Center for American Progress

Caring for U.S. Veterans

A Plan for 2020

By Larry Korb and Aminata Diallo December 4, 2019

Military veterans have served in myriad ways, often putting their lives on the line for their country. Yet every day, these veterans—and the U.S. Department of Veterans Affairs (VA), which was created to care for military veterans—seem under siege, facing one calamity or challenge after another. From suspicious deaths at veterans health care facilities to extreme wait times for care to high rates of suicide—often at VA campuses and cemeteries—the nation's veterans are not getting the full support they need and deserve.[1] At the same time, the debate continues as to how much, if any, of veterans' health care should be contracted out or privatized. The Veterans Choice Act of 2014[2] and the VA Mission Act of 2018,[3] for example, have made it easier for eligible veterans to seek health care options outside of the VA system.

To determine whether the VA is carrying out its mission efficiently and effectively, it is important for Congress and the next administration to understand four primary issues: why the current era of military conflicts is so different; how the United States has historically dealt with and cared for its veterans; how the VA is currently organized and funded; and what pressures the VA receives from the well-oiled veterans lobby. Only by understanding these issues will U.S. political leaders make the right choices for the country's military veterans.

Unique challenges for today's veterans

Veterans of all wars and combat face challenges. However, the more than 2 million women and men who served in the global war on terrorism, which has been waged primarily in Afghanistan, Iraq, and Syria, experience significant and unique challenges.

These wars are the first major set of conflicts that have been fought exclusively by the all-volunteer force (AVF), established in 1973 when the United States abolished the draft as a result of the protests about the war in Vietnam.[4] In addition, the U.S.-involved conflicts directly preceding the global war on terrorism were also much smaller, both in duration and in troop deployment. For example, the first Gulf War

in 1991 consisted of only 38 days of sustained bombings and 100 hours of ground combat;[5] and the conflicts in the Balkans, Grenada, Panama, and Lebanon did not involve large deployments of forces for extended periods. In contrast, the wars in the greater Middle East have been ongoing for nearly two decades.

The current wars are also the first since World War II in which U.S. service personnel have undergone multiple deployments. This increases the risk of a veteran suffering post-traumatic stress disorder (PTSD) by 50 percent and has resulted in 45,000 veterans and active-duty personnel committing suicide over the past six years.[6] Often, these personnel do not receive adequate rest, or what the military calls "dwell time," between each deployment—at least two days at home for every day spent in a combat zone.

In addition, the reserve component—which consists of the National Guard and Reserves—has been used as an operational rather than a strategic reserve, with reserve units alternating combat deployments with the active force. However, when these men and women complete their deployments, they are normally deactivated and lose their U.S. Department of Defense (DOD) military health care benefits and are thrown back into the civilian health care system. Even if reserve veterans have health insurance from their employers, it may not fully cover their specific war injuries and needs.

Another issue facing today's veterans results from advances in medical care. On the battlefield and in theater, medical advances have dramatically increased the chances of military personnel surviving their wounds today, from 2.6-to-1 in Vietnam and 2-to-1 in WWII to 15-to-1 today.[7] Thus, the number of wounded veterans in proportion to overall casualties has increased significantly.

The current wars are also the first in which women, who now comprise about 17.5 percent of the total U.S. military force, have been habitually and directly exposed to combat. In addition to the physical and mental toll of combat, about 15 percent of the women serving in Iraq and Afghanistan have experienced sexual trauma during their deployments.[8]

At the height of the wars in Iraq and Afghanistan, the U.S. Army—which has borne the brunt of the fighting—had to lower its admission standards to attract and retain sufficient volunteers to wage the increasingly unpopular conflicts.[9] Consequently, some people were sent into war zones with physical and mental health problems that were exacerbated by the pressures, rigors, and dangers of combat. At the same time, the current conflicts are being waged by a small and select segment of U.S. society. Today, the active-duty military consists of approximately 1.3 million women and men out of a population of 330 million. In contrast, at the height of the war in Vietnam in 1968, there were 3.4 million people in the active armed forces out of a total population of 200 million; and during the Korean War, there were 4 million active-duty members in a nation of 150 million.[10]

Additionally, the wars in Afghanistan, Iraq, and Syria are the first extended conflicts in which the Army and Marines have deployed whole units rather than individuals, as they did in Vietnam and Korea. This practice has resulted in many individuals having their enlistments involuntarily extended: Once a unit receives notice of a coming deployment, members of the unit cannot leave active duty until after their unit has returned from the deployment, which often lasts a year.[11]

Finally, the nature of the current wars is markedly different from previous conflicts and more challenging for the individual fighting person. The Korean War was a conventional conflict fought against the armies of North Korea and China. In Vietnam, the United States fought primarily against the regular army of North Vietnam and Viet Cong guerrillas who shared the goal of creating a unified, communist Vietnam. In Iraq, Afghanistan, and Syria, the United States is fighting several groups that have different agendas, often fight each other, and sometimes blend in with the civilian population. Upon their return from the war zone, today's veterans also experience a higher rate of mental health problems, such as PTSD, than veterans from previous conflicts.[12]

Historical treatment of veterans

How the United States has treated its war veterans since the establishment of the country is critical context for understanding the current challenges facing veterans and the VA. It was not until nearly 40 years after the end of the American Revolutionary War that Congress provided a pension for indigent veterans, and it was not until after the Civil War that the government began to provide for its veterans in a systematic fashion.[13]

After World War I, veterans, most of whom were draftees, were promised a bonus for the low pay they received relative to the pay civilians received for producing war material at home. But in order to pass the measure, fiscal conservatives in Congress who were concerned about the effect on the federal budget delayed the bonus until 1945. During the height of the Great Depression in 1932, some 17,000 veterans organized a march on Washington, D.C., to demand early payment of their bonus money, but they were driven out of the city by the Army.[14]

The poor treatment of these WWI veterans eventually led Congress to pass the most sweeping benefits in the nation's history in 1944—the GI Bill of Rights, or the Servicemen's Readjustment Act. The GI Bill would go on to help WWII veterans and build the postwar middle class. Like WWI veterans, Vietnam War veterans also had to fight for some of their benefits. For example, it took the government almost 20 years after the end of the Vietnam War to acknowledge U.S. responsibility for the effects of Agent Orange and PTSD on combat veterans. Moreover, the GI Bill that passed to support Vietnam War veterans was much less generous than the WWII version.

After the attacks of 9/11 and the passage of the Authorization for the Use of Military Force of 2001, and partially in reaction to how poorly the United States treated Vietnam War veterans, Congress and the administrations of George W. Bush, Barack Obama, and Donald Trump have moved to provide adequate care and benefits to the veterans of the global war on terror. These benefits include expanding the VA and the Post-9/11 Veterans Educational Assistance Act of 2008 sponsored by former Sens. Jim Webb (D-VA) and Chuck Hagel (R-NE), both Vietnam veterans themselves. This GI Bill doubled college benefits for veterans to roughly $90,000, up from $40,000, and provided a 13-week extension to federal employment benefits. In 2018, the VA spent approximately $10.7 billion on 700,000 beneficiaries of the GI Bill.[15]

The budget and organization of the VA

The VA, which was given Cabinet status in 1988, is responsible for providing for U.S. veterans. It contains three parts: the Veterans Health Administration (VHA), which is responsible for providing health care and conducting biomedical research; the Veterans Benefits Administration; and the National Cemetery Administration.

Since 9/11, the VA's budget has increased dramatically. In fiscal year 2001, the total VA budget was $45 billion. By the end of the George W. Bush administration, which started the wars in Afghanistan and Iraq, it had grown to $85 billion. When Obama left office, the VA's budget had more than doubled to $180 billion. Since Trump has taken office, it has grown by another $40 billion.

The VA's budget for FY 2020 is $220.2 billion, an increase of 9.6 percent over that of FY 2019. It is the second largest government agency, trailing only the DOD.[16] The VA's budget comprises two components: $97 billion in discretionary funding and $122 billion in mandatory funding.[17] The VHA is part of the discretionary budget and accounts for approximately $80 billion, or about 40 percent of the total VA budget. The VA has around 370,000 employees, provides services to approximately 9 million veterans each year, and maintains 172 medical centers and 1,200 health care facilities.[18] Its hospital system is the largest in the country. In addition, the VA oversees education funding for veterans using the GI Bill, handles disability compensation, and manages the nation's military cemeteries.

There is no doubt that the VA, like any government bureaucracy, has some problems. But independent assessments of the VA[19]—including those by private firms such as Grant Thornton and McKinsey & Company as well as research organizations such as the RAND Corporation and the Mitre Corporation—have found that, when compared with the private sector, VA health care in nearly every case is better and more effective.[20]

Moreover, at least four of the VA's current problems are not of its own making. First, the VA has seen too much turmoil at the top, thanks to four different secretaries over the past seven years. The VA also currently has 33,000 job vacancies,[21] including several senior staff positions, and continues to struggle to retain employees in part due to President Trump's pay freeze and open war on government bureaucrats.[22] In addition, the VA's aging infrastructure needs to be replenished, and the guidelines for who is eligible for benefits need to be stabilized by Congress. Finally, the VA needs to modernize its health records system and make it comparable to that of the DOD so that individuals can move seamlessly from the Pentagon to the VA.

Nonetheless, critics of the VA who want to provide more private care and get the government out of the health care business altogether continue to voice several complaints. They argue that the VA cannot provide timely access to medical care and, as a result, veterans often die while waiting for care. In May 2014, a doctor who retired from the VA said that at least 40 veterans died because of delays in getting care at the Phoenix VHA facility. However, an inspector general investigation found that three, not 40, veterans had died while waiting for care, and there was no evidence that they had died because of the delay. The IG did find, however, that some VA personnel altered scheduling data to make it seem like they had met their appointment scheduling targets.[23]

This scandal led Congress to pass and then-President Obama to sign the Veterans Choice Act of 2014. Four years later, Congress passed and President Trump signed the VA Mission Act of 2018, which superseded the Choice Act. Both of these laws had the purpose of providing veterans with more access to health care outside of the VA because of concerns that the VHA was in a state of crisis.

To analyze the situation, Congress established a 15-member Commission on Care in 2015. According to Phillip Longman, a member of the commission, there are five myths about VA-provided health care.[24] First, the claims process is not slow because of VA bureaucrats, but rather restrictions in the law that make it difficult for veterans to receive VA care. Veterans must show that they are below a certain income threshold and/or that their disability is directly related to their military service. Second, wait times at the VA are actually shorter than those in the private sector, whether for new-patient primary or specialty care, urgent care, or nonurgent care. Third, the quality of care delivered by the VA is generally equal to or better than care delivered in the private sector. In fact, the quality of the VA's behavioral health programs generally exceeds those of the private sector, and not surprisingly, 91 percent of veterans who use the VA would recommend it to others. Fourth, giving patients the right to choose their doctors and clinics without conditions would not improve the quality of care. Instead, it would be prohibitively more expensive and would threaten the viability of VA hospitals and clinics. Finally, allowing veterans to see private doctors under certain conditions does not mean privatizing the VA as the Choice Act claims. The VA should continue partnering with private medical schools, as it does now, and should continue to provide care in all communities, especially in rural areas.

More than 9 million U.S. veterans are currently enrolled in the VA and eligible to receive health care from the VA's medical centers and outpatient clinics. The overall number of veterans in the United States has been declining because of the deaths of veterans from the WWII, Korean War, and Vietnam War eras. However, the number of veterans receiving health care has increased, both because of expanded coverage for Vietnam War veterans exposed to Agent Orange and because today's veterans are living longer.

The veterans' lobby

When it comes to shaping policies on veterans' issues, particularly health care and suicide, the federal government must take into account the views and actions of at least five major organizations. These powerful groups represent veterans and lobby the administration and Congress on issues that affect veterans.

At present, there are three major groups that have broad veterans' agendas:

- Veterans of Foreign Wars (VFW),[25] founded in 1899 after the Spanish American War, with 1.6 million members
- American Legion,[26] founded in 1918 after WWI, with slightly more than 1 million members
- Iraq and Afghan Veterans of America (IAVA),[27] founded in 2004, which now has about 400,000 members

In addition, there are two comparatively newer groups that have a narrower focus:

- Vote Vets,[28] founded in 2006, has about 600,000 supporters.
- Concerned Veterans of America (CVA),[29] founded in 2011 as the Vets for Economic Freedom Trust, does not publicly release its membership numbers.

All of these groups, with the exception of the CVA, work against privatization of VA health care and want to see an increase in the VA's budget. The American Legion, VFW, and IAVA also want Congress to provide more funding for suicide prevention, homelessness, and women's health care.

The American Legion also wants immigrants to complete the naturalization process before discharge, while the VFW advocates for veterans hiring preferences, not only for civil service jobs but also for government contractors. The IAVA wants to streamline the appeals process for veterans seeking to become eligible for health care or compensation.

Vote Vets and the CVA want to end the so-called forever wars in the Middle East. Vote Vets, however, also seeks to prevent the privatization of the VA, while the CVA wants not only to privatize the VA but also to reduce the national debt by reforming Social Security and Medicare.

None of these groups, except for the CVA, spend large sums on lobbying: IAVA spends about $140,000 a year; Vote Vets spends $100,000; the Legion spends $50,000; and the VFW spends $40,000. CVA, on the other hand, has poured $52 million into supporting various political campaigns and legislative proposals since its founding.[30] In 2018, it spent nearly $400,000 supporting Republican candidates. Unlike the other groups, which receive funds primarily from their members, the CVA receives substantial funds from the Koch brothers.[31]

The agenda for veterans for the next administration

Congress and the next administration need to build on the existing VA system and take several steps to ensure that U.S. military veterans receive the care and financial and emotional support they deserve.

The VA's budget is currently the second-largest discretionary budget in the federal government. Even though the budget for FY 2020 is approximately $220 billion—about 10 percent greater than the VA's FY 2019 budget and five times greater than its pre-9/11 budget—it will need to continue growing as long as the Unites States remains involved in endless wars in the Middle East that result in physical and mental wounds for the people serving in these conflicts. The next presidential administration should levy a specific tax to raise the money to pay for these increases in order to ensure that the VA can continue to perform well and provide essential services to veterans.

At the same time, the individual nominated to be the secretary of the VA needs to be a person of the same stature as the secretaries of defense and state and have the background necessary to assume the responsibilities of running the agency. Former President Harry Truman's appointment of WWII icon Gen. Omar Bradley and Obama's appointment of Gen. Eric Shinseki, a former Army chief of staff and a wounded Vietnam War veteran, are good models. These types of experienced and respected nominees are necessary because of both the scope of the job and the political clout of the veteran's lobby.

The new administration also needs to stop the rush to privatize veterans' health care. Although the Veterans Choice acts of 2014 and 2018 do give veterans more options when it comes to deciding whether to go to a private doctor or facility, the number of veterans actually doing so has declined since this legislation was passed.[32] Moreover, as noted above, objective studies of the VA health care system have shown that it provides better and less expensive health care and suicide prevention than the private sector.

In addition, the next administration and the new VA secretary should not overreact to every problem that becomes public. Upon close analysis, many of these claims have turned out to be exaggerated. And given the size of the VA health care system, problems will inevitably arise but can be corrected.

Moreover, the new government needs to put more resources into and pay more attention to the needs of the country's 2 million female veterans. Women make up an increasingly large share of military personnel, and in addition to dealing with the physical and mental wounds of war, many have also been subjected to sexual assault and harassment while in the service.

The VA needs new policies for dealing with members of the reserve component as well. Reserve and National Guard units have become an operational rather than a strategic reserve, with units deployed almost as often as active-duty forces. But when the reserve units are demobilized and these women and men enter the civilian workforce, they can lose their military health benefits.

Next, the new administration needs to put pressure on the private sector to give veterans more preferences in hiring. In the federal government, veterans receive preference in hiring, but this is not the case in the private sector. As organizations try to diversify their workforces, they should be encouraged to consider prioritizing veterans.

The next administration should also pay close attention to the views of veterans who have served in places such as Iraq, Afghanistan, and Syria when deciding how to pursue these conflicts. Furthermore, both to prevent the physical and mental health problems caused by multiple deployments and the lowering of standards for new recruits, the administration should appoint a high-level administrator to run the Selective Service System. This individual must make plans for activating the system if the country becomes involved in another large-scale, prolonged conflict that the administration believes cannot be waged without putting too much stress on the AVF. For example, these plans could include having women register for the draft.

Finally, the next administration should ensure that the naturalization process for immigrant veterans is completed before they are discharged. This will prevent the people who have sacrificed so much for the country from being deported after they complete their service.

Conclusion

Only by taking these steps, which are based on the understanding of how and why the current VA system came into existence, will the administration and the Congress begin to ensure that U.S. veterans receive the care and benefits they have earned.

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