Final Report for MIE459 Winter 2016
Organizational Structure and Culture of the United States Veterans Heath Administration

Approach and Scope

We will analyze the organizational foundations of corruption. More specifically, we will outline the facts behind, and the different types of misconduct that led to, the 2014 scandal. We will also outline VHA's policies and corporate culture as of 2014 and provide a description of the common characteristics of corrupt organizations. We will then analyze how corporate culture led to the problems that caused the scandal as well as how VHA's corporate culture fits the description of corrupt organizations. To finish, we will describe the improvements taken by VA after 2014 to remedy the problems behind the scandal. Our scope will be solely VHA's organizational problems and their associated roles. Although criminal felonies committed by VHA employees against veterans did occur, they do not entirely reflect organizational corruption and will not be in the scope of this report. We will also focus our scope on the scandal of 2014, so any post-2014 allegations of misconduct will not be covered in the report.

Executive Summary

Veterans Health Administration is the largest component of the United States Department of Veterans Affairs and is responsible for providing both physical and mental care to American military veterans. Although the organization's mission is laudable, VHA has problems with corruption that resulted in significant lapses in level of care which led to several deaths nation-wide. A scandal ultimately surfaced in 2014 that led to a criminal investigation by the Justice Department and the resignation of the Secretary of Veterans Affairs.

Why did America's veterans receive such a treatment by an agency whose sole purpose was to take care of them upon their return from war? The answer is thus: organizational corruption caused the VHA as a whole to turn away from its original mission and engage in practices that only served the interests of a corrupt management instead of the veterans.

The corruption has its causes in a combination of extremely unrealistic standards as well as high rewards for managers whose facilities meet those standards. The lack of oversight and public accountability led to managers to resort to deceit in order to appear to meet those goals in the eyes of their superiors in Washington, DC and turned corrupt practices into a high reward and low risk venture. It was the veterans themselves who felt the effects of VHA's corruption, as many died while waiting for care even though money that was supposed to be used help them was squandered on unaccountable items.

The corrupt management, who wanted to keep their schemes running, demanded total silence from their subordinates. The ethical employees who raised awareness about VHA's corruption were punished and made examples to discourage further whistleblowing.

Ultimately, the Federal Government did intervene, but the damage was already done by that point. Nearly one hundred veterans died while waiting for care, and VHA, as well as Veterans Affairs in general, lost the public's trust. Although measures were taken to address the culture of corruption at VHA including the removal of the unrealistic 14-day goal for waiting periods, it remains to be seen if the VHA would remain scandal-free.