Dems Demand: Give Veterans Healthcare; Cancel Bush's Cuts

by Marcia Merry Baker and Judy DeMarco

In May 2004, the Bush Administration, through the Office of the Secretary of Veterans' Affairs (VA), released plans for *downsizing* the already over-loaded national Veterans Affairs medical system, despite the dramatic need for just the opposite—its major expansion. In particular, as of 2004, the VA was bearing the triple burden of the war-wounded from Iraq and Afghanistan, the growing number of untreated and uninsured veterans from Vietnam- and Gulf War-era service, and the growing ranks of homeless vets as the economy worsens.

All told, there are about 23,067,000 veterans today in the United States. Of the sub-group who are under 65 years old—which numbers about 17.1 million—an estimated 12% have no healthcare coverage at all (not VA, not Medicaid, not private). These are the ranks who served in the Vietnam era and since. During the Bush Administration, from 2000-2003, the number of medically uninsured veterans rose by over 235,000!

Apart from medical treatment questions, an estimated 500,000 veterans are homeless nationwide; the returnees from Iraq and Afghanistan are adding to these numbers. Yet the VA maintains only a very few homeless accommodations. In Illinois, for example, there are some 900,000 veterans resident, with an estimated 20,000 homeless, but the VA funds only 200 homeless beds in the whole state. This is typical across the nation.

Thus, the newly announced Bush budget for FY 2006, in which an increase of merely $25 million was proposed for the VA medical budget, dramatically spotlights both the record and intent of the Bush-Cheney Administration: Damn the services and the veterans.

In opposition, bills have been introduced in the 109th Congress in both houses, to fund and expand health care for veterans. On Feb. 2, Rep. Lane Evans (D-Ill.) the ranking Democratic member of the House Veterans' Affairs Committee, introduced legislation—since co-sponsored by 19 others—called the "Assured Funding for Veterans Healthcare Act of 2005" (H.R. 515), which, he said, will "place veterans' healthcare on par with all major Federal healthcare programs by determining resources based on programmatic need rather than politics and budgetary gimmicks." On Jan. 24, a new bill was introduced into the Senate, S. 13, titled, "Fulfilling Our Duty to America's Veterans Act." It is summarized below (see *Documentation*).

The import of H.R. 515, is that "need-based" medical treatment for veterans must be met, as Evans stated Feb. 2, by requiring "the Treasury Secretary to annually provide funding for the VA healthcare system based on the number of enrollees in the system and the consumer price index for hospital and related services."

Hill-Burton Principle: Meet Needs

On the "need-basis" criterion, an expansion, modernization, and upgrading of the network of VA medical and residential facilities of all kinds is urgently required. The map in *Figure 1* shows the core network of the nationwide system to provide healthcare: the main 148 Veterans Affairs Medical Centers (VAMC) as of 2004. These hospitals are institutions in the community, employing local staff, served by local vendors, etc. In the past (before cuts made in the VA system), many were allied with world-class teaching centers. The VAMC facilities in turn anchor a web of ancillary outpatient clinics, long-term care facilities and other treatment centers.

But there is no category of VA care at present—from psychiatric, to advanced-tech orthopaedic, to geriatric domiciliary, etc.—that is adequate to meet the needs of the veterans and their families right now. The issue is not at all a "quality" question—over the past decades, the VA system has been in the forefront of many aspects of medical treatment; for example, spinal injuries, and also, in medical education. Funding and resources must be mobilized for the VA to be put back on a footing to accomplish its assigned mission.

Lyndon LaRouche, through his LaRouche PAC policy assignments, has commissioned a work-up of what is required to expand the VA national medical system, both to serve veterans properly, *and as the model and key component for upgrading the entire U.S. medical care and public health infrastructure system.*

The Veterans Affairs medical network, from the start,

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was "need-based," providing the model and principle for the revolutionary 1946 civilian hospital system law—Hospital Survey and Construction Act, known as the "Hill-Burton Law." In just one generation, from the 1950s to the 1970s, under Federal, state and local collaboration, each of some 3,000 counties in the nation came to have a hospital, with the number of beds determined as a ratio with the area's population. For example, about 4 beds per 1,000 persons in cities; and 5.5 beds per 1,000 in rural areas. These ratios of beds were determined, based on the expected load and range of local treatment needs for infectious diseases, cancers, accidents, births, etc.

On top of this Hill-Burton baseline of beds-per-thousand, specialty staff and services were figured in, according the varying regional demographics. For example, some localities were demographically "young," as in California after World War II, and needed more natal and pediatric services. Other areas had large retirement populations, and needed geriatric services, as in Florida.

This principle—assay what is needed, and mobilize to provide the care—is what is posed right now, by how the VA system should be upgraded to care properly for the 23,067,000 U.S. veterans.

Yet the Bush Administration is pursuing drastic cuts. In May 2004, it proposed shutting 11 of the VAMCs completely, and downsizing 33 more! The excuse? A ruse called Capital Asset Realignment for Enhanced Services (CARES), which offered all kinds of rationalizations, including recourse to more "e-medicine." The Administration has even called in property appraisers on several of the older VA medical center campuses in beautiful settings, like St, Petersburg, Florida, with intent to sell off the sites for sweetheart real estate deals. The rationalization? The facility is old, so give up the site.[1]

Veterans' Needs Today

Here are some of the obvious categories of need, among the veterans today, that must be met by an expanded VA medical, and U.S. healthcare infrastructure system. The first rule can be stated: Shut nothing down! Keep all the VA infrastructure at present, even if any facility—as many do—dates to the Civil War era, until actual replacements and improvements are under way, measured as part of the overall U.S. healthcare infrastructure.

The figures used here, and cited above, are from a 2004 report, *America's Neglected Veterans: 1.7 Million Who Served Have No Health Coverage.*[2] By the term "coverage," the report, and the figures cited, refer to enrollment in either the VA system, Medicaid, Medicare, or some commercial insurer. Therefore, some of people lacking coverage, may, indeed, be getting medical treatment of some type in some ad hoc way, but this is a small fraction.

- Geriatric. There are an estimated 3,900,316 World War II veterans, of whom 6,039 lack healthcare coverage. The Korean War veterans number an estimated 3,044,749, of whom, 6,921 lack coverage. In addition to specialty treatment, many of these people simply need domiciliary care, for which the VA space is insufficient at present.
- Under-65s with no coverage. There are an estimated 7,851,118 Vietnam-era veterans, with a large cohort still under 65 years old (not eligible for Medicare), among whom, 681,800 are estimated to be without any healthcare coverage at all at present.

Other service-era veterans since the Vietnam War, including the Gulf War and other military duties, now number some 8,270,505. Among this group, it is estimated that over 12%, or 999,548, have no medical coverage.

- 15,000-plus veterans from Iraq, Afghanistan, with severe physical and psychological wounds. This roster has need for the most advanced treatment of all kinds—psychiatric, surgical, orthopaedic, neurological, and rehabilitation. While the on-the-ground MASH units may have been equipped with remarkable technologies, the VA system stateside is now faced with trade-offs in caring for these newly wounded, at the expense of providing treatment for millions of other veterans.
- Post Traumatic Stress Syndrome. An estimated 15%, at least, of military personnel having served in Iraq, are experiencing PTSD, with effects extending to their families and communities.

1. *Capital Asset Realignment for Enhanced Services (CARES) Decision,* Department of Veterans Affairs, Office of the Secretary, May 2004.

2. Report of the Harvard/Campbridge Hospital Study Group, Cambridge, Mass.

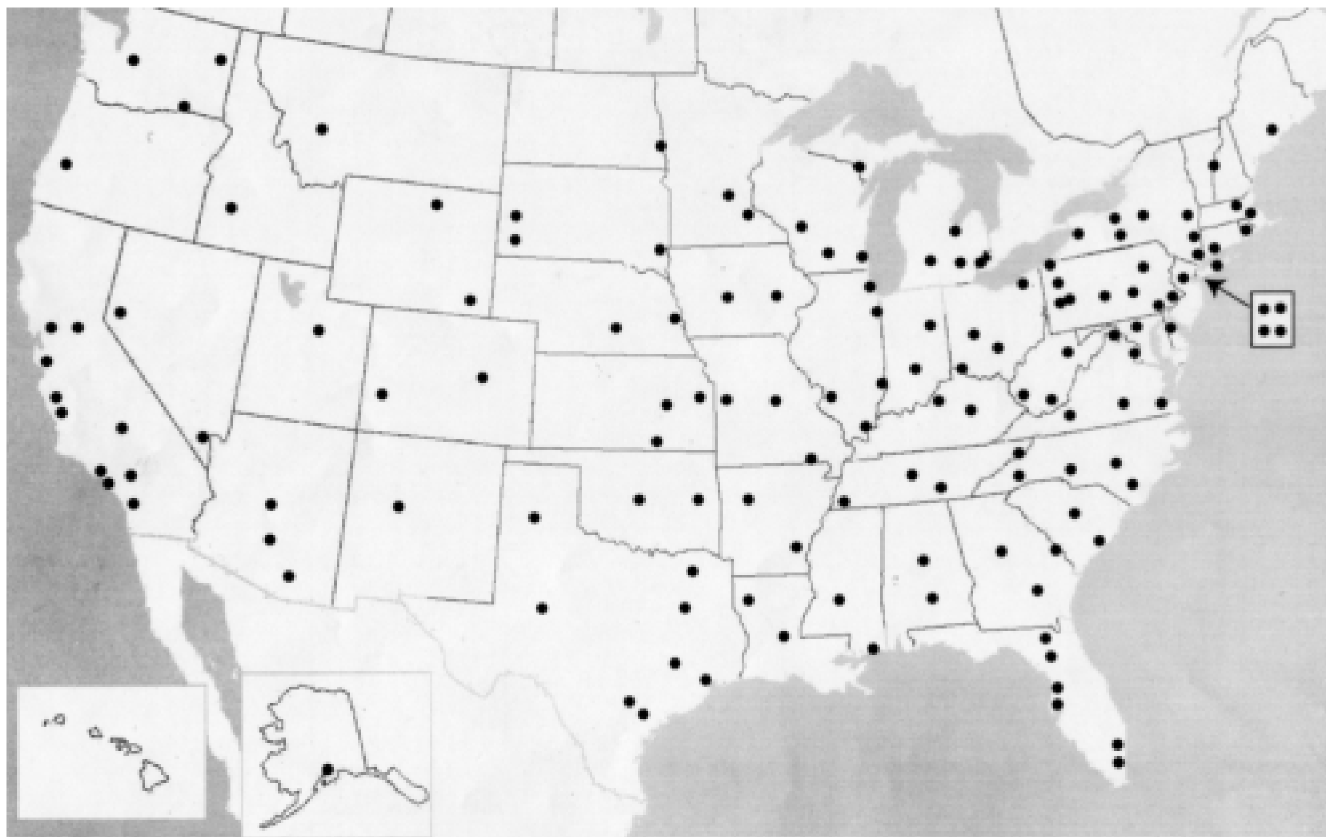
Documentation

'Fulfilling Our Duty To America's Veterans'

On Jan. 24, S. 13 was introduced in the Senate, with the full title, "Fulfilling Our Duty to America's Veterans Act of 2005." The principal sponsor is Daniel K. Akaka (D-Hawaii), joined by 19 other Democrats, including Harry Reid (D-Nev.), the Senate Democratic Minority Leader. In brief, this is, "A bill to amend titles 10 and 38, United States Code, to expand and enhance healthcare, mental health, transition, and disability benefits for veterans, for for other purposes."

The bill has four main sections: Title I Healthcare Matters; Title II Concurrent Receipt of Retired Pay and Service-Connected Disability Compensation; Title III Seamless Transition from Military Service to Veterans Status; Title IV Increased Commitment to Veterans; Education. Here are excerpts from subsections of Titles I, II and III.

Veterans Affairs Medical Centers, 2004



Source: Department of Veterans Affairs, CARES Decision, May 2004, Office of the Secretary; www.va.gov.

Title I, Healthcare Matters; Section 100, Findings

(1) The three largest veterans advocacy groups, the Disabled American Veterans, the American Legion, and the Veterans of Foreign Wars, have called upon Congress to change veterans funding to a mandatory process, stating, "We believe it is time to guarantee healthcare funding for all veterans. We believe healthcare rationing must end. We believe it is time the promise is kept."

(2) The May 2003 report of The President's Task Force To Improve Healthcare Delivery for Our Nation's Veterans found that "there is a significant mismatch in VA between demand and available funding—an imbalance that . . . if unresolved, will delay veterans' access to care and could threaten the quality of VA healthcare."

(3) Under the current funding process, the VA has experienced billion-dollar shortfalls every year for the past several years, resulting in waiting lists several months long for appointments with physicians, a substantial disability claims backlog, and policies designed to prevent veterans from obtaining the health care they were promised.

Subtitle B, Mental Health Matters; Section III, Findings

(1) A study published in the New England Journal of Medicine reported that about one in six soldiers of the Iraq war displays symptoms of Post-Traumatic Stress Disorder.

(2) Clinical experts are anticipating an increase in the number of post-traumatic stress disorder cases in light of the increasing duration of military deployment.

(3) 86 of 163 Department of Veterans Affairs Medical Centers have Post-Traumatic Stress Disorder treatment programs.

(4) United States Code requires that the Department of Veterans Affairs maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans within distinct programs or facilities of the Department.

Section 112, PTSD Treatment for Veterans of Service in Afghanistan and Iraq and the War on Terror

(a) Enhanced Capacity for Department of Veterans Affairs— . . . the Secretary shall employ at least one psychiatrist and a complementary clinical team at each medical center.

(b) Outreach at the Community Level

(1) Program—The Secretary . . . shall carry out a program to provide outreach at the community level to veterans who participated in Operation Iraqi Freedom or Operation Enduring Freedom who are or may be suffering from Post-Traumatic Stress Disorder.

(2) Program sites—The program shall be carried out on a nationwide basis through facilities of the Department of Veterans Affairs.

(3) Program content—The program shall provide for individualized case management to be conducted on a one-on-one basis, counseling, education, and group therapy to help participants cope with Post-Traumatic Stress Disorder.

Section 113, Armed Forces Review of Mental Health Programs

(a) Review of Mental Health Programs—The Secretary of each military department shall conduct a comprehensive review of the mental healthcare programs of the Armed Forces under the jurisdiction of that Secretary in order to determine ways to improve the efficacy of such care, including a review of joint Department of Defense and Department of Veterans Affairs clinical guidelines to ensure a seamless delivery of care during transitions from active duty or reserve status to civilian life.

(b) Report to Congress—The Secretary of Defense shall submit to Congress a report setting forth the results of such review, not later than 90 days after the date of the enactment of this Act.

Section 121, Authority of VA Pharmacies To Dispense Medications; Findings

(1) Under longstanding regulations of the Department of Veterans Affairs, most veterans who receive prescriptions for medication from private doctors are forced to complete physicals conducted by Department of Veterans Affairs physicians before the veterans can have their prescriptions filled by a pharmacy. This bureaucratic red tape can prevent veterans from quickly receiving the medical treatment they need.

(2) In December 2000, the Inspector General of the Department of Veterans Affairs reported that eliminating this unnecessary red tape would save the underfunded Department of Veterans Affairs over $1,000,000,000 per year.

(3) In 2004, the Department of Justice, in a reversal of an earlier legal opinion, stated that the Secretary of Veterans Affairs has the authority to eliminate this rule without further legislative action. The Secretary has failed to take such a step, thus necessitating action by Congress.

Title II, Retired Pay Restoration Act of 2005; Section 202, Findings

(1) The United States Government has an essential obligation to provide support and care for men and women who have completed honorable military service in defense of the Nation. In no instance is this obligation more critical than for veterans who were injured or disabled during their military service.

(2) Disability compensation and military retired pay are benefits earned for two distinct reasons. Disability compensation is provided to veterans for disabilities resulting from their military service to the Nation, as an expression of the Nation's gratitude and as recompense for their sacrifice. Military retired pay is earned by members of the Armed Forces for the devotion of 20 or more years of their lives to the military service of the Nation.

(3) Until 2002, Federal law prohibited disabled veterans from concurrently receiving both disability compensation and retirement pay. The prohibition against concurrent receipt was a gross violation of the Government's commitment to veterans.

(4) Despite recent legislative advances, over 1,500,000 disabled veterans continue to be prohibited from receiving both military retirement and disability payments concurrently.

(Section 203) Full payment of both retired pay and compensation to disabled military refugees.

Title III, Seamless Transition from Military Service to Veterans Status; Section 301, Findings

(1) In its final report, the President's Task Force To Improve Healthcare Delivery For Our Nation's Veterans found that "increased collaboration between the Departments [of Defense and Veterans Affairs] for the transfer of personnel and health information is needed.

Within VA, broader sharing of the information received from the DOD and individual veterans is required so that veterans are not met at every turn with the question, "Who are you and what do you want?" A "seamless transition" from military service to veteran status is especially critical in the context of healthcare, where readily available, accurate, and current medical information must be accessible to healthcare providers.

(2) The Task Force put forward a series of seven recommendations designed to create a seamless transition from military service to veteran status. Nearly two years after the submittal of its final report, few of the recommendations have been adopted.

(3) Leading nonpartisan veterans' advocates, including the American Legion, Veterans of Foreign Wars, Disabled American Veterans, and the Military Officers Association of America, support the adoption of the recommendations made by the Task Force to create a seamless transition from military service to veteran status.