The Deferred Cost of War: Short and Long Term Impact of OEF/OIF on Veterans Health Care

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In 2001, the US veteran population was 25.3 million, the majority of whom were 58 years of age or older. In that year, 3.9 million veterans used health care services of the Veterans Health Administration (VHA). Approximately, half of the population were 65 years or older. The medical care budget for the VA that year was $20.1 billion, an 11% increase from 1999. An additional $1.5 billion was spent on medical education and research.

Since that date, the US has engaged in two major military operations: Operation Enduring Freedom and Operation Iraqi Freedom, deploying 2.2 million troops to these theaters of war as of the beginning of 2007. Over 3,000 military personnel have died in those two operations and another 22,000 have been injured, including 725 amputees, 1,567 diagnosed Traumatic Brain Injuries (TBI), and an undetermined number of undiagnosed TDI and PTSD.

Conventional wisdom holds that caring for these injured veterans will place a large burden on the VA system, especially for mental health services. The impact needs to be assessed in the context of the other demands on the VA system, especially given the potential demand from the Vietnam War cohort, which is entering that period of life with the greatest health burden from chronic disease, old age, etc.

Demand for immediate post-deployment VHA services by the OEF/OIF veterans will be overshadowed by the demands of the aging Korean and Vietnam War cohort. The increase in the number of OEF/OIF veterans demanding health care from VHA currently represents at most about 5% of the current VHA patientload (about 200,000 out of about 5 million). A small proportion of these require intensive surgical and/or rehabilitative care for severe injuries. A larger number require treatment for mental health disorders. The largest proportion may simply be availing themselves of their benefit that allows them free VHA services for the first two years post-discharge, however.

These demands on the VHA require additional resources for TBI centers and psychiatric care as well as for outpatient clinics for healthy veterans who need health care coverage immediately after discharge from the service. However, these resource demands are spread across the county and not necessarily concentrated near VHA locations. In the past, the veteran population has adjusted around existing VHA facilites. Relocation is a reality facing returning veterans and will need to be addressed.

Cost of patients depends on the pattern or cycle of care for their condition. Those wounded during military service require heavy resource use at the beginning, but that need will very likely decline until the cohort ages and develops more chronic conditions.