Program Research Project

REFORM OF THE ARMY PHYSICAL DISABILITY EVALUATION SYSTEM

BY

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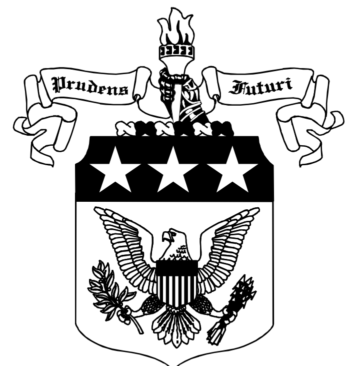

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ABSTRACT

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The medical disability evaluation process for Army Soldiers has been a source of significant confusion and frustration for many years. Although the United States Army Physical Disability Agency was not established until 1967, the historical roots contributing to this problem can be traced to the post-Civil War era. The increased number of Soldiers requiring disability consideration as a result of injuries sustained during current contingency operations has brought renewed attention to this long-standing problem. The current process is cobbled together by multiple governing Statutes, Defense Directives, Defense Instructions, and Army Regulations. Reform of the Physical Disability Evaluation System (PDES) that severs disability adjudication from the Army will promote improved process efficiency without decrement in the access or quality of medical care provided to Wounded, Ill, and Injured (WII) Soldiers. It will clarify the delineation of responsibilities that allows the Army to focus on medical treatment and fitness for duty. Further, it will present the opportunity to re-evaluate and potentially revise national compensation and benefits policy for retired disabled veterans.

REFORM OF THE ARMY PHYSICAL DISABILITY EVALUATION SYSTEM

Introduction

The current Army Physical Disability Evaluation System (PDES) is extremely complex given that is has developed and transformed over time to meet changing strategic assumptions and considerations. Multiple governing directives[1] contribute to a process that has become increasingly bureaucratic and slow. The Global War on Terrorism (GWOT) spearheaded by Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) has engaged the military services in continuous combat operations since 2001. Not surprisingly, the number of Soldiers that have required processing through the PDES as a result of becoming wounded and injured has risen dramatically. When aggregating those with the individuals who have developed illness requiring disability evaluation, over 80,000 Soldiers have traversed this system.[2] The PDES has become the number one source of dissatisfaction among the Wounded, Ill, and Injured (WII) population of Soldiers.[3] The key problem centers on regulations and statutes that support a dual rating system. This dual rating system creates an unnecessary adversarial relationship between the individual and the organization, as Soldiers must achieve an Army adjudicated level of disability at 30% to be eligible for continued pay and benefits.[4]

The Army has attempted to make improvements to the PDES over the past year. Efforts have been focused on decreasing confusion, eliminating bureaucracy, improving coordination, and increasing services to take care of Soldiers and their families. A demonstration pilot program that began in November 2007 has mitigated some of the complexity of the system by forging an improved and closer connection between all of

the military services within the Department of Defense (DoD) with the Department of Veteran Affairs (VA). The centerpiece of the demonstration pilot has been the single physical examination performed by the VA from which all disability determinations are made. Further, this facilitates a smoother civilian transition for Soldiers who are unable to continue their service in the Army. Nonetheless, the nexus of the problem, the dual rating system, remains essentially unchanged.

Soldiers deserve a disability system that is efficient and fair. It should focus on the rehabilitation their individual capabilities and promote maximal workforce reintegration. The challenge of the PDES as it exists is that it was not developed to support an Army that is engaged in persistent conflict. It is time to embark on complete reform of the PDES that is consistent with the current operational needs. The clear line of delineation should be such that:

- DoD determines fitness for duty and compensates for service.
- VA determines medical limitations and compensates for disability.

The military services should focus on fitness determination, providing the maximal medical treatment that encourages continued service. This will disengage the Army from the adjudication process that promotes conflict with Soldiers. Supporting legislative changes will be required that provide an equitable service-related compensation package that will assist impaired Soldiers through the transition process if they are found unfit. Disability determination by the VA follows a natural course given that the VA is the statutory agency that provides life-long medical care for disabled veterans. Additionally, there should be provisions that will guarantee continued

healthcare benefits for the families of disabled Soldiers. These combined changes will underscore the Nation's commitment to Soldiers and their families.

Historical Background

Historical precedent for providing disability compensation to war veterans dates to 1862 when Congress passed the "General Law System", establishing the Pension Bureau.[5] The limitations of medical treatment and rehabilitation served as the key justification for providing compensation. The General Law allowed for Union Army veterans to submit claims for war-related disabilities to receive remunerative compensation. 'Disability' was defined in relation to the performance of "severe and continuous" manual labor[6] and rated by locally retained physicians who completed standard "surgeon's certificates".[7] Compensation was based on a percentage proportion relative to the maximal amount provided for total disability. Multiple modifications and amendments occurred in the ensuing years leading to the Consolidation Act of 1873 which broadened the timeframe used to classify war-related injuries and added disease entities that were deemed "equivalent" to disability.[8] The 1879 Arrears Act allowed veterans to receive lump sum back payment for disability claims that could be substantiated as war-related regardless of when presented to the Pension Bureau. This led to a dramatic increase of claims by veterans who were increasingly important as a political constituency.[9] The Disability Pension Act of 1890 marked the shift from a disability compensation system based on war-related injury and impairment to one based on service length and age.[10] Further, it allowed for pension eligibility to be awarded for disabilities that that were not service-related. The Disability Pension Act of 1890 was one of the most liberal and costly pension measures ever

passed. At its peak in the mid-1890s, veteran pensions accounted for 50% of the total federal budget.[11] In 1904, Executive Order No. 78 stipulated that old age itself was a 'disability' that would be covered by the Disability Pension Act of 1890 regardless of health condition.[12] In 1907, the Service and Age Pension Law replaced the 1890 Act granting pensions to veterans over the age 62 based on age and service length.[13] This laid the foundation for service retirement pensions, and de-emphasized the attention given to disability compensation.

The challenge of addressing war-related injury and disability re-emerged during World War I. A maximalist approach to provide medical care shaped policy. Improvements of medical technology were sufficient such that the goal was to provide all necessary treatment and rehabilitation to 'cure' patients to the 'maximum extent'.[14] This was done so by the Army as no other governmental agency existed at the time to do so. The Army rapidly built a medical care system that provided 40,000 general hospital beds to accommodate injured veterans.[15] On behalf of the nation, the Army undertook the goal of rehabilitating disabled veterans to be "wage earners independent of charity".[16] From a governmental perspective, this was expected to help avoid the burden of the extreme expense that had been incurred providing pensions to disabled Civil War veterans. Subsequent to World War I in 1921, the Veterans' Bureau (later Veterans' Administration) was created to provide for the medical care of World War I veterans. Over the following 20 years, the VA gradually grew to become the largest medical system in the United States caring for an aging population of veterans irrespective of disability.[17] This allowed the Army to streamline operations and refocus

on providing medical health care for a relatively young and healthy population without disability.

World War II added the dimension of volume that challenged both the Army as well as the VA in terms of caring for and treating the injured. Both medical systems needed to grow rapidly just to accommodate the increasing numbers of patients, while expanding medical capabilities to address rehabilitation of the disabled. From the Army perspective, providing the 'maximum benefit' of medical services to the injured was emphasized with the goal of conserving the fighting strength.[18] It became the Army responsibility to determine fitness for service, and thus, disability as well. This was fostered by significant advances in medical techniques and practices. Simultaneously, there was resistance to transfer patients to the VA due to lack of services and poor quality of care. Public attention mounted with media outlets highlighting that the VA provided, 'third-rate medicine to first-rate men'.[19] Further, the VA had developed a reputation for 'institutionalizing' veterans rather than providing adequate rehabilitative treatment.[20] Public pressure was sufficient such that President Truman moved to modernize the VA immediately after the war and appointed GEN Omar Bradley as its Administrator. While the organization underwent transformation promoting expanded services and improved quality, the demarcation line for the responsibility of caring for the injured, and by default assigning disability, remained blurry.

During the post-war years, the VA continued to grow while the Army began to drawdown. The differing cultures of the two organizations with respect to treating the injured facilitated a continued reluctance by the Army to transfer patients to the VA despite significant improvement of the VA medical system. The Career Compensation

Act of 1949 carried a provision for the creation of the Temporary Disability Retirement List (TDRL) which extended the period of retention for medical treatment to five years.[21] The intent of providing the additional time was to reach full rehabilitation such that Soldiers could be retained in the service rather than medically retired for disability. The onset of the Korean War in 1950 prompted President Truman to issue Executive Order 10122 which directed that chronic patients and those judged not likely to return to duty were the responsibility of the VA.[22] Two years passed before the Army published Army Regulation 40-680 (Length of Hospitalization and Disposition of Patients) which provided the guidelines for disability separation for those that were considered permanently medically unfit for service. The process that evolved with the consideration by a Medical Board and Physical Evaluation Board still provided ample time for the Army to retain otherwise disabled Soldiers. The increasing complexity of medical treatment available increased the time it could take to reach 'optimal' improvement, such that 'maximal hospital benefit' was left to wide interpretation. [23] Although the regulation seemed clear and firm, disposition practices did not change. The essential outcome was that the Army had greater leeway to retain disabled patients.

The Dependents Medical Care Program that was established in 1956 added a competing priority to the Army Medical Department. Since 1884, the Army offered healthcare to family dependents on a space-available basis only. The new program, which eventually became the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), was a new entitlement. The total cost of CHAMPUS to government in its first full year in 1967 was $106 million.[24] This encouraged the Army Medical department to expand its medical capabilities to cover all aspects of medical

care across a much wider age spectrum to retain patients within the military system rather than subsidize the cost of care through civilian networks. This became an increasing challenge as fewer medical professionals opted for military careers at the end of the draft which had afforded the Army the ability to absorb the medical care requirements for the wounded from the Vietnam War. The response was to build a robust medical education program that offered residency and fellowship specialty training as a recruiting incentive in exchange for committed periods of military service. This in turn, required a solid patient population base to meet education standards. In 1973, President Nixon issued Executive Order 11733, which essentially reversed Truman's position such that the Army could choose when it would send wounded patients to the VA for treatment. At that time, Vietnam wounded veterans represented less than 2% of the VA beneficiary population.[25]

The Cold War years minimized the attention given to the medical treatment or rehabilitation for war-injured given the lack of any major conflict. The advent of an all-volunteer force led to a significant increase of family member dependents. The outcome was that active-duty Soldiers became the minority among patients treated within the Army medical system. The practice of medicine witnessed a shift in phased care from inpatient to outpatient settings. This added further complexity to the determination of 'optimum hospital care' and 'maximum benefit'. Throughout this period the overwhelming majority of Soldiers processed for disability were for medical ailments and illnesses unrelated to war wounds or injuries. While the Army retained tremendous flexibility to retain and treat disabled Soldiers, little emphasis was needed to develop rehabilitation programs to treat the types of injuries sustained in combat. Not

surprisingly then, there was little public attention given to the Army disability process or problems. This changed in 2001 with the onset of combat hostilities in the Middle East. The increase of war-injured Soldiers, especially those surviving severe wounds, has refocused public attention on the government's responsibility to provide rehabilitation, determine disability, and compensate appropriately. This was recognized early by the then-Assistant Secretary of Defense (Health Affairs), William Winkenwerder, who issued a policy memo that stated that the DoD's vision was to improve its relationship with the VA to be "mutually beneficial" to optimize "federal resources and infrastructure" while still "respecting the unique missions" of the DoD and VA medical systems.[26] This was remarkably prescient given that the foundation of disability system, a large post-World War II draft Army of individuals with predominantly manual labor skills, would continue unchanged for another 6 years.

Current System

The primary governing statute for the Physical Disability Evaluation System (PDES) for all military departments is found in Chapter 61 of Title 10, U.S.C.[27] It provides the Service Secretaries with the authority to separate or retire active duty members for physical disability.[28] Required determinations by the services include: fitness for continued military service due to physical disability, service connection of the incurred physical disability, stability of disability for the purposes or separation or retirement, and disposition with regard to service termination. A key component within the overall process is the adjudication of the percentage of disability which dictates future compensation and benefits for those found disabled.

In the Army the functional proponent for disability evaluation is the U.S. Army Physical Disability Agency (USAPDA) located in Washington, D.C. which was created in 1967. It is significant to note that USAPDA currently falls under the Army Human Resources Command and not the Army Medical Command in that the medical department only provides recommendations upon which the personnel department must act. The USAPDA does hire physicians that are qualified to understand medical recommendations, but those professionals are often experts in only one specialty while individual cases may cross into several distinct specialty categories. The overall process is dominated by two main phases. The first is the Medical Evaluation Board (MEB) phase. Soldiers can be referred to their local Military Treatment Facility (MTF) for medical evaluation upon concern that any medical condition limits their medical fitness. The most common avenue for referral to the MEB is by a medical provider who establishes a medical diagnosis and issues a permanent 'profile', a medical document that limits physical aspects of duty performance. However, current practice allows medical providers to issue temporary 'profiles' limiting physical activities for an entire year to provide for adequate time to treat the medical condition identified. This is consistent with the long-standing policy of achieving 'optimal' recovery to promote retention versus disability separation. This provides more than adequate time for Soldiers to receive a comprehensive medical evaluation and follow-on treatment. It also provides ample latitude to the medical system in terms of time flexibility. Historically, this has led to significant confusion by Soldiers who are unsure whether they are even in the PDES process, and if so, where. The more pressing issue to line Commanders has been the assignment of Soldiers in their units who are on limited profiles for

extended periods of time. The current operational requirements with the high pace of deployment cycles to support contingency operations, creates problems in unit readiness, as these Soldiers fill authorized slots and count against overall end strength.

The second key phase of the PDES is the Physical Evaluation Board (PEB) phase. When an MEB determines that a Soldier's medical condition does not meet retention standards, the case will advance to one of three regional PEBs.[29] The MEB will make a recommendation to the PEB with respect to fitness based on the severity and extent of the identified medical condition(s). The PEB will review the entire case with all documentation and first determine whether the Soldier is 'fit for duty'. The caveat at this juncture is that fitness is determined relative to the Soldier's rank and Military Occupational Specialty (MOS). If the Soldier is found fit for duty, the Soldier returns to work and the case does not progress any further. If the Soldier is found unfit for further duty and deemed stable for rating[30], the PEB must then adjudicate the case and assign a percentage disability. The caveat at this juncture is that the PEB will only rate those conditions that render the Soldier unfit for military duty. Medical conditions that do not affect fitness are disregarded for disability purposes. In general, if the combined disability rating is below 30%, then the Soldier is separated from the service with a single severance compensation amount. There are even some circumstances in which separation will occur without compensation or benefits. If the combined rating is greater than 30%, then the Soldier is medically retired and provided lifelong compensation and benefits. Additionally, the Soldiers retain medical care for themselves and their families as if retirement had been achieved by a 20-year full career. Figure 1 provides a schematic diagram of the entire PDES Process.

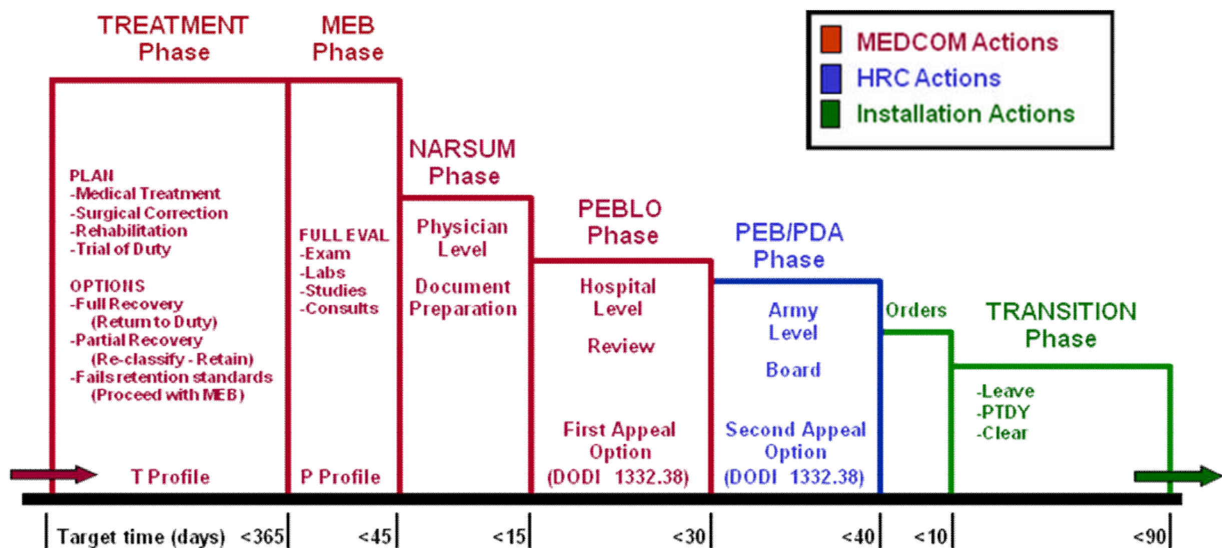

Figure 1: Current Army Physical Disability Evaluation System[31]

The current system has several key problems. The first is that of confusion in understanding the process, which has been a repeated complaint in surveys over time. While there is an element of medical complexity that cannot be mitigated, the length of time and amount of documentation required to complete a full disability case has played a significant factor. As demonstrated in Figure 1, some cases can take as long as 18 months or more to complete. That assumes that there is clarity by all involved through the process and no complications that require resolution. In actuality, the complete process is understood by few, and all too often, problems arise that require as many back steps as forward ones. Nonetheless, the frustration that arises from negotiating the PDES process promotes an impersonal bureaucratic feel to those in the system.

The second problem is related to the dividing line set at 30% disability, which must be exceeded for Soldiers to receive lifelong compensation and medical benefits for

their families. Historically, this threshold percentage stems from an Advisory Committee that made recommendations to the Secretary of Defense in 1948. At that time, the medical system was still dealing with scores of individuals that were undergoing disability evaluation as a result of wounds and injuries suffered during World War II. It was felt that 30% disability represented a "reasonable dividing line between real disability determinable by medical men, and a doubtful disability."[32] That recommendation was ultimately incorporated into the Career Compensation Act of 1949, and has remained in effect since. Achieving 30% disability has become an adversarial focal point for Soldiers undergoing disability evaluation who perceive this threshold as arbitrary and irrelevant in terms of fitness determination. Exceeding the dividing line provides the emotional validation for having 'real' medical problems. More importantly, it provides the justification for receiving desired compensation and benefits.

The third problem is perhaps the most controversial one. Soldiers are rated for disability by the Army first, which is a key determinant of the amount of compensation and benefits provided. This is controversial because it can be perceived as a conflict of interest. Upon separation, veterans may file a claim with the VA as well. While both the Army and the VA use the Veterans Administration Schedule for Rating Disabilities (VASRD), not all the general policy provisions set forth in the VASRD apply to the military. Hence, disability ratings for the same condition may vary between the two. More significantly, the Army only rates those conditions that are determined to be physically unfitting for service, compensating for a military career cut short. The VA rates all service-connected and service-aggravated conditions, compensating for loss of earning capacity resulting from disability as compared to employability. Further, the

Army's ratings are permanent upon final disposition even if the condition degenerates after separation. Conversely, ratings by the VA may fluctuate, increasing over time if a medical condition worsen. The end result is that the VA disability ratings are almost always higher than those of the Army. This dual adjudication process is confusing to Soldiers, and leaves the impression that the Army 'underrates' disability in order to achieve fiscal savings.[33] While that may not be the intent, it is the outcome.

Demonstration Pilot

The media exposé of deficiencies at Walter Reed Army Medical Center in February 2007 focused public attention on the care provided to Wounded Warriors (WWs), Soldiers wounded or injured in combat. The primary aspect of their care that was criticized was the Physical Disability Evaluation System which was described as complex, confusing, and cumbersome.[34] The Army immediately conducted an inspection by the Department of the Army Inspector General (DAIG), which released its report findings in March 2007. That report highlighted 41 observations and findings for corrective action covering the policies, procedures, and practices related to the PDES.[35] Additionally, a formal organizational process review (Lean Six Sigma[36]) was conducted. Under the leadership of then-BG Michael Tucker, known as the 'Bureaucracy Buster', the number of required documents and forms, many duplicative, was significantly reduced.[37] Robust efforts were made to provide Soldiers with the necessary information and knowledge with respect to understanding the PDES process. Soldiers were provided with dedicated Case Managers and MEB Physicians that were assigned lower patient ratios to ensure more personalized service. The most significant change was the creation of Warrior Transition Units (WTUs) to which medically impaired Soldiers

were assigned.[38] These units were modeled on the traditional Army unit structure with a Commander and complete support staff. The only requirement of the cadre of the WTUs was to support wounded warriors with all their administrative and medical needs. Co-location of the WTUs with MTFs facilitated the sole mission for the assigned Soldiers, to medically heal.[39]

The Senior Oversight Committee (SOC) was created in May 2007 as part of the effort to improve all aspects of military medical care. Co-chaired by the Deputy Secretary of Defense and Deputy Secretary of Veterans' Affairs, the goal was to integrate the DoD and VA into a single team that would better support the needs of Wounded, Ill, and Injured (WII) service members.[40] One specific Line of Action (LoA 1) was devoted to making improvements upon the Disability Evaluation System (DES). Within the framework of the committee guidelines, improvements were restricted to those that could be accomplished without legislative change to existing statutes. Subsequent to a combined service 'Clean Sheet' assessment[41], the DoD and VA embarked on a Demonstration Pilot project in November 2007.[42] The key improvements were numerous. The most significant change was improved coordination between the two agencies with earlier involvement by the VA. Previously, Soldiers transferred to the VA system only after all service requirements were completed. This often resulted in gaps in medical care and delays in provision of compensation and benefits because of administrative requirements between the two. Earlier involvement by the VA started with a single physical exam performed by VA physicians that would be used by both agencies for the disability evaluation case. Figure 2 highlights the overlap of the two agencies.

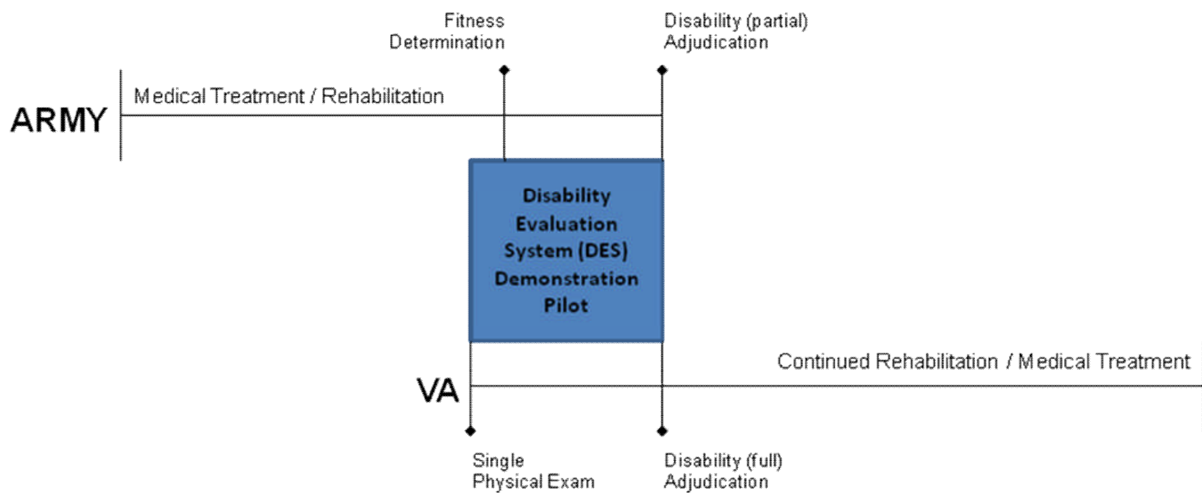

Figure 2: DES Demonstration Pilot Overlap

Further, the VA was given the task of determining disability for all identified medical conditions. The Veterans Benefits Administration (VBA) also co-located satellite offices with Army MTFs in order to enroll prospective veterans earlier and provide information with regard to compensation and benefits. Among the pilot cases, greater consistency was noted and gaps in care have been eliminated.[43] All of the combined improvements have decreased the confusion, and in that regard, improved satisfaction with the PDES. Nonetheless, these improvements did not address the dual-adjudication aspect of disability. While the VA performs the single physical exam, and determines the disability ratings from that exam, the Army is still responsible for using those disability ratings for the unfitting conditions. Hence, the entire Army disability process still exists. Most significantly, Soldiers do not “trust” the process or system.[44] Figure 3 demonstrates the Army system in conjunction with the DES Pilot.

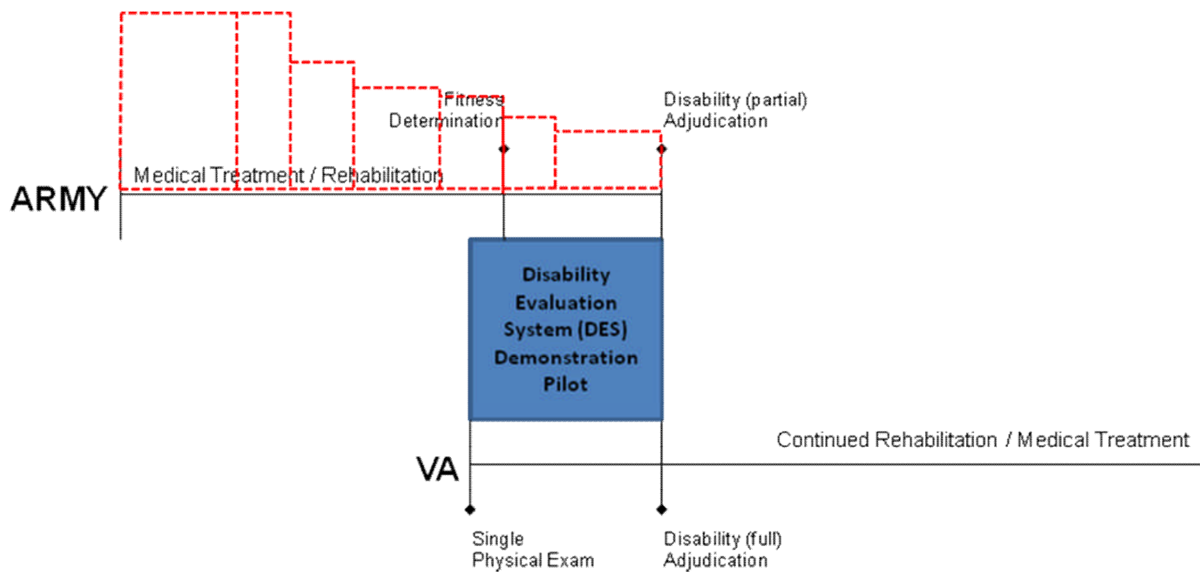

Figure 3: Retained Army PDES overlapping the DES Demonstration Pilot

Further, the outcome of the Army disability adjudication determination is still different than that of the VA's. This propagates a continued adversarial relationship between the Army and the Soldiers that it separates for disability.

<u>Proposed System</u>

The original intent of assessing disability and providing compensation for Civil War veterans was borne out of a sense of national obligation to care for Soldiers who had serve the Nation. Questions in this arena subsequent to other conflicts over the past 150 years have been challenging. What is reasonable and fair compensation for the combat disabled? How should disability be determined? What government agency should be responsible for providing rehabilitative care? To what extent should rehabilitative care be provided? Despite the passage of time and advances in medicine, the answers to these questions have not been simple or obvious. Nonetheless, the

government's overall responsibility for taking care of its citizens in uniform has always been justified, and perhaps more than ever, considered strategically important.

Reform of the Physical Disability Evaluation System (PDES) that changes the paradigm to focus on rehabilitation and transition instead of disability and compensation is the direction that should be taken. Redesign of the process is conceptualized in Figure 4.

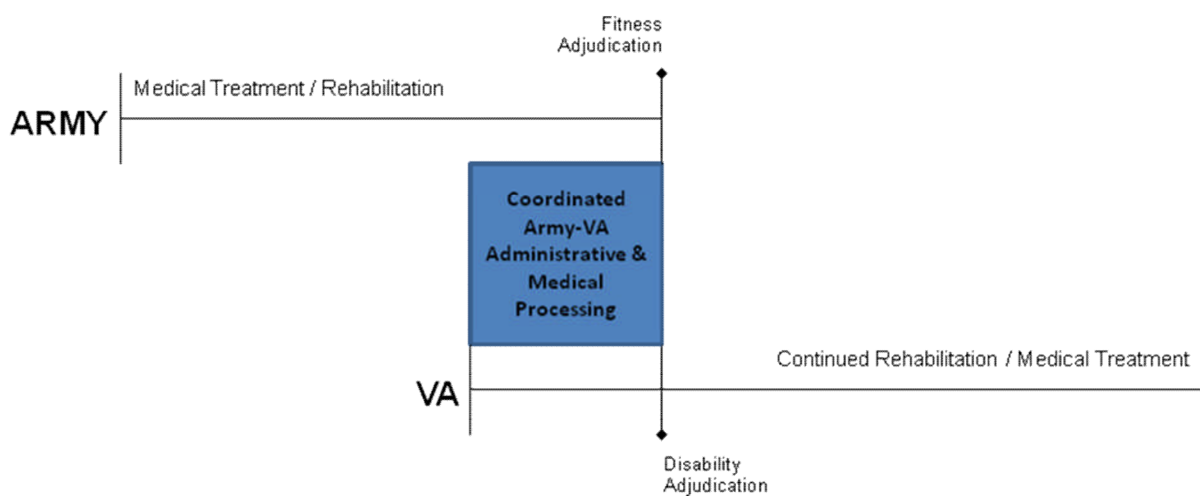

Figure 4: Proposed Physical Disability Evaluation System

The Army retains the responsibility for initial medical evaluation and treatment of Soldiers that are identified as Wounded, Ill, or Injured (WII). Further, the Army will continue to initiate rehabilitation. Advances in medical technology have shown that despite suffering devastating injuries, Soldiers with the desire to serve have the potential, with appropriate rehabilitation, to return to full duty.[45] Hence, by limiting the Army to adjudication of "fitness for duty," flexibility is provided to the medical treatment team in cases that require extended and intense rehabilitation to achieve 'optimal' recovery. This approach is consistent with the Army Warrior Ethos of never leaving a

"Fallen Comrade." Further, it encourages maximal recovery while endorsing retention for continued service. In cases where fitness cannot be achieved, the medical rehabilitation process will have still set the course for medical recovery that emphasizes self-reliance and transition to the civilian sector. In the absence of providing any military disability compensation, the Army could devise a process of equitable compensating for service rendered, based on achieved rank and length of service.

The VA would assume responsibility for the complete adjudication of disability in cases that are 'unfit' with amendment to Title 38, U.S.C. Following the established methodology of determining percentage disability using the VASRD would eliminate the complexity of dual adjudication and with it, the adversarial stance between the Army and disabled Soldiers. Continued early involvement would leverage the cohesive and cooperative spirit that has been created by the demonstration pilot program. The inter-agent relationship places the focus of importance on the Soldier and limits the risk of administrative and clinical gaps. Most importantly, it creates a seamless transition for Soldiers whether they continue to serve in a military role or convert to a civilian position. All would remain united in the goal of achieving maximal recovery. Disability compensation and benefits would be equitably provided based on the medical impairment(s) that limit veterans' earning capacity and create loss of quality of life.

The major disadvantage to reforming the PDES will be the need to realign federal funding streams to both the Departments of Defense and Veteran Affairs. It is likely that the DoD will realize a significant cost-avoidance in the absence of providing disability compensation while the VA will assume a corresponding significant cost-liability with the

responsibility of all disability compensation. To be clear though, the likely outcome will result in an overall increased tax burden.

Conclusion

The Army Medical Department has a long and rich history that has been an integral supporting part of the Nation's defense. Despite increasing complexity, the mission has been variously described in a succinct manner. Dr. Richard L. Meiling, the then-Assistant Secretary of Defense (Health Affairs) in 1951, described it as follows.

> The basic reason for the existence of the military medical services is to provide support for the men who fight. Other activities, in peace and war, frequently compete for time, talent, and funds: but anything that deflects the medical services from this supporting mission is a liability against the military strength of the Nation.[46]

While seemingly straight forward then, the current culture of persistent conflict and its consequences has resulted ina much broader view in defining 'support' to Soldiers.

> The AMAP vision for Army medicine, VA and other support agencies is the creation of a sustainable health care system where all injured and ill Soldiers are medically treated, vocationally rehabilitated and returned successfully to active duty, or transitioned back to civilian life with follow-up health care provided by the VA.[47]

Today's all-volunteer force requires Americans that choose to embark on a career in a military organization that does, and most likely will continue to, request service in a combat zone. Those that serve in the Army are aware of this, and the inherent risk that combat duty poses. In the face of injury, the Soldiers expectations are straight forward as depicted in Figure 5.

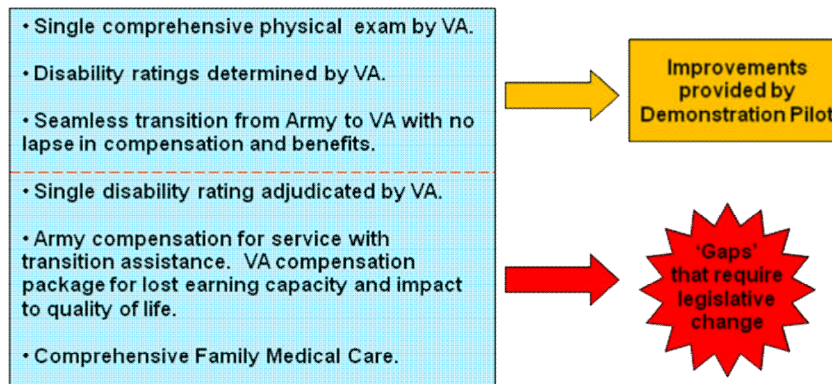

Figure 5: Expectations by the Combat Disabled

They desire a medical retirement that validates their service and consequent sacrifice. They desire the assistance through transition to the civilian sector that avoids any significant income stream loss or gap. They desire healthcare benefits for their Family that were equal to those while they were in the service. Reform of the Disability Evaluation System that severs the Army from adjudication is the first step that can close the existing gaps such that Soldiers' expectations can be met. Anything less, risks the possibility that future generations of Soldiers will not be available or willing to serve the Nation.

Endnotes

[1] The Physical Disability Evaluation System covers all Department of Defense military members. While this project focuses on the Army, legislative reform would have to be applied to all military departments to ensure equitability. The governing directives that apply to the US Army include: Title 10 U.S.C., Chapter 61; Department of Defense Directive 1332.18; Department of Defense Instruction 1332.38; Department of Defense Instruction 1332.39; Army Regulation 40-400, Patient Administration; Army Regulation 40-501, Standards of Physical Fitness; Army Regulation 600-60, Physical Performance Evaluations; Army Regulation 635-40, Physical Evaluation for Retention, Retirement, or Separation; and the Department of Veterans Affairs Schedule for rating Disabilities (VASRD).

[2] As of 1May 2009 as reported by the Army electronic data case collection system provided by USAPDA.

[3] Veterans' Disability Benefits Commission, Written Statement by LTG(ret) James T. Scott to accompany testimony before the Senate Committee on Veterans' Affairs, 17 October 2007, 2.

[4] The origin for this percentage level comes from Recommendation 27 (Disability Retirement: Officers, Warrant Officers, and Enlisted Personnel) by the Advisory Commission on Service Pay, found in "A Report and Recommendation for the Secretary of Defense", December 1948.

[5] Robert W. Fogel, ed., 'The Aging Veterans of the Union Army'*, Data User's Manual – Surgeon's Certificates, 1862-1940*, Version S-1, 2001, 332-333.

[6] Dora L. Costa, *The Evolution of Retirement: An American Economic History*, (Chicago: University of Chicago Press, 1998), 36.

[7] Peter Blanck, 'Civil War Pensions and Disability', *Ohio State Law Journal* 109*,* no. 62, 2001, 112-116.

[8] Fogel, 342-344.

[9] Heywood T. Sanders, "Paying for the Bloody Shirt: The Politics of Civil War Pensions", in Barry Rundquist, ed., *Political Benefits* (Lexington, Massachusetts: Lexington Books, 1980), 139-140.

[10] Ibid, 141-142.

[11] Theda Skocpol, America's First Social Security System: The Expansion of Benefits for Civil War Veterans, *Political Science Quarterly* 85*,* no. 108, 1993, 114.

[12] William H. Glasson, *Federal Military Pensions in the United States*, (New York: Oxford University Press, 1918), 246-247.

[13] Ibid, 250.

[14] History of the United States Army Medical Department in the World War, (Washington, DC: Department of the Army), vol. 13, 8.

[15] Ibid, Vol. 5, 54.

[16] Memorandum to CSA, 7 December 1917, National Archives and Records Administration, Record Group 165, roll 275, document 8574-30.

[17] Gustavus Weber and Laurence Schmeckebeir, *The Veterans' Administration, its History, Activities, and Organization*, (Washington, DC, Brookings Institution, 1934).

[18] Clarence Smith, *The Medical Department: Hospitalization and Evacuation, Zone of the Interior*, (Washington, DC: Government Printing Office, 1956), 190.

[19] Robinson Adkins, *Medical Care of Veterans*, (Washington, DC: Government Printing Office, 1967), 171-175.

[20] Editorials, *Modern Hospital*, January 1944, 41 and May 1945, 42.

[21] Military Compensation Background Papers, 6th Edition, Department of Defense, Under Secretary of Defense (Personnel & Readiness), 2005.

[22] Report to the President from the Committee on Veterans' Medical Services, (Washington DC: Government Printing Office, 22 September 1950).

[23] Although AR 40-680 included the definition of 'optimum hospital improvement', interpretation was left to the individual physicians treating patients.

[24] Rod Powers, "Understanding Military Medical Care", http://usmilitary.about.com/cs/healthcare/a/medicalcare.htm (accessed 28 May 2009).

[25] Paul Starr, *The Discarded Army: Veterans After Vietnam,* (New York: Charterhouse, 1973), p. 56.

[26] "Policy for Veterans Affairs Participation in TRICARE", ASD (HA) Policy Memo 02-022, 18 December 2002.

[27] Although amended multiple times, the basis for the majority of the provisions within Chapter 61 (Sections 1201 thru 1206) were set forth in 1949. This is significant from the perspective of disability given the societal transformation from an industrial base to a technological one with corresponding dramatic advances in the practice of medicine.

[28] These are detailed in Section 1216 of Chapter 61 of Title 10 U.S.C.

[29] The three regional PEBs are co-located with Walter Reed Army Medical Center, Brooke Army Medical Center, and Madigan Army Medical Center.

[30] The PEB has the option to place the Soldier on the Temporary Duty Retirement List (TDRL) for up to 5 years in cases in which the medical condition is not considered stable for rating purposes. Final adjudication occurs at the conclusion of the TDRL period. The original intent of TDRL was to provide Soldiers with the opportunity to heal from war injuries so as to achieve 'fitness' and remain on active duty. In practice, very few Soldiers placed on TDRL ever return to active duty.

[31] Adapted from the PDES Review for the Commanding General, Human Resources Command as presented by the U.S. Army Physical Disability Agency, 3 July 2008.

[32] Recommendation 27 (Disability Retirement: Officers, Warrant Officers, and Enlisted Personnel) by the Advisory Commission on Service Pay, found in "A Report and Recommendation for the Secretary of Defense", December 1948.

[33] Kelly Kennedy, "Critics: Army Holding Down Disability Ratings", Army Times, 27 February 2007.

[34] Multiple independent groups made recommendations to revamp the Disability Evaluation System. The most prominent was, *"The President's Commission on Care for America's Returning Wounded Warriors"* often referred to as the Dole-Shalala Report released in July 2007. In that report 6 major recommendations were made of which was to, Completely Restructure the Disability and Compensation Systems (pp.5-6). Data collected by that commission revealed that less than 50% of the respondents surveyed understood the process, and even ewer (less than 40%) were satisfied.

[35] Memorandum for Under Secretary of the Army, 6 March 2007, "Report on the Army Physical Disability Evaluation System (APDES)", Executive Summary.

[36] Lean Six Sigma is a business improvement methodology which combines tools from both 'Lean Manufacturing' and 'Six Sigma'. Lean Manufacturing focuses on speed and traditional Six Sigma focuses on quality. By combining the two, the result is better quality faster. The overall methodology uses a teamwork approach that analyzes facts and data to improve processes for the benefit of the customer.

[37] "Army Medical Action Plan", MEDCOM NOW, Vol.1, No. 1, 14 May 2007, 1.

[38] Gary Sheftick and Franz Holzer, "Army to Establish 'Warrior Transition Units'", October 9, 2007, http://www.military.com/features/0,15240,152058,00.html (accessed 20 April 2009).

[39] As of 1May 2009 a total of 9,456 Soldiers were assigned to WTUs. Of those, 2,641 Soldiers were undergoing evaluation of medical disability. 354 were wounded or injured as a result of combat operations. The remaining 2,287 sustaining injuries or illnesses unrelated to battle activities. Data provided by USAPDA.

[40]Slides 2-7 of the July 2008 SOC-WII Update Presentation that provides a brief overview of the Senior Oversight Committee is found at http://www.*tricare.mil/conferences/ccs2008/downloads/tuesday/Sessions%20110_305%20Senior%20Oversight.ppt* (accessed 7 April 2009).

[41] Clean Sheet The objective of LoA 6, or the Clean Sheet Design effort, was to develop a comprehensive, holistic, end-to-end, non-clinical support process to meet the needs of wounded, ill, or injured Service members/veterans, their families, and Committed And Designated Representatives (CADRE).

[42] The DES Pilot commenced on 26 November 2007 in the National Capital Region (NCR) which included Walter Reed Army Medical Center. Pilot Expansion began in October 2008 which as of 1 May 2009 included: Fort Belvoir, Fort Meade, Fort Stewart, Fort Polk, Fort Richardson, Fort Wainwright, and Fort Drum.

[43] Data Report from DoD LoA 1 as of 17 May 2009 provided by USAPDA shows that 1130 Soldiers have been enrolled in the DES Pilot since 26 November 2007. 53 have returned to duty, 117 have retired with full compensation and benefits, 5 have been separated with severance pay. The mean average processing time is 250 calendar days with an average of 9 claimed conditions. 921 remained enrolled in the process of which 467 are at the Informal PEB stage. Consistency was noted as opposed to data within *"The President's Commission on Care for America's Returning Wounded Warriors",* (p. 19) which noted that ratings varied between the DoD and VA, between services, and between servicing PEBs within each service. Statistically

significant differences were also noted in the *"Statistical Analysis of the Percentages Remunerated in Compensation to Disabled US Army Soldiers", (*pp. 53-54) conducted by the Center for Army Analysis released in October 2008 (included Pilot and non-Pilot PEBs).

[44] Survey results from 1200 responses collected in January and February 2009 by the Physical Disability Evaluation System Task Force (PDES TF) led by GEN (ret) Frederick Franks, Jr., commissioned by the CSA, GEN George W. Casey in July 2008. It should be noted that despite the low level of trust in the system, 86% of the respondents are satisfied with their medical care.

[45] Survey results by the PDES TF indicate that 40% of officers and 60% of enlisted personnel express a desire to continue their military service.

[46] Richard L. Meiling, "Medical Care for Members of the Armed Services", *Annals of the American Academy of Political and Social Science,* January 1951, 93.

[47] "Army Medical Action Plan", MEDCOM NOW, Vol.1, No. 1, 14 May 2007, 1.