collected over the past several years (as available) to evaluate the extent to which performance measures reflect resource allocations.

The analysis revealed that between FY 1999 and FY 2007, VHA's budget authority for medical care increased by an average rate of 8.8 percent. Although it is difficult to attribute funding decisions to any one causal factor when in fact there are many, graphic representation of trends in funding requests and enactments show that the *IB* has consistently requested more funding for VHA Medical Care than the President's Budget by an average $2.1 billion. Additionally, Congress consistently appropriated more for VHA medical care than was requested by the President's Budget and consistently less than what was proposed by the *IB*. Preliminary qualitative data show generally bipartisan positive sentiments of policymakers in regard to the usefulness and importance of the *IB*.

Given the available data over the past decade, this study provides an analysis of the potential impact two factors have on funding outcomes for the VHA budget: the participation of veterans' service organizations in the budget process and the correlation between performance measurement

and appropriations outcomes. The analysis compares the President's Budget and the *IB*'s funding requests for VA health care, including how they match up to the actual appropriations, and concludes that the *IB* and its authors are considerably influential in the congressional budget decision-making process for VHA.

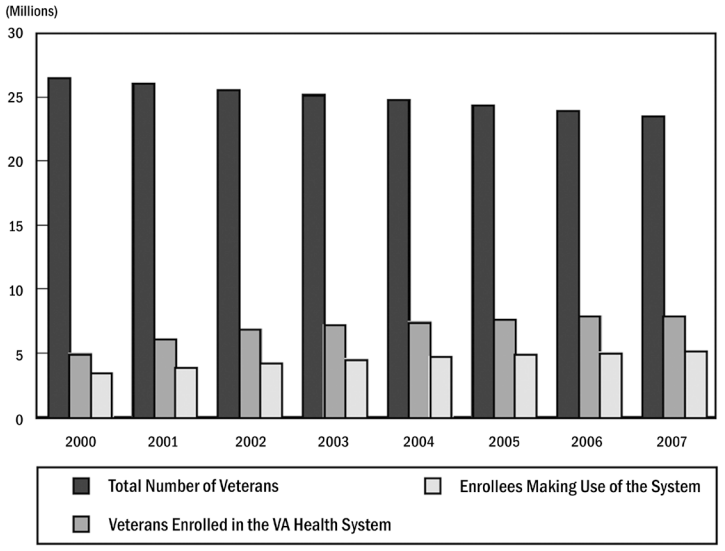
Although VA bureaucratic performance data have only been available since 2001, a preliminary comparison of funding trends versus performance reports shows that the connection between VA performance measurements and funding remains unclear. The Medical Care component of the VHA budget has increased by an average of 13 percent over the past two years and an average of 8.8 percent over the past ten years, despite the agency's mediocre performance measures. When more performance measurement data are available, a systematic analysis of the correlation between performance and funding outcomes may provide insight into the level of influence that performance, as well as other factors, has on funding outcomes for VHA.

Background

Veteran Constituency and Benefit Trends

Currently there are 23.5 million veterans in the United States, down from 26.5 million in 2000 (CBO 2007, 3) (See Figure 1). Of this population, 7.9 million are enrolled in the VA health system—a substantial increase from the 4.3 million enrolled in 1999 due in large part to the establishment of an enrollment system as directed by the Veterans' Health Care Eligibility Reform Act of 1996 (CBO 2005, 3). Reforms that took place over the course of the past decade, coupled with a growing veteran population from the Afghanistan and Iraq wars, have resulted in an increase in the proportion of veterans seeking VA health services, from 13 percent in 2000 to 21 percent in 2006 (CBO 2007, 2).

Figure 1:
The Population of Veterans, 2000–2007



Source: Congressional Budget Office 2007, 2.

Note: Based on data from the Department of Veterans Affairs and Budget of the United States Government (FY 2006 to 2008).

VHA Budget and Funding Trends

Recent trends in VHA funding are best analyzed with an understanding of current veteran demographics and growth in health care expenditures. Although similar to its government-run entitlement health service delivery counterparts, Medicare and Medicaid, the VHA budget is discretionary and thus vulnerable to substantial political influence and competition from other funding demands. Between FY 1999 and FY 2007, VHA's budget authority for medical care increased by an average rate of 8.8 percent (see Table 1). This growth nearly kept pace with the 9.9 percent average growth in health care costs (measured by health insurance premiums), as compared to markedly lower 2.7 percent average overall inflation growth and 3.2 percent average workers' earnings growth (Kaiser Family Foundation

Table 1:
Budget Authority for VA Medical Care,[1] FY 1999–2008

Fiscal Year	Budget Authority Enacted[2]	% Increase
1999	17.3	N/A
2000	18.9	9.2%
2001	20.2	6.9%
2002	21.3	5.4%
2003	23.9	12.2%
2004	26.6	11.3%
2005	27.7	4.1%
2006	28.7	3.6%
2007	32.3[3]	12.5%
2008	36.7	13.6%
Average % Increase		8.8%

Sources: Congressional Budget Office 2007; U.S. House of Representatives Committee on Veterans Affairs 2007; U.S. House and Senate Committees on Veterans Affairs 1998–2007.

and Health Research and Education Trust 2006).

The increases in appropriations detailed in Table 1 reflect benefit expansions, the transition to more outpatient-based services and facilities as instituted in VHA reforms of the 1990s, and specific military events over the past two decades (namely the Afghanistan and Iraq wars) that have stimulated the new growth in the veteran population. FY 2008 funding requests and proposals ranged from the President's Budget request of $34.2 billion to the *IB* request of $36.3 billion (U.S. House of Representatives Committee on Veteran Affairs 2007, 1), with the minimum request representing a six percent increase above FY 2007's medical care appropriations. The 2008 Omnibus Appropriations bill designated $37.2 billion to VHA Medical Care (U.S. House of Representatives Appropriations Committee

2007, 1).

Although many budgets tend to evolve incrementally by means of adjusting for the inflation rate and other marginal factors, the VA budget (and other direct service agency budgets) must also take into account the following factors (CBO 2007, 6-7):

- Demographic changes in the eligible population;
- Number of new veterans who transition from the Department of Defense;
- Rising cost of health care;
- Economic growth forecasts;
- U.S. foreign policy initiatives;
- Changing policies on out-of-pocket cost-sharing from different cohorts among the veteran population; and
- Perceptions and anecdotes about the quality of VA health services.

Due to various political factors inherent in the discretionary funding process and the strong representation of veterans' interests by VSOs, multiple interpretations of an optimal VHA budgetary proposal exist. The *IB* has emerged over the past two decades as a prominent proposal informing the budgetary decision-making process for the VA.

The Independent Budget

The Independent Budget (*IB*) is a comprehensive budget and policy document produced by a coalition of four congressionally chartered veterans' service organizations (VSOs). It was first published 21 years ago based on a suggestion from the former VA Chief Medical Director and Surgeon General of the Navy, retired Vice Admiral Donald Custis. Vice Admiral Curtis had suggested that AMVETS, Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars (VFW) form a unique partnership to develop a yearly VA budget review and to estimate how the intended budgetary process would impact subsequent funding outcomes.

These four authoring organizations, collectively known as *The Independent Budget* Veterans' Service Organizations (IBVSOs), describe the *IB* as a "collaborative effort of a united veteran and health advocacy community

that presents policy and budget recommendations on programs administered by the Department of Veterans Affairs and the Department of Labor" (AMVETS et al. 2007, i). The *IB*, released annually, is intended to provide an accurate analysis of health care and other programmatic funding needs of the VA and serve as a guide to Congress during the authorizing and appropriating processes. Additionally, throughout the budget cycle, the *IB* authors release "Critical Issue Reports" intended to bring specific VA health care and benefits issues to the attention of the administration as they craft the upcoming President's Budget request. The impetus to create the *IB* stemmed from displeasure with the President's Budget and the appropriations process, which, according to an *IB* author, was routinely influenced "more by political considerations and the changing pressures of the federal budget policy than by objective budget modeling" (Vollmer 2005, 1).

According to AMVETS et al. (2005), the authors of the *IB* use a current services baseline to project what it would cost to provide the same level of services in the following year and then take into account the following:

- Expected changes in the demographics of the veteran population and the associated benefit needs;
- Number of veterans expected to seek each offered benefit or service;
- Federal employee wage increases and cost of living adjustments;
- Generally accepted estimates in medical care inflation and trends in health care utilization;
- Construction needs for new or improved VA facilities;
- Estimates of the numbers of veterans to be buried in the nation's cemeteries;
- Advancements in medical and information technologies; and
- Other changes in the effective and efficient means of delivering needed benefits.

This budget model is the same as that mandated for use by the Congressional Budget Office (CBO) and is therefore a model familiar to congressional members.

Since its inception, the *IB* has been presented at all House and Senate Committee on Veterans Affairs Budget Hearings (U.S. House and Senate Committees on Veteran Affairs 1988–2008). This fact alone is indicative

of the continued participation of veteran interest groups in the policymaking process and in the importance Congress places on the veteran constituency. Moreover, the most recent *IB* boasts the endorsement of a majority of active national veterans' interest groups, including more than fifty VSOs and medical and health care advocacy groups (AMVETS et al. 2007).

Despite the consistent and formidable promotion of the *IB*, several of its central tenets have been ignored over the years. For example, this year, as in the past, the *IB* called on Congress to provide VA health care funding from the mandatory side of the federal budget as opposed to from the discretionary side, where it is vulnerable on an annual basis to changes that may undermine the needs of sick and disabled veterans. Further, the IBVSOs reiterate in nearly every testimony and printed document their objection to the President's Budget's incorporation of Medical Care Collections Fund (MCCF) receipts into the appropriated amount.[4] The *IB*'s authors and supporters argue that MCCF receipt estimates serve as a means to offset actual needed appropriations and therefore should be considered as a supplement to the appropriated dollars (Blake 2007; U.S. House and Senate Committees on Veterans Affairs 1998–2007). No action has been undertaken to date by OMB or Congress on either of these issues.

Preliminary Data Findings

In an attempt to gauge the extent to which *The Independent Budget* (*IB*) and its supporting veterans' service organizations (VSOs) influence the budget process, oral and written testimony of budget hearings held by the U.S. House of Representatives and Senate Committees on Veterans Affairs were analyzed from 1999 through 2008. Testimonies were analyzed from these committees specifically because the committees:

- Are resident "experts" in Congress on veterans affairs;
- Understand the programmatic issues and challenges faced by VA which impact the budget decisions;
- Hold consistently reliable and substantively comprehensive hearings on the budget for each fiscal year; and
- Reliably publish hearing transcripts and prepared testimony (with

Table 2:

Number of References to *The Independent Budget* during Budget Hearings of Congressional Veterans Affairs Committees and Participation of VSOs in Hearings, 1999–2008

	Observations	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	Avg
House Committee on Veterans Affairs	Number of *IB* references in budget hearing oral testimony[6]	37	32	37	36	47	29	34	31	24	60[7]	37
	Ratio of VSO witnesses to total number of witnesses	6/8	6/7	7/8	7/8	7/9	7/8	9/10	7/8	6/7	6/7	85%
	Ratio of IBVSOs[8] to total number of witnesses	4/8	4/7	4/8	4/8	5/9	4/8	4/10	4/8	4/7	4/7	51%
Senate Committee on Veterans Affairs	Number of IB references in budget hearing oral testimony[6]	NA[9]	NA	NA	19	50	12	20	26	26	60[7]	30
	Ratio of VSO witnesses to total number of witnesses	NA	NA	NA	5/6	7/8	5/6	5/6	5/7	5/6	6/7	83%
	Ratio of IBVSOs to total number of witnesses	NA	NA	NA	4/6	6/8	4/6	4/6	4/7	4/6	4/7	65%
	Number of *IB* references in prepared written testimony[10]	NA	NA	NA	35	71	54	58	41	65	60	55

Source: U.S. House and Senate Committees on Veterans Affairs 1998–2007.

the exception of Senate hearings from 1999 to 2001).

It is evident from the testimony that the *IB* was referenced by both committee members and witnesses at the hearings and served an integral role in the hearing discussion. In order to quantify this observation, the number of times *The Independent Budget* (and its abbreviation "*IB*") was referenced in all oral testimonies for the aforementioned budget hearings was counted. The results in Table 2 show that on average, 37 and 30 references were made to the *IB* in each budget hearing in front of the House and Senate Committees on Veterans Affairs, respectively. Moreover, when compared to the average of 55 references made to the *IB* in the written, prepared testimony from the Senate hearings,[5] the oral testimony appears to under-represent the extent to which the *IB* is referenced or given consideration from the Committees.

Further, in order to quantify the relative participation of both VSOs and the authors of the *IB* (IBVSOs) as compared to all participating witnesses, the list of participating witnesses at each budget hearing was analyzed. It was found that on average 85 percent of all witnesses presenting in both the House and the Senate budget hearings from 1999 to 2008 were from VSOs. Moreover, 51 percent of witnesses in House hearings and 65 percent of witnesses in Senate hearings were representatives from one of the four *IB* authoring organizations (see Table 2).

The observational data raise interesting questions about the extent to which the data presented in the *IB* and the participation of the IBVSOs in congressional hearings impact the funding outcomes of VHA's medical care budget. The following section, in an attempt to begin to understand this dynamic, presents funding trends over the past decade as compared to the President's Budget and the *IB*.

Funding Outcomes and the Influence of *The Independent Budget*

With an understanding of the participation of VSOs and references to *The Independent Budget* (*IB*) during congressional budget hearings, it is relevant to explore to what extent the *IB* has an impact on funding outcomes of VHA. Although difficult to attribute political decisions to any

Table 3:

Comparison of President's Budget, *The Independent Budget*, and Appropriations for VA Medical Care,[11] FY 1999–FY 2008 (in billions of dollars)

Fiscal Year	President's Budget Request	*Independent Budget* Request	Budget Authority Enacted	% Change in Enacted Funds	Difference *IB* & President's Request	Difference *IB* & Enacted	Difference President's Request & Enacted
1999	17.0	18.2	17.3	N/A	+1.2	+0.9	—0.3
2000	17.3	19.7	18.9	9.2%	+2.4	+0.8	—1.6
2001	20.3	20.8	20.2	6.9%	+0.5	+0.6	+0.1
2002	21.0	22.9	21.3	5.4%	+1.9	+1.6	—0.3
2003	22.7	24.5	23.9	12.2%	+1.8	+0.6	—1.2
2004	25.2	27.2	26.6	11.3%	+2.0	+0.6	—1.4
2005	26.9	29.8	27.7	4.1%	+2.9	+2.1	—0.8
2006	27.8	31.2	28.7	3.6%	+3.4	+2.5	—0.9
2007	31.5	32.4	32.3[12]	12.5%	+0.9	+0.1	—0.8
2008	34.2[13]	36.3	36.7	13.6%	+2.1	—0.4	—2.5
Average Difference				*8.8%*	*+1.9*	*+0.9*	*—1.0*

Sources: Congressional Budget Office 2007, 1-14; U.S. House of Representatives Committee on Veterans Affairs 2007, 21; U.S. House and Senate Committees on Veterans Affairs 1998–2007.

one causal factor when in fact there are many, it remains interesting to compare the funding requests from both the President's Budget and the *IB* against the actual enacted dollars, from FY 1999 through FY 2008, as seen in Table 3.

Trends in funding requests and enactments over the past ten years (Table 3 and Figure 2) suggest that the *IB* has consistently requested more funding for VHA Medical Care than the President's Budget, by an average of $1.9 billion. Additionally, Congress consistently appropriated more for VHA Medical Care than was requested by the President's Budget (save for FY 2001), by an average of $1 billion, and consistently less than what was proposed by the *IB* (save for FY 2008), by an average of $900 million.

Although the percentage changes in the President's Budget and *IB* funding requests show no obvious correlation with the percentage changes in enacted funds by year[14] (see Figure 3), Figure 2, which shows dollar amounts, shows a relatively consistent correlation between the budget requests and appropriations.[15] The yearly variance in percentage increases of funding requests and funding outcomes likely results from the assumptions made on the factors considered in the budgeting model when funding VHA, as listed previously. Perhaps this variance over time represents substantive or political elements that merit further study.

Given the observed funding trends, it is reasonable to assume that the consistent action by Congress to appropriate more to VHA medical care than has been requested in the President's Budget is affected by the political importance to Congress of the veteran constituency and their consistent presence in presenting and promoting the *IB*. Yet in order to make a more definitive conclusion, additional evidence is needed to assess the relative influence of the *IB* and VSOs and to understand the opinions of policymakers as to the relevance and impact of each.

Observational Data: The Policymakers' Perspective on the *IB*

Longitudinal data from the committee testimony sheds light on the relationship between VSOs, the Committees on Veterans Affairs, and VA, and provide a clearer understanding of the reliance placed on the infor-

Figure 2:

Comparison of President's Budget, *The Independent Budget*, and Appropriations for VA Medical Care, FY 1999–FY 2008

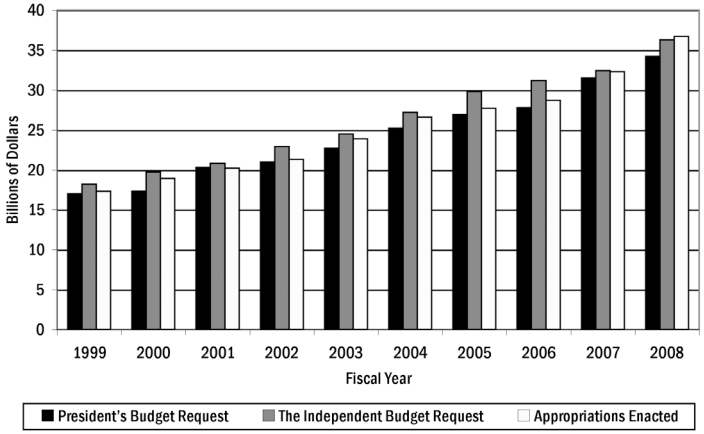
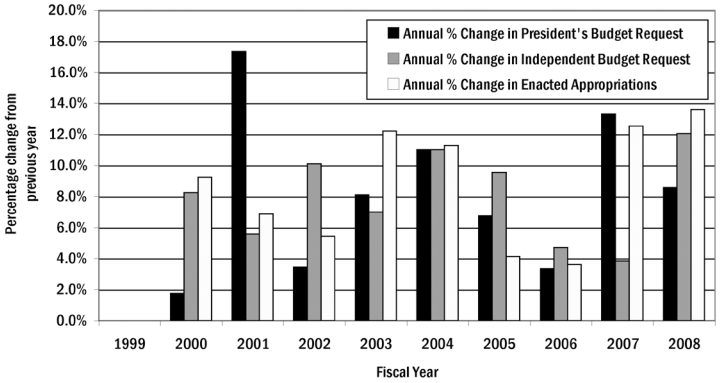


Figure 3:

Percent change in VA Medical Care Requests and Enactments, FY 2000–FY 2008



Sources for Figures 2-3: Congressional Budget Office 2007; U.S. House of Representatives Committee on Veterans Affairs 2007; U.S. House and Senate Committees on Veterans Affairs 1998–2007.

mation provided in the *IB*. In an observational attempt to understand the perspective with which the legislators view the *IB* and the relative level of "friendliness" between committees and VSO witnesses, several significant statements made by members of the House and Senate Committees on Veterans Affairs regarding the *IB* were extracted from the budget hearing testimony. Although hundreds of references to the *IB* were made during budget hearings over the past ten years (see Table 2), the following statements represent the more opinionated comments made by committee members (U.S. House and Senate Committees on Veterans Affairs Budget Hearings 2002–2007):

- *We all know that the veterans' organizations do a tremendous job each and every year putting forward what they call* The Independent Budget. *This* Independent Budget *details the funding that would be needed to truly meet the needs of our veterans. They are to be congratulated because they put it out every year regardless of what party is in charge…We should look to the veterans' organizations and their* Independent Budget *as a guide.* –Senator Bernard Sanders (I-Vermont), FY 2008
- *The groups that authored* The Independent Budget: *AMVETS, DAV, PVA and VFW; you have continued to serve your country with this budget. Showing the inadequacies of veterans funding, whether Democrat or Republican, is important to the advancement of veterans rights.* –Congresswoman Corrine Brown (D-Florida), FY 2008
- *I would like to thank your organizations for visiting with us last month, and giving the full Committee staff an overview of the methods used in developing the* IB, *as well as a preliminary idea of what the* IB *would recommend this year. I don't know if such a briefing has ever been done before, and it is a good example of how the veterans' groups and the Committee can work proactively together, for the good of our veterans.* –Congressman Steve Buyer (R-Indiana), FY 2007
- *Are you familiar, in your two weeks as Secretary, with* The Independent Budget*? I would read it carefully. Most of us take this as a Bible. It is put together by people who understand the system. They are not asking for the moon. They are not asking just for the asking. It is a professional and very conservative look at the VA, what it takes to save the veterans.*

–Congressman Bob Filner (D-California), FY 2006.

- *In addition to the Secretary, we have the veterans'* Independent Budget *to help guide us, and as in the past years, it sets an ambitious goal for Congress, and we do take that budget very, very seriously.* –Congressman Chris Smith (R-New Jersey), FY 2005

These statements are largely representative of the general sentiments toward the reliance on the *IB* and appear to show a bipartisan acceptance of the document. However, there were some statements in the FY 2006 House Committee hearing suggesting that the *IB* is used as a partisan tool. For example, Chairman Filner remarked (Filner 2006, 27–40):

> *Certainly, this Congressman and most of the people on this side are not going to vote for a budget that is not worthy of our veterans…* The Independent Budget *is one that many of us, certainly on this side, take very seriously.*

Congressman Gus Bilirakis (R-Florida) responded with the following (Bilirakis 2006, 40):

> *We could probably approach something like [complete coverage for veterans] if we would all work together, but we don't. You pit us one against the other with your* Independent Budget. *I remember in the days when the other party was in charge. I don't remember an* Independent Budget. *I don't remember going through an* Independent Budget *business or anything of that nature.*

The above exchange may be an outlier in regards to the level of bipartisanship usually present during VA budget hearings. Nonetheless, it is interesting to analyze in more detail the partisan sentiments towards the *IB* and to gauge the extent to which the VA budget is affected by partisanship and committee politics.

Martha Gibson provides some perspective on this issue in her hypothesis that cross-cutting policy issues tend to be more vulnerable to partisan politics, whereas sector-specific policy issues (e.g. trade and agriculture) are more indicative of bipartisan coalitions and divergence along institutional lines (Gibson 1995, 22). Although veterans affairs are thought to be sector-specific and constituent-specific, and thus often supported by bipartisan

coalitions, Gibson found that they tend to cleave more along partisan lines characteristic of cross-cutting issues perhaps because the veteran constituency is broadly distributed throughout the nation and the issues tend to be economic. This area of research offers interesting questions to consider regarding the extent to which veterans' health care is a "party-associated" issue, particularly in regards to the subject of entitlement and the likelihood of veterans' health care being financed through mandatory spending like other government-run health care programs.

Bureaucratic Performance and Accountability: How Valid are the Funding Consequences?

The data from this study provide an initial understanding of the funding trends of VHA over the past several years and some of the influences that impact the funding levels. Although VA bureaucratic performance data are not complete and have only been available since 2001, an initial comparison of funding trends versus performance reports highlights the extent to which funding consequences of management reform are implemented, and provides scope for future research when more data become available.

Over the past several decades, governments around the world have launched ambitious reforms motivated by a widespread desire for better performance and accountability through performance measurement. In 1993 the first phase of the National Performance Review was initiated by Vice President Al Gore, and the Government Performance and Results Act (GPRA) was passed, "requiring all federal agencies to develop strategic plans for their activities and establish indicators for measuring outcomes" (Kettl 2005, 33). In 2001 the Bush Administration followed suit introducing the *President's Management Agenda* (PMA). The five-point strategy focuses on strategic management of human capital; expansion of 'e-government' initiatives; increase in contracting out government services; improvement of financial management; and integration of the performance measure of agencies with budget decisions (Lee et al. 2004, 309).

In an effort to track how well the agencies and departments execute the five government-wide management strategies, the Administration has

subjected twenty-six departments to a "traffic light" scorecard review every three months since 2001. Green lights signify compliance with the core management goals; yellow lights signify needing improvement; and red lights signify significant impediments to achieving the expectations of the PMA. The government-wide, baseline assessment in 2001 revealed that out of a total of 130 lights, 110 were red; nineteen were yellow; and only one was green[16] (U.S. Executive Branch Management Scorecards 2001-2007).

As apparent in Table 4, the VA scorecard reveals a rather poor performance. The VA earned red lights across all five core initiatives at the baseline assessment. It improved slightly to three red lights and two yellow lights by December 2002, only to see them both downgraded to red again over the next three years. The most recent Executive Branch Management

Table 4:
"Traffic Light" Performance of VA, 2001–2007

Status	Human Capital	Competitive Sourcing	Financial Performance	E-Gov	Budget/Perf Integration
2001 (baseline)	●	●	●	●	●
December 2002	●	●	●	■	■
December 2003	●	●	●	■	■
December 2004	■	●	●	●	■
December 2005	■	●	●	●	●
December 2006	▲	●	●	●	●
March 2007	▲	●	●	●	■

Red Light ● Yellow Light ▲ Green Light ■

Source: Executive Branch Management Scorecards 2001 to 2007.

Scorecard (March 2007) shows modest improvement for VA, with three red lights, one yellow light (budget and performance integration), and one green light (human capital). In relation to other agencies and departments, VA is second only to OMB in its poor performance and preponderance of red lights (U.S. Executive Branch Management 2001–2007).

In a further attempt to link resources to results, OMB developed the Performance Assessment Rating Tool (PART), which builds on the performance data generated by GPRA to promote a more explicit debate between OMB, agencies, and Congress regarding performance and its implications in the federal budget formulation process. PART, used for the first time in FY 2004, analyzes elements of programs that reflect performance such as program purpose and design; program management; performance measurement, evaluations, and strategic planning; and program results (OMB n.d.). Program performance ratings fall into one of five categories: "effective," "moderately effective," "adequate," "ineffective," and "results not demonstrated." The tool was designed to identify a program's strengths and weaknesses in order to inform management and funding decisions, and to allow for visible changes in program performance over time.

Table 5 shows the most recent PART scores for ten VA programs that were evaluated for the FY 2008 budget. Because each program is evaluated every four to five years, the comparative data are limited and the aggregate program data over time may promote skewed interpretations of results based on which programs were evaluated and when they were assessed. When enough data are available on PART assessments, it would be interesting to track the rating for Medical Care over time to analyze the influence of PART scores on funding outcomes.

The data suggest that the relationship between PART scores and funding remains unclear, at least for the past cycle. Three of the four "moderately effective" programs show a decrease in the funding request in FY 2008 as opposed to the 2006 actual appropriation, whereas the largest increase in funding (23 percent) is linked to Disability Compensation—rated in the worst performance category. In fact none of the three VA programs receiving the greatest increase in funding falls into the "effective" or "moderately effective" categories.

Table 5:

Program Assessment Rating Tool (PART), Department of Veterans Affairs 2008 Budget

Program	Program Purpose & Design (20%)	Planning (10%)	Management (20%)	Results (50%)	Rating	Program Funding Level (dollars in millions)			% Change 2006 to 2008
						2006 Actual	2007 Estimate	2008 Request	
General Administration	100%	88%	57%	67%	Moderately Effective	294	318	274	(7%)
Health Research & Development	80%	64%	100%	78%	Moderately Effective	509	508	476	(6%)
Life Insurance	100%	88%	86%	53%	Moderately Effective	1,242	1,238	1,229	(1%)
Burial Benefits	100%	86%	72%	73%	Moderately Effective	155	159	167	8%
Pension	60%	50%	86%	47%	Adequate	3,694	3,812	3,939	7%
Medical Care	**55%**	**75%**	**70%**	**60%**	**Adequate**	**32,163**	**32,262**	**36,761**[17]	**14%**
Vocational Rehab & Employment	80%	88%	100%	40%	Adequate	685	775	831	21%
Home Loans	40%	0%	33%	40%	Results Not Demonstrated	6,555	6,945	5,963	(9%)
GI Bill Education Benefits	60%	63%	86%	42%	Results Not Demonstrated	2,833	2,276	2,723	(4%)
Disability Compensation	20%	0%	57%	0%	Results Not Demonstrated	30,927	35,487	38,060	23%

Source: Office of Management and Budget 2007, 1-27

As a further mechanism of enforcing bureaucratic performance and accountability, each agency releases an annual *Performance and Accountability Report* detailing the extent to which it reached set targets for each of its strategic goals. Table 6 shows the most recent data released (FY 2006) by VA and reveals a negative trend of targets achieved over the past three years.

With significant resources and effort invested in actualizing the PMA, the more interesting question is not *why* VA has performed so poorly, but rather *what budgetary consequences* VA has faced in response to its routinely red scorecard and mediocre performance ratings. The administration made its intent clear for the PMA in its FY 2002 release, stating explicitly that "high performing programs will be reinforced and non-performing activities reformed or terminated" (OMB 2002, 29). Yet, aside from "traffic light" scorecards, cynics of the PMA approach suggest that the measurement has done little more than provide "a rationalization for ideological decisions the administration had already made" (Kettl 2005, 38). It has been suggested that the baseline was set strategically very low so as to appear that agencies

Table 6:
Percentage of Targets Achieved: VA Performance and Accountability Report, FY 2006

	Strategic Goals and Percentage of Targets Achieved				
	1: Restoration and Improved Quality of Life for Disabled Veterans	2: Smooth Transition to Civilian Life	3: Honoring, Serving, and Memorializing Veterans	4: Contributing to the Nation's Well-Being	5: Applying Sound Business Principles
FY 2004	50%	38%	66%	63%	N/A[18]
FY 2005	39%	56%	53%	70%	N/A
FY 2006	40%	45%	63%	42%	N/A

Source: Department of Veterans Affairs 2006.

were making substantial progress and that the PMA was achieving its intended goals, and further, that the performance-based budgeting initiative was generally futile in its attempts to rationalize funding decisions. Laurent (2000) writes:

> If, as its drafters and their disciples have contended, the point of GPRA was to tie agency funding to the achievement of program results, then it was doomed from the start…Administrations and appropriators have shown themselves to be utterly unwilling to relinquish the power of the purse for any reason, least of all a GPRA-induced, quasi-scientific linkage between programs enacted primarily to bring home political bacon and whatever happens after they are enshrined in law and ensconced in agencies (36–39).

Thus, the connection between performance measurements and funding remains unclear. The Medical Care component of the VHA budget, for example, has increased by on average 13 percent over the past two years and on average 8.8 percent over the past ten years, despite the agency's mediocre "adequate" PART rating, red score card, and poor performance and accountability measures. Besides the obvious limitation that the measures have only been available a short period of time, the lack of correlation between performance and resource allocation may be largely due to the growing needs of VA during wartime, and politics and ideologies factoring into the resource allocation process.

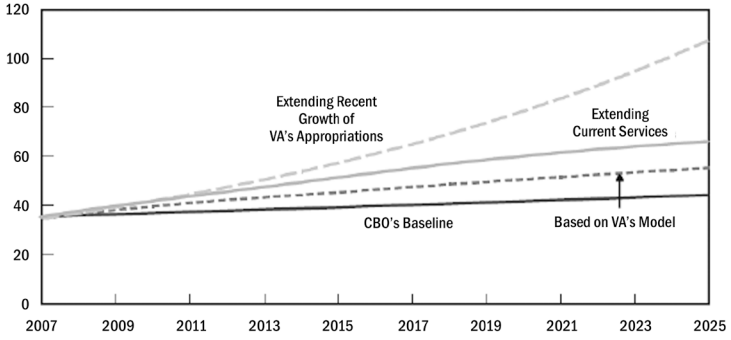
Conclusions and Implications for Future Funding

The active veteran population is undoubtedly a formidable and respected constituency. This nation's implicit, if not explicit social covenant to care for and provide services to the veteran population, and the strong representation of veterans' interests by VSOs creates a unique and dynamic political relationship between VSOs and policymakers. Perhaps as a result of this reality, or as a function of the valuable information they provide, the major national VSOs have been consistent and valued participants in the federal

budget decision-making process for VA. The *IB* has become a relied upon and trusted analysis of, and alternative to, the President's Budget—a perspective that estimates the needs of the veteran population absent from the complicated, competitive, and political VA budget formation process.

Yet it remains sufficiently difficult to evaluate the extent to which VSOs are influential in the policymaking process versus the extent to which the lawmakers are responsive to the myriad of other factors that motivate and influence their voting behavior. In order to more comprehensively understand the role of the *IB* as compared to other influences that impact VA health care funding levels, further in-depth longitudinal data collection and quantitative and qualitative analyses are necessary. This analysis looks specifically at hearings that took place within the authorizing subcommittees and should be replicated for both the House and Senate Appropriation Subcommittees on Military Construction and Veterans Affairs. Such research will provide a more detailed understanding of the extent to which VSOs have a direct impact on VA funding outcomes. Finally, more data on performance measurement will enable more informative analyses of the im-

Figure 4:
Four Scenarios for Growth in VA's Medical Spending



(in billions of dollars)

Source: Congressional Budget Office 2007, 9.

pact that performance has on funding outcomes, and the capacity of VHA to absorb significant funding increases and translate such resources into a well-functioning and reputable system of care.

Given recent funding trends as shown in Table 1, it is worth considering the impact of continuing such trends if in fact VHA does not have the administrative, managerial, or service delivery capacity to efficiently and effectively expand their functions at the same rate. As CBO illustrates (Figure 4), extending the current rate of growth of VA appropriations will cause appropriations to rise exponentially faster than VA model projections, CBO's baseline projections, or current services projections over the next seventeen years.

Understanding the factors that influence the budget process will assist in matching budget growth with capacity to ensure that the veteran population receives high quality, efficient, and cost-effective care. Given the high profile attention and scrutiny that veterans' health care has received in recent times, it will be important to analyze both the role of VSOs and VHA performance outcomes as the system faces the challenges and health care demands associated with the influx of veterans from the Afghani and Iraqi wars.

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Notes

1. Figures include accounts for medical services, medical administration, and medical facilities. Figures exclude medical and prosthetic research, the VA information and technology fund, major and minor construction, and grants for state extended care.
2. The *IB* advocates that all funding should be provided through appropriations and that MCCF collections should be considered as a supplement to appropriations. Therefore, MCCF receipts are not included in the *IB* requests and have been subtracted from the President's request and enacted funds for comparison purposes.
3. Amounts for FY 2007 are from P.L. 110-5, H.J. Res. 20, a joint resolution making further continuing appropriations for the fiscal year 2007. It was signed into law February 15, 2007.
4. The MCCF is a fund for collections from third party insurance, outpatient prescription co-payments and other medical charges and user fees that are used to fund VA medical care and other related indirect expenses.
5. The House Committee's written testimony from the hearings was not published in a searchable electronic format.
6. Represents the number of times "Independent Budget" and "*IB*" were said in the oral testimony, by both congressional representatives and witnesses.
7. This count is from prepared testimony; the oral transcripts have not yet been released.
8. The following four IBVSOs are the authors of *The Independent Budget:* Paralyzed Veterans of America; Disabled Veterans of America; AMVETS; and Veterans of Foreign Wars.
9. Transcripts of Senate Committee on Veterans Affairs Budget Hearings were not released from 1999 to 2001.
10. Represents the number of time "Independent Budget" and "*IB*" were said in written, prepared testimony as a comparison to the oral testimony. Author was only able to retrieve the data from the Senate's hearing records due to the presentation format of the documents. The comparison of the number of references in oral versus written testimony suggests that the oral testimony reflect an under-representation of the number of times references were made

to *The Independent Budget*.

11. The *IB* advocates that all funding should be provided through appropriations and that MCCF collections should be considered as a supplement to appropriations. MCCF receipts are not included in the *IB* requests and have been subtracted from the President's request and appropriated funds for comparison purposes.
12. Amounts for FY 2007 are from P.L. 110-5, H.J. Res. 20, a joint resolution making further continuing appropriations for the fiscal year 2007. It was signed into law on February 15, 2007.
13. The FY 2008 numbers represent proposed numbers. The U.S. House Committee on Veterans Affairs has submitted $35.5 billion to the Committee on the Budget for FY 2008.
14. Running a bivariate correlation calculation reveals no statistical significance between the overall change in appropriation levels and the President's or *IB*'s request.
15. This correlation is significant at the .01 level (2-tailed).
16. National Science Foundation, Financial Management received the only green light.
17. This number differs from Table 1 and 2 because it includes MCCF receipts.
18. Data not reported for the fifth strategic goal.

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