Statement of Congresswoman Carolyn B. Maloney
to the Local Advisory Panel
regarding the Stage I Summary Report for Brooklyn-Manhattan VAMCs
September 19, 2005

Thank you for providing an opportunity to comment on the Stage I Summary Report for the Brooklyn and Manhattan VAMCs. This is a process that could easily result in a serious reduction in the quality of health care for New York veterans, and it is extremely important for PricewaterhouseCoopers and this advisory panel to listen carefully to the concerns of veterans and other stakeholders. At a time when tens of thousands of Americans are fighting in Iraq, any move that would reduce veterans' access to medical services is short-sighted. We owe our veterans the best possible health care now and into the future. Regrettably, some of the Pricewaterhouse Coopers recommended options for the Manhattan and Brooklyn hospitals will seriously erode the high quality of care veterans currently receive.

Except for the baseline option, and options 6 and 7 which call for unspecified consolidation and incremental realignment, the PricewaterhouseCoopers proposals simply do not make sense. They would lead to a serious deterioration in the quality of care for patients, and a serious reduction in patients' access to healthcare. You cannot eliminate affiliations with world class medical institutions without degrading the quality of care for veterans. You cannot move these hospitals to new locations without impacting access to care.

Unfortunately, in proposing its options, PricewaterhouseCoopers consistently downplays both the strengths and the vulnerability of the affiliations. The ability of New York harbor hospitals to draw upon the expertise of NYU, Bellevue and SUNY Downstate is key to the high quality of care they provide veterans. It would be a serious mistake to do anything to jeopardize those affiliations. Shockingly, not only does PricewaterhouseCoopers contemplate terminating those affiliations, they seem to think that the affiliations can end without any adverse impact on the quality of care for veterans. That's just simply not credible.

Quite clearly, closing the Manhattan VA hospital will sever the affiliations with NYU and Bellevue. There is no possibility that the affiliations will survive a move away from 23rd Street. The only reason those affiliations work is that the NYU medical staff and students don't have to travel. The VA is a short walk from their facilities. These talented medical practitioners can not take time from their busy schedules to travel to another facility, even one that is located near mass transit. To suggest otherwise is pure fantasy. Nonetheless, PricewaterhouseCoopers reports, without any data to back it up, that the quality of medical services would not be affected by relocating patient services to the existing Brooklyn hospital or to new facilities in Brooklyn

and Queens.

The fact is, quality of care will seriously deteriorate if the VA moves out of 23rd Street. I am told that the Manhattan VA hospital is the only VA hospital in the nation with six Centers of Excellence, including the largest AIDS program in the VA system. It is also the only facility in the entire Northeast corridor that makes prosthetics. We are told that returning Iraqi vets are more likely to have lost limbs than returning veterans of other wars – thus the Manhattan VA's expertise in prosthetics will be essential to care for wounded soldiers returning from Iraq and Afghanistan now and in caring for those veterans throughout their lifetimes. Naturally, the prosthetic lab is as good as it is, in large part because of the NYU affiliation. The lab cannot simply be moved across the river. Curiously, the PricewaterhouseCoopers report is silent on the issue of the prosthetic lab. It makes no mention of how the Brooklyn facility, or a new facility, would address the prosthetic needs of veterans from the Northeast corridor. Similarly, the report is silent on the provision of dental services. It should be noted that the Manhattan facility had nearly twice the number of dental visits as the Brooklyn facility, but both served a significant number of veterans. Further, the NYU School of Medicine is directly across the street from the Manhattan VA.

One of the biggest bloopers in this report is Option 5, which suggests converting the Brooklyn hospital to a psychiatric facility. This makes no sense whatsoever. There are currently 47 psychiatric beds in Manhattan, and only six in Brooklyn. I understand that NYU Medical School has a large psychiatric residency program thanks in part to its affiliation with Bellevue, while SUNY Downstate has none at all. In effect, moving the psychiatric program to Brooklyn would leave the VA system with an obligation to rebuild, virtually from scratch, all of its psychiatric staff and leave the Brooklyn hospital with no meaningful affiliations at all. I am told that PricewaterhouseCoopers made a concerted effort to minimize its contact with stakeholders, and it shows. Perhaps as it moves into the next phase of analysis, PricewaterhouseCoopers will spend more time working with stakeholders to gain a better understanding of the ways the affiliations work and how they interact to meet the needs of veterans.

PricewaterhouseCoopers notes that the VA evaluates access to health care in terms of its impact on drive time, and correctly acknowledges that this makes no sense in the New York market. Unfortunately, the report indicates that the VA and PricewaterhouseCoopers will not be developing a methodology to address these concerns until Stage II. That's already too late. It means that the Stage II options will be selected based on totally irrelevant drive time analysis, and will have no real data about how these proposals impact access to care. If a real analysis of access were done, it would be clear that Options 2, 8 and 9, will have significant impacts for many veterans, with Option 2 being the most significant. A hospital with six Centers of Excellence cannot be replaced by expanding two health clinics.

The single factor that seems most likely to prompt a veteran to use VA facilities is proximity. While both campuses receive veterans from other boroughs and counties, in both cases, the largest volume of visits comes from veterans from that borough. But Brooklyn veterans were significantly more willing to use the Manhattan facility than the percentage of Manhattan veterans willing to use the Brooklyn facility. Fewer than 100 veterans from New York county were in-patients at the Brooklyn campus, while nearly 600 Brooklyn veterans came

to Manhattan. What's more, while nearly 1/3 of Brooklyn veterans who used outpatient services from New York harbor sought treatment in Manhattan, only 1/5 of Manhattan veterans sought treatment at the Brooklyn facility.

The PricewaterhouseCoopers report makes no effort to discover whether veterans will actually use a consolidated facility. If there is any diminution in the number of veterans willing to use the VA for health care services following a consolidation, this would be the clearest indication that the VA has in fact reduced access to medical services. Since PricewaterhouseCoopers has not tried to determine what veterans would do, it is hard to know what impact, if any, these options would have on veterans' ability or willingness to seek appropriate health care.

It is frustrating to note that this is labelled a summary report, yet the full report does not seem to be available anywhere. The VA tells my staff that they haven't seen it, if it exists. Without the full report, there are no numbers and no way to figure out how PricewaterhouseCoopers is reaching its conclusions. Arrows may be meaningful in a powerpoint presentation, but to determine cost-effectiveness they are simply inadequate. How does PricewaterhouseCoopers determine that building new facilities in Brooklyn or Queens is cost effective?; how much does it cost to buy 20 acres of land near a subway?; how much does it cost to build a brand new state of the art facility?; how much does it cost to rebuild six Centers of Excellence and a prosthetic lab?; how much does it cost to recruit and retain medical staff?; how much will the sale of the Brooklyn and Manhattan facilities yield?; how much of the current staff would be willing to relocate to a new facility? Without real numbers it's hard to tell, but it appears possible that PricewaterhouseCoopers looked at the positive side of the equation without taking into account the negatives.

One of the most serious omissions from this report is the fact that the Manhattan and Brooklyn facilities are designated for use by first responders in the event of any future terrorist attack on New York City. New York has already survived two significant terrorist attacks and is considered the most likely target of any future attack on U.S. soil. Thus, the need to preserve these facilities for such a possibility is not merely academic. Hurricane Katrina should have taught us the folly of not being prepared for an emergency. Furthermore, as the financial capital of the world, Manhattan is undoubtedly the prime target. Some consideration should be paid to the ability of the federal government to meet its homeland security goals if these hospitals are closed.

Finally, it should be noted that PricewaterhouseCoopers adopts the VA's 2003 projections for veteran enrollment. Unfortunately, those projections were likely made early in the Iraq war, before we understood just how deadly it would become. I understand that more than 1,430 Iraq war veterans have already enrolled in New York harbor, as well as hundreds more from Afghanistan. That's undoubtedly the tip of the iceberg. More than 183,000 or 26% of the returning Gulf War veterans have already been classified as disabled, and tens of thousands of claims are currently pending. By contrast, the disability-rate for World War II was 8.6 percent, for the Korean conflict was 5 percent and for the Vietnam war was 9.6 percent. It is too soon to know whether veterans of the current conflicts will have disability rates similar to the Gulf War, or whether disability rates will return to more traditional levels, but we have to

assume that this war, like the Gulf War and the Vietnam War, will result in unexpected illnesses. Thus, the VA should tread very carefully before reducing services to veterans.

Regrettably, it is easy to conclude that the PricewaterhouseCoopers analysis will boil down to a consideration of land values. Because PricewaterhouseCoopers has carefully skewed results to suggest that all nine of its options have an equivalent impact on access to healthcare and healthcare quality, the only remaining consideration appears to be cost-effectiveness. Since there are no numbers, we can only guess that PricewaterhouseCoopers believes that while building a new hospital may be costly, the windfall from the sale of the existing properties will more than make up for it (that conclusion comes from the fact that Pricewaterhouse gives three up arrows for the level of re-use proceeds versus two down arrows for the level of capital expenditure anticipated). I believe that they are getting it precisely wrong. Contrary to the conclusions in this report, impact on healthcare quality and access is not equivalent among the nine options, and the VA would lose significantly more than it would gain by closing or diminishing the existing facilities. I hope that as PricewaterhouseCoopers narrows down the options, they will take into account the truly devastating impact on veterans' access to high quality health care that would result from severing affiliations.