Strictly Speaking

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President George W. Bush
Addresses Veterans Service Organization Representatives
at the White House
March 28, 2003

Good afternoon. Thanks for coming and welcome to the people's house. It is my honor to welcome distinguished veterans to the White House. I'm especially pleased to have met with leaders from the veterans organizations at this crucial time for our country.

The men and women who have worn the nation's uniform set an example of service and an example of sacrifice for future generations. And the current generation of our military is not letting us down. Today's Armed Forces are upholding the finest traditions of our country and of our military. They are making great progress in the war in Iraq. They are showing great courage and they are making this country proud.

I'm honored that Tony Principi introduced me. I'm proud of his service to our country, not only as a Vietnam vet, but now as the head of the Veterans Affairs, Department of Veterans Affairs. He's doing a really good job.

I want to thank the national commanders and presidents of our national veteran service organizations for coming. I want to thank you all for your service to your fellow Americans. I appreciate your members being here with us. I'm particularly pleased that Brian Thacker, a Medal of Honor recipient, is with us as well. I want to thank all our vets — And I want to thank all the vets who are here.

You're here at a time when our — the coalition, the United States and our partners, are acting together in a noble purpose. We're out to keep the peace, to make the world more peaceful, to make our nation and other nations more secure, and we're going to free the people of Iraq from the clutches of Saddam Hussein and his murderous allies.

We are sending a clear signal to the world that we will not submit to a future in which dictators and terrorists can arm and threaten the peace without consequence. We are enforcing the demands of the United Nations, and we refuse to leave the Iraqi people in slavery under Saddam Hussein. When the war in Iraq is won, all of who have joined this cause will be able to say to the Iraqi people, we were proud to fight for your freedom.

The regime that once terrorized all of Iraq now controls a small portion of that country. Coalition troops continue their steady advance and are drawing nearer to Baghdad. We're inflicting severe damage on enemy forces. We are now fighting the most desperate units of the dictator's army. The fierce fighting currently underway will demand further courage and further sacrifice. Yet we know the outcome of this battle: The Iraqi regime will be disarmed. The Iraqi regime will be removed from power. Iraq will be free.

In the last week, we have seen the brutal and cruel nature of a dying regime. In areas still under its control the regime continues its rule by terror. Prisoners of war have been brutalized and executed. Iraqis who refuse to fight for the regime are being murdered. Some in the Iraqi military have pretended to surrender and then opened fire on coalition forces that were

willing to show them mercy.

Given the nature of this regime, we expect such war crimes, but we will not excuse them. War criminals will be hunted relentlessly and judged severely.

In the last week, we have also seen the nature of the young men and women who fight on our behalf. Coalition forces have begun delivering food and water to liberated parts of Iraq. I was pleased to hear today that the United Nations Security Council acted to resume food and medical supplies under the existing U.N. program, which will bring urgent relief to millions of Iraqis.

We care about the human condition of the people who have suffered under Saddam Hussein. We provided $60 million to the World Food Program, to help get this humanitarian effort up and running. We're shipping hundreds of thousands of metric tons of food to Iraq. In every possible way, coalition forces are showing kindness and respect to the Iraqi people. They're going to extraordinary lengths to spare the lives of the innocent. We treat wounded Iraqi soldiers.

The contrast could not be greater between the honorable conduct of our forces and the criminal acts of the enemy. Every Iraqi atrocity has confirmed the justice and the urgency of our cause. Against this enemy we will accept no outcome except complete victory.

To meet this outcome, we must give our armed services the support and the resources they require. As veterans, all of you understand the importance of a well-supplied and well-trained fighting force. I've asked Congress for a nearly $75 billion wartime supplemental appropriations bill. This funding would provide fuel for ships and aircraft and tanks; supplies for our troops in the theater of operations; new high-tech munitions to replace the ones we have used in this war. The supplemental would also provide funds to assist in the reconstruction of Iraq, and to help protect the American homeland in this time of high alert.

I want to thank the veterans groups for their strong support, unwavering support, for this wartime supplemental, and I call upon the United States Congress to pass the supplemental as quickly as possible.

I also appreciate all the veterans are doing for America's military families in time of hardship. I appreciate your compassion. Across our country, local chapters of the American Legion, for example, are stepping forward to help those families in practical ways, from making household repairs to helping with child care. Members of the VFW and Auxiliary are sending care packages with baby supplies to military families. Operation Uplink Program is helping thousands of service members keep in touch with their loved ones.

Both the American Legion and the VFW are working with the U.S.A. Freedom Corps on a project called On the Home Front. This effort will match Americans who want to volunteer their times and skills with the military families who need help. Because of all this generosity, our men and women serving overseas will know that their loved ones are not facing this time alone.

I want to thank the veterans — the veterans groups for understanding the compassion needed to help those who are here, wondering and worrying about their loved ones overseas. The people who serve in the military are giving their best to this country, and we have the responsibility to give them our full support. Our full support not only here in Washington, D.C., but our support all across the country.

I want to thank each veteran here today and across our land for the lifetime of service you have given our nation. I thank you for standing behind the men and women of today's Armed Forces, as they fight for the liberty of an oppressed people, for the security of the United States and our friends and allies, and for the peace of the world. May God bless our troops.

Anthony J. Principi
Secretary of Veterans Affairs
Veterans of Foreign Wars National Legislative Conference Washington, DC
March 11, 2003

Commander-in-Chief Sisk; distinguished officers of the VFW; Executive Director Wallace; Auxiliary President Morris; distinguished officers and members of the Veterans of Foreign Wars; honored guests, ladies and gentlemen. It's a great pleasure to be with you.

Thank you, Commander Sisk, for your kind introduction. You and I have been friends and colleagues, fellow Navy veterans and fellow Californians, for many years. Your extraordinary stewardship of VFW is leading our organization to new heights of service to veterans and to America.

My fellow VFW members and I are fortunate to have the benefit of your outstanding leadership as we continue VFW's second century of honoring the dead by helping the living. Thank you, Commander, for inviting me here today.

More than sixty years ago, at the dawn of World War II, Winston Churchill launched the lifeboats that saved our liberty.

It is beyond imagination what our lives and the lives of our children would be like today had Churchill not lived, acted, written and spoken as he did, and when he did.

His words, and the actions and courage of millions of allied servicemen and women, changed the course of history.

Churchill not only believed victory was possible during the darkest days of the war—he made others believe it too.

In 1940, he told the Royal Air Force: "Two years is not a long time, even in our short lives. When we are doing the finest thing in the world, we must not weary as we toil and struggle through them."

Two years ago, I committed myself to a cause as well; a cause honored and sanctified by you. For it was your service and your sacrifice that changed history in World War II and in all of the conflicts and wars that followed in our nation's history.

I committed myself to do more to redeem America's debt to her veterans by improving the quality of and access to the benefits and healthcare veterans earned in the service of our country.

Two years have now passed in our shared campaign of service and we've accomplished a lot together already, but we must do more—we can do more—in the next two years to make a difference in the lives of every American veteran.

In his book about the Second World War, Churchill wrote: "To have the United States at

our side was to me the greatest joy."

To have the Veterans of Foreign Wars at my side in our battle for veterans is a joy, and certainly a comfort, to me.

Like the United States and Great Britain during World War II, the Veterans of Foreign Wars and VA are true partners. Partners and friends may not always agree on every issue—but they always work towards a common goal.

Washington is a town in which there is entirely too much divisiveness and bickering: between parties, between interest groups, between individuals.

There has got to be a better way; and we set an example of what that better way can be when we work together.

For my part, I will never shy away from making the difficult decisions, the tough decisions, but support me or not, you will always know the basis for every decision I make.

My guiding principle will always be service to veterans. I have but one constituency and that is the men and women who served our nation in uniform.

In a few moments, Commander Sisk and I will sign a Memorandum of Agreement for VA and VFW to co-sponsor the 2003 Golden Age Games.

Nothing contributes to keeping bodies and minds healthy like recreation and sports, and your willingness to co-sponsor these games enables thousands of veteran competitors to display courage, determination and a sense of purpose that cannot fail to inspire the rest of us to live our lives with renewed purpose, zest and vigor. I am grateful for VFW's generosity in supporting these Games.

Of all the many wonderful programs sponsored by VFW members and there are plenty of them, there is one I would particularly like to thank VFW members for supporting. Operation Uplink.

This program brings home a little closer to servicemembers and veterans by providing them with free long-distance calling time.

As we speak, hundreds of thousands of young American men and women are poised at the brink of an uncertain future—a future that for some may be far too brief.

As they bravely await the bugle's call to action, their thoughts turn to many things—most often, to their homes and their families and their loved ones.

Operation Uplink gives these young heroes—two of whom are my own sons—the little touch of home they need in these tense and troubling times.

Thank you, as a parent and a Secretary, for sponsoring this wonderful program.

While Operation Uplink comforts our young men and women on the frontiers of freedom throughout the world, VA is offering their predecessors service improvements that honor the sacrifices you made when it was your turn on the firing line.

Two years ago, I set some high goals for the VA defining my objectives for redeeming the debt America owes its veterans.

I promised to restore veterans' faith in VA's ability to fairly and promptly decide their claims for benefits.

I promised to do what I could to improve access to quality health care for America's veterans.

I promised to restore our national cemeteries as national shrines and open new cemeteries where needed.

I promised to harness the promise of modern technology to deliver VA's services faster and more efficiency.

I promised to be a good steward of the taxpayer dollars entrusted to me.

And I promised to fight as hard as I possibly could for every dollar I could get out of OMB and Congress.

As Churchill said: "It is no use saying, 'we are doing our best.' You have got to succeed in doing what is necessary."

My number-one priority as Secretary was to restore timeliness and quality to this enormous backlog of disability claims, claims for disability compensation and pension.

To provide prompt and accurate decisions on disability claims, the President appointed a battle-tested leader in Admiral Dan Cooper, who as chairman of the VA Claims Processing Task Force created the road map we are using to guide us in our campaign.

Together, Dan and I found the funds to add thousands of new or retrained ratings specialists. But success in this campaign depends upon more than just throwing money at the problem.

To meet our commitment to disabled veterans, we had to change the culture in VBA. We insisted on employee performance standards that truly measure performance.

We demanded improved training methods and centralized training to make sure everyone involved in deciding a veteran's claim knows how to achieve the outcomes for which we are holding them accountable.

We've returned to a system of triage, in which cases are looked at as soon they come in the door, and simple claims are decided quickly instead of being thrown on someone's desk

where they may wait for six months when just a simple signature would have gotten a death pension to a grieving widow.

By doing so, we were able to provide many veterans and their widows with immediate service—an example of how to put veterans needs first before VA's procedures.

And we have also returned to specialization, in which our claims examiners specialize in handling claims that require special expertise or knowledge.

Specialization is particularly effective in enabling us to make best use of new employees, who are able to become much more productive earlier in the process, to start helping veterans earlier in the process.

And we've given our claims examiners increased access to new technology, including electronic access to medical records in our computerized patient record system rather than sending over a piece of paper to a VA medical center and waiting for paper to come back, it's all done electronically today, and that should also help speed the resolution of some of these claims that have been pending for years.

These and dozens of other innovations are now bearing fruit.

Last year, VBA's inventory of pending disability claims peaked at 432,000. Today, the number stands at slightly more than 300,000, even though we receive an additional 60,000 new claims each and every month, and we are on target to reach my goal of never having more than 250,000 claims in our inventory.

To achieve that progress, we increased the average number of claims decided every month from 40,000 to 66,000 while maintaining the quality of our decisions.

The Tiger Team which I established to address the claims of our oldest veterans who have been waiting over a year and the 9 offices around the country supporting them have decided 77,000 claims.

Behind those numbers are veterans who have been waiting over a year for a decision. And I'm proud that most of those decisions are favorable, but in any event, the veteran has a decision and they can appeal if they're not happy with the result.

Last March, it took an average of 233 days to process a claim. Today, it takes less than 200 days.

Now you might say, Mr. Secretary, that doesn't sound like much of an improvement but the fact of the matter is we're deciding the oldest claims first And there's a funny thing in this business, if you never decide claims you'd have a perfect timeliness record—so we had to put these old claims out of the backlog. Once you've done that, hopefully, the timeliness will go down to 100 days, which is my goal.

I thank the VFW's nationwide network of Service Officers for their exceptional work they

do representing veterans, and for the hundreds of thoughtful and detailed suggestions they provided to improve our system—many of which we adopted over the past year and a half.

We simply could not have succeeded without the work of the VFW and their Service Officers.

I am acutely aware that the relatively modern technological battleground poses more dangers than the simple bullet wound or saber cut. Environmental hazards of the modern battlefield can be as deadly as a bullet wound.

And where we can show scientific evidence of an association between service and illness, we must compensate veterans with that illness.

That is why, last month, I directed VA to compensate Vietnam veterans with chronic lymphocytic leukemia, known as CLL, after the Institute of Medicine found suggestive evidence to support a correlation between dioxin in Agent Orange and CLL.

And that is why—also last month—I asked the Institute of Medicine to review the medical and scientific literature on the health effects of Sarin gas, nerve gas that Saddam Hussein had stockpiled in Iraq at Khamisiyah. And when we hit that ammo dump, some Sarin gas was exposed to the atmosphere.

We need to know the long term effects of releasing that Sarin gas into the atmosphere can have on our troops who served in that area of Iraq.

I will simply not hesitate to act decisively on veterans' behalf when the evidence warrants my intervention.

And I did not hesitate last year to provide service connection to veterans with Lou Gehrig's disease, ALS, when we found evidence that there was an acute increase in risk of contracting ALS for veterans who served in the Gulf between 1990 and 1991 than those who did not.

Churchill vowed that England would wage war by sea, land and air, with all its might and with all its strength.

His aim was victory—victory at all costs, victory on every front, however long and hard the road may be.

I want you to know that together we are fighting to improve our claims decision process on every front; and we shall not rest until we succeed in getting down that backlog and getting veterans the benefits they deserve.

Victory brings its own set of problems, as Churchill well knew. "The problems of victory," he wrote, "are more agreeable than the problems of defeat, but they are no less difficult."

We have won tremendous victories in our mission of health care for America's veterans—but we face challenges that are no less difficult than we faced in getting our claims decision process back on track.

Today's VA is at the forefront of the health care industry in critical areas like quality improvement, patient safety, disease prevention, the use of computerized patient records, and telemedicine.

Our researchers' discoveries benefit not only veterans, but all Americans, and all the peoples of the world.

Today's VA provides health care for more than four million veterans from all walks of life every year. We treat veterans at more than 1,300 locations. In the past eight years, we have opened 664 outpatient clinics across the country.

And today's VA ranks best in the nation in sixteen of eighteen indicators of health care quality for managed care organizations.

But, as Churchill predicted, we now face the challenges brought on by our victory.

You see, before 1996 in America, VA provided care primarily to veterans with service-connected disabilities, low-income veterans, and those veterans who needed our specialized service, like spinal cord injuries, blind rehabilitation, and mental health.

Other veterans were limited to space available for inpatient hospital care. There was no eligibility for outpatient care. When Congress enacted eligibility reform it made all 25 million veterans eligible for comprehensive health care, but it did not, Congress did not, create an entitlement to care, only for eligibility.

In 1998 VA treated 2.9 million individual veterans. In 2002, we treated more than 4.5 million.

We saw more than 46.5 million veterans on outpatient visits; Dispensed more than 191 million prescriptions; Filled more than 6.4 million requests for new prosthetics; And admitted 565,000 veterans to our 162 hospitals around the country.

Our workload is staggering. And we expect it to continue to increase in Fiscal Year 2003.

Today, 6.8 million of our colleagues, our fellow veterans have enrolled for VA health care. Last year, we added almost 900,000 new veterans to our enrollment to our system.

The 1996 eligibility reform legislation passed by Congress, however, clearly contemplated that more veterans may seek care than VA can provide for with the resources available to us.

The statute established and defined seven priority groups. Last year, they added an eighth priority group—and it directs me as Secretary to make an annual enrollment decision on which of the priority groups can be provided VA care with the resources made available to me in appropriation acts.

Now, the politically easy course for me would be to continue unconstrained open enrollment fully knowing that we have a waiting list of some 200,000 veterans who are currently enrolled who have not been able to get in and see their primary care physician.

But taking that course would result in ever-increasing waiting lists, and it would threaten the quality of our care as our health care providers labored to care for overwhelming numbers of veterans.

I simply cannot be part of such a course.

It would be an injustice to sick veterans, for whom enrollment would hold out the false promise of timely high quality care. I therefore proposed to suspend for this year new enrollment for priority group 8 veterans until we can get a handle on the current workload, eliminate the waiting list so veterans would never have to wait for more than 30 days for primary care appointments and somewhat longer for specialty care appointments.

When we get to that goal with the money that was appropriated after five months of waiting this fiscal year, I believe we can eliminate the backlog by the end of this fiscal year and we'll see what we can do in the following year in regard to once again opening enrollment.

Revolutionary changes in health care brought about by technology, research and new modes of treatment compel us to make the changes necessary to stay on the leading edge of health care in this century and not in the century gone by.

Our Capital Asset Realignment for Enhanced Services which began several years ago, it's called the CARES initiative will identify areas where we need to realign our health care assets based on veteran population projections, the demographics of our veteran population, where they live, the new modalities of providing health care and ambulatory centers of health care and on and on and on, so that we stay on the leading edge in this new century.

I hope every VFW post will take an active interest in the CARES process in their area, and that you will partner with us to design a twenty-first century health care system worthy of the veterans it will serve.

I have appointed a commission of fifteen members chaired by Everett Alvarez, who was the longest held prisoner of war in the Vietnam war, and I expect they will be going out and holding hearings on the record and I will not act until that commission comes back and tells me whether the recommendations of my Under Secretary are appropriate or not.

VA also has the sacred responsibility to provide a dignified and respectful setting for American veterans who go before us.

To meet that responsibility, we have established the most aggressive schedule of opening new cemeteries since the Civil War. We will open new cemeteries in the next few years near Atlanta, Detroit, Pittsburgh, Sacramento and South Florida.

We are working with the Department of the Navy on an agreement to transfer 300 acres

near Miramar Air Base in San Diego so we can expand Fort Rosecrans National Cemetery.

After that, our highest priorities for new cemeteries are near Birmingham, Alabama, the Columbia-Greenville area of South Carolina, and Sarasota County, Florida. These new cemeteries will join our 120 existing National Cemeteries as national shrines for decades to come.

No war—and no peace—can be won without resources. As Sir Winston once said to President Roosevelt, "Give us the tools, and we will finish the job."

I am proud of the President's proposed Fiscal Year 2004 budget, which includes a total of $63.6 billion for VA—a 7.7 percent increase over the budget for Fiscal Year 2003 in which we received an increase in health care of 7.6 billion dollars.

I have always been heard to say that I could use more money, and I'll continue to fight for every dollar that I can, but I am very, very proud that this is the largest percentage increase of any agency in the Federal Government—including the Department of Defense.

Let me speak briefly about the threat to peace America now faces. All of us who have seen the horror of war first hand know that a decision to turn to the sword can not be made lightly, but all who have read history also know that sometimes the actions of others make the decision for us.

And once again Churchill's great words about steadfast resolve, spoken when the British Empire stood absolutely alone against the forces of evil throughout the globe, are worth remembering in these troubled times:

"If we stand up to the enemy now," he said, "the life of the world may move forward into broad, sunlit uplands. But if we fail, then the whole world may one day sink into the abyss of a new Dark Age."

If Iraq chooses the destruction of war over the tranquility of peace, I want you to know that VA stands ready to meet the needs of our warriors when they return to our shores.

We are working with the Department of Defense to ensure that the men and women who now stand ready for battle at distant outposts in the Persian Gulf receive appropriate health care and compensation in return for their duty.

DoD intends to document the health care provided to forces deployed in the Gulf, to monitor the environment in which our forces are deployed, and to document which servicemembers were exposed to danger in the event toxic exposure is detected, much like Khamisiyah.

DoD will also provide us with rosters of service members who have separated from military service, and will work with us to develop processes to share information including individual assignments data, unit location data, environmental surveillance data and medical surveillance data.

This information will help make a seamless transition for today's servicemembers as they become tomorrow's veterans.

Together, our two departments are working together to ensure that our brave men and women now serving in the Gulf will be cared for with the dignity and respect they deserve.

And, I want to remind you, for two years after serving in a combat theater of operations, including Reservists and Guardsmen, the VA will be made available to those men and women for two years following their separation. So they can receive the health care they deserve. They earned it, and they will receive it without delay.

In conclusion, two years ago, I joined with you on a mission to ensure America's veterans receive all of the benefits and services to which they are entitled in a manner honoring their service.

We still have far to go on this journey. But we can be proud of how far we have come, and of the further progress still on the horizon well within our grasp.

Thank you for welcoming me to join with you on our shared journey of service to America's veterans. Thank you for everything you have done to help our people achieve our noble mission. Thank you for sharing the joy of making a difference in the lives of our nation's defenders.

God bless our great country and all the men and women who defend her.

Anthony J. Principi
Secretary of Veterans Affairs
Statement before the
Senate Committee on Appropriations
March 13, 2003

Mr. Chairman and members of the Committee, good morning. I am pleased to be here today to present the President's 2004 budget proposal for the Department of Veterans Affairs.

The centerpiece of this budget is our strategy to bring balance back to our health care system priorities. I have by my decisions and by my actions focused VA health care on veterans in the highest statutory priority groups—the service-connected, the lower income, and those veterans who need our specialized services. This budget reflects those priorities.

The President's 2004 budget request totals $63.6 billion—$33.4 billion for entitlement programs and $30.2 billion for discretionary programs. This represents an increase of $3.3 billion, which includes a 7.7 percent rise in discretionary funding, over the enacted level for 2003, and supports my three highest priorities: sharpen the focus of our health care system to achieve primary care access standards that complement our quality standards; meet the timeliness goal in claims processing; ensure the burial needs of veterans are met, and maintain national cemeteries as shrines.

Virtually all of the growth in discretionary resources will be devoted to VA's health care system. Including medical care collections, funding for medical programs rises by $2.1 billion. As a key component of our medical care budget, we are requesting $225 million to begin the restructuring of our infrastructure as part of the implementation of the Capital Asset Realignment for Enhanced Services (CARES) program.

We are presenting our 2004 request using a new budget account structure that more readily presents the funding for each of the benefits we provide veterans. This will allow the Department and our stakeholders to more effectively evaluate the program results we achieve with the total resources associated with each program.

Medical Care

The President's 2004 budget includes $27.5 billion for medical care, including $2.1 billion in collections, and represents an 8.0 percent increase over the enacted level for 2003. These resources will ensure we can provide health care for over 4.8 million unique patients in 2004.

The primary reason VA exists is to care for service-connected disabled veterans. They have made enormous sacrifices to help preserve freedom, and many continue to live with physical and psychological scars directly resulting from their military service to this Nation. Every action we take must focus first and foremost on their needs.

In addition, our primary constituency includes veterans with lower incomes and those

who have special health care needs. By sharpening the focus of our health care system on these core groups, we will be positioned to achieve our primary care access standards.

The demand for VA health care has risen dramatically in recent years. From 1996 to 2002, the number of patients to whom we provided health care grew by 54 percent. Among veterans in Priority Groups 7 and 8 alone, the number treated in 2002 was about 11 times greater than it was in 1996. The combined effect of several factors has resulted in this large increase in the demand for VA health care services.

First, the Veterans Health Care Eligibility Reform Act of 1996 and the Veterans Millennium Health Care Act of 1999 opened the door to comprehensive health care services to all veterans.

Second, the national reputation and public perception of VA as a leader in the delivery of quality health care services has steadily risen, due in part to widespread acknowledgement of our major advances in quality and patient safety.

Third, access to health care has greatly improved with the opening of hundreds of community-based outpatient clinics.

Fourth, our patient population is growing older and this has led to an increase in veterans' need for health care services.

Fifth, VA has favorable pharmacy benefits compared to other health care providers, especially Medicare, and this has attracted many veterans to our system.

And finally, some feel that public disenchantment with Health Maintenance Organizations, along with their economic failure, may have caused many patients to seek out established and traditional sources of health care such as VA.

All of these factors have put a severe strain on our ability to continue to provide timely, high-quality health care, especially for those veterans who are our core mission.

Through a combination of proposed regulatory and legislative changes, as well as a request for additional resources, our 2004 budget will help restore balance to our health care system priorities and ensure we continue to provide the best care possible to our highest priority veterans.

The most significant changes presented in this budget are to:

- ∑ assess an annual enrollment fee of $250 for nonservice-connected Priority 7 veterans and all Priority 8 veterans;
- ∑ increase co-payments for Priority 7 and 8 veterans—for outpatient primary care from $15 to $20 and for pharmacy benefits from $7 to $15;
- ∑ eliminate the pharmacy co-payment for Priority 2-5 veterans whose income is below the pension aid and attendance level of $16,169;
- ∑ expand non-institutional long-term care with reductions in institutional care in recogni-

tion of patient preferences and the improved quality of life possible in non-institutional settings.

Revolutionary advances in medicine moved acute medical care out of institutional beds and rendered obsolete "bed count" as a measure of health care capacity. The same process is underway in long-term care and this budget proposes to focus VA's long-term care efforts on increased access to long-term care for veterans, rather than counting institutional beds.

This budget focuses long-term care on the patient and his or her needs. Our policies expand access to non-institutional care programs that will allow veterans to live and be cared for in the comfort and familiar setting of their home surrounded by their family.

While we will shift our emphasis to non-institutional forms of long-term care, we will continue to provide institutional long-term care to veterans who need it the most—veterans with service-connected disabilities rated 70 percent or greater and those who require transitional, post-acute care. Coupled with this, our budget continues strong support for grants for state nursing homes.

In addition, we are working with the Department of Health and Human Services to implement the plan by which Priority 8 veterans aged 65 and older, who cannot enroll in VA's health care system, can gain access to a new "VA+Choice Medicare" plan.

This would allow for these veterans to be able to use their Medicare benefits to obtain care from VA. In return, we would receive payments from a private health plan contracting with Medicare to cover the cost of the health care we provide. The "VA+Choice Medicare" plan will become effective later this year as the two Departments finalize the details of the plan.

Coupled with my recent decision on enrollment, these proposed regulatory and legislative changes would help ensure that sufficient resources will be available to provide timely, high-quality health care services to our highest priority veterans.

If these new initiatives are implemented, veterans comprising our core mission population will account for 75 percent of all unique patients in 2004, a share noticeably higher than the 67 percent they held in 2002. During 2004, we will treat 167,000 more veterans in Priority Groups 1-6 (those with service-connected disabilities, lower-income veterans, and those needing specialized care).

In return for the resources we are requesting for the medical care program, we will be able to build upon our noteworthy performance achievements during the past 2 years.

During 2002, VA received national recognition for its delivery of high-quality health care from the Institute of Medicine in the report titled "Leadership by Example."

In addition, the Department received the Pinnacle Award from the American Pharmaceutical Association Foundation in June 2002 for its creation of a bar code medication administration system. This important patient safety initiative ensures that the correct medication is administered to the correct patient at the proper time.

Patient satisfaction rose significantly last year, as 7 of every 10 inpatients and outpatients rated VA health care service as very good or excellent.

We will continue to use clinical practice guidelines to help ensure high-quality health care, as they are directly linked with improved health outcomes. We will employ this approach most extensively in the management of chronic disease and in disease prevention.

For 16 of the 18 quality of care indicators for which comparable data from managed care organizations are available, VA is the benchmark exceeding the best competitor's performance.

Mr. Chairman, one of our most important focus areas in our 2004 budget is to significantly reduce waiting times, particularly for patients who are using our health care system for the first time. As we begin to rebalance our health care system with a heightened emphasis on our core service population, we will drive down waiting times.

By 2004, VA will achieve our objective of 30 days for the average waiting time for new patients seeking an appointment at a primary care clinic. In addition, we have set a performance goal of 30 days for the average waiting time for an appointment in a specialty clinic. With this budget and the enacted funding level for 2003, we will eliminate the waiting list by the end of 2003.

We remain firmly committed to managing our medical care resources with increasing efficiency each year. The 2004 budget includes management savings of $950 million. These savings will partially offset the need for additional funds to care for an aging patient population that will require an ever-increasing degree of health care service, and rising costs associated with a sharply growing reliance on pharmaceuticals necessary to treat patients with complex, chronic conditions.

We will achieve these management savings by implementing a rigorous competitive sourcing plan, reforming the health care procurement process, increasing employee productivity, increasing VA/DoD sharing, continuing to shift from inpatient care to outpatient care, and reducing requirements for supplies and employee travel.

Our projection of medical care collections for 2004 is $2.1 billion. This total is 32 percent above our estimated collections for 2003 and will nearly triple our 2001 collections.

By implementing a series of aggressive steps identified in our revenue cycle improvement plan, we are already making great strides towards maximizing the availability of health care resources.

For example, we have mandated that all medical facilities establish patient pre-registration to include the use of software that assists in gathering and updating information on patient insurance.

We are in the midst of a series of pilot projects at four Veterans Integrated Service Networks to test the implementation of a new business plan that calls for reconfiguration of the

revenue collection program by using both in-house and contract models.

In addition, the Department will award the Patient Financial Services System this spring to Network 10 (Ohio), which will acquire and deploy a commercial system of this type. This project involves comprehensive implementation of standard business practices and information technology improvements.

As you know Mr. Chairman, one of the President's management initiatives calls for VA and the Department of Defense (DoD) to enhance the coordination of the delivery of benefits and service to veterans. Over the past year, our two Departments have undertaken unprecedented efforts to improve cooperation and sharing in a variety of areas through a Joint Executive Council (JEC).

To expand the scope of interdepartmental cooperation, a benefits committee has been added to complement the longstanding Health Executive Council. The VA and DoD Benefits Executive Council is exploring improved transfer and access to military personnel records and a pilot project for a joint physical examination to improve the claims process for military personnel.

The JEC provides overarching policy direction, sets strategic vision and priorities for the health and benefits committees, and serves as a forum for senior leaders to oversee coordination of initiatives.

To address some of the remaining challenges, the Departments have identified numerous high-priority items for improved coordination such as the joint strategic mission and planning process, computerized patient medical records, eligibility and enrollment systems, joint separation physicals and compensation and pension examinations, and a joint consolidated mail-out pharmacy pilot.

Capital Asset Realignment for Enhanced Services (CARES)

The 2004 budget includes $225 million of capital funding to move forward with the Capital Asset Realignment for Enhanced Services (CARES) initiative. This program addresses the needed infrastructure realignment for the health care delivery system and will allow the Department to provide veterans with the right care, at the right place, and at the right time.

CARES will assess veterans' health care needs across the country, identify delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets so that we can optimize health care delivery in terms of both quality and access.

As demonstrated in Veterans Integrated Service Network 12, restructuring will require significant investment to achieve a system that is appropriately sized for our future.

Our preliminary estimate for resources that can be redirected to medical care between now and 2010 as a result of the appropriate alignment of assets and health care services, and the sale or enhanced-use leasing of underutilized or non-performing assets, is $6.8 billion.

It is extremely important to have funding in 2004 to begin the multiyear effort to restructure. Given the timing associated with identifying CARES projects, we will be working with your committee on the authorization process in order not to delay the start of these projects.

Medical and Prosthetic Research

Mr. Chairman, we are requesting $822 million in funding for VA's clinical research program, an increase of 2.6 percent from the 2003 level.

For the first time, our request includes funds in the form of salary support for clinical researchers, resources that previously were a component of the Medical Care request. This approach provides a more complete picture of VA's resources devoted to this program.

In addition to the Department's funding request, nearly $700 million in funding support comes from other federal agencies such as DoD and the National Institutes of Health, as well as universities and other private institutions.

This $1.5 billion will support more than 2,700 high-priority research projects to expand knowledge in areas critical to veterans' health care needs—Gulf War illnesses, diabetes, heart disease, chronic viral diseases, Parkinson's disease, spinal cord injury, prostate cancer, depression, environmental hazards, women's health care concerns, and rehabilitation programs.

Veterans' Benefits

The Department's 2004 budget request includes $33.7 billion for the entitlement and discretionary costs supporting the six business lines administered by the Veterans Benefits Administration (VBA). Within this total, $1.17 billion is included for the management of these programs — compensation; pension; education; vocational rehabilitation and employment; housing; and insurance.

Improving the timeliness and accuracy of claims processing is a Presidential priority, and during the last year we have made excellent progress toward achieving this goal.

A year ago, I testified that I had set a performance goal of processing compensation and pension claims in an average of 100 days by the summer of 2003.

I am pleased to report that we are on target to meet that goal and we will maintain that improved timeliness standard for 2004. When we reach this goal, we will have reduced the time it takes to process claims by more than 50 percent from the 2002 level.

At the same time that we are improving timeliness, we will be increasing the accuracy of our claims processing. The 2004 performance goal for the national accuracy rate is 90 percent, a figure 10 percentage points higher than last year's level of performance, and markedly above the accuracy rate of 59 percent in 2000.

The driving force that will allow us to make this kind of progress with only a slight budget increase continues to be the initiatives we are implementing from the Claims Processing Task

Force I established in 2001.

Located at the Cleveland Regional Office, our Tiger Team has been working over the last year to eliminate the backlog of claims pending over 1 year, especially for veterans 70 years of age or older. This aggressive effort of reducing the backlog and improving timeliness is underway at all of our regional offices.

VBA has established specialized processing teams, such as triage, pre-determination, rating, post-determination, appeals, and public contact.

Other Task Force initiatives, such as changing the procedure for remands, revising the time requirements for gathering evidence, and consolidating the maintenance of pension processing at three sites, have allowed us to free up resources to work on direct processing at the regional offices.

This budget includes additional staff and resources for new and ongoing information technology projects to support improved claims processing.

We are requesting $6.7 million for the Virtual VA project that will replace the current paper-based claims folder with electronic images and data that can be accessed and transferred electronically through a web-based solution.

We are seeking $3.8 million for the Compensation and Pension Evaluation Redesign, a project that will result in a more consistent claims examination process.

In addition, we are requesting $2.6 million in 2004 for the Training and Performance Support Systems, a multi-year initiative to implement five comprehensive training and performance support systems for positions critical to the processing of claims.

In support of the education program, the budget proposes $7.4 million for continuing the development of the Education Expert System. These resources will be used to expand upon an existing prototype expert system and will enable us to automate a greater portion of the education claims process and expand enrollment certification. This initiative will contribute toward achievement of our 2004 performance goal of reducing the average time it takes to process claims for original and supplemental education benefits to 27 days and 12 days, respectively.

VA is requesting $13.2 million for the One-VA Telephone Access project, an initiative that will support all of VBA's benefits programs. This initiative will result in the development of a Virtual Information Center that forms a single telecommunications network among several regional offices. This technology will allow us to answer calls at any place and at any time without complex call routing devices.

All of these information technology projects are consistent with the Department's Enterprise Architecture and will be supported by improved project administration from our Chief Information Officer.

Burial

The President's 2004 budget includes $428 million for VA's burial program, which includes operating and capital funding for the National Cemetery Administration (NCA), the burial benefits program administered by VBA, and the State Cemetery Grant program. This total is $17 million, or 4.2 percent, over the 2003 level.

This budget request includes $4.3 million for the activation and operation of five new national cemeteries in 2004.

NCA plans to open fast-track sections for interments at four new national cemeteries planned for Atlanta, South Florida, Pittsburgh, and Detroit. Fort Sill National Cemetery opened a small, fast-track section for interments in November 2001, and Phase 1 construction of this cemetery should be complete by June 2003.

In addition to resources for these five new cemeteries, this budget request also includes resources to prepare for the future opening of a fast-track section of an additional national cemetery near Sacramento. The locations of these national cemeteries were identified in a May 2000 report to Congress as the six areas most in need of a new national cemetery.

With the opening of these new cemeteries, VA will increase the proportion of veterans served by a burial option within 75 miles of their residence to nearly 82 percent.

The $108.9 million in construction funding for the burial program in 2004 includes resources for Phase 1 development of the Detroit cemetery, expansion and improvements at cemeteries in Fort Snelling, Minnesota, and Barrancas, Florida, as well as $32 million for the State Cemetery Grant program.

The budget request includes $10 million to support the Department's commitment to ensuring that the appearance of national cemeteries is maintained in a manner befitting a national shrine. One of the key performance goals for the burial program is that 98 percent of survey respondents rate the appearance of national cemeteries as excellent.

A new performance measure established for NCA is marking graves in a timely manner after interment. We have established a 2004 performance goal of marking 75 percent of graves in national cemeteries within 60 days of interment. When we achieve this goal, it will represent a dramatic improvement over the 2002 level of 49 percent.

Management Improvements

Mr. Chairman, we have made excellent progress during the last year in implementing, or developing, several management initiatives that address our goal of applying sound business principles to all of the Department's operations.

We are particularly pleased with our accomplishments in addressing the President's Management Agenda that focuses on strategies to improve the management of the Federal government in five areas—human capital; competitive sourcing; financial performance; elec-

tronic government; and budget and performance integration.

We have developed a sound workforce and succession plan that includes strategies VA will pursue to implement a more corporate approach to human capital management, and a workforce analysis of several of the Department's critical positions—physicians, nurses, and compensation and pension veterans service representatives.

We are moving forward with a competitive sourcing study of our laundry service, and other studies will be conducted of our pathology and laboratory services, and facilities management and operations.

With regard to financial performance, we achieved an unqualified audit opinion for the fourth consecutive year.

During 2003 and 2004, we will be involved in 10 electronic government studies.

And finally, we continue to progress in our efforts to better integrate resources with results. One major accomplishment in this area is the restructuring of our budget accounts. This new account structure is presented in our 2004 budget and will lead to a more complete understanding of the full cost of each of our programs.

VA has a variety of other management improvement efforts underway that will lead to greater efficiency and will be accomplished largely through centralization of several of our major business processes.

I am committed to reforming the way we conduct our information technology (IT) business, and to help the Department meet this objective, we have aggressively pursued new approaches to accomplishing our IT goals.

We have developed a One-VA enterprise strategy, embarked on a nationwide telecommunications modernization program, and laid a solid foundation for a Departmental cyber security program.

In order to facilitate and enhance these efforts, I recently centralized the IT program, including authority, personnel, and funding, in the office of the Chief Information Officer. This realignment will serve to strengthen the IT program overall and ensure that our efforts remain focused on building the infrastructure needed to better serve our Nation's veterans.

This budget includes $10.1 million to continue the development of the One VA Enterprise Architecture and to integrate this effort into key Departmental processes such as capital planning, budgeting, and project management oversight.

Our request also includes $26.5 million for cyber security initiatives to protect our IT assets nationwide. These initiatives aim to establish and maintain a secure Department-wide IT framework upon which VA business processes can reliably deliver high-quality services to veterans.

The 2004 budget includes funds to continue the CoreFLS project to replace VA's existing core financial management and logistics systems—and many of the legacy systems interfacing with them—with an integrated, commercial off-the-shelf package.

CoreFLS will help VA address and correct management and financial weaknesses in the areas of effective integration of financial transactions from VA systems, necessary financial support for credit reform initiatives, and improved automated analytical and reconciliation tools. Testing of CoreFLS is underway, with full implementation scheduled for 2006.

We are developing a realignment proposal for finance, acquisition, and capital asset functions in the Department. A major aspect of this effort centers on instituting much clearer delegations of authority and improved lines of accountability.

This plan would establish a business office concept across the Department and would enhance corporate discipline that will lead to uniformity in operations and greater accountability, and will make the transition to the new financial and logistics system much easier to implement. A component of the plan under review and consideration will result in a consolidated business approach for all finance, acquisition, and capital asset management activities.

Closing

Mr. Chairman, I am proud of our achievements during the last year. However, we still have a great deal of work to do in order to accomplish the goals I established nearly 2 years ago. I feel very confident that the President's 2004 budget request for VA will position us to reach our goals and to continue to provide timely, high-quality benefits and services to those who have served this Nation with honor.

That concludes my formal remarks. My staff and I would be pleased to answer any questions.

Statement of
The Honorable Robert H. Roswell, M.D.
VA Under Secretary of Health
U.S. House of Representatives Veterans' Affairs Committee
"State of VA Health Care"
January 29, 2003

Mr. Chairman and members of the Committee, I am pleased to be here today to discuss the challenges facing VA in meeting the current demand for VA health care services. As you know the Secretary and I will be testifying before you on the President's FY 2004 budget request in less than 2 weeks. I will not be able to discuss the details of the budget request today.

Today's VA health care system is one of the most effective and successful health care systems in the Nation. VA's performance now surpasses many government targets for health care quality as well as measured private sector performance.

For 16 of 18 clinical performance indicators, critical to the care of veterans, and directly comparable externally, VA is now the benchmark. This includes use of beta-blockers after a heart attack, breast and cervical cancer screening, cholesterol screening, immunizations, tobacco screening and counseling, and multiple aspects of diabetes care.

These improvements don't just look good on paper; they save lives, reduce hospitalizations, preserve function, lower costs, and satisfy patients. By the way, VA is essentially identical to the best private sector health care performance on the last two indicators.

Our performance measurement program creates a framework for accountability, specifying the improvement we will achieve, not simply recording where we have been.

The recent Institute of Medicine study entitled "Leadership By Example," lauded VA's approach to translating the best scientific evidence of research into increasingly effective patient care. Quoting from the study, "VA's integrated health care information system, including its framework for using performance measures to improve quality, is considered one of the best in the nation."

VA's research program is specifically directed toward ensuring that the best science reliably informs our patient care, and that our research portfolio increasingly focuses on the clinical and health services research that specifically addresses the needs of Veterans.

VA is widely recognized as a leader in such research areas as aging, women's health, AIDS, post-traumatic stress disorder, and other mental health issues.

Our partnership with 107 medical schools and 1,500 other health professional training programs ensures that we bring state-of-the-art thinking to patient care.

Conversely, as VA improves technologies such as computerization, advances account-

ability through measurement, and develops delivery models that better address patient needs, we improve health care for the country, as sixty percent of all health professionals, and 70 percent of physicians, experience some portion of their training in VA.

VA now has nearly 1,300 sites of care and provides health care services at locations much closer to where our patients live. Eighty-seven percent of VA's patient population now lives within 30 minutes of a VA medical facility. VA is providing care to nearly 48 percent more veterans than it did in 1997. At the same time, we have reduced the cost of care per veteran by 26 percent, not by cutting corners, but by delivering care more efficiently and more effectively.

Toward this end, VA is implementing management initiatives that will produce an unprecedented offset to the overall cost of the projected growth in workload and utilization.

We have undertaken a rigorous competitive sourcing plan to determine whether commercial activities should be performed in-house using government facilities and personnel, or with private procurement processes.

In addition, we continue to implement aggressive strategies to leverage our purchasing power, standardize equipment and supplies, ensure that any provider working part-time for VA provides services for every hour paid by VA, and maintain other management costs at or below 2003 levels. VA will also achieve efficiencies at the local level.

While transforming VA health care to a more efficient, effective, and accessible system, VA has become an industry leader in customer satisfaction, as is shown by its consistent benchmark-level scores on the American Customer Satisfaction Index, an econometric measure of government and private sector customer satisfaction. It is also noteworthy that VA medical facilities' average accreditation scores exceed those of private sector facilities.

VA continues to place a strong emphasis on comprehensive specialty care for which it has long been highly respected within the medical community, but we now also emphasize coordination of care through the universal assignment of primary care providers.

With this transformation to a primary care delivery model, and by employing new models of care coordination and delivery, veterans have gained access to an integrated health care system, focused on addressing their health care needs before hospitalization becomes necessary.

In the past year, top leadership in DoD and VA created a Joint Executive Council that developed an overarching shared vision for the future and began to implement changes.

The Departments have made unprecedented progress in sharing/coordinating medical care resources. Two of the President's priorities are jointly underway which will greatly enhance the seamless delivery of services to veterans – the information technology efforts on enrollment systems and electronic patient records.

Many impressive collaborations have been made in other areas such as shared facilities

and equipment, coordinated human resources, procurement, and other common business practices and training. We have shown significant progress and expect continued results as we coordinate the delivery systems beyond that experienced in the past.

The changes in the VA health care system have been profound, and the benefits have been recognized both inside and outside the Department.

We provide better care to our nation's veterans, closer to their homes, and using the latest technology.

However, we also face significant challenges, which we must meet to assure that our nation maintains a comprehensive, integrated health care system for all veterans who choose to come to VA for their care.

Resources and Demand

Because of the successes we have had in transforming VA health care and because of problems of coverage and availability of some services in the private sector, VA is experiencing an unprecedented demand for health care services.

In FY 2002, VA enrolled approximately 800,000 additional veterans bringing the enrollment in the veterans health care system to nearly 6.5 million veterans.

In FY 1996, VA provided care to 2.7 million veterans. In FY 2002, the number of veterans who received VA care increased to nearly 4.3 million. For FY 2003, we currently project that we will provide care to approximately 4.6 million veteran patients.

It is clear that continued workload growth of the magnitude we have seen in recent years is unsustainable. VA has been unable to provide all enrolled veterans with timely access to health care services because of the tremendous growth in the number of veterans seeking VA health care.

During the past year, the Secretary took steps to assure that VA would afford priority access to veterans with service-connected disabilities. He has recently announced additional steps that are necessary for the system to adequately serve all its patients and, in particular, to ensure that VA has capacity to care for veterans for whom our Nation has the greatest obligation: those with service-connected disabilities, lower-income veterans, and those needing specialized care.

Fully recognizing the extraordinary service that veterans have rendered to their fellow Americans, the Administration's budget for fiscal year 2004 will, we understand, seek a significant increase in VA medical care funding.

As the demand for services from the Department continues to grow at a substantial pace, the Department must, of course, allocate its limited resources according to the priorities set by law.

Accordingly, on January 17, 2003, the Secretary announced that, while it will continue to enroll veterans in the top seven priority groups that it serves, the Department must take steps to limit enrollment of new patients in Priority Category 8. Specifically, the Secretary has stated that the VA will enroll all priority groups of veterans, except those veterans in Priority 8 who were not in an enrolled status on January 17, 2003, or who request disenrollment on or after that date.

To understand the wisdom of the decision to limit enrollment of certain persons in Priority Group 8, it is important to understand the Priority Group system established by law for the Department. Our priorities are as follows:

Priority Group 1
- ß Veterans with service connected disabilities rated 50% or more disabling.

Priority Group 2
- ß Veterans with service connected disabilities rated 30% - 40% disabling.

Priority Group 3
- ß Veterans who are former POWs.
- ß Veterans awarded the Purple Heart.
- ß Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty.
- ß Veterans with service-connected disabilities rated 10% or 20% disabling.
- ß Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation".

Priority Group 4
- ß Veterans who are receiving aid and attendance or housebound benefits.
- ß Veterans who have been determined by VA clinicians to be catastrophically disabled.

Priority Group 5
- ß Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds.
- ß Veterans receiving VA pension benefits.
- ß Veterans eligible for Medicaid benefits.

Priority Group 6

All other eligible veterans who are not required to make co-payments for their care, including:
- ß World War I veterans;
- ß Mexican Border War veterans
- ß Veterans solely seeking care for disorders associated with:
- ß exposure to herbicides while serving in Vietnam; or
- ß exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
- ß for disorders associated with service in the Gulf War or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.
- ß Compensable 0% service-connected veterans.

Priority Group 7
- ß Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and income below the VA's Geographic Means Test.

Priority Group 8

- ß Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and the VA Geographic Means Test threshold.

Thus, it is clear that the decision regarding limitation of enrollment of certain persons in Priority Group 8 reflects a sound application of limited resources to priorities.

Let me emphasize that those in Priority Group 8 who were enrolled prior to January 17 are not affected by the limited enrollment decision and may continue to receive health care from VA.

We believe that the difficult decision to limit enrollment of certain persons in Priority Group 8 had to be made in order to maintain the quality of the health care we provide to currently enrolled patients and those higher-priority veterans who have yet to enroll.

It will allow the VA to refocus the mission of the health care system and rebuild the capacity of the system to provide for the tertiary care and special needs of the service-connected, low income, and special needs veterans, as well as future veterans who may suffer significant disability resulting from combat service.

On a related point, the Secretary has announced that work is underway with the Department of Health and Human Services (HHS) to determine how to give Medicare eligible Priority Group 8 veterans who cannot enroll in VA's health care system access to a "VA+Choice" Medicare plan.

To accomplish this, VA could contract with a Medicare+Choice organization, and eligible veterans would be able to use their Medicare benefits to obtain care from VA. Additional details will be forthcoming as we work out the details of this approach. We are hopeful that the "VA+Choice Medicare" plan will become effective later this year.

Waiting Lists

During much of the past year, we had over 300,000 patients on waiting lists to receive medical care. Currently, about 201,000 veterans are on waiting lists. It should be noted that these numbers are not static. New enrollees join the list, even as enrollees come off of the waiting list to become new patients in the system.

While the enrollment decision will serve to reduce the number of veterans who will be allowed to enroll in the VA health care system, we must continue our efforts to reduce and eliminate excessive waits. VA has made a concerted effort to reduce waiting times and is fostering multiple efforts including:

- ∑ Developing the Advanced Clinic Access (ACA) initiative in collaboration with the Institute for Healthcare Improvement: The core of ACA is a training program that provides strategies and change concepts to assist clinic staff make their processes more efficient to reduce wait times, improve access, and decrease costs.
- ∑ Developing a national Waiting Times Web Site and computerized wait list and schedul-

ing package: This effort enhances measurement of wait times for every patient seeking access to VA services and improves scheduling, efficiency and effectiveness, and

- ∑ Developing monitors to identify the percent of active patients assigned to primary care providers and the percent of primary care provider capacity that is utilized by active patients.

Despite all of these efforts, we now must recruit additional primary care and specialty provider staff in order to keep pace with the current demand for care and assure our ability to meet the comprehensive needs of the veterans we serve.

Improved Health Management

Although our efforts to reduce waiting times have been highly successful, we must continue to find better ways to deliver health care.

Historically, health care in this nation has been managed from the perspective and needs of the provider. As a hospital system, we waited until veterans required hospital care. Even now, we schedule appointments based on the provider's best guess of when the patient will need to be seen and when an appointment might be available, not based on when the patient actually requires care.

We're not alone; this is the approach taken by most health care systems today. However, we believe that better health care management strategies are now possible.

We must find new ways to partner with patients to more effectively manage health and disease processes continuously, 24 hours a day, 365 days a year. We need to be able to see the patient "just in time" when a complication or need starts to develop.

This shift constitutes a fundamental change in how we view health care and this approach will have a groundbreaking impact on both primary care and long-term care. While the impact on primary care and the management of many chronic conditions will be substantial, the impact on long-term care will be even more profound, especially as we are a system that will experience a 200 percent increase in veterans over 85 years of age by decade's end.

Institutional long-term care is very costly and may impair a long-term spousal relationship and reduce overall quality of life. Long-term care should focus on the patient and his or her needs, not on an institution. The technology and skills exist to meet a substantial portion of long-term care needs in non-institutional settings.

In those situations where long term care in the veteran's home is not practical, assisted living facilities may meet the needs of veterans and their spouses.

VA recognizes that assisted living facilities are used in the private sector as a lower cost alternative to institutionalization, and more importantly, as an option which keeps the pair bond between the husband and wife intact, providing a higher quality of life. VA currently is operating an assisted living pilot project and will evaluate the significant impact of the pilot in terms of

quality of care, veteran satisfaction, and cost.

VA must leverage its leadership in computerization and advanced technologies to better provide patient-centric care. Technology is increasingly available to provide the limited health care that is needed to support long-term care for many veterans in their homes or in assisted living facilities.

Technology can be used to monitor how patients feel and whether they are taking their medications properly. Technology can also be used to monitor various health status indicators in the patient's home, such as blood pressure, blood glucose levels for diabetics, and weight for patients with heart failure.

With tele-health support, many of our nation's veterans will be able to stay in their homes or in assisted living facilities with their spouses in the towns where they have a support network. Nursing home care should always be the option of last resort, where it is medically infeasible or inadvisable for a veteran to receive care at home or in an assisted living facility.

To oversee many of the initiatives needed to implement a patient-centered model for primary and long-term care, I have instructed creation of a Care Coordination Office. Although the final responsibilities of this office are still under consideration, it will have in its charge such things as the use of technology in care coordination and the development and implementation of policy and initiatives in chronic disease management and long term care.

But while there is much that VA can do on its own, there are also legislative impediments that need to be addressed. First, we must revisit the long-term care capacity provisions implemented by the Veterans Millennium Health Care and Benefits Act (Millennium Act).

Currently, only VA-operated and VA-staffed extended care programs may be considered for purposes of meeting the capacity requirement for institutional and non-institutional extended care. For more than 30 years, however, VA has developed a continuum of institutional and non-institutional services to meet the extended care needs of veterans, including VA-provided, contracted, and state home-provided services.

In FY 2002, for example, approximately 70 percent of VA's institutional nursing home care occurred in contract community and state home nursing homes. Also in FY 2002, approximately 37 percent of VA's total extended care patient population was served in non-institutional settings.

The availability of these programs has improved access and created choices for veterans who have family and social support systems far from VA nursing home facilities. As a result, the quality of remaining life in this group of veterans has increased significantly. I believe that the capacity requirement should better reflect VA's current direction in the provision of long-term care.

Recruitment and Retention

To work down the waiting lists, and to continue to provide the quality and safety our

veterans deserve, and to provide care with the efficiency that the budgetary environment demands, we need to be able to recruit and retain appropriate health care professionals.

National nursing leaders and health care organizations are projecting a shortage of registered nurses that will be unlike any experienced in the past. The current and future numbers of professional, registered nurses may be insufficient to meet our national health care needs. At the same time, changes in health care delivery will require larger numbers of well-educated nurses who perform increasingly complex functions in hospitals and the community.

VA expects to face increasing challenges in maintaining its nursing workforce and we must remain competitive in pay and workforce innovations.

VA is also facing a critical situation in which its compensation system for physicians and dentists is unresponsive to the demands of the current market. The effect of noncompetitive pay and benefits is seen in dramatic increases in VA's scarce-specialty, fee-basis, and contractual expenditures. In addition, the short supply of some clinical subspecialties in the medical community is causing rapid increases in salaries, benefits, and perquisites.

VA's special pay authorities have not been revised since 1991. VA's current pay authorities are stretched to the maximum, and the Department can no longer offer competitive salaries for these medical sub-specialists. More importantly, the current statutory compensation structure does not offer a way for VA to link physician and dentist compensation to quantitative and qualitative outcomes.

We are currently developing a comprehensive workforce improvement proposal that would improve our ability to recruit and retain physicians, nurses, and other health care occupations. The Administration expects to submit this proposal by late spring of this year.

This proposal will be vital to our ability to recruit the additional providers needed to increase our capacity, eliminate waiting lists, and refocus on our core mission of comprehensive care for service connected, low income, and special needs veterans.

Mr. Chairman, the current state of VA health care is excellent, but we still have much to do to maintain that excellence and build upon it in order to provide the right services, at the right time, and in the right place to the veterans of the 21st century. My vision of the future of VA health care is positive, but to realize that vision, we must address head-on the challenges I have outlined and do so deliberately, or we risk a different future.

This concludes my statement. While I cannot answer any specific questions regarding the content of the FY 2004 President's Budget that will be released next week, I will now be happy to answer any other questions that you and other members of the Committee might have.

Robert H. Roswell, M.D.
Under Secretary for Health
"Protecting the Health of Deployed Forces: Lessons Learned from the Persian Gulf War"
Statement before the Committee on Government Reform
March 25, 2003

Mr. Chairman, I am pleased to be here to testify before the Subcommittee on "Protecting the Health of Deployed Forces: Lessons Learned from the Persian Gulf War." With me today is Dr. Craig Hyams, VA's Chief Consultant for Occupational and Environmental Health.

Since nearly 250,000 U.S. troops are engaged in renewed conflict in the Gulf region, I am grateful for the opportunity to emphasize that VA today is better prepared to provide high quality health care and disability assistance than at any other time in our history.

Since Operations Desert Shield/Desert Storm in 1991, VA has developed and implemented the following policies and programs in response to the lessons learned from that conflict.

Health Care, Surveillance, Education and Outreach

Health Care following Combat

It is critical to provide informed, knowledge-based health care after every war. Congress has shown an appreciation for the importance of providing health care for combat veterans.

Under 38 U.S.C. § 1710(e)(1)(D), added by Public Law 105-368, VA is authorized to provide health care for a two-year period to veterans who serve on active duty in a theater of combat operations during a period of war after the Gulf War, or in combat against a hostile force during a period of hostilities after November 1, 1998.

Under this provision, all veterans of conflicts now have a two-year period of access to VA health care for any illness, regardless of whether there is sufficient medical evidence to conclude that the illness is attributable to that service. An exception to this general rule occurs when VA has found that a particular condition is not due to the period of service in question.

Veterans of the current conflict with Iraq will be eligible for health care under this provision of law. Although they may be deemed to be serving in the Southwest Asia Theater of Operations during the Gulf War era, our special authority to provide treatment to such veterans expired December 31, 2002 (38 U.S.C. 1710(e)(1)(C)).

In addition to providing needed health care, VA has the capability to collect and analyze information on the health status and health care utilization patterns of veterans. The capability to collect this basic health information helps us evaluate specific health questions, such as determining the causes of difficult-to-explain symptoms experienced by some veterans returning from certain combat theaters or areas of hostilities.

VA's medical record system now permits patient health information to be tracked for special groups of veterans. Moreover, standard health care databases allow VA to evaluate the health care utilization of veterans every time they obtain care from VA, not just on the one occasion that they elect to have a registry examination, as was the practice in the past.

This will provide a much broader and longer-term assessment of the health status of these veterans because many veterans return frequently for VA health care and are often seen in different clinics or even different parts of the country for specialized health care.

Ensuring High Quality Post-Deployment Health Care

Specialized health care during the post-deployment period can help prevent long-term health problems. Therefore, VA has developed evidence-based clinical approaches for treating veterans following deployment.

Newly developed Clinical Practice Guidelines (CPG's), which are based on the best scientifically supported practices, give health care providers the needed structure, clinical tools, and educational resources that allow them to diagnose and manage patients with deployment-related health concerns.

Two post-deployment CPG's have been developed in collaboration with DoD, a general purpose Post-Deployment CPG and a CPG for unexplained fatigue and pain.

Our goal is that all veterans who come to VA will find their doctors to be well informed about specific deployments and related health hazards. Information on Clinical Practice Guidelines are available online at www.va.gov/environagents. This web site also contains information about unique deployment health risks and new treatments.

Assessment of Difficult-to-Diagnose Illnesses

We have learned that sustained clinical care and research is needed to understand post-deployment health problems. Congress also understood this need and in legislation enacted as Public Law 105-368 required establishment of a plan to develop national centers for the study of war-related illness and post-deployment health issues.

Subsequently, in 2002, VA established two such centers, known as "War-Related Illness and Injury Study Centers" (WRIISC's), in East Orange, N.J., and Washington, D.C., to provide specialized health care for veterans from all combat and peace-keeping missions who suffer difficult-to-diagnose but disabling illnesses.

These centers are available through referral to veterans from all eras, including veterans of a future war with Iraq. These centers also provide research into better treatments and diagnoses, develop education programs for health care providers, and develop specialized health care programs to meet veterans' unique needs, such as the National Center for PTSD.

The majority of veterans returning from combat and peacekeeping missions are able to make the transition to civilian life with few problems. Most who come to VA for health care receive conventional diagnoses and treatments, and leave satisfied with their health care.

Nevertheless, VA has learned that some veterans have greater problems on their return to civilian life, and a small percentage of them develop difficult-to-diagnose symptoms. The two WRIISC's focus on determining the causes and most effective treatments for difficult-to-diagnose symptoms, problems seen in veterans of all wars. More information on the WRIISC's can be found at the VA website, www.va.gov/environagents.

Veterans Health Initiative

VA has built upon the lessons learned from our experiences with Gulf War and Vietnam veterans' programs to implement an innovative new approach to health care for veterans.

The Veterans Health Initiative (VHI) is a comprehensive program designed to increase recognition of the connection between military service and certain health effects, to better document veterans' military and exposure histories, to improve patient care, and to establish a database for further study.

The education component of VHI prepares VA health care providers to better serve their patients. We have completed modules on spinal cord injury, cold injury, traumatic amputation, Agent Orange, the Gulf War, PTSD, blindness/visual impairment and hearing loss, and radiation. We are currently developing modules on infectious disease health risks in Southwest Asia, sexual trauma, traumatic brain injury, and military occupational lung disease.

These important tools are integrated with other VA educational efforts to enable VA practitioners to more quickly and accurately arrive at a diagnosis and to provide more effective treatment.

Enhanced Outreach

Outreach is critical, and the Gulf War made clear the value of timely and reliable information about wartime health risks for veterans and their families, elected representatives, the media, and the nation at large.

VA has already developed a brochure that addresses the main health concerns for military service in Afghanistan and is preparing another brochure for the current conflict in the Gulf region.

These brochures answer health-related questions that veterans, their families, and health care providers have about these hazardous military deployments. They also describe relevant medical care programs that VA has developed in anticipation of the health needs of veterans returning from combat and peacekeeping missions abroad.

Another challenge for outreach is to address the specific concerns of veterans and their families over the potential health impact of environmental exposures during deployment. Veterans also have questions about their symptoms and illnesses following deployment.

These concerns are addressed through newsletters and fact-sheets to veterans covering health and compensation issues, including environmental health issues; regular briefings of veterans service organizations; organization of national meetings on health and research issues; media interviews; other educational material and websites with information, like www.va.gov/environagents.

Recruit Assessment Program (RAP)

Based on the Department's experience providing health care and benefits to Gulf War veterans, VA recognizes the critical importance of health documentation and life-long medical records that cover pre-, during-, and post-deployment period.

Previously, new health problems among Gulf War veterans were not readily verifiable due to a lack of detailed computerized records documenting enlistment and pre-deployment health status. Research efforts to understand Gulf War veterans' illnesses were also hampered by inadequate base-line health information, and inadequate documentation of health status during active duty.

DoD and VA have recognized these shortcomings and are attempting, through development and implementation of the Recruit Assessment Program (RAP), to collect comprehensive baseline health data from all U.S. military recruits.

The RAP is a DoD program, which is under development with the support of VA. The goal is for the RAP to be the first module of a life-long health record for military personnel and veterans. The RAP will help DoD and VA to evaluate health problems among service-members and veterans after they leave military service, to address post-deployment health questions, and to document changes in health status for disability determination.

It is important to note that during the last two years all U.S. Marine Corps recruits initially trained on the West Coast have completed a RAP questionnaire as part of a pilot RAP development program. Therefore, baseline health data is available for over 31,000 Marines, many of whom are currently serving in the Gulf region.

VA Vet Center Program

VA's Vet Centers, originally conceived to provide a wide variety of readjustment services to Vietnam veterans, have been invaluable in providing similar services to veterans from more recent combat and peacekeeping missions.

More than 115,000 veterans of Operations Desert Shield/Desert Storm have made use of their services. We fully expect that the VA Vet Centers will be available to help both veterans of the current hostilities in Afghanistan and Iraq and veterans of future conflicts elsewhere in the world.

Disability Compensation

To assist in disability determinations, VA has actively worked with DoD to develop separation physical examinations that thoroughly document a veteran's health status at the time of separation from military service and that also meet the requirements of the physical examination needed by VA in connection with a veteran's claim for compensation benefits.

VA has also worked to provide fair compensation for Gulf War veterans with difficult-to-diagnose illnesses. Under 38 U.S.C. § 1117 (as amended by Public Law 107-103), VA has authority to compensate Gulf War veterans for chronic disabilities resulting from an undiagnosed illness or certain medically unexplained chronic multisymptom illnesses.

It is our belief that servicemembers serving in the Southwest Asia Theater of Operations during the current conflict with Iraq would, as veterans, also be eligible for compensation for disabilities resulting from undiagnosed illnesses.

Coordination with the Department of Defense

Enhanced Interagency Collaboration

One of the important lessons learned from addressing Gulf War health issues was the need to significantly increase intergovernmental coordination among VA, DoD, and Department of Health and Human Services (HHS).

The initial Government response to Gulf War veterans' concerns about their illnesses was not effectively coordinated among these Departments. As a consequence, the Persian Gulf Veterans Coordinating Board (PGVCB) was established in January 1994. This board, consisting of representatives from VA, DoD, and HHS, was created to coordinate Federal efforts in the areas of research, clinical care, and benefits.

The initiation in 2000 of the tri-agency Military and Veterans Health Coordinating Board (MVHCB), replacing the PGVCB, served to institutionalize future interagency cooperation.

In 2002, the MVHCB was disbanded and a special deployment-health working group of the VA-DoD Health Executive Council was established to further its work and ensure continued interagency coordination for all veteran and military deployment health issues. Governmental coordination will continue to play a critical role in addressing health problems among veterans in future conflicts and peacekeeping missions.

Increased collaboration has also extended beyond America's borders and strengthened coordination with Military and Veterans Affairs agencies in other countries. On post-war health issues, such as those arising after Operations Desert Shield/Desert Storm, VA scientists and policy makers collaborate and share lessons learned with their counterparts in Canada, the United Kingdom, and Australia.

Because of the similarity of health problems among war veterans of different countries, these collaborations have focused on difficult-to explain-symptoms that consistently arise among military personnel returning from hazardous deployments.

Transmission of Health Data between DoD and VA

VA and DoD are closely collaborating to develop the ability to share medical information electronically. Recently, the VA/DoD Joint Executive Council and Health Executive Council approved the adoption of the Joint VA/DoD Electronic Health Records Plan.

This Plan provides for the exchange of health data and development of a common health information infrastructure and architecture supported by common data, communications, security and software standards, and high performance health information systems.

Since June 2002, the Departments have successfully been sharing electronic medical information. Key initiatives in the Electronic Health Records Plan are the Federal Health Infor-

mation Exchange (FHIE) and HealtheePeople (Federal).

FHIE (formerly known as the Government Computerized Patient Record) provides historical data on separated and retired military personnel from the DoD's Composite Health Care System (CHCS) to the FHIE Data Repository for use in VA clinical encounters, and potential future use for aggregate analysis.

Patient data on laboratory results, radiology reports, outpatient pharmacy information, and patient demographics are now being sent from DoD to VA via secure messaging. This first phase of FHIE is fully deployed and operational at VA medical centers nationwide. The next phase is currently being deployed and includes admission discharge transfer data, discharge summaries, allergies, and consult tracking.

HealthePeople (Federal) is a strategy to achieve full interoperability among Federal health information systems, starting with the ability to provide a two-way exchange of health-related information between VA and DoD by 2005.

VA and DoD are collaborating on several important health information applications in moving toward HealthePeople (Federal). Taken together, they will permit the Departments to offer a seamless electronic medical record.

- ß Clinical Data Repository/Health Data Repository (CHDR): This project seeks to ensure the interoperability of the DoD Clinical Data Repository with the VA Health Data Repository by FY 2005.
- ß Consolidated Mail-Out Pharmacy: The Departments are testing a system that allows VA to refill outpatient prescription medications from DoD's Military Treatment Facilities.
- ß Lab Data Sharing and Interoperability: VA and DoD are testing an application that will allow both Departments to combine resources and provide laboratory services to one another.
- ß Credentialing: A project team has identified common credentialing data to be exchanged between the DoD and VA. Software is being jointly developed and there are plans to begin testing at three sites by 4th Quarter FY 2003. This will decrease the time and resources needed to credential providers who need to practice in both health care systems.
- ß Scheduling: VA and DoD are sharing technical requirements to ensure interoperability between scheduling applications of each Department. This will allow providers to see all appointments a patient might have scheduled at both VA and DoD facilities and, where authorized, to schedule appointments in each other's clinics.
- ß E-portal Systems: The Departments are collaborating on a joint acquisition of health content for their electronic web portal systems. This will provide uniform patient health information to VA and DoD beneficiaries.

Deployment Health

VA applauds the efforts of DoD to prevent health problems among deployed troops and to provide immediate care for combat casualties. However, just as DoD has made substantial progress preventing morbidity and mortality on the battlefield, we also need to focus greater attention on the long-term health problems of veterans after the war.

The trauma of warfare has lasting effects. The physical and psychological wounds of war can heal slowly, and toxic exposures on the battlefield may have enduring health consequences long after the actual war has ended.

The key to addressing the long-term needs of veterans is to improve medical record-keeping and environmental surveillance. To provide optimal health care and disability assistance after the current conflict with Iraq, VA needs the following:

- a complete roster of veterans who served in designated combat zones; and
- data from any pre-deployment, deployment, or post-deployment health evaluation and screening of deployed troops.

Furthermore, in the event Iraq uses weapons of mass destruction against U.S. troops, it will be vital for VA to have as much health and environmental information as possible on potential exposures and their health effects in order to provide appropriate health care and disability compensation for veterans of this conflict.

Ideally, information would be available from representative environmental samples, biological samples obtained from exposed troops, clinical data from exposed troops who seek medical care, and data from an epidemiological survey of symptoms and illnesses among potentially exposed troops.

Summary

A veteran separating from military service and seeking health care today will have the benefit of VA's decade-long experience with Gulf War health issues.

VA has successfully adapted many existing programs, improved outreach and education, and readjustment counseling services for Gulf War veterans. VA now has significance experience with the special provisions in law authorizing disability compensation for Gulf War veterans.

In collaboration with other federal agencies, VA has additionally initiated new programs for developing and coordinating federal research on veterans' health questions.

The Department of Veterans Affairs has learned many lessons since Operations Desert Shield/Desert Storm. The Federal government is committed to caring for deployed service members both during deployment and after they leave military service.

Mick Kicklighter
Director, Office of Policy, Planning and Preparedness
Battle of the Bulge Commemoration Program
September 1, 2002

As our Nation commemorated the 50th anniversary of World War II, it was my honor to work with this organization on many occasions, and have the pleasure of getting to know many of you. I am very privileged to have some very special friends in this room tonight.

The last time we were together was in St. Louis, at the 50th anniversary of the Battle of the Bulge, where Dr. Bill Perry, Secretary of Defense, provided your keynote address. He and Mrs. Perry were very honored to have been with you that night.

I am also proud to represent the Department of Veterans Affairs tonight, and also to have another opportunity to help a grateful Nation continue to thank the veterans of World War II – and especially the veterans of the longest and one of the most critical battles in World War II.

Winston Churchill called this, "the greatest American battle of the Second World War."

Before the start of World War II, President Franklin Delano Roosevelt stated in a speech: "To some generations much is given. Of other generations, much is expected. This generation of Americans has a rendezvous with destiny."

And you did.

You fought and won the most destructive war in history. This room is filled with America's greatest heroes.

Although the winds of war were all around us when we were hit with a surprise attack on Sunday morning, December 7, 1941, at Pearl Harbor, Hawaii, we were not ready for that war. We had to buy time to get ready, and we bought that time with the lives of young Americans. We should never have to do that again.

At the start of World War II, we were fighting against great odds. Our Armed Forces were very small and poorly equipped. As an example, the U.S. Army was about number 17th in the world in size.

After December 7, 1941, Americans answered their Nation's call to arms. Our Armed Forces expanded very rapidly. They came from the farms, from the small towns, and from the cities. Never has our Nation been more united.

Almost overnight, our industrial might was converted to produce the guns, planes, ships and tanks needed to fight that war. We also supported our allies with badly needed supplies and equipment, which helped them to stay in the war.

Our enemies did not believe this miraculous transformation was possible. Every American – whether it was Rosie the Riveter who left home to work in our factories; boy scouts who gathered scrap metal; or families who planted victory gardens or bought victory bonds – everyone supported the brave fighting troops at the front – we were one Nation united. We were one Nation standing with our allies against this great evil.

During the months following D-Day, the U.S. military forces had great success on the battlefield in Europe. Early in December 1944, the American soldier's morale was high and their spirit was sustained by the belief that the war was almost won.

The allied forces were pushing the Germans out of France and the Low Countries. The Russian army was closing in on the eastern front. The Americans and British air campaign was very successful. The Italian peninsula had been liberated. And, in southern Europe, the Rumanians and Bulgarians had hastened to switch sides and join the Russians.

Hitler knew the end was close at hand, if the allied advance could not be halted. He commanded his general staff to develop a plan to conduct a major offensive to stop the allied advance. Germany's senior military leaders opposed the plan. But, as usual, Hitler overruled his military commanders.

The plan was bold and masterful, and was supported with German's best remaining combat hardened troops.

More than a million troops fought in that battle:

- The major forces were 500,000 Americans,
- 55,000 British, and
- 600,000 Germans.

There were more than 200,000 casualties:

- American: 81,000 casualties with 19,000 killed in action and more than 23,000 taken prisoner;
- The British had 1,400 casualties, 200 killed in action;
- The Germans had 100,000 killed or wounded.

The German army launched a powerful counter offensive in the Ardennes. The plan was to drive through the allied forces and split them in half, thereby forcing a negotiated peace.

In the preface to the official DoD military history, "The Ardennes: Battle of the Bulge," the author states:

"The mettle of the American soldier was tested in the fires of adversity and the quality of his response earned for him the right to stand shoulder to shoulder with his forebears of Valley Forge, Fredericksburg, and the Marne."

He goes on to say: "this is the story of how the Germans planned and executed their

offensive. It is the story of how the high command, American and British, reacted to defeat the German plan once the reality of a German offensive was accepted. But, most of all, it is the story of the American fighting man and the manner in which he fought a myriad of small defensive battles — until the torrent of the German attack was slowed and diverted, its force dissipated and finally spent.

"It is a story of squads, platoons, companies and even conglomerate scratch groups that fought with courage, with fortitude, with sheer obstinacy, often without information or communications or the knowledge of the whereabouts of friends."

As late as December 15th 1944, the allied forces believed that the German forces could not possibly assemble the forces needed for a serious counterattack.

The Ardennes was called "a ghost front." A quote from the daily situation report of the U.S. VIII Corps for December 15th read: "there is nothing to report."

But that illusion was about to be shattered. Without detection, the Germans assembled an attacking force that numbered more than 200,000 men, 1,000 tanks, 2,000 artillery pieces, and a reserve force that numbered more than 300,000.

Early on the morning of December 16th, the Nazi troops stormed through the thinly defended, stark woods of the Ardennes. Many of you in this room met that attack head on. Others were on airfields waiting for the weather to clear. The allied forces were caught totally by surprise.

The battle was launched with an all out attack against the five divisions of the 1st U.S. Army. The attack was led by the Fifth (5th) and Sixth (6th) Panzer Armies. They committed 20 divisions against five U.S.

The Sixth (6th) Panzer Army pushed north while the Fifth (5th) Panzer Army pushed south. The Sixth (6th) Panzer Army attacked the two southern divisions of U.S. V Corps at Elburn ridge, but made very little progress.

At the same time, the Fifth (5th) Panzer Army was attacking the U.S. VIII Corps, some 100 miles to the south. U.S. VIII Corps had only recently arrived in Europe. They were quickly surrounded.

Gen. Omar Bradley, known as "the soldier's general," stated that: "Bravery is the capacity to perform properly, even when scared half to death." As you also know, Gen. Bradley was also the first Chairman of the Joint Chiefs of Staff, and the first Administrator of the Department of Veterans Affairs.

On December 17, the U.S. 7th Armored Divisions engaged the Sixth Panzer Army at Saint Vith, which was the road that led to the Meuse River and to Antwerp. The Americans were successful in slowing the Germans down and altering the timing of their attack plan.

The same day, 140 Americans were taken prisoner, and 86 were executed while on

a road headed for Maimed. Of the 140 men taken prisoner, 43 managed to survive and tell the story of what happened. The Maimed massacre was the worst atrocity committed against American troops in Europe. Word of the massacre spread quickly through the American divisions, causing the Americans to stiffen, even more their resolve.

Bastogne was a strategic position. The Germans and Americans both wanted to occupy these key cross roads. This led to a race between the U.S. 101st Airborne Division and the German forces. The Americans got there first, but the Germans were not far behind and quickly surrounded the U.S. forces and laid siege to the city.

On December 22, German troops under the flag of truce delivered a message from their commander demanding surrender of Bastogne. LTC. Harry Kannard (Div. G-3) drafted the response of one word, "nuts." Brigadier General McCauliff, Acting Division Commander, approved and signed the reply.

When the German commander had difficulty translating the response, the messenger told the Germans it meant they "could all go to hell."

Many American units were surrounded and cut off, and the only way they could get supplies was by airdrops. At this time, the weather was so bad, aircraft could not get off the ground. The American troops survived the best they could, hoping and praying for better weather.

They were relieved when the VII Corps moved down and enlarged the U.S. line. This allowed General Patton's Third Army to counterattack the Germans surrounding Bastogne. And, at 1650 hours on December 26, the 4th Armored Division linked up with the 101st Airborne Division.

The allies launched a counteroffensive two days before the new year. It involved the Third Army striking to the north — with the First Army pushing to the south. The plan was for the two armies to link up and trap the German forces.

The fighting was tough. Day after day, soldiers trudged through the snow. Newspapers were put under clothes as added insulation.

On January 1st, Hitler launched a plan he called "The Great Blow." The goal was to eliminate allied air power. German fighter planes swarmed over Belgium, Holland, and northern France. For more than two hours, allied airfields were bombed. The U.S. lost 206 aircraft and many bases lay in ruin. Hitler's plan did a great deal of damage, but, in the end, he paid a devastating price. The German luftwaffe lost 300 planes and 253 of his best pilots.

On January 8, Hitler ordered his troops to withdraw from the tip of the Bulge.

By January 16th, the Third and First Army linked up and the allies now controlled the front. On January 23, Saint Vith was retaken, and finally, on January 28th, the Battle of the Bulge was over. Hitler's last-ditch attempt to win the war had failed.

This allied victory, achieved at a very high price, meant that Germany's final defeat was only months away.

If you had not won this battle, the final solution would have been – the final solution. There would have been no survivors in the death camps.

The Battle of the Bulge could have been a great defeat had it not been for the courage and dedication of the men and women in this room. This decisive victory broke the back of the German army.

There were 32 Medals of Honor awarded for this battle. You and your comrades paid a very high price in blood. With some 80,000 U.S. casualties, the Battle of the Bulge was the bloodiest battle in American history – bloodier than Antietam, bloodier than Gettysburg; bloodier than Pearl Harbor; and bloodier than Normandy.

The veterans of the Battle of the Bulge, and so many more of your brothers and sisters in World War II, fought some of the toughest battles ever recorded in military history. You fought these battles and won the war and not only saved this Nation, but you literally saved the world.

Many of your brothers and sisters never returned home. They gave all their tomorrows so that we could live in peace and freedom. And that is a very high price to pay when you are only 18 or 19 years old.

You came home, took off your uniforms, and said very little about the war. You rolled up your sleeves and went to work. Some went back to school on the GI Bill, and together you built this strong, free and beautiful America that we are privileged to wake up in each morning.

It has been said that any Nation that forgets its veterans soon ceases to be a great Nation. America will never forget its veterans.

Tom Brokaw wrote a book about World War II veterans and he titled it "The Greatest Generation" — he got it right.

At the close the 20th century, the New York Times was attempting to identify the most outstanding person of that century. They turned to Stephen Ambrose, one of our great historians, for his recommendation. Without hesitation, professor Ambrose recommended the one person who, based on all his research and writing, had made the greatest impact during the past 100 years. Would it be Eisenhower? Truman? Churchill? FDR? Gandi? King?

The only nomination made by Stephen Ambrose was "GI Joe" — the World War II veteran.

Ambrose told the New York Times that these very young men did not fight for fame or fortune. They fought for right. They fought to save their way of life.

Wherever the World War II veterans were stationed, they were respected and loved for their many acts of kindness — by sharing food, passing out candy, and providing medical support. The World War II veterans knew what they were fighting for – to destroy evil and restore good.

The 20th Century's most outstanding person is all around us tonight. They are from all ethnic backgrounds, all faiths. The most outstanding person of the 20th Century is the World War II veteran! It is you!

This great Nation is – once again – at war. The world was changed forever on September 11, 2001, and we now face a new evil.

The tragedies of September 11th were horrible, but they did not intimidate the American people. It revived our spirit. America is more unified than ever, once again united against a great evil.

As in the past, our Armed Forces will not let us down. They will protect and preserve this great Nation, and the American people will continue to live in freedom. And they can't take that away.

In one of his many books on the history of World War II titled, this one titled, "The Victors," Stephen Ambrose wrote:

"At the core, the American citizen soldiers [of World War II] knew the difference between right and wrong, and they didn't want to live in a world in which wrong prevailed. So they fought, and won, and we, all of us, living and yet to be born, must be forever profoundly grateful."

We thank you for your courage against great odds. And we thank you for your service to our country. We salute you – and we will never forget what you accomplished. We will strive to be worthy of this great gift that came at such a high price.

Let there be no doubt – this Nation will live up to your legacy as we – once again — stand united as one Nation fighting against another great evil – "terrorism."

May God continue to watch over the United States of America, and other peace and freedom loving people all over the world. God bless you and bless your family. God bless America.

Ruth J. Mahnken, M.S.S.W
Professional Staff Member, House Committee on Veterans' Affairs, Oversight and Investigations Subcommittees
Women's Equality Day Program
VA Central Office, Washington, DC
Aug 26, 2002

Greetings! I wish to thank Ivonne and the VA Federal Women's Program for inviting me to speak to you today.

We are here, on the 31st Women's Equality Day, to "Celebrate Women's' Right to Vote." I, for one, do not take for granted the fact that I can step into a voting booth and pull some levers, or punch some holes, although nowadays I can't be quite sure as to what happens to that vote after I open the curtain.

One thing I am sure of, and that's the 19th Amendment:

"The right of citizens of the United States to vote shall not be denied or abridged by the United States or by any state on account of sex. Congress shall have the power to enforce this article by appropriate legislation."

Two sentences that changed the lives of women in this country; two sentences fought for by generations of women in the attempt for true equality.

I would like to begin by presenting an historical perspective on the struggle our foremothers had in attaining equal rights. I ask that you listen not with 21st century minds; put yourself in the minds of Susan B. Anthony, Elizabeth Cady Stanton, Carrie Chapman Catt, all the others on the forefront and in the background of women's suffrage, and remember:

The struggle was not only for the vote; it was hard fought for property rights; for equal access to education and employment, for fair wages and for recognition that women are not second class citizens. The first woman in the North American colonies to demand the vote was Margaret Brent, the owner of extensive lands in Maryland. In 1647 Brent insisted on two votes in the colonial assembly, one for herself and one for Cecil Calvert, Lord Baltimore, whose power of attorney she held. When the governor denied her request, Brent boycotted the assembly.

During the second Continental Congress, in 1776, Abigail Adams entreated her husband John to "remember the ladies" in the new code of laws he is writing.

In 1790, New Jersey granted the vote to "all free inhabitants," but in 1807, New Jersey women lost their right to vote, through a repeal sponsored by a politician who was nearly defeated by a female voting block ten years earlier. Even in colonial times women were exercising their political will. I like that, seeing that one of those Jersey girls might have been my ancestor.

The world's first women's rights convention was held in Seneca Falls, New York, July 19 and 20, 1848. A Declaration of Sentiments and Resolutions was debated and ultimately signed by 68 women and 32 men, setting the agenda for the women's rights movement that followed.

In 1855, Lucy Stone became the first woman on record to keep her own name after marriage – shocking in those times. Also, the University of Iowa becomes the first state school to admit women.

The fight for woman's right to vote was set aside during the Civil War, as women suffragists assisted in anti-slavery efforts, and supported their brothers in arms, with some joining them on the battlefield.

The 14th Amendment was passed by Congress in 1866 (ratified by the states on 1868); the first time "citizens" and "voters" were defined as "male" in the Constitution.

The women's right movement in the 19th century was not as unified as we would think. There were 2 main groups; one who fought on the state level, and another whose goals were to achieve a Federal amendment for the woman's vote. The 2 groups merged in 1890 to focus their efforts to win the right to vote.

In 1870, the 15th Amendment receives final ratification. By its text, women are not specifically excluded from the vote. During the next two years, approximately 150 women will attempt to vote in almost a dozen jurisdictions from Delaware to California, including Sojourner Truth in Battle Creek, Michigan. In South Carolina, a few African-American women, protected by Reconstruction officials, cast ballots.

In 1872, through the efforts of lawyer Belva Lockwood, Congress passes a law to give women federal employees equal pay for equal work.

In 1879, Belva Lockwood is the first woman lawyer admitted to practice before the U.S. Supreme Court. Her years of lobbying pay off when Congress passes legislation permitting women to practice law in all federal courts. She is also the first woman to receive votes in a presidential election, running as a candidate of the National Equal Rights Party.

In 1883, Mary Hoyt earns the top score on the first civil service exam and becomes the first woman (and second person) appointed under this new merit system. She starts out as a clerk in the Treasury Department.

In 1889, the work of educated women serving the Chicago poor at Hull House establishes Social Work as a paid profession for women.

In 1893, Colorado is the first state to adopt a state amendment enfranchising women.

Nannie Helen Burroughs' speech to the National Baptist Convention in 1900, "How the Sisters are Hindered from Helping," results in the formation of the Women's Convention, which becomes the largest African-American women's organization.

In 1911, Jovita and Soledad Pe?a organize La Liga Femenil Mexicanista (League of Mexican Feminists) in Laredo, Texas. Its motto: "Educate a woman and you educate the family."

Alice Paul and Lucy Burns organize the Congressional Union in 1913, which later becomes the National Women's Party. Members picket the White House and engage in other forms of civil disobedience, drawing public attention to the suffrage cause. On March 3 of this year, over 5,000 suffragists parade in Washington D.C., drawing people away from newly-elected President Wilson's arrival in the city. They are mobbed by abusive crowds along the way.

The women of Finland receive the right to vote in 1916. Before World War I women in Norway and Denmark also enjoyed the right to vote. Swedish women were not enfranchised until 1919.

During World War I, U.S. women move into many jobs working in heavy industry such as mining, chemical manufacturing, automobile and railway plants. They also run streetcars, conduct trains, direct traffic, and deliver mail.

Jeannette Rankin of Montana becomes the first woman elected to the U.S. Congress in 1917.

In January 1917, National Woman's Party pickets appear in front of the White House holding aloft pro-suffrage banners. They remain there despite frigid weather or violent public response. In October, 168 NWP members are arrested and convicted for peacefully picketing the White House, becoming the first U.S. citizens held as political prisoners. In prison, they staged hunger strikes and were force-fed. In response to public outcry, they are eventually released without comment or pardon.

In 1918, women over the age of 30 in Britain are enfranchised; 10 years later all British women achieve the right to vote.

1919 - Congress passes the 19th Amendment – in the House the vote was 304-89; the Senate passes it with just two votes to spare, 56 to 25.

But – 36 states had to ratify the amendment before it could become law. By the summer of 1920, only one more state was needed – Tennessee. When, on August 18, it appeared that Tennessee had ratified – the result of one 24-year-old legislator from the mountains, Harry Burn, who changed his vote at the insistence of his elderly mother, official ratification was delayed due to parliamentary tricks. Finally, Tennessee reaffirmed its vote for ratification, and the 19th Amendment was officially added to the U.S. Constitution on August 26, 1920 – 82 years ago today.

Most of the world's women have been granted the right to vote only since World War II.

The United Nations enacted the Covenant on Political Rights of Women in 1952. It was the first instrument of international law to state that in all nations women should be entitled to

the vote and to hold political office. Nonetheless, women in Kuwait, Saudi Arabia and other nations are not allowed to vote. Since 1954, numerous International United Nations Conventions have been held to protect and further women's rights throughout the world.

The civil rights movement in America in the 1960s and 70s galvanized women to fight for more than voting rights.

At the behest of Rep. Bella Abzug (D-NY), in 1971 the U.S. Congress designated August 26 as "Women's Equality Day." The Joint Resolution reads in part:

WHEREAS, the women of the United States have been treated as second-class citizens and have not been entitled the full rights and privileges, public or private, legal or institutional, which are available to male citizens of the United States; and

WHEREAS, the women of the United States have united to assure that these rights and privileges are available to all citizens equally regardless of sex; and

WHEREAS, the women of the United States have designated August 26, the anniversary date of the passage of the Nineteenth Amendment, as symbol of the continued fight for equal rights: and

WHEREAS, the women of United States are to be commended and supported in their organizations and activities,

NOW, THEREFORE, BE IT RESOLVED, the Senate and House of Representatives of the United States of America in Congress assembled, that August 26th of each year is designated as Women's Equality Day.

What about today? Yes, "we've come a long way, baby," BUT - we have a ways to go, and here's where I get a little feisty. Please remember the following two issues as I continue:

- ÿ The Equal Rights Amendment was first presented in Congress in 1923. Never ratified, and repeatedly brought up in Congress, women today are still fighting for the rights and privileges available to all citizens equally.

- ÿ The Census Bureau reports that in the year 2000, there were 6 million more women in the United States than men.

Education: "The National Coalition for Women and Girls in Education's" June 2002 report, "Title IX at 30: Report Card on Gender Equality," lists the following items needing Room for Improvement:

- ÿ Sexual harassment remains pervasive in public schools – 81 percent of students surveyed have experienced it.
- ÿ Sex segregation persists in career education, with more than 90 percent of girls clustered in training programs for the traditionally female fields of health, teaching, graphic arts, and office technology.
- ÿ Just 21 percent of all full professors at colleges and universities are women.
- ÿ For every new dollar going into athletics at the Division I and II levels, male sports receive 65 cents while female sports receive 35 cents.

- ÿ Women receive only 20 percent of computer science and engineering-related technology bachelor's degrees.
- ÿ Female students typically get less attention, praise, criticism, and encouragement from teachers than male students get.
- ÿ The lower test scores of African American females, Native American females, and Latinas compared to their white and Asian peers remains a serious and deep educational divide.

Military and Veterans:

There are over 200,000 women on active duty in the military; over 210,000 in the Guard and Reserves.

More than 40,000 American women served in the war against Iraq. The Marine Corps awarded twenty-three women the Combat Action Ribbon for service in the Persian Gulf War because they were engaged by Iraqi troops. Desert Storm was a huge turning point for women, and it showed that modern war boundaries between combat and non-combat zones are being blurred.

The 1990 census reported 1.2 million female veterans, the fastest growing veteran population. How many women here today are veterans? How many are active duty military? How many access the VA for services? How many have checked the "veterans preference" box when applying for a job? As a female disabled veteran, I for one would like to see, if not a female Secretary, than at least a female Under Secretary for Veterans Affairs. Maybe someday…

Congress enacted the Equal Pay Act (PL 88-38) in 1963. Despite the many improvements in women's economic status, wage discrimination exists:

Where I work, in the House of Representatives, as reported on the 2000 House Staff Employment Survey, the split between female and male staffers is almost even, and in House district offices, the ratio of female to male staff is 2 to 1. Yes, females are far more heavily employed in Congress than in other sectors (56 % overall). Among Federal civilian employees, 45.5% are women, and 46% of the U.S. labor force is female.

But there is a glass ceiling on the Hill. 65% of Legislative Directors are male, and 60% report that their level of responsibility is the same with respect to the given job description. Compare that to Office Managers, what one would consider to be a traditional female position: 86% are female, and 65% report that they perform more duties than prescribed in their job description. They also got paid $22,000 less in 2000.

What's it like in your workspace? How many female SES's do you know, or work for?

Wage discrimination persists despite women's increased educational attainment, greater level of experience in the workforce, and the decreased amount of time spent out of the workforce raising children.

According to a 2001 study by the Institute for Women's Policy Research, the gender wage ratio, which had remained virtually constant from 1955 through the 1970s, began to

increase in the 1980s. For full-time year-round workers, the ratio of women 's median annual earnings to men 's increased gradually over the 1980s, reaching 71.6% in 1990. The ratio is currently holding steady at around 73%.

- ÿ The median earnings for a Hispanic woman with a college degree are $3,504 less than the median earnings for a non-Hispanic white man with just a high school education.
- ÿ On average, a woman who has a Masters' Degree makes $6,456 less than a man with a college degree.
- ÿ The median wages of female college graduates fall behind those of male college graduates by $15,297.

Legislative Arena:

In the United States, women's unique experiences and shared concerns may be ignored in the policymaking process due to their under representation in elected office.

As of spring 2002, women hold 13 of the 100 seats in the U.S. Senate and 60 of the 435 seats in the U.S. House of Representatives – the percentage of women in Congress grew from 3% in 1979 to 14% overall in the last election cycle. Three states are represented in the Senate by women only: Maine, California and Washington.

I don't want to get TOO political, but next time there's a major vote on the House or Senate floor, watch CSPAN and count how many women are represented on either side of the aisle. A picture is worth a thousand words.

Women make up just 22.4 percent of state legislatures and are just 5 of 50 governors across the country.

On an aggregate level, women's presence in legislatures and other state-level elected offices is closely associated with better policy for women. This suggests that having women in elected office may be important to encouraging states to adopt policies relevant to women's lives. Conversely, women's resources and rights may influence the number of women elected to public office.

What can we do now to further the cause of women's rights in the 21st century?

GET EDUCATED:

Study the issues important to you, your family, your community, your country, and the world.

GET INVOLVED:

Check out women's organizations, your political party of choice, women in leadership roles, to find out what they are doing to advance women's rights.

Last, but not least: VOTE! Who here today lives in the District? How do you feel about not having true representation in Congress? Who lives in Maryland or Virginia? What do you think about your school systems, your taxes? Your commute? Are your representatives on the local, state or Federal level doing all they can about the issues important to you?

Ask your relatives, friends and neighbors if they're registered to vote:

In 1996, 67.3% of women eligible to vote were registered; 55.5% actually voted.

I consider my vote a hard fought privilege, and the most basic tool for creating change in this country.

Remember:

71 days until the General Election: November 5, 2002.
The Maryland and DC primaries are Tuesday, September 10.
You must be registered to vote for the general election by 10/7/2002.

Thank you very much, and I hope we all can celebrate true equality as we move forward in the 21st century.