Thomas J. Berger, Ph.D. Chair, National PTSD & Substance Abuse Committee, Testifying on behalf of VIETNAM VETERANS OF AMERICA

Statement
of
VIETNAM VETERANS OF AMERICA

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With
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Regarding
Pending Health Care Legislation

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Good morning, Mr. Chairman, Ranking Member Burr, other Distinguished Senators of this Committee, and guests. On behalf of VVA National President John Rowan and all of our officers and members, I thank you for the opportunity to share our views on pending health care legislation for our nation's veterans and for your leadership in holding this hearing today.

My name is Tom Berger, Chair of the National PTSD & Substance Abuse Committee for Vietnam Veterans of America (VVA). I am a Vietnam combat veteran, having served as a Fleet Marine Force Navy corpsman with the 3rd Marine Division, 1966 - 68, in I Corps, Vietnam.

S.2573, the "Veterans Mental Health Treatment First" Act

Obviously there is a range of issues to be considered here today, but VVA wishes to start by focusing on the proposed legislation S.2573, the "Veterans Mental Health Treatment First" bill that is to some degree, derived from the Dole-Shalala Commission's recommendations. Although this bill focuses on service-connected disability compensation and does not directly address evidence-based mental health diagnoses, treatment modalities, or recovery programs, the potential impact of this bill if enacted on veterans suffering from PTSD, TBI and related mental health disorders cannot be overstated. This in practice has the potential to change virtually everything - but not in a positive direction.

I am certain that we're all aware of the independent Rand Corporation study released last month showing that 18.5 percent of returning OEF/OIF troops meet the criteria for either PTSD or depression (i.e., 14 percent for PTSD and 14 percent for depression) some 19.5 percent have experienced a probable TBI. Even more distressing is the testimony by Colonel Charles Hoge, M.D., before the House Veterans' Affairs Health Subcommittee last month in which he indicated a 20 percent PTSD rate for troops serving two combat tours and a 29.9 percent PTSD rate for those serving three tours -- a number that is very close to that obtained for Vietnam veterans in the original National Vietnam Veterans Readjustment Study conducted in the 1980's, some years

after the end of the war that put PTSD on the reality map. Our troops now are seeing both more and longer deployments, with at least four Army Brigade Combat Teams (CBCTs) now in their fourth deployment cycle. What is beyond argument is that the more combat exposure a soldier sees, the greater the odds that soldiers will suffer mental and emotional stress that can become debilitating. And in wars without fronts, "combat support troops" are just as likely to be affected by the same traumas as infantry personnel.

While we are appreciative of Senator Burr's sincere motivation to do what is best for all concerned, including potentially affected veterans, VVA does not believe that the program outlined in this legislative initiative is either the best way to address this problem nor is it a prudent course in regard to assisting veterans to continue to serve our nation in civilian life as they did in the military.

In truth, with no end to the Iraq and Afghanistan wars in sight, the true incidence of PTSD among active duty troops may still be underreported because of stigma and discrimination. Without proper diagnosis and treatment, the psychological stresses of war never really end, increasing the odds that our soldiers will suffer mental and emotional stress that can become debilitating if left untreated. This places them at higher risk for self-medication and abuse with alcohol and drugs, domestic violence, unemployment & underemployment, homelessness, incarceration, medical co-morbidities such as cardiovascular diseases, and suicide.

VVA remains opposed to S.2573 principally because it would create a two-tiered disability benefits system that would treat veterans differently based on their periods of service - that is, a system that gives different disability rating awards to classes of veterans from different combat eras under the guise of saving the VA money. VVA is especially concerned with the impact of the so-called "buy out" program of this bill, not only on those veterans currently suffering from mental health disorders, but also on those who will encounter mental health problems later in life as a result of their military service. As you know one of the well-known characteristics of PTSD is that the onset of symptoms is often delayed, sometimes for decades, despite unfunded assertions to the contrary.

We are not disputing the fact that claims for mental health service-connected disability compensation are rising and the accompanying costs for such are growing as well. But under S. 2573, this problem cannot be resolved unless fewer vets are rated disabled and/or fewer disabilities are rated, and/or smaller amounts of compensation are awarded. The responsibility of providing service-connected disability compensation for a veteran's mental health injuries must not be trivialized by providing a one-time payment for wounds that may take years to heal, if ever.

This is especially applicable to our nation's largest living veteran cohort, Vietnam veterans, who are now aging, retiring, and suffering the aftermath of physical and emotional injuries incurred as a result of their military service 40 years ago.

The legitimacy of veterans' claims that they suffer from PTSD is apparently again under the gun by a small number of media savvy professional skeptics (some would call them "hired guns"), who have waged a campaign to discredit PTSD as a valid diagnosis, and whose views, I might add, are not generally shared by mainline PTSD experts nor by the vast majority of mental health

professionals nor by the Institute of Medicine of the National Academies of Science. (The IOM convened several panels at the request of the Department of Veterans Affairs relating to this issue of whether PTSD was a legitimate medical condition, whether PTSD could be accurately diagnosed, and whether PTSD could be effectively treated. (All three of these reports, released on June 16, 2006, May 8, 2007, and October 17, 2007, respectively, are available at www.iom.edu in the Military & Veterans section.)

Without a shred of evidence veterans who suffer from PTSD are portrayed by these skeptics as looking for easy disability payments that provide an incentive for staying sick rather than getting well, with the implication that sick veterans are welfare cheats. In addition to claims of veteran fraud, these skeptics also claim that cases of delayed onset of PTSD "are rare to non-existent," and that "PTSD is an acute, not chronic, disease and only rarely should there be a need to give long-term disability." In fact, there are no data to support these opinions. Studies done at the National Center for PTSD confirm the delayed onset of PTSD, as well as the fact that mental health utilization is actually higher for veterans granted disability claims than for those who apply and are turned down. VVA would also argue that use of the standardized and validated PTSD diagnostic assessment tools in the "Best Practices Manual for PTSD" would pick up any factitious PTSD disability claims, and provide for better guidance in developing individualized treatment plans.

VVA's concern is also focused on those veterans suffering from TBI, the so-called "signature wound" of the war in Iraq, because it presents a most puzzling challenge, especially in mild to moderate cases. Symptoms can be hidden or delayed, diagnosis is difficult, and evidence-based treatments are as of yet largely undetermined. And if left untreated over time, even mild TBI can cause epilepsy/seizure disorder. Very few medical facilities in the U.S. are capable of providing even the most minimal level of specialized care for brain-injured patients, forcing most survivors to find treatment hundreds of miles from home, if they can find it at all -- and more than 40 percent of our military deployed in Afghanistan and Iraq come hail from rural America.

In addition, the most commonly utilized current treatment modality for epilepsy/seizure disorder is medication. However, we must remember that epilepsy/seizure disorder caused by either a concussive or contusive brain injury, is never just an isolated incident. Over time without proper treatment and care, TBI can affect nearly everything associated with the survivor, including one's cognitive, motor, auditory, olfactory, and visual skills, perhaps resulting in behavioral modifications, not mental illness. Epilepsy/seizure disorder treatment, recovery services and programs can also collapse a family and its finances. Of all the medically challenging injuries, brain injuries require the most involvement and cost over time.

And so the question then becomes: How can we really expect a veteran currently suffering from chronic PTSD or TBI - perhaps even on medication for such wounds -- to be able to make an informed decision now about his/her future mental health care needs and service-connected disabilities?

Lastly, VVA acknowledges that the culture of the VA mental health system itself may play a yet undefined role in this current debate over PTSD and VA compensation. For example, the studies of Sayer and Thuras (1), as well as Kimbrell and Freeman (2) suggest that VA clinicians had a more negative view of the treatment engagement of veterans who were seeking compensation

and of clinical work with these patients in comparison with those veterans not seeking compensation and those certified as permanently disabled and thus not needing to reapply for benefits. The longer VA clinicians had been working with veterans who had PTSD, the more extreme were these negative perceptions.

What is clear to us is that these so-called clinical "researchers" are not even aware that their patients seek service connection so that they will not have to pay for medical treatment for a condition that they believe resulted from their military service. This, and the sense of validation of the reality of the suffering they endure is in fact a result of neuro-psychiatric wounds suffered in service are often more important to the individual veteran that any compensation payment he or she may derive (and deserve!) as a result of this psychiatric wound(s) that are every bit as real as a gunshot wound, if properly diagnosed according to the VA's own "Best Practices Manual."

VVA would point out that the VA refuses to issue these manuals to relevant staff in the Veterans Benefits Administration and in the Veterans Health Administration because "it takes too much time" and to follow the best practices is "too expensive." VVA's rejoinder is that if you do not have the time and resources to do it right the first time, when are you going to have the time and money to do it over, and then do it over yet again? Our veterans deserve better than slapdash, simplistic "fixes" that in fact do not address their legitimate needs, and would actually serve to exacerbate their very real wounds incurred in military service.

S.2273: The Enhanced Opportunities for Formerly Homeless Veterans Residing in Permanent Housing Act of 2007

VVA strongly supports this legislation. The crux of the problem with transitional housing for homeless veterans (aside from the fact that there is not enough of it) is that often there is no available permanent housing to which a transition can take place. In other words, persons make it off the street into a transitional housing unit, but then have no permanent affordable housing to go to when their time in the transitional supportive housing is done. What is needed are both affordable permanent housing, and supportive services that are available and focused on the needs of these persons to help them maintain a stable life situation. It is very important that the VA provide grants to fund such services, as HUD is increasingly cutting back on program dollars and focusing on "bricks and mortar." (Whether that is a smart public policy move on the part of HUD is certainly debatable, but the fact remains that this is the direction in which they seem to be heading.)

The pilot program as outlined in this proposal is solid, but we would suggest that you consider both enlarging the size of the pilot, provide for regular reporting to Congress at regular intervals (at least once per year), and after evaluation of the experience of what works and what does not work, provide for moving beyond the pilot in short order should the model(s) prove to be as successful as we think they will be if the VA implements them correctly. VVA has no doubt that Pete Dougherty (who coordinates homeless programs at VA nationally) will do a sterling job of the implementation and running this additional needed aspect of the VA homeless program(s), if he is given the resources and the backing.

S. 2377: A bill to amend title 38, United States Code, to improve the quality of care provided to veterans in Department of Veterans Affairs' medical facilities, to encourage highly qualified doctors to serve in hard-to-fill positions in such medical facilities, and for other purposes.

VVA endorses passage of this bill. We do however, have some suggestions that we hope you will consider. First, the Chief of Staff and the top medical officer of each VA Medical Center need s to be written into the chain of reporting in this bill. Similarly, so does the clinical director of each Veterans Integrated Services Network (VISN and the Under Secretary for Health of the Department of Veterans Affairs. While the principal ones to carry out the activities mandated by this bill may in fact be as described, it is the chief medical officer at each level who does have, and should have, ultimate responsibility for the overall quality of medical care delivered to veterans by that unit. While the mechanism prescribed in this legislation will be another tool toward that end, it is only part of the puzzle of how to maintain the highest quality of care for our nation's veterans.

VVA also strongly favors additional financial and other incentives to attract and keep high-quality physicians and other vitally needed clinicians and medical specialists in the VA.

Lastly, although it is not at the high professional credential level of the mechanism described in this legislative proposal, the fact is that many veterans cannot properly communicate with their clinician, nor is their clinician able to effectively communicate with them and others in the VA. Language barriers have become an impediment to quality care in too many instances. The lack of full command of the English language by clinicians and others at the VA is probably the most common complaint we hear from our members, their families, and other veterans.

This is a complaint that is founded on frustration voiced by many veterans that they cannot understand what their physician is trying to say to them, and their physician simply does not understand or misunderstands what they are trying to communicate. This can result in erroneous medical notes in the veterans' record, or even misdiagnoses. In more than a few cases, it would appear that these communication barriers impede the delivery of quality medical care. At minimum, it detracts from it.

The reality is that the VA will likely need to continue to hire foreign born physicians. So the question is: what can be done to help those physicians to be more effective in communicating with their patients, and therefore more effective clinically? VVA urges that Congress consider mandating the VA to regularly offer basic communication skills courses to clinicians and others within the VA, and to make it a requirement for a physician or other clinician (no matter where they were born or what their native tongue) to pass both an oral and written test in English before being made permanent in their employment. (The same would hold true for Spanish at the Puerto Rico VAMC.)

S. 2383 - A bill to require a pilot program on the mobile provision of care and services for veterans in rural areas by the Department of Veterans Affairs, and for other purposes.

VVA endorses this proposal.

As VVA noted in our last appearance before this distinguished Committee, the current paradigm for delivery of health care is predicated on placing resources where there is a large concentration of veterans eligible for service. In other words, the mechanism for service delivery of veterans' health care is in or near urban centers. However, those fighting our current wars in Iraq and Afghanistan (and elsewhere) comprise the most rural army we have fielded since before World War I.

The Department of Defense reports that about 40 percent of the current military force comes from towns of 25,000 or less. What this means is that we collectively must re-think the paradigm of how we deliver medical services to veterans in need.

The pilot program outlined in this bill is a good start toward testing what is going to work in regard to delivering quality health care to veterans (including demobilized National Guard and Reserves) who live in less populous areas of our country, and deserves to be immediately enacted, and implemented as quickly as possible.

S. 2639 - The Assured Funding for Veterans Health Care Act

Americans have long held that health care for veterans is a national obligation, part of the covenant between the American people, through our democratically elected representatives and agencies of government, and the men and women who have pledged to defend the Constitution and the cherished principles of our nation. Because those who render military service pledge not only their loyalty but their life, knowing that they may be called to combat, understanding that they may give up their life, this covenant is more profound than a legal contract. Now, at a time when a new generation of our sons and daughters is on the front lines defending America's interests, it is our obligation as citizens of a generous and compassionate society to ensure that the funding to care for the injuries, illnesses, and disabilities they may suffer is assured and not relegated to a "discretionary" appropriation of inadequate proportions.

Those who serve during times of war or conflict, particularly those who are deployed to a war zone, return home changed. Many are seared psychologically. Some are wounded or maimed by the weapons of modern warfare. Yet just as they have fulfilled their obligation to their country - to all of us - it is our collective obligation to do all that we can, through the appropriate agencies of government, to restore as much as possible to each veteran who has been lessened physically, psychologically, or economically; and all that we can individually and through our communal and religious institutions to heal each veteran who has been lessened spiritually.

All Americans committed to justice for veterans understand that the annual budget battles in Congress do little to inspire confidence that we will do right by our veterans. Budgets and appropriations are, of course, a reflection of the values and priorities of the administrators who design them and the legislators who approve them. What does "discretionary" funding for the care of men and women who defend our country say about America? What does the "temporary" triage of veterans classified as "Priority 8" say about our government's priority for veterans who want to use the VA health-care system?

In the last five sessions of Congress, legislation has been introduced in both the House and Senate that would drastically re-engineer the process by which the Administration and Congress fund veterans' health care.

The highest legislative priority of Vietnam Veterans of America is the institution of assured funding for veterans' health care, or another mechanism that will enable predictable schedules of appropriations increases that account for medical inflation and is calculated on a truthful per capita basis of projected use of VHA services. The Disabled American Veterans have been working on such a model that while still not what VVA's ultimate goal is - assured funding - is still better that the mess we have now.

Of all such mechanisms, however, VVA is still committed ultimately to the assured funding mechanism as described in Senator Johnson's bill.

VVA also strongly supports immediate reinstatement of eligibility for enrollment for Priority 8 veterans. VVA asks that this Committee take the first steps toward directing that the VA use numbers for its future planning and projection purposes that include provision of services for Priority 8 veterans who are not currently enrolled. A funding mechanism that annually makes allowances for the growth in the beneficiary population and inflation would ensure adequate additional funding as needed. Many of these plans offer similar funding mechanisms that already exist for the TRICARE for Life program serving the nation's military retirees and their dependents who are also eligible for Medicare. The funding mechanism created for this program requires annual increments based on health care inflation and growth in the number of beneficiaries. Rather than allowing politics to affect funding decisions, the Government Accountability Office (GAO) considers whether the annual increment determined will be adequate to meet costs. This methodology brought stability and predictability to a program that, in its infancy, suffered significant problems attributable to funding.

Unfortunately, despite a recommendation from its own Task Force to Improve Health Care For Our Nation's Veterans (Final Report, 2003) to consider mandatory funding for VA health care, the Administration has rejected any meaningful consideration of funding reform. Bills have been introduced in both the House and Senate to no avail.

VVA is grateful to and salutes Senator Tim Johnson of South Dakota for his fortitude in not only overcoming his own health crisis, but for his extraordinary efforts in continuing to push for real reform in the way in which our nation funds health care for our nation's veterans.

Unfortunately the debates regarding funding of veterans' health care continue to focus on the year-to-year "band-aids" and quick fixes needed to keep the health care system afloat. Last year, $3.7 billion had to be appropriated as emergency supplemental funding in order to make progress on restoring both the infrastructure and the organizational capacity of the VHA to deal with the needs America's veterans.

It is time to act to ensure a consistent, predictable, and responsible level of funding that will give more than lip service to the mandates for health care set forth in law, and by the will of the American people, for those who have borne the battle in the fertile fields of Europe, the islands

of the South Pacific, the rice paddies and jungles of Southeast Asia, the sands of Kuwait and Afghanistan and Iraq, and the peacetime confrontations of the Cold War.

Establishing a method that will ensure the fair, adequate and predictable funding of the VA health care system which would better ensure timely access to quality care remains the highest legislative priority of Vietnam Veterans of America.

In the five years that have followed publication of our original White Paper asserting the need for assured funding, the Administration and Congress have continued to provide compelling demonstrations of the weaknesses of the current funding method.

VVA is grateful to you, Senator Akaka, and to all Senators on both sides of the aisle who have accorded the veterans health care system with more increase in the past eighteen months than they have ever had, and to your counterparts on the other side of the Hill for all of their hard work as well to achieve these record increases.

However, despite these efforts and progress, the appropriations for the VA health care system continue to be inadequate to the degree that the VA is still barring eligibility to health care for many working-class veterans without compensable service-connected disabilities, limiting long-term care options, and compromising access to quality health care.

The uncertainty of when and how much funding it will receive wreaks havoc upon the VA's ability to make effective planning, policy and purchasing decisions. While that has appeared to improve, it will take increases of the magnitude of the last calendar year for another several years to restore what was lost from the funding base, and the overall organizational capacity of the VHA during the "flat line" years of 1996 to 1999, and several years thereafter when the increase in funding did not keep pace with either the increase in veterans entering the system, nor rapidly rising costs of medical care, many of which are not controllable.

Recent budget cycles call into question the VA's ability to produce a budget that credibly funds its health care system. Even after compensating for the savings and foregone revenues that have proven to be distasteful to Congress (new enrollment fees and dismantlement of the state home program, for example), the VA had to admit it would be $1 billion deficient in funding for fiscal year (FY) 2005 and also would require almost $2 billion more than originally projected for FY 2006.

Critics of the VA continue to call for it to live within its budgets by increasing efficiency. While VVA supports much greater accountability for VA officials, VA has proven its efficiency by actually reducing per user costs in a time of double-digit health care inflation. VA users' per capita costs actually decreased by about 6 percent (without including the eroding effects of inflation), while Medicare per capita costs and those of the average American consumer will have almost doubled.

Other federally funded health programs do not annually suffer through the funding cycle as the VA does. The nation's largest health care system that serves some of our most deserving citizens-veterans-should be accorded the same funding assurances as Medicare and TRICARE for Life.

Accordingly, VVA has joined every other major veterans' service organization as part of the Partnership for Veterans Health Care Budget Reform in calling for assured funding that is indexed for medical inflation and accounts for a credible expectation of utilization of health care services of all eligible veterans who desire enrollment. Without fundamental changes in the VA's budget process, veterans who rely upon the VA's health care services will continue to have a system plagued by deficiency and unpredictability.

For the coming fiscal year (FY 2009), VVA testified earlier this year that we believe the VA medical care business line will require at least $5.24 billion over FY 2008 VHA appropriations. Some contend that even adding that amount will not allow VHA the latitude to restore access to all veterans.

As we all are aware, on January 17, 2003, then-Secretary Anthony J. Principi decided to "temporarily" suspend enrollment to Priority 8 veterans. While this decision may be reconsidered on an annual basis, every budget proposal sent to the Congress by the Administration since continues to omit funding for this group, and attempts to discourage use and enrollment of "higher income" groups-that is, all Priority 7 and Priority 8 veterans who had enrolled prior to the suspension. The Administration has proposed new enrollment fees for these groups in addition to imposing higher co-payments for the pharmaceutical drugs that are largely responsible for bringing many into the system. These proposals are designed to do two things-eliminate services provided to higher income veterans and generate additional revenues to partially cover the cost of their care.

Priority 8 veterans-mostly working-class Americans without compensable disabilities incurred during their military service-are known as "higher-income" veterans. "Higher income" is a misleading label considering the growing rates of uninsured Americans directly subjected to spiraling health care costs and the relatively low-asset levels of those affected (currently, as low as about $27,000 for a veteran with no dependents). Far from redressing what veterans' advocates were given to believe was a "short-term" panacea, budgets for the five years since suspension of enrollment have omitted funding to restore access to these veterans and have espoused policies-such as new enrollment fees and higher co-payments-that are specifically designed to discourage these veterans' use of their health care system.

In last year's proposal, the VA estimated that more than one million "higher-income" veterans who have not been suspended from enrollment would be discouraged from using their health care system under their plan. Additionally it has been reported that more than a half a million veterans have been excluded from vitally needed services of the VHA system since that time. VVA has reason to believe that this is too conservative a figure, and the number of those excluded is higher still.

In an era in which health care inflation has regularly outstripped increases in wages, it is not surprising that veterans remain attracted to the re-engineered VA system. The proliferation of new outpatient clinics in addition to the benefits provided to all enrollees, including some that are not typically covered by private-sector health plans, such as prescription drugs, eyeglasses, and hearing aids, continue to encourage veterans' use of VA health care services. Even more veterans who are not considered regular users will be enrolled. VVA estimates 8.4 to 9 million would enroll if Priority 8 veterans were reinstated for enrollment without an enrollment fee).

Enrollment is a prerequisite for eligibility for health care services for all but the most highly rated service-connected disabled veterans.

Recent budgets sent to Congress have also attempted to ration services for veterans-particularly long-term care. In recent years, state homes have overtaken the VA in the long-term care workload they provide veterans and these homes are the only VA-sponsored settings that continue to support custodial care for veterans whom VA is not mandated to treat. Yet in VA's FY 2006 budget request, a policy shift was proposed that would have effectively shuttered as many as 80 percent of the state veterans homes (as estimated by the National Association of State Veterans Homes) with whom the federal government has been working for more than 100 years. The VA is currently planning a study of the law that requires to provide nursing home care for veterans with a high-level of disability because of military service that may result in requests for further curtailments in their authority. Over the last decade VA has attempted to shift care as quickly as possible from its own settings to the community where veterans can be made eligible for the similarly fiscally challenged Medicaid program. The folks at OMB just want to shift the cost away from the federal budget, whether the states have the resources to help here or not. Frankly, it is easy to get the impression OMB does not care whether these veterans get the services they need or not as long as the federal government does not have to pay.

The uncertainty of when and how much funding it will receive wreaks havoc upon VA's ability to make effective policy (including enrollment), personnel, contracting and other purchasing decisions. The VA often misses critical windows to hire new physicians and nurses because officials do not know when new funding will become available. Health care workers are not willing to put off employment indefinitely when other-and often more lucrative-opportunities are readily available in their communities. In years of relative scarcity, most of the VHA 21 regional Veterans Integrated Service Networks (VISNs) routinely delay badly needed equipment purchases and repairs to meet their operating expenses.

Since FY 2002, management "efficiencies" have accumulated, creating a $1.8 billion hole in the VA's medical services funds by FY 2006 (or about 8 percent the medical services budget). In a February 1, 2006 report to Senator Daniel Akaka, Ranking Member of the Senate Veterans Affairs Committee and Congressman Lane Evans, Ranking Member of the House Veterans Affairs Committee, the Government Accountability Office found that VA lacked a methodology for producing the management efficiencies projected in budget submissions for FY 2003 and FY 2004 and that:

the management efficiency savings assumed in these requests were savings goals used to reduce requests for a higher level of annual appropriations in order to fill the gap between the cost associated with VA's projected demand for health care services and the amount the President was willing to request.

From FY 1996 through FY 2006, however, it is clear that the VA has had to do "more with less." Although the Administration continues to tout increases in the funding for the veterans health care system, the VA's resources per veteran user have dropped precipitously, particularly in comparison to the per capita costs based on national health care expenditures and the costs per Medicare enrollee. VA users' per capita costs actually decreased by about 6 percent (without

including the eroding effects of inflation), while Medicare per capita costs will have almost doubled.

VA's per capita costs for users, once higher than national per capita costs and costs per Medicare enrollee, have actually dropped below both of these groups and this was not included third party collections While national health care expenditures and Medicare enrollees' costs have almost doubled over the period of time studied, VA's per capita costs have actually decreased. FY 2006 dollars were adjusted for health care inflation they would not have nearly as much buying power as the 1996 dollar. The average annual medical care inflation for 2001-2004 has been double the growth for the Consumer Price Index for all other items (2.2% v. 4.4%). A comparison of per capita costs is particularly compelling since national health care expenditures include the costs of all Americans-many of whom are young and healthy and may not be expected to require the same level services as the mostly older and disabled populations Medicare and VA serve.

Without considering the effects of medical care inflation, in sharp contrast to the average American's health care expenditures or the average Medicare enrollee's costs (both of which almost doubled), VA's per capita costs actually drop slightly from 1996 to 2006. This is because VA health-care funding is not linked to growth in the beneficiary population or medical inflation.

What led to this drop in funding per VA user during a time when other health care consumers' costs doubled? Simply put, the growth in the number of veterans who now use their health system has outpaced the growth in financial resources the federal government has invested in it (or, at least the growth has outpaced to willingness of the OMB to recommend increases that are needed just to maintain stasis.)

Still, the effects of deficient budgeting are still being felt in many areas, despite the tremendous strides made in the past two years. The VA estimates that almost half of its obligations for medical services in 2006 would be spent on personal services and benefits for its 130,000 employees. Decreases in the VA's per user costs have clearly translated to fewer doctors and nurses per patient. The most likely outcomes of understaffing are adverse effects on the timeliness and quality of care. At this time there are still many thousands of veterans projected to wait longer than six months for an appointment with a clinician, even though the "official" estimates are much smaller than VVA would estimate. The Inspector General report that was released research points out that VHA is still often not telling the truth about waiting times, and so many clinics are "gaming" the system that it is hard to figure out what the actual figures might be. In many areas of the country, such as Florida, VA has experienced severe problems placing even service-connected veterans on waiting lists.

With funding uncertainties removed, the VA leadership could focus on implementing measures to create a true veterans health-care system-a system in which every veteran who enrolls would be given a full physical examination, including a comprehensive military health and medical history and a psychosocial evaluation. This history would provide an epidemiological baseline to help measure future health conditions not only for a particular veteran but potentially for others with whom (s)he served. When an extensive epidemiological database is finally compiled, it can serve as an invaluable tool for physicians. With more information about a patient's military background, a doctor would know to test for particular conditions, parasites, and toxic exposures that may already be adversely affecting the health of that veteran. Such a database could reveal

whether others who served in the same unit reported similar health effects. It could also serve as a tool to identify common exposures that may be related to the incidence of conditions that have long latency periods.

Such findings, combined with better sharing of military records, including the location of troops, deployment health, and pre- and post-deployment health information, could serve as the basis for research into the health effects of a particular exposure, occupation or even combat or theater experience.

VVA has long stressed the importance of collecting such information, and the results are taking root in the Veterans Health Initiative (VHI). This VA endeavor educates providers about certain exposures and health effects that are prevalent among veterans or for which veterans have been shown to be at unique risk The VA has made these training modules available to its providers and should take further steps to educate the general medical community from whom most veterans seek care.

VVA still maintains that managerial accountability goes hand-in-hand with assured or "mandatory" funding. To its great credit, the VA has implemented a clinical information system which allows it to evaluate its success in meeting a variety of clinical and administrative goals. However, some managers who have had problems overseeing high-investment projects or publicized breaches in government protocols, spotty records of adherence to departmental directives and law, and cited problems in Government Accountability Office and Inspector General reports on their area in negative ways continue to be rewarded. Rewards cannot solely be based on achievement of certain goals, if there are well documented (and often highly publicized) problems that are not rectified. The deposition of the Associate Deputy Under Secretary for Health for a recent civil action in Federal Court demonstrated (in his own words) that in regard to quality assurance for delivery of PTSD and other neuro-psychiatric are that "we do not have metrics in place to measure that."

When clearly understood performance standards have been met and there are not clear violations in protocol, rewards should be made from the top-down. Just as rewards must be provided, the system must also sanction those whose performance is inadequate.

While there is a legitimate need to make significant adjustments in the compensation for critical healthcare workers, the current use of "merit bonuses" has been corrupted. Merit bonuses must be just that: bonuses for merit and achievement above and beyond that which is required. The current mode does a disservice to the many fine VA physicians and administrators who deserve more competitive pay and bonuses for truly outstanding performance. The system of rewards and punishment must be adjusted to sanction those who do a poor job or are not fully open and honest with appointed or elected officials.

To ensure accountability, the VA must develop adequate training and testing tools for personnel at all levels of the organization. Neither managers nor their employees can be held responsible for violating protocols of which they are not aware. In a constantly evolving health care environment governed by a complex array of law, regulations, internal guidance and voluntarily imposed guidelines from accreditation agencies, compliance is difficult. Without ensuring that management and employees receive updates and appropriate training it is impossible.

We as a nation can and must do better for our veterans. Funding for veterans' health care has been woefully inadequate for years. As Dr. Linda Spoonster Schwartz, currently Commissioner of Veterans Affairs for the State of Connecticut and Chair of the Health Care Committee of the National Association of State Directors of Veterans Affairs put it: "The lack of a consistent, reliable budget has, in essence, obstructed VA's capacity to respond to the changing needs of the health-care system, to efficiently grow, to acquire competent personnel and maintain a viable service infrastructure." And as the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans concluded:

Funding provided through the current budget and appropriations process for VA health care delivery has not kept pace with demand, despite efforts to increase efficiencies and focus health care delivery in the most cost-effective manner. . . . Full funding should occur through modification to the current budget and appropriation process by using a mandatory funding mechanism, or by some other change in the process that achieves the desired goal.

It is imperative to enact legislation that would assure funding for veterans' health care. An assured, predictable and reliable funding stream would enable the VA to concentrate on achieving accountability for performance from senior managers and building a system that is not only cost-effective and efficient, but contributes to the mission of restoring veterans who have been lessened physically through injury or illness or the psychic wounds of war, or economically by virtue of military service.

VVA and other VSOs believe it is ultimately disingenuous for our government to promise health care to veterans and then fail to provide adequate funding. Rationed health care must only be a temporary expedient as Congress moves toward an assured funding model. We endorse the proposition that "by including all veterans currently eligible and enrolled for care, we protect the system and the specialized programs VA has developed to improve the health and well-being of our nation's sick and disabled veterans."

A Word on the Office of Management & Budget (OMB)

It should be clear to all that the current method of funding health care services to veterans has not been working very well for some years now, despite some nigh on to heroic efforts by the Congress. Some of this is due to the funding for this vital function being classified as "discretionary" funding. But it needs to be publicly noted that much of the difficulty in this being "discretionary" spending is the difficulty of overcoming the churlish attitude toward veterans of the OMB and their willful ignorance of the reality of veterans' needs or even of what actually happens in VA facilities.

The current Deputy Director of OMB and her staff have never visited a VA medical center, not even once. The previous permanent ranking civil servant permanent employee the veterans unit at OMB had held her job for about two decades and never once even entered a VA medical facility. We would also point out that the last time we checked, OMB less than 10 veterans employed out of more than 970 employees, and 0 disabled veterans. And yet OMB is theoretically subject to the same Veterans' Preference laws as the rest of the government.

The only way this could happen is in a corp. Just by accident they should have had more than 10 veterans and at least SOME disabled veterans in their orate culture that condones the conscious and deliberate patterns and practices of overt discrimination against persons who served our nation in military service, and particularly prejudice against employing disabled veterans.

If OMB had hired no women, or no African-Americans, or no of Hispanic decent, or no Asian Americans would anyone accept their contention that could find no qualified candidates from those groups to work there? VVA thinks not, and that similarly we should not accept this continued illegal pattern and practice by OMB that discriminates against veterans, particularly disabled veterans.

Given OMB's clear attitude toward employing veterans, it should come as no surprise to anyone that this lack of respect should be reflected in their work and budgets produced in regard to the VA and other programs vital to veterans. At least it is now more understandable that they always try to give too few resources to properly assist veterans, no matter how good the program. That does not make it proper or legitimate, but at least we know what we are dealing with.

S. 2796 - Community-Based Organization Pilot Programs

VVA strongly endorses this bill. The experience of Vietnam veterans in the 1970s showed that the most effective, and certainly the most efficient, mechanism for serving otherwise "under-served" veterans was by means of funding community based organizations (CBOs) for specific purposes on a pay for performance basis. The experience in the past decade has clearly shown that the most cost effective, cost efficient means of reaching and properly serving homeless veterans has been though funding community based organizations to do this.

For example, the Homeless Veterans Reintegration Project (HVRP) which helps place homeless and formerly homeless veterans in full time employment is far and away the most cost effective, cost efficient program administered though any branch of the U. S. Department of Labor. It is therefore a mystery to VVA as to why this program is not funded at the full $50 million that is authorized, as it works and works well to move veterans from the welfare dole to the tax rolls, and helps them restore their sense of dignity and self worth, in addition to helping them lift themselves off of the street and back into society, through supporting them in their effort to work their way back up.

A similar program funded by up to $50 million at VA to perform the duties as outlined in this proposed legislation would be similarly successful. We can cite at least two organizations that are CBOs that have been doing this multi-service center work successfully for three decades. One is Swords to Plowshares, in San Francisco, California, and the other is the Veterans Outreach Center in Rochester, New York. Both of these organizations have received funding from various sources over the years, some from private donations, some via grants from private donations, at times they have received state funding, and sometimes local government funding. From time to time their funding sources have changed, but their core commitment to serving the whole person, and assisting the veteran in all aspects of his or her life to re-construct a decent life and a way forward toward a more complete human existence has not changed or wavered. Furthermore, they do so and achieve a success rate of reaching and substantially assisting veterans to meet

their recovery goals at a cost per participant that is far less than most programs delivered by large agencies. This model already demonstrably works.

Chairman Akaka is to be commended for introducing this legislation, but we suggest that you consider giving this pilot an authorized amount of funding for at least three years, and direct VA to work with already existing similar programs in developing the Request For Proposal, as well as consulting with the National Coalition for Homeless Veterans and the veterans' service organizations who may have knowledge of such programs. We also suggest that the VA be directed to report back to you within 180 days of enactment their plan for issuing a Request for Proposal, and that VA deliver a report and analysis of the pilot to VA on a yearly basis thereafter.

S. 2797 -Construction Authorization

VVA has no objection to most of these requests, as most of the items requested by the Administration are needed. VVA does believe, however that the pace of reconstructing and replacing of the physical infrastructure of the Veterans Health Administration needs to be quickened. For quite a number of years virtually no construction was funded until VA designed a plan that had some sense and rationale to it. Even though VVA still has significant reservations in regard to the CARES formula, at least there is a comprehensible model to formulate a plan for facilities for the future. Therefore, we should get on with it at a faster pace, before construction costs soar even higher.

However, in regard to the medical facility in San Juan, Puerto Rico VVA has serious reservations about VA's plan to try and jury rig and shore up an outdated and outmoded early 1960s style building that is in danger of collapsing in a hurricane currently, as opposed to designing and building a new, strong, and modern medical facility. If you fix up an outmoded structure that was poorly designed to begin with, then you have a poorly designed facility that still is inadequate to meet the needs of the future.

Frankly, one has to question whether some other factor was operating here that Denver gets a $2 billion state-of-the-art beautiful facility that will not even be fully owned by VA, but San Juan gets some left-overs and an as cheap as possible retrofit of an outmoded and energy inefficient structure that even when the projected work is finished will not even approach being the "best," nor will it be able to withstand a direct hit of the likely stronger storms that we will experience in the coming decades. VVA understands that if the money is authorized and appropriated to do this retro-fit in San Juan, then the possibilities of a proper new building will be slim to none.

Therefore, VVA strongly encourages the Committee to take a very strong look at Puerto Rico as to every aspect of services provided there, from medical services to claims adjudication to the state of the cemetery which will be full in a relatively short time. The construction plans for parking, the medical facility, and additional space for proper burial of veterans there all seem to be less than one would expect, or certainly less than accorded other areas in the United States. The veterans in Puerto Rico performed no less well, and fought no less valiantly, and in fact served in a higher than average percentage in the combat arms than those from elsewhere, and so should not be relegated to cut rate facilities or service. The veterans of San Juan deserve no less consideration than the veterans of Denver.

S. 2799 - Women Veterans Health Care Improvement Act of 2008

VVA salutes Senator Murray for introducing this much needed legislation, which should be enacted as soon as possible.

Women comprise the fastest growing segment of the Armed Forces, and therefore as they leave the military, the fastest growing sub-set of the veterans' population. Thousands have been deployed to Iraq and Afghanistan. This has particularly serious implications for the VA healthcare system because the VA itself projects that by 2010 more than 14 % of all veterans utilizing its services will be women.

Women's health care is not evenly distributed or available throughout the VA system. Although women veterans are the fastest growing subset, there remains a need for increased focus on health care and its delivery to women, particularly the young women coming home today. What is needed are real women's medical clinics that are separate places within each hospital, and ensure that the women get the privacy and the "comfort level" needed for them to seek assistance for he full range of maladies from which they may suffer, including Military Sexual Trauma (MST).

Although women veterans are the fastest growing population within the VA, there remains a need for an increased focus on health care and its delivery for women, particularly the new women veterans of today. Although VA Central Office may interpret women's health services as preventive, primary, and gender-specific care, this comprehensive concept remains ambiguous and splintered in its delivery throughout all the VA medical centers. Many at the VHA appear (unfortunately and wrongly) to view women's health as only a GYN clinic. It certainly involves more than gynecological care. In reality, women's health is viewed as a specialty unto itself as demonstrated in every University Medical School in the country.

Furthermore, some women continue to report a less than "accepting," "friendly," or "knowledgeable" attitude or environment both within the VA and/or by third party vendors. This may be the result, at least in part, of a system that has evolved principally (or exclusively) to address the medical needs of male veterans. But reports also indicate that in mixed gender residential programs, women remain fearful and unsafe.

The nature of the combat in Iraq and Afghanistan is putting service members at an increased risk for PTSD. In these wars without fronts, "combat support troops" are just as likely to be affected by the same traumas as infantry personnel. They are clearly in the midst of the "combat setting". No matter how you look at it, Iraq is a chaotic war in which an unprecedented number of women have been exposed to high levels of violence and stress as more than 160,000 female soldiers have been deployed to Iraq and Afghanistan... This compared to the 7,500 who served in Vietnam and the 41,000 who were dispatched to the Gulf War in the early ‘90s. Today, nearly one of every 20 U.S. soldiers in Iraq/Afghanistan is female. The death and casualty rates reflect this increased exposure.

With 15-18 percent of America's active-duty military being female (20% of all new recruits) and nearly half of them have been deployed to Iraq and/or Afghanistan, there are particularly serious implications for the VA healthcare system because the VA itself projects that by 2010, more than

14 percent of all its veterans will be women, compared with just two percent in 1997. Although the VA has made vast improvements in treating women since 1992, returning female OIF and OEF veterans in particular face a variety of co-occurring ailments and traumas heretofore unseen by the VA healthcare system.

There have been few large-scale studies done on the particular psychiatric effects of combat on female soldiers in the United States, mostly because the sample size has heretofore been small. More than one-quarter of female veterans of Vietnam developed PTSD at some point in their lives, according to the National Vietnam Veterans Readjustment Survey conducted in the mid-'80s, which included 432 women, most of whom were nurses. (The PTSD rate for women was 4 percent below that of the men.) Two years after deployment to the Gulf War, where combat exposure was relatively low, Army data showed that 16 percent of a sample of female soldiers studied met diagnostic criteria for PTSD, as opposed to 8 percent of their male counterparts. The data reflect a larger finding, supported by other research that women are more likely to be given diagnoses of PTSD, in some cases at twice the rate of men. Matthew Friedman, Executive Director of the National Center for PTSD, a research-and-education program financed by the Department of Veterans Affairs, points out that some traumatic experiences have been shown to be more psychologically "toxic" than others. Rape, in particular, is thought to be the most likely to lead to PTSD in women (and in men, where it occurs). Participation in combat, though, he says, is not far behind.

Much of what we know about trauma comes primarily from research on two distinct populations - civilian women who have been raped and male combat veterans. But taking into account the large number of women serving in dangerous conditions in Iraq and reports suggesting that women in the military bear a higher risk than civilian women of having been sexually assaulted either before or during their service, it's conceivable that this war may well generate an unfortunate new group to study - women who have experienced sexual assault and combat, many of them before they turn 25.

Returning female OIF and OEF troops also face other crises. For example, studies conducted at the Durham, North Carolina Comprehensive Women's Health Center by VA researchers have demonstrated higher rates of suicidal tendencies among women veterans suffering depression with co-morbid PTSD. And according to a Pentagon study released in March 2006, more female soldiers report mental health concerns than their male comrades: 24 percent compared to 19 percent.

VA data showed that 25,960 of the 69,861 women separated from the military during fiscal years 2002-06 sought VA services. Of this number approximately 35.8 percent requested assistance for "mental disorders" (i.e., based on VA ICD-9 categories) of which 21 percent was for post traumatic stress disorder or PTSD, with older female vets showing higher PTSD rates. Also, as of early May 2007, 14.5 percent of female OEF/OIF veterans reported having endured military sexual trauma (MST). Although all VA medical centers are required to have MST clinicians, very few clinicians within the VA are prepared to treat co-occurring combat-induced PTSD and MST. These issues singly are ones that need address, but concomitantly create a unique set of circumstances that demonstrates another of the challenges facing the VA. The VA will need to directly identify its ability and capacity to address these issues along with providing oversight

and accountability to the delivery of services in this regard. All of these issues, traumas, stress, and crises have a direct effect on the women veterans who find themselves homeless. Early enactment of Senator Murray's bill on women veterans currently pending in the Senate will do much to rectify this situation, and VVA commends her for her leadership in this and other matters of vital interest to veterans.

Although veterans make up about 11% of the adult population, they make up 26% of the homeless population. Of the 154,000 homeless veterans estimated by the VA, women make up 4 percent of that population. Striking, however, is the fact that the VA also reports that of the new homeless veterans more than 11% of these are women. It is believed that this dramatic increase is directly related to the increased number of women now in the military (15% - 18%). About half of all homeless veterans have a mental illness and more than three out of four suffer from alcohol or other substance abuse problems. Nearly forty percent have both psychiatric and substance abuse disorders. Homeless veterans in some respects make use of the entire VA as do any other eligible group of veterans. Therefore all delivery systems and services offered by the VA have an impact on homeless veterans. Further, the failure of the Department of Labor system to provide needed employment assistance in a nationwide accountable manner to many veterans means they lose their slim purchase on the lower middle class, and therefore end up homeless. Once homeless, it becomes very difficult for these veterans to find employment for a multiplicity of reasons.

The VA must be prepared to provide services to these former servicemembers in appropriate settings.

VVA thanks Senator Patty Murray for her leadership on the issue of ensuring that women veterans get proper health care and services that is different but equal to me. This bill warrants speedy passage and prompt full implementation.

S. 2824 - A bill to amend title 38, United States Code, to improve the collective bargaining rights and procedures for review of adverse actions of certain employees of the Department of Veterans Affairs.

VVA supports collective bargaining rights, and commends Senator Rockefeller for his leadership in introducing this bill.

S. 2889 (Akaka, by request) Veterans Health Care Act of 2008, Sections 2, 3, 4, 5, and 6

VVA generally supports Sections 3, 4, 5, and 6 of this proposed legislation. In regard to Section 2, VVA suggests you consider revising to say Global War on Terror, which is generic enough to cover anyone who experiences such deficits due to traumatic brain injury wherever they might be serving in the world in the United States Armed Services. Further, VVA suggests that a clause be added to the effect "and other such veterans who may be eligible for and in need of this type of care."

As you know, VVA's founding principle is "Never again shall one generation of veterans abandon another generation." VVA continues to try and live up to that principle in regard to both

our fathers who served in World War II and toward the young people serving today and who have already come home, all too often wounded. However, the disturbing tre