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THE UNITED STATES BENEFIT DEFICIT FOR VETERANS

by

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A Dissertation Submitted to the Faculty of
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ABSTRACT

THE UNITED STATES BENEFIT DEFICIT FOR VETERANS

Leslie-Dawn Quick
Old Dominion University, 2017
Director: Dr. Ruth Triplett

Over the last few years the Department of Veterans Affairs has faced an increase of public scrutiny for its handling of veteran health care claims. Allegations that mismanagement created extensive waiting times and appointment scheduling manipulations resulted in veterans dying were made against the VA. This research examined data from the VA Monday Morning Workload Reports, the National Survey of Veterans, the VA Office of Inspector General, and media reports of whistleblowers accusing the VA of mismanagement to determine whether the VA was guilty of a state crime of omission and commission resulting in a social harm to its veterans. This study found that the VA met several indicators identified in previous literature in that the VA 1) failed to act in a timely and appropriate manner in response to the problem, 2) had prior knowledge of the problem, and 3) that there was significant public and political response to the problem. Therefore, this study demonstrates that the VA committed a state crime of omission through its inactions and a state crime of commissions for its direct actions and role in attempting to manipulate records. Furthermore, this study also shows that the VA's inactions and actions have resulted in a growing social harm to its veterans wherein veterans, their families, and their communities face higher rates of post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), suicide, intimate partner violence (IPV), homelessness and other criminogenic consequences than those of the civilian population.

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This dissertation is dedicated to my parents. Without them, I would neither be the person I am today nor have had the opportunities I have had thus far. To my mother, Valerie Dawn Quick, who has provided me with endless support and faith in my abilities as a person and a scholar. On the rainiest of days, knowing that she would give me an umbrella of encouragement has meant more than I can properly express in writing. To my father, Claude Leslie Wallace Quick, you have only ever wanted better for your children than you had and to accomplish that, you gave all for your country. This dissertation was inspired by the sacrifices you, and so many others, have made.

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CHAPTER I

INTRODUCTION

Access to health care within the United States is a problem many citizens continue to face. This problem is largely due to a private for-profit system that resulted in an estimated 40 million individuals uninsured prior to the enactment of major healthcare reforms (Martinez and Cohen 2014). In order to promote healthcare reforms, The Patient Protections and Affordable Care Act (PPACA) was signed into law March 23, 2010 by President Obama. The Affordable Care Act (Obamacare Facts), dubbed “Obamacare” by supporters and detractors alike, reforms healthcare law by eliminating insurance exclusions for preexisting conditions, ending discriminatory rate hikes, adding rights to appeal insurance decisions, and allowing children to stay on parents’ plans until they are 26 (U.S. Department of Health & Human Services 2015). As part of the requirements of the ACA, all Americans had to either obtain or maintain health insurance plans unless they qualify for an exemption. Failure to abide by this new rule results in a fine, a monthly fee called a Shared Responsibility Payment (Obamacare Facts 2015, U.S. Department of Health & Human Services 2015). This fee is handled through annual tax return filings.

Though now with the possibility of eventual repeal, the ACA increased health care coverage for millions of Americans. This important outcome was achieved in part by expanding Medicaid in numerous states and thus to millions of Americans, providing tax breaks to small businesses which offer health insurance to employees, and ending life-time and dollar amount limits on health insurance plans (Obamacare Facts 2015). Other health insurance coverage expansions came in the form of Medicaid expansion and as the result of children being able to remain on their parents’ insurance plans until age 26. Through the ACA, health insurance

reforms have resulted in coverage for about 20 million grievously uninsured Americans with about 12.7 million of those being through new enrollments in the Health Insurance Marketplace, or Healthcare.gov (Obamacare Facts 2015). Additionally, many individuals were able to save money through new requirements that routine procedures and certain prescriptions, such as birth control, be completely covered by insurance.

The reform created by the ACA made healthcare more accessible and affordable for millions of citizens; however, in practice, accessibility to reform has been dependent on state participation in the expansion of Medicaid. As of early 2016, there were 22 states that had not yet expanded Medicaid, with 5 of those considering expansions. The failure to expand Medicaid in these states has resulted in a coverage gap for poor working families. These families do not qualify for Medicaid in their state and they also do not qualify for a large enough marketplace subsidy to make insurance affordable (Obamacare Facts 2015, U.S. Department of Health & Human Services 2015). While the ACA has had great results in reducing the number of uninsured, problems still exist for many seeking healthcare. Under the new administration, the ACA has faced multiple challenges and may face eventual repeal; however, as of June 2017, repeal has not been successful.

Unlike private citizens, the United States provides healthcare to former and current soldiers (honorably discharged) through the Department of Veterans Affairs (VA) and a government operated health care system. Historically, the VA has guaranteed rights to soldiers from the first battles ever fought on U.S. soil onwards to the current wars in Iraq and Afghanistan (Affairs 2013b). All entitlements and benefits are defined in the VA's benefit manual—*The 2013 Federal Benefits for Veterans Dependents and Survivors*—a 71-page document detailing benefits ranging from life insurance and health care to education and debt

management. Veterans discharged with a status other than dishonorable, whom were active in any branch of the military, are eligible for VA benefits provided that they fulfilled their service time (Affairs 2013c). The VA, as of 2014, has over 9.1 million enrollees and provided 92.4 million outpatient visits to those under its' care (Affairs 2016a). These numbers have greatly increased since 2002, when there were 6.8 million enrollees and 46.5 million outpatient visits (Affairs 2016a).

Still, this system has recently received criticism. Since the Spring of 2014, accusations against the VA have been made by whistleblowers, veterans, and the media that the VA has denied veteran's access to care. The claim is that through the course of its operations, the VA has directly interfered with veteran's ability to receive care in a multitude of instances through acts of commission involving improper scheduling, and delays in receiving medical care. An interim report, published May 28, 2014, from the VA Office of Inspector General confirmed the scheduling problems and contained allegations of patients dying as a result of the inadequate care they received (General 2014a). Several of the most severe instances occurred at the Phoenix, AZ VA where at least 40 veterans died waiting for care due to improper scheduling and wait-time manipulation by staff, and in Cheyenne, WY where employees were suspended for engaging in scheduling manipulation over e-mail (Pearson 2015). Another 19 veteran deaths, across several VA hospitals throughout the country, were also directly linked to improper scheduling procedures between 2010 and 2011. In addition, in the past two decades, veterans have been exposed to legionnaires disease while receiving dental care, and more than 10,000 veterans were exposed to improperly sterilized equipment during routine colonoscopies in Florida, Georgia, and Tennessee resulting in seven cases of hepatitis and six cases of HIV (Pearson 2015).

Over the last decade, the VA has also been accused by veterans of indirectly denying access to care through acts of omissions occurring within an overwhelmed system. Due to an inadequate budget, the VA is not currently capable of handling the number of new veterans from the Iraq and Afghanistan wars (General 2014a, Pearson 2015). Out of 23 million veterans, a total of 10 million are enrolled in the VA system or currently being seen as VA patients (NCVAS 2014). Within that number, there are 1,086,748 veterans who have entitlements and are not receiving them (NCVAS 2014).

The VA Compensation and Pension Rating Bundle report released in 2014 stated that the number of backlogged claims in the VA system over 125 days peaked at 611,073 in 2014 (NCVAS 2014). Numbers for 2014 show a significant decrease in claims pending more than 125 days with pending claims at 589,767 and claims backlogged over 125 days at 308,285 (MMWR 2016). Claims backlogged more than 125 days have been reduced to 83,178 as of early 2016. It is important to note then that there has been significant progress on backlogged claims. However, there are two important facts to remember. First, these numbers do not include veterans that have given up trying to apply for benefits, do not know they are entitled to benefits, have yet to apply for benefits or have appealed previous decisions (MMWR 2016). Second, the VA has faced numerous other accusations of fraud and mismanagement throughout 2014 and 2015. These accusations include reports of veteran's appointment dates being manipulated to meet quotas and claims being marked as cleared despite their pending status (Oppel 2014a, Zoroya 2014c).

These accusations are only the beginning of the alleged mismanagement and inadequate care received by our veterans. "People who fought, and who earned the right to VA health care were never given VA health care. They literally died while waiting for the VA to process their

health care application,” explained Scott Davis, one of several whistleblowers who worked for the Department of Veteran’s Affairs (Devine 2015b). Reports indicate that 307,000 veterans died before their claims were processed by the VA (Affairs 2013g, Devine 2015a). The VA reported that due to data limitations, they did not have estimates on when these deaths occurred, only that these individuals had died at some point according to the Social Security Administration (General 2015). This number is problematic because it includes all pending claims open when the VA began a new system of enrollment in 1998; however, the data does represent veterans with some sort of pending claim at the time of their death. Furthermore, the VA reports that 48,806 veterans died within the four years prior to the September 2, 2015 report issued by the VA (General 2015). While it is impossible to discern how many of those veterans’ deaths were preventable with adequate care, it does call into question whether or not the VA has systematically failed to provide care for its veterans.

Veterans having problems receiving healthcare through the VA face negative and sometimes criminogenic consequences as a result. A veteran suffering through PTSD, David Morris (2015), wrote about his experiences dealing with the VA:

“Post-traumatic stress disorder has stalked me for most of my adult life. I don't mean to say that I've suffered from it all that time. But the idea of it, the specter of it, has haunted me, as it haunts virtually everyone who has served in the military. You may not have PTSD, but most of your fellow citizens assume you do, and this fact alone has a powerful effect. A year or so after the episode at the movie theater, with my symptoms not improving, I went to the V.A. for help.

There are two widely used treatments for PTSD at the V.A. One is called cognitive processing therapy. The other is prolonged ex-posure therapy, the effectiveness of which the V.A. heavily promotes” (p. 1).

Morris (2015) explains that exposure therapy did not work for him, and that it was “an overhyped therapy built on the premise that the best way to escape the aftereffects of hell was to go through hell again” (p. 1). Despite being the preferred treatment for PTSD by the VA, it may adequately address veterans issues. Colby Buzzell (2014), writing for *The New York Times* about suicide, explains that “YEARS after I first returned from Iraq and started having thoughts and visions of killing myself, I'd call the Department of Veterans Affairs. They always put me on hold” (p. 19). Buzzell (2014) goes on to say that the long wait times and inadequate care that he and other veterans face go against what the VA promises.

If the VA is continuously and knowingly failing to meet its obligations to veterans following their service contract they have with the VA, then it has created a cycle of social harm, thus a state crime. A social harm, defined under the human rights perspective, uses harms to define crime rather than relying on the law or a legalistic perspective (Schwendinger and Schwendinger 1970). This perspective was originally adopted by the Schwendinger's in the 1970s to examine events that, while they may not have been illegal, still resulted in grave harm. Access to basic health care is a human right they identified and failure to provide it is a grave harm. Michalowski and Kramer (2006a) also argue that events that cause harm but may not fall under illegal behavior or activities can still be fully understood for the harm that they cause by including an analogous social harm perspective in this study. In addition, a cycle of social harm is that which continues to occur over time. Finally, if there is a cycle of social harm, then a

perpetuation of a culture of social harm (Friedrichs 2011, Green and Ward 2000, Kramer and Michalowski 2006a, Schwendinger and Schwendinger 1970) may exist.

Failure by the VA, a state actor, to provide health care results in serious social, physical, and emotional harms to individuals serving in the military and their dependents. If so, this may be a state crime. According to Rothe and Kauzlarich (2016) state crimes consist of acts of omission or commission performed by state actors that violate domestic or international law, human rights, or cause other institutionalized harms. State crimes can occur even if the harm results as an unintended consequence of the state's action. State crimes are often harder to measure than street crimes, and are less known to the public. Events like a benefit deficit may not seem like a 'crime' at all; however, the negligence involved, and the VA's failure to fulfill obligations to veterans make this issue a potential state crime. Is the VA creating a grave social harm for its veterans, requiring a further analysis within the social harm perspective?

It is through my own experiences with veterans and their stories of ongoing struggles in obtaining necessary medical benefits and care, that this topic has impassioned me. As such, this dissertation explores whether or not the Department of Veterans Affairs (VA) for United States Veterans' has perpetrated state crimes and social harms against current and former soldiers seeking medical care largely by the failure to act, omissions. In order to reach this goal, 5 questions are asked—1) Is the VA committing a state crime of omission or commission through its handling of veteran benefit claims? 2) Are the accusations against the VA of falsifying records and knowledge of changing veteran appointments evidence of this state crime? 3) Have these omissions and commissions persisted overtime despite knowledge of their existence and 4) what has the response to the problem been, and 5) what are the outcomes that this has on veterans? This research also attempts to show the impact that this has by exploring the level of

care veterans have received and the impact on their everyday lives and families. This dissertation uses a case study methodology allowing an in-depth analysis of the current and historical issues within the VA.

A mixed methods approach is used to examine data from three sources. A content analysis is used to examine media reports using two national newspaper sources, *USA Today*, and *The New York Times*. Newspaper articles were examined from the period beginning in January of 2014 and ending in January of 2016. This time frame represents the period when whistleblower reports first began to appear in the media. The focus of the analysis was to uncover the harms that occurred to individual veterans. Analysis of the next data source, the VA's weekly work load reports from 2004-2016, will be used to examine the number of backlogged cases, the issue of backlogged claims, and the status of all pending claims during this time period. This allows consideration of whether the VA has known of the problem for a long period of time. Next, descriptive statistics from survey data collected by the VA in 2010 are used to examine veteran's awareness of services provided by the VA and their overall level of satisfaction with those services. Finally, content analysis was used to examine Veteran's Health Administration reports published by the VA beginning in May of 2014 regarding direct harms the VA caused veterans. Examining these VHA reports explores whether the VA knew about this problem previously, what the response, if any, has been, and what outcomes exist for veterans.

Importantly, this dissertation also explores a method of documenting state crimes through examining previous literature and documented cases of state crime while drawing on current state crime definitions. Using previous literature (Faust and Kauzlarich 2008, Gerkin, Teal and Reinstein 2010, Kauzlarich, Mullins and Matthews 2003, Kauzlarich and Kramer 2006, Kramer

2009, Matthews and Kauzlarich 2006, Rothe and Mullins 2011, Schotter and Rhineberger-Dunn 2013) that will be outlined in the next chapter, this dissertation looks for key indicators of state crime. This dissertation will therefore determine whether there was prior knowledge of the problem, a failure to act on such knowledge, and if any subsequent weakening of regulations or lax enforcement of existing regulations contributed to the problem. Furthermore, this dissertation will determine if the organizational culture was such that over time, a process of normalization of deviance occurred, allowing deviant actions to become ingrained within culture and acceptable practice (Gerkin, Teal and Reinstein 2010, Vaughan 1996).

By exploring crime as phenomena that occurs outside of the Uniform Crime Reports or Index crimes (FBI 2015), we incorporate a greater understanding of harm and we explore this harm in the context it occurs within by understanding that politics, the economy, and the state do not exist separately (Michalowski and Kramer 2006b). Using a state crime framework to examine the VA allows us to engage in a public criminology (Kramer 2012, Rothe and Kauzlarich 2016) and to fully understand the cultural, political, economic and organizational structure within which such events occur (Michalowski and Kramer 2006b). As Michalowski and Kramer (2006a) explain, crime is often focused on the individual and not the organizational or structural aspects that coalesce to create social harms. State crime deviates from an individual explanation of crime and the criminal and instead focuses on harms resulting from events such as omissions or commissions that occur within existing structures. A state crime framework allows us to, theoretically, explore harm outside of a traditional legal framework, to politically, engage in public criminology and use public outrage for change, and legally, to explore how to move from harms to law and have accountability for wrongdoing. Rothe (2009) argues that state crime

allows us to engage in public criminology, create public outrage, and generate demand for change and political intervention.

If the VA is committing a state crime against its veterans, public outrage will be an important aspect of generating political capital to enact tangible change. Reports from the VA and whistleblowers indicate that veterans have faced long waiting times in receiving care and potentially even death (Affairs 2013g, Devine 2015a). The potential harms that veterans face through VA inaction and through not receiving proper care include outcomes such as increased domestic violence rates, PTSD, improper care of traumatic brain injuries (TBI), and issues such as homelessness (Affairs 2013d, Affairs 2013f, Affairs 2016a, Department of Veterans Affairs 2013a, Department of Veterans Affairs 2016, Statistics 2016). These harms reach beyond the veteran and their families and further explain why determining if the VA is committing a state crime is an important contribution to the literature.

Chapter one briefly presented the accusations made by the media and Department of Veterans Affairs (VA) whistleblowers while introducing the research question, whether or not the VA has caused social harms and committed state crimes of omission/commission against current and former soldiers. Chapter two identifies relevant and current research surrounding this issue by examining literature on state crimes of omission/commission and social harms. Chapter two also explores the relevant definitions for state crime and social harm and demonstrates the importance of using a state crime theoretical framework to analyze the VA. Chapter three gives a historical overview of the VA and explains why and how soldiers are entitled to benefits. VA benefits can be traced back to as early as the Civil War and the benefits that veterans currently receive are a compilation of several decades of piecemeal legislation. Chapter four outlines the case study methodology used. Chapter five provides findings and

analysis from the media reports collected from *The New York Times* and *USA Today*. Chapter six gives the analysis and findings from the documentation collected from the VA itself including the *Monday Morning Workload Reports*, several VA investigative reports on the accusations of schedule manipulation and veteran deaths, and a summary from The National Survey on Veterans. Chapter seven ends the dissertation with the conclusions, a summary of the findings, and provides policy recommendations moving forward.

CHAPTER II

LITERATURE REVIEW

This chapter outlines the importance of using a state crime theoretical framework to examine behavior of the state and state actors. This framework allows us to explore the actions (commissions) and inactions (omissions) of the state and state actors and to determine the harm caused. Furthermore, a state crime perspective allows us to examine both the micro and macro level impacts that such harms have on those involved. Using the state crime framework allows us then to engage in public criminology and create a call for action if social harms are being perpetuated (Kramer 2012, Rothe and Kauzlarich 2016). Currently, there are not any known studies examining the VA as a healthcare entity that is potentially committing a state crime.

This chapter focuses on three issues within state crime literature, first, the definition of state crime, second, the state crime framework that outlines the causal mechanism for how state crimes occur, and third, the methods for identifying when state crimes occur. To determine whether or not the VA engaged in a state crime of omission and commission and caused its soldiers social harms, it is important to first define what a state crime and a social harm is. Additionally, it is important to understand how definitions of these terms has changed over time and how we arrived at our current definitions. There has been much debate on the specifics of what is or is not a state crime; however, there is consensus on two points. The first is that human rights violations are state crimes (Kramer 1982, Kramer and Michalowski 2006a, Michalowski and Kramer 1987, Rothe 2009, Rothe and Friedrichs 2006, Turk 1982). Second, it is accepted that definitions of state crime and state crimes of omission include those committed through violations of obligations that result in social harms and human rights violations. Defining state

crime and social harms in this careful way is a first step in examining the case of the VA within a state crime theoretical framework.

In order to understand state crime and social harm, this chapter will also describe a state crime theoretical perspective. This is not done to test the theoretical perspective but to provide an understanding of the causal mechanisms within which state crime can occur. Finally, we will review research on state crimes that resulted largely from omissions by the state or state actors. Describing this research will illustrate how past researchers have documented cases of state crimes. Doing this will describe a method for determining whether or not the VA is guilty of state crime and social harm against its veterans.

DEFINING STATE CRIME

In order to understand the emergence of state crime literature within criminology, we have to first go back to white-collar crime. The study of white collar crime represents the first shift in the focus of criminology away from street crimes and to those crimes of trusted or respected individuals. It is from this line of work that state crime and the study of crimes of the powerful eventually emerges.

White Collar Crime and State Corporate Crime

Edwin Sutherland is recognized as the first scholar to define white-collar crime within *Sociology and Criminology* (Rothe 2009, Rothe and Friedrichs 2006, Sutherland 1939). Sutherland introduced the term white-collar crime during his 1939 Presidential Address to the American Sociological Society to its annual meeting in Philadelphia. In this address, Sutherland (1939) attempted to reform criminology by advocating for the inclusion of the study of white

collar crimes. He argued that despite the pervasiveness of their crimes, white collar criminals maintained their status and were largely ignored by criminologists.

Despite Sutherland's (1939) call for attention to be paid to trusted individuals who commit crimes, little scholarly progress in the area occurred until his book *White Collar Crime* was published in 1949 (Friedrichs 2009). In this book, Sutherland defined white collar crimes as those crimes "committed by a person of respectability and high social status in the course of his occupation" (Sutherland 1949: 9). Sutherland explained that the crimes of those not in the lower classes were largely being ignored and that, "[w]hite-collar criminality is found in every occupation, as can be discovered readily in casual conversation with a representative of an occupation by asking him, 'What crooked practices are found in your occupation?'" (Sutherland 1939: 2). The crooked practices Sutherland was referring to were the illegal activities individuals engaged in during their occupations; white-collar crimes. In addition, Sutherland included regulatory violations that were not criminal violations. Thus, in his definition of white collar crime, Sutherland suggested criminology include regulatory violations in the understanding of white collar crimes.

Sutherland worked then to redefine what crime, and being a criminal meant. Not everyone agreed with Sutherland, however, on whether or not criminology should be expanded to include consideration of regulatory violations and other harms not included in the criminal law. Notably Paul Tappen (1947) questioned whether acts normally falling under regulatory agencies should be monitored by the criminal justice system. Furthermore, he argued that acts that had not yet been deemed illegal should not be studied within criminology (Michalowski and Kramer 2006a, Tappen 1947). As a legal scholar, Tappen (1947) argued against continually adding to the purview of criminology as he felt crime only occurred when the law was violated,

therefore, if no law was violated, no crime occurred. Therefore, Tappen (1947) argued that regulatory violations and white-collar crimes existed outside of the scope of criminology.

The debates between Tappen and Sutherland resolved mostly in favor of Sutherland with many scholars calling for the expansion of criminology to include regulatory violations and eventually acts that may not have been deemed illegal yet (Michalowski and Kramer 2006a). However, since Sutherland's famous debates with Tappen, definitional issues have plagued criminology and the study of white-collar crime. Much of the debate centered on whether criminology should maintain its focus exclusively on street crimes or expand to include events that result in harm, even if the events themselves may not be illegal. These definitional issues have led to an expanded definition of, first, white-collar crime to include state-corporate crimes, and, second, to state crime and crimes of the powerful (Michalowski and Kramer 2006a, Rothe 2009, Rothe and Kauzlarich 2016).

Through the evolution of the definition of white-collar crime, recognition of state-corporate crime emerged in the early works of Kramer and Michalowski, who first coined the term state-corporate crime (Friedrichs 2009, Kauzlarich and Kramer 2006, Kramer 1982, Kramer, Michalowski and Kauzlarich 2002, Kramer 2006, Kramer and Michalowski 2006a). Michalowski and Kramer (2006) define state-corporate crime as:

“...illegal or socially injurious actions that result from a mutually reinforcing interaction between (1) policies and/or practices in pursuit of the goals of one or more institutions of political governance and (2) policies and/or practices in pursuit of the goals of one or more institutions of economic production and distribution” (Kramer and Michalowski 2006a: 20).

The understanding of how corporations and the state collude in order for state-corporate crime to occur is an important development in state crime literature. It is also important to consider that the study of state-corporate crime is complicated when we consider that government defines crime, and therefore, may have a limited capacity to define itself as criminal (Barak 1991, Michalowski and Kramer 2006b, Rothe 2009).

Using only a definition of white collar crime or a definition of state-corporate crime is not adequate for studying all the harmful behavior of the state. After all, not all state crimes include state-corporate collusion or corporate involvement. Instead, using a more expansive definition of what entails state crime and a state crime theoretical framework is more appropriate to study crimes of governments. In the next two sections, we will explore the evolution of the definition of state crime. While we are not testing the state crime theoretical framework, it is important to review it to understand the causal mechanisms that state crime occurs within. Finally, the theoretical framework used to understand the causal mechanisms underlying state crime is outlined and the indicators for determining if omissions and commissions have occurred is reviewed.

State Crime

For the purposes of this dissertation, a current definition of state crime from Rothe and Kauzlarich (2016) is used. They write:

“...we suggest state crime can be defined as an act or omission of an action by actors within the state that results in violations of domestic and international law, human rights, or systematic or institutionalized harm of its or another states population in the name of

the state regardless if there is or is not self-motivation or interests at play” (Rothe and Kauzlarich 2016).

This definition includes crimes of *omission* from inaction by either the state or state actors, and crimes of *commission* resulting from action by the state or state actors. This definition thus allows us to examine the direct actions that an organization is accused of committing and also any inactions or omissions that may have indirectly contributed to causing potential harm.

Rothe and Kauzlarich’s (2016) definition of state crime is an inclusive definition that also includes violations of human rights, and systematic harm regardless of the original motivations these actions (or inactions) were committed under. However, earlier definitions of state crime were not so inclusive and were often limited in scope. Studying state crime, after all, arose from the seminal works on white-collar crime, as scholarly interest shifted away from a focus on street crimes to crimes by trusted individuals, those in power, and eventually state-corporate and state crimes (Rothe 2009, Rothe and Friedrichs 2006). Recognition and definition of state crime arose when scholars answered Sutherland’s call to research white-collar crimes and further expanded the definitions of crime and what a criminal was. Briefly reviewing earlier definitions of state crime will show how key elements of the current definition evolved.

After Sutherland, scholars such as Quinney (1970) addressed the need to explore the role of the state in crime. In this seminal work, *The Social Reality of Crime*, Quinney (1970) argued, “crime is a definition of human conduct that is created by authorized agents in a politically organized state” (Quinney 1970: 15). Later in *Class, State, and Crime*, Quinney (1977) argued that crime exists as a product of how society is structured and that those with power are the ones who determine what the law is and who the law benefits. He argues that those with power typically operated to maintain their own power or to benefit themselves and not to protect public

interests (Quinney 1970, Quinney 1977). The criminal justice system is another means to serve this purpose. Despite Quinney's (1970, 1977) writings on the state and the criminal justice system, the term "state crime" was not used by him or others until 1989.

It was in his 1989 American Society of Criminology Presidential Address, that William Chambliss specifically addressed crimes of the state. Chambliss (1989) defined state crime for the first time when he argued that:

"There is a form of crime that has heretofore escaped criminological inquiry, yet its persistence and omnipresence raise theoretical and methodological issues crucial to the development of criminology as a science. I am referring to what I call "state-organized crime." (Chambliss 1989: 1).

Since Chambliss' 1989 address, scholars have debated definitions of state crime. A key issue was what types of harms should be included—environmental, corporate, government, and/or crimes of the powerful? An early definition of state crime was by Friedrichs. Friedrichs defined state crime as any "harmful activities carried out by the state on behalf of some state agency" (Friedrichs 1996: 122). This definition is concise but it does not explain what types of activities or situations would be included within it. Two years later, Kauzlarich and Kramer (1998) use Friedrichs definition and expand upon it by defining who state actors are and what state actions are. Kauzlarich and Kramer (1998) "define state-corporate crime as criminal acts that occur when one or more institutions of political governance pursue a goal in direct cooperation with one or more institutions of economic production and distribution" (p. 10).

Kauzlarich and Kramer (1998) rely on a legalistic definition of state crime when they explain state use or threat of use of nuclear weapons against other countries may be state-sponsored terrorism. This legalistic definition of state crime relies on international law to define

such acts as state crimes. The reliance on international law is ineffective because it does not have very many formal sanctions should a state decide to disobey the law. Instead, states may face informal sanctions with little actual enforcement taking place. Green and Ward (2000) argue that while the inclusion of informal sanctions within this definition is important, it still lacks any substantive ability to define acts as state crimes due to the heavy reliance on international law.

Green and Ward (2000) attempt to reconcile two perspectives within state crime literature, the legalistic definition (Kauzlarich and Kramer 1998) and the human rights definition (Friedrichs 1996), by arguing "that 'crime' can be defined independently of the state by drawing on the concepts of human rights and deviance" (p. 103). They, thusly, argue that state crimes "should be restricted to the area of overlap between two distinct phenomena: (1) violations of humans rights and (2) state organizational deviance" (Green and Ward 2000: 110).

In 2003, Kauzlarich, Mullins, and Matthews, in an important work in the state crime literature, expanded the definition of state crime. They make note that it is important to understand the difference between elite driven state crime and state crime committed by a state seeking to protect itself. "Elites creating an epistemology and an ideology of a society explicitly in their own interests, and using the state as one tool among many, is qualitatively different to a state seeking to expand or protect its own interests" (Kauzlarich, Mullins and Matthews 2003: 242). Kauzlarich and colleagues (2003) further explain that these elite ideologies are utilized to exert direct and indirect control within organizations, furthering their view and beliefs within the organization.

Kauzlarich et al (2003) then turn to their definition of state crime. They define state crime as involving five elements. They write that state crime first "generates harm to

individuals, groups and property” which is in agreement with previous definitions while also expanding criminology to include those acts that may cause harm but are not illegal. This relies on the Universal Declaration of Human Rights (Kauzlarich, Mullins and Matthews 2003). Second, state crime is defined as having the potential to be a result of both commission and omission—requiring either “action or inaction on Behalf of the State or State Agencies” that, third, “relates directly to an Assigned or Implied Trust/Duty...” (Kauzlarich, Mullins and Matthews 2003: 245-46). Fourth, these actions are “....Committed, or Omitted by a Governmental Agency, Organization or Representative”. It is the failure of a state to act that results in state crimes of omission. Finally, these acts are done all either in the interest of the state, or those controlling it (Kauzlarich, Mullins and Matthews 2003: 245-46). This definition, though useful, was still problematic in that it lacked an adequate framework from which to measure harm. This issue is addressed in revisions by Rothe (2006) where an international approach to state crime is adopted.

By taking an international approach to state crime, Rothe (2006) explains that a framework with both human rights, and social and economic harms standards is built upon a legalistic foundation. She points out that there is a precedence within law that allows the inclusion of human rights and social harms within the definition of state crime. Therefore, Rothe (2009) defines state crime as:

“any action that violates international public law, and/or a state’s own domestic law when these actions are committed by individual actors acting on behalf of, or in the name of the state, even when such acts are motivated by their personal economical, political, and ideological interests” (Rothe 2009: 6).

With this definition, Rothe (2009) improved upon the definition of state crime by adding public international law, domestic law, and human rights violations.

This definition is problematic, however, in that omissions are not included. Barak (2011) argues that “[c]onceptually, crimes of state omission encompass the failure to protect the rights and to serve the needs of all persons subject primarily (but not exclusively) to the territory of a particular nation-state”. In examining state crimes of omission, understanding a failure to act can be complicated by the interaction between the organization and the greater economic and social context of the organization. Fully examining the potential harm that an organization’s, or state’s, actions or inactions have caused allows a greater understanding of whether or not a state crime occurred. Thus, in 2016, Rothe and Kauzlarich (2016) defined state crimes as consisting of acts of omission or commission performed by state actors that violate domestic or international law, human rights, or cause other institutionalized harms. Importantly, state crimes can occur even if the harm results as an unintended consequence of the state’s action. It is this definition of state crime that is used in this dissertation.

Social Harm

This section briefly outlines why the inclusion of social harms to the definition of state crime is important. The issue of social harms is one such issue where criminal or regulatory laws are not broken; however, human rights are being violated (Michalowski and Kramer 2006b, Rothe 2009, Rothe and Friedrichs 2006, Rothe et al. 2009). Throughout history, various social harms have gained more attention than others, with extreme cases like the Holocaust and use of

nuclear weapons causing grave and lasting harm for decades¹ (Friedrichs 2011). Overall though, criminology's individualistic focus on crime allows criminologists to overlook social harms and instead focus on the fear caused by individual level victimizations (e .g. street crimes). Though these fears may result in a moral panic capable of mobilizing action, the crimes that initiate them may not be those that do the most social harm (see Cohen 1972) (Michalowski and Kramer 2006b).

Social harm was first defined by the Schwendingers in 1970 when they proposed a social harm perspective that defined crime by human rights violations. The Schwendingers use Article 22 of the Universal Declaration of Human Rights in order to create a human rights health paradigm that grants additional rights to such key matters as well-being, freedom, bodily integrity, health, education, and work (Green and Ward 2000, Schwendinger and Schwendinger 1970). These additional rights are "second generation" human rights that, while existing in the Universal Declaration of Human Rights, go beyond the basic right to life free of torture (Schwendinger and Schwendinger 1970). Since these are so fundamental to the wellbeing and dignity of humans, the Schwendinger's argue that criminology broaden its definition of crime to include social harms. Including social harms effectively created another delineation within the field.

Since the Schwendingers' work, there has been some expansion of both the definition of social harms and arguments made for the importance of paying attention to social harms. Expanding upon early works that define social harm, Michalowski (1985) defines analogous social injuries as "legally permissible acts or sets of conditions whose consequences are similar to those of illegal acts" (Michalowski 1985: 357). This definition outlines a framework where

¹ Friedrichs first published *The Crime of the Century: The Case for the Holocaust* in 2000 where he argued that the criminal aspect of the Holocaust and nuclear weapon usage was largely ignored by criminologists. Instead, the focus was placed on what harms were caused and their remedies.

even if an act is technically legal, if it results in harm, it should still be examined within the scope of criminology. The importance of this work is clarified, later, when Michalowski and Kramer's (2006a) inclusion of analogous social injuries is used to expand the social harm perspective by allowing the difference between legal and illegal harm to be examined. They explained that it is the factors that determine the difference between legal and illegal harms that allow the formation of law, and thus that inform us as to how the law is formed (Michalowski and Kramer 2006b). By examining the impact that social harms cause, and including these 'analogous social injuries' within the scope of criminology, they argue new laws can be formed to protect citizens from future harms. Examining social harms, then, serves to both expand the scope of criminality and "to examine the political and cultural forces that result in some harms being labeled crimes, others regulatory violations, others noncriminal deviance, and still others praiseworthy acts" (Kramer and Kauzlarich 2011: 13).

Arguments for the use of the social harm perspective have also been developed. In a recent argument for social harm's studies, Lasslett (2010) explains that "social harms arise when socially generated processes undermine the organic reproduction of 'man', or the organic/inorganic reproduction of man's environment" (p. 12). Using a dialectical understanding of harm, and social, Lasslett outlines the requirements for a social harm to occur. She explains that "the category, social harm, captures moments where the relations, processes and flows of social being either disrupt or fail to preserve the structures of organic and inorganic being" (Lasslett 2010: 13). This allows for an understanding of social harm that includes harms created directly through action and indirectly through negligence or inaction. Lasslett (2012) has even called for the social harm framework to be used in place of the traditional criminological focus on street crime. Most, however, argue that it is more useful to have a definition and framework

of state crime that includes social harms in criminology than replace the traditional focus (Hillyard and Tombs 2007, Lasslett 2012, Michalowski and Kramer 2006b). Friedrichs and Schwartz (2007) argue that the costs of abandoning criminology all together are far too great and may not have the desired results.

DESCRIBING STATE CRIME THEORETICAL FRAMEWORKS

In this section, a description of theoretical frameworks for understanding state crime are examined. The goal in examining the theoretical state crime framework is not to theory test but to instead understand the causal mechanisms that state crime occurs within. A state crime theoretical framework allows us to explore actions and inactions of the state, determine what harm, if any, was caused, and engage in public criminology and activism if social harms are being perpetuated (Kramer 2012, Rothe and Kauzlarich 2016). As the definition of state crime has emerged and changed over time, so have the theoretical frameworks that “direct us to examine the linkages between levels of analysis and catalysts for action” (Kramer and Michalowski 2006a: 26).

Kramer and Michalowski (2006b) created the first integrated model designed to explore such linkages within state-corporate crime in 1993 for an unpublished manuscript, *State-Corporate Crime: Toward an Integrated Model*. This manuscript was revised, updated, and published in 2006. In the updated manuscript, they outline three levels of analysis (institutional environment, organizational, interactional) and three catalysts for action (motivation, opportunity, control) where state-corporate crime occurs (Kramer and Michalowski 2006a). From this initial model, a series of adaptations were made to expand the model to cover state crimes and crimes of the powerful (Kramer, Michalowski and Kauzlarich 2002, Kramer and

Michalowski 2006a, Rothe 2009, Rothe and Mullins 2009, Rothe 2013, Rothe and Mullins 2011).

The current expanded model was developed by Rothe (2013) (See Figure 1). This integrated theoretical framework of state crime allows researchers to examine the motivations, opportunity, constraints and controls that exist at the International, macro, meso, and micro levels of analysis (Rothe 2013). The framework also explains causal mechanisms that state crime can occur within. Rothe (2013) explains that at the international or structural level, anomie and the political economy may be useful in understanding state crime. At the state or macro level, Foucault's theory on power and the regimes of truth, social disorganization, and realpolitik are appropriate theories, while the organizational or meso level crimes can be explained using routine activities, legitimacy, or the diffusion of responsibility to explain state crimes (Rothe 2013). Finally, at the interactional or micro level, strain, learning theory, normalization of deviance, and techniques of neutralization may explain why state crime is committed by individuals who act on the state's behalf (Rothe 2013). Rothe (2013) explains the value of using an integrated approach: "It offers a set of logically related concepts that can explain state crime and offers insight into the interaction between the crime and the institutional responses we currently have to deal with these problems" (p. 41).

Beginning with the macro level of analysis then, Rothe (2013) argues that motivations may include structural transformations, economic, military and political goals. Structural transformations may be any changes that the organization has undergone and any relevant economic, military and political goals of the organization. For Rothe (2013), opportunity at this level of analysis includes controlling information, propaganda, and promoting ideology or nationalism. Information released by the organization or any attempts to lessen the impact that a

problem may have through careful public relations management may contribute to an organizations opportunity to commit state crimes. Constraints, Rothe (2013) argues, may include political pressures, media scrutiny, public opinion, and social movements, and finally, the controls are domestic laws. Constraints may thusly be whistleblower reports, politicians calling for reform, media coverage of the organization, or public calls for change.

At the meso level, Rothe (2013) finds motivations for state crime result from the organizational culture and goals, authoritarian pressures, and reward structures. Here opportunity includes communication structures, means availability, role specialization, and the diffusion of responsibility. Constraints for Rothe (2013) are internal oversight, authority structures and finally, controls are codes of conduct. At this level, the organizational culture and goals may contribute, over time, she argues, to the presence of deviance within the organization. Opportunity within the organization may exist in how the organization operates, if there is a top-down hierarchy of command, and constraints are wholly dependent upon the organizations willingness to follow its own policy and procedures.

When it comes to the micro level, Rothe (2013) argues motivations include strain, obedience to authority, socialization, individual goals and ideologies, and definitions of the situation. She argues that individuals who have increasing definitions that neutralize wrong doing or contribute to deviant behavior may provide additional opportunity within the organization for state crime to occur. Opportunity may rely on techniques of neutralization, the normalization of deviance, or group think. It is this normalization of deviance, she argues, that may allow state crimes or deviant acts to continue unchecked within an organization. Constraints include personal morality, socialization, and informal social controls. Finally, at the

micro level, controls include the legitimacy of the law and the perception of its reality and application (Rothe 2013).

State crime theoretical frameworks such as that proposed by Rothe (2013) are not without criticism. Models of an integrated theory of state crime have been accused of being overly complex and untestable (Lynch, Long and Stretesky 2012). Lynch et al (2012) argue that “[t]he Rothe et al. state crime models incorporate numerous assumptions, concepts, indexes and variables, creating an extraordinarily elaborate, non-parsimonious model of state crime” (p. 100). Perhaps the most important criticism Lynch et al. (2012) make is that the complex nature of integrated state crime theoretical models results in untestable and ad-hoc theorizing that results in validity and reliability issues. In reply, Rothe (2013) argues of the value of beginning with complex models instead of starting with overly simplistic models despite the problems that this poses to theory testing. Furthermore, Rothe (2013) explains that the complicated integrated theory “offers insight into the interaction between the crime and the institutional responses we currently have to deal with these problems” (p. 41). Therefore, this model provides an example with which a state crime case can be explored in order to understand the catalysts for actions as they occur at various levels of analysis (Kramer and Michalowski 2006a, Rothe 2013).

The state crime and social harm theoretical frameworks allow an examination of the Department of Veteran’s Affairs. Thus far we have looked at two key issues in state crime literature, first, how do we define state crime, and second, how do we understand what causes state crimes. A third issue is the focus of this dissertation given a current definition of state crime, how do we document or know when state crime has occurred? This is especially difficult for two reasons because we cannot rely on the criminal justice system to identify these crimes,

and state crimes include omissions. The next section covers research on state crimes, with a focus on omissions, and then turns to the few studies on the VA.

An Integrated Theory of State Crime

Routine Activities	Motivation	Opportunity	Constraints	Controls
International Level	Political interests Economic interests Ideological interests (i.e., International Political economy)	International relations (i.e., System Criminality) Complementary legal systems (i.e., Anomie)	International reaction Social movements Political pressure Public opinion	International Criminal Justice System
Macro Level	Structural transformations Economic goals Military goals Political goals (i.e., Realpolitik; Political economy)	Control of information Propaganda Power Ideology/nationalism (i.e., Foucault) Social Disorganization	Political pressure Media scrutiny Public opinion Social Movements	Domestic law
Meso Level (i.e., Organizational Theory)	Organizational culture and goals Authoritarian pressures Reward structures	Communication structures Means availability Role specialization Diffusion of responsibility	Internal oversight Authority structures of	Codes of conduct
Micro Level	Strain to Obedience authority Socialization (i.e., Learning Theories) Individual goals and ideologies Definition of the situation (i.e., D.A.)	Techniques of Neutralization Normalization of deviance Group Think	Personal morality of Socialization (i.e., Learning Theories) Informal social controls	Legitimacy of law i.e., D.A.) Perception of reality of law application (i.e., Deterrence)

For previous versions see Rothe (2009, 2006); Rothe & Mullins (2009, 2008); Mullins & Rothe (2008).

Figure 1: An Integrated Theory of State Crime as Depicted in D. L. Rothe, 2009. Reprinted from “Criminological Theory and State Crime: How Far Can It Go?” D. L. Rothe, 2013, *Revista Critica Penal Y Poder*, p. 40.

DOCUMENTING STATE CRIME

State crime is not a new phenomenon. It has existed throughout history in a variety of forms ranging from despotic leaders to state actions resulting in war (Bassiouni 2011). Definitional debates within criminology, however, have resulted in the study of state crime within criminology being rather relatively recent. Since Chambliss' 1989 address, state crime frameworks within criminology have been used to explore the harms the state, and state entities, have committed in a variety of instances and circumstances. The examples of research documenting state crime described below are important cases that demonstrate how to apply a state crime theoretical framework to the Department of Veteran's Affairs to examine whether the VA is committing a state crime and causing social harms to its soldiers largely through omissions or failures to act. While there are many examples of state crime within the literature, this review highlights, then, cases that address crimes of omission, or commission and omission. A review of past research demonstrates first that there are documented cases of failures to act by the government which have caused great social harm. Second, the review shows how past researchers have made the case that a particular instance of a failure to act is a state crime and they thus provide a framework used in this study for determining state crime occurrence.

There have been several well-documented cases where government failure to act led to state crimes of omission. NASA's failure to act in the Challenger disaster, a state-corporate crime, contained acts of omission (Kramer 2006). This failure occurred through the creation of a corporate culture or normalization of deviance process wherein safety standards were slowly eroded leading to eventual disaster (Kramer 2006, Vaughan 1996). The fire in a Hamlet, N.C. Imperial Chicken plant that doomed 25 workers was a result of regulatory agencies such as OSHA (the Occupational and Safety Health Administration) and the USDA (the United States

Department of Agriculture) failing to act on regulatory violations of which they were aware (Aulette and Michalowski 2006). Airline deregulation and the failures of the FAA (Federal Aviation Administration) to act on poor safety records led to the crash of ValuJet Flight 592 (Matthews and Kauzlarich 2006).

Karmer (2012) has argued that even failures of the government to act on issues of environmental harm are state crimes of omission. Kramer (2012) argues that state and corporate actions have increasingly led to global warming which has potentially catastrophic results for humans and animals alike. Kramer (2012) explains that “[t]he orchestrated denial of global warming and climate change, despite the extensive evidence to the contrary, can also be labelled a state-corporate crime” (p. 31). Kramer (2012) goes on to argue that deliberate actions and inactions leading to global warming will require the international community to step in and increase protective regulations. Furthermore, it is the duty of criminologists to facilitate and bring to light whenever such crimes occur (Kramer 2012). BP’s disaster in the Gulf of Mexico in 2010 and the subsequent cover-up that occurred (Bradshaw 2014) are two examples of environmental state crimes. In addition, researchers have documented that oil companies have caused irreparable damage to the land, community, and the people of countries such as Nigeria (Lenning and Brightman 2009).

During one of this century’s worst natural disasters, Hurricane Katrina in August of 2005, we find another example of government failure resulting in state crime. In a 2008 article, “Hurricane Katrina Victimization as a State Crime of Omission”, Faust and Kauzlarich argue that victimization occurring after hurricane Katrina and the subsequent levee breach that occurred in New Orleans resulted from a state crime of omission. Faust and Kauzlarich (2008) explain that a state crime of omission can be examined within two frameworks, from a deviance-

based perspective, or from a social harm perspective. A deviance-based perspective requires an audience to accept that a standard has been violated and that there are significant reactions or sanctions as a result (Faust and Kauzlarich 2008). They use both frameworks to examine the aftermath of hurricane Katrina. In using these frameworks, Faust and Kauzlarich illustrate how to make the case that failure to act is a state crime.

In order to examine hurricane Katrina in the context of a state crime of omission, Faust et al. (2008), first, analyzed previous literature and reports which documented that the government had failed to act appropriately and timely. Secondly, they explored public opinion on how the response to hurricane Katrina was handled by analyzing public polling within national news media. With this information, and using Green and Ward's (2004) perspective, Faust et al. (2008) argue that "this might be a prima facie case of state crime because the inaction has been largely condemned by numerous social audiences" (p 89). Furthermore, the researchers analyzed reports coming directly from a bipartisan committee created to analyze the government's role and failures during Hurricane Katrina. Using reports from the government about potential weaknesses that existed should a category 4 or 5 hurricane strike New Orleans, media reports and polls from the event itself, and victim narratives collected directly, Faust et al. (2008) could determine that the U.S. government's failures to act and prior knowledge of the potential harm that a strong hurricane would cause what happened in New Orleans was a state crime of omission. U.S. government failure to act on prior knowledge about the problem, for example, data on the levees from the U.S. Army Corps of Engineers that a strong hurricane could have devastating effects on New Orleans, resulted in social harms and a state crime of omission.

In the case of Katrina, the government's failure to act can be considered deviant, and this, Faust and Kauzlarich (2008) demonstrated in the reports and committee conclusions of various

government entities. They write “[m]ost observers, including some state bodies themselves, agree that various governmental failures occurred in the context of Katrina” (p. 89). For example, a special committee convened to determine what went wrong and outlined a systemic failure to act by several government entities including FEMA (Federal Emergency Management Agency), the Department of Health and Human Services, and the National Response Plan. This was in addition to failures in communication and to execute proper and complete evacuations of the areas impacted by hurricane Katrina (Faust and Kauzlarich 2008). These failures led to catastrophic results for those living in New Orleans.

Faust and Kauzlarich (2008) also use a social harm perspective and document that these failures affected the victims by analyzing victim narratives obtained through interviews of survivors. The victims that they interviewed all had differing experiences in the aftermath of Hurricane Katrina, however they agreed that the government response to the disaster was not acceptable and that more should have been done. Faust and Kauzlarich (2008) explain that evidence collected support both the social harm and deviance-based definitions of state crime in classifying the governments failures as a state crime of omission.

Agreement by reviewers that important failures occurred and that harm resulted are not the only indications of state crime. Other researchers have also used an ongoing knowledge of a problem, weak regulatory systems, lax enforcement, and organization goals such as cost savings that limit action as indicators. These are illustrated in another case of state crime of omission where Gerkin et al. (2010) document how members of the Office of the Architect of the Capitol (AOC) ignored asbestos beneath tunnels in the capitol and allowed workers to continue to be exposed for several years. They document how, over the course of several years, the Architect of the Capitol was repeatedly warned of immediate danger to employees working in the tunnel

system beneath the capitol. Corrective actions were not taken in light of the cost of the extensive repairs needed, instead, the problem was largely ignored. The results were documented:

“Asbestos exposure has been linked to incurable diseases for over a century and is responsible for an enormous manmade public health crisis. Inhaling asbestos fibers can cause permanent and irreversible damage to vital organs” (Gerkin, Teal and Reinstein 2010: 114). One employee was diagnosed with severe lung scarring as early as 1998, eight years prior to his employer releasing the records or telling him anything was wrong (Gerkin, Teal and Reinstein 2010).

Gerkin et al. (2010) performed secondary data analysis on documents collected by the Architect of the Capitol, used congressional testimony, employee medical records, and even media reports to determine that the Architect of the Capitol knew of the dangers to those working in the tunnels. They argue that the AOC did not act upon this knowledge because it became a case of normalized deviance where acting upon the knowledge would go against the norms of the organization. Vaughan (1996) explains that this normalization occurs through a process where the organization accepts a negative result and it becomes a normal part of organizational culture over time. Gerkin et al. (2010) argue that “[t]his case of normalized deviance is best understood within the confines of a structural analysis that examines the availability and attractiveness of the deviant decisions that presented themselves within a weak regulatory environment, confounded by a lax enforcement of the regulations” (p. 119). This normalization process allowed the organization to ignore multiple citations and warnings of danger and to continue to operate at the status quo. The process of the normalization of deviance can occur within any type of organization, including government (Vaughan 1996).

Furthermore, Gerkin et al. (2010) explain that “[o]rganizational goals often contribute to criminal actions on the part of an organization or individual by promoting an unreasonable

expectation; one that inclines individuals to use illegitimate means to achieve success” (p 119). For the AOC, the cost of properly maintaining workers’ health or addressing issues within the tunnel was greater than the safety of the employees involved. Gerkin et al. (2010) utilize a cost-saving framework to explain how this could have been justified in that the AOC had increasing expenses and chose to try to save money by not investing in proper repairs. Through the normalization process, this easily occurred without further oversight on the AOC and a lack of social control (Gerkin, Teal and Reinstein 2010).

The importance of regulation comes up again as critical in additional research, as well as the importance of funding. In exploring how state crime can be a result of both omissions and commissions, Schotter and Rhineberger-Dunn (2013) examined the collapse of the I-35W Bridge over the Mississippi River in Minneapolis, Minnesota. They used official reports from the National Transportation Safety Board (NTSB) and the Minnesota Department of Transportation (MnDOT), the firms hired to produce the reports, and newspaper articles covering the event. Using Kauzlarich and Kramer’s (1998) integrated theoretical framework, they found that the bridge collapse was a result of crimes of commissions and omissions by the state regarding the creation and maintenance of critical infrastructure (Schotter and Rhineberger-Dunn 2013). “Essentially, then, the state and its representatives engage in crimes of omission because regulation and oversight are not present. Additionally, and simultaneously, the state is engaging in crimes of commission for having either failed to create regulation or to enforce that what exists” (Schotter and Rhineberger-Dunn 2013: 479-80). Much like in the case of Katrina, and the AOC, the government failed to enforce a regulation that was in existence resulting in a critical failure, gross negligence and harm to its citizens.

Finally, Schotter and Rhineberger-Dunn (2013) found that the I35W Bridge collapse occurred in Minneapolis, Minnesota as a result of the failures of multiple government agencies including both the US Department of Transportation and the MN Department of Transportation, the National Transportation Safety Board (NTSB), and the Federal Highway Administration (FHWA). They argue that these organizations failed to uphold existing regulations, they failed to fund critical repairs, and they failed to create infrastructure replacement plans to ensure an incident like a bridge collapse would not occur. Schotter and Rhineberger-Dunn (2013) conclude that by focusing on both the incident itself and the interactions, processes, and relationships between the various entities involved this state crime is revealed as being both a crime of commission and omission.

Past research in the area of state crime has documented instances of failures by the government or its agencies to act. These failures have at times come at great cost to individuals and society. In addition, this research illustrates several factors one can use to demonstrate when an action, or failure to act, is a state crime. Indicators used to determine if a state crime occurred include: 1) was there documentation of government failure to act in both a timely and appropriate manner, 2) was there prior knowledge of the problem, and 3) what the response to the problem has been, if any. In particular, these factors can be documented through the use of official agency documentation, media reports, and surveys of those affected. In the next section, literature on the Department of Veteran's Affairs is discussed and an argument for using a state crime theoretical framework to identify it as committing a state crime is made.

LITERATURE ON THE DEPARTMENT OF VETERAN'S AFFAIRS

Few studies have explored the government agency under study here, the Department of Veteran's Affairs. Further, much of the scholarly research concerning the VA is research that the VA participated in directly, funded, or involves clinical trials or treatment outcomes. For example, several studies explore the effectiveness of suicide interventions (McCarthy 2015, McCarthy et al. 2013) or the impacts of traumatic brain injuries (Carlson 2013, Scholten et al. 2012). Additional work covers issues such as domestic violence, Post-Traumatic Stress Disorder, HIV, sleep disorders, and other health concerns among veterans (Hendin 2014, Korte et al. 2016, Mittal et al. 2016). In addition, there are a plethora of articles concerning the health of veterans (see for example (Affairs 2016a, Department of Veterans Affairs 2013a, Korte et al. 2016, Martinez and Cohen 2014, McCarthy 2015, McVeigh 2013, Medicine 2013, Mittal et al. 2016, Veterans 2013, Violence 2013, Westat 2010, Yerman 2011)). Little work has been done on the success or failures of the VA itself in fulfilling its obligations. The following three studies use a legalistic framework to describe the VA and problems that veterans have faced.

First, on a report about Post-9/11 Veterans completed at the William and Mary Law School through their Veterans Benefits Clinic, Roberts (2015) outlines the legal issues veterans may face when returning home as well as the issues they may face as students at the University of Memphis. While only briefly explaining some of the issues veterans may face (PTSD, cultural adjustments, and as students), the report does highlight the problems veterans may have obtaining benefits or medical care through the VA (Roberts 2015). For example, Roberts (2015) explains that veterans who did not document blast exposures may have difficulty proving or documenting that they have traumatic brain injuries or suffer from post-traumatic stress disorder because of such exposures.

Second, in an article from the University of Memphis Law Review and the Veterans Law Clinic at Nova Southeastern University, Cassidy (2015) examines the legal gaps that veterans may face in transitioning back into society. Cassidy (2015) explains that in order for veterans to successfully transition, legal services must be integrated into the VA to provide needed help to veterans trying to navigate complex benefits and legal issues. Furthermore, Cassidy (2015) outlines struggles veterans face such as traumatic brain injuries, post-traumatic stress disorder, and increased suicide rates. Using reports from the VA Office of Inspector General, Cassidy (2015) identifies veteran wait times and the falsification of records as being a major issue within the VA. She then suggests that there be a VA overhaul and that reform to legal aid for veterans is necessary. For example, she suggests the need for veterans to receive legal aid once service ends and that changing legislation within Congress is necessary to give the VA the authority to grant such aid to veterans (Cassidy 2015).

Finally, Daniel L. Nagin (2015) uses a legalistic framework to explain that the “VA’s system was originally designed to consider average loss of earning capacity based on disability within the context of a mostly agrarian and industrial economy; it was not designed for today’s service economy and diversified labor market” (p. 888). In addition, Nagin (2015) argues that the VA never took into consideration how much time obtaining such disability ratings would take nor did they consider how many individuals would have service connected injuries. Further, Nagin (2015) argues that problems exist with the evidentiary nature of VA claims. The burden of proof falls on veterans and they may never be made aware of the VA questioning the evidence they have provided. This results in the veteran having a denied claim with little to no recourse from within the VA (Affairs 2012, Nagin 2015). Ultimately, Nagin (2015) argues that

while some progress has been made on issues such as claim backlogs, the system itself is still fundamentally an issue and in need of an overhaul and redesign.

CONCLUSION

This chapter addresses three issues within the state crime literature and provides an explanation of how this dissertation fills a gap in the literature through the examination of the Department of Veterans Affairs. First, this chapter outlined the evolution of the definition of state crime and provided a current definition of state crime. Second, while this dissertation does not seek to theory test the state crime theoretical frameworks, it provided an overview of the causal mechanisms within these frameworks within which state crime occurs. Finally, how acts of state crimes of omission and commission were identified within the literature was discussed in a review of past research. While literature on problems that veterans face exists, there is little to no research on the VA itself as an organization potentially guilty of state crime. This dissertation fills the gap in the literature by examining the VA within this context.

The purpose of this dissertation is to fill the gap in criminological literature surrounding veterans and their inability to obtain benefits from the VA by using a state crime and social harm framework. This dissertation looks to examine the denial of benefits to veterans both directly and indirectly as a state crime of omission. This is accomplished by determining if the VA had prior knowledge of the problem, if there was a failure to act timely and appropriately, what the response, if any, was, and what the result was for veterans. Additionally, the actions of the VA in the wake of the media attention on their failures, and the uncovering of an ongoing scandal involving appointment changing and record altering will be examined as a state crime of commission. This research also attempts to determine the impact that this has by exploring the

level of care veterans have received and the impact on their everyday lives and families. The following chapter outlines the current case and provides a brief historical overview of the VA.

CHAPTER III

CASE DESCRIPTIVE

As recent wars of aggression demonstrate, the military is an entity used by the U.S. Government to fulfill both economic and political goals (Kramer and Michalowski 2006b). While potentially committing socially injurious acts and social harms, the Department of Veteran's Affairs is not necessarily making economic gains or participating in a mutually beneficial relationship with any corporate entities regarding health care. Green and Ward (2000) argue however that, "the key point about state crime in liberal democracies is that it is not aberrant or anomalous, and has no clear boundaries, but shades imperceptibly into the routine, "legitimate" activities of the state" (p. 103).

Normalization of deviant behavior is key to understanding state crime. According to Kramer and Kauzlarich (2011), everyday politics and culture have been normalized as a part of the organization in such a way that there is a potential for social harms to occur (Vaughan 1996). They further argue that the potential to normalize its deviant behavior occurs through a lack of adequate social controls and through the available, illegitimate means existing under current structures .

With the VA's limited budget, and priority being given elsewhere in the government, funding for political, social, and economic goals of the military occur first, further contributing to this potential for social harm. Therefore, there is the potential that the VA is currently creating and maintaining a grave social harm for veterans both by its actions and its failures to act. Furthermore, additional problems are created for the individual who is denied services including homelessness, joblessness, lack of medical benefits, and other financial issues.

The state crime framework argues the VA is violating soldiers second generation human rights by denying them previously guaranteed care. This is further exemplified by plausible deniability that the VA creates for itself when a potential social harm arises because "they created a political culture and organizational frameworks that ultimately led to heinous acts that would not have occurred without that culture and those frameworks" (Michalowski and Kramer 2006b: 9).

In order to understand why this behavior can be examined within a state crime and social harm theoretical framework, it is important to first understand the history of the VA, and that soldiers are guaranteed benefits. This chapter briefly explains the history of the VA and the benefits to which soldiers are entitled. The chapter ends with a demonstration of the harms veterans face.

HISTORICAL OVERVIEW OF THE DEPARTMENT OF VETERAN'S AFFAIRS

The Department of Veteran's Affairs has a long history of providing care for soldiers dating back to the first battles ever fought on U.S. soil and continuing through our most recent wars in Iraq and Afghanistan (Affairs 2013b). The VA guarantees certain rights to soldiers and veterans, a guarantee that dates to 1636. The VA itself states that "The United States has the most comprehensive system of assistance for Veterans of any nation in the world, with roots that can be traced back to 1636, when the Pilgrims of Plymouth Colony were at war with the Pequot Indians" (Affairs 2013b). The Pilgrims passed laws that soldiers would be cared for within the colony, thus beginning the long tradition of care for soldiers in the United States.

The next documented guarantees for benefits came during the revolutionary and civil wars. Veterans of the Revolutionary War were given pensions if they were disabled while the

first medical facility for soldiers was established in 1811 and veterans of the Civil War received medical care for all illnesses or injuries whether service connected or not (Affairs 2013b). The VA's current motto "[t]o care for him who shall have borne the battle and for his widow, and his orphan" stems from Lincoln's second inaugural address in 1865 wherein he created a continued precedence for benefits when he explained that both the veteran, their spouse, and their children would be taken care of after the veteran's service (Affairs 2013e).

The VA as we know it today was created during World War I in 1930 through the creation of the Veterans Bureau, the Bureau of Pensions of the Interior Department, and the National Home for Disabled Volunteer Soldiers, all of which provided various veteran benefits ranging from medical care to rehabilitation to compensation (Affairs 2013b, Affairs 2013e, Nagin 2015, Ridgeway 2015). Congress combined these four WWI creating the Veterans Bureau in 1921. It further consolidated the organization under President Hoover on July 21, 1930, creating a federal administration, the Veterans Administration (Affairs 2013b, Affairs 2013e). Following WWII, benefits were added to the VA including the GI Bill in 1944, and additional educational benefits following each major war since.

Current veteran benefits are defined in *The 2013 Federal Benefits for Veterans Dependents and Survivors*. The VA's benefit manual is a 71-page document detailing all veteran benefits ranging from life insurance and health care to education and debt management. Honorably discharged veterans active in any branch of the military are eligible for VA benefits provided that they fulfilled their required service time (Affairs 2013c). The VA manual explains that for basic enrollment there is a minimum duty requirement wherein "[v]eterans who enlisted after Sept. 7, 1980, or who entered active duty after Oct. 16, 1981, must have served 24 continuous months or the full period for which they were called to active duty in order to be

eligible” (Affairs 2013c:6). Individuals discharged for hardship, early out, or disability due to line of duty are not required to meet minimum service requirements.

The guarantee of benefits to those injured or disabled during service, and the guarantee that basic benefits are allowed provided duty requirements are met, guarantees veterans a level of care that a 1.1 million veteran backlog did not provide. In one egregious example, already well documented, there are still Vietnam Veterans who have filed Agent Orange claims, or had their claims reopened following the granting of additional benefits for those harmed by Agent Orange, that are still awaiting benefit decisions decades after they were harmed (Affairs 2013g). The failures of the VA to provide benefits, address failures within the system that affect delivery of services, and the existence of huge backlogs lend to the perspective question of whether the VA is engaging in state crime.

DEMONSTRATED HARMS AND DENIALS

Similar to the argument made in the Katrina case, the argument here is that the failure of the VA to act may be an important example of a state crime of omission. Both cases deal with a systematic failure of the government to act in the face of known problems with resulting social harms and knowledge of those harms. In the case of Katrina, research has shown that while government entities such as FEMA and the Army Corp of Engineers knew the potential for catastrophic levee failure if a major hurricane hit New Orleans, they did nothing (Faust and Kauzlarich 2008). In the case of the VA, the VA has largely failed to act upon backlogged cases, despite knowing of their existence (Zoroya 2014c).

The need to investigate the case of the VA as a possible state crime of omission is also found in the harm that failures to receive care create or perpetuate. Veterans face harm through

the inaction of the VA despite knowledge of the harm that the veteran may incur should proper care not be provided. Such harms include increased domestic violence rates, unemployment, homelessness, and suicide as we will see below. These have all been linked in the research to increased levels of posttraumatic stress disorder (PTSD), and traumatic brain injuries (TBI), two harms that can be mitigated with proper and timely care (Affairs 2013d, Affairs 2013f, Affairs 2013g, Department of Veterans Affairs 2013a, Department of Veterans Affairs 2013c).

Denial of Benefits, Exposure Harms, and Fear of Retribution

In addition to barriers that the VA may have created for veterans, barriers to individual healthcare for veterans also exist in soldier's fear of retribution. This fear of retribution however, stems from veterans being concerned over losing their current or future career paths if they seek medical treatment. Brown (2015) explains that this fear of retribution for illness often prevents soldiers from reporting or properly maintaining records of service connected injury or illness, a requirement of the VA for a soldier to later receive medical benefits. Brown (2015) asks us to:

“Imagine you're in the military. Now, we are taught since day one that the mission is the most important thing. Service before self. If you can't do your job, you're useless. I was intel. If one was to have anything that could compromise your clearances, you're done. That includes mental health” (Brown 2015).

This fear of retribution only further complicates and contributes to veterans' issues with obtaining care. Though any lack of services may be seen as a result of the individual's choice, that choice is made in the context of a culture that discourages medical attention and may actively punish those who seek it.

There are significant harms perpetuated by the government against its soldiers, in addition to the benefit deficit that they face. One such harm includes exposure harms that are tracked through a Special Environmental Health Registry Evaluation Program for Veterans. Exposures tracked include Agent Orange exposure, Ionizing Radiation, Gulf War exposure, depleted uranium, toxic embedded fragments and additional occupational exposures such as asbestos, lead, noise, and other radiation exposure (Department of Veterans Affairs 2013b). Many of these harms occurred over several years and served to not only harm soldiers but often innocent civilians. These harms also result in a wide range of diseases, cancers, birth defects, and medical problems.

The greatest problem with exposure harms is that in order for a veteran to receive treatment for the harm from the VA, the veteran must first prove that the exposure harm was the responsibility of the government during the course of their military service, or that their service was qualifying to receive such treatment. Failure to prove service connection results a denial of responsibility by the VA for the harm. While the Agent Orange Act was passed by Congress in 1991, authorizing presumptive illnesses to be assumed related to Agent Orange exposure, monitoring of this harm and those exposed has continued to be problematic (Affairs 2017e). In 2010, due to changes in how claims are tracked in the Monday Morning Workload Report, and due to changes in the presumptive illnesses and birth defects the VA recognizes as being related to Agent Orange, an herbicide used to destroy foliage during the Vietnam War, claims from veterans of that war were able to receive care and benefits, some for the first time (Affairs 2013a, Affairs 2013g, Affairs 2017e, Department of Veterans Affairs 2012, Department of Veterans Affairs 2013d, MMWR 2016).

Roughly 150,000 cases were reopened for evaluation in 2010 due to such changes. The VA reported that by September 30, 2012, 638,846 Agent Orange claims had been evaluated or had a follow-up evaluation (Department of Veterans Affairs 2012). While progress has been made in reducing the number of claims, there are still about 100 pending Agent Orange claims (MMWR 2016). Additional presumptive illnesses are still being added to guarantee veterans care many decades after they were first exposed to harm, with some exposures beginning in the 1950s, and most occurring between 1969 and 1986 (Affairs 2017e). It is important to note that these numbers only include surviving veterans who have applied for benefits through the Department of Veterans Affairs.

For the VA, there is implied social contract and stated trust (VA manual of benefits) that it will uphold its obligations to veterans and provide adequate care (Affairs 2013c). Instances where the VA is guilty of altering records or appointment deadlines may fall under the category of state crime of commission while instances of the VA failing to act (provide benefits) may be state crimes of omission (Kauzlarich, Mullins and Matthews 2003). In the case of the Department of Veteran's Affairs, the inaction of the state in not providing care and the action of the state in covering up a lack of care or inability to provide care may serve as examples of this ideological replication. A social harm perspective provides a framework to analyze both the VA's failure to provide benefits and the need for addressing such a failure. It is this inclination for the VA to use illegitimate means to fulfill deadlines and meet goals that this dissertation is interested in exploring as a state crime of omission and commission causing social harm to our veterans.

Demonstrated Harms

Numerous research studies have linked PTSD and brain trauma to negative social outcomes. For example, a study by the Institute of Medicine (2013) on behalf of Congress reports returning veterans from Iraq and Afghanistan suffer difficulties with traumatic brain injuries (TBI) and posttraumatic stress disorder (PTSD), depression, and even substance use or abuse. The study estimated that 44% of these returning veterans faced these issues along with many facing an overlap of problems (Medicine 2013). These findings are supported by other research (Department of Veterans Affairs 2013a) that finds that more than 20% of new veterans are believed to have a diagnosis of PTSD. These studies link this disorder to additional problems like substance abuse, alcoholism, joblessness, homelessness, and increases in domestic abuse and intimate partner violence (Affairs 2013d, Hendin 2014, Korte et al. 2016, Mittal et al. 2016, Tanielian and Jaycox 2008, Veterans 2013, Violence 2013). It is important to note that The Institute of Medicine (2013) also found that the VA was often too slow in meeting the needs of individual veterans (McVeigh 2013).

One issue that has received national attention in the last few years is homelessness. The National Coalition for Homeless Veterans (2013) reports that of the adult homeless population, 13% are veterans with service spanning nearly all theatres of U.S. war. Each year the coalition reports that there are an additional 1.4 million at risk veterans who may be facing public housing living condition problems, non-existent support, and poverty (Veterans 2013). In 2012, the VA estimated that, on any given night, there were more than 62,000 homeless veterans with twice that number being homeless at some point during the year (Affairs 2013f). Furthermore, the coalition links homelessness to a multitude of factors including the effects of PTSD:

“[i]n addition to the complex set of factors influencing all homelessness – extreme shortage of affordable housing, livable income and access to health care – a large number of displaced and at-risk veterans live with lingering effects of post-traumatic stress disorder (PTSD) and substance abuse, which are compounded by a lack of family and social support networks” (Veterans 2013).

Research also exists on three other issues—all of which are linked to PTSD—unemployment, domestic violence/intimate partner violence, and suicide. Recent work has estimated that the unemployment rate for veterans was a staggering 30% compared to 16% of the civilian population (Affairs 2013f, Affairs 2013g, McVeigh 2013, Veterans 2013). Individual veterans may find that military jobs do not translate into the civilian workspace thereby making employment difficult to obtain and maintain. However, research indicates that barriers to unemployment include the results of PTSD (Department of Veterans Affairs 2013a, Korte et al. 2016, Lowery and Hicks 2014, McVeigh 2013, Mittal et al. 2016, NCVAS 2014).

Veterans face high rates of sexual assault and domestic violence rates that vary from 13.5% to as high as 58% in some places (Affairs 2013d). In 2013, the VA’s Evidence-based Synthesis Program (ESP) Center Durham VA Medical Center published a report on Intimate Partner Violence and how prevalent it was among veterans and active duty service members (Gierisch et al. 2013). In the report, Gierisch et al. (2013) explains that “[o]utcomes associated with IPV include a wide range of social, physical, and mental issues such as family dissolution, adverse pregnancy outcomes, mental health issues (depression, posttraumatic stress disorder [PTSD], anxiety), incarceration, and death.” The researchers conclude that IPV is prevalent among both veterans and active duty service members. Gierisch et al. (2013) estimate rates

ranging from 30% to 41% for victimization of women veterans and a 22% perpetration rate and 30% victimization rate for all active duty service members.

In a report issued in 2012, a concerning numbers of veteran suicides occurred at a rate of 22 per day and in the VA's newest report on suicide published in 2016, an estimated 20 veterans a day committed suicide in 2014 (Department of Veterans Affairs 2016). Veterans make up 18% of those in the United States who commit suicide despite being only 9% of the total population and the risk of suicide for veterans is 21% higher than the risk for civilians (Department of Veterans Affairs 2016). Furthermore, the VA reports that since 2001, veterans who use VA services saw increases in suicide rates by 8.8% while those who do not use VA services saw increases in suicide rates by 38.6%. The VA goes on to state that veterans using VA services saw increases in male veterans of rates of suicide by 11% and in female veterans of 4.6% but those veterans not using VA services faced much greater increased suicide rates with males experiencing increased rates by 35% and females by 98% (Department of Veterans Affairs 2016).

Historically, veterans have also faced legal problems and even incarceration, some of which may result from diagnosis of mental illness, PTSD or other service connected issues. In a 2004 report from the Bureau of Justice Statistics on Veterans in State and Federal Prison, the number of veteran inmates has declined from a peak post-Vietnam of 24% to 20% in 1986, 12% in 1997, and to 10% in 2004 (Noonan and Mumola 2007). Furthermore, Noonan et al. (2007) reported that the majority of veteran inmates did serve during wartime, 54% State and 64% Federal, but only 20% State and 26% Federal inmates saw combat. New data from the BJS reported continued declines in the number of veteran inmates as of 2011-2012 (Lawrence 2015). Lawrence (2015) explains that "[t]he study tracked an estimated 181,500 incarcerated veterans in

2011-2012, 99 percent of whom were male. During that period, veterans made up 8 percent of inmates in local jails and in state and federal prisons, excluding military facilities.” These numbers exclude military facilities. It is important to note that if soldiers break the law before they are discharged from service they may face harsh consequences resulting in limited to no VA benefits or care, dishonorable discharges, or other outcomes related to poor adjustment to the return to civilian life (Lawrence 2015).

Due to the lasting harm PTSD and other outcomes veterans have faced, it still may be too soon to fully understand all the outcomes veterans may face following the wars in Iraq and Afghanistan.

THE VA AND THE STATE CRIME THEORETICAL FRAMEWORK

In order to fully understand state crimes of omission and commission, it is important to use an integrated theoretical framework of state crime that allows the causal mechanisms and the motivations, opportunity, constraints, and controls existing at the international, macro, meso, and micro levels to be understood (Rothe 2013). While not proposing to test this theoretical framework, the framework does offer important causal mechanisms for understanding how indicators of state crime operate. This explains why using a state crime framework increases understanding of indicators of state crime. For the purposes of this dissertation, international levels of analysis are not included since this case focuses on the Department of Veteran’s Affairs, an organization limited to the care of U.S. veterans. Beginning with the macro level of analysis, the VA’s motivations may include structural transformations, economic, military and political goals.

Following the increase in the number of Veteran's after September 11, 2001's terrorist attacks on The World Trade Center, the subsequent wars in Iraq and Afghanistan and resulting increase in the number of soldiers and veterans altered existing structures within the VA (Affairs 2013a, Affairs 2013g, McVeigh 2013, Medicine 2013). Additionally, economic, military, and political goals shifted dramatically in a push towards increased securitization policies post 9/11 (Rothe and Muzzatti 2004, Simon 2007). Opportunity at this level of analysis include controlling information, propaganda, and promoting ideology or nationalism. The VA engages in this type of behavior through carefully managing information it releases to the public, maintaining a strict image, and regularly publishing reports on its own conduct. Constraints may include political pressures, media scrutiny, public opinion, and social movements, and finally, the controls are domestic laws (Rothe 2013). Recent accusations against the VA have increased media scrutiny and resulted in the potential for public opinion backlash.

At the meso level, motivations are the organizational culture and goals, authoritarian pressures, and reward structures. Media reports on VA wrongdoing and reports from whistleblowers question the VA's ability to provide benefits to the number of soldiers that require them (Devine 2015a, Zezima 2014, Zoroya 2014b). Opportunity includes communication structures, means availability, role specialization, and the diffusion of responsibility. Constraints are internal oversight, authority structures and finally, controls are codes of conduct (Rothe 2013). The VA regularly conducts surveys and issues reports on its own performance, including the weekly benefit claim reports that this study will examine (General 2014a, General 2015, MMWR 2016)

At the micro level, motivations include strain, obedience to authority, socialization, individual goals and ideologies, and definitions of the situation. Opportunity may rely on

techniques of neutralization, the normalization of deviance, or group think. Constraints include personal morality, potentially why whistleblowers within the VA came forward, socialization, and informal social controls. Finally, at the micro level, controls include the legitimacy of the law and the perception of its reality and application (Rothe 2013). This case is an example where individual's deviant behavior may have become normalized through the day-to-day operations of the VA (Gerkin, Teal and Reinstein 2010, Vaughan 1996). Understanding how the causal mechanisms that the motivations, opportunities, constraints, and controls that exist at the macro, meso, and micro levels operate reveals a series of actions and inactions perpetrated by the VA against its veterans. Data collected from the VA itself, whistleblowers, and media reports will demonstrate how the VA could potentially be committing a state crime against its veterans.

CONCLUSION

The key question in this dissertation is should the problem veterans face in obtaining benefits be examined, along with the benefit deficit, as a state crime of omission. The VA's failure to act has led to further problems with agents acting on behalf of the VA to cover up internal issues (Devine 2015a, McVeigh 2013, Zoroya 2014c). This case has repeatedly been in the media following several reports from the Department of Veteran's Affairs released at the end of 2012 and beginning of 2013 (Affairs 2013c, Affairs 2013d, Affairs 2013f, Affairs 2012).

Examining the actions and inactions of the VA, through the state crime framework and considering the grave social harm caused by such, is an important area of sociological and criminological inquiry. The benefit deficit is not new to the Iraq and Afghanistan war and is in fact a result of the perpetuation of a cycle of social harm that has occurred throughout all theatres of U.S. war. The social harms caused by this benefit deficit range from suicide and

homelessness to a lack of medical treatment and care to joblessness and all of the associated problems in between. While numerous scholars have explored how state crimes of omissions and commissions have occurred and the impact they have had on their victims (Barak 2011, Faust and Kauzlarich 2008, Friedrichs 2011, Gerkin, Teal and Reinstein 2010, Kauzlarich, Mullins and Matthews 2003, Kauzlarich and Kramer 2006, Kramer 2009, Matthews and Kauzlarich 2006, Rothe and Mullins 2011, Schotter and Rhineberger-Dunn 2013), little work has been done on the failures of the VA within this framework.

The VA has a historic agreement to care for and protect its veterans, and by breaking this agreement, they are not only potentially perpetuating social harm but also potentially committing state crimes of omission and commission (Affairs 2013b, Affairs 2013e, Faust and Kauzlarich 2008, Friedrichs 2011, Rothe and Kauzlarich 2016). This dissertation explores the cycle of harm that has continued throughout many theaters of US war, including Vietnam, both World Wars and Korea and asks whether the VA is committing a state crime. Under the paradigm of human rights, individuals have the right to health care and to not be exposed to known harms (Green and Ward 2000, Schwendinger and Schwendinger 1970).

By using Rothe and Kauzlarich's (2016) definition of state crime wherein they argue state crime is defined as omission and actions by state actors regardless of self-motivation, we can examine documentation from the VA itself where evidence of harm exists. The next chapter outlines the methodology used to examine the case of the VA as an actor possibly engaged in state crime and discusses data and research design.

CHAPTER IV

METHODS

This dissertation explored whether or not the Department of Veteran's Affairs (VA) omissions and commissions have resulted in social harms perpetrated against current and former soldiers seeking medical care thus identifying this as a state crime. This research uses the state crime framework to examine the actions and inactions of the VA to determine what harm, if any, was caused, and whether those harms are still in progress. This research also attempts to determine the impact that such omissions and commissions have had by exploring the level of care veterans have received, and by identifying problems veterans have experienced in receiving care by then documenting prior knowledge of such problems.

This dissertation used Rothe and Kauzlarich's (2016) definition of state crime to examine actions of the VA. This definition includes both acts (commissions) and inactions (omissions) by state actors that either violate the law, human rights, or causes systematic or institutionalized harms regardless of the motivation these actions/inactions are performed under. The literature suggests that state crimes occur when there are documented failures by an organization, prior knowledge of those failures, actions (commissions) in response, and resulting social harms (Faust and Kauzlarich 2008, Kramer 2006). Additional indicators of state crime include weak regulatory systems, lax enforcement, and organizational goals limiting action (Gerkin, Teal and Reinstein 2010, Schotter and Rhineberger-Dunn 2013).

In order to determine whether the VA has committed a state crime and understand the impact that its actors have had on veterans this dissertation utilizes a case study methodology. A case study approach allows for a thorough investigation of the VA from several sources and at both the macro and micro levels of analysis. This dissertation uses media reports surrounding

the 2014 scandal occurring over veteran appointment scheduling and wait times made public due to whistleblower reports. This data aims to identify problems and both the public response and veteran response to the accusations that whistleblowers have levied against the VA. In addition, much like previous literature (Faust and Kauzlarich 2008, Gerkin, Teal and Reinstein 2010, Schotter and Rhineberger-Dunn 2013) this dissertation examined secondary data from the Department of Veterans affairs directly that attempts to address known issues within the organization and Monday Morning Workload Reports that demonstrate the number of claims the VA has historically dealt with. Survey data on veteran satisfaction and knowledge of veteran services were summarized before three reports from the Veteran Health Administration are analyzed.

The goal of this dissertation is to advance the state crime literature by exploring the VA as a case of state crime resulting in social harm to veterans. Understanding the role social harm, and analogous social harm has in our understanding of state crime is a vital component to understanding that even when entities act within the legal purview of the law, harm can still result. This is accomplished by focusing on several key research questions: 1) Is the VA committing a state crime of omission or commission through its handling of veteran benefit claims? 2) Are the accusations against the VA of falsifying records and knowledge of changing veteran appointments evidence of this state crime? 3) Have these omissions and commissions persisted overtime despite knowledge of their existence? 4) What has the response to the problem been? And 5) hat are the outcomes that this has on veterans?

RESEARCH DESIGN

A researcher's paradigm is a vital component that serves to guide how the research takes shape, what the research question is, and how the researcher answers that question (Creswell 2013). Therefore, the type of data that researchers obtain is determined by the paradigm used within research. Guba and Lincoln (1994) explain that a paradigm "...represents a worldview that defines, for its holder, the nature of the "world," the individual's place in it, and the range of possible relationships to that world and its parts..." (Guba and Lincoln 1994: 107). This dissertation uses a critical theory paradigm in order to inductively analyze themes emerging from data from the VA itself and media reports. A critical theory paradigm allows the researcher to use grounded data to inductively explore themes as they emerge from the data (Creswell 2013). A critical framework allows for an understanding of reality based on power struggles understood through structures as they operate within society (Creswell 2013, Guba and Lincoln 1994).

Throughout the history of criminology and its sociological roots, positivism has been the dominant construct. As a scientific approach to research, positivism focuses on "objective measurement of social issues, where it is assumed that reality consists of facts and that researchers can observe and measure reality in an objective way with no influence of the researcher on the process of data collection" (Hennink, Hutter and Bailey 2011: 14). Assumptions about positivistic approaches lead to the creation of an idealistic model and an ideology wherein positivism is viewed as "better" than other methodologies. This assumption is made under the guise that positivistic approaches are bias and judgment free. This approach to research incorrectly assumes that through hypotheses testing and theory generation, an epistemological approach to research that uncovers a bias-free "truth" is possible (Creswell 2013, Hennink, Hutter and Bailey 2011, King and Horrocks 2010). A critical theory paradigm

allows themes within data to emerge through a reflexive process. This type of research is not attempting to assign pre-constructed values to the data but is designed to instead allow emergent themes to be explored.

By using a qualitative approach to research, we attempt to understand individuals' experiences within the context that they experience them and can thus gain a greater understanding of the world (Hennink, Hutter and Bailey 2011, King and Horrocks 2010, Lincoln and Denzin 2003). An important aspect within qualitative research is the role of the researcher in knowledge creation, their awareness of that role, and the importance of reflexivity in understanding how the role the researcher plays contributes directly to such knowledge creation (King and Horrocks 2010). Furthermore, qualitative research allows the researcher to understand the full range of truths existing within our world and to better understand human behavior, experiences, and individuals lived realities while also accepting the full extent of the role the researcher plays in knowledge creation (Creswell 2013, Hennink, Hutter and Bailey 2011, Lincoln and Denzin 2003, Silverman 2005).

DATA AND ANALYSIS

Data for this dissertation came from four sources: media reports, the Monday Morning Workload Reports, Veterans Health Administration reports, and the National Survey of Veterans. Much like previous research on state crime documents, state crime can be examined using media reports and reports published by the organization itself, in this case, the VA. Using previous literature, this dissertation looked for key indicators of state crime. Indicators of state crime used within this dissertation include whether there was prior knowledge of the problem, a failure to act on such knowledge, if any subsequent weakening of regulations or lax enforcement of

existing regulations contributed to the problem, or if organizational culture allowed for a process of normalization of deviance to occur (Faust and Kauzlarich 2008, Gerkin, Teal and Reinstein 2010, Kauzlarich, Mullins and Matthews 2003, Kauzlarich and Kramer 2006, Kramer 2009, Matthews and Kauzlarich 2006, Rothe and Mullins 2011, Schotter and Rhineberger-Dunn 2013, Vaughan 1996).

First, primary data was collected from media reports both from and about whistleblowers and several reports directly from the VA, including an interim report published in May of 2014 regarding direct harms the VA is accused of causing. Both aid in the documentation of prior knowledge and persistence of these problems within the VA. In addition, analysis of media reports on these harms allows for a micro level of analysis of the individual impacts veterans may have faced in dealing with the VA. Harmful effects are another factor important in demonstrating the occurrence of a state crime. For the purposes of this dissertation, a content analysis was performed on these reports. A content analysis is a detailed and systematic analysis of data so that emergent themes and meanings can be fully extrapolated from the data (Berg 2007, Creswell 2013). Analysis of the data must be so thorough that if others were to perform the analysis, comparable results would be obtained (Berg 2007).

Media reports were obtained by using LexisNexus Academic. LexisNexus Academic allows for a thorough and exhaustive search for specific date ranges and topics within a given medium or source. For our purposes, media reports were analyzed from the two most highly circulated national newspapers available to Old Dominion University through LexisNexus Academic. These newspapers are *USA Today*, with a total circulation of 3,866,618 for Monday through Friday, and 4,010,437 for Sunday, and *The New York Times*, with a daily circulation for Monday through Friday of 2,237,707 and a Sunday circulation of 2,566,771 readers (Media

2016). To analyze the impact of the accusations the VA faces from whistleblowers, and the Veterans Health Administration Interim Report, published May 28, 2014, newspaper articles from January of 2014 through December of 2015 will be collected. Articles were searched using a BOOLEAN keyword search of “veteran* affairs” OR “Department of Veteran Affairs” allowing for any mention of veteran affairs or the Department of Veterans Affairs to be collected in the initial data collection processes. Articles about Veteran’s Day activities, obituaries, sports, or other non-news articles were not included in the search. Articles were narrowed further by using LexisNexus’ to specify that only articles on veteran’s healthcare were of interest. The results were 59 articles from *USA Today* and 115 articles from *The New York Times* all pertaining to veteran healthcare.

Second, the Department of Veteran’s Affairs (VA) publishes a weekly work load report, the “Monday Morning Workload Report”, for each week of the year. This data is available from the VA itself from 2004 until the current year. Weekly reports were collected from January of 2004 until December of 2016, totaling 676 reports. These reports include information on the number of completed claims from veterans per week, the number of pending claims, and the number of backlogged claims over 125 days. This data was entered into a database to analyze changes in the VA’s workload over time. This data shows whether there have been problems that have periodically plagued the VA in clearing backlogged claims. Furthermore, this data is used to indicate knowledge of persistent problems clearing the backlog over time. Existence of problems and knowledge of them are two key factors in documenting a state crime.

Third, in order to have a point of reference, the Department of Veteran’s Affairs National Survey of Veterans, Active Duty Service Members, Demobilized National Guard and Reserve Members, Family Members, and Surviving Spouses was reviewed. This survey was distributed

by the VA to better understand beneficiary awareness and satisfaction of the VA's services and what benefits are offered to soldiers and veterans (Westat 2010). This survey included 10,972 within the population, with 8,710 of those being veterans. Having data on the satisfaction level of veterans receiving care, as well as data on whether individuals were even aware of the benefits available to them is a valuable asset. This data was used to indicate the VA's potential knowledge of the problems existing with the VA as reported by the veterans receiving care. This data also allows for a comparison to be made between soldiers' perception of care and the VA's reports on its own efficacy—through the Monday Morning Workload Reports.

Finally, the Veteran's Health Administration (VHA) published several reports, including an interim report in May of 2014, regarding the accusations that VA health center employees were falsifying veteran records and keeping secret lists in order to manipulating veteran appointment scheduling. This report, the final report published in August of 2014, and a third report published in September of 2015, were analyzed to understand the VA's response to the accusations made against VA health clinics and the harms veterans were facing.

The next chapter details the findings and analysis within media reports collected from 2014 through 2015 in *The New York Times* and *USA Today*.

CHAPTER V

FINDINGS: MEDIA REPORTS

Two key sets of discourses surround the VA. One is the public discourse that emerged surrounding the VA and accusations of wrongdoing through schedule and appointment manipulation. At the same time a similar narrative emerges within the VA through data the VA itself produced. This chapter focuses on media reports collected from January of 2014 through December of 2015 in *The New York Times* and *USA Today*. This chapter details the narrative and public discourse that emerges within media reports while the next chapter will review the findings and analysis of VA's own data and reports.

The Data

Media reports were gathered from January of 2014 through the end of December 2015 by using LexisNexus Academic through Old Dominion University's library database. LexisNexus allowed for an exhaustive search for both date ranges and key words using a BOOLEAN search. For the purposes of this dissertation, articles were examined within two major national newspaper publications: *The New York Times* and *USA Today*. A keyword search of "veteran* affairs" OR "Department of Veteran Affairs" allowed for any mention of veteran affairs or the Department of Veterans Affairs to be included in the initial data collection process.

Using LexisNexus Academic's *focus* feature allowed articles only discussing veteran's healthcare to be included in the final search. This search resulted in 59 articles from *USA Today* and 115 articles from *The New York Times* all pertaining to veteran's healthcare. From this initial collection, 9 articles were discarded from the 59 *USA Today* articles because they were either duplicates or articles that mentioned the VA's health care woes without being about the

VA or veterans. From the initial 115 articles from *The New York Times*, 22 articles were discarded because they were duplicates, about a VA doctor and not the VA itself, or an article that only casually mentioned the VA without focusing on it. This left the total number of articles at 143; 50 from *USA Today* and 93 from *The New York Times*.

USA Today

The remaining 50 *USA Today* articles were reviewed multiple times for content and overall themes. Generally, articles fell into five important categories: articles about the consequences veterans face and their problems receiving care from the VA (*consequences*); articles about allegations that the VA falsified records, engaged in schedule manipulation; and the resulting investigation (*falsified records*); leadership within the VA (*leadership*); politics surrounding the VA (*politics*); and other miscellaneous articles about the VA (*other*) that did not fit one of the main categories.

Two issues with the classification of the articles should be noted. First, articles within the consequences category were also analyzed to determine if they were about specific consequences veterans faced to include suicide, homelessness, PTSD, other issues, or if the article was about the general impact of the consequences the veteran faced in dealing with the VA. Second, articles were categorized based on the entirety of their content sometimes resulting in articles falling into more than one category. For example, many of the articles that discussed *falsified records* either discussed VA *leadership* or *consequences* that veterans face in dealing with the VA. Within the *USA Today* articles, 28 of the 50 articles fell in only one category and 22 of the 50 fell in 2 categories.

Within *USA Today* most of the articles reported on the VA falsifying records and the subsequent investigations that resulted from these accusations of wrong doing. There were 45 articles within the *falsified* category. Within the *consequences* category, there were 20 total articles. Out of the 20 articles, 12 articles were generally about the consequences veterans face and the problems they experience obtaining care from the VA. An additional 8 articles were about specific consequences to individuals' outcomes. Of these 8 articles, there were 3 articles about suicide, 3 about PTSD, and 2 about issues of homelessness.

An additional 11 articles specifically mentioned the VA's leadership, a push to change the leadership, or the removal of key VA officials after accusations against the VA began to be substantiated. These 11 articles were categorized within the *leadership* category. Within the *politics* category there were 5 articles that specifically mentioned politician's roles in dealing with the VA scandal, mentioned the VA scandal as a political point of contention, or discussed how to proceed from a political standpoint. The last category, *other*, included 4 articles about the VA and the VA's health care scandal that were either opinions about the scandal or letters from VA doctors detailing their experiences in the VA system.

The New York Times

The 93 articles in *The New York Times* were reviewed several times to determine what themes, if any, were present. Like the *USA Today* articles, articles in *The New York Times* could be divided into several thematic categories including *consequences*, *falsified records*, *leadership*, *politics*, and *other*. Articles were categorized dependent upon their content and many articles had more than one category. Within *The New York Times* articles, of the total 93 articles,

there were 40 articles with whose contents fell in only one category, 39 fell into two categories, and 14 articles fell into three categories.

Within *The New York Times* articles, the majority of the articles, 52, had content that was in the *falsified* category. These were about the accusations the VA faced regarding their manipulation of appointment scheduling, falsifying records, and the subsequent investigations that took place.

The *consequences* category had a total of 48 articles within it. Articles within the *consequences* category were analyzed to determine if they belonged to any specific sub categories regarding the specific harm or consequence veterans face such as suicide, PTSD, homelessness or other issues. The vast majority of these articles, 33 of the 48, were about the general consequences veterans faced because of the VA scandal and the investigation that followed. The content of the articles was also about veteran's inability to get care in a timely fashion and the extended delays veterans faced in obtaining care, a central problem resulting in the manipulation of appointment scheduling. Within the *consequences* category, there were 15 articles about specific harms veterans face. There were 6 articles about suicide, 5 articles about homelessness, and 4 articles that addressed PTSD. These articles occurred when the newspaper had an individual story to tell about veteran experiences, programs available to the VA, or specific problems veterans faced.

Within *The New York Times* 31 articles were about the leadership within the VA and the political ramifications that resulted from the investigation and accusations levied against the VA. Articles in the *leadership* category addressed failures of VA leadership to address ongoing problems within the VA, the change and removal of Eric Shinseki as head of the VA, the appointment of a new VA secretary, or various VA executives' involvement in the scandal and

investigations. There were also 23 articles in the *politics* category that addressed the political ramifications of the VA's scandal and demonstrated clear partisan lines along how the VA should recover from the scandal and address its many ongoing issues. *The New York Times* focused more heavily on the political outcomes surrounding the VA scandal than *USA Today* did. An additional 9 articles were in the *other* category. The other category contained articles about programs at the VA, opinions from veterans about the VA, and a series of articles in *The New York Times* about a new VA hospital in Denver, Colorado that was severely over budget by the time approval was granted to fund and complete its' construction.

The next section analyzes media reports from January 2014 through December 2015 that first brought allegations of VA wrongdoing to light and detail the lived experiences of some veterans throughout their dealings with the VA.

Analysis of Media Reports

This section discusses the major categories within the two newspapers as they relate to the VA and the accusations that whistleblowers made against the VA. This section focuses primarily on three of the categories, *consequences*, *politics*, and *falsified records*. These articles were those pertinent to analysis of the VA's actions and inactions and the consequences and resulting social harms that veterans face. While many of the articles had repeated information from one article to the next, an important narrative emerged within both newspapers. While it is important to understand the categories that emerged from analyzing the articles, the articles are discussed in chronological order. As articles the chronology of the narrative is reviewed, factors that indicate state crime will also be examined. These factors are whether there was prior knowledge of the problem, a failure to act on that knowledge, if any weakening of regulations or

lax enforcement of existing regulations contributed to the problem, or if organizational culture contributed to a process of the normalization of deviance (Faust and Kauzlarich 2008, Gerkin, Teal and Reinstein 2010, Kauzlarich, Mullins and Matthews 2003, Kauzlarich and Kramer 2006, Kramer 2009, Matthews and Kauzlarich 2006, Rothe and Mullins 2011, Schotter and Rhineberger-Dunn 2013, Vaughan 1996). Understanding the timeline of the emerging narrative is an important part of the public discourse and how the VA's narrative emerges through its data.

USA Today

Within the *USA Today* articles, 45 articles were about the falsified records investigation (*falsified records*), 20 about the consequences veterans face (*consequences*), 11 about VA leadership (*leadership*), 5 about politics (*politics*), and 4 in the *other* category. Throughout the two-year period, a narrative of whistleblower reports, VA investigation and follow-up reporting, the consequences veterans faced as a result, and political and partisan efforts to reshape the VA leadership and purpose emerges. This section highlights details within the articles demonstrating this narrative.

In early May of 2014, reports began to surface that due to whistleblower reports, the VA had opened an investigation into allegations of delays in medical care for its veterans. A *USA Today* article from May 5, 2014 reported on the VA's Office of Medical Inspector report wherein veterans at Fort Collins were waiting months to be seen and any staff who allowed official records to reflect such delays were punished (Zoroya 2014f). Here we see reports of delays veterans face and the resulting consequences and harms and we are introduced to the possibility that organizational culture may have played a role in contributing to these delays. Zoroyo (2014f) writes that:

“Department officials revealed last month that 23 deaths of veterans were linked to delayed cancer screenings dating back four years. More recently, a retired doctor, Sam Foote, alleged that 40 other veterans died because of treatment delays at a VA hospital in Phoenix. VA officials say there's no evidence to support those claims, but the hospital administrator was placed on leave pending an investigation by the agency's inspector general. The medical inspector's probe in the Fort Collins case could not confirm that patients had been harmed ‘due to the lack of specific cases evaluation.’”

Soon after this story, reports from whistleblowers began to emerge from more than just the Fort Collins and Phoenix VA medical centers. *USA Today* reported that, “[t]he allegations came from a retired doctor who worked at the hospital. Since then, whistle-blowers at other hospitals or clinics have stepped forward to report similar problems at other VA facilities around the nation” (Zoroya and Madhani 2014:1A).

As allegations against the VA began to surface in the public, details on how systemic the delays and employee manipulation of appointment scheduling were slowly beginning to emerge. *USA Today* (2014) reported that VA leaders, including Eric Shinseki, should not be surprised by allegations of scheduling abuses since reports emerged in 2010 detailing how VA employees actively gamed the system to manipulate such data.

By the end of May, 2014, when the Interim VHA report *Review of Patient Wait times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System* (General 2014a) was released, Eric Shinseki, the Secretary of Veterans Affairs, released several statements about what the VHA had already done and was going to do to fix the VA. These statements included the ordering of a complete audit of all VA health facilities, putting

leadership within the Phoenix, AZ VA on leave, and working to assess the extent of the problem (Shinseki 2014, Zoroya 2014b).

Despite political support for Shinseki by some, he tendered his resignation to President Obama May 30, 2014 after turning in results from the internal audit. The audit revealed widespread record manipulation to meet the 14-day appointment goals set forth within the VA. Shinseki acknowledged that having a stringent goal linked to bonuses and salary increases was probably a bad idea (Hoyer and Zoroya 2014). This evidence supports an organizational culture that results in the normalization of deviance. Hoyer and Zoroya (2014) wrote that:

“The Department of Veterans Affairs official internal data show it failed to treat three out of five veterans within its 14-day target period for care, VA statistics obtained by USA TODAY show. As bad as those numbers are, greater numbers of patients may have been kept waiting, according to an audit released last week that shows rampant fraud in keeping official appointment records. Some 13% of schedulers at 216 VA health facilities said *they were instructed in how to falsify the wait times they reported to VA headquarters*. At least one instance of false scheduling occurred at 64% of the facilities, the audit showed. Those numbers, made available through a Freedom of Information Act request, showed that even without fraud, patients were kept waiting. In the six-month period ending March 31, the VA's 150 hospitals and 820 outpatient clinics failed to treat more than 200,000 veterans who came in for first-time primary care appointments in 14 days” (p. 1A) (Italics added).

Through Freedom of Information Act requests, *USA Today* was critically important in breaking the story of just how negligent and serious the accusations against the VA were. Information obtained by the newspaper revealed failures to provide timely and adequate care for veterans

even before including fraudulent schedule manipulation for salary and bonus increases at many the facilities audited.

In addition to veterans not receiving appointments, the internal audit revealed that veterans waited as long as 145 days, in Hawaii, to receive initial primary care appointments with their VA doctors (Zoroya 2014a). Zoroyo (2014c) stated:

“About 100,000 veterans across the country are waiting long periods to see doctors, according to an internal Department of Veterans Affairs audit released Monday. The VA says it already has contacted 50,000 veterans trying to get them quicker medical care. A total of 57,436 veterans across the country have waited 90 days to see a doctor and still did not have an appointment as of May 15, the VA said. The agency also found evidence that in the past 10 years, nearly 64,000 veterans who sought VA care were simply never seen by a doctor” (p. 3A).

While this article continues to outline the systemic problems across the VA health care system, it is unclear how many veterans faced consequences related to their inadequate care.

The investigation within *USA Today* aligned with reports from the VA to show that employees at various VA hospitals and clinics feared retribution for reporting scheduling manipulating and other inappropriate record keeping. This is suggestive of an organizational culture that is promoting a circumstance where normalization of deviance is bound to occur. When the VHA released its final report on scheduling, a *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, published on August 26, 2014 (General 2014b), the VA claimed that the deaths of 40 veterans in Phoenix could not be substantiated but, to address the issues within the report, promised changes to come (Zoroya 2014d).

As the end of 2014 approached the newspaper reported that the VA did begin to report some progress in addressing the backlog; however, 600,000 veterans, or 10%, continued to wait over a month for care (Hoyer and Vanden 2014). The new Secretary of the VA, Bob McDonald, announced a restructuring of the VA on November 10th that included increases in pay for VA doctors, goals of recruiting additional doctors and nurses, and a system allowing veterans to use vouchers to obtain care with private doctors if needed.

USA Today made additional Freedom of Information Act requests in March of 2015. These requests were for 140 reports on various health care investigations that had taken place within the VA since 2006 (Slack 2015a). Within 10 days of reporting that the VA was withholding information on reports related to veteran care, the VA released 5 reports to the newspaper, detailing 5 cases where veterans were impacted by some type of health care failure (Slack 2015c). The severity of these cases ranged from the over use of opiate prescriptions potentially causing a veterans' death to a missing liver biopsy and a provider who refused to see patients. The paper reported that an important result from these FOIA requests was that the VA agreed to change its policy on how it handled these reports, setting an official policy for the release of such information (Slack 2015c).

In June of 2015, Secretary Bob McDonald and Deputy Secretary Sloan Gibson testified before Congress that the VA was short \$2.6 billion dollars and that they needed the flexibility to shift money across budgetary lines within the VA's budget (Hoyer and Zoroya 2015). Through another Freedom of Information Act request, *USA Today* obtained information on the VA's employment vacancies revealing that the VA had "openings for 5,000 physicians, nearly 12,000 nurses and more than 1,200 psychologists" (Hoyer and Zoroya 2015:1A). These vacancies, according to Gibson, were largely why the VA was sending veterans to private health care

providers for a cost of \$7.7 billion dollars in the previous year. Vacancies occurred because of complex hiring procedures, high turnover rates, and the inability to attract new employees. Furthermore, the investigative journalism by *USA Today* revealed that “[f]our locations were short at least 100 doctors: Orlando, Portland, Ore., Baltimore and Salt Lake City. Each of those locations also had at least 100 vacant nursing positions. Portland needed nearly 300 part-time and full-time nurses” (Hoyer and Zoroya 2015:1A).

USA Today then reported that even a 1% increase in job vacancies within the VA could potentially push veteran wait times back over a month (Hoyer 2015). Hoyer (2015) explains:

“About one in three jobs are vacant at nine of the nation's regional Veterans Affairs health care systems, leaving veterans waiting weeks to get care. Nationally, one in six positions -- nearly 41,000 -- for critical intake workers, doctors, nurses and assistants were unfilled as of mid-July, in part because of complex hiring procedures and poor recruitment, according to critics of the nation's network of 139 hospitals and clinics that treat veterans” (p. 1A).

Not only were VA hospitals critically in need of nurses and doctors, Hoyer (2015) also reported that high vacancy rates for psychologists existed throughout the VA as well. “In 13 regional health care systems, 40% to 64% of psychologist positions are vacant. Nationally, about 21% of such positions are vacant” (Hoyer 2015:1A).

By the end of 2015, there was one more VA scandal reported within *USA Today*. In November of 2015, it was reported that the VA gave out \$142 million in bonuses for 2013 during 2014 (Slack and Theobald 2015). Thus, despite the criticism that the VA faced for creating a system of bonuses and salary increases that effectively incentivized systemic cheating by manipulating veteran appointment records and scheduling, the VA still gave large bonuses to

some of its employees. This serves as another example of organizational culture promoting the normalization of deviance within the VA. Senator McDonald responded to criticism stating that most VA employees were hard working and did not deserve to be punished, especially since many of them were veterans as well (McDonald 2015). Senator McDonald (2015) further argued that rewarding employees was an important way to maintain and attract talent to the VA.

Overall, *USA Today* reports that the VA has made significant progress in reducing the number of backlogged claims since they peaked in 2013; however, much progress is still needed, and some argue that the existing progress has come at a cost. Kennedy (2014) reports that the VA may have reduced the number of new claims but the cost has been to older, pending claims of veterans of previous engagements. There are at least 350,000 veterans waiting for appeals, a process that may take 19 months (Kennedy 2014). Kennedy (2014) explains that:

“Walinda West, a VA spokeswoman, said a simple appeals case takes an average of 562 days, but each supplemental piece of evidence can extend that delay by 200 more days. Bergmann said veterans appeal their cases after they are told their medical conditions were not caused by military service. That often includes post-traumatic stress disorder (PTSD) or respiratory cancer that could be traced to exposure to Agent Orange, the chemical defoliant used in the Vietnam War. The cases often involve incorrectly filled-out forms, improperly given medical exams or lost medical records” (p. 1A).

Despite the progress on reducing backlogged claims, a backlog exists currently, in 2017, and veterans are still waiting for care. Additionally, veterans may face additional consequences outside of waiting extended periods for health care to include consequences such as PTSD, TBI, IPV, homelessness and suicide.

Newspaper reports not only chronicled the abuses occurring within the VA but also illustrated some of the consequences that veterans face as a result. When articles discussed the consequences veterans face, many articles focused on specific outcomes veterans were experiencing. For example, an article on veteran suicides stated the VA was reporting suicide rates of younger veterans as three times the rate of those who were still active duty (Zoroya 2014e). Zoroya (2014) reports:

“The Army has struggled with suicide among active-duty troops more than other service branches during the wars in Iraq and Afghanistan, and the risk persists after soldiers return to civilian life. Veterans ages 18-24 enrolled in the VA's health program killed themselves at a rate of 46 per 100,000 in 2009 and nearly 80 per 100,000 in 2011, the latest year of data available, according to the figures. Non-veterans of the same age had a suicide rate during 2009 and 2010, the most recent data available, of about 20 per 100,000, according to data from the Centers for Disease Control and Prevention” (p. 1A)

Veteran suicides continued to climb to a rate of more than 22 per day before falling to 20 per day in the following years. Veterans also face higher rates of homelessness than civilians, and according to the VA, the number of homeless veterans is continuing to increase (Foscarinis 2014).

Slack (2015) reports that Secretary McDonald initiated supervisor training to try and protect whistleblowers from facing retribution. Even with efforts to fix a broken system, instances of veterans suffering the consequences of war, and the failures of the system designed to care for them, are easily uncovered. Veterans are forced to question whether they are actually going to receive needed medical care or if the VA is adequately addressing their medical concerns (Slack 2015b). Slack (2015) writes:

“The VA has struggled to meet unprecedented demand as waves of veterans with complex needs return from the wars in Iraq and Afghanistan at the same time Vietnam veterans are aging and requiring more care. VA failures have played out in crisis after crisis in recent years, from the benefit claims backlog that reached more than a half million applications in 2013 to the revelation last year that patient wait-time records were manipulated while veterans died waiting for care. Former VA secretary Eric Shinseki stepped down, President Obama installed a new secretary, and Congress passed legislation trying to fix the agency. On the front lines, it can be hard to tell the difference” (p. 1A).

Individual veterans are left facing the consequences of inadequate care, such as those interviewed by *USA Today* reporter, Donovan Slack, where veterans reported permanent disfigurements and failures to catch cancer resulting from the VA’s inadequacies. These outcomes for individual veterans interviewed by reporters could have been prevented or mitigated if they had adequate and timely care.

Through reporting on this issue, *USA Today*, then uncovered evidence about the problem, that the VA knew about problems within its hospitals and clinics, and that the culture within the VA facilitated abuses revolving around scheduling changes and appointment manipulations. This occurred through direct manipulation of veteran wait times when employees created secret waiting lists and changed appointment times to secure bonuses and positive employment performance reviews. Fear of retribution for not going along with the scheme or for reporting wrong doing created an organizational culture that allowed the normalization of deviance to occur. The lack of oversight and lax regulation occurring within individual VA clinics and hospitals further compounded this issue. Furthermore, reporting in this newspaper, and *The New*

York Times, show public and political outrage over the treatment of our veterans and served to bring this scandal to the public's attention. Articles in *The New York Times* are discussed next.

The New York Times

The articles in *The New York Times* were primarily about the falsified records investigation with 52 articles in the *falsified* category. There were 33 articles in the *consequences* category, 31 in *leadership*, 23 in *politics*, and 9 in the *other* category. Much like within *USA Today*, a narrative of how whistleblowers uncovered and reported on the scandal within the VA, the VA's leadership and the politics surrounding the problem, and the consequences veterans face emerged in the articles. Select articles are reviewed to illustrate this narrative.

In March of 2014, *The New York Times* broke down the \$164 billion dollar budget of the VA and Secretary Shinseki's three goals of expanding health care access, ending homelessness, and clearing the backlog of claims (Sotak 2014b). Sotak (2014) writes:

“Clearing the backlog - defined as disability claims that have taken 125 days or longer to process - remains a benchmark that the department struggles to reach. Though the backlog has decreased in the last year, to just under 370,000 claims, veterans groups continue to criticize the department for its inability to eliminate the delays. And the work continues to grow. According Mr. Shinseki, 1.5 million new compensation and pension claims are expected to be filed in 2015, an increase of 20 percent over 2014” (para. 3).

Shinseki further explained that VA budgeting was reactive to veterans' war service, multiple deployments, and compounded mental health issues and that they will require collaboration and continued support (Sotak 2014b).

By the middle of May 2014, much like *USA Today*, *The New York Times*, began reporting on delays in veterans receiving care and the possibility that secret waiting lists were being kept at several VA hospitals, including the one in Phoenix, AZ (Oppel 2014c, Oppel 2014d). Oppel (2014c) explained that:

“A major factor behind long waiting periods for care, outside experts and department officials agree, is that demand for primary care has risen sharply in recent years, fueled not only by younger veterans who served in Iraq and Afghanistan, but also a tide of Vietnam-era veterans, many with complex health problems relating to both their age and their military service. Yet amid that rising demand, the department has been unable to maintain enough primary care doctors to keep pace in some locations. According to the department, the number of primary care visits in the system rose by 50 percent over the past three years; the number of new nurses and other staff members increased a similar amount, but the number of full-time primary care doctors rose by only 9 percent” (p. 14).

The increase in the number of patients seeking care, combined with pressures on staff and doctors to continue to meet performance goals, such as the 14 day first time appointment metric, all led to a culture where creating secret waiting lists while reporting above board numbers was an acceptable response.

These problems were exacerbated by the political motivations of those on both sides who viewed the VA’s failures as an opportunity to be critical of the Obama administration and the government health care that makes up the VA (Shear and Weisman 2014, Weisman 2014b). Shear and Weisman (2014) write “Republican lawmakers intensified their criticism of Mr. Obama, and some made it clear they intended to use the incidents at the hospitals as fodder for a broader political theme about incompetence in his administration” (p. 1). Furthermore, the

authors noted that an increasingly bi-partisan call for something to be done within the VA grew as more details of the scandal emerged. Solutions for the VA fell largely on partisan lines with republicans calling for the expansion of veterans access to private medical care and democrats arguing that the real fix for the VA was in creating timely and quality health care systems that can address the needs of all veterans (Weisman 2014a, Weisman 2014b). Weisman (2014b) writes:

“Beyond the Shinseki debate, Republicans and Democrats are grappling with a more profound issue, the future of veterans' health care, that goes to the core of their political identities: Should the collection of government-owned-and-run medical centers be expanded to cope with millions of young service members returning from Iraq or Afghanistan? Or should care for such veterans increasingly be privatized?” (p. 18).

On May 24, 2014, *The New York Times* published an editorial by the doctor who blew the whistle on the VA, Dr. Sam Foote. Dr. Foote explained his reasons for becoming a whistleblower were because he knew patients were dying and, despite his previous reports of the problem to VA leadership, nothing was being done about it (Foote 2014). Dr. Foote's statements are evidence that the VA had prior knowledge of the problem and that organizational culture within the VA was problematic. Dr. Foote explains that:

“It is apparent to me that the scheduling scandal is a symptom of a much more serious disease -- a mismatch between the V.A.'s mission and its resources. Today's V.A. health care system in general does a very good job at providing chronic care, and it excels at things like blood pressure and diabetes control. It has an excellent computerized records system that is second to none in transferring clinical information from facility to facility across the nation. Where it breaks down badly, especially out West and in other sparsely

populated parts of the country, is in the provision of urgent and emergency care where the distance to any suitable hospital, let alone a V.A. hospital, can be great” (p. 2).

Dr. Foote, who helped to bring this scandal to the public’s attention through his actions as a whistleblower, argued primarily that veterans were not receiving adequate care and were experiencing long delays in receiving care, despite multiple reports on the problems within individual health centers such as Phoenix.

Dr. Foote was not the only whistleblower to report the VA to *The New York Times* for discrepancies and outright accusations that the VA was falsifying veterans’ records and manipulating appointment schedules. Dr. Phyllis Hollenbeck explained that doctor shortages and an overwhelmed system could not keep up with patient demand (Oppel and Goodnough 2014). Oppel and Goodnough (2014) reported:

“Representative Jeff Miller, a Florida Republican who is chairman of the House Veterans Affairs Committee, said whistle-blowers at several veterans hospitals had told his staff members that they would be threatened if they failed to alter data to make patient-access numbers look good for their supervisors, one reason he has called for a criminal investigation into the Veterans Affairs hospital system” (p. 1).

Furthermore, *The New York Times* reported that anonymous whistleblowers revealed that clinic staff were instructed to falsify data in order to meet internal metrics for management (Oppel and Goodnough 2014). Oppel and Goodnough (2014) go on to report:

“But documents suggest that using the data in annual performance reviews may be commonplace. One review at a Pennsylvania veterans medical center showed that a significant portion of the director's job rating was tied to "timely and appropriate access," which would include waiting times for doctor appointments. One of those goals would be

met only if nearly all patients were seen within 14 days of their desired appointment date -- a requirement not found in the private hospital industry.

Schemes to disguise wait times generally followed a handful of approaches, whistleblowers and officials in Congress say. In Phoenix, where administrators were overwhelmed by new patients, many veterans were not logged into the official electronic waiting list, making it easier to cloak delays in providing care” (p. 1).

These articles provide further evidence that the VA had prior knowledge of problems in scheduling and patient wait times and that organizational culture led to the normalization of deviance. Additionally, articles demonstrate that knowledge of the problem was not limited to just employees but was more than likely encouraged by upper level management in order for management to meet performance goals.

The New York Times also reported that several additional doctors faced retaliation for reporting issues within the VA, including 37 cases that were investigated by the Office of Special Counsel (Lichtblau 2014). Lichtblau (2014) reported that:

"Dr. Jacqueline Brecht, a former urologist at the Alaska V.A. Healthcare System in Anchorage, said in an interview that she had a heated argument with administrators at a staff meeting in 2008 when she objected to using phantom appointments to make wait times appear shorter, as they had instructed her. She said that the practice amounted to medical fraud, and complained about other patient care problems as well. Days later, a top administrator came to Dr. Brecht's clinic, put her on administrative leave, and had security officers walk her out of the building” (p. 1).

Eight additional doctors and nurses spoke with *The New York Times* about reporting scheduling manipulation and other problems and the subsequent backlash that they faced as a result. *The New York Times* reported on the severity of the scandal throughout the end of May and into June.

When the Interim VHA report, *Review of Patient Wait times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System* (General 2014a) was released *The New York Times* summarized it and reported on its content to its readers. This report explained just how severe the consequences for veterans were, and outlined the types of delays they were experiencing (Oppel and Shear 2014). Oppel and Shear (2014) write:

“The scathing report by Richard J. Griffin, the acting inspector general, validates allegations raised by whistle-blowers and others that Veterans Affairs officials in Phoenix employed artifices to cloak long waiting times for veterans seeking medical care. Mr. Griffin said the average waiting time in Phoenix for initial primary care appointments, 115 days, was nearly five times as long as what the hospital's administrators had reported” (p. 1).

Oppel and Shear (2014) also write that Mr. Griffin, the acting secretary, reported that his office received “numerous allegations daily of mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior-level managers at this facility” (p. 1).

Further, the reporters pointed out that these delays were systemic throughout the VA and that manipulation may have occurred in order for employees of the VA to obtain better bonuses and pay increases. This suggests the normalization of deviance and organizational culture played a role in the delayed care veterans experienced.

Calls for Secretary Shinseki’s resignation would eventually be successful with the aftermath resulting in calls for an overhaul of the VA system and immediate fixes for veterans

whom have been denied access to care (Goodnough and Higuera 2014, Shear and Opperl 2014).

In interviews with veterans, Goodnough and Higuera (2014) explain:

“...veterans around the country expressed frustration with delayed access to care and what many described as an impenetrable and unresponsive bureaucracy at department hospitals and clinics, even as many praised the quality of care they received once they saw doctors. Their complaints -- including repeated canceled appointments and unreturned calls, lengthy waits for appointments and rapid turnover in physicians -- give voice to findings by the inspector general of the Department of Veterans Affairs last week that officials at the veterans medical center in Phoenix and elsewhere used a variety of schemes to hide increasingly long waits for medical care. The complaints were not independently verified” (p. 1)

Abuses within the VA were both systemic and a problem that the VA had prior knowledge of.

When an audit of VA facilities was released in June of 2014, *The New York Times* reported on veterans facing extensive delays amidst VA employees manipulating appointment schedules and falsifying records with threats of retaliation for reporting such behavior (Lichtblau 2014, Opperl 2014f, Opperl 2014g). Opperl (2014f) writes:

“The audit also found that 13 percent of patient schedulers said that they had been instructed by "supervisors or others" to enter false information related to how long veterans had to wait for appointments. Of the 731 facilities that were part of the audit, 112 have been flagged for further review. And the report seemed to confirm what many whistle-blowers had been saying, but which the department denied: that the goal of trying to schedule patients within 14 days had created perverse incentives for administrators because their job performance reviews were partly tied to how many patients were seen

within that two-week window. The goal of having patients see doctors and nurses within 14 days will no longer be included in employee performance contracts, the agency said” (p. 12).

Reports suggest organizational culture not only encouraged the falsification of records but actively punished those employees unwilling to participate in the scheme, as whistleblowers reported. Unfortunately, even a year after news of the original scandal broke, veterans still faced delays in care, long waits for appointments, and the VA itself faced a budgetary crisis, in part, due to paying for private care that it was unable to itself provide for veterans (Board 2015, Opiel 2015b, Shear and Philipps 2015).

Amidst the entirety of the scandal that engulfed the VA throughout 2014 and well into 2015 according to news reports, the actual consequences for those involved in perpetuating these acts were few and far between. The VA reported that only a handful of employees were actually punished, including the head of the problematic Phoenix, AZ VA who was fired (Opiel 2014b, Opiel 2014e, Opiel 2014f, Philipps 2015). Philipps (2015) writes:

“...the department punished a total of eight of its 280,000 employees for involvement in the scandal. One was fired, one retired in lieu of termination, one's termination is pending, and five were reprimanded or suspended for up to two months. The only person fired was the director of the Phoenix hospital, Sharon Helman, who technically was removed not for her role in the manipulation of waiting lists but for receiving "inappropriate gifts," according to the department. In a statement released Wednesday night, the department did not dispute the numbers released by the committee, but said that more than 100 other employees were facing disciplinary action” (p. 16).

Despite prior knowledge of the problem and public outrage over the consequences veterans faced as a result of the VA's action, news reports indicated that the VA did little to punish those responsible largely due to an organizational culture of normalized deviance. Veterans, however, continued to face additional consequences due to delays in care and inadequate care.

The New York Times reported on consequences veterans faced, ranging from chemical exposures (Chivers 2014), suicides (Buzzell 2014, Oppel 2015a, Philipps and Oppel 2015, Smith 2014), and homelessness (Huetteman 2014, Sotak 2014a, Sotak 2014b). In 2014, Congress put forth a bill to extend treatment for care for mental illness for veterans following the increase in veteran suicide rate to 22 veterans per day (Smith 2014). Smith (2014) writes:

“Volunteers in dark green hooded sweatshirts spread out across the National Mall on Thursday, planting 1,892 small American flags in the grass between the Washington Monument and the Capitol. Each flag represented a veteran who had committed suicide since Jan. 1, a figure that amounts to 22 deaths each day” (p. 18)

According to *The New York Times* reports, veteran suicide rates did not see much change, but legislation did successfully pass Congress in early 2015 unanimously to provide support for at risk veterans (Oppel 2015a). The bill, named for veteran Clay Hunt, aimed to increase suicide prevention programs within the VA and subject such programs to outside evaluations. Oppel (2015) explains that:

“Another provision will create a peer-support pilot program in at least five of the agency's 22 regional networks, with the intention of quickly matching returning veterans with colleagues they can talk to and confide in about mental health concerns. The measure also calls for the creation of an interactive website with all of the department's mental health and suicide prevention resources so that veterans -- and spouses and

parents -- can find help. It provides for medical school debt repayments for psychiatrists who join the agency, reflecting the department's extreme difficulty recruiting mental health professionals. And it includes a provision extending by one year the period under which returning late-stage combat troops who served in Iraq and Afghanistan can obtain Veterans Affairs health care without first proving a service-related disability” (p. 14).

According to *Times* reporters, attempts to address veteran suicides were made within the VA; however, suicide rates and consequences for veterans, such as delays in care, remained high. Delays in veteran access to care may have been related to some suicides within the Phoenix, AZ VA, for example (General 2014a). A news article opined that new technology hopes to incorporate databases to track at risk veterans and offer an early intervention by predicting which veterans are most at risk for suicide (Philipps and Oppel 2015).

Despite official VA, VA leadership, and political talk about ending homelessness, homelessness for veterans remains a problem as reported in 5 articles. Sotak (2014) explains that much of the work to help homeless veterans is done at the local level through local, grassroots, organizations. While these organizations are performing important work, the VA must also step in and pick up the burden that veterans face. Huetteman (2014) writes, “[m]ore than 80 state and local officials committed to try and end the problem of homelessness among veterans by the end of 2015, the Obama administration announced Wednesday, news that comes amid a scandal over medical care for veterans.” (para. 1). Despite progress to end veteran homelessness, the goal of ending homelessness by 2015 was not met. The Department of Veterans Affairs (2016) estimated that there were still about 40,000 homeless veterans during the annual point-in-time count conducted in January of 2016.

Beyond reporting on the problems itself, in analyzing media reports within *The New York Times* between January of 2014 through the end of December 2015, it is clear that the Department of Veterans Affairs had extensive prior knowledge of the problem of veteran scheduling manipulation and the delays in care that veterans faced, that the VA failed to address these problems in a timely or adequate manner, that organizational culture created a situation that allowed for the normalization of deviance to occur, and that there was resulting a significant public and political response to these actions. Through the VA's omissions and commissions, veterans faced a grave social harm not only in delays or blocked access to care but also in other outcomes such as homelessness, suicide, and PTSD.

CONCLUSION

This chapter analyzed media reports collected from *USA Today* and *The New York Times* during a period of January 2014 through December 2015. Media reports focused on the accusations the VA faced regarding the manipulation of veteran appointment schedules, the falsification of records, and the subsequent investigation that occurred. The significance of each data point was reviewed and it was determined that indicators of a state crime of omission or commission were present within the data. Indicators used to determine if a state crime occurred included: 1) was there documentation of government failure to act in both a timely and appropriate manner, 2) was there prior knowledge of the problem, 3) what the response to the problem has been, if any, and 4) whether organization culture was an issue leading to the normalization of deviance. This chapter also analyzed whether social harms to veterans resulted due to the VA's actions and inactions and determined that veterans faced direct consequences due to delays in their care and increased rates of suicide, homelessness, and PTSD.

Articles contained details on the consequences veterans face resulting from inadequate care and from their experiences with the VA not providing timely access to care. Furthermore, articles detailed information on VA leadership and the politics and partisan differences resulting in attempts to find a solution in Congress to address the VA's issues. While both newspapers contained similarities in the types and quality of articles examined, significant differences exist within the tone and content of some article categories. Media reports also illustrate a public discourse that emerges within the narrative surrounding the accusations levied at the VA. This discourse is continued through the VA's data. Some of this data, including Veteran Health Administration reports and Freedom of Information Act requests, resulted directly from the efforts of whistleblowers and investigative journalists.

The next chapter provides an overview and analysis of data collected from the Monday Morning Workload Reports (MMWR), the National Survey of Veteran's, the Interim and Final VA report regarding the accusations of falsifying appointment scheduling records, and a third report reviewing mismanagement at VA health eligibility centers.

CHAPTER VI

FINDINGS AND ANALYSIS: VA DATA

This chapter focuses on the findings and analysis uncovered within the three sources of data obtained from the VA itself. Discussions of data begin with data in the Monday Morning Workload Reports, continue to the Department of Veteran's Affairs National Survey of Veterans, Active Duty Service Members, Demobilized National Guard and Reserve Members, Family Members, and Surviving Spouses, and end with discussion on the Veterans Health Administration (VHA) reports. In discussion of all reports, the goal is to determine if there was documentation of the VA's failure to act, what prior knowledge, if any, the VA had about these issues, the response the VA had to the problem, and if organizational culture contributed to this issue.

MONDAY MORNING WORKLOAD REPORTS

The Monday Morning Workload Report (MMWR) is the weekly workload report used by the Department of Veteran's Affairs to measure weekly workloads across the VA. It serves to "display a snapshot of the Veterans Benefits Administration's (VBA) workload as of a specified date, typically the previous Saturday" (Integrity 2015). The Monday Morning Workload Report contains several parts. The data used within this dissertation includes information from the "Transformation tab" and "The Traditional Aggregate (TA)" tab, displayed as separate worksheets in each weekly Excel report. The transformation tab contains national totals for pending compensation, pension, and education cases currently in the workload of the VBA. The traditional aggregate tab contains "national, district, and regional office or state level data for different groups of claims, including non- Rating Bundle, entitlement bundle, award adjustments

bundle, program review bundle, other bundle, burial claims, accrued claims and appeals” (Integrity 2015).

Understanding Structures of the MMWR

The MMWR contains information on the VBA’s workload which is measured through the use of “end products” outlined in the M21-4 Manual, Appendix B. The M21-4 Manual, or the Manpower Control and Utilization in Adjudication Divisions, provides descriptions of how staff should measure the workload of the VA, and the measurement and reporting structures used. The overall system used to tally end products is the Veteran Service Center(VSC)/Pension Management Center (PMC) and measurements collected include staff allocation and alignment, claims processing accuracy, rework, and timeliness, inventory control, management analysis and evaluations, and customer service outcomes (Affairs 2017a). The M21-4 Manual explains that end products (EP) are the way in which workload is managed and monitored within both the VSC and PMC. Furthermore, “[r]eceived and completed EPs are also used to formulate the annual budget submission to the Secretary, Office of Management and Budget (OMB), the President, and Congress (Affairs 2017a). The VA has a vested interest in fully developing end products and completing veteran claims.

According to the M21-4 Manual, “[e]ffective workload management and inventory control includes constant monitoring of all available systems to ensure that claims are promptly put under control, completely developed the first time, and decided timely according to Veteran’s Benefit Administration (VBA) priorities and targets” (Affairs 2017a). The VA guidelines place a value on both the quality and accuracy of service that veterans are receiving.

Throughout the history of the MMWR and use of end products, the reporting structures have undergone multiple changes, purportedly to promote transparency and ease of use of the reports.

It is important to note that per the VBA's explanation of the type of data contained in the MMWR reports, information is only compared within the tab (Excel worksheet) it was found in. No comparisons are drawn between information found on the transformation tab with information found on the traditional aggregate tab (Integrity 2015). The VBA explains that rating bundles are not compiled using the same end products on each tab (worksheet) thereby making comparisons impossible. According to the VBA then, it is only possible to compare data within individual worksheets and not across them, despite the data often being culled from one source.

The MMWR has undergone two key changes during the time period under consideration beginning with those made to the October 5, 2009 report. For purposes of this dissertation though, differences in the MMWR will only be discussed when it impacts data collection or the overall compensation and pension (C&P) bundle used to determine veteran benefits. First, in October of 2009, the MMWR was completely redesigned in order to promote transparency and make the report easier for the reader to understand. The report underwent significant changes wherein additional data was included and the C&P rating bundle was altered to meet specific goals first introduced by a new GI Bill authored by Senator Jim Webb (D-VA). This bill which was approved by President Bush and expanded upon by President Obama and Congress to promote transparency in the VA, provide better support for veterans, and to increase education benefits available to veterans (Post 2008).

Second, in addition to a visual overhaul and an overhaul in how C&P ratings were being reported, the MMWR changed its tracking procedures to reduce the time before a record is

flagged from 180 days (pre-October 5, 2009) to 125 days (post October 5, 2009). This dramatically increased the number of pending claims flagged by the VA. Due to this methodological change in the reporting and flagging process within the MMWR reports, this dissertation will examine data contained in the MMWR in two sequences—one from 2004 to September 2009 with cases pending >180 days and one from October 5, 2009 to December 2016 with cases pending >125 days.

To fully understand the MMWR, it is important to understand what information is contained within the report, including what the End Products are. Appendix B of the M21-4 Manual outlines the specific End Products assigned to a variety of outcomes and claims veterans may have, and further details specific circumstances and results that EP's may qualify veterans for. There are eight Rating Bundle End Products that have been continuously listed within the MMWR. They are EP 010, Initial entitlement for service-connected disability (≥ 8), EP 110 – Initial entitlement for service-connected disability (≤ 7), both under Original Entitlement – Veterans, Ep 140 – Initial claims from surviving spouses, children or parents, under Original Entitlement – Survivors, EP 020 – Increased evaluation and/or additional claims conditions, EP 320 – Increased entitlement due to hospitalization or surgery, under Supplemental Entitlement, EP 180 – Initial entitlement – Veteran, EP 120 – Increased entitlement and/or reconsideration, under Pension Original Entitlement, and EP 310 – Future examination for disabilities, under Award Adjustments. Four additional EP's were added related to claims tied to Agent Orange in 2010. These are EP 681 – Reopened or new Agent Orange claims prior to August 30, 2010, Ep 687 – Nehmer review cases based upon new Agent Orange presumptive, EP 405 – Reopened or new Agent Orange claims after September 1, 2010, and EP 409 – Agent Orange claims where an interim decision was provided. These four EP's were changed to have a designation of Agent

Orange EP as of November 2010. EP 681, 687, and 405 were added to the MMWR on November 1 of that year while EP 409 was added December 13, 2010. Noting these additions are important to clearly understanding numbers within the MMWR.

Prior to November 1, 2010, the four Agent Orange EP's (681, 687, 405, 409) were not included in the Compensation and Pension Rating Bundle and were therefore excluded from the VA's goal target calculations (including claims pending over 125 days and accuracy goals). Four EP's were also removed from the MMWR's Compensation and Pension Rating Bundle and while they remain an Entitlement Bundle EP, they are no longer counted with the 12 targeted EP's in the C&P Ratings Bundle. These four EP's are EP 095 -Initial entitlement decisions for Vocational Rehabilitation and Employment, EP 420 - Spina bifida and/or birth defects reconsideration, EP 410 - Initial claims from children of Veterans with Spina bifida and/or birth defects, and EP 190 - Initial entitlement – Survivor's Pension.

While data for this dissertation is only collected from the Traditional Aggregate and the Transformation tab within the MMWR, it is relevant to note that the majority of the reports have hidden tabs or spreadsheets within each file. Earlier reports contain additional sheets with calculation data on the workload within each VA location, region, and a breakdown of the number of EP's and how many claims are filed within each. This is typically found on the VOR Summary sheet. Another sheet breaks down the number of Spina Bifida claims and calculations by regional office and another is the SOP, or Standard Operating Procedure where instructions for VA employees on how to log in and report claims is located. Later years of the MMWR have additional information included on the calculation of the accuracy of reporting. While these sheets are not necessary to review for the average viewer, they do contain additional information that may be useful for breaking down VA workload management by region.

The MMWR Data

This dissertation first examines two sequences of data from the MMWR: first is the Compensation & Pension Ratings Bundle Claims and Compensation & Pension Ratings Bundle Claims Pending Over 180 Days from January 05, 2004 through September of 2009, second is the the Compensation & Pension Ratings Bundle Claims and Compensation & Pension Ratings Bundle Claims Pending Over 125 Days from October of 2009 through December of 2016. Within this data, it is important to remember that we are looking for indicators of state crime, in particular, whether the VA had prior knowledge of the delays in receiving care veterans face.

Figure 2 compares the Compensation & Pension Ratings Bundle from January of 2004 through September of 2009 to those claims pending over 180 days during that time frame. Compensation & Pension Ratings Bundle Claims pending over 180 days represent a part of the total number of claims pending and once a claim is defined as pending for longer than this time frame, it is considered to be backlogged. During 2004, the number of claims pending within the Compensation & Pension Ratings Bundle hovered around 350,000 claims, increasing to 400,000 pending claims by 2006 through 2008 and topping out at around 420,000 claims pending by September of 2009. Claims pending increased from 2004 to 2009 with some variation from week to week. Weekly variation is demonstrated by the jagged nature of the time series scatter line graph for this period. Variations exist month to month with claims continually decreasing and increasing; however, overall trends throughout this period showing steady increases, a decrease and then continued upward trend as it gets closer to the end of 2009.

Those claims pending over 180 days started around 88,000 in 2004, decreased to 66,000 by July of 2004 before continuing a pattern of increasing and decreasing until the backlog peaks at just over 116,000 in April of 2007 before decreasing to 88,000 again by September of 2009.

The following time frame shows both an increase in the number of veterans making claims and increases in claims that occurred through systematic changes made to the MMWR by the VA. Changes made to the MMWR, according to the VA, were made in order to be more transparent in how the data was presented.

Figure 3 the Compensation & Pension Ratings Bundle from October of 2009 through December of 2016 to those claims pending over 125 days during the same time. This time frame used 125 days as the metric to measure the backlogged claims, a change the VA made in order to increase transparency. Both lines on the time series scatter plot in Figure 3 follow the same general pattern where we see a steady increase until there is a sharp vertical increase in 2010 from the inclusion of Agent Orange claims, a continued increase throughout 2011, 2012, and decreases in pending claims beginning by the end of 2013 and continuing until they level off by the end of 2015.

There are three key characteristics of the data in Figure 3 on Compensation & Pension Ratings Bundle. The first includes the sharp increase notated as a vertical line in the Compensation & Pension Bundle Rating claims. This vertical increase in the chart is the point at which Agent Orange claim EPs were moved in to the C&P Ratings Bundle calculations; roughly 150,000 claims were added to the pending claims at this time. October 25, 2010, pending claims were at 550,346 and following the change in Agent Orange claims, pending claims jumped to 709,772. The second occurs when pending claims peaked at over 883,000 in July of 2012. Finally, the third occurs in April of 2016, when Compensation & Pension Ratings Bundle claims were reduced to 341,929 before they slowly increased through the remainder of the year. December 31, 2016 had 389,824 recorded claims.

The time series scatter plot for claims in this period that are backlogged, and pending over 125 days, follows a similar pattern to those claims in the Compensation & Pension Bundle Rating. There are four important characteristics within the data. First, the pattern includes a sharp increase in 2010 with the inclusion of Agent Orange claims, and a steady increase through 2012 before a slow uneven decline begins. Second, on July 26, 2010, backlogged claims pending over 125 days were recorded as 196,413 claims but the following week, August 02, 2010, only 144,127 claims were recorded as pending over 125 days. Third, the reported claims on August 09, 2010 appear to correct within the data and the backlogged claim number returns to 198,002 claims. Finally, it appears that this data was moved to Compensation Award Pending Claims over 125 Days. The data was moved back to C&P the following week.

In addition to the change in Agent Orange claims, 2010 also had several points where oddities exist in the data—either data was moved around as in the previously mentioned example, or data does not seem to appear to be calculated correctly in the MMWR it is pulled from. These oddities in the data are significant because the Compensation and Ratings Bundle is the data that the VA uses to assign resources to meet internal metrics and to meet demand within the VA. If oddities exist, or data is reported incorrectly, veterans may face an additional barrier to care through mismanagement of resources. The best example of this occurs during the week of August 02, 2010. This MMWR has several oddities including negative numbers for reported workloads and instances where the number of pending claims over 125 days are higher than the number of actual pending claims despite the backlogged number being a subset of the total pending claims. The only notation to explain these is that the report has been “revised to more accurately categorize the Agent Orange presumptive workload” (Integrity 2015, MMWR 2016). The MMWR’s through August, September, and October of 2010 have the same notation with a

notation that “[a]s of 10/30/10 Agent Orange presumptive claims (Eps 681, 687, and 405) are counted as entitlement rating claims” appearing in the November 01, 2010 report (Integrity 2015, MMWR 2016).

For example, under Compensation, Original Entitlement – Veterans, EP 095 has 457 claims pending but 54,601 claims pending over 125 days, 11,947.7% of the total and EP 010 has 30,150 claims pending and 69,855 claims pending over 125 days, or 231.7% of the total. Compensation Award Adjustments, EP 130, Dependency, has 42,555 claims pending and 116,857 claims pending over 125 days; EP 133 has 7 pending and 252 pending over 125 days; and EP 290 has 29,010 claims pending and -5,223 claims pending over 125 days.

Under the Pension Award Adjustment Eps, EP 050, Annual eligibility verification reporting – no adjustment, reports 0 pending claims but 3,585 claims pending over 125 days. Similarly, in the same category, EP 135, Hospitalization adjustment (non-rating) reports 1,245 claims pending but 15,380 claims pending over 125 days which is 1,235.3% of the total. Under the Award Adjustments category, EP 297, Misc. determinations also seems to have an error in reporting with 11,205 total pending claims reported and 18,964 claims reporting as pending over 125 days, 169.2% of the total claims pending. EP 696 has 60 claims reported as pending and 4,942 pending over 125 days which is 8,236.7% of the total while EP 697 has 2,211 claims pending and 10,816 claims pending over 125 days, 489.2% of the total. Additional oddities exist under Compensation Program Reviews, Other, and in the Pension worksheets as well.

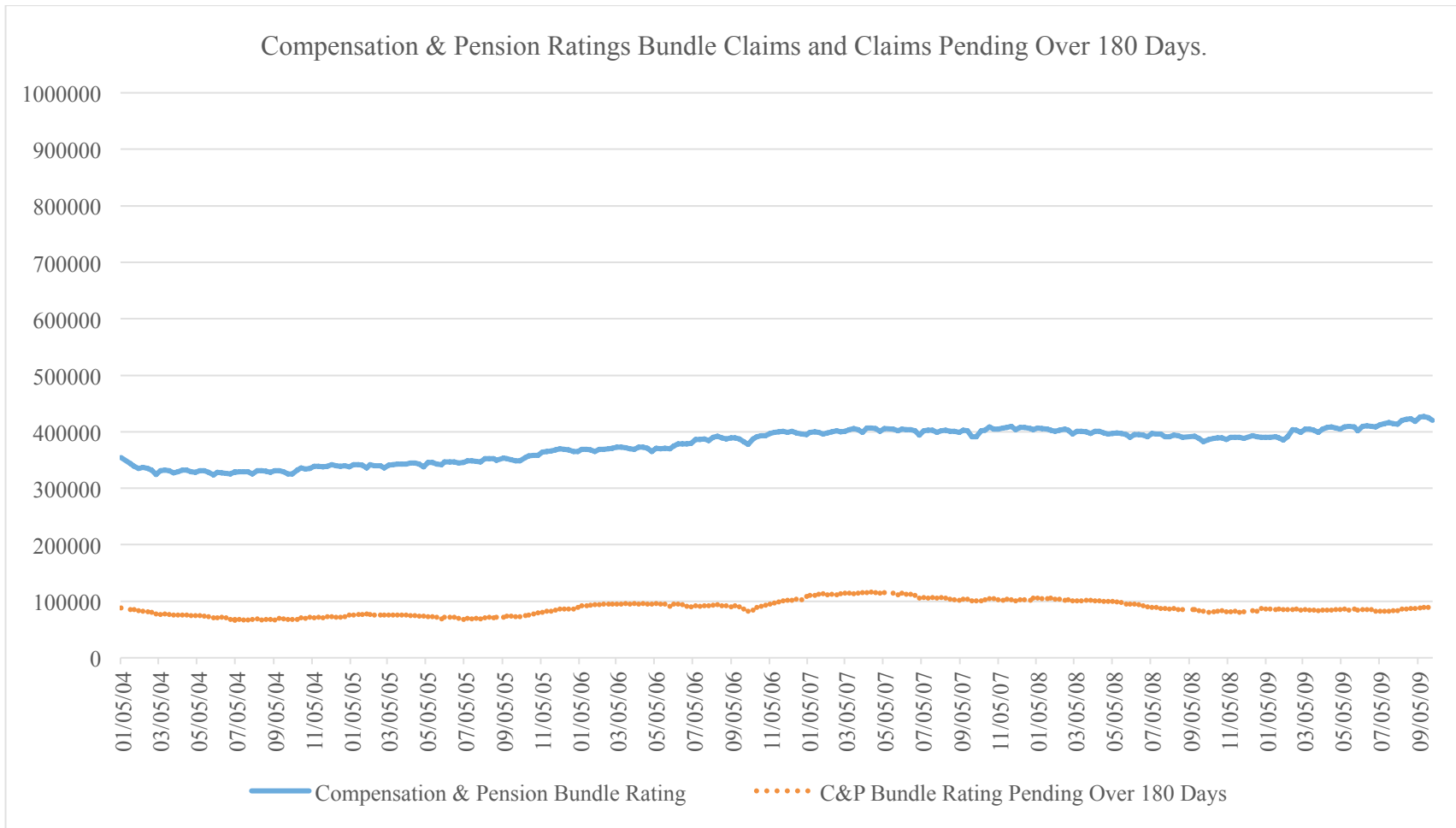


Figure 2: Compensation & Pension Ratings Bundle Claims and Claims Pending Over 180 Days.

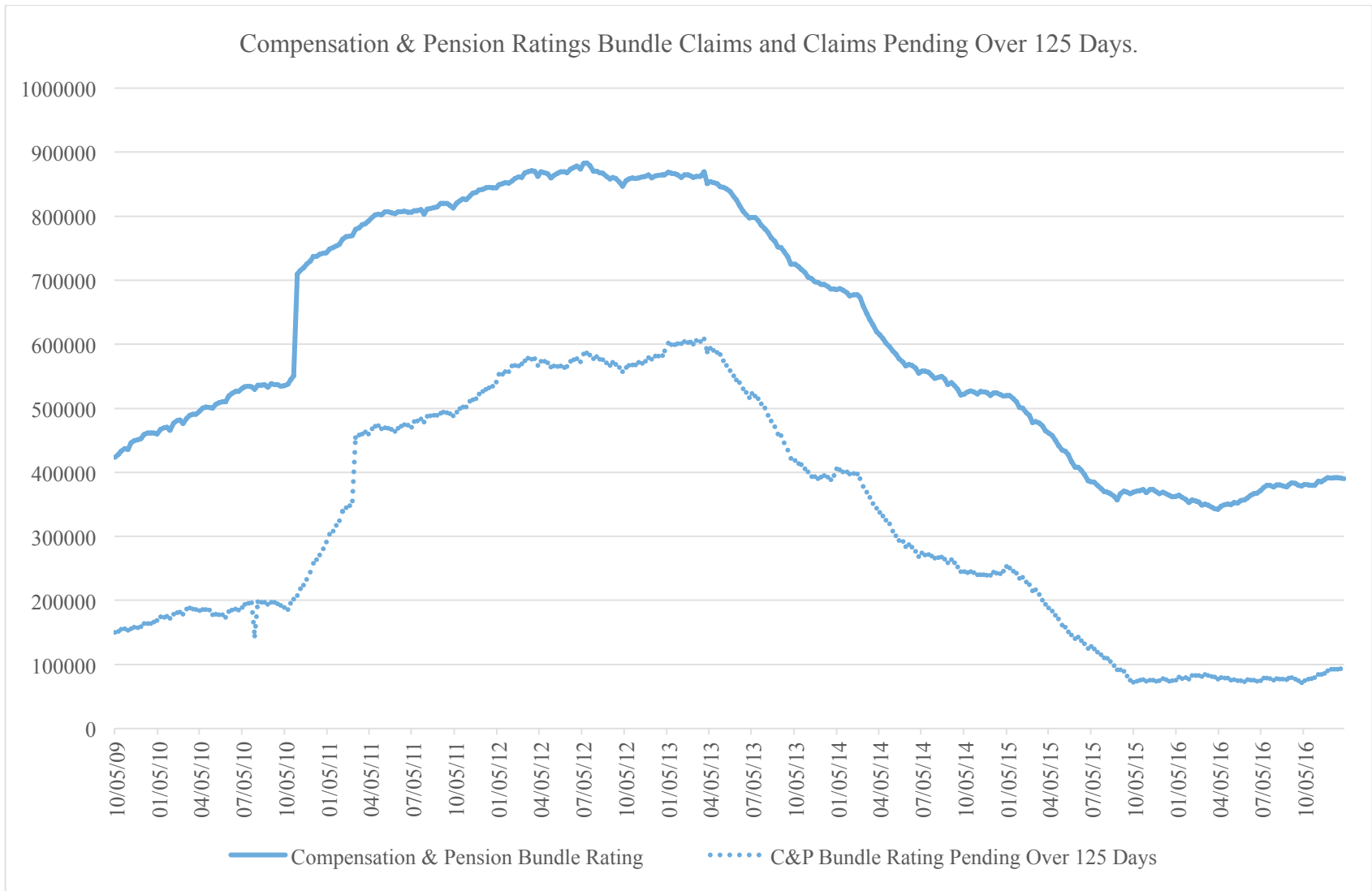


Figure 3: Compensation & Pension Ratings Bundle Claims and Claims Pending Over 125 Days.

While much of this data is not included in the VA's official metric of the 12 End Products that make up the Ratings Bundle, this data is relevant because data is often moved in and out of these categories. In addition to data being moved around on a permanent basis, such as with the Agent Orange claims, data is sometimes pulled from one category and returned the following week without justification from the VA. Furthermore, this data provides an overall picture of the claims that the VA is processing, not just the Ratings Bundle claims. There are many more veterans with 100,000s of claims still pending. Therefore, it is important to consider the full scope of the MMWR and not just the Compensation and Pension Ratings Bundles. Since this data provides a snapshot of the week-to-week workload within the VA, it is important to look for evidence that the VA had prior knowledge of the problem, an indicator of state crime. If the VA consistently knew that the numbers of veterans with backlogged cases was not decreasing, then it calls in to question if organizational culture is problematic.

Figure 4 compares the Compensation Entitlement Claims, which includes Original Entitlement – Veterans, Original Entitlement – Survivors, and Supplemental Entitlement, and Claims Pending Over 125 Days. When looking at Figure 4, trends in the data follow similar patterns in Figure 3 in that there is a steady increase in the data in 2009, a vertical increase representing the inclusion of Agent Orange claims, and continued increases from that point until claim amounts begin to level off in 2012 and decrease in 2013. Some of the EP's measured in the C&P Ratings Bundle are measured in the Compensation Entitlement Claims, therefore it is expected to see similar trends. However, these numbers also include EP 420 - Spina Bifida and/or birth defects reconsideration, EP 410 – Initial claims from children Veterans with Spina Bifida and/or birth defects, and EP 095 – Initial entitlement decisions for Voc Rehab. Unlike the C&P Ratings Bundle, EP 310, EP 180, and EP 120 are not included.

Pending Compensation Entitlement claims were around 388,000 in October of 2009 and they increased to 513,139 claims before Agent Orange claims are added in, wherein claims increase to 673,314. Claims in this category peaked at 843,533 in July of 2012 before slowly declining to 363,986 by December of 2016. Compensation Entitlement claims pending over 125 days were at 142,652 claims in October of 2009 and peaked at 588,959 in March of 2013 before eventually declining. In October of 2016, claims fell as low as 70,770 before increasing to 94,845 claims by December of 2016. It is notable that in both January of 2014 and 2015 there is a leveling out effect in the time series scatter chart where claims momentarily increase before beginning to decline again.

Figure 5 shows the Compensation Program Claims and Compensation Program Claims Pending Over 125 Days. This time series scatter chart shows several sharp increases and decreases within the data, some for unclear reasons. Pending Program Claims begin at 22,129 claims in October of 2009 and peak at 140,154 claims on June 28, 2010. The next three weeks of July continue to show increases, to 147,413 claims on July 19th before dropping back to 17,866 claims on July 26, 2010. It is not immediately clear where this data came from or where it went after this period ends. The changes to Agent Orange claims occur shortly after this period but the number of claims involved are double these numbers. In analyzing the data, and reports from the VA for this time, it is unclear why this occurs.

Steady increases continue until October of 2012 where a similar vertical increase in the data is visible wherein claims jump from 53,732 October 29, 2012 to 75,532 on November 05, 2012. Claims do decrease some but not nearly the amount they increased before there are several increases and decreases and another substantial increase in 2015. Pending claims increase from 84,607 on November 09, 2015 to 110,282 claims on November 16, 2015 and then increase again

to 131,921 claims on December 21, 2015 before seeing another decrease and slow increase. Claims significantly decrease and level off beginning on September 24, 2016 when claims go from 126,985 to 107,128 on October 01, 2016.

Pending Program Claims over 125 days follow similar increases and decreases as the pending claims; however, the increases occurring in 2010 is not as sharp or significant as presented in the pending claims. Claims here increase steadily from 9,108 in October of 2009, to 37,510 pending over 125 days on July 19, 2010. However, claims decrease dramatically to 7,601 by July 26, 2010 and as low as 867 by August 02, 2010. Program claims pending over 125 days then follow similar patterns as claims pending and increase to 86,999 claims pending over 125 days by the end of 2016.

Figure 6 is a time series scatter chart comparing the Compensation Award Pending Claims and the Compensation Award Pending Claims Over 125 Days. Compensation Award Pending claims in this category begin at 148,042 in October of 2009 and steadily decrease to 99,638 claims until September 07, 2010 where claims increase to 100,066 by September 13, 2010. Claims in this category continue to increase until they level off a little in 2014, with 440,979 claims on August 04, 2014, before a sharp increase to 470,498 claims on August 11, 2014. By July 13, 2015, pending claims peak at 504,355 before they begin an accelerated decline to 364,725 on June 27, 2017 before jumping the next week, July 04, 2016, to 455,192 claims. Claims declined for several weeks to 425,936 by September 10, 2016 before dropping sharply again to 342,664 on September 17, 2016.

Unlike pending claims, those claims backlogged over 125 days in this category follow the same general pattern of increasing steadily and then declining but this time series lacks the sharp increases and decreases the non-backlogged claims has. Compensation Award claims

backlogged over 125 days began at 47,131 in October of 2009 and steadily declined to 26,801 on July 26, 2010 before they peaked sharply to 115,520 claims on August 02, 2010. The following week, August 09, 2010, claims dropped back to 26,321 backlogged claims pending over 125 days for this category. This increase and decrease aligns with the decrease and increase that occurred in Figure 3 during the same time. Therefore, it is most likely that data was moved from the Compensation and Pension Ratings Bundle pending over 125 days to the Compensation Award Claims pending over 125 days.

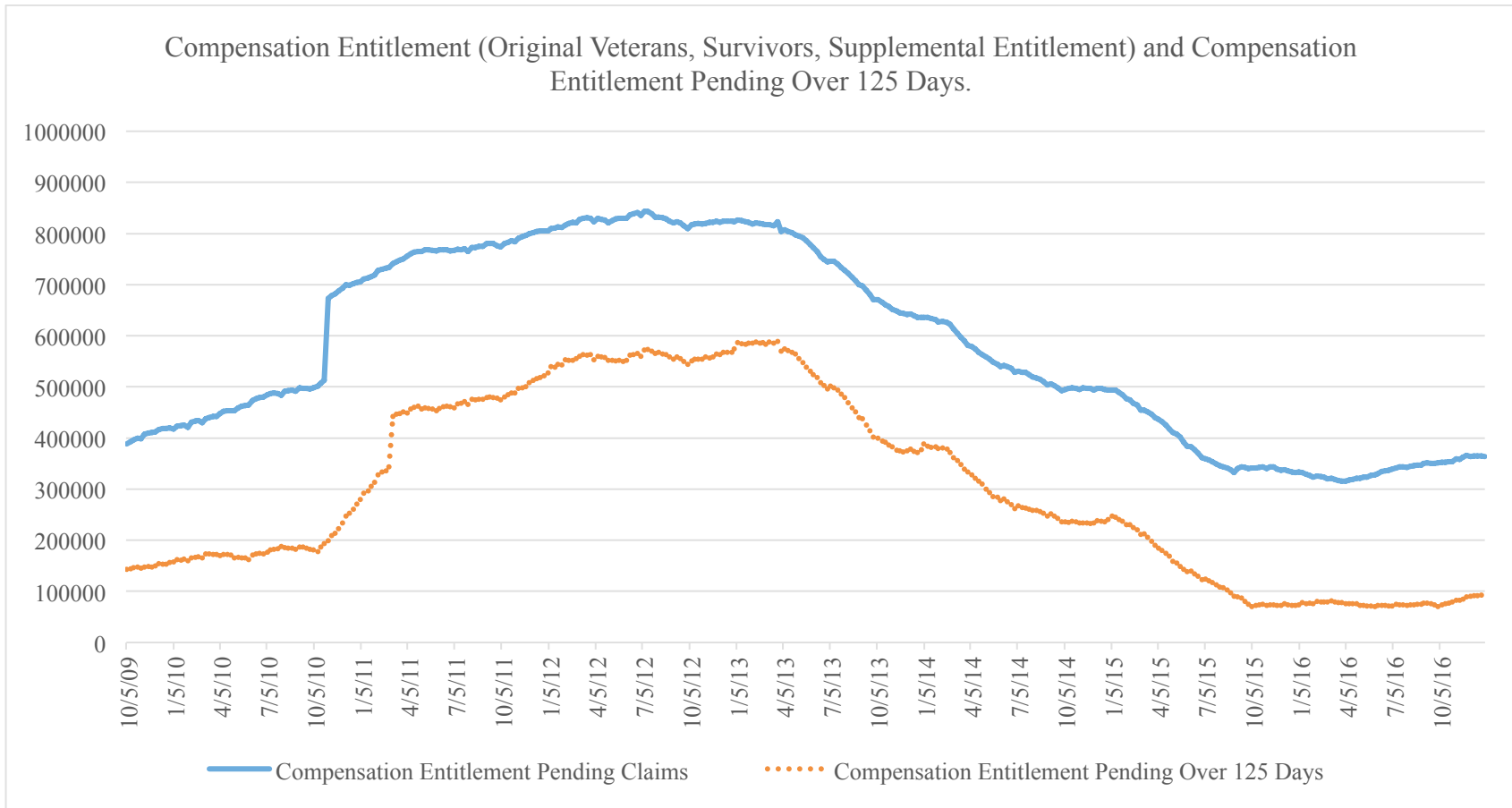


Figure 4: Compensation Entitlement (Original Entitlement – Veterans, Original Entitlement – Survivors, Supplemental Entitlement) Claims and Claims Pending Over 125 Days.

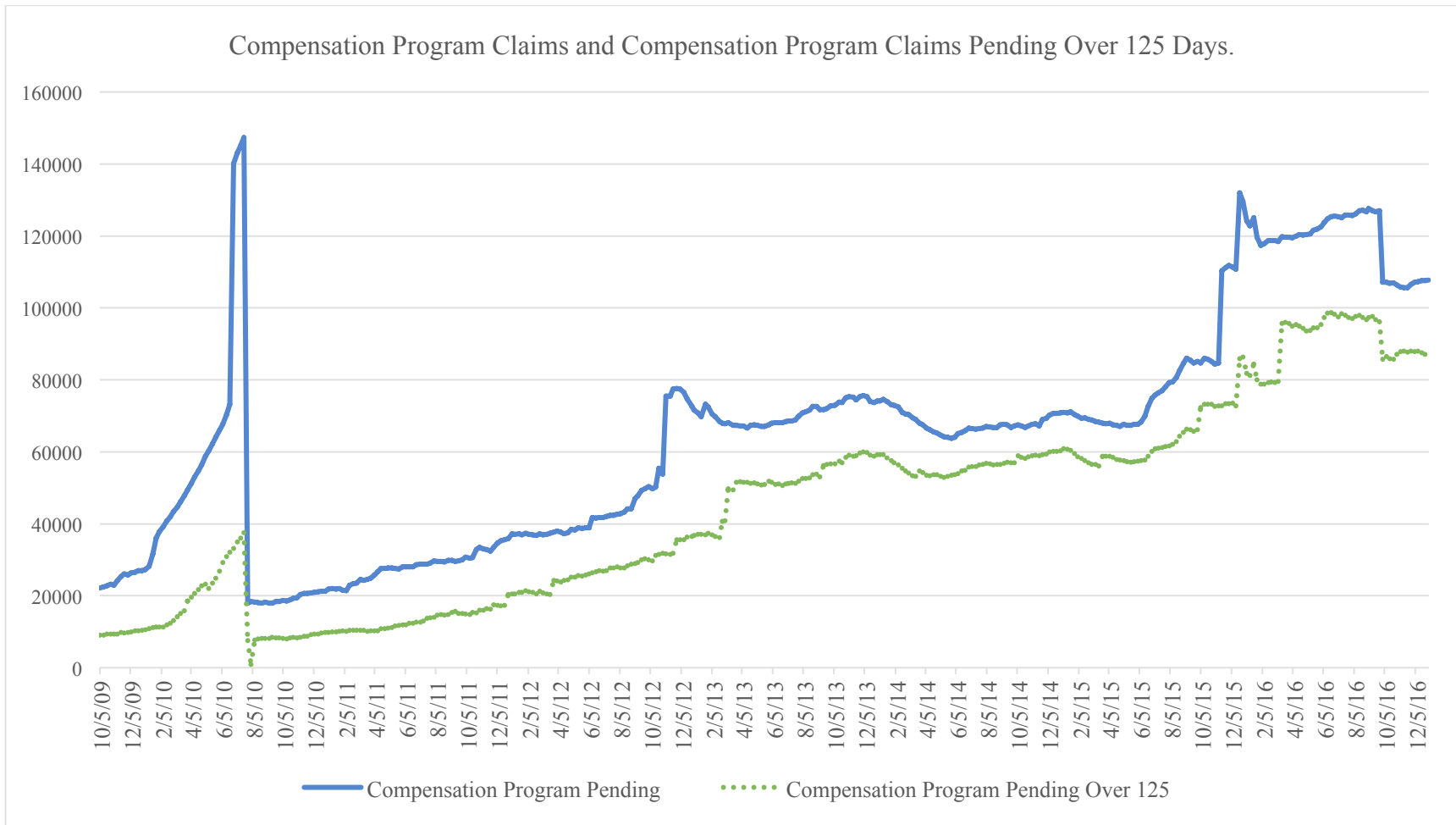


Figure 5: Compensation Program Claims and Compensation Program Claims Pending Over 125 Days.

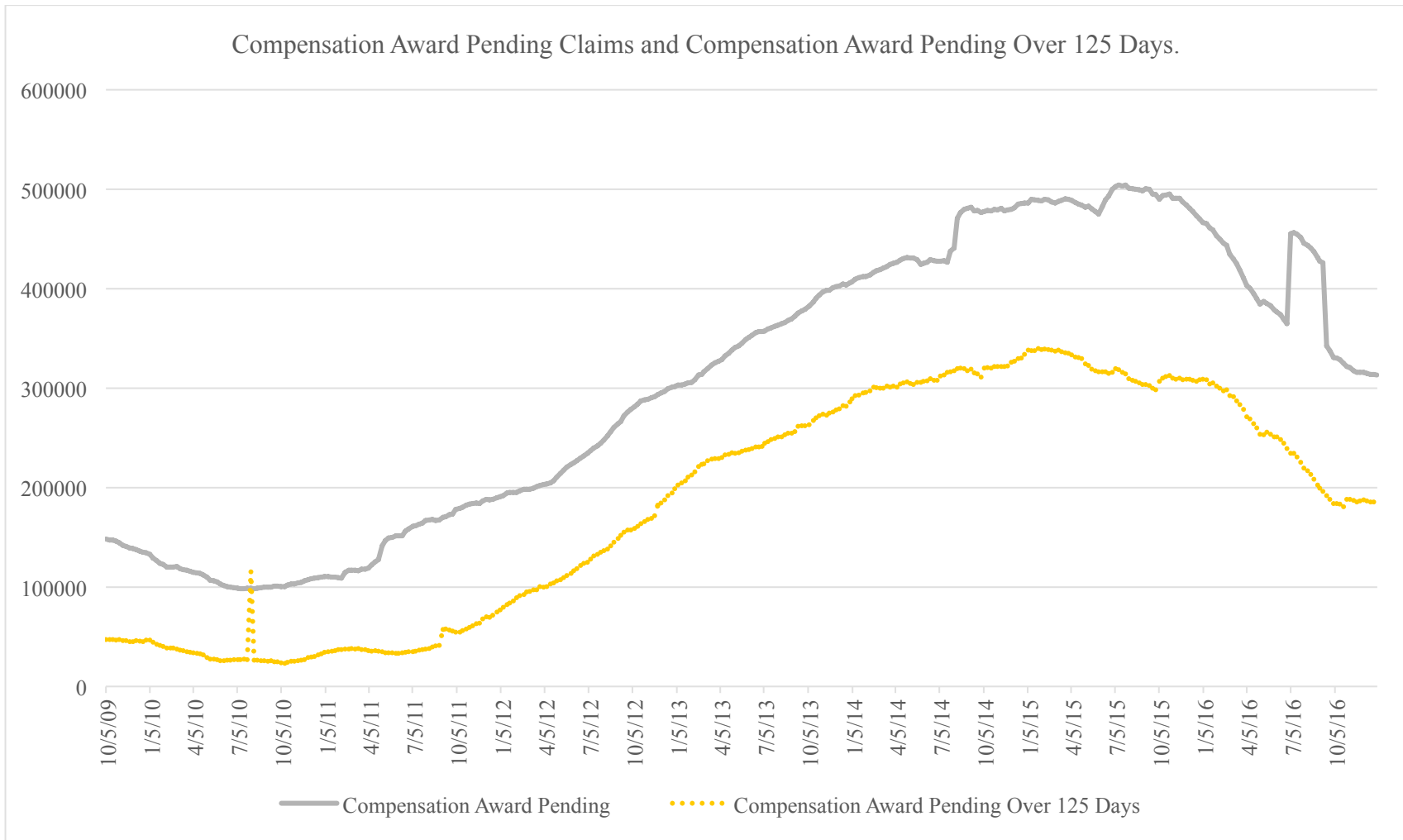


Figure 6: Compensation Award Claims Pending and Compensation Award Claims Pending Over 125 Days.

Figure 7 compares the Compensation Other Claims and Compensation Other Claims Pending Over 125 Days. Compensation Other Claims include claims related to correspondence, Freedom of Information Act (FOIA) requests, Pre-decisional hearings, and error corrections. Claims in this category slowly increase from October 2009 with 27,635 claims to July 26, 2010 with 39,052 claims before a significant jump occurs on August 02, 2010 to 163,694 when Agent Orange claims are briefly tracked in this category. Claims increase at a sharp rate until October 25, 2010 with 198,047 claims, where they then drop back to 49,577 on November 1, 2010. This drop is where the VBA moved the data from this category to the Compensation & Pension Ratings Bundle and began tracking Agent Orange claims within its targeted EP's.

Claims increase through 2012 where they begin decreasing once again before another jump over the next few weeks from 78,626 claims on February 27, 2012 to a high of 168,128 on July 02, 2012 before decreasing again. Another steady increase occurs through 2013 at an increasing rate before claims level off around 180,000 before dropping again on October 13, 2014 to 157,340 and peaking over the next few weeks to 276,110 on April 20, 2015 before once again sharply declining, leveling off, declining again, and then increasing. By December 31, 2016 there were 163,269 claims pending in the Compensation Other category.

Backlogged claims in the Compensation Other category follow pending claims closely while not experiencing as sharp increases or decreases outside of the movement of Agent Orange claims in 2010. The time series chart shows backlogged claims beginning at 15,176 in October of 2009, increasing first to 45,060 in August 02, 2010 and then to 63,562 by September 27, 2010 at a steady rate before jumping significantly to 127,111 by October 04, 2010. Backlogged claims follow a similar pattern as pending claims here where they increase steadily up to 136,609 on October 25, 2010 before dropping to 21,054 by November 01, 2010. Backlogged claims follow

the pattern of pending claims as shown in Figure 7 and peak at 137,158 on July 07, 2014, decline, and then peak again on April 27, 2015, with 167,320 claims backlogged over 125 days. By the end of December 2016, backlogged claims decline to 116,570 days, more than 100,000 claims higher than the starting point. Outside of data movement surrounding Agent Orange claims, it is unclear why so many data changes occurred within this period in this category.

Figure 8 compares Pension Entitlement, including Original Veterans, Survivors, Supplemental Entitlement, and Pension Entitlement Pending Over 125 days. This includes two ratings bundle EP's, EP 180 - Initial entitlement veteran, and EP 120 - Increased entitlement and/or reconsideration in addition to EP 190 Initial entitlement survivor. Pending Pension Entitlement claims increased to 74,974 on August 02, 2010, decreased to 54,474 in February 28, 2011 and increased to 73,936 on November 28, 2011 before they dropped sharply to 29,389 December 05, 2011 until the following week where claims returned to 74,082. Claims in this category leveled off for the most part with some increases and decreases until they increase through the beginning of 2013, peaking at 87,211 on May 20, 2013 before steadily declining over the next year. By the end of 2016, claims in the Pension Entitlement were at 23,946.

Figure 8 shows Pension Entitlement claims pending over 125 days and backlogged claims follow a similar plot as the pending claims. Claims begin at 15,637 on October 05, 2009 and trend upwards before decreasing again by the end of the year. There is a temporary drop where claims pending over 125 days go from 26,494 on July 26, 2010 to 18,261 on August 02, 2010 and then back to 26,397 on August 09, 2010, a difference of about 8,000 claims. It appears this data was recorded in the Pension Program claims pending over 125 days before being moved back to its original category (see Figure 10). It is not always clear why data is moved from claim group to another and because of this, it is important to notate when it happens at significant

levels. A sharper drop occurs with the pending pension claims on December 05, 2011, where claims drop from 33,785 on November 28, 2011 to 10,197 on December 05, 2011 before returning to 34,562 the following week. Backlogged claims peak on June of 2013 to 46,507 before ending 2016 with 3,185 claims backlogged.

Figure 9 compares Pension Award Adjustment Claims and Pension Award Adjustment Claims Pending Over 125 days. This data includes 7 EPs, with the largest categories EP 607 – Due Process, and EP 150 – Income adjustments. The remaining EPs are EP 050 – annual eligibility verification, EP 135 – Hospitalization adjustment, EP 137 – Dependency, EP 155 – Annual eligibility verification reporting, and EP 297 – Misc determinations. This grouping of EPs includes any changes made to the veterans' pension, dependency, or income ratings. This time series chart shows that the data does not seem to gradually increase or decrease but instead to sharply increase and decrease at regular intervals.

There were 70,158 claims pending in this category on October 05, 2009 before claims decreased to 59,965 claims on January 04, 2010. Claims peaked on April 26, 2010 at 128,391 claims before they declined to 65,923 on January 10, 2011, they peaked again on April 04, 2011 at 129,342 claims, declined back to 81,319 on December 11, 2011, and finally peaked again on April 09, 2012 to 142,833. Claims began an overall trend downward while still experiencing a yearly increase, although not nearly as sharp as in previous years. By the end of 2016, pending claims were reduced to 25,777 claims. One interesting point occurred in the data where data was moved temporarily from this category and immediately moved back the following week. Claims dropped from 114,156 on June 20, 2011 to 79,062 on June 27, 2011 before returning to 110,743 on July 05, 2011. It is not clear why this irregularity occurs within the data, where data was

moved, or why. The same drop in the data also occurs in the backlogged claims pending over 125 days.

Figure 9 also shows Pension Award claims pending over 125 days begin at 30,910 on October 05, 2009 and experience the same yearly increases and decreases as the pending claims in this category. Backlogged claims also experience a spike in the data when nearly 10,000 claims are added taking claims from 44,249 on July 26, 2010 to 54,319 on August 02, 2010, and then back to 44,032 on August 09, 2010. This was the period where Agent Orange adjustments were made. Backlogged claims peak on August 20, 2012 at 76,781 claims. By the end of 2016, backlogged Pension Award Claims were at 3,317 claims.

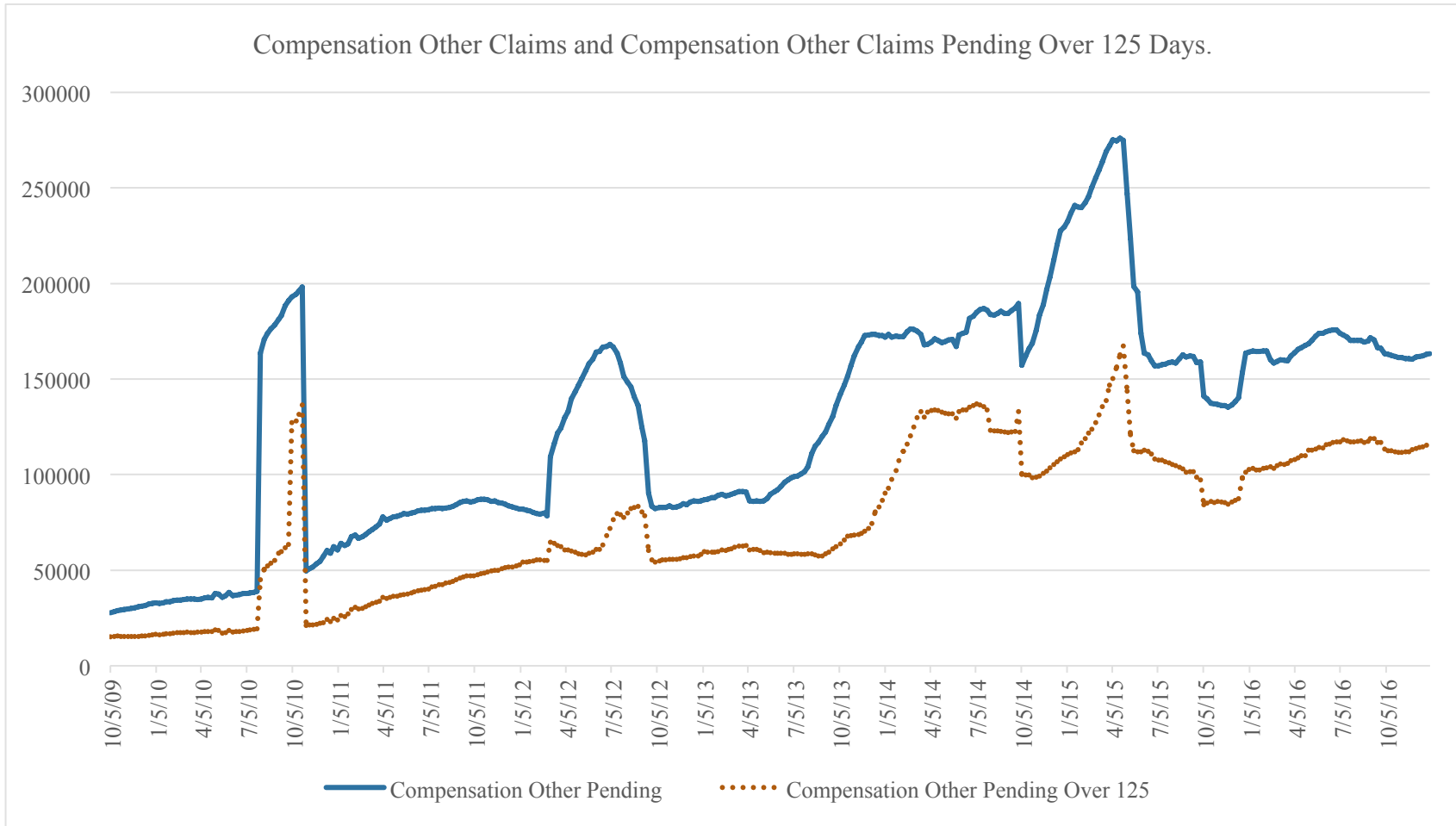


Figure 7: Compensation Other Claims Pending and Compensation Other Claims Pending Over 125 Days.

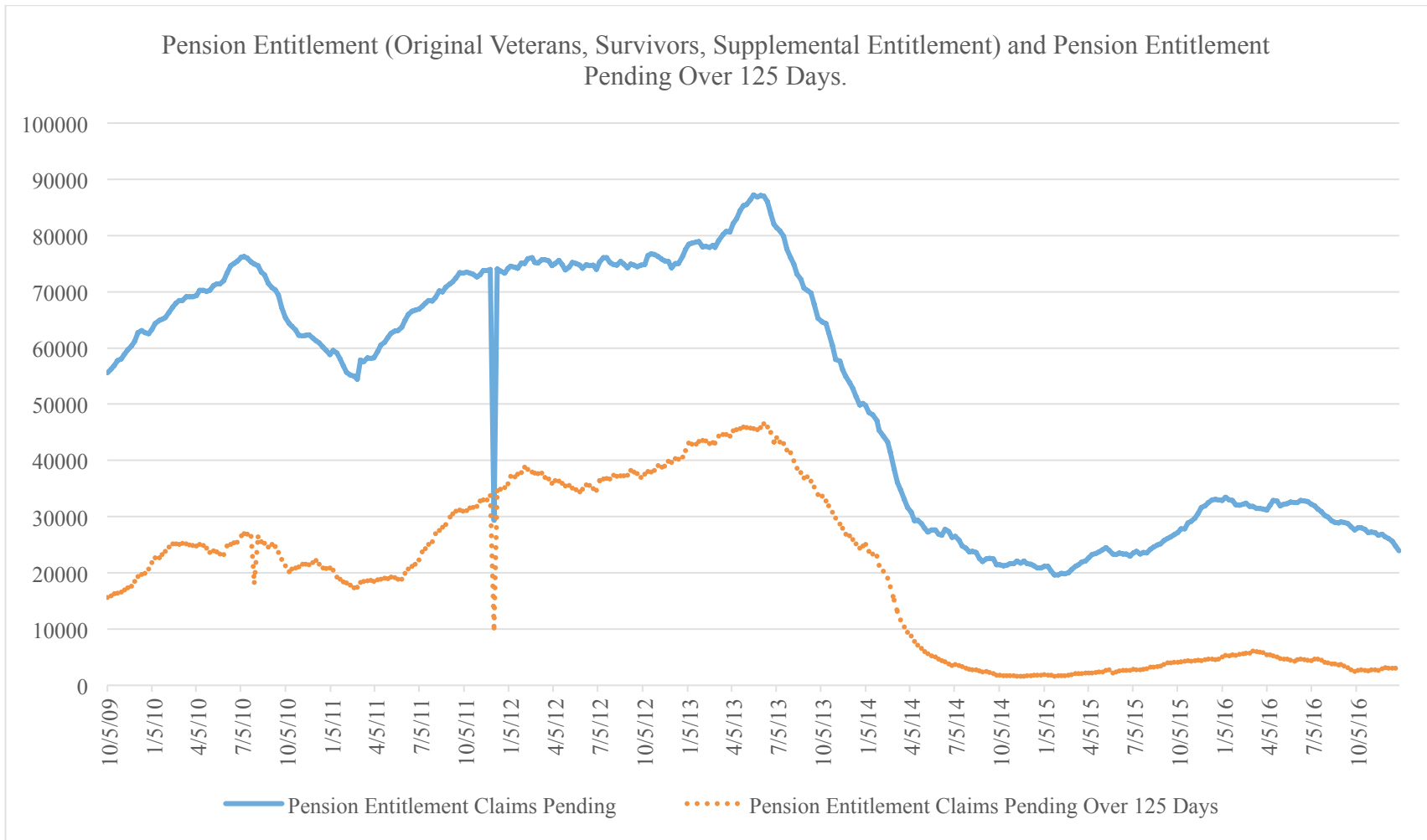


Figure 8: Pension Entitlement (Original Veterans, Survivors, Supplemental Entitlement) and Pension Entitlement Pending Over 125 Days.

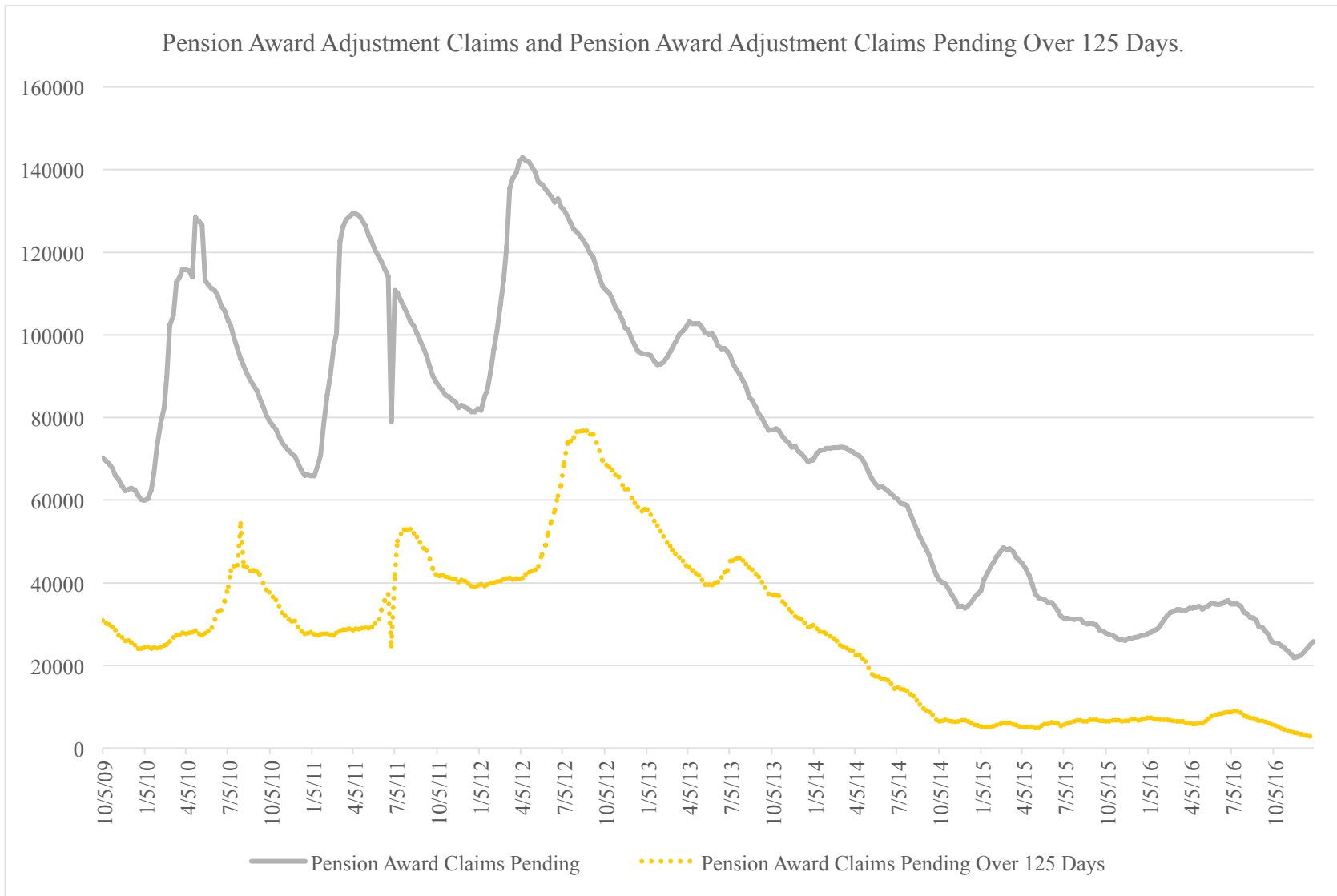


Figure 9: Pension Award Adjustment Claims and Pension Award Adjustment Claims Pending Over 125 Days.

Figure 10 compares Pension Program Reviews Claims and Pension Program Claims Pending Over 125 days. Claims in this category were 25,815 on October 05, 2009. Claims decline until October of 2011 where they increase slightly to 1,698 on October 17, 2011. This time series chart has several instances where there are vertical increases in the data, the first vertical increase occurs on October 24, 2011 when claims jump to 24,556, an increase of over 22,000 claims. While claims do decline, the next increase occurs in June of 2012 when claims increase from 14,891 on June 04, 2012 to 36,953 on June 11, 2012. Claims in this category jump significantly one more time in October of 2012 from 29,985 on October 22, 2012 to 77,258 on October 29, 2012. Claims decline from this point forward, leveling off in 2015 and ending 2016 with 340 claims.

Figure 10 shows that while backlogged claims in the Pension Program Reviews category begin at 9,044 on October 05, 2009, they jump to similar number as the pending claims on November 30, 2009 with 23,862 claims backlogged, a difference of only 64 claims between pending and backlogged claims. On August 02, 2010, Agent Orange claims also affect this category of claims as they are moved here temporarily, increasing the backlog by about 8,000 claims as shown and referenced in Figure 8, and then moved back the following week. In December of 2009 claims increased from 247 to 17,102, in October of 2012, claims increased from 12,800 to 29,209, and in February of 2013, claims increased from 24,063 to 53,759 backlogged claims before beginning a declining trend to end 2016 with 204 claims.

Figure 11 compares Pension other claims and pension other claims pending over 125 days. The Pension Other category contains EP 407 - Correspondence, EP 507 - Congressional Correspondence, EP 937 Internal quality reviews, and EP 967 - Correction of errors. This

category of claims fluctuates severely throughout the 2009-2016 period, in particular as claims appear to be moved in and out of the category.

The data peaks at 16,551 claims on March 05, 2012, an increase from 5,915 claims on February 27, 2012. This significant increase does decrease over the next few weeks before increasing again, decreasing some, and increasing again before beginning a trend downward. While the data appears very rigid in Figure 11, it is important to note that the number of cases is relatively low thereby increasing the sharpness created by fluctuations within the data week to week. In April and May of 2010, there are several weeks where claims drop before increasing again a few weeks later, for example from 4,006 claims on April 26, 2010 to 1,851 on May 03, 2010 and back to 3,941 on May 24, 2010, down to 1,679 on May 31, 2010 and back to 3,876 on June 07, 2010. Similar fluctuations occur in the weeks from December 27, 2010 through April 11, 2011.

Claims backlogged and pending over 125 days in the Pension Other category follow a similar pattern as those claims pending in this category. October 05, 2009 begins with 1,338 claims and jumps to 3,120 by November 30, 2009. Backlogged claims undergo the same fluctuations during the April-May 2010 period and the December-April 2011 period. Backlogged claims peak on March 05, 2012 at 11,324 claims with claims immediately declining with a few weeks back to the 5,000 range before increasing through 2012 and then trending downward through 2016. There were 420 claims remaining backlogged by the end of 2016 in the Pension Other Category pending over 125 days. The next section analyzes the significance of the findings within the MMWR.

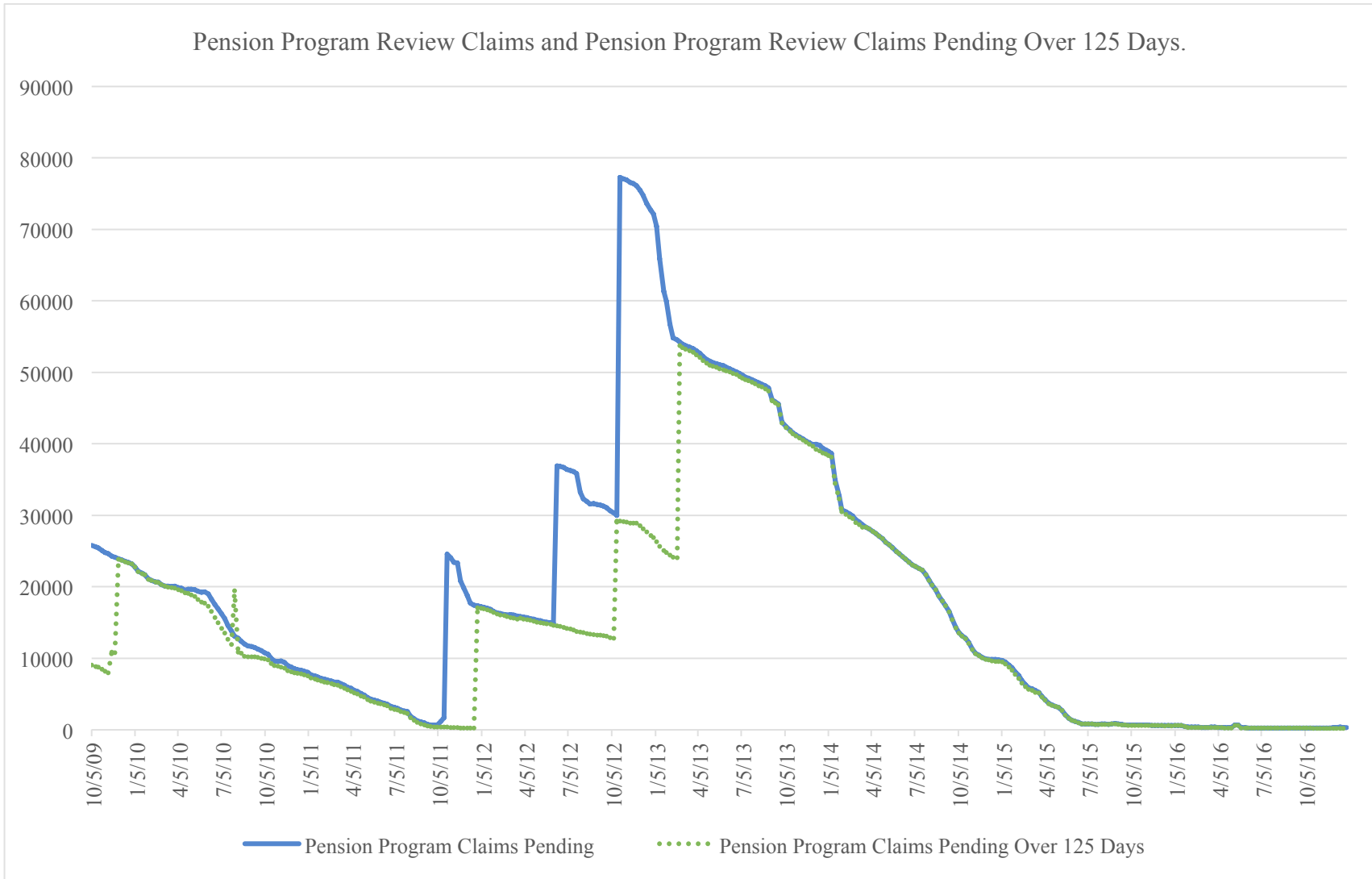


Figure 10: Pension Program Review Claims and Pension Program Review Claims Pending Over 125 Days.

Pension Other Claims and Pension Other Claims Pending Over 125 Days.

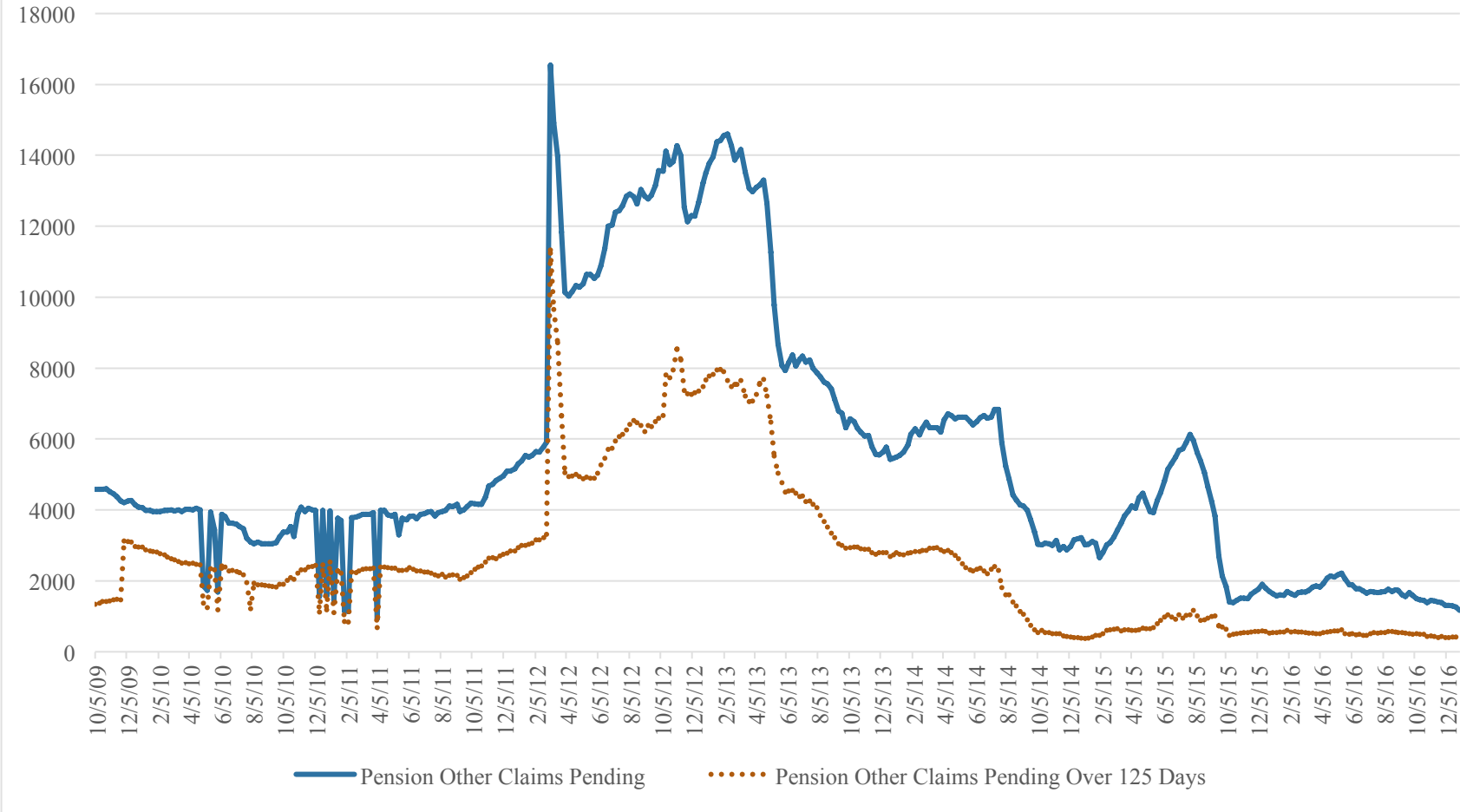


Figure 11: Pension Other Claims and Pension Other Claims Pending Over 125 Days.

Analysis: Monday Morning Workload Reports (MMWR)

Findings in the Monday Morning Workload Reports (MMWR), first, show continuous problems in reducing and eliminating the backlogged claims across multiple benefit allocations within the VA. Data on Compensation and Pension Ratings Bundle Claims, and claims pending over 180 days were available from January of 2004 through September of 2009. Second, this data shows a steady increase in the number of claims during this time frame from 354,409 claims to 420,243. Third, claims pending over 180 days begin 2004 at 88,287, peak in April of 2007 at just over 116,000, and end 2009 with 88,195 claims (MMWR 2016). Finally, during this time period the VA increases the number of enrollees from 7.3 million in 2004 to 8.1 million in 2009 bringing outpatient visits from 54.0 million in 2004 to 74.9 million in 2009 (Statistics 2016).

Data on compensation and pension ratings bundles and claims pending over 125 days, were available from October of 2009 through December of 2016. The metric measuring backlogged claims was lowered from 180 to 125 days, creating an increase in backlogged claims at this time period. There were just 388,774 pending claims in the beginning of October 2009 with 142,652 claims backlogged and pending over 125 during this time frame. In addition, roughly 150,000 pending claims and over 98,000 backlogged claims were added to the pending ratings bundle claims in late 2010-early 2011 when changes to Agent Orange presumptive claims took effect.

Claims in the compensation and pension entitlement bundle rating consist of the 8 compensation and pension End Products (EP) and after 2010, the 4 Agent Orange EPs tracked by the VA to measure the workload of the VA. Compensation and entitlement ratings bundle claims peaked at 843,434 in July of 2012 and backlogged claims in the ratings bundle peaked at 588,959 claims in March of 2013. These numbers only include the 12 EPs used in the VA's ratings

bundle metric and not additional metrics that include appeals, adjudication, education, pension, and other benefit claims. The number of veteran enrollees increased to 9.1 million by 2014 with 92.4 million outpatient visits (Statistics 2016). There were 363,986 claims pending in the Compensation and Pension Ratings Bundle by the end of 2016 with 94,845 of those claims pending over 125 days, or backlogged (MMWR 2016).

It is important to understand that obvious jumps in the data occur when the metric of measuring the backlog is changed from 180 to 125 days and again in 2010 when Agent Orange presumptive claims are added and allowed to be reopened for veterans suffering exposure harms. Importantly though, these additions do not account for all of the backlog or the perpetuation of the backlog across this time period. Instead, to understand the increase in the demand for the VA's services, and the subsequent increase in the number of claims filed and backlogged at the VA, it is important to understand the socio-political climate occurring during this time. By 2004, the U.S. was engaged in war in two countries; both Afghanistan (2001-Present) and Iraq (2003-2011, officially), under the banner of three wars including the Global War on Terror (Oct 2001-Present), Operation Enduring Freedom (2001 – Present), and Operation Iraqi Freedom (2003-2011) (Affairs 2016b). Operation Iraqi Freedom became Operation New Dawn in 2010.

When looking at the number of new veterans and new claims within the social, political, and economic context that they exist within, the VA's problems may continue if further intervention is not taken as more and more veterans retire from service or seek treatment for service related injuries and illnesses. In so much as the VA knows the number of claims it receives and reports on such data on a weekly basis, it is expected that they are able to examine trends and increases in the number of claims and respond accordingly to avoid backlogs. However, the data demonstrates both a knowledge of the problem, and a failure to remedy the

problem in a timely or an adequately manner throughout the period being analyzed. While changes in the MMWR have occurred over the last few years, the majority of such changes have been to make the MMWR more transparent and easier to read. It was not until 2013 that the backlogged claims began to decline; however, VA usage tends to increase and decrease with the economy (Mockenhaupt 2014).

The VA was beginning to face scrutiny for internal policies surrounding delays in care that began as early as 2005 and escalated through a 2011 policy that began tracking appointment scheduling metrics and set 14-day goals to see patients (Mockenhaupt 2014, Zezima 2014). Dr. Sam Foote, the primary whistleblower throughout the VA scandal reported poor practice at his home VA in Phoenix, AZ, as early as 2011, and again in 2013. The VA openly acknowledged problems in 2011 related to patient wait times and scheduling delays but changes to policy were not made and instead the problems escalated until Dr. Foote reported the VA to both the Office of Inspector's General and an investigation was opened. Vindication would not come until Spring of 2014 when interim reports revealed that as many as 40 veterans may have died waiting for care (General 2014a, Lowery and Hicks 2014, Mockenhaupt 2014, Oppel 2014a, Zezima 2014, Zoroya 2014c).

Whistleblower reports and the VA's own documentation within the MMWR and the interim and final reports on veteran scheduling and delays to health care reveal that the VA had both prior knowledge of the problem and that the VA failed to act in a timely and appropriate manner to address these issues. The resulting harm includes not only the potential deaths related to delays in care but also harm for those suffering unnecessarily while waiting for care. The Monday Morning Workload Report demonstrates weekly changes in veteran claims from 2004

through 2016. An analysis of this data reveals prolonged problems in dealing with backlogged cases from week to week.

Further context is provided through analysis of the National Veteran's Survey and media reports. The National Veteran's Survey provides an understanding of veteran satisfaction of their care and veteran knowledge about the VA services available to them. The next section examines the National Survey of Veterans (NSV) and the VA reports.

DEPARTMENT OF VETERAN AFFAIRS NATIONAL SURVEY OF VETERANS

On October 18, 2010, the Department of Veterans Affairs and Westat released the final report detailing results from a national survey. The report, "National Survey of Veterans, Active Duty Service Members, Demobilized National Guard and Reserve Members, Family Members, and Surviving Spouses" provides information from the 2010 National Survey of Veterans which also includes a subsection assessing beneficiary awareness of available services and benefits that the VA provides (Westat 2010). The VA conducted and used the 2010 survey to assess current benefits and services and to plan and allocate resources for future programs. According to the report:

"[d]ata collected through the NSV enables VA to: follow changing trends in the Veteran population; compare characteristics of Veterans who use VA benefits and services with those of Veterans who do not; study VA's role in the delivery of all benefits and services that Veterans receive; and update information about Veterans to help the department develop its policies" (p. 10).

The survey was broken down into six individual surveys delivered based upon recipient's current status (Veterans, Active Duty Service members, Active Duty Spouses, demobilized

National Guard and Reserve members, Veteran spouses, and Surviving Spouses). Using both address and list-based sampling techniques, the survey was mailed between October 16, 2009 and March 19, 2010 by first issuing a screening survey and then delivering the appropriate survey depending upon which sample group the participant fell into. The NSV received a response of 10,972 total surveys with 8,710 of those being veterans, the veteran response rate of 66.7 percent (Westat 2010). For purposes of this dissertation, we are only interested in the survey sample of Veterans and what they had to report about healthcare and the VA.

Demographic data from the NSV shows that 63.9% of the sample were 55 or older, 94.9% were non-Hispanic, 84.7% white-only, 91.9% males, 11.2% African American/Black only, among the males 69.7% were married and 75.5% of them owned their own homes. About one-third of the population report serving in combat and one-third report seeing dead, dying, or wounded while serving, all events that are related to PTSD.

In terms of the level of benefits available to them, veterans were asked to indicate how much they understood a benefit available to them, a lot, some, a little, or not at all. The NSV viewed responses of ‘a lot’ or ‘some’ as a positive response and responses of ‘a little’ or ‘not at all’ as a negative response. When asked if veterans understood “Veterans benefits available to [them]” 41.0% selected “a lot” or “some”. When asked about specific benefit entitlements, such as whether they were entitled to health care, education, or burial benefits, understanding declined (Westat 2010). In many instances veterans had heard about a benefit type (education, burial, life insurance) but did not know the specifics of such benefits or what their entitlements were.

The NSV also reports that those enrolled in VA care were more likely to report ‘a lot’ or ‘some’ responses (76%) than non-enrollees (25.6%) with those veterans serving post-September 11th had higher understandings (60.5%) compared to other eras of veterans (44.6% for WWII).

Younger veterans are also more likely to use the internet and request information about VA services more than other cohorts of veterans. The number of veterans reporting combat service is about 35%, with almost 34% also reporting exposure to dead, dying, or wounded people. When asked about environmental hazards, 23% reported they were definitely or probably exposed to hazardous materials in their environments and only 0.2% reported being a prisoner of war.

While there was positive response to general knowledge questions, only 28% reported using VA health care services and the NSV reports “[m]ore than 42 percent of Veterans who have never used VA health care indicated that they were not aware of VA health care benefits. Also, over 26 percent indicated they did not know how to apply for benefits” (p. 16). Veterans also reported they would use the VA if the cost increased for health insurance (60%) or if they had no other care (58%) with a large number stating they would use the VA for nursing home care (86%). About 18% of veterans responded positively when asked if they knew what services were available to them through their VA health coverage.

Veterans were asked to respond if they agree or disagree with the following statement: "Veterans like me who use VA are satisfied with the health care they receive" regarding satisfaction of the care the VA provides (Westat 2010). The NSV reports that 49.8% of veterans responded that they were satisfied; however, breaking the responses down within the codebook reveals that 45% of veterans surveyed (3,919) responded with 'Don't Know' while 9.2% (797) veterans did not answer. Only 10.4% (905) of veterans responded, "Completely Agree" and 14.4% (1255) responded 'Agree'. The majority, 16.5% (1437) responded 'Neither Agree nor Disagree' with 2.8% (248) responding that they 'Disagree' and 1.7% (149) responding that they

'Completely Disagree'. Therefore, it is difficult to agree with the NSV that the majority of veterans feel veterans are satisfied with the health care they receive.

The NSV also divided benefit awareness down by period served and results show that rates of veterans understanding their benefits typically decreased from those serving November of 1941 or earlier to those serving in 1955 before increasing again through those serving September 2001 or later. Knowledge of available benefits did vary along time periods that veterans served within; however, the newest cohorts of veterans serving post September 2001 had the most knowledge of benefits available in all categories asked about (understanding benefits available, health benefits, burial benefits, education and training benefits, insurance, home loan benefits, health coverage or discharge knowledge). Figure 12 illustrates this change over time.

Examining the National Survey of Veterans demonstrates the level of knowledge veterans have about what benefits are available to them as veterans. This information is important analyzing the extent of the problems that the VA may face. If additional veterans are not receiving services because they are unaware of their eligibility then backlogs may continue to rise whenever awareness in access increases and the VA could face additional issues meeting the demands of current veterans. The salient issue in veterans experiencing backlogs in obtaining care from the VA is further demonstrated by reports from whistleblowers that accuse the VA of manipulating scheduling and veteran records to meet internal goals and markers. The next section provides a brief analysis of the data summarized within the NSV.

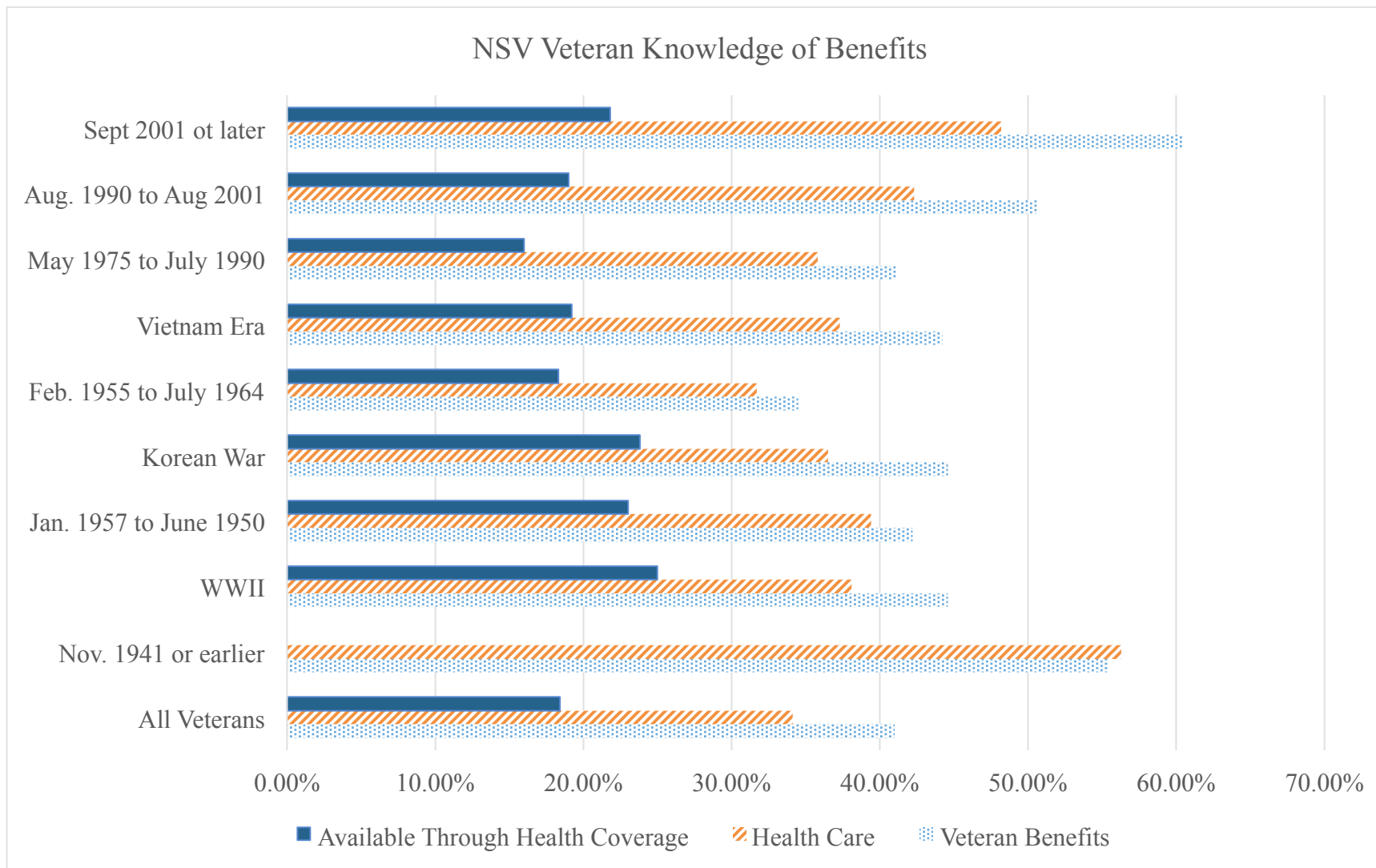


Figure 12: National Survey of Veterans Knowledge of Benefits.

Analysis: National Survey of Veterans (NSV)

The latest National Survey of Veterans (NSV) occurred in 2010 and it enabled the VA to look at the numbers of veteran using its services, how the VA delivers services to veterans, and updated information about veteran demographics. Results of the survey as previously reported indicated that veterans do know at least some about general benefits available to them but that their knowledge declines when asking about the specifics of individual benefit allotments (e.g. education, burial, et cetera). For example, only 34.1% of veterans responded positively when asked if they understood the health care benefits they were entitled to and only 18.4% responded positively that they know what is available to them through VA health coverage (Westat 2010). Furthermore, knowledge of benefits shows that older veterans and younger veterans surveyed have the most knowledge about the benefits available to them and veterans serving after the Korean War but before the Vietnam War have the least knowledge of the benefits available to them.

While the NSV demonstrates that the veterans surveyed had general knowledge of the benefits available to them, it also showed that veterans did not have strong knowledge of the health care benefits or health coverage available to them as veterans. The primary implication here is that if more veterans knew about services, would they request care? If so, they would be requesting care within a VA system that is already facing continual backlogs over the past decade. It is questionable whether the VA could provide care for all veterans if a majority are not even aware they are entitled to such care and therefore aren't requesting it. There is also an issue in that the VA is failing to provide veterans with adequate knowledge of the benefits available to them. The good news for the VA is that only 19.8% of veterans from all periods of service report searching for health care eligibility information; however, 34.6% from the period

after September 2001 report searching for information on health care eligibility (Westat 2010). The numbers indicating that 42% of those surveyed had never used nor were they aware of health care services is unacceptable and is potentially creating a gap in health care and health coverage for these veterans.

The VA reports data from the NSV as the veteran having responded positively, with ‘a lot’ or ‘some’ understanding, or negatively, with ‘a little’ or ‘not at all’ for many of the questions asked. When a question, such as how much the veteran understands health care benefits that they are entitled to is reported in this way, the results are reported as 36.5% positive; however, only 10.6% of veterans responded they had ‘a lot’ of understanding while 25.9% responded ‘some’ understanding. The majority of veterans responded ‘negatively’ with 23.7% reporting ‘a little’ understanding and 37.9% reporting ‘not at all’ understanding (Westat 2010). The NSV consistently groups responses in order to report a favorable response from veterans. This discourse, and the resulting narrative, is at odds with what the survey purports to do.

In looking at the data from the NSV it is clear that the VA is aware that of those surveyed, a large number are unaware of the benefits available to them and are unaware that health coverage exists for veterans. Whether the veterans would use such services if they knew about their eligibility cannot be determined. What is clear is that the VA is aware of the level of usage and knowledge about the services available to its veterans. The next section details 3 reports from the Veterans Health Administration that were undertaken by the VA as a result of the accusations the VA faced in 2014.

VETERANS HEALTH ADMINISTRATION (VHA) REPORTS

This section analyzes three reports released by the Veterans Health Administration to determine what prior knowledge the VA had of the accusations levied against it, what course of action was taken, and if the VA response occurred in a timely and adequate manner. All three reports are examined for indicators of state crime including 1) if the VA failed to act in a timely and appropriate manner, 2) was there prior knowledge of the problem, 3) what the response to the problem was, if any, and 4) whether organizational culture led to the normalization of deviance.

The May 28, 2014 Report

The Veterans Health Administration (VHA) and the VA Office of Inspector General (OIG) released three reports concerning the accusations of lengthy wait times and veteran deaths due to scheduling manipulation in the VA health care system. The first report, was an interim report, published May 28, 2014, and was the initial investigation following whistleblower accusations against the VA. That report, *Review of Patient Wait times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System* made immediate recommendations to help veterans at the Phoenix, VA, and gave an overview of the problem and allegations the VA was facing at the time (General 2014a). This report identifies the fact that these allegations and issues are not new and have been an on-going issue for the VA, with the VA Office of Inspector General having issued 18 separate reports on the issue since 2005.

This report reveals that in 2005, the Office of the Inspector General issued a report from the *Audit of VHA's Outpatient Scheduling Procedures* that the Veterans Health Administration was not following its' own procedures and the result was inaccurate wait times and lists due to

insufficient oversight, a lack of standardized training, and understated waiting lists (General 2014a). The report explains that “For almost a decade the OIG and Government Accountability Office (GAO) reviews identified that VHA managers needed to improve efforts for collecting, trending, and analyzing clinical data” (General 2014a:11). In addition to 18 reports showing prior knowledge of patient scheduling and wait time problems, the VA also included a memorandum from William Schoenhard, the Deputy Under Secretary for Health for Operations and Management, published April 26, 2010, wherein Schoenhard outlined the process that VA employees were ‘gaming’ the scheduling system and he called for immediate action to stop this practice (General 2014a). As further demonstrated by the interim report, scheduling manipulation did not stop after 2010. This demonstrates clear lax enforcement of existing standards and a regulatory environment that was lacking enforcement in addition to prior knowledge of the problem.

This interim report, released during the current set of accusations, set out to determine whether VA employees were circumventing the Phoenix, AZ VA’s electronic wait list by creating non-standard scheduling lists, and whether the deaths of any veterans were connected to delays in care. This resulted in the VA opening a national level investigation that eventually expanded to over 100 veteran hospitals and clinics and would demonstrate wide-spread practices against the VA’s official scheduling and electronic wait-list policies. The biggest issue uncovered within this report is that the data that was being officially reported by the Phoenix, AZ VA was not the reality for most veterans—an average waiting time of 24 days with only 43% waiting more than the 14-day goal set by the VA (General 2014a). The reality for these veterans is that many waited an average of 115 days for their first appointment, well beyond the 14-day metric set forth by the VA. The investigation and report also revealed that VA employees were

using multiple secondary lists, not within the VA's official databases, to keep track of veterans needing appointments. This report, and the whistleblower accusations, demonstrated in the analysis of the media reports to follow, show clear public response to the problem in addition to prior knowledge of the problem. Since problems from the OIG date back to 2005, it is also clear that the VA did not respond to scheduling issues in a timely or adequate manner.

The August 26, 2014 Report

The second report, a *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* was published on August 26, 2014 (General 2014b). This report followed up on the first report and the subsequent investigation opened by the VA Office of Inspector General. According to the VA, this follow-up report confirmed serious issues at the Phoenix, AZ, VA and that such issues were prevalent throughout the Veterans Health Administration. The report focuses on five major points to determine if 1) clinically significant delays in care existed, 2) were veterans omitted from official scheduling lists, 3) were personnel following procedures, 4) did organizational culture play a role, and 5) were scheduling issues systemic throughout all of the VHA (General 2014b).

In terms of the first and second point, the OIG also identified secret waiting lists kept outside of the purview of the official VA electronic waiting-list (EWL) wherein over 3,500 veterans were waiting for care and according to the VHA, “[t]hese veterans were at risk of never obtaining their requested or necessary appointments. PVAHCS senior administrative and clinical leadership were aware of unofficial wait lists and that access delays existed” (General 2014b:iii). Figure 13 shows the number of veterans reported to the VHA as being on the official VHA electronic waiting list (EWL) (solid line) versus the number of actual veterans on the

Phoenix, VA’s waiting lists (dashed-line). The OIG conclusion was that senior administration at the Phoenix, AZ VA did not adequately address these issues or work towards a solution in a timely manner, therefore significant delays exist.

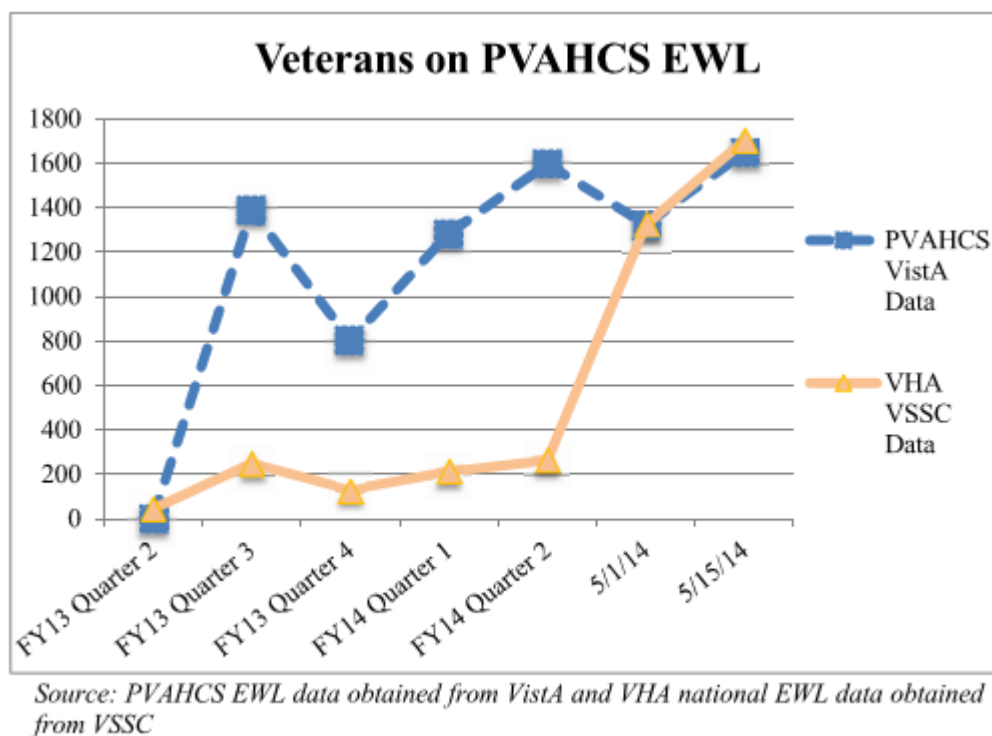


Figure 13: Veterans on Phoenix, VA’s Electronic Waiting List.

On the first and second issues, delays and scheduling, from this report, the OIG “identified 28 instances of clinically significant delays in care associated with access to care or patient scheduling” wherein 6 of the patients had died, and an additional “17 care deficiencies that were unrelated to access or scheduling” wherein 14 of the 17 patients were deceased (General 2014b:ii). It can be concluded, as notated in point 3, employees were not following procedures.

Suicides committed by veterans at the Phoenix, AZ VA were also reviewed and it was determined that 15 of 77 cases had some sort of delay or quality of care issues; 9 veterans faced delays in care, 1 clinically significant delays, and 5 quality of care issues that the VHA described as “related to Mental Health, Primary Care, and the ED” (General 2014b:31).

By completion time of this second report, the OIG and VHA were investigating 225 allegations against the Phoenix, AZ VA and 445 allegations nationwide about similar practices occurring within other VA hospitals and clinics resulting in investigations at 93 sites (General 2014b). Here we can conclude that organizational culture did play a role, per point 4, and that as point 5 suggests, these issues were systemic throughout the VA. The VHA explains (General 2014b):

“Inappropriate scheduling practices are a systemic problem nationwide. We identified multiple types of scheduling practices that did not comply with VHA’s policy. VHA missed opportunities to hold senior headquarters and field facility leadership responsible and accountable for implementing action plans that addressed compliance with scheduling procedures. Then in May 2013, the Deputy Under Secretary for Health for Operations Management waived the FY 2013 annual requirement for facility directors to certify compliance with the VHA scheduling directive, further reducing accountability over wait time data integrity and compliance with appropriate scheduling practices. Additionally, the breakdown of the ethics system within the VHA also contributed significantly to the questioning of the reliability of wait time data in the scheduling system” (p. 65).

By the OIG and VHA’s own admission, these issues did not originate in 2013; reports on scheduling issues and delays in veterans receiving care have occurred since 2005 and resulted in

18 other reports. Evidence of a cultural problem exists not only within the 18 reports on scheduling issues and reports of employees gaming the scheduling system for personal benefit, but also in a failure by the VA administration to adequately respond and remedy these issues. One must then conclude that this problem is neither new nor something unknown to the VA but is instead a part of the larger culture existing within the VA, a normalized deviance now occurring systemically throughout. It is this process of the normalization of deviance that Vaughan (1996) and Gerkin et al. (2010) argue occurs whenever an organization ignores warnings to operate within weak regulations and lax enforcement despite the negative results that may occur. In this case, however, those negative results are the lives and quality of life our veterans have. The VA not only engaged in the normalization of deviance in its scheduling procedures but it also rewarded its employees for doing so and meeting internal scheduling targets further encouraging such behavior. This is demonstrated in media reports that illustrate how employee bonuses and pay increases were tied to internal VA metrics, including patient scheduling.

The September 2, 2015 Report

The third report, a *Review of Alleged Mismanagement at the Health Eligibility Center* that was published on September 2, 2015 addresses several questions regarding mismanagement at the VHA and the Health Eligibility Center (HEC). These included, first, if the HEC had a backlog of 889,000 claims, second, if 47,000 veterans died while waiting for care, or finally, if 10,000 veterans were deleted from the workload system (General 2015). On the first issue, the VHA determined that many of the 889,000 pending claims to the enrollment system were missing dates (477,000 claims) and could not be validated as a result or they were inactive since enrollment claims do not expire. We can conclude from the missing data and poorly handled

records that lax enforcement and weak regulations played a role in why these issues were not immediately addressed.

On the second issue, the VA set out to determine if 47,000 veterans died while their enrollment claims were pending. They instead discovered that more than 307,000 veterans died with pending or open claims in the enrollment system (General 2015). The VHA explained that (General 2015):

“We substantiated the second allegation that pending ES records included entries for individuals reported to be deceased. As of September 2014, more than 307,000 pending ES records, or about 35 percent of all pending records, were for individuals reported as deceased by the Social Security Administration. However, due to data limitations, we could not determine specifically how many pending ES records represent veterans who applied for health care benefits. These conditions occurred because the enrollment program did not effectively define, collect, and manage enrollment data” (p. ii).

The VHA goes on to report that unless enrollment systems are updated to adequately monitor and reflect when veterans die, this problem will continue. Of the 307,000 pending claims, 84% of the veterans died more than 4 years ago, 6% died between 2 to 4 years ago, and 10%, or 30,706 died within the last two years of this report (General 2015). While these reports speak to inadequate reporting metrics, it is impossible to determine whether or not the veterans’ failure to achieve enrollment and their pending status had any impact on their quality of life, available health care, or even their deaths.

Finally, at least 10,000 veterans were deleted from the workload report. The report explains that the 10,000 or more cases deleted from the Workload Reporting and Productivity tool were lost because “the Office of Information and Technology (OI&T) did not provide proper

oversight for the development, security, and data backup retention for WRAP” (General 2015:ii). This demonstrates lax regulations and oversight.

What these reports demonstrate is a consistent knowledge of the problem of both veterans’ access to care and their access to care in a timely manner. The VA reports that it has known about scheduling and appointment waiting time issues since as early as 2005 and yet the problem persists at potentially criminal levels with employees directly misappropriating appointment scheduling and keeping secret appointment lists, effectively denying veterans care, let alone timely or adequate care. Furthermore, an organizational culture promoting lax regulations and poor oversight led to the normalization of deviance wherein employees were rewarded for manipulating veteran’s appointment times. The VA created and maintained a benefit deficit for many veterans and they knew they were doing it. The following section outlines the whistleblower accusations against the VA and the ensuing public and political response to the allegations that plagued the VA during 2014 and 2015.

CONCLUSION

This chapter provided an analysis of the data collected from the Monday Morning Workload Reports (MMWR), the National Survey on Veterans (NSV), the final Veterans Health Administration (VHA) report and Review of Alleged Patient Deaths. This chapter examines the significance of each data point, the knowledge of problems within the VA and discusses what harms veterans faced as a result of the Department of Veteran’s Affairs omissions and commissions. This chapter also puts forth the argument that the VA’s omissions and commissions were a state crime resulting in social harms to its veterans. Using Rothe and Kauzlarchi’s (2017) definition and the models for documenting state crime and set forth in

previous literature (Faust and Kauzlarich 2008, Gerkin, Teal and Reinstein 2010, Schotter and Rhineberger-Dunn 2013, Vaughan 1996), this dissertation will analyze the data to determine: 1) Is the VA committing a state crime of omission or commission through its handling of veteran benefit claims? 2) Are the accusations against the VA of falsifying records and knowledge of changing veteran appointments evidence of this state crime? 3) Have these omissions and commissions persisted overtime despite knowledge of their existence and 4) what has the response to the problem been, and 5) what are the outcomes that this has on veterans? An argument for the VA's actions and inactions resulting in a case of state crime is made in the next chapter.

CHAPTER VII

DISCUSSION AND CONCLUSION

In this dissertation, I examined the Department of Veterans Affairs to see if it was committing a state crime that has resulted in social harm to veterans. The evidence shows that the VA committed a state crime of omission and commission. In the analysis, I used several indicators of state crime. These indicators include if there was prior knowledge of the problem, if a failure to act on such knowledge existed, if any subsequent weakening of regulations or lax enforcement contributed to the problem, or if organizational culture contributed to the normalization of deviance.

While it has not yet been determined if any of the VA's hospitals or clinics will face criminal charges for their roles in falsifying veteran records and manipulating appointment data, an analogous social harm perspective demonstrates clear harm to veterans due to the delay in care and failure of the VA to provide adequate and timely care. Unfortunately, behavior in the current scandal is not new and it instead has perpetuated throughout all known theatres of war creating a cycle of social harm. The existence of a cycle of social harm suggests that a culture of social harm (Friedrichs 2011, Green and Ward 2000, Kramer and Michalowski 2006a, Schwendinger and Schwendinger 1970) may well exist in the VA. This chapter will summarize the case for state crime, discuss the benefit deficit veterans face as a result, explain the implication of this being a state crime, and end with limitations and future research.

FINDINGS: A CASE OF STATE CRIME

In order to determine if a state crime occurred within the Department of Veterans Affairs, a definition of state crime was used. The definition best suited to examine the VA, a government

organization with a multitude of motivations sometimes at odds with one another, was Rothe and Kauzlarich's (2016) definition:

“...we suggest state crime can be defined *as an act or omission of an action by actors within the state that results in violations of domestic and international law, human rights, or systematic or institutionalized harm of its or another states population in the name of the state regardless if there is or is not self-motivation or interests at play*” (Rothe and Kauzlarich 2016).

This definition includes omissions and actions by the VA, regardless of whether the motivation was related to the individual employee's goals or the goals of the organization itself. It also includes violations of human rights and systematic or institutionalized harms. Using a state crime framework to examine behavior of the state or state sanctioned organizations such as the VA allows us to explore the actions (commissions) and inactions (omissions) of the state, the state actors, and ultimately determine what the resulting harms are (Kramer 2012, Rothe and Kauzlarich 2016). There are not any other known studies examining the VA as a health care provider guilty of a state crime against the veterans it purports to care for.

This dissertation used factors indicated in past research (Faust and Kauzlarich 2008, Gerkin, Teal and Reinstein 2010, Kauzlarich, Mullins and Matthews 2003, Kauzlarich and Kramer 2006, Kramer 2009, Matthews and Kauzlarich 2006, Rothe and Mullins 2011, Schotter and Rhineberger-Dunn 2013, Vaughan 1996) as evidence that the VA committed a state crime of omission and commission that has persisted overtime despite prior knowledge of it. This state crime resulted in negative outcomes and criminogenic consequences for veterans that include homelessness, suicide, PTSD, and higher rates of intimate partner violence (IPV); a social harm. Data collected and analyzed included media reports found within *USA Today* and *The New York*

Times from January 2014 through December 2015, Monday Morning Workload Reports (MMWR) from the VA for the years 2004-2016, the National Survey on Veterans, and the Veterans Health Administration reports on alleged patient wait times and deaths.

Using Rothe and Kauzlarchi's (2017) definition of state crime and the models for examining state crime found in previous literature (Faust and Kauzlarich 2008, Gerkin, Teal and Reinstein 2010, Schotter and Rhineberger-Dunn 2013, Vaughan 1996), this dissertation answered: 1) Is the VA committing a state crime of omission or commission through its handling of veteran benefit claims? 2) Are the accusations against the VA of falsifying records and knowledge of changing veteran appointments evidence of this state crime? 3) Have these omissions and commissions persisted overtime despite knowledge of their existence, 4) what has the response to the problem been, and 5) what are the outcomes that this has on veterans? The next section summarizes the result and conclusion for each of these research questions in turn.

Is the VA committing a state crime of omission or commission through its handling of veteran benefit claims?

The analysis indicated that the VA is committing a state crime of omission and commission through its handling of veteran benefit claims. Data collected from the VA and media were analyzed in order to answer the question. The analysis shows that the VA failed to act in a timely and appropriate manner. For example, reports dating as far back as 2005 indicated there was a problem in how the VA was handling veteran claims and appointment scheduling. Next the evidence shows that the VA had prior knowledge of the problem. For example, the Veterans Health Administration's reports indicated that there were at least 18 other reports produced by the VA on this issue. Finally, documents indicate that the response was both

outrage for veterans experiencing harm and political insomuch as the VA became additional political ammunition. Media reports indicated that the public was outraged over the way veterans were treated and politicians seized the opportunity to push their party's agenda. The overall result is a social harm experienced by our veterans caused and perpetuated by the Department of Veterans Affairs. This was, and continues to be, a state crime of omission and commission resulting in social harms to veterans.

Are the accusations against the VA of falsifying records evidence of this state crime?

Findings indicate that the VA was indeed falsifying records and this is evidence of a state crime. Data from the VA was analyzed. The three reports analyzed from the Veterans Health Administration show that the VA was guilty of falsifying records and that they had prior knowledge of veterans experiencing delays in care.

The first report, the interim report published May 28, 2014, a *Review of Patient Wait times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System* opened a national level investigation and audit of VA health care systems, determined average waiting times were much higher than the 14-day metric and were instead 115 days, and detailed prior knowledge of scheduling issues (General 2014a). This report revealed that not only was the VA guilty of manipulating veteran appointment scheduling and wait times but that the VA had previously reports on the same problem.

The second report, a *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, published August 26, 2014, confirmed the scheduling issues and prevalent problems within the Phoenix, AZ VA and that such issues were systemic throughout the Veterans Health Administration (General 2014b). This

report also identified secret waiting lists kept by employees to meet internal metrics and 18 previous reports on similar issues. Secret waiting lists were used to falsify veteran records.

The third report, a *Review of Alleged Mismanagement at the Health Eligibility Center*, published September 2, 2015 addressed a backlog of 889,000 claims, and determined that more than 307,000 veterans died while waiting for care (General 2015). While this report was unable to verify if veteran deaths were linked to inadequate or delays in care, the report does not make a determination that links did not exist. This report also found that more than 10,000 veteran records were deleted from the system.

It is unknown if any of the veteran deaths could have been prevented through adequate care. These reports show a willingness to falsify veteran records with consistent knowledge of the problem of veterans' access to adequate and timely care, delays in care, and scheduling manipulation occurring within the VA. Furthermore, these reports demonstrate lax enforcement of existing procedures on patient scheduling and weak regulatory systems unable to properly intervene despite long-term knowledge of the problem. As organizational goals were tied to the 14-day scheduling metric, actions were limited in such a way that schedule manipulation and record falsification were encouraged. Through analyzing data from the Monday Morning Workload Reports, the National Survey of Veterans, and the Veterans Health Administration Reports, evidence of a state crime was confirmed through the VA's manipulation of veteran records and falsification of data.

Have these omissions and commissions persisted overtime despite knowledge of their existence?

Findings from the analyzed documents determined that despite the VA's prior knowledge of these problems, as shown in the VA's data, the omissions and commissions persisted over time.

The MMWR demonstrated that the VA had prior knowledge of the backlog, as shown in this weekly report dating back to 2004. While data from the MMWR shows progress on addressing the most egregious examples of backlogged cases, the backlog persists as of mid-2017. The primary measure for such cases was the compensation and pension ratings bundle; a bundle of 8 compensation and pension end products and 4 Agent Orange end products that the VA defines as its primary claims metric. By the end of 2016, compensation and pension ratings bundle claims were still at 363,986 claims with 94,845 of those claims pending over 125 days, or backlogged. Furthermore, claims cannot be analyzed outside of the social, political, and economic structures that exist within society since factors such as poor economic opportunities may contribute to veterans relying on the VA more heavily (Mockenhaupt 2014). It is also vital to consider the numerous military engagements that have occurred post-September 2001 and the three wars the United States entered into; including the Global War on Terror and the war in Afghanistan, which are both ongoing, with new military action in Iraq as recent as Spring 2017 (Affairs 2016b).

Data from the National Survey of Veterans show that veterans, overall, have limited knowledge about the VA health care and health coverage available to them through the VA (Westat 2010). This raises more questions than it answers. If more veterans were aware of the health care options available to them through the VA, would they use them, and, if they did use such services, would the VA be able to handle the influx in new claims? This another example

of the VA having data on veterans' knowledge, or lack of knowledge, of its' services. In addition to data from the VA, reporting in both newspapers revealed prior knowledge within the VA of the problem and a culture wherein the normalization of deviance had allowed such problems to continue unabated.

The VA's failure to act upon prior knowledge of delays in care that veterans were experiencing, and failures to properly address previous reports of scheduling manipulation and that records were being falsified demonstrates an organizational culture where such actions have become what Gerkin et al. (2010) (see also Vaughan, 1996) call normalized deviance; a normal part of day-to-day operations. Weak regulatory oversight, that the VA itself outlines in its Veterans Health Administration reports, allowed such normalization processes to occur and be perpetuated as systemic levels throughout the VA. Furthermore, the VA actively incentivized such deviance by tying difficult to attain 14-day metrics to employee bonuses and salary increases, further contributing to and encouraging abuses.

A state crime of omission occurred because regulation and oversight did not exist to prevent VA employees from manipulating records and falsifying data. What oversight did exist was ignored by upper VA administration until the problem was brought to the public's attention and was no longer something that could be handled internally. At the same time, actors within the VA were engaging in state crimes of commission through their direct actions tied to manipulating records, falsifying veteran records, and delaying or blocking veterans access to care to meet internal reporting metrics. The result, an analogous social harm to veterans perpetuated by the VA.

What has the response to the problem been?

The fourth research question addressed what the VA's response to the problem has been. Before reviewing responses, it is important to note that documents indicated that while the Department of Veterans Affairs took several steps to address problems with the VA, they only acted after whistleblowers, such as Dr. Sam Foote, went public with the information, and *USA Today* and other news organizations began to investigate.

The media reports outline specific consequences and the outcome of the ensuing investigations that occurred throughout 2014 and 2015. Articles collected within *USA Today* and *The New York Times* from January 2014 through December 2015 consistently invoke a narrative of how whistleblower reports and the VA's investigation shaped public outrage, provided political ammunition, and altered the future of the VA as everyone involved scrambled to make the necessary changes to address the allegations levied against the VA. While articles in *USA Today* were centered more on the investigation and the consequences veterans faced, articles within *The New York Times* were often substantially more political in nature discussing the partisan lines that this scandal cemented over what the future of the VA should look like. Furthermore, reporting in both newspapers demonstrated that employee fears of retaliation contributed to a culture of silence and the continued practice of falsifying records within the VA.

Responses were numerous and were notably, partisan. Republicans used the VA scandal as an opportunity to increase privatization within the VA and to push for further decentralization of the organization while Democrats made the argument that current VA failures were due to the overwhelming number of veterans needing care and the inability of the budget to keep up, despite budgetary increases. Eventually the results were bi-partisan efforts to first privatize veteran care through a voucher program, and second, to increase in the VA's budget to address

specific health care concerns such as mental health and the hiring of additional doctors and nurses.

In addition, under public scrutiny, the VA, Congress, and even President Obama put forth efforts to resolve some of the most damaging failings of the VA health care system. First by ultimately removing Eric Shinseki as the Secretary of the VA and replacing him with Robert McDonald. Second, Obama signed \$16 billion dollars in legislation designed to aid the VA with reducing veteran wait times, offering private care options, and the funds needed to fill a multitude of vacancies (Shear and Oppel 2014, Shear and Weisman 2014, Weisman and Steinhauer 2014, Zoroya 2014f). Replacing Secretary Shinseki and the subsequent investigations resulted in only a few VA employees being fired or put on probation with the most notable punishment being the firing of the head of the Phoenix, AZ, VA. However, ultimately, despite additional funding and pledges to ‘fix the VA’ the VA still faces a backlog in claims within the MMWR as of mid-2017 and budgetary problems were not alleviated through the voucher program.

What are the outcomes that this has on veterans?

Despite ongoing issues within the VA, the data demonstrates that veterans are generally satisfied with the health care they receive from the Department of Veteran’s Affairs when they can get such care in a timely manner. The problem for many veterans remains getting claims approved so that the veteran can then receive adequate care in a reasonable amount of time. By failing to provide adequate and timely care to veterans the VA committed a state crime of commission and omission through its actions and inactions. This state crime resulted from prior knowledge of these issues and subsequent attempts to cover up or mitigate the affect that delays

in care were having. As a result, veterans faced a grave social harm and an inability to receive care with veterans at some VA hospitals waiting for an appointment an average of 155 days or more before they were seen and their health concerns were addressed (General 2015).

The next section will expand upon the outcomes veterans face and discuss some of the possible reasons that this gap in care exists.

BENEFIT DEFICIT: THE GAP IN VETERAN'S HEALTH CARE

As demonstrated within this work, the benefit deficit created by the VA through the denial of care and inadequate care provided to veterans is not new and is instead a perpetuation of a cycle of analogous social harm occurring throughout the theatres of U.S. war. The social harms experienced by veterans include lack of treatment for treatable problems such as PTSD and brain trauma. Veterans facing issues like PTSD are also more likely to have additional problems such as suicide, substance abuse, alcoholism, joblessness, homelessness, and increases in domestic abuse and intimate partner violence (Affairs 2013d, Hendin 2014, Korte et al. 2016, Mittal et al. 2016, Tanielian and Jaycox 2008, Veterans 2013, Violence 2013). This section will discuss the criminogenic consequences veterans face and discuss why veterans are not receiving the care the VA promises them.

Criminogenic Consequences

The VA has made efforts to reduce the consequences veterans face when they have inadequate care; however, many veterans still face many issues including homelessness, PTSD, IPV, unemployment, and suicide at concerning rates. For example, while the VA has brought the numbers of homeless veterans down from 62,000 in 2012 to around 40,000 in 2016, the VA failed to meet its goal to end homelessness for veterans by the end of 2015. Estimates of PTSD

among veterans are as low as 11-20% for veterans of Operations Iraqi Freedom, Enduring Freedom, and Desert Storm, and as high as 30% for Vietnam (Department of Veterans Affairs 2013a). The VA (2013a) also estimates that 20% of all new veterans may suffer from PTSD. Veterans also experience higher rates of intimate partner violence (IPV) and unemployment than the civilian population. Because military jobs often do not translate to the civilian workforce, unemployment for veterans was 30% compared to a civilian 16% (Affairs 2013f, Affairs 2013g, McVeigh 2013, Veterans 2013). Veterans experience IPV at anywhere from 13.5% to as high as 58% (Affairs 2013d). Finally, the rate of suicide for veterans is 21% higher than the rate of suicide that civilians face (Department of Veterans Affairs 2016). Veterans may face incarceration for any of these outcomes.

I argue, the criminogenic consequences veterans face is the result of the “expendable status” gained once they retire from military service and are no longer a necessary component of the military-industrial complex. The idea of the expendable soldier itself is not new, soldiers have argued against the nature of their military service as being expendable in the past. For example, Colby Buzzell, in an article in *The New York Times*, writes about how his, and other veterans treatment makes them feel expendable instead of lauded. About his experiences within the VA, Buzzell (2014) writes:

“I enrolled in the V.A. health care system in 2004, soon after a year of service in Iraq. I've been to countless V.A. hospitals since, and they're all the same. If you want to know what the price of freedom looks like, go to a V.A. waiting room -- wheelchairs, missing limbs, walking wounded, you get all of the above. One day not long ago, while waiting for my PTSD medication, I struck up a conversation with a Vietnam veteran, who told me the message he'd gotten from his treatment at the V.A., and his country, was not

"Thank you for serving," but "Thank you for being expendable." I agreed with him. Soldiers are expendable in war, and veterans are expendable and forgotten about when they return. That's just the way it is. This recent V.A. "scandal" over prolonged wait time for veteran care doesn't surprise me one bit. Politicians and many hawkish Americans are quick to send our sons and daughters to go off to fight in wars on foreign soil, but reluctant to pay the cost" (para. 8).

Veterans serve their country, some give limbs, their mental wellbeing, or even their lives in exchange. They return home only to face a system purporting to care for them that in reality, is guilty of an analogous social harm through a state crime of omission and commission. The VA has repeatedly failed veterans through delays in their care and inadequate care. The next section will examine possible reasons that the VA is not providing adequate care.

Explaining the VA's Actions

Despite efforts made by the VA to reduce the waiting time veterans experience and eliminate deficits in their care, backlogged claims remain a problem and there are still veterans who have not received adequate care. This section starts with the explanation state crime gives as to why a deficit of care exists, continues to explain how Simon's (2007) governing through crime may be useful in understanding shifts within the VA and concludes with Klein's (2007) 'shock doctrine' and the impacts privatization has had on the VA.

If we return to the state crime framework, we can look at this deficit or gap in care through the causal mechanisms of state crime. These include the motivations, opportunity, constraints and controls and how they operate at different levels of analysis across the VA. Rothe (2013) argues that at the macro level, motivations include structural transformations which may include economic, military, and political goals of the organization. Structural changes

within the VA have occurred through political and military action occurring post 9/11 due to an increase of the number of veterans seeking care. Furthermore, while extending care to additional veterans has required increases in the VA's budget, some politicians have used this as an opportunity to privatize and outsource veterans care. The VA's internal reports and media reports served as a constraint with media and public ire drawing attention to this problem; however, the controls at this level are limited because domestic law has little to say about state crimes that deal with denial of benefits.

At the meso level, Rothe (2013) argues that organizational culture and reward structures provide motivations. The findings demonstrate that the organizational culture and reward structures within the VA were such that opportunity existed within the VA for state crime to occur. The constraints consisting of internal regulation and the enforcement of that regulation, failed, resulting in state crime. At the micro level, Rothe (2013) argues that motivations can include strain and obedience to authority, that opportunity may rely on the normalization of deviance, that constants include personal morality and socialization, and finally that controls include the perception and application of the law. Within the VA, pressures to meet internal performance metrics and obey commands from a top-down hierarchical structure provided the motivations while opportunity occurred with the normalization of deviance. The constraints operated through the personal morality of the whistleblowers who reported a problematic organizational culture that was violating its own procedures and policy. Little controls exist outside of the organization itself which further contributes to the harm veterans experience. This further contributes to the perpetuation of the veteran being viewed and treated as an expendable resource through this benefit deficit.

The expendable reality that veterans face after their service is done can be further critiqued through Massey's (2007) reproduction of inequality. According to Massey (2007) inequality is reproduced through processes of discrimination, exclusion, and structural processes that limit individuals. This is especially true for homeless veterans who are duly marginalized by their expendable status and through their homelessness. While the VA has set forth to end homelessness, reduce veteran suicides, and address issues veterans face in dealing with PTSD, these issues have continued to plague veterans. Rather than quick or responsive care, veterans and soldiers facing these issues are often left marginalized by society especially if their problems begin before they are honorably discharged from the military. At this point, the veteran no longer has the same rights as other veterans.

While state crime focuses on complex models of motivation, opportunity, control, and constraints, Simon's (2007) governing through crime offers another approach to understanding the VA as veterans find themselves governed through crime. Simon (2007) writes:

“When we govern through crime, we make crime and the forms of knowledge historically associated with it—criminal law, popular crime narratives, and criminology—available outside their limited original subject domains as powerful tools with which to interpret and frame all forms of social action as a problem for governance” (p. 17).

Simon (2007) argues that crime then becomes central to exercising authority within the U.S., first through its strategic use, second, through crime being deployed as an outcome instead of other legitimate interventions, and third, through crime and crime controls' pervasive visibility in institutions previously unknown to it. Veterans themselves are governed through the criminogenic consequences they face: suicide, PTSD, homelessness, drug use and abuse, and high rates of IPV.

It is still too early to determine how much involvement in the criminal justice system veterans of the Iraq and Afghanistan war have had in comparison to previous military actions. There are some indicators, however, of the size of the problem. One key indicator is what has occurred through the creation and expansion of a deferral program for veterans known as “Veterans Treatment Court” (VTC) which defers veterans from the criminal justice system into a special court (Department of Veterans Affairs 2017a). The VA explains that VTCs work by first determining if an arrestee is a veteran and their eligibility for the program and VA benefits. “Only Veterans charged with non-violent crimes who are in need of mental health or substance abuse treatment are eligible for treatment court” (Department of Veterans Affairs 2017a:para 1). Baldwin (2015) explains that veteran treatment courts are operated by the public criminal justice system, not the military, and they are designed to attempt to deal with the extralegal and legal problems that veterans face, sometimes due to the VA’s failures. Veterans Treatment Courts (VTC) serve a similar function as drug courts or other specialized courts in that the goal is treatment and rehabilitation for the underlying problem not just punishment for the offense that brought the individual to the court in the first place (Baldwin 2015, Baldwin 2017).

While this, in theory, is a great step towards getting veterans the help that they need, I argue it is yet another instance where veterans are governed through crime. While it is good to give troubled veterans deferrals to the VA to receive the mental health care they need, this should not occur after they have had a legal problem and a run in with the criminal justice system. This is, as Simon (2007) argues, an instance where the criminal justice system has pervaded an area of our day-to-day lives and is now existing within the realm of health care. This has occurred through the criminalization of homeless populations and the increase use of

criminal sanctions in schools (Simon 2007). Similarly, veterans face Veteran Treatment Courts instead of receiving the care from the VA to begin with.

For the individual veterans experiencing these consequences, this lack of health care may lead to criminalization of their behaviors and further denial of adequate care. The VA is governed through the military-industrial complex, itself an extension of the war on terror and securitization (Graham 2010, Simon 2007). This military-industrial complex is evidenced in bipartisan politics that seek to reduce the VA's budget and privatize it during a time where veteran populations needs are ever expanding through previous and on-going military actions, despite those military actions being the very source of the expanding need.

The move to privatize brings us to a third and final explanation. Naomi Klein (2007) explains how a 'shock doctrine' is used during crisis to make permanent and lasting changes resulting in privatization of and loss of core public institutions. Klein (2007) explains:

"That is how the shock doctrine works: the original disaster--the coup, the terrorist attack, the market meltdown, the war, the tsunami, the hurricane--puts the entire population into a state of collective shock. The falling bombs, the bursts of terror, the pounding winds serve to soften up whole societies much as the blaring music and blows in the torture cells soften up prisoners. Like the terrorized prisoner who gives up the names of comrades and renounces his faith, shocked societies give up their housing projects and public schools" (pg. 17).

Instances of crisis and instability are used as political mechanisms to promote ideological shifts towards privatization.

In the case of the VA, the 'shock' or 'crisis' occurred with the expansion of veterans' needs through military actions in Iraq and Afghanistan and the VA's inability to care for them.

From this crisis point, and the whistleblowers who brought it to the public's attention, politicians, especially Republicans, seized upon an opportunity to promote the privatization of the VA. According to the GOP (2016), Republicans prefer states' rights to federal, deregulation and the freeing of the market. Furthermore, Republicans tend to shy away from government aid programs. For the VA, the result was a voucher program that allowed veterans to see private physicians thereby creating a VA budgetary shortfall and continued problems within the VA itself. Klein (2007) argues after Hurricane Katrina, similar events occurred. The disaster destroyed public schools and politicians seized the opportunity by creating a voucher program for privately owned charter schools thereby eliminating the majority of the public schools in New Orleans. For the VA, the problem was only addressed once under public scrutiny despite the fact that the VA's internal reports (General 2014a, General 2014b) indicate that they knew about the problem for nearly a decade.

While state crime (Rothe 2013), governing through crime (Simon 2007), and shock doctrine (Klein 2007) all explain the VA's gap in care for veterans differently, there are some commonalities to these approaches. Veterans are experiencing a benefit deficit largely due to expanding veteran needs and a system that does not have the resources to care for the number of new and aging veterans. Efforts to privatize segments of the VA through voucher programs further impact the VA. Lax enforcement of existing regulations and lack of regulations to prevent harm or punish those who are guilty of causing such harm only further contributes to the problem. The results are veterans who experience criminalization and other criminogenic consequences such as PTSD, TBI, increased rates of IPV, drug use and abuse, homelessness and suicide. The VA must do more to address the ongoing issues that veterans have and to limit the number of criminogenic consequences that veterans face. It is a central tenant of this work that

identifying VA actions as a state crime will help develop a proper response. The next section will discuss the implications of calling this benefit deficit a state crime.

IMPLICATIONS OF STATE CRIME

There are multiple reasons for approaching the VA as a case of state crime. The reasons fall into 3 broad categories. They are the theoretical, legal and political implications of calling the failures of the VA a state crime.

Theoretically using the state crime framework has two important implications. First, it opens the possibility of introducing international controls to the harms the VA has caused its veterans. While these controls may only be symbolic in nature because of the limited jurisdiction of international law over a sovereign state (Kauzlarich, Mullins and Matthews 2003, Rothe and Mullins 2009, Rothe et al. 2009, Rothe and Mullins 2011), symbolically determining that the VA is causing a grave social harm to its own veterans and is guilty of human rights violations sends a powerful message. Secondly, labeling the VA's actions as a state crime creates the opportunity to engage in public criminology (Kramer 2012, Rothe and Kauzlarich 2016).. Public criminology allows us to engage with the public and the resulting public outrage over the problem can then translate to political action which could lead to enacting lasting change that results in more than a handful of employees losing their jobs.

Beyond theoretical implications in using the state crime framework, there are also legal implications of calling the VA's actions state crime. Jurisdiction issues prevent legal action at the international level and many of the actions the VA is guilty of resulted in harms and not actual crimes. There is also an issue of limited liability, with veterans having little resource against the VA. Currently, veterans experience several criminal justice outcomes that the

civilian population does not experience. The first is the previously discussed Veteran Treatment Courts wherein veterans with existing mental or health problems who have legal problems may be deferred to this alternative outcome. The second is that veterans have limited capacity to sue the VA in the traditional sense if the VA acts in a negligent fashion. According to the VA:

“The Federal Tort Claims Act prescribes a uniform procedure for handling of claims against the United States, for money damages only, on account of damage to or loss of property, or personal injury or death, caused by the negligent or wrongful act or omission of a Government employee while acting within the scope of his or her office or employment, under circumstances where the United States, if a private person, would be liable in accordance with the law of the place where the act or omission occurred.”

The Federal Tort Claims Act allows veterans to use tort law to fill out a specific form, Standard form 95, Claim for Damage, Injury, or Death, to name a sum that they are seeking in damages to be investigated by the Office of General Counsel within the VA (Department of Veterans Affairs 2017b). Awards will never exceed the sum named in the initial claim and may be up to that amount dependent upon the results of the investigation into the claim. While this does allow veterans who have faced harm to file a tort claim, it is handled internally by the Office of General Counsel, a much different outcome than if the veteran were using traditional civil court. Therefore, outside of veterans experiencing the criminogenic consequences of the VA’s actions, there is limited legal recourse for the veteran who is harmed.

Much like the push within white collar crime literature to include harmful regulation violations within the purview of criminology and the law, state crime too seeks to include human rights violations and social harms within the purview of criminology and criminal law. The harm caused by the VA’s systemic manipulation and outright falsification of patient records is

not legal behavior and should be punished as such. Individuals engaging in such acts should be punished more severely than losing their jobs and the organization itself must face operational changes above and beyond a change in the VA Secretary and the firing of a few other employees. Legislation to address these issues could include changes in the VA's use of the Federal Tort Claims Act to allow veterans to fully engage with the civil and criminal courts to charge and prosecute individual VA employees engaging in harmful behaviors. The lack of international jurisdiction to enact sanctions on the VA and the lack of clear punishments for organizations guilty of state crimes and social harms does provide us the opportunity to take a humanistic approach to examining harms and utilize public outrage over the problem for political change (Rothe 2009).

Finally, political implications of using a state crime framework include the potential for public outrage to enact political change and the importance of politics in how the VA is managed. Public outrage over the problems within the VA have served to motivate the public to demand change through political leaders and legislation. After the scandal erupted in 2014, numerous pieces of legislation were passed to increase the VA's budget and, ideally, provide additional services for veterans. However, political change continues to be an issue within the VA as efforts to privatize and threats to VA funding continue. As of mid-2017 over 370,000 claims are pending in the compensation and ratings bundle with over 93,000 of those claims backlogged more than 125 days (MMWR 2016). Additionally, veterans wait an average of 113 days for disability once their claim is fully developed and an average of 136 days for claims that are not fully developed. Ultimately, if the VA is going to continue to provide quality health care to the numerous new veterans who have served multiple tours of duty in Iraq and Afghanistan in a post-9/11 era of war, funding will have to continue to be a priority.

While the VA's budget doubled under President Obama, it is important to consider that the majority of the budget increase comes from mandatory spending² on programs that were already approved (Affairs 2017b). Mandatory spending did see increases in the inclusion of Agent Orange claims and the additions of programs to care for veterans still suffering from its effect. However, from 2009 to 2017, the VA's mandatory funding went from \$47.1 billion to \$103.6 billion and the VA's discretionary funding went from \$47.8 billion to \$75.2 billion (Affairs 2017b). Mandatory funding has increased largely due to engagement in prolonged wars in two countries post 9/11 and increases in the presumptive for Agent Orange claims, which allowed veterans exposed in previous wars to open new claims. Discretionary funding has increased over the past few years; however, it is clear that increasing the day-to-day operating budget of the VA, which also contains the budget for medical care and would allow existing vacancies to be filled, is necessary.

As of the Spring of 2017, the new administration initiated a hiring freeze for federal jobs that originally included the VA; however, memos released at the VA unfroze 73 jobs critical to the VA's operations (Kheel 2017). Under this hiring freeze, claims processors and other non-medical VA positions faced potential problems in maintaining adequate employees to continue to make progress on reducing backlogged claims. This is occurring at a time when the VA still has over 97,000 backlogged claims pending. Acting Secretary Ron Snyder said that this allowed the VA to hire roughly 37,000 of the 45,000 unfilled positions within the VA (Affairs 2017d). After reports that the backlog was steadily increasing under the hiring freeze (Affairs 2017f), VA Secretary David Shulkin expanded the exemption to include claims processors and approved the

² The Department of Veteran's Affairs budget contains both mandatory spending, a pre-approved budget item that contains guaranteed spending such as benefit claims, disability claims, pensions, and education benefits and a discretionary budget which must be passed by Congress every year.

VA moving forward with hiring 300 additional positions to continue to work on the backlog (Affairs 2017c).

This incident speaks to the incredible importance in continuing to adequately fund the VA and provide the resources necessary not only for day-to-day operations but to continue to reduce the number of backlogged claims. Without continual work to reduce backlogs and provide previously guaranteed benefits to veterans in both a timely and acceptable manner, the VA continues to cause social harm. The resulting social harm impacts not just veterans and their families but also the communities that they live in. Issues surrounding VA funding must not be viewed within a narrow partisan lens but instead with an understanding of the social, political, and economic reasons that have led to the current problems within the VA—including the vast expansion in the numbers of veterans requiring its services. Further policy implications occur for individual veterans who do not receive timely care of adequate treatment for both physical and mental illness resulting from the costs of war. Such consequences include PTSD, TBI, increase rates of suicide, IPV, and drug use and abuse.

By defining the VA's actions as a state crime, there are theoretical, legal, and political implications that can be utilized to not only adequately acknowledge and define the problems within the VA but to also begin making appropriate changes to ease the burdens that veterans continue to face. A gap, or benefit deficit still exists for veterans in need of care and eliminating this gap will require aligning the laws and rules on the books with the reality of veterans' experiences. The VA guarantees medical care to those veterans who have been harmed as a result of their military service and they should be held accountable to provide such care. The next section discusses the limitations of this dissertation and future research.

LIMITATIONS AND FUTURE RESEARCH

There are several limitations to the work done in this dissertation, some of which suggest avenues for future research. Importantly, relying on the state crime framework and indicators of state crime is a limitation in that while definitions of state crime have coalesced over the last few decades, ways to theoretically test such definitions have been problematic. State crime operates at multiple levels of analysis through several catalysts of actions thereby making theory testing of state crime models difficult. What is possible, however, is to rely on indicators of state crime as past literature has demonstrated. Therefore, this dissertation relied on indicators of state crime to argue that the Department of Veterans Affairs is committing a state crime of commission and omission against its' veterans, a social harm.

Past research, including this dissertation, have relied on documents created by the offending agency as indicators that the organization is guilty of state crime. Having clearly defined indicators of what constitutes state crime would help in identifying when a state crime is occurring; however, it is understood that the complicated nature of state crime makes this a difficult endeavor. In order to move the literature forward, it is necessary to include more qualitative components to include interviews with victims and those impacted by the harms state crimes create (Faust and Kauzlarich 2008, Rothe 2009, Rothe and Mullins 2011). It is also possible to include qualitative components that include data from individuals who are participating in the organization. For example, interviews can be conducted with VA employees who had varying levels of participation within the organization's wrong doing.

Another limitation I encountered includes the narrow time frame used to analyze media response to the scandal within the VA. Future research can address this limitation by further analyzing if previous reports of the VA creating delays for veterans and scheduling

manipulations received a similar media response. Additionally, this dissertation is limited in that it only provides a limited view of the individual effects that veterans face as a result of the VA's state crimes.

Future research is necessary to determine if the VA continues to make progress on reducing the harm it has caused its veterans. Furthermore, research is necessary to further examine the individual level harms and experiences veterans have had with the VA over the course of two wars and subsequent military action in the fight against terrorism. In the future, I hope to interview veterans and learn more about their personal lived experiences with the VA. Research has been done using geographic information systems (GIS) to map specific veteran problems, such as multiple sclerosis, with the resources available to them (Culpepper 2010). This literature can be expanded upon by using GIS to determine where veterans are having the greatest issues at. This can be accomplished by using GIS to map veteran claims by region along with data on the number of veterans experiencing certain harms (e.g. suicide, IPV, TBI, PTSD). Utilizing GIS will provide a visual representation for VA data, demonstrating where access to care is and is not.

Harms to veterans are not new and while this dissertation looked at current and specific harms veterans are facing, future research plans include an examination of harms veterans have faced throughout history including Agent Orange, legionnaires disease, chemical exposure, and toxic water exposure at Camp Lejeune, North Carolina.

Finally, as the daughter of a disabled veteran who served in previous war and military action, I hope to eventually detail both my family and my own experiences with the VA through ethnographic and autoethnographic work.

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APPENDIX

PERMISSION TO USE TABLE

RE: Permission to use a table
Dawn Rothe <dawnrothe1@gmail.com>
Mon 7/31/2017 8:43 AM
To: Quick, Leslie-Dawn <lquick@odu.edu>;

Hi Leslie,

It is good to hear from you and I hope your new job in Kansas will be a great place and a good experience. Of course you can use the table, though I do not know about their copyright requirements. You may want to read the journals copyright statements. But I do give my permission.

d

Dawn L. Rothe, PhD
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Recent Books:

Crimes of the Powerful (2016) with Dave Kauzlarich:
<https://www.routledge.com/products/9781138797949>
Crimes of Globalization (2015) with David Friedrichs:
<https://www.routledge.com/products/9780415856300>

Towards a Victimology of State Crime (2014) with DaveKauzlarich:
<https://www.routledge.com/products/9780415639002>

From: Quick, Leslie-Dawn [mailto:lquick@odu.edu]
Sent: Sunday, July 30, 2017 8:55 PM
To: Rothe, Dawn <Dawn.Rothe@eku.edu>
Cc: Triplett, Ruth A. <rtripler@odu.edu>
Subject: Permission to use a table

Hi Dr. Rothe,

I hope you are doing well! I am busy getting settled in Topeka, KS. I am e-mailing to ask permission to use one of your tables from an article you wrote in my dissertation. The table is from "Criminological Theory and State Crime: How Far Can It Go?" D. L. Rothe, 2013, Revista Critica Penal Y Poder, p. 40.

If you have copyright over the article (instead of the journal) can you e-mail a statement if it is OK to use the table?

Thank you for all of your help,

Best,

Leslie

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Quick, Leslie-Dawn. 2015. "The Case of the United States." Annual Meeting of the American Society of Criminology, Washington D.C, USA

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