

Vets Face Deepening Austerity at the VA

by Carl Osgood

The Bush Administration, from the President himself, to Secretary of Defense Donald Rumsfeld, to public affairs officers at every level, constantly proclaim the virtues of the American soldier, and their support for giving him everything he needs. On Memorial Day, President Bush will make the solemn journey to Arlington National Cemetery, and extol the sacrifices made by the members of America's armed forces in every war, including the present wars in Iraq and Afghanistan. Yet, veterans of those same wars are finding a different story when they turn to the Department of Veterans Affairs for health care. They are finding "reprioritization"—where different groups of veterans have to compete against each other for care—and a ratcheting down of services.

Steve Robinson, the executive director of the National Gulf War Resource Center, gave a number of anecdotal examples to *EIR* on May 25. He reported that a Veterans Affairs hospital in Kansas has only two doctors to treat 800 people in its mental health program. He also learned, in a Washington state meeting between veterans and Democratic Rep. Jim McDermott, that Vietnam veterans there say they are being told that they can get only one clinical visit every three months for post-traumatic stress disorder (PTSD), whereas they used to be able to get two per month.

Robinson also reported that older groups of veterans from earlier wars are seeing their appointments cut back or canceled, so that the system can make room for the new ones. Robinson called this pitting of one group of veterans against another "unconscionable." "I think both [World War II and Iraq war veterans] equally have a right to care, and as an obligation of the government, they have an obligation to make the system so that you don't pit one veteran against the other, or reshuffle priorities in order to take care of the newer veteran," he said.

Human Toll of the Iraq War

While VA officials downplay the numbers of Iraq and Afghanistan war veterans seeking care at VA facilities, as only a small percentage of the patients in the system, the need is nonetheless large, and will only grow as long as the Cheney policy of perpetual warfare is in effect. The cost of that policy is, in fact, many times larger than the official Pentagon statistics would suggest. As of May 26, the Defense Department reported that 1,646 American military personnel had been killed in Iraq and another 12,630 wounded. Yet, Air Force

Surgeon General Lt. Gen. George P. Taylor, Jr. testified to the Senate Appropriations Committee on May 10, that Air Force aeromedical evacuation units had completed 55,000 patient movements since the beginning of the Iraq war.

Nine days later, John Brown, the director of the VA's "Seamless Transition Office," in a prepared statement to the House Veterans Affairs Committee, reported that out of 360,674 Iraq and Afghanistan veterans who had separated from active duty as of February 2005, nearly one-quarter, or 85,857, had sought care at VA medical facilities. The number of patient movements out of Iraq, plus the number of veterans seeking VA health care, is about 140,000. Even allowing for some overlap in the two figures, the human cost of Dick Cheney's Iraq war is already very large. Many of these people will be suffering from the effects of their service for the rest of their lives.

The most common health problems of Iraq and Afghanistan veterans, Brown reported, have been joint and back disorders, and diseases of the digestive system, including teeth and gum problems. But 11,224 have sought services for PTSD or other psychological disorders. Brown claimed that these numbers only represented about 1% of VA's overall patient load and 3% of VA's PTSD patients. But they are apparently enough to deny services to older veterans of previous wars, in order to address the needs of these new veterans.

Estimates are that 1.1 million-1.4 million service members have deployed to Iraq or Afghanistan (or both). If one quarter of that number seek medical care, that adds up to about 275,000 going to Veterans Affairs hospitals and clinics over the next few years. Despite this foreseeable increased load, the Senate in April rejected an attempt to add more money for veterans' health care to the Iraq war supplemental bill. Sen. Patty Murray (D-Wash.), the sponsor of the amendment, told the Senate, "The VA is not prepared to deal with soldiers coming home. It is an emergency today. If we don't deal with it, it will be a crisis tomorrow." Her amendment would have provided \$1.975 billion to the VA, including \$525 million for mental health programs, but it was turned back by a vote of 54-46. Senate Appropriations Committee chairman Thad Cochran (R-Miss.) lamely explained the rejection: "The Administration has not asked for these funds."

Most people who have joined the military over the last couple of decades, expected that they would receive lifetime medical and dental care, especially if they are injured or suffer psychological trauma as a result of their service. Although veterans were put into categories in the mid-1990s, by degree of military-related disabilities and income, it took the Bush Administration to make a mockery of that lifetime promise. Its Fiscal 2006 budget increases co-payments and fees from certain categories of veterans, for the express purpose of reducing the number of veterans in the VA's medical system. What veterans need, Robinson said, is "a funded VA. We need access to care and we need the nation to uphold the commitment that it made when we volunteered to join."

Cuts, Real Estate Deals Target VA Hospitals

by Marcia Merry Baker

The Veterans Affairs Department is currently carrying out a process intended to designate, by February 2006, more than a dozen major VA hospital campuses for real estate sell-off, or lease—all or in part. The sites range from New York City, to Pittsburgh, to Los Angeles (see map, page 24). Using talk about “business-based” decision-making for “asset-value” and real estate revenue, the VA calls its scheme, “Capital Asset Realignment for Enhanced Services” or CARES. It speaks of divesting itself of outmoded properties and facilities to marshal assets and provide better service. However, CARES is part of an overall operational policy of implementing *reductions in ratios of hospital beds, staff, and facilities to serve the nation’s 23,100,000 Veterans.*

VA waiting lines are already long for all kinds of medical procedures and appointments. The crisis-situation of lack of infrastructure would show up even more, but in 2003, the Bush/Cheney Administration closed enrollment to certain categories of Vets, who are above a certain income, and/or may have not had combat injuries (VA Categories 7 and 8). Among veterans now under 65 years old—about 17.1 million people—an estimated 12% have no health care coverage at all. This cohort, plus the over-65 Vets, and the newly demobilized Vets from Iraq and Afghanistan postings, who have intense medical needs, show that the VA system should be expanded, not reduced. However, the Bush FY 2006 budget called for an increase of merely \$25 million for the VA medical program, and also called for upping enrollment fees, copays for drugs, and other levies on Veterans.

Over April and May, a round of public meetings was held to take public comment at 18 VA hospital sites, more than 10% of its hospital centers, targeted for potential sell-off, shutdown, relocation, etc. The VA has hired PriceWaterhouseCooper and other firms to provide sales and lease valuations of VA properties as commercial cash sources—many are sited for decades on prime urban or rural campuses. The process was launched in May 2004, with the release of the VA “CARES” Report, which identified an initial pool of dozens of the 150 or so VA hospitals for such rationalization.

PriceWaterhouse lists 15 medical campuses for its “re-use” considerations, by which is meant, revenue-generation, and not exclusively health care activities: Boston; Brooklyn/Manhattan; Louisville; Waco and Big Spring, Tex.; Walla Walla, Wash.; Canandaigua, New Montrose/Castle Point, and St. Albans, N.Y.; Lexington; Livermore, Calif.; White City, Ore.; Perry Point, Md.; Gulf Port/Biloxi, Miss.; and West

Los Angeles. PriceWaterhouse explicitly states the real estate swindle intentions of the Bush/Cheney Administration, describing CARES’ objectives:

- “Determine best use of VA assets and the best configuration of these assets”;
- “Determine Potential for VA to capitalize on valuable real property”;
- “Determine the real estate potential for each campus.”

The claim that the VA is underutilizing these centers covers up the fact that enrollment is being suppressed; and the replacement, expansion, and upgrading of facilities, for a full-service VA system, has not been taking place. The VA projection that demand for its medical services will decline after 2009 ignores the realities of the ongoing and recent wars.

In Walla Walla, Wash., for example, on May 4, the VA forecast that patient demand at the Medical Center there would rise 38% in 10 years, and fall after that. Sen. Patty Murray (D) urged them to relook at their figures, saying that keeping the Walla Walla hospital open, is, “absolutely necessary to meet the diverse needs of this region’s veterans population.” There are at present some 69,000 Veterans living in that VA service area, and the Walla Walla VAMC is facing a \$1.4 million budget deficit this year because of increased demand from Vets. Shutting it down would kill 350 jobs. A counter proposal, for how to upgrade the hospital and meet future needs, has been presented by Walla Walla Port Commissioner Fred Barnett.

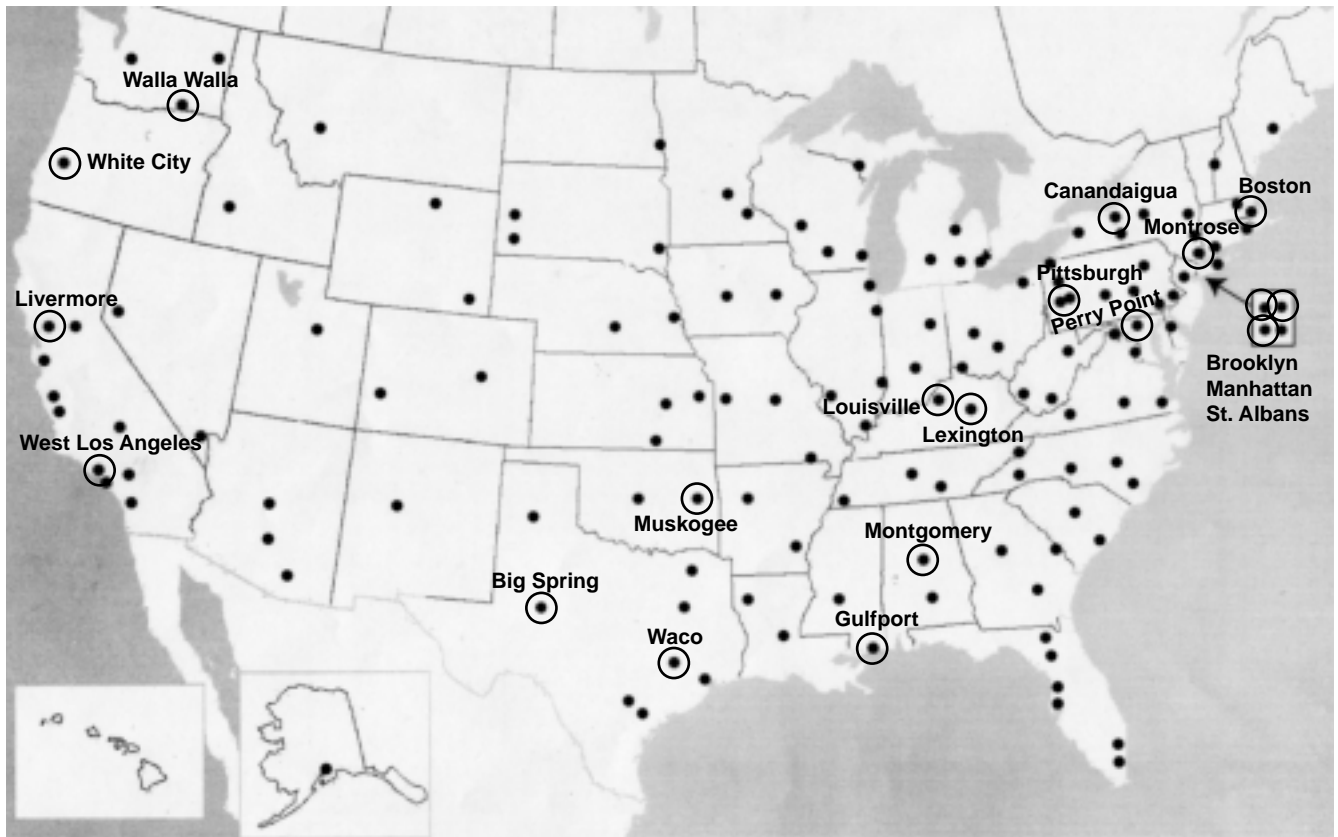
On May 3, 500 people attended a public meeting in Waco, demanding that the VA cancel any intentions to shut the VA Center, and called for expanding services especially to treat post-traumatic stress syndrome. Waco Mayor Robin McDurham and community leaders proposed—as a counter to shutdown—to invite area medical service providers like Hillcrest Baptist Medical Center, Salvation Army, and so on, to utilize any currently unused VA buildings on the Waco campus. In the face of this, Jose R. Coronado, VA Regional Director for South Texas, backpedaled. He told the adamant crowd, “I don’t think anyone has evil thoughts about Waco,” and he maintained that the VA has backed off plans for closing the Waco VAMC.

Suppressing services, and stiffing VA staff and facilities, is already reaching the acute stage in many locations. On May 24, for example, a class action suit was filed by residents of the U.S. Armed Forces Retirement Home in Washington, D.C., against Defense Secretary Donald Rumsfeld, claiming that Defense Department’s mandated cuts since 2002 have resulted in substandard care, harm, and deaths. Since 2003, the number of staff doctors has been cut from nine to three, and other staff reduced by 10%; deaths among the 1,000 veterans at the home (founded in 1851) more than doubled in 2004.

Anthony Principi, VA Secretary from 2001-04, who led the development of the CARES destructuring proposal, was made interim head of the base-closing drive this Spring—against strong bipartisan Congressional opposition—in a recess-appointment by Bush.

FIGURE 1

Veterans Affairs Medical Centers, 2004: Eighteen Are Targetted for Shut-Down and Sell-Off



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

Shown are locations of most of VA's 163 major hospitals, known as Veterans Affairs Medical Centers. The 18 named sites are on the short list currently under active consideration for VA decision by February 2006, to close them, relocate their services to a different site, or "re-organize" them. This process was begun during the first George W. Bush Administration, and euphemistically termed, "Capital Asset Realignment for Enhanced Services" (CARES). Photos and specifics for four of the targetted sites are accompanied by quotes from the May 2004 "CARES Decision" report. They rationalize an intended real estate-gain objective from the lease or sale of the hospital properties.



The VA Medical Center in Waco, Texas, on a 123 acre site, is part of a 36-facility complex called the Central Texas Veterans Health Care system. Waco accepts referrals from several Veterans Integrated Service Networks (VISNs)—the regional organization units for the VA—for chronically mentally ill patients, and is a national referral facility for rehabilitation of the blind. The Waco facility itself operates 346 acute inpatient beds, 191 psychiatry beds, and 15 beds for rehabilitation of the blind, with an average daily census of 206 patients. CARES says it will "identify options for divesting or leasing a significant portion of the underutilized property in order to generate savings and revenues," and transfer services to other locations.

The VA New York Harbor Healthcare System (VA NYHHS) consists of three campuses located in Manhattan, Brooklyn, and Queens. Shown are the Manhattan (above right) and Brooklyn facilities (center).

Manhattan has bed services in acute medicine, surgery, acute psychiatry, neurology, and rehabilitation medicine. It is the referral center for Interventional Cardiology, Cardiac Surgery, and Neurosurgery. The facility has been at the forefront of clinical care and research for patients with HIV/AIDS since the beginning of the epidemic. A Preservation and Amputation Care Team (PACT) and the Prosthetic Treatment Center are also located here. The Prosthetic and Orthotic Lab is the only laboratory authorized to fabricate definitive artificial limbs. Four of the many programs here are designated VHA Programs of Excellence.

The Brooklyn Campus is a tertiary-care academically affiliated medical center, housing beds in acute medicine, surgery, psychiatry, and residential substance abuse. Specialized programs exist in comprehensive cancer care and non-invasive cardiology. It is affiliated with the State University of New York-Downstate (SUNY) with residency programs in many, many fields, and is a preferred site for the training of medical students.

The CARES report says the VA will study the feasibility, the “expected cost-effectiveness” and impact of combining the Brooklyn and Manhattan VAMCs. Plans include the development of “multi-specialty” outpatient clinics.



The Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington is a 66-bed facility. It is located on an 84-acre campus, at the site of an historic U.S. cavalry fort, Fort Walla Walla, established in 1858. Fifteen of the 28 buildings of the VA complex are listed on the national register of historic sites.

This VA Medical Center currently provides inpatient medicine, psychiatric, and nursing home care services, as well as outpatient care, reaching a 42,000-square-mile primary service area.

The CARES Commission proposes to close the Walla Walla VAMC, to contract in the geographic area for the services it now provides, and to let the VA “identify options to divest or lease excess property to generate revenues.”