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Veterans' Past, Present, and Future

This chapter serves as a backdrop to the Commission's analysis of veterans' benefits. The first section of the chapter summarizes milestones in the history of U.S. veterans' benefits, giving the reader a context for those benefits available today. The second and third sections of the chapter outline the demographics of today's veterans and the projected demographics of future veterans for consideration in the development of policies for disabled veterans, their dependents, and their survivors.

I History of Veterans' Benefits

America has a long history of caring for those who have served in defense of the Nation. From the early colonial days to today, veterans and their families have been cared for through various types and iterations of benefits and programs.

American veterans' benefits date back to the colony of Plymouth, which ordered in 1636 that any soldier who became disabled as a consequence of injury while defending the colony would be maintained by the Colony for life.[1] Other colonies followed this lead, which ultimately was continued by the Continental Congress.[2]

In 1776, the Continental Congress passed a resolution to give a pension to veterans who became disabled during military service. The resolution promised veterans half pay for life in cases of loss of limb or other serious disability.[3] Although this resolution was a significant milestone, the Congress lacked the authority and resources to implement the law, and the fulfillment of pension payments was left to the states. The burden of those payments was transferred to the Congress beginning in 1789.[4]

[1] PBS, *Veterans Benefit History*.
[2] VA, *History in Brief*, 3
[3] Ibid., 6
[4] VA, *History in Brief*, 3

In the early 1800s, all veterans' pensions were administered by the Bureau of Pensions under the Secretary of War. Legislative and administrative changes to veterans' benefits at that time included the extension of benefits to dependents and survivors, the increasing of allowances to match the rising cost of living, and the addition of veterans of militias and state troops to the federal rolls. The era also saw enactment of the Service Pension Law of 1818, which introduced pension payments to the indigent. That law had an immediate impact, increasing the number of pensioners from 2,200 to 17,730.[5] Controversy surrounded the law, however, with allegations of abuse resulting in a second piece of legislation requiring affirmation of one's income to continue receiving pension payments.

Veterans' pension programs were again affected by legislation in the early 1830s. At that time, the focus was on those veterans' who served during the War for Independence; the legislation adopted a "pure service" principle in which benefits for a life pension were contingent on the amount of time served in the military.[6]

Veterans of the Mexican War (1846-1848) and their dependents received pensions which were limited to death and disability incurred in service, unlike benefits that were in force for veterans of earlier conflicts.[7]

I.1 Civil War

As the nation entered the Civil War, Congress created new benefits and services for veterans and families of the deceased. The General Pension Act of 1862 provided disability payments to Union troops based on rank and degree of disability, and included compensation for illnesses contracted during service.[8] (Confederate veterans were barred from receiving federal benefits until 1958, when Congress issued a pardon and granted benefits to the few remaining survivors.[9])

There were an estimated 2.2 million (Union) troops who participated in the Civil War.[10] This influx of troops caused the number of pensioners to rise from about 80,000 veterans before the war to 1.9 million after it ended in 1865.[11] With an expenditure of $117 million in pension benefits, the Federal Government spent

[5] Veterans Benefits Administration, *Annual Benefits*, 8.
[6] Ibid.
[7] Ibid.
[8] President's Commission, *Veterans Benefits,* 4.
[9] VA, *History in Brief,* 4.
[10] President's Commission, *Veterans Benefits,* 62.
[11] Ibid., 11.

more on veterans' benefits between 1866 and 1870 than it had during the preceding 75 years.[12]

The period following the Civil War witnessed several legislative efforts take place that solidified the system of veterans' benefits. These included the Arrears Act of 1879 and the Dependent Pension Act of 1890. The former allowed, for the first time, that a claim may be retroactive while the latter broaden pension eligibility to those incapable of manual labor.[13] Collectively, legislation passed in the 19th century sufficient for its time and that of future needs such that no additional legislation was introduced after the Spanish-American War or the 1899-1901 Philippine Insurrection.[14]

I.2 World War I

By the early 20th century, the reconstituted Armed Forces of the United States had grown to more than 4.7 million[15] through a draft instituted by President Woodrow Wilson. These forces were called upon to protect national interests when America entered World War I on April 6, 1917. The doughboys experienced new types of warfare including trench warfare, air warfare, and chemical warfare.

By the time the armistice was signed on November 11, 1918, 204,000 Americans were wounded and 116,708 had died, leaving behind a new generation of widows and orphans.[16] By 1919, when the Versailles Treaty ended the "war to end all wars," disabled service members were discharged at a rate of 23,000 per month, stimulating institutional changes and shifts in responsibility in the administration of veterans' benefits through the early 1920s.

In 1921, President Warren G. Harding created a commission to reform the World War I veterans' benefits system. The commission recommended the formation of a single administrative agency to streamline the administration of veterans' benefits.

Consequently, the Veterans Bureau Act of 1921 consolidated the undertakings of the Federal Board for Vocational Education, the Bureau of War Risk Insurance, and the U.S. Public Health Service component that cared for World War I veterans. However, the Veterans Bureau quickly became an unwieldy organization fraught with waste, fraud, and abuse. Congress responded by

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[12] VA, *Veterans Benefits Administration,* 9.
[13] Ibid 10-11
[14] Ibid 12
[15] President's Commission, *Veterans Benefits*, 62.
[16] VA, *History in Brief,* 7.

enacting the World War Veterans Act of 1924, which was intended to remedy the blurring and overlap of previously passed laws and to liberalize accrued benefits to disabled World War I service members.[17]

Although rating schedules had existed since 1917, the first *official* schedule for rating veterans was promulgated in 1921.[18] The schedule rated specific injuries and diseases according to their estimated impact on "average impairments of earning capacity resulting from such injuries in civil occupations."[19] In 1924, the law was revised by adding the phrase "similar to the occupation of the injured man at the time of enlistment" World War Veterans' Act of 1924, Pub. L. No. 242, 1924. In response, a new schedule of disability ratings was implemented in 1926[20] that considered occupational factors in evaluating the impact of a given impairment—an innovation for the time.[21] For instance, a lawyer and a carpenter who each lost a leg received different amounts of compensation for their injuries. The lawyer was viewed as less affected because his profession was mostly sedentary, so he received less compensation than the carpenter, who needed mobility to work. Despite the merits of this approach to compensation in theory, it soon became viewed as overly subjective and complex in practice. Another problem was the rating of young veterans who had never been employed before serving.[22] Consequently, VA issued a new schedule, the VA Schedule for Rating Disabilities (VASRD), in 1933 that returned to the average impairments in civil occupations philosophy of the 1921 rating schedule.[23] The revision also established policies on reasonable doubt, combined ratings, and other factors still in effect in 2007.[24] A second edition of the VASRD was also published in 1933.

In 1930, Congress authorized the consolidation of the Veterans Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers into a single independent agency: the Veterans Administration (VA).[25] The consolidated agency administered benefits to 4.7 million veterans and brought together medical and domiciliary services, World War I compensation and allowances, government life insurance, adjusted service certificates, emergency officers' retirement pay, Army and Navy pensions, and civilian employee retirement.[26] By 1933, VA had 54 regional offices that adjudicated claims,

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[17] VA, *Veterans Benefits Administration,* 19.
[18] Veterans Bureau, *Disability Rating Table*.
[19] Dillingham, *Federal Aid to Veterans*, 39.
[20] President's Commission, *Disability Rating Schedule,* 47.
[21] McBrine, *Rating Schedule*.
[22] Dillingham, *Federal Aid to Veterans*, 48.
[23] McBrine, *Rating Schedule*.
[24] Ibid.
[25] VA, *Veterans Benefits Administration,* 19.
[26] Ibid., 25.

provided medical and dental treatment, collected insurance premiums, and made loans. The Board of Veterans Appeals (BVA) was established the same year.

In light of the Great Depression, a newly elected President Franklin D. Roosevelt was concerned with controlling the Federal budget and promoting economic reform through his New Deal plan. In that context, he rescinded all veterans' benefits dating back to the Spanish-American War by signing the Economy Act of 1933.[27] Under an Executive authority, President Roosevelt then issued 12 regulations that effectively cut veterans' benefits by 88 percent. However, when this authority expired in 1935, Congress reinstated many of those benefits.[28]

In 1936, overriding a veto by President Roosevelt, Congress authorized early payment of the World War I insurance bonuses. Some 3.5 million World War I veterans collected their lump sum, resulting in a $2.5 million disbursement from the Federal Government.[29] Also significant at this time was the passage of the Social Security Act of 1935, which relied on employer and employee contributions to care for the elderly and disabled, including veterans.[30] Active duty service members did not have their military pay withheld for Social Security contributions until 1956.

During the 1930s, many veterans sought medical care, especially during a tuberculosis epidemic. The number of VA hospitals increased from 64 to 91, and bed capacity increased from 33,669 to 61,849. VA research made its first significant contribution to medicine when it broke ground in the treatment of tuberculosis, which plagued the population of VA patients; by the mid-1930s, the disease affected only 13 percent of that population.[31] Neuropsychiatric patients then accounted for more than half of VA's patient population.[32]

I.3 World War II

The failures of the Versailles Treaty, economic hardships, and the impotence of the League of Nations set the stage for World War II. Although the United States attempted to remain neutral, Congress enacted the Selective Training and Service Act of 1940, America's first peacetime draft, which guaranteed reemployment to anyone who left a job for military service.[33] The draft called

[27] Ibid., 27.
[28] Ibid.
[29] Ibid., 22.
[30] Nelson, *About the Great Depression.*
[31] VA, *History in Brief,* 12.
[32] Ibid., 12-13.
[33] Ibid.

800,000 men to service, overriding the previously set legal limit of 375,000[34] and far outstripping the size of the 185,000-man standing Army that the country had previously maintained exclusively on U.S. soil. Isolationism remained the widespread political sentiment, and President Roosevelt refused to enter another European conflict until the Japanese attacked Pearl Harbor on December 7, 1941. Four days later, Hitler declared war against the United States.

To fight the war, the United States mobilized more than 16.5 million Americans,[35] the largest mobilization in U.S. history, including many more women and minorities than ever before. In total, 671,876 American troops were wounded and 405,399 died, leaving many dependents in need.[36] For every three Americans killed in action, two died from other causes.[37] Advances in armaments, the conditions in prisoner of war (POW) camps, and experimentation with atomic radiation gave World War II veterans' health challenges not experienced by previous generations. In particular, psychiatric casualties increased by 300 percent from World War I to World War II and accounted for 23 percent of all evacuees. The traumatic aftereffects of combat were widely rejected as the cause of these psychiatric casualties.

The VA Schedule for Rating Disabilities (VASRD) underwent its last major revision in 1945 to account for World War II veterans' organ-system injuries and illnesses. In a significant change, the revised VASRD allowed VA to reevaluate a veteran and change his disability rating—and consequently the amount of compensation he received—if the veteran had recovered from his original service-connected disability. Previously, a veteran's original disability rating could not be changed.[38] The revised 1945 version of the VASRD forms the foundation of the VA Schedule for Rating Disabilities in effect today.

Between 1945 and 1962, testing programs for nuclear weapons exposed thousands of participants to ionizing radiation,[39] yet veterans did not receive assistance for health problems associated with ionizing radiation until 1981. That year, Congress authorized medical and nursing home care for such health problems, and in 1988 it authorized disability compensation for diseases associated with radiation.[40]

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[34] Sulzberger, *American Heritage Picture History*, 130.
[35] President's Commission, *Veterans Benefits,* 62
[36] VA, *Veterans Benefits Administration,* 30.
[37] Summers, *Vietnam War Almanac,* 111.
[38] Institute of Medicine, *21st Century System,* 86.
[39] VA, *History in Brief*, 21
[40] Ibid.

While President Roosevelt tasked two different committees to explore options for the 12 million service members about to demobilize, The American Legion drafted the GI bill of rights, a plan that included hospitalization, employment, home and business loans, mustering-out pay, and education. Within 6 months, Congress passed the Servicemen's Readjustment Act of 1944, more commonly known as the GI Bill.[41] Five years after the end of World War II, four out of every five veterans received benefits under one or more of the three major GI Bill programs for education and training, home loans, and unemployment compensation.[42] By 1955, veterans who used their GI Bill benefits had higher income levels than nonveterans of similar age, were more likely to be in professional and skilled occupations, and were better educated. Three out of five married veterans owned their own homes.[43] The GI Bill paved the way for World War II veterans to become known as the "Greatest Generation," given their considerable contributions to the American economy and social structure.

In response to explosive growth of the veterans' population—from 4.3 million in 1942 to more than 18.2 million in 1947—VA reorganized to meet occupational and educational needs. In 1946, VA added the Vocational Rehabilitation and Education division, which had 13 branch offices and 69 regional offices.

I.4 The Cold War

The end of World War II fostered the standoff that became the Cold War, as the United States and the Soviet Union warily monitored each other's every move. In 1947, the National Security Act created the Department of Defense (DoD) to oversee the three service branches, gave oversight authority to the Joint Chiefs of Staff, established the National Security Council to advise the President, and created the Central Intelligence Agency.[44] The Truman Doctrine and the Marshall Plan to contain Communism became defining American policy for the next 30 years[45] and led America to maintain a strong military presence around the world. In 1950, when the North Koreans crossed the 38th parallel, the United States responded with force. The selective service draft was reinstated in 1951.

I.5 The Korean War

Almost 1.5 million World War II veterans returned to duty to become part of the 6.8 million troops mobilized from 1950 to 1953 to stop Communist expansion in Korea.[46] These troops not only faced combat wounds, but also injuries from

[41] VA, *Veterans Benefits Administration*, 30.
[42] President's Commission, *Veterans Benefits,* 254.
[43] Ibid., 254, 266-267.
[44] Ambrose, *Rise to Globalism*, 140.
[45] Ibid., 132.
[46] President's Commission, *Veterans Benefits*, 62.

extreme cold and frost. With new strides in medicine and the advent of the MASH unit, lives were saved at a greater rate during the Korean War than during World War II.[47] Notwithstanding, 54,256 American service members died from injuries and diseases in Korea[48] and 103,284 were wounded.[49]

In a departure from previous wars, the military took a more realistic approach to psychiatric casualties of the Korean War. The recognition that service members suffering from combat stress needed immediate treatment in the field decreased the evacuation rate for psychiatric reasons from 23 percent in World War II to 6 percent.[50]

As Korean veterans readjusted to civilian life, those with disabilities immediately benefited from the programs already established under the Vocational Rehabilitation Act of 1950. Eventually, 77,000 veterans availed themselves of the programs created by that act.[51] In 1952, 2.5 million veterans were receiving outpatient care, and VA was disbursing $125 million in compensation and pensions.[52] The "Korean GI Bill," enacted in 1952, provided benefits similar to those granted to World War II veterans, but with limitations and restrictions designed to mitigate administrative problems and abuses that had riddled implementation of the original GI Bill.[53] These problems contributed to the decision to reorganize VA in 1953. That reorganization created the Department of Medicine and Surgery, the Department of Insurance, and the Department of Veterans Benefits.[54]

After the fighting in Korea ended, the President's Commission on Veterans' Pensions chaired by General Omar Bradley deliberated on the status of veterans' benefits and expressed guidelines for the future.[55] The Bradley Commission found in 1956 that the "present structure of veterans' programs is not a 'system,' but an accretion of laws based largely on precedents built up over 150 years of piecemeal development."[56] The Bradley Commission believed that most programs were sound, but that some were in

> urgent need of revision and modernization to bring them in line with the basic changes which [sic] have occurred and are still occurring in our society. There is, at present, no clear national philosophy of

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[47] Summers, *Vietnam War Almanac*, 111.
[48] Ibid., 112.
[49] Office of Public Affairs, *America's Wars.*
[50] Goodwin, "Etiology," 2.
[51] VA, *Veterans Benefits Administration,* 33.
[52] Ibid*.,* 39.
[53] Ibid., 33.
[54] Ibid., 41.
[55] President's Commission, *Veterans Benefits,* 9-13.
[56] Ibid*.,* 9.

> veterans' benefits. This Commission has endeavored to develop a philosophy and guiding principles, on the basis of which our national obligation to veterans can be discharged generously.[57]

Consequently, the Veterans Benefits Act of 1958 revised, codified, and enacted as title 38 of the United States Code all laws relating to VA.[58] The Bradley Commission accurately predicted the return of the draft that would bring the population of veterans to approximately 25 million at the close of the century.

I.6 Vietnam War

More than 8.7 million men and women served in the military during the Vietnam War, 3.4 million of them specifically in Southeast Asia.[59] By 1975, when the last Americans in Vietnam were evacuated, 57,690 troops had lost their lives and 303,704 were wounded.[60]

Only 12 in 1,000 troops needed to be evacuated from Vietnam for psychiatric casualties, an all-time low for the U.S. military[61] attributed to the advances in military psychology made during the Korean War.[62] Despite the low proportion of psychiatric casualties on the battlefield, many factors specific to the Vietnam War and American culture at the time left many veterans with psychiatric problems long after the war ended. In addition, some veterans gradually developed diseases correlated to exposure to the harmful contaminant dioxin in Agent Orange, a herbicide that U.S. troops sprayed to defoliate jungles.

Unique characteristics of the Vietnam War accounted for the level of emotional stress that those veterans experienced. Unlike previous wars, Vietnam combatants rotated in and out of country alone, and not as a unit. Enemy troops engaged in guerrilla warfare in dense jungles and were not as easily identifiable as World War II enemy troops. Civilians could be just as dangerous as soldiers. There were no battle lines and no front. Booby traps were common. Land was secured, but not held. The drug culture and racial issues prevalent in America at the time seeped into the military, affecting unit cohesion. These factors combined to impose high levels of psychological stress on many U.S. troops.[63]

Above and beyond the challenges in the war zone, the controversy in the United States over the Vietnam War had emotional repercussions for the war's veterans.

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[57] Ibid., 10.
[58] VA, *Veterans Benefits Administration,* 41.
[59] VA, *Fact Sheet: America's Wars.*
[60] Summers, *Vietnam War Almanac*, 111.
[61] Goodwin, "Etiology," 3.
[62] Ibid.
[63] Ibid., 3-7.

The lack of concrete strategic objectives, ineffectiveness of U.S. operational concepts for defeating the enemy, death toll among both American service members and Vietnamese civilians, and other factors led many U.S. citizens and veterans to protest the war. Graphic images from the battlefield were broadcast on television into American homes for the first time in U.S. history, which had an acute emotional impact on the civilian population. As service members became increasingly aware of the antiwar movement in the United States, it dampened their morale.[64] Antiwar activists vented their discontent on veterans as they returned home from the war, creating an unwelcoming and even hostile environment on college campuses, in workplaces, in churches, and even at VSO posts. These factors plus a depressed American economy contributed to many veterans' disillusionment and poor readjustment to civilian life.[65,66] Emotional problems plagued an estimated 800,000 Vietnam veterans by 1985.[67] Although those veterans had not manifested the same rate of neuropsychiatric disorders during active duty as had World War II or Korean War veterans, Vietnam veterans were more likely to suffer psychiatric symptoms years after returning home.

I.7 Vietnam Era Benefits

In 1965, Congress created the largest-ever national insurance program with the passage of Servicemen's Group Life Insurance (SGLI), and the next year, Congress passed the Vietnam GI Bill to restore educational benefits.[68]

VA attempted to engage Vietnam veterans in benefits programs by placing VA representatives in Long Binh in 1967 and by installing toll-free phone lines to regional VA offices in each state.[69] Congress attempted to increase veterans' participation in education programs through amendments to the GI Bill in 1970, 1972, and 1974, and through the 1977 Vietnam Era Veterans' Educational Assistance Act (VEAP). In 1979, VA opened its first Vet Center tailored to the needs of Vietnam-era veterans. Despite these efforts, some Vietnam veterans avoided government assistance and succumbed to illness, substance abuse, homelessness, incarceration, or suicide.

Vietnam veterans and their families brought the Agent Orange product liability litigation against major manufacturers of the herbicide in 1978.[70] The resolution of the lawsuit in 1984 for $180 million led to the creation of the Agent Orange

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[64] Ibid.
[65] Ibid., 7.
[66] Brende and Parson, *Vietnam Veterans,* ix.
[67] Ibid., 21.
[68] VA, *History in Brief,* 18.
[69] Ibid., 19.
[70] VA,. *Agent Orange—Herbicide Exposure.*

Settlement Fund, which was distributed to class members through two programs: the Payment Program, which distributed funds to totally disabled Vietnam veterans or their survivors, and the Agent Orange Class Assistance Program (AOCAP), which funded 72 programs that assisted nearly 200,000 veterans and their families in every state for 6 years.[71,72] AOCAP gave grants to existing small local agencies, nonprofits, VSOs, and related organizations that provided grassroots support services, outreach, and treatment. Case managers tracked the progress of many veterans who participated in AOCAP-funded programs. The success of these community-based programs with case managers influenced VA to change the way it delivered treatment and services to veterans.

VA responded to health concerns related to Agent Orange by providing medical care beginning in 1978. Eligibility for medical treatment for illnesses related to Agent Orange was expanded in 1981. In the early 1990s, VA began granting compensation for cases of chloracne, soft-tissue sarcoma, and non-Hodgkin's lymphoma thought to be connected to exposure to Agent Orange. The Agent Orange Act of 1991 provided presumptive service connection for diseases caused by exposure to the herbicide. VA began granting compensation in 1993 for other cancers presumed to be connected to wartime exposure to Agent Orange.[73] A study that found a correlation between Agent Orange and the birth defect that causes spina bifida led VA in 1997 to provide benefits to more than 940 children who had the disease and were the offspring of Vietnam veterans.[74]

I.8 Post-Vietnam Era

In 1973, the draft system that had been in place for over 30 years was replaced by an all-volunteer force. At the same time, World War II veterans began turning 65 years of age and looked to VA for pensions. Consequently, the number of pensioners increased from 89,526 in 1960 to 691,045 in 1978.[75]

To facilitate recruiting, Congress passed the Veterans' Educational Assistance Act of 1984, otherwise known as the Montgomery GI Bill (MGIB).[76] The first peacetime GI Bill, MGIB successfully attracted volunteers to the military and helped them attain their long-term educational goals. The New GI Bill Continuation Act of 1987 made the MGIB permanent. By 1990, approximately 900,000 service members had participated in MGIB programs,[77] representing a

[71] Ibid.
[72] Rhodes, Leaveck, and Hudson, *Legacy of Vietnam Veterans*, xv–xvi.
[73] VA, *History in Brief*, 20.
[74] Ibid.
[75] Ibid., 23.
[76] VA, *Federal Benefits for Veterans and Dependents,* 29–33.
[77] VA, *Veterans Benefits Administration,* 59.

72 percent participation rate. In contrast, only 20 percent of eligible individuals had participated in the Vietnam GI Bill by 1978.[78]

In 1986, Congress limited access to free medical care from VA. Only individuals who were considered indigent or disabled by VA or were part of certain special groups (e.g., former prisoners of war) could receive health care from VA without payment. All others had to pay for part of their treatment.[79] In 1990, Congress no longer allowed previously low-income wartime veterans over the age of 65 to automatically be classified as disabled.

President Ronald Reagan elevated the Veterans Administration to a Cabinet-level department in 1988. The new Department of Veterans Affairs contained the Veterans Benefits Administration (VBA), the Veterans Health Administration (VHA), and the National Cemetery System (later to also become an administration). At the same time, Congress created the Court of Veterans Appeals as a component of the Judicial Review Act, giving veterans the ability to appeal decisions by the Board of Veterans Appeals (BVA) to an independent court.[80]

In response to a report by the General Accounting Office (GAO), VBA began an update in 1989 of each of the 14 body systems sections of the VASRD, but only completed 11 of the sections, and never fully completed a comprehensive review as GAO had initially advised and VA had agreed.[81]

Before 1990, veterans of war who were older than 65 years and considered by VA to have low incomes automatically became classified as disabled—even if they lacked a true disability—and received disability pensions. That policy changed with the passage of the Omnibus Budget Reconciliation Act of 1990. The new law required that to be determined totally disabled, a veteran of any age had to be unemployable as a result of a disability.[82]

I.9 The Persian Gulf War

Some 700,000 American troops were deployed to the Persian Gulf in response to the Iraqi invasion of Kuwait in 1990.[83] U.S. forces and their partners from other countries quickly accomplished their mission. Within months after

[78] Ibid., 58-59.
[79] VA, *History in Brief*, 23.
[80] VA, *Veterans Benefits Administration,* 66.
[81] Institute of Medicine, *21st Century System,* 92.
[82] VA, *History in Brief*, 25.
[83] Institute of Medicine, *Gulf War Veterans*, 12.

demobilization, some individuals who served in the Persian Gulf War began reporting symptoms that were difficult to relate and diagnose. In response to the concern that environmental exposures to substances in the Persian Gulf region caused these symptoms, Congress legislated that VA should obtain independent evaluations of the scientific evidence of associations between symptoms and exposures to various chemical, biological, and physical substances connected to military service in the Persian Gulf region during the war.[84] These evaluations are ongoing; none so far has identified a single cause for what is commonly termed "Gulf War Illnesses." Veterans who suffered from Gulf War Illnesses were the first generation of veterans for whom an undiagnosed illness was deemed to be service connected.

I.10 Reforms to Delivery of VA Health Care and Benefits

VHA underwent a sweeping restructuring beginning in 1994.[85] This restructuring set the stage for a significant change in veterans' access to health care marked by the passage of the Veterans' Healthcare Eligibility Reform Act of 1996. Before the law was passed, the only individuals allowed free access to the VA health care system were those deemed disabled or indigent by VA standards or belonging to a special group (e.g., former prisoners of war). After the law's implementation, VA had the authority to use a means test and enhanced third party billing. The law's passage also enabled VA to eliminate the distinction between hospitalization and outpatient care and to provide prevention services and primary care.[86] To help VA estimate the costs it would incur under the new policy, the law placed each veteran in one of seven priority groups based on an array of factors including level of disability, level of income, and POW status.[87] In addition, VA reorganized its medical centers into 22 Veterans Integrated Service Networks (VISN), each of which determined how best to serve the veterans in its geographic area.[88] (Later, VISN 14 and 15 were combined into VISN 23 for a total of 21 networks.) The VISNs can electronically track patient records throughout the health-care system.

Health care eligibility reform and the restructuring of the VA health care system resulted in improved access to primary care, shifted the delivery of care from predominantly inpatient to predominantly outpatient, and allowed for greater accountability and performance measurement. As a consequence of the restructuring, the number of unique patients treated in the VA health care system

[84] Institute of Medicine, *Gulf War and Health.*
[85] VA, *Prescription for Change,* 5.
[86] VA, Employee Handbook, 0-1–0-2
[87] VA, *Eligibility Reform.*
[88] Government Accountability Office, *VA Health Care*.

rose from 3.0 million in FY 1998 (before enrollment) to 3.4 million in FY 2000 (one year after enrollment began) to 4.9 million in FY 2006.[89]

In 2001, VHA undertook the Capital Asset Realignment for Enhanced Services (CARES) study, which recommended that VA close some facilities while expanding other points of care. By 2004, new construction projects were requested, community-based outpatient clinics (CBOCs) expanded to over 850 sites, rural access issues were being addressed, and sharing initiatives between VA and DoD were being created.[90]

To improve VA services to service members who were transitioning back into civilian life, VA and DoD jointly created the Benefits Delivery at Discharge (BDD) program in 2000 so service members could file claims with VA while still on active duty. Some 40,600 transitioning service members filed original compensation claims through the BDD program in fiscal year 2006.[91]

Vet Center eligibility was extended in 1991 to veterans from conflicts in Lebanon, Grenada, Panama, and Somalia; in 1996, that eligibility was expanded further to include veterans of World War II and Korea.

I.11 The Global War on Terrorism

On September 11, 2001, Americans watched as the twin towers of the World Trade Center collapsed, a section of the Pentagon burned, and smoke rose from a field in Pennsylvania after the hijacking of four jetliners by members of Al Qaeda. By the end of that day, almost 3,000 people had died in the deadliest attack on American soil since Pearl Harbor. In response, President George W. Bush declared a Global War on Terrorism. Troops were sent to Afghanistan for Operation Enduring Freedom (OEF), and later in 2003, to Iraq for Operation Iraqi Freedom (OIF).

As the war continued, some 1.3 million men and women were on active duty in 2006, while another 1.1 million served in the National Guard and the Reserves, often on double and triple deployments.[92] Injuries to deployed OEF and OIF service members include amputations, traumatic brain injury, blindness, burns, and multiorgan system damage. Yet a record 85 percent of the injured have

[89] Kendall, E-mail message.
[90] VA, *CARES Decision,* 4–5.
[91] VA, *Annual Performance and Accountability Report*.
[92] DoD, *Defenselink, DoD 101*.

survived as of August 2007, thanks to improvements to body armor and coagulants and the modern medical evacuation system.[93]

DoD and the service branches have created specialized programs for the severely injured, and VA has retooled its approach to rehabilitation for polytrauma. Transition assistance programs are being offered, outreach is being conducted at multiple levels, and the Benefits Delivery at Discharge program is available at 140 installations. Traumatic Servicemembers' Group Life Insurance (TSGLI) became effective in December 2005 to provide financial assistance to the severely injured. This traumatic injury protection rider pays a lump sum to any service member who sustains a severe injury. TSGLI pays between $25,000 and $100,000 depending on the severity of the injury.

II Demographics of Today's Veteran Population

About 23.5 million veterans live in the United States and Puerto Rico in 2007, accounting for about 8 percent of the U.S. population.[94,95] The number of veterans has been decreasing for more than a decade. From 2000 to 2004, the size of the veterans' population shrunk by an average of 437,000 people a year, or 1,200 a day.[96]

Table 3.1 illustrates the total number of living veterans by unique periods of wartime service and the approximate percentage of each population receiving disability benefits at the end of fiscal year (FY) 2006. There are also many veterans, especially retirees, who have served during peacetime, during both peacetime and wartime, or during multiple wars (Table 3.2). Vietnam veterans were the largest group in the veteran population at the end of FY 2006 and the largest group receiving service-connected disability benefits at that time (Table 3.1). Note that the percentage of each group receiving benefits relates only to the number of living veterans, not to the percentage of all veterans who served during those periods. For example, over 16 million individuals served during World War II, but only 3.5 million of them remain alive.

Today's veterans are an average of 58 years old, and the majority of veterans are between 45 and 64 years old.[97] There are about 9.2 million veterans aged

[93] DoD, *Defenselink*, *Department of Defense Casualty Reports*.
[94] Office of the Actuary, *Veterans by State, Age Group, Period, Gender*.
[95] Population Projections Branch, Interim Projections by Age, Sex, Race, and Hispanic Origin.
[96] Office of the Actuary, *Veterans by State, Age Group, Period, Gender*.
[97] VA, *2001 National Survey of Veterans*, 3–4.

65 or older, representing 38 percent of the veteran population.[98] By contrast, the median age of the U.S. population is 35 years.[99]

Table 3.1 Veterans Receiving Service-Connected Disability Benefits at End of FY 2006 by Period of Wartime Service

UNIQUE PERIOD OF WARTIME SERVICE	NUMBER OF LIVING VETERANS[a]	VETERANS RECEIVING SERVICE-CONNECTED DISABILITY BENEFITS	
		No.[b]	Percentage (%)
World War II	3,525,769	328,042	9.3
Korean War	3,256,925	159,804	4.9
Vietnam War	8,054,993	947,598	11.7
Gulf War	4,377,845	694,813	15.9
Global War on Terror	588,923[c]	Not available	Not available

[a] Veteran Data and Information, VA. *Table 2L: Veterans by State, Period, Age Group, Gender, 2000-2033.* Washington, DC: VA, 1995. www1.va.gov/vetdata/docs /2l.xls.

[b] Hessling, E-mail message.

[c] This figure is for Nov. 2006. Office of Public and Intergovernmental Affairs, VA. *Fact Sheet: America's Wars*. Washington, DC: VA. http://www1.va.gov/opa/fact/amwars.asp. .

Table 3.2 Veterans Receiving Service-Connected Disability Benefits, End of FY 2006

PERIOD OF SERVICE	NUMBER OF LIVING VETERANS[a]	VETERANS RECEIVING SERVICE-CONNECTED DISABILITY BENEFITS	
		No.[b]	Percentage (%)
Wartime	18,155,573	2,130,259	11.7
Peacetime	6,231,463	595,565	9.6
All periods	24,387,036	2,725,824	11.2

[a] Veteran Data and Information, VA. Table 2L: Veterans by State, Period, Age Group, Gender, 2000-2033. Washington, DC: VA, 1995. www1.va.gov/vetdata/docs/2l.xls.

[b] Marshall, E-mail message.

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II.1 Service-Connected Disability

More than 2.7 million veterans had service-connected disabilities at the end of FY 2006, a 14 percent increase over the number at the end of FY 2002.[100] The

[98] VA, *Fact Sheet: Research in VA Geriatrics.*
[99] Census Bureau, *Census 2000 Summary.*
[100] Marshall, E-mail message .

three most prevalent service-connected disabilities among veterans receiving compensation at the end of FY 2006 were musculoskeletal disorders, auditory disorders, and skin disorders.[101]

Compensation for disability is determined by the number of conditions considered to be connected to military service, the degree to which each condition is disabling, and the overall degree of disability caused by the conditions combined. Chapter 4 contains an in-depth discussion of the disability rating system.

Table 3.3 illustrates the number of veterans with service-connected disabilities who received VA compensation and the average amounts of compensation received per person in FY 2006, the most recent year for which data are available. As of 2006, the average cost of compensation was $9,381 per disabled veteran.[102] 28.4 percent of all service-disabled veterans have combined ratings of 10 percent. 56.7 percent of all service-disabled veterans have combined ratings of 30 percent or less.

Veterans have, on average, three different disabilities for which they are rated. A 10 percent rating is the most common individual rating; 40 percent of all ratings are at the 10 percent level. Some 89 percent of all individual ratings are between 0 percent and 30 percent.[103]

[101] Ibid.
[102] Ibid.
[103] Veterans Benefits Administration, *Annual Benefits Report*, 27.

Table 3.3 Estimated Amount of Service-Connected Disability Compensation Paid and Number of Veterans Receiving Compensation, End of FY 2006

COMBINED DEGREE OF DISABILITY (%)	NUMBER OF VETERANS	ESTIMATED TOTAL ANNUAL AMOUNT PAID ($)	ESTIMATED AVERAGE ANNUAL AMOUNT PAID PER VETERAN ($)
0	14,309	$12,749,510	$891
10	779,789	$1,054,734,550	$1,353
20	421,709	$1,113,945,680	$2,642
30	335,358	$1,509,571,822	$4,501
40	260,165	$1,695,282,651	$6,516
50	161,774	$1,480,760,925	$9,153
60	184,499	$2,804,358,638	$15,200
70	165,468	$3,694,285,023	$22,326
80	113,549	$2,818,009,618	$24,818
90	60,623	$1,642,610,621	$27,096
100	238,966	$7,843,014,446	$32,821
Total	2,736,209	$25,669,323,485	$9,381

[a] "Combined" means the percentage captures the total degree of disability from one or more service-connected injuries or illnesses.

Source: Hessling, E-mail message.

II.2 Survivors

More than 326,000 spouses, children, and parents of deceased service members who died on active duty or of service-connected conditions were receiving more than $4.3 billion in annual service-connected death benefits at the end of FY 2006.[104] On average, each survivor received $13,187 in annual compensation at that time.[105] Some 11,700 of the survivors were the children of the deceased; members of that group on average received $6,357 in annual compensation. Most of the beneficiaries—over 41 percent—were survivors of Vietnam War veterans, and nearly 32 percent were survivors of World War II veterans.[106]

II.3 Racial Composition of the Veteran Population

Table 3.4 illustrates the racial composition of the veteran population according to the 2000 U.S. Census.

[104] Hessling, E-mail message
[105] Ibid.
[106] Ibid.

Native American veterans (including Alaskans and Hawaiians) have the highest rate of military service per capita of any ethnic group, yet it can be challenging for those veterans to access the health care and other benefits they need because of the remote locations of many of the reservations and rural communities where they live.[107]

Table 3.4 Numbers of Veterans by Race and Hispanic Origin[a], 2000

RACE	NUMBER OF VETERANS	PERCENT OF TOTAL VETERAN POPULATION (%)
Caucasian alone	22,573,027	85.5
Black or African-American alone	2,571,981	9.7
Hispanic or Latino (of any race)	1,139,179	4.3
Asian alone	284,297	1.1
American and Alaskan Native alone	195,871	0.7
Native Hawaiian and other Pacific Islander alone	28,592	0.1
Other race alone	367,867	1.4
Multiracial	382,067	1.4

NOTE: Respondents were given the opportunity to choose more than one racial category. The groups designated "alone" indicate that the veteran chose to identify with only one racial group.

[a] "Hispanic" was not considered a race by the creators of this table.

SOURCE: Richardson, Christy and Judith Waldrop. *Veterans: 2000: Census 2000 Brief*. Washington, DC: U.S. Census Bureau, 2003, 10. http://www.census.gov/prod/2003pubs/c2kbr-22.pdf; Center for Minority Veterans, *Veterans by Race: Census 2000.* Washington, DC: VA, 2006. http://www1.va.gov/centerforminorityveterans/page.cfm?pg=5.

II.4 Women

Today's 1.7 million female veterans[108] make up 6 percent of the total veteran population, and 15 percent of the current armed forces are women. The 2001 National Survey of Veterans found female veterans to be younger than their male counterparts, more likely to have college degrees, and more likely to classify themselves as Black.[109] African-American women are the largest group of

[107] Huff, "Crossing the Cultural Divide," 22–24.
[108] VA, *VetPop 2004*.
[109] VA, *2001 National Survey of Veterans*.

minority women serving in the military today, comprising 30.8 percent of female service members.[110] The most common conditions for which VA treated female veterans in 2004 were hypertension, depression, and hyperlipidemia.[111]

II.5 Veterans' Families

Family issues are of great importance to today's veterans—almost 75 percent of them are married[112]—yet VA does not have the same statutory authority as DoD to provide services to the families of the severely disabled. The Civilian Health and Medical Program of VA (CHAMPVA) is authorized to provide health care to dependents of veterans who are totally and permanently disabled or who were so at the time of death, and to the surviving spouses or children of service members who died in the line of duty, not due to misconduct, and who are not eligible for DoD's Tricare health care program.[113] CHAMPVA had 263,700 beneficiaries enrolled in 2005.[114]

The Vet Centers are providing some family counseling services, especially to bereft families who have recently experienced an active duty death; however, this authority is limited. Spouses, parents, grandparents, and siblings have become a growing presence at VA facilities as they help care for severely injured service members.

The changing composition of the American military has significant implications. VA must be able to care for the younger veterans of the Global War on Terror and their families while maintaining the infrastructure that fulfills the need for long-term care of the veterans of wars and conflicts dating back to World War II. VA and DoD also need to care for the growing numbers of women, minorities, and married veterans. It is with an understanding of these factors that the Commission contemplates how to shape benefits for future generations of disabled American veterans.

III Demographics of Tomorrow's Veteran Population

In crafting recommendations that will affect future generations of veterans, the Commission studied demographic projections for the United States overall and

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[110] Evans, *Out of the Shadows,* 26.
[111] Center for Women Veterans, *National Summit,* 43.
[112] VA, *2001 National Survey of Veterans,* 3–4.
[113] VA, *CHAMPVA*.
[114] Data on the Civilian Health and Medical Program of VA was given to the Commission by the Health Administration Center in Denver, CO, in 2006.

the veteran population specifically. An estimated 1.1 million new veterans are projected to enter the population between 2006 and 2030 (Table 3.5). DoD is expected to maintain troop strength at about 2.4 million active-duty personnel, National Guardsmen, and reservists;[115] thus, projections of the numbers of new veterans through 2030 should remain accurate, absent a major or long-term conflict. In other trends, the population of veterans is expected to decline sharply during the next several decades (Table 3.5). Increases in the proportion of women veterans and in ethnic and racial diversity among veterans are also anticipated.

III.1 Aging and Shrinking of the Veteran Population

The population of veterans is projected to shrink by nearly 37 percent between 2006 and 2030 because the death rate—primarily deaths of World War II veterans—is projected to exceed the rate of separations from the military. The greatest percentage declines will occur in northeastern states, and the smallest, in southern and western states.[116] Some of the most populous states, such as California, New York, and New Jersey, will lose the greatest percentages of veterans.

The majority of veterans from the Vietnam era will be 65 or older by 2011. Although the population of veterans over age 65 is decreasing, the rate at which those veterans use VA benefits is increasing, and this trend is expected to continue.[117] The number of veterans aged 85 years or older presently exceeds 1 million and is projected to rise through 2010, then to begin declining by 2020 and to number about 1.4 million in 2033.[118]

According to VA, "As the veteran population ages, the demand for geriatric and all forms of long-term care should increase significantly relative to acute care. In particular, nursing home care policies, programs, and services will require continual monitoring and assessment."[119]

[115] Defenselink, DoD 101
[116] VA, *VetPop April 2001.*
[117] Federal Interagency Forum, *Older Americans Update 2006,* 51.
[118] VA, *Fact Sheet: Research in VA Geriatrics.*
[119] Klein and Stockford, *Changing Veteran Population.*

Table 3.5 Projected Veteran Population, 2006–2030

GROUP	NUMBER OF VETERANS			
	2006	2010	2020	2030
Total	23,976,991	22,148,322	18,120,496	15,155,603
Age				
18–29	1,072,207	1,045,491	979,419	982,645
30–39	2,159,502	1,841,471	1,755,975	1,696,527
40–49	3,483,934	3,149,685	2,072,688	2,005,472
50–64	8,060,978	7,192,188	4,944,876	3,490,641
65–84	8,125,036	7,635,813	7,229,123	5,878,456
85+	1,075,334	1,283,674	1,138,415	1,101,861
Gender				
Male	22,245,866	20,374,164	16,234,771	13,152,632
Female	1,731,125	1,774,158	1,885,725	2,002,971
Period of service				
Gulf War	4,297,284	5,042,553	5,489,107	5,425,080
Vietnam Era	7,286,528	6,909,650	5,359,785	3,018,058
Korean War	2,530,634	1,986,831	660,582	64,458
World War II	2,821,966	1,642,282	184,166	3,067

SOURCE: VA Office of Policy and Planning. "Veteran Population Model," *VetPop 2004,* Version 1.0. Washington, DC: VA, 2007.

III.2 Greater Proportion of Female Veterans

The presence of women among the veteran population will become more pronounced during the next several decades. Thus, while the total number of veterans will drop by about 25 percent, women will account for more than 10 percent of the veteran population in 2020, up from 7 percent in 2006.[120] DoD projects that the percentage of women will continue to increase — especially African-American women, which will increase at greater rate than that of African-American men.

III.3 Increased Ethnic and Racial Diversity

Census data project more ethnic diversity among older Americans by 2050 (Table 3.6); the population of veterans will likely reflect these ethnographic shifts. Caucasians are the only group expected to decrease proportionally, and by a

[120] VA, *Veteran Population Model*.

remarkable 20 percent. Meanwhile, the greatest growth—10 percent—will occur among Hispanics.

Table 3.6 Proportions of Older Americans by Origin

ORIGIN	PERCENTAGE IN 2000 (%)	PERCENTAGE PROJECTED FOR 2050 (%)
Caucasian	84	64
Black	8	12
Hispanic	6	16
Asian	2	7

SOURCE: U.S. Census Bureau. *Census 2000, National Institute on Aging Portfolio for Progress* (02-4995). Washington, DC: Census Bureau, 2001, 43.

IV Summary

For 400 years, America has cared for its veterans. The U.S. has provided compensation, pension, health care, rehabilitation, education, insurance, loans, burial, and other benefits that have reflected the economic, cultural, and political climates of the times. The meaning of being a "grateful nation" has been debated, legislated, and revised as each generation of veterans has returned home. The systems to assist disabled veterans today exist as a result of struggles and challenges faced by veterans of the past. VA's preparations for the veterans of today and tomorrow should reflect the changing composition and concerns of present and future service members.

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