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Policy Implications of Demographic Changes in the VHA Veteran Population Following OEF/OIF

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Abstract:

The US Department of Defense (DoD) and the US Department of Veteran's Affairs (VA) are the two institutions responsible for the medical care of military personnel and Veterans. DOD major policy and operational personnel changes impact the VA by modifying the characteristics of Veterans presenting at the VA for medical health care. The challenges to VA resulting from DOD changes over the past four decades include managing the large influx to the VA of aging Veterans; accommodating the Veterans from OEF/OIF; responding to the expanded role of female service members in DoD; accepting increased numbers of National Guard and Reserve Components resulting from extended deployment and expanded operational role.

INTRODUCTION

In the United States (US), the US Department of Defense (DoD) and the US Department of Veteran's Affairs (VA) are the two institutions responsible for the wellbeing and welfare of Veterans especially those military members who have been injured while serving on active military duty. Medical care is provided by the DoD's health service system for military service members in the combat theater for injuries or other medical conditions sustained while deployed. Other service members that have combat-related medical conditions are treated after they return from war either in the DoD's health care system for active-duty personnel or in the VA for Veterans and Reserve and National Guard Components (RC).

Prior to 1811, the U.S. States and communities in which the Veterans resided provided direct care to Veterans. The U.S. Federal Government provided the first direct benefit to Veterans in the form of medical care and established the first resident medical facility for Veterans. In the later part of the 19th century, the Federal Government extended its Veterans assistance program to include pensions and benefits for the surviving dependents of Veterans. The turning point for Veterans benefits came in 1917 at the commencement of World War I. The U.S. Congress established an extensive system of programs including disability compensation and rehabilitation for disabled and wounded Veterans. By the 1920s, the Veteran benefits were administered by three agencies of the Federal Government, the Veterans Bureau, the Bureau of Pensions of the Interior Department, and the National Home for Disabled Volunteer Soldiers.

The US Congress established the VA in 1930 and authorized the President to consolidate the activities of all government institutions dealing with war Veterans. With

the advent of World War II and the large number of personnel serving in the war, VA was forced to deal with a massive influx of Veterans into the system. To reward the Veterans for their service to their nations and to deal with their needs, Congress enacted a large number of new benefits for them most significantly the World War II Servicemen's Readjustment Act of 1944, commonly referred to as the GI bill of 1944. Benefits included low-cost mortgages, low-interest loans to start a business or farm, cash payments of tuition and living expenses to attend college, high school or vocational education, as well as one year of unemployment compensation. Further acts were passed for the benefit of Veterans of the Korean Conflict, the Vietnam Conflict, and finally the All-Volunteer force. In 1989 and as an indication of its importance, the Department of Veterans Affairs was established as a Cabinet level position.

The VA provides benefits to Veterans through several divisions, the Veterans Benefits Administration, the National Cemetery Administration, and the Veterans Health Administration (VHA) the division responsible for providing health care services and treating eligible Veterans for service connected conditions and other ailments. The VHA operates the largest health care system in the US maintaining an extensive system of hospitals, nursing homes, residential rehabilitation treatment centers, and community based outpatient clinics. The VHA health care benefits are funded by discretionary allocations that Congress reviews every year and VA funding has more than doubled from $21 billion in 2001 to about $53 billion for 2013.

Across all military services in the US, there are over 1.4 million active duty military personnel serving and there are approximately 23 million Veterans in the US (United States Census Bureau, 2011). For the majority of these Veterans, the period of

military service is relatively brief, averaging about 6.5 years. In the National Survey of Veterans (Department of Veteran's Affairs, 2010), 69 percent of Veterans are over 55 years old; 92 percent are male; 34 percent of respondents reported having served in a combat or war zone; 19 percent of female Veterans reported serving in a combat zone compared with 34 percent of overall Veterans; 47 percent of respondents reported that they had served in the Army; 23 percent reported service in the Navy; 20 percent reported service in the Air Force; 10 percent reported that they served in the Marine Corps; 15 percent of deployed were from the National Guard or Reserve Components (RC); 12 percent served after September 11.

The US has deployed more than 2 million troops to active war duty in Afghanistan and Iraq, conflicts labeled Operation Enduring Freedom and Operation Iraqi Freedom (OIF/OEF). Not every Veteran is automatically entitled to health care for life from the VHA and access to health care is established by a system of priorities and eligibility categories defined in the Veteran's Health Care Eligibility Reform Act of 1996, P.L. 104-262. The act defined eligibility for benefits as primarily determined by the individual's active duty military service and the individual's being discharged under conditions other than dishonorable. Under the Veterans Programs Enhancement Act of 1998, Public Law 105-368, service members who have served on active duty in combat operations since November 1998, including the RC, are eligible to access services through the VHA system for a two year period after separating from active military service. Congress, in 2008, extended the period of eligibility after separation from two years to five (Congressional Budget Office, 2010). The extension of health care benefits is primarily in recognition that certain medical conditions, especially Traumatic Brain

Injury (TBI), may manifest after a period of time (Sayer, Rettmann, Carlson, & et al., 2009), (Department of Veterans Affairs and Department of Defense, 2008). The act enables service members who have been on active duty in combat operations since November 1998, including the RC, to be eligible to access services through the VHA system for a five year period after separating from active military service instead of the two years prior to the passage of the act. This effectively extends care to Veterans since the commencement of OEF/OIF (Congressional Budget Office, 2010). VHA will provide combat Veterans free medical care for any illness possibly associated with service for five years from the Veteran's discharge. After the five years, the Veteran is placed in one of eight Priority Groups. Veterans eligible for Priority Groups 1-6 are regarded as high priority and are eligible for health services. Veterans with service connected disabilities, Veterans with a compensable service connected condition, Veterans whose discharge was for a compensable disability incurred in the line of duty, Veterans who are POWs, Veterans awarded the Purple Heart, Veterans who are catastrophically disabled, Veterans with disorders resulting from hazardous agents, Veterans whose income is below a certain threshold are given priority for VHA health services and automatically placed in Priority Groups 1-6 depending on the rating of their disabilities. Those in Priority Group 7 are Veterans with non-service connected conditions and with incomes and net worth above a VHA mandated threshold. They are evaluated for eligibility on a case by case basis. The VHA suspend enrollment of Veterans in Group 8, those with high income and without military related disabilities, in 2003.

Insert Table 1

Although DoD and the VHA have different disability systems, they both rate disabilities based on the VHA Schedule for Rating Disabilities. Military members are given medical evaluations and assigned disability ratings in 10 percentage point intervals based on their medical condition. The disability evaluation process begins at a military treatment facility, when a physician identifies conditions that may interfere with a service member's ability to perform duties after receiving the maximum benefit of medical care. A medical evaluation board determines if the service member meets the military retention standards and can be returned to duty. Service members who do not meet the retention standards are referred to a physical evaluation board responsible for determining whether service members can perform their assigned military duties after being injured or ill. If the member is found unfit for duty and the condition was incurred or aggravated by military service the board assigns disability ratings. While DoD disability rating is permanent, the VHA ratings could change based on the Veteran's medical condition.

The population of Veterans with service connected disabilities consists of non-medical and medical military retirees, Veterans who receive disability severance, and disabled Veterans. Non-medical military retirees qualify for VHA medical care by completing 20 or more years of active duty service and retiring with some disability or a service related disability that develops after leaving active duty service. Medical military retirees are determined to be unfit for continuing military service by a physical evaluation board and discharged from the military due to injuries. Veterans who receive disability severance are those whose injuries are less severe and time in the military shorter than the non-medical or medical retirees. The other disabled Veterans category applies to Veterans who have less service time than retirees and are injured in the military but their

injury is not severe enough to preclude them from continuing their term of service. After leaving the military, they are eligible for military disability compensation for their injuries.

VHA has had to respond to major policy and operational personnel changes in DoD over the past four decades. The challenges to VHA resulting from DoD changes over the past four decades include managing the large influx to the VHA of aging Veterans; accommodating the Veterans from OEF/OIF; responding to the expanded role of female service members in DoD; accepting increased numbers of National Guard and Reserve Components resulting from extended deployment and expanded operational role.

THE AGING US VETERAN POPULATION

Over the past seventy years, the number of Veterans grew following the nation's involvement in World War II, the Korean conflict, and the Vietnam War, all of which used drafts to enlist military personnel (Amara, Hendricks, 2013). While the total number of Veterans peaked around 1980, it has generally declined since then as many older Veterans died and the military downsized at the end of the Cold War. However, the large cohorts from World War II (9 percent of Veterans), the Korean conflict (11 percent of Veterans) and the Vietnam War (34 percent of Veterans) still make up the majority of today's Veterans. In 2001, the US veteran population was 25.3 million, the majority of whom were 58 years of age or older. In 2012, most (55.5 percent) of the 21.8 million US Veterans are age 60 or older; only 5.5 percent are age 30 or younger (VETPOP 2007).

Insert Figure 1

The relatively stable or perhaps declining (Feickert & Henning, 2012) numbers of active military projected for the next few decades imply that the total number of Veterans will continue to decline through 2030 to about 14 million. By that time, the number of Veterans over age 75 will be greater than the number under the age of 40.

Insert Figure 2

The largest cohort of current Veterans, almost 7 million, is from the Vietnam War. Another 5.5 million or so are counted as "peacetime" Veterans with service between major conflicts. There are more than 3.4 million living Veterans from World War II and the Korean War combined, but in another twenty years, there will be virtually no Veterans still alive from either of these wars. About 2.5 million Vietnam Veterans will still be alive, but the rest of the Veteran population will have served from 1980 onward.

The concern about the nation's ability to provide medical care for service members returning from active war duty must be assessed in the context of the demands of the aging Veteran population on the system. For example the Vietnam War cohort outnumbers the OEF/OIF cohort more than threefold and is entering old age, the period of life with the greatest health burden from chronic disease. In fact, demand for immediate post-deployment services by the OEF/OIF Veterans is overshadowed nationally by the demands of the Korean and Vietnam War cohorts in terms of the number of patients and the average cost of care. The importance of the aging Veteran

cohort is apparent from Figure 2. The healthcare needs of these older Veterans are those of most elderly Americans with complex chronic conditions such as diabetes or heart failure. Elderly Veterans, however, often have additional complications from disabilities sustained during military service, including mental health disorders. These Veterans will continue to comprise most of the demand on VHA funding and services until the majority of World War II, Korean War, and Vietnam War cohort pass through the system. By 2030, Veterans from OEF/OIF will be middle-aged or older and will have additional disabilities that are not service-connected, but that will require health services nevertheless.

OEF/OIF Veterans

OEF/OIF are the first major large scale military engagements that the US has been involved in since the end of the Vietnam War, necessitating the deployment of large numbers of troops for extended periods of time. Since 2001, the US has deployed more than two million troops to Afghanistan and Iraq for OEF/OIF, often for more than one tour of duty (Tan, 2009). These conflicts mark a shift to a new form of warfare resulting in injuries and medical concerns that have been labeled "signature" injuries of OEF/OIF, in particular, traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). TBI is a structural injury or disruption in brain function caused by an external force. Blast exposure (e.g., from improvised explosive devices) is the most prevalent mechanism of TBI for OEF/OIF service members. Moderate to severe forms of TBI can be recognized by physical signs or functional limitations; however, mild TBI (commonly known as concussion) may go undetected for many reasons. PTSD is a stress reaction than can

occur after someone goes through a traumatic event like combat or a blast. PTSD symptoms usually start soon after the traumatic event, but they may not appear until months or years later. The symptoms also may manifest over many years.

Physical casualties in recent wars are far more numerous than deaths. Table 2 details the US military deaths and casualties from the Civil War to OEF/OIF. The table indicates the ratio of casualties to deaths increased over time starting at about one casualty per death during the Civil War and ending at about 7.5 casualties per death for OEF/OIF. This change can be attributed to the improvement in medical services, particularly those located close to hostilities, over the years. Battlefield medicine, evacuation procedures, and battlefield medical support services have evolved tremendously, leading to greater survival rates for troops. In addition, the very high ratio of casualties to deaths for OEF/OIF may be due in part to the use of body armor and helmets, among other changes. This protective gear shields the user from bullets and shrapnel, improving overall survival rates.

Insert Table 2

Despite the high ratios of casualties to deaths, the absolute number of disabled Veterans from OEF/OIF is small compared to the number of disabled Veterans from earlier actions. For example, Veterans from the Vietnam War era still comprise over 40 percent of today's disabled Veterans, in large part because the largest number of Veterans who are still alive served during those years. In addition, several important conditions were recognized as service-connected only after the Vietnam War adding to the ranks of the disabled. The primary one is PTSD, which the American Psychiatric Association

added as an official diagnosis only in 1980. Because this condition may not be recognized as disabling until years after a service member has become a Veteran, the number of Vietnam Veterans with disabling mental or emotional conditions far exceeds the 153,000 recognized by the military at the end of the war.

Although amputations have been prominent in the news, the absolute numbers for OEF/OIF Veterans are relatively small: fewer than 1,500 as of September 1, 2010 (Fischer, 2010). The majority of health complaints for both active duty military and Veterans are relatively mundane, such as gastrointestinal or musculoskeletal complaints such as back pain. For example, Deyton (2008) reported that the largest proportion (46.6%) of OEF/OIF Veterans accessing VHA health care had diagnoses for musculoskeletal conditions. Haskell et al., (2012) found that the odds for musculoskeletal and joint problems were even greater for female OEF/OIF Veterans compared to males.

The OEF/OIF wars are the most sustained combat operations since Vietnam. Two major Veteran health conditions stemming from these conflicts have received particular attention, TBI and PTSD. Neither of these is unique to OEF/OIF, but the needs of these two groups of patients have garnered attention. In the case of OEF/OIF, 15.6 to 17.1 percent of Veterans deployed to Iraq reportedly displayed symptoms of PTSD and 11.2 percent of Veterans deployed to Afghanistan reportedly did so (Hoge et al. 2004). Of the OEF/OIF Veterans who have used VHA services, however, almost 37 percent had a diagnosis for any mental health condition (Deyton, 2008). Within this broad category, PTSD was the most common diagnosis listed, with substance use disorders, major depression, and neurotic disorders also reported for at least a quarter of the patients

(VHA Office of Public Health and Environmental Hazards 2007). Among women OEF/OIF Veterans, PTSD is potentially identified for at least as large a proportion of women as men. According to the Defense and Veteran's Brain Injury Center (DVBIC), the facility that coordinates treatment and research for TBIs, from 2000 through the fourth quarter of 2011, 233,425 soldiers had a TBI, either combat- or non-combat-related. Non-combat-related brain injuries can result from vehicle accidents, falls, and blows that could occur during training, recreational activities or other pursuits. Symptoms of TBI may not be evident on first examination since some cases of closed brain injury are not diagnosed properly at the time and may manifest later (Okie 2005). DVBIC (2012) reports that 2.7 percent (over 6,000 cases), were penetrating or severe injuries and 76.7 percent (almost 180,000) were "mild". Another estimate is that 22 percent of wounded OEF/OIF soldiers have TBI (Lew et al., 2006).

Studies indicate that more frequent and more intense involvement in combat operations increases the risk of developing mental health problems (Office of the Surgeon Multinational Force, 2006). Due to the intensity of combat in OEF/OIF, returning veterans are at a high risk for mental health problems—specifically those resulting from TBI or PTSD. These two injuries often coincide. Because of its chronic nature, it is difficult to predict the pattern of utilization and therefore the costs for treatment of PTSD.

Outpatient treatment for mental health issues is the norm in VHA; some specialized residential treatment programs do exist, but these programs are not located in every state.

It is currently difficult to determine the amount of care that the OEF/OIF cohort requires and the burden this care will place on VHA because of all the politically

mandated changes in eligibility. Another complicating factor in determining the amount of care required is the nature, severity, and number of Veterans with PTSD and TBI. For example, depending on the sample and the measure of PTSD use, the range of estimates for OEF/OIF veterans with PTSD is between 15 to 40 percent. The spread between limits is so high that translating these percentages into lower and upper limits of utilization of VHA care is not policy relevant.

Female Veterans

Until 1973 and the move to an all-volunteer force, women made up less than one percent of the active forces. In contrast, women have comprised 10 to 20 percent of deployed personnel at different points in time during OEF/OIF with the total number of deployed female personnel reaching 283,000 since 2003, and over 20,000 females are deployed as of February 2012. Women constituted 14.4 percent of the active duty forces and 16.9 percent of those serving in the National Guard and Reserve Components as of September 30, 2009 (National Survey of Veterans, 2010; Department of Defense, 2009, 2011).

The numbers of women Veterans discharged from the military since 9/11 is now approximately 21 percent of all living women Veterans whereas the proportion for men is 9.9 percent. The proportion of female Veterans was 5.9 percent of all Veterans as reported in the 2001 National Survey of Veterans and increased to 8.1 percent in the 2010 National Survey of Veterans (Department of Veteran's Affairs, 2010). Women make up 8.7 percent of all living Veterans, almost 1.9 million individuals (VETPOP, 2007). However, they make up only 3.5 percent of the World War II, Vietnam, Korea Veteran

cohort. Women Veterans are younger than male Veterans; about half of women Veterans are currently younger than 50 while only about a quarter of the men are that young. This difference in age reflects increased military opportunities for women after the Vietnam War, which in turn increased the number of female recruits. Projections through 2030 show the total number of women Veterans increasing to over 2.1 million or one out of every seven Veterans (VETPOP, 2007). In 2009, the average age of VHA users was 48 years old for women and 63 years old for men (Frayne, et al., 2010). Among women veterans returning from OEF/OIF, 79 percent are age 40 or below and 50 percent are 30 or younger.

The pattern of usage of health care services also varies among women Veterans with a substantial proportion of the younger female Veterans accessing VHA. The 2010 National Survey of Veterans reports that all 58 percent of all female Veterans utilize VHA services; 8.4 percent of WWII female Veterans; 22 percent of Korean War female Veterans; 49 percent of Vietnam Era female Veterans; and 71 percent of female Veterans from the after September 11 era. In addition, their utilization patterns are unique with 28 percent of women Veteran using a women's health clinic or gynecology clinic at a VHA facility and 25 percent using a primary care clinic at a VHA facility.

The proportion of women veteran VHA patients with service-connected disabilities has increased over the past ten years. Over 50 percent of women veterans in VHA now carry some service-connected disability rating, making them eligible for lifelong VHA care for their service-connected conditions (Frayne, et al., 2010)

When considering the impact of DoD policy changes on women Veterans' use of VHA care, it is critical to consider the role of female service members during deployments in and around Iraq and Afghanistan. The absolute number of women involved in deployments to OEF/OIF has increased and the nature of their involvement in Afghanistan and Iraq and their assignments have changed along with changes in DoD policy. Women veterans of OEF/OIF are substantially more likely to seek VHA health care than women from previous eras. This influx of new women veterans represents a changing face of women in VHA. With more than two-thirds of the OEF/OIF cohort in reproductive age groups, there is a projected need for enhanced services across many domains. There is a growing need for reproductive health care, including attention to the issues of contraception and childbirth. These age groups also represent the peak years for utilization of mental health services among women. As such, there is a need for increased attention to access for mental health services, including treatment of war-zone exposures, and attention to couples and family issues that are especially relevant to women's adjustment.

Reserve Component

Each of the Armed Services, Army, Navy/Marines, and Air Force, in the U.S. military have both an Active Component and a Reserve Component (RC). The RC consists of the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air Force Reserve, the Coast Guard Reserve, the Army National Guard of the United States, and the Air National Guard of the United States. The purpose of the RC as codified in U.S. law, is to fill the gap in the ranks of the Active Duty U.S. armed services when

shortages exist. The reserves are activated to supplement regular armed forces during times of war or national emergency and provide trained units and qualified persons to serve.

There are important differences between the RC. The Army Reserve, Navy Reserve, Marine Corps Reserve, Air Force Reserve, and Coast Guard Reserve, commonly referred to as the Reserves, are part of the federal government of the U.S. and are under federal control. The Reserves were established in the 20th century under the constitutional authority of Congress to support and provide Armies and a Navy.

The Army National Guard and the Air National Guard, know as the National Guard, have both a federal and state role. In addition to providing trained personnel to the armed forces of the U.S., the Army National Guard and the Air National Guard, assist the states in responding to various emergencies, such as disasters and civil disorders. The National Guard is the modern evolution of the militias that existed in the U.S. colonial period before the establishment of the U.S. as an independent nation with a constitution. There are separate National Guard organizations for every state in the U.S. There are 50 National Guard organizations for the states and they are identified by the state name (the California National Guard, the Texas National Guard) and the state's governor controls each organization. Puerto Rico, Guam, the U.S. Virgin Islands, and the District of Columbia also have National Guard units. The District of Columbia National Guard is an exclusively federal organization and operates under federal control at all times. The other 3 National Guard organizations operate as territorial organizations.

Members of the RC play a major role in the military in the U.S. by combining a military career with a civilian career. They maintain their military skills by training on a

regular basis. The US military activated the RC at unprecedented levels during the engagements in Afghanistan and Iraq for OEF/OIF. Recent estimates of soldiers deployed in service of OEF/OIF indicate that nearly 40 percent of the forces deployed to the theatre of war were RC, with 87,525 serving on active duty on December 27, 2011. Approximately 850,000 men and women from the RC have separated from active duty and transitioned to civilian life since 2003, joining the newest generation of Veterans.

The RC has played an increasingly vital role in sustaining military operations. During the cold war era from 1945 to 1989, the RC was activated only four times. During the Korean War (1950-1953) 857,877 reservists were activated and 37,643 reservists were activated between 1968 and 1969 for the Vietnam War. In addition, there were short activations during the Berlin Crisis (1961-1962) and the Cuban Missile Crisis (1962) when respectively 148,034 and 14,200 reservists were activated. The nation has relied more heavily on the RCs since the end of the cold war for peacekeeping, nation building, and military operations. The RC was activated for federal service six times (Haiti, Bosnia, Kosovo, Persian Gulf War) over the past 21 years with the latest activation for the engagements in and around Iraq and Afghanistan. The National Defense Authorization Act for 2005 (P.L. 108-375) suggests that the deployment of the RCs will continue at a high rate. The change in statutory language, as explained in a House Armed Services Committee report (H. Rept. 108-491), revised the purpose of the RC and officially acknowledged the components' evolution from a strategic reserve force into an operational reserve force critical to supplementing active forces and making repeated extended combat deployments common. The operational role for the RC implies that large numbers of guard and reserve personnel will be called to active duty in the coming

years, underscoring the importance of understanding the post-deployment health and health care use patterns of this under-studied population.

Depending on the length of active military service and the conditions of their discharge, members of the RC, who serve on active duty and establish Veteran status, may be eligible for VHA care. Survey data reports that the vast majority of demobilized reserves have served after September 2001; 27 percent served between August 1990 and August 2001; 18 percent between May 1975 and July 1990; 4 percent in the Vietnam era from August 1964 to April 1975 (National Center for Veterans Analysis and Statistics, 2010).

With the cohort that served after September 2001 constituting the overwhelming majority of reserves with potential eligibility for health care service at the VHA, the pattern of their utilization of health services differs from the active components (Amara et. al., 2013). Statistics from the National Center for Veterans Analysis and Statistics, 2010 indicates that the primary services accessed (63 percent of the RC) are outpatients services for doctor visits, urgent care, routine exams, medical tests, or shots, 64 percent use dental care, 7 percent utilized inpatient stay in hospital, and none reported an overnight stay in a rehabilitation hospital or nursing care facility.

Summary

Over the past four decades the composition of the VHA patient population has shifted. Notably, the number of older Veterans, National Guard and Reserve Components, and women Veterans, especially young women, using VHA services has increased. This shift in population is likely the result of several factors, including the

change in policy on increasing the RC and women's military roles, expanded VHA eligibility for OEF/OIF Veterans, increased efforts for a seamless transition between DoD and VHA, significant outreach efforts, or other factors such as economic hardships.

The healthcare needs of the aging Korean and Vietnam War Veterans remains greater than the demands of the other three cohorts identified in this paper, OEF/OIF Veterans, women Veterans, and the RC. The average expenditure per VHA patient in fiscal years 2006-2009 was approximately $6,000 with over 95% of the patients from periods prior to OEF/OIF. During the same period, OEF/OIF Veterans use of VHA services was less than $3,000. This suggests that the demands and costs associated with the health care needs of aging Veterans are higher than that of the younger cohorts medical needs. In the short term, the most critically injured OEF/OIF Veterans and those with TBI and PTSD will require more health care than the average. However, in the long run, many of the less critically ill OEF/OIF Veterans will not continue to use VHA care. Most of these Veterans are young and relatively healthy and will utilize the health care system available to them outside the VHA. They will be quite indistinguishable from the rest of the U.S. population in terms of health care needs. Eventually, the aging OEF/OIF cohort will also require services for more chronic conditions but their numbers will be much less than their predecessors. Whether they utilize VHA services or not will depend largely on their disabilities and prevailing economic environment.

The members of the RC appear to have higher utilization rates of VHA services than their corresponding Active Duty Component. A possible explanation could be cases of malingering when they present to VHA clinicians. By reporting symptoms as related to possible combat exposure or by doing worse on neuropsychological tests, some RC may

try to establish a medical record to enable continuing access to VHA services. Utilizing the VHA and establishing a record of use of services could be a means of ensuring future access to medical services.

As the number of young women Veterans using VHA services increases, the need for clinical services appropriate for women will grow. The most important factor contributing to the level of comfort for women undergoing treatment is the availability of specialized treatment for women that focuses on gender sensitive care with attention to privacy. In addition, due to the younger age of this group, there is potentially an increase in demand for care at Women's Health Clinics that allow women to chose the gender of their health care provider and cater to specific needs such as gynecology.

The changing deployment patterns and demographics of Veterans will continue to present health care providers at the VHA with new challenges associated with caring for Veterans and understanding their differential needs.

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