

To Hell and Back: Wounded Warriors Return Home to Fight Yet Another Battle

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Abstract

As wounded warriors return home from Operation Iraqi Freedom and Operation Enduring Freedom in Afghanistan they face a number of challenges amidst a vast industrialized military complex's healthcare and disability system. For those with traumatic brain injury, the signature injury of this war, this system of care seems to be anything but that. Walter Reed Army Medical Center, the Veterans Administration, and the Pentagon are beleaguered by scandal. This paper reviews current challenges, recommendations of the Task Force on The Future of Military Health Care, the West and Marsh Commission report on Walter Reed and the Naval Medical Center, the President's Commission on Care for America's Returning Wounded Soldiers, and legislative policy proposals and solutions. Resources for military members and their families are included.

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In February 2007, Washington Post reporters revealed appalling conditions at Walter Reed Army Medical Center. The report startled many, causing much consternation. "How could the crown jewel of our military medical system have deteriorated so? Is our current military healthcare system prepared to care for active duty military personnel, their family members, as well as retired military personnel and their families?"

As of July 30th, 2007, more than 4,000 US soldiers and defense department workers have died in Operation Enduring Freedom (Afghanistan and adjoining countries) and Operation Iraqi Freedom (Dept. of Defense (DOD), 2007). More than 28,000 have been injured; slightly more than half returned to action within 72 hours (DOD, 2007). A running total of war injuries and deaths are maintained by the DOD ([online](#)).

The military health system budget includes training, scholarships, medical services, and medical equipment. As is the case for the rest of the US healthcare system, costs are increasing at a rate greater than inflation. TRICARE is the military's health benefits program. In order of

increasing benefits and cost the programs are: TRICARE Prime (a managed care option), TRICARE Extra (a preferred provider organization), and TRICARE Standard (fee for service). TRICARE Prime offers a point of service (POS) option, but entails substantial out of pocket costs (Office of the Assistant Secretary, 2007). Health spending by the Department of Defense more than doubled between 2000 when expenditures were \$17.4 Billion, and 2005 when spending increased to \$35.4 Billion (GAO, 2007).

Given our war time situation, and the need to control costs and create efficiencies, the Secretary of Defense appointed the Task Force on the Future of Military Health Care. An interim report was issued May 31st 2007 (DOD, Subcommittee of the Defense Health Board, 2007). "Recommendations are offered in the following areas: improving business and management practices; altering incentives in the pharmacy benefit; cost-sharing and realignment of fee structures; and ensuring that, when applicable, TRICARE is the second payer" (DOD, Subcommittee of the Defense Health Board, 2007, p. ES2). In essence the recommendations are to adopt mechanisms from

the private sector where it is anticipated that cost-savings could be achieved. This calls for review of provider contracts, audits to determine eligibility for coverage, implementation of incentives to use generic and mail ordered pharmaceuticals, shifting more costs to the service recipients thereby creating an incentive to use less services, indexing of premiums and deductibles to assure that as healthcare costs increase, the military does not bear a greater share of costs (they note that future recommendations may include incentives to either forgo use of TRICARE or lessen reliance upon it), tiering premiums, deductibles, and co-pays consonant with pay grade at retirement, and ensuring that TRICARE is used as the "secondary" payer rather than the primary payer (DOD, Subcommittee of the Defense Health Board, 2007).

The United States Governmental Accountability Office (GAO) however, has indicated that the savings won't be as large as the Task Force predicted. The Department of Defense had hoped to capture \$9.8 Billion in savings over five years as a result of increased enrollment fees, deductibles, co-pays, and through discouraging retiree and dependent enrollments in TRICARE. The DOD also had anticipated savings of \$1.5 Billion related to increased pharmaceutical co-pays for anyone having prescriptions filled by retail pharmacies (2007). "Personal protective equipment, casualty treatment and evacuation, (and) medical care advancements" have contributed to a more than 90% survival rate for soldiers wounded in today's Global War on Terror (Gamble, 2006, p. 1033). This improved survival rate is particularly evident among those with traumatic brain injury (TBI), the signature injury of the current war (Lengell, 2007). In Vietnam "...mortality from brain injuries among U.S. combatants ...was 75 percent or greater" (Okie, 2005, p. 2045). Improved survival rates however, sometimes mean learning to live with debilitating injuries and their sequelae.

In Iraq most TBI injuries are the result of encounters with IEDs or improvised explosive devices (Armonda, et al., 2006). The National Institutes of Health (NIH) Consensus

Development Panel states that "TBI is a disorder of major public health significance. Mild TBI is significantly underdiagnosed and the likely societal burden is even greater" (1999, p. 974). Battle situations may preclude prompt diagnoses and evacuation. Additionally, more obvious injuries may cause TBI to be overlooked (NIH, 1999; Ryan, & Warden, 2003).

TBI among the war wounded was estimated in 2005 to be 22% (Okie). However, Defense and Veterans Brain Injury Center Director Deborah L. Warden, believed then that the estimates were low "since some cases of closed brain injury are not diagnosed promptly" (Okie, 2005, p. 2045). "Approximately 38% of soldiers, 31% of Marines and 49% of National Guard members returning from combat abroad report psychological conditions such as brain injury and post-traumatic stress disorder" (Kaiser, 2007, July 13). A presidential commission report released July 25, 2007, puts the number of TBIs at 2,726 (President's Commission on Care, 2007).

TBI can result in mild concussion, moderate to severe disability, or death (NIH Consensus, 1999). "The consequences of TBI include a dramatic change in the individual's life-course, (and) profound disruption of the family..." (NIH, 1999, p. 975) The injury may be transient or permanent. Brain injuries may significantly impair one's judgment, memory, ability to think clearly, problem-solve, or even the ability to express one's self or understand what is being said (Okie, 2005). Behavioral symptoms such as "...mood changes, depression, anxiety, impulsiveness, emotional outbursts, or inappropriate laughter" may occur (Okie, 2005, p. 2045-2046); as well as personality changes (Ropper and Gorson, 2007). Balance may be impaired (Ropper and Gorson, 2007) and other physical impairments may result (NIH Consensus, 1999). All of these potential consequences depend upon the injury's location within the brain and the magnitude of trauma. In instances where TBI related disability are not readily apparent (Okie, 2005), this may give rise to cognitive dissonance among family, friends, and even for the injured party, as they begin to reconcile the changes that have occurred.

The NIH Consensus Development Panel on Rehabilitation of Persons with Traumatic Brain Injury noted a number of costs to society, including "...increased risk of suicide, divorce, chronic unemployment, economic strain and substance abuse" (1999, p. 976). In reality the costs are too many to enumerate. Among the economic costs are "... enormous loss of income or earning potential, and costly lifetime expenses" (NIH, 1999, p. 975). The panel estimates the cost for acute and rehabilitative care for new TBI cases (This includes the civilian population.) is between \$9 and \$10 Billion dollars annually, and average lifetime costs for severe TBI cases range between \$600,000 and \$1,875,000. According to the panel, there are other hidden costs to consider, including loss of income for family members needing to take off from work to assist the TBI survivor, and costs to social service and law enforcement agencies.

Disability benefits for veterans are incredibly low and extreme disparities exist, even among those with like disabilities. The Institute for Defense Analysis was commissioned to analyze the situation, and the report is not yet publicly available. However, a Washington Post report of July 19, 2007 stated that "average annual disability payments swung widely from \$7,556 in Ohio to \$12,395 in New Mexico. Nationwide, the average pay was \$8,890" (Yen, 2007b). The report further indicated that how well you fare, may depend upon who is rating your claim, rather than upon objective criteria. "Some soldiers and veterans groups have charged that Army disability review boards, which are under the Pentagon's purview, unfairly reject PTSD claims to avoid paying disability pay" (Yen, 2007b). Veterans' Affairs secretary Jim Nicholson will be leaving October 1st of 2007. This announcement comes at a time when Congress and a Presidential Commission are considering the transfer of more responsibility for determining disability benefits from the Pentagon to the VA (Yen, 2007b). It remains to be seen how persons with TBI will fare.

However, on July 23, 2007 a lawsuit was filed by "hundreds of thousands of veterans" against the VA and Nicholson, alleging that they

deliberately conspired to deny them "disability pay and mental health treatment" (Yen, 2007a). The suit states that unless something is done about these injustices, the legacy for Iraqi veterans with disabilities will be one of broken families, drug addiction, alcoholism, unemployment and homelessness (Yen, 2007a). The suit also alleges that the VA worked with the Pentagon to "misclassify PTSD claims as pre-existing personality disorders to avoid paying benefits" (Yen, 2007a). Surely such intense scrutiny will lead to improvements.

The NIH Consensus Panel indicates that the sequelae of TBI may not become fully apparent until later in a person's life (1999). TBI is closely related to posttraumatic stress disorder; this is particularly true for those with mild TBI. It is difficult to estimate the true prevalence of posttraumatic stress disorder, anxiety or depression among military personnel, due to stigma and career concerns attached to seeking mental health services (Friedman, 2006, Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004). According to Ropper and Gorson (2007), "Anxiety and depression are reported by more than a third of patients with persistent post concussive symptoms" (p. 169). A Walter Reed study published in 2004 indicated that between 15.6% and 17.1% of participants returning from Iraq had experienced "major depression, generalized anxiety, or PTSD," however, among "...those whose responses were positive for a mental disorder, only 23 to 40 percent sought mental health care" (Hoge et al., 2004, p. 13). A 2005 Governmental Accounting Office (GAO) report stated "Mental health experts estimate that the intensity of warfare in Iraq and Afghanistan could cause more than 15 percent of service members returning from these conflicts to develop PTSD" (GAO, 2005). Those who are most in need are the least likely to seek help (Friedman, 2006), and there is evidence to suggest that the incidence of PTSD related to service in Iraq and Afghanistan may increase as time progresses (Wolfe, Erickson, Sharkansky, King, King, 1999).

Friedman indicates that the issue of PTSD is more likely to occur among activated National Guard members and the military reserve, than

among regular military personnel. This is because up until deployment, their primary concerns have been those surrounding work, family, and other aspects of civilian life. When these soldiers find themselves in combat, they have not yet immersed themselves within the military culture (2006). The National Services Advisory Group's report "The US Military: Under Strain and Risk," stated "Nearly all of the available combat units in the U.S. Army, Army National Guard and Marine Corps have been used in current operations" (2006, p.7) The group indicates that there is little if any reserve left for combat duty unless current laws regulating tours of duty are changed. Many wonder in the face of the Walter Reed Scandal, whether our military medical system is up to the task.

Among those evacuated to Walter Reed Army Medical Center approximately 28% have received some type of traumatic brain injury (Warden, 2006). Washington Post reporters Dana Priest and Ann Hull (2007) revealed the appalling conditions at Walter Reed Army Medical Center's outpatient facilities in February. Soldiers discharged from the inpatient facility, but still needing outpatient treatment include those who "...suffer from brain injuries, severed arms and legs, organ and back damage, and various degrees of post-traumatic stress" (p. a01). According to an online Washington Post special series entitled *Walter Reed and Beyond*, "The Army has no PTSD center at Walter Reed, and its psychiatric treatment is weak compared with the best PTSD programs the government offers" (Hull & Priest, 2007b). Rot and mold are prevalent. "Signs of neglect are everywhere: mouse droppings, belly-up cockroaches, stained carpets, cheap mattresses" (Priest & Hull, 2007, p. a01). The soldiers themselves have been blamed and ridiculed for the deteriorating conditions. The reporters describe bedlam, in which the soldiers are left to tend each other. At the time that the report was published, "...many soldiers with impaired memory from brain injuries sat for weeks with no appointments and no help from the staff to arrange them" (Priest & Hull, 2007, p. a01).

On March 1st 2007, Hull and Priest reported that the Army Surgeon General, Lt. General Kevin C. Kiley had been aware of the deteriorating conditions in building 18 for years (2007a). March 11th 2007 brought the resignation of Lt. General Kevin C. Kiley (Army Surgeon General, 2007)

In the wake of the Walter Reed Army Medical Center scandal, a Gallup poll revealed that 80% of Americans feel that our military veterans are not receiving the attention they deserve (Jones, 2007). It is important to note that "Nearly 30% of all patients with combat-related injuries seen at Walter Reed Army Medical Center from 2003 to 2005 sustained a TBI" (DOD Post Deployment, 2007). These persons are particularly vulnerable.

Public outrage over the treatment of our soldiers and veterans built momentum for a number of initiatives. The Secretary of Defense Robert Gates appointed an independent review group to investigate both the Walter Reed situation and the Naval Medical Center at Bethesda (Kaiser, March 8, 2007). This group is also known as the West and Marsh Commission. The report (Independent Review Group) released in April of 2007 is entitled: *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* is available [online](#).

The West and Marsh Commission report on Walter Reed and the Naval Medical Center at Bethesda includes references to "A Perfect Storm" in which a convergence of events led to failure. These events include the Base Realignment and Closure (BRAC) Commission's decisions that are intended to increase efficiency, the Office of Management and Budget's A76 directive to open up opportunities for public and private competition in instances when an undertaking wasn't necessarily of a governmental nature, and conversion of military workforce positions to civilian (Independent Review Group, 2007). The *Rebuilding the Trust* report is based upon public meetings, interviews, site visits, web postings, and a toll-free telephone hotline. The report

finds excellent care from the time of injury up to the point where military personnel are admitted to outpatient services. This is echoed in a Presidential Commission's findings as well. The major deficiencies reported by the West and Marsh Commission are problems with continuity of care, and problems with "leadership, policy and oversight" (Independent Review Group, 2007).

President Bush appointed former Health and Human Services Secretary Donna Shalala and Former U. S. Senator and U. S. Presidential Candidate Bob Dole, a WWII disabled veteran, to head the President's Commission on Care for America's Returning Wounded Soldiers to investigate the military health system in its entirety (Kaiser, March 8, 2007). The findings of this Presidential Commission were reported July 25, 2007, and are available online ([President's Commission on Care, 2007](#)).

In three words, the Presidential Commission's goals are to "serve, support, and simplify" (2007). This commission is unique in the scope of its investigation, as President Bush commissioned them to examine "... the whole continuum of care and programs for wounded service members, as well as what is needed to assure their successful return to military duty or civilian life (President's Commission on Care, 2007, p. 3).

The President's Commission surveyed nearly 6,000 wounded between June 7-19, 2007, and achieved a 30% response rate. They also received over 1,200 letters and e-mails, from a much wider constituency of persons whose lives have been in some way touched by these injuries. The commission found that the military healthcare system in many ways is reflective of the larger US healthcare system. They both provide excellent care most of the time; mental health services still carry a stigma and there are problems with coordination of services and implementation of information technologies. Furthermore, the focus is on acute or short-term care rather than long-term rehabilitative care. Also noted are personnel shortages in certain professions (2007).

Presidential Commission recommendations follow:

- Single contact care coordination to streamline encounters with bureaucracy, ensuring that appropriate and timely supportive services are delivered from first contact through "medical services, rehabilitation, and disability programs" (p. 5)
- Complete restructuring of disability and compensation systems to eliminate redundancies and assure more equitable service provision
- "Aggressive" prevention, recognition, treatment, and follow up for PTSD, and TBI, as well as education to reduce stigma attached to mental health services
- Enhanced support for family members of injured service personnel, including respite care and extension of the "Family and Medical Leave Act for up to six months for spouses and parents of the seriously injured" (p. 9)
- Creation of "an interactive 'My eBenefits' website that provides a single information source for service members" that would facilitate information exchange between the Department of Defense and the Veteran's Administration (p. 10)
- Recruitment and retention of highly qualified, skilled administrative and health professionals

Health services often mean the difference between life and death. At the very least, these services can alter one's quality of life and/or longevity. Any successful administrator knows that efficiency is a part of fiduciary duty. A good administrator knows that quality of care is paramount. Excellence in care is achieved when an administrator balances both efficiency and quality of care. The Task Force on The Future of Military Health Care focuses on efficiencies, cost-shifting to military consumers and their families and employers, and finding other ways to limit coverage. The West and Marsh Commission provide a realistic view of the problems that, in their words, created "The Perfect Storm." The Presidential Commission

has offered some excellent recommendations. It remains to be seen whether or not their goals and objectives will be attained.

At this writing, the National Defense Authorization Act for Fiscal Year 2008 is being considered in the Senate. U. S. Senator Barbara A. Mikulski (D) of Maryland stated for the Congressional Record on July 13, 2007, that the Dignity for Our Wounded Warriors Act, which was approved to amend the National Defense Authorization Act for Fiscal Year 2008 (p. S9199) is a "... comprehensive response to the failures of the Bush administration to properly care for our wounded service members and veterans." Using the words of former Secretary of Defense Donald Rumsfeld in reference to the Iraqi War 2003 air campaign, she stated, "We were all shocked and awed by the sorry state of outpatient care at Walter Reed (p. S9199)." The amendment (p. S9199) authorizes at least \$73 million in additional funding to enhance care for traumatic brain injury, TBI and post traumatic stress disorder, PTSD, including \$3 million for pilot projects to monitor TBI; \$10 million for Centers of Excellence for TBI; and \$50 million for additional TBI and PTSD research. This is in addition to the \$900 million in funding for TBI and PTSD programs added by Congress to the fiscal year 2007 Emergency Supplemental Appropriations Act.

U. S. Representative Michael H. Michaud of Maine introduced HR 2199 the Traumatic Brain Injury Health Enhancement and Long-Term Support Act of 2007 which "Directs the Secretary to establish within the VHA the Committee on Care of Veterans with Traumatic Brain Injury." The resolution also Requires: (1) the Secretary to establish and operate up to five centers for TBI research, education, and clinical activities; (2) the establishment of a peer review panel to assess the scientific and clinical merit of proposals submitted for the designation of such centers; (3) the VA Under Secretary of Health to ensure that information produced at such centers is disseminated throughout the Veterans Health Administration (VHA); and (4) annual reports from the Secretary to the veterans' committees on the status and activities of the centers.

The resolution passed the House and upon second reading in the Senate has been referred to the Senate Committee on Veterans Affairs (Traumatic Brain Injury, 2007).

H.R.. 1538, the Wounded Warrior Assistance Act of 2007 was passed in the Senate with an amendment unanimously agreed upon by Senators, as of July 25, 2007. The purpose of the act is "to improve the management of medical care, personnel actions, and quality of life issues for members of the Armed Forces who are receiving medical care in an outpatient status, and for other purposes". As amended the Act would also address the discrepancies in disability payments encountered by many. It should also aid in the transition from DOD to the services provided by the Veteran's Administration. According to the Congressional Budget Office the act could potentially cost in the billions of dollars, but that is based upon incomplete information (CBO, 2007).

On July 12th, 2007 Bill HR 2956, the Responsible Redeployment from Iraq Bill passed the House with a 223 – 201 vote. The bill requires President Bush to provide the "...congressional defense, appropriations, and foreign relations committees a comprehensive US strategy for Iraq." The bill also requires "...the Secretary of Defense to commence the reduction of the number of United States Armed Forces in Iraq to a limited presence by April 1, 2008, and for other purposes". The bill further provides that there must be a reduction in the number of troops in Iraq within 180 days of the bills passage. As of July 30, 2007, the bill has been read twice in the Senate and has been referred to the Committee on Foreign Relations.

Congress adjourns the first week of August for Recess. What does the future hold? Will we be out of Iraq anytime soon? Will there be a continued "surge"? Will banners herald the tidings of "Mission Accomplished" anytime soon? It appears that President Bush is "staying the course." A 2005 Congressional Research Services report entitled Operations Noble Eagle, Enduring Freedom, and Iraqi Freedom: Questions and Answers about U. S. Military Personnel, Compensation, and Force Structure,

raises the issue of conscription. The report concluded that it was unlikely that the draft would return. "However, should reconstruction and peacekeeping efforts in Iraq require a major

U. S. presence for a prolonged period of time, the utility of a draft might become a more active consideration" (Kapp, 2005, p. 17). Let's hope not.

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