VA Losing the Ability To Care 'For Him Who Has Borne the Battle'

by Linda Everett

As U.S. military involvement in Iraq and Afghanistan continues, the number of new veterans needing medical care and other services through the Department of Veteran Affairs (VA) facilities, eascalates. As of December 2003, some 10,000 new veterans from U.S. military actions in Iraq were being treated by the VA. Soon, 25,000 active-duty Reserve and National Guard will be eligible as veterans. How prepared is the nation to care for them and for the nearly 27 million other veterans of World War II, the Korea, Vietnam, and (first) Gulf Wars—who together represent 13% of the population?

While the missions for which the VA was established, and which are central to the functioning of the nation, were already severely threatened by policies begun before the Bush-Cheney Administration, they face catastrophic collapse by this administration's VA budget, and by its disastrous VA Capital Assessment and Realignment for Enhanced Services (CARES) plan (see box). The importance of the Veterans healthcare system is such, that it is a critical policy focus of Democratic Presidential candidate Lyndon LaRouche, who, in an Oct. 22, 2003 Internet webcast from Washington, made restoring the VA medical system among the first actions of a LaRouche Presidency.

Case Study of Collapse

Today, more than ever, U.S. veterans are under siege. Veterans—particularly huge numbers of aging and disabled vets, and especially those with complicated chronic medical and psychiatric illnesses—have no idea where or even if the VA will be there to help them in the future. For decades, VA healthcare, a discretionary item in the Federal budget, has been severely underfunded. Under a policy of planned shrinkage and privatization, the VA has shifted radically from hospital-based services to outpatient clinics.

As one Vietnam-era veteran nurse serving in a Pittsburgh VA hospital reported, patients have been deliberately squeezed out of the system by the administration in an effort to show "low demand and justify closures. "There seems to be a concerted effort to divert patients," she reported. "Patients have been put out and units closed. There's no place for them to come back to. We can't take them [back]. They have to go someplace else. Sometimes there isn't a someplace else. Sometimes they have even been sent out of state."

The case of the ongoing closing of Lakeside VA Hospital in Chicago, illustrates the severity of the problems being created by deliberate and systematic underfunding of the Veterans administration, compounded by the draconian CARES shutdown program of the Bush-Cheney White House. Lakeside, since the end of World War II, had been affiliated with the Northwestern University Medical School (NWMS), one of America's top 20 medical schools. Almost 300 physicians on the NWMS faculty served Lakeside and Northwestern Memorial Hospital, one of Chicago's premier healthcare institutions, connected to Lakeside via a bridge. NWMS gladly provided high-end speciality care to VA patients at no compensation; the VA provided the school with excellent teaching facilities for their medical students.

NWMS performed hundreds of highly specialized procedures each year, like cardiac catheterization with interventional angioplasty, which requires surgical back-up of an operating room team. The VA cannot afford to do many of these high-priced procedures, because it pays physicians so little. Lakeside Hospital's affiliation with NWMS provided it hundreds of hours of free speciality care in cardiology, hematol-

The Veterans Administration, the leading caregiver for hospital patients and the number-one trainer of skilled medical personnel in the nation, has been degraded by budget stinginess for decades; now 11 more of its hospitals have been slated for closure. Sen. Robert Corzine talks with medical personnel at the East Orange, New Jersey VA hospital.

ogy, oncology, nephrology, and more. When inpatient care at Lakeside was closed on Aug. 7, 2003, this speciality care disappeared for the VA. The Booz Allen Hamilton consultants, paid obscenely high fees to study the CARES shutdown plan, never factored this into their analysis, nor did they consider how crowded the delapidated VA West Side Hospital would become, trying to care for Lakeside patients.

Without Lakeland and its NWMS affiliation, veterans will have to travel for hours outside of Chicago or into Iowa City for care—and wait up to nine months for it. Doctors call the CARES plan "a disgrace" because in Chicago—the third-largest city in the country—if a veteran needs emergency cardiac interventional surgery, he or she can't get it! Veterans have to travel up to 90 minutes away to Hines VA Hospital. They also have to go outside the city for radiation-oncology treatment, neurological services, and infectious disease specialists—all once provided by Northwestern. Worse, Northwestern will no longer be able to serve the huge outpatient VA clinic at Crown Point, Indiana.

The VA had 171 hospitals nationwide in 1993; by 2003, there were 163. Between 1971 and 2003, VA medical-surgical beds were cut by 75.6% (41,595 beds eliminated). As states closed psychiatric hospitals and literally dumped millions of mentally ill into the streets, the VA slashed 38,602 VA psychiatric beds, a cut by 88% from 1971-2003. It is estimated that there are anywhere between 200-400,000 homeless veterans, 45% of whom suffer from mental illness; 33% suffer from both psychiatric illness and substance abuse. As one long-time VA nurse explained: No matter how healthy you are, seeing 500 people around you blown to pieces in a war will affect you for the rest of your life. Now, 30 years after the end of the Vietnam War, thousands of Vietnam vets are suffering from post-traumatic stress disorder. A large percentage of the deinstitutionalized mentally ill veterans end up homeless or in jails and prisons—just as in the private sector. VA-operated domiciliary beds—crucial residences for veterans undergoing multiple medical treatments, along with psychiatric or substance abuse treatments—dropped 52% in those three decades.

Unique Nursing-Home Care Privatized

The VA is expert in managing veteran patients who are the hardest to treat—patients with wandering disorders, severe dementia, paralysis, or who are ventilator-dependent. Yet, As Rep. Lane Evans (D-Ill.) has testified, "Private-sector providers and, oftentimes, state [veteran nursing] homes are loath to admit these high-need patients. That's why I fought to maintain in-house capacity of VA's nursing home program." Lane was referring to the Veterans Millennium Healthcare and Benefits Act, which President Clinton signed into law in 1999. It required the VA to maintain its "in-house" long-term care programs, and required it to keep nursing-home capacity at the 1998 baseline level of 13,391 Average Daily Census (ADC).

The Bush White House and the conservative Republican-dominated Congress have ignored the 1999 law—despite the explosion in the number of veterans age 85 and older to nearly 2 million by the year 2010. Privatization—contracting out of long-term, nursing, and psychiatric care—is the Bush VA policy, along with shifting the burden of care of these veterans to the states. State VA nursing homes provide enormous services (the VA, the state, and the individual veteran pay for the care). Although the number of state veteran nursing homes is slowly increasing each year, the states cannot match the needs of the growing number of elderly vets. With most states' revenues shrunken since 2000, they cannot take on the increased daily costs of care, especially of impoverished veter-

'CARES': Wartime Rationing, Not Wartime Care

The VA rationing plan euphemistically called CARES (Capital Realignment for Enhanced Services) has as its alleged goal, to assess veteran healthcare needs and to "enhance" delivery of healthcare services in the geographic areas most populated by a shifting veteran population in the decades to come. Initially, the Administration's draft CARES plan targeted 11 VA hospitals for total closure, and 33 others for major mission changes—they would be downgraded to clinics or to "Critical Access Hospitals" (limited to only 16 acute-care beds and to patient stays of 96 hours or less). Congressional Veteran Affairs committees and veterans services organizations estimated that as many as 7,066 beds nationwide are on the chopping block. So, in addition to the beds already closed, an estimated 2,152 long-term care beds, 1,630 domiciliary beds, 991 psychiatric beds, and 2,293 medical-surgical beds have been targeted for closure.

The Administration's draft plan was released to an independent CARES Commission, which then released its proposals in January 2004. The final decision on the Commission's proposal will be made by the Administration's VA Secretary Principi at any time. Hospitals listed by the Commission for closure, merger, or major mission change, have been ordered not to speak about the impact of the Commission's changes may have on veterans' lives or on the economic and other impact on the surrounding communities.

ans without family.

The VA itself recognizes that at least 17,000 more nursing home beds are needed for the care of elderly veterans. Yet, the Bush Fiscal Year 2004 budget projected the VA nursing home Daily Census to drop to 8,500. The FY 2005 VA budget called for slashing another 5,000 nursing beds, lowering Daily Census projections even more. Most communities cannot absorb these patients, nor provide for their complex needs.

At the same time, the VA claims to have changed its mission from providing VA medical center-based nursing-home care, to privatized care, or to focusing on at-home care or day-care for elderly vets. However, this assumes most elderly vets have families to care for them, could manage at home, and had no additional medical complications which only the VA-medical center-nursing homes could address.

What is at stake is more than the loss of a bed—all of the VA's four critical missions are at the edge of losing their function. We review these in turn.

VA's Threatened Missions

The primary mission of the VA is provision of healthcare to veterans. The Department of Veteran Affairs is the largest direct provider of healthcare services in the nation.

In its second mission, it provides education and training for healthcare personnel. The VA produces the highly specialized, highly dedicated staff experienced in treating the com-

Case Study: Waco VA Hospital

One of the targets in the Administration's draft CARES plan and the CARES Commission is the total closure of the Waco, Texas VA hospital, which has 346 hospital beds, including 278 psychiatric beds, and a 20-bed Post-Traumatic Stress Disorder Residential Rehabilitation Program. It is considered the most comprehensive VA psychiatric hospital in the nation and the only one in Texas for long-term psychiatric care. It is the only VA facility in Texas for rehabilitation of blinded veterans; and one of only three VA centers in Texas for acute psychiatric care. It serves tens of thousands of vets, employs a highly trained workforce of 800, and has an occupancy rate of 90%. Instead of expanding the number of beds as VA doctors recommended (to eliminate long waits for treatment and for emergency care), the Adminstration's plan is to shut Waco down and have VA patients travel for care to other cities; or to privatize their care, "unloading" elderly nursing-home patients into whatever Medicare allows in the community.

The CARES Commission agreed with most of the Administration's plan, except that it would allow Waco to keep its 33 nursing-home beds. Gerald Cowan, senior Vice Commander of the Department of Texas Disabled America Veterans, testified that the VA "can no longer meet the needs of our nation's service-connected disabled veterans." Cowan said veterans in Texas are already asking, "Why do we have to travel hundreds of miles to Oklahoma or to Louisiana for care?" Some vets have to travel six hours roundtrip. According to a VA report, there were 134,287 vets on waiting lists for care, nationally—over 51,000 are waiting at least six months for their appointment.

Waco Mayor Linda Ethridge said the VA invested over $100 million since 1998 to create state-of-the-art buildings at Waco's VA Medical Center, that are suited to becoming a center for excellence for long-term psychiatric care. She warned against shutting it down: Severely mentally disturbed VA patients are not candidates for deinstitutionalization. There is no capacity in the Waco or neighboring communities to care for so many patients. Closing it will endanger local non-profit community and psychiatric hospitals, due to the costs associated with emergency detention of mentally ill veterans. Waco's private or hospital psychiatrists will not treat VA patients due to "low, slow, or non-existent reimbursements."

—Linda Everett

The Bush Administration's slated shutdown of the large and modern Central Texas Veterans Hospital in Waco, would eliminate a score of special medical programs ranging from MRI/CAT Scan and Nuclear Medicine, to Hearing and Speech Pathology; and it would eliminate in one stroke, within Texas:

Authorized Beds:

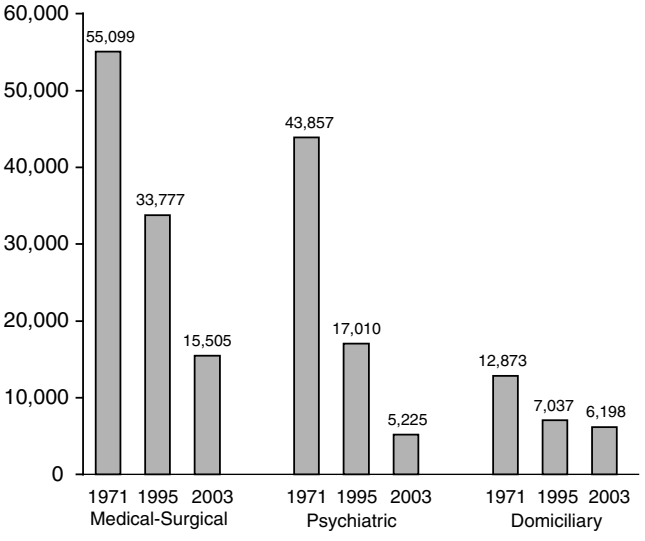
459 Psychiatry	36 Intermediate Medicine
408 Domiciliary	20 Post-Traumatic Stress Rehabilitation
303 Nursing Home	15 Blind Rehabilitation
134 Internal Medicine	
44 Surgery	

plex mix of medical-psychological challenges veterans face. This crucial part of VA infrastructure is not available in private sector hospitals, long-term care, or nursing homes. Once these people retire or are lost through closure of a VA facility, they are gone. The VA manages the largest medical education and health professions training program in the United States. Its facilites are affiliated with 107 medical schools, 55 dental schools, and more than 1,200 other schools across the country. These affiliations have produced some of the most advanced medical and technological treatments for veterans and for the nation. VA hospitals have the unique capability to translate progress in medical science to improvements in medical care and in public health. Each year, 81,000 health professionals are trained in its medical centers. More than half of the physicians practicing in the United States have had part of their professional education in the VA healthcare system. How this country's leaders support our veterans and the health and hospital infrastructure that serves them, affects every aspect of the country's private health and public healthcare sector, as well as the country's capability to respond to a national emergency.

The third VA mission is medical research. The advances for which the VA is reknowned both nationally and worldwide, benefit everyone. Its research contributed to advances in blind rehabilitation, geriatrics, long-term care, amputation care, prosthetics and orthotics, spinal cord injury, serious mental illness, post-traumatic stress disorder, paralyses, and more—all of which depend on strong acute care infrastructure to address veterans' care comprehensively. They cannot exist in isolation from the rest of the system, according to reports of the Independent Budget Veteran Services Organizations (VSOs), made up of over 50 veterans services groups. The VA is the world leader in research for Hepatitis C and prosthetics. Yet for FY 2005, the White House proposed cutting VA medical research by $50 million, or 5%, from the FY 2004 level.

More egregious, in this time of national insecurity, is the underminning of the VA's fourth mission—to provide medical care in times of national medical disaster or public health emergency, as a back-up for the Department of Defense. In 1986, the Assistant Secretary of Defense for Health Affairs testified before the House Armed Services Committee that "VA was directed to serve as primary back-up to the DOD in the event of war or national emergency. The two Departments have made great strides in designing a VA back-up system to our contingency system at DOD. Today the system stands ready to provide 32,506 contingency beds for use by DOD in the event of war or national crisis." Just one month after the Sept. 11, 2001 attack on the World Trade Center Towers and the Pentagon, the Congressional General Accounting Office (GAO) reported that: "VA has plans for the allocation of up to 5,500 of its staffed operating beds for DOD casualities within 72 hours of notification. VA's plans would provide up to 7,574 beds within 30 days notification."

FIGURE 1
Decline in VA Medical Care Infrastructure, 1971-2003
(Staffed, Operating Beds)



Source: U.S. Department of Veterans Affairs.

But in December 2003, the VA Emergency Management Group told *EIR* that the VA, in fact, has *no* surge capacity in event of a national emergency. It has no beds set aside for such a crisis. The VA supposedly would simply make available whatever beds were empty, and those it could empty by sending patients elsewhere.

In reality, considering the lack of care for Iraq War veterans, it is not clear that the United States has advanced beyond a status report presented in 1992 by the U.S. General Accounting Office (GAO) before the House Committee of Veterans Affairs, Subcommittee on Oversight and Investigations, on the adequacy of plans by the Department of Defense, and the VA and other organizations, to care for wartime casualties returning to the United States. Called "Readiness of U.S. Contingency Hospital Systems to Treat War Casualties," the report found, in part, that "The number of beds expected to be available in DOD, VA, and the National Disaster Medical System (NDMS) hospitals is overstated."

The GAO report, though a decade old, raised a pertinent question: Where were VA medical centers planning to get the continued care of patients displaced from the VA centers to make room for national-emergency casualties? The ratio of private/public hospital beds per 1,000 population is now at its lowest level in 30 years.

Severe shortages in medical staffing and speciality care abound in the VA, and are growing acute due to chronic underfunding. It is well known that veterans have to wait up to a

year for an appointment with a primary care physician. VA Secretary Anthony Principi dealt with the problem by restricting the right to VA medical care to only the poorest and most disabled veterans. Overnight, thousands of veterans were banned from getting VA care. This "temporary" restriction, in the Bush FY 2005 budget, now appears permanent—despite the law Congress passed in 1996 to allow all eligible veterans the right to VA medical care (the law led to a 134% increase in enrollment of veterans in the VA system between 1996-2003—from 2.9 million to 6.8 million enrollees. But Congress refused to increase funding for patient care, leading to a continual drop in staff and beds.)

The VA's loss of critical affiliations to medical schools, like that of Chicago's Lakeside to Northwestern, compounds a historically worsening shortage of physicians in military medical centers. At one point, a GAO study found that the severe shortage of military physicians from 1973 (after the end of the draft) caused 60% of military hospitals to close medical services or to curtail whole units for up to six months. Then came a concerted effort to close military medical training centers. By 1992, the GAO found the military had inadequate plans to train more speciality care physicians.

Today, the problem is glaring. Not only are our soldiers in Iraq reporting a severe shortage of physicians; the main reason for returning Iraqi soldiers being placed on "medical hold" for months, is the lack of physicians and facilities to treat them or to perform surgeries.

Military Hospital System Unprepared

VA bed closures become even more profound given the drastic drop in the military's medical care capability. According to the DOD, "Between FY 1987 and FY 2002, the Military Health System reduced from 163 hospital and 583 clinics to 75 hospitals and 461 clinics." The closure of 88 hospitals (54%) and 122 clinics (21%) was due in part to medical advances requiring less hospital time, and in part to Base Realignment and Closure (BRAC) actions of 1995, 1993, 1991, and 1988. In 2001, *EIR* was told that some 26 other hospitals were scheduled for closure. A new BRAC round of base, and possible hospital, closings is set for 2005—President Bush wanted it to begin in 2003.

Since there is no public disclosure of just how many medical-surgical beds the military has closed, an accurate assessment of the actual number of hospital beds per 1,000 population available in event of a national crisis is not available. Congress must mandate that information be released, so that a county-by-county overview of civilian, veteran, and military medical capacity is available in the interests of military preparedness and public health. While the military can fly in hospitals in a pinch, for this or that medical emergency, this does not address the long-term healthcare needs of the population in an era of global biological threats, man-made or otherwise.

The primary issue is that in the last two decades, hospital and public health capacity and trained, experienced medical personnel in the private, VA, and military health systems were decimated, just as the Baby Boomers reach the age of chronic illnesses, tripling of the number of sick elderly, and those age 85 and over. At the same time, the prestigious Institute of Medicine warned in 2003 that the nation faces the potentiality of a "catastrophic storm of microbial threats," such as the surge of new infectious diseases like SARS.

Neither the VA, military, nor civilian hospital systems have any redundancy built into them. Such redundancies are crucial to national health security, but they have been hammered out of the system since the managed care "revolution" began in 1973 under President Richard Nixon. Thus Presidential candidate LaRouche calls for banning health maintenance organizations, and all managed care established under the 1973 law.

LaRouche prescribes the restoration of the general welfare approach embodied in the legislation developed by Sen. Lister Hill (D-Ala.) and Rep. Harold Burton (R-Ohio) in 1946, after the nation had found that nearly one-third of its males ages 18-37, when called up for draft in 1941, were physically or mentally unfit for military duty. The draftees had came from counties that lacked basic access to hospitals, physicians, public health, and dental care. The Hill-Burton Act of 1946 set out the objective standard of the number of hospitals, beds, type of beds, and medical personnel needed for every 1,000 people, by county. It called for states to "afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people." Federal monies were available to construct hospitals to bring counties up to the Hill-Burton standards of 4.5-5.5 general-use hospital beds per 1,000 population, with extra beds for long-term care, psychiatric care, isolation of infectious disease, and chronic care.

Medicine and technology have advanced today so that the necessary ratio of hospital beds per population may differ somewhat; but the standard, of ensuring the health of all, in and out of the military, cannot vary. When the Hill-Burton and other General Welfare proposals went into force, the nation saw a radical drop in life-threatening disease and serious medical conditions (tuberculosis, a marker for general health, declined from 137,000 new cases in 1948 to 55,000 cases in 1960).

Damning testimonies presented in Congressional hearings in January 2004 attest that we, as a nation, are not doing the same for soldiers with diseases and disabling conditions of as a result of the Gulf wars.