STATEMENT OF
DENNIS MICHAEL DUGGAN, DEPUTY DIRECTOR
NATIONAL SECURITY/FOREIGN RELATIONS COMMISSION
BEFORE THE
SUBCOMMITTEE ON TOTAL FORCE
COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES
ON
FORCE HEALTH PROTECTION AND SURVEILLANCE IN THE GLOBAL WAR ON TERRORISM

FEBRUARY 25, 2004

Chairman McHugh and Members of the Subcommittee:

The American Legion, as the Nation's largest organization of wartime veterans, is pleased to appear before this Subcommittee to express its concerns with regard to the Department of Defense Force Health Protection (FHP) and surveillance efforts for service members deployed to Operation Enduring Freedom and Operation Iraqi Freedom. The American Legion is supportive not only of veterans, but national security issues and military quality of life concerns of the active duty military, Guardsmen, Reservists, military retirees, and their families. A lot of our first-hand observations come from the immediate families of Guardsmen and Reservists who have either deployed or have returned from deployments. Since the Persian Gulf War, The American Legion's Family Support Network has worked with literally tens of thousands of service members and their families.

As American military forces are once again engaged in combat overseas, the health and welfare of deployed troops is of utmost concern to The American Legion. The need for effective coordination between the Department of Veterans Affairs (VA) and the Department of Defense (DOD) in the force protection of U.S. forces is paramount. It has been thirteen years since the first Gulf War, yet many of the hazards of the 1991 conflict are still present in the current war.

A pretreatment for the nerve agent soman, pyridostigmine bromide (PB), was approved by the Food and Drug Administration just prior to the start of Operation Iraqi Freedom. Although its effectiveness is questionable, and it has not been ruled out as a possible cause of multi-symptom illnesses reported by thousands of Gulf War veterans, this treatment turned out to be unnecessary; however, PB available for use at commanders' discretion. The contentious anthrax vaccine is also being administered to deployed personnel and controversial depleted uranium munitions continue to play a large role in American combat operations.

Although Chemical and biological weapons have not been used against American troops in Afghanistan and Iraq, the potential for such an attack in future operations and deployments still exists. The American Legion is concerned about the ability of American military forces to operate and survive in a nuclear, biological or chemical (NBC) environment. During the 1991 Gulf War, the thousands of chemical detection alarms were later reported as "false alarms." The

ability to properly detect the presence of NBC agents in the area of operation remains a grave concern.

Just prior to Operation Iraqi Freedom, questions surfaced around DOD's ability to properly identify, track and locate defective chemical protective suits. In October 2002, the General Accounting Office (GAO) reported that in May 2000, DOD ordered storage depots and units to locate 778,924 defective suits produced by a single manufacturer. As of July 2002, military officials were unable to account for 250,000 defective suits. Responding to an American Legion inquiry, officials from the Deployment Health Support Directorate reported they "believed" the remaining defective suits had either been destroyed or used in training activities. The difficulty in locating the defective suits was a result of inventory records lacking contract and lot numbers. GAO also reported that DOD could not determine whether its older suits would adequately protect military personnel because some of the systems' records do not contain data on suit expiration. Finally, GAO reported that the risk of shortages of protective clothing might increase dramatically from the time of its report (October 2002) through at least 2007.

Prior to the 1991 Gulf War deployment, troops were not systematically given comprehensive pre-deployment health examinations, nor were they properly briefed on the potential hazards, such as fallout from depleted uranium munitions, that they might encounter. Record keeping was poor. Numerous examples of lost or destroyed medical records of active duty and reserve personnel were identified. Vaccines were not administered nor recorded in a consistent manner and records were often unclear or incomplete. Moreover, personnel were often not provided information concerning vaccinations or prescribed medications. Some medications were distributed with little or no documentation, including dosage instructions, information on possible side effects or instructions for service members to immediately report unexpected side effects to medical personnel.

Physical examinations (pre- and post-deployment) were not comprehensive and information regarding troop movements/locations and possible environmental hazard exposures was severely lacking. The lack of such baseline data and other information is commonly recognized as a major limitation in the evaluation and understanding of potential causes of the unexplained multi-symptom illnesses, referred to collectively as Gulf War veterans' illnesses, still plaguing thousands of Gulf War veterans thirteen years after the war. Although the government has conducted more than 230 research projects, at a cost of more than $240 million, lack of crucial deployment data has resulted in many unanswered questions. Unfortunately, many questions will probably never be answered.

The goal of DOD's FHP policies and programs is to promote and sustain the health of service members during their entire length of service. On the surface, the FHP concept and related policies appear to have addressed the major problems of the past. Unfortunately, reality may be a different story. In previous congressional testimony, officials from GAO reported that although DOD placed the responsibility for implementing its FHP policies with a single authority, the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness, each service branch is ultimately responsible for implementing DOD initiatives and policies to achieve FHP goals. GAO noted that this caused concerns about how the services would uniformly collect and share core data on deployments and how DOD will integrate information

on the health status of service members. According to GAO, DOD officials also verified that its medical surveillance policies and efforts depend on the priority and resources dedicated to their implementation.

The American Legion would like to specifically identify an element of FHP that deals with DOD's ability to accurately record a service member's health prior to deployment and document or evaluate any changes in his or her health that occurred during deployment. This is exactly the information VA needs to adequately care for and compensate service members for service-related disabilities once they leave active duty. Section 765 of PL 105-85 directed DOD to take specific actions to improve medical tracking for personnel deployed overseas in contingency or combat operations, outlining a policy for pre- and post-deployment health evaluations and blood samples. The conduct of a thorough "examination" (pre- and post-deployment), including the drawing of blood samples, was specifically identified in the law.

DOD initially created a brief health questionnaire for deploying and returning service members to fill out, contrary to the medical examinations as required by PL 105-85. The pre-deployment questionnaire, DD Form 2795, contained eight questions and the post-deployment questionnaire, DD Form 2796, contained six questions. The American Legion, in congressional testimony presented last year in the early days of Operation Iraqi Freedom, asserted that a self-reported health assessment questionnaire is not of the same value as an examination conducted by a physician or other medical officer. Self-reported health assessment is not necessarily an accurate, or reliable gauge of an individual's health status prior to or following deployment.

In response to immense concern over the brevity and usefulness of the health questionnaire, the Under Secretary of Defense for Personnel and Readiness issued an "enhanced" post-deployment questionnaire (DD Form 2796) on April 22, 2003. The pre-deployment questionnaire was not changed. Upon review, The American Legion did not see any significant changes. Although the new version is more detailed than the previous one, it still does not fulfill the requirement of "thorough" medical examinations nor does it even require a medical officer to administer the questionnaire or counsel participating personnel. The Under Secretary's guidance to combatant commanders specifically states that, in addition to a physician, physician assistant, or nurse practitioner, an enlisted independent duty corpsman or independent duty medical technician are also authorized to administer the questionnaire. This means that an actual physician or other medical officer may not even be part of the post-deployment health assessment process in at least some, if not most, instances. This is unacceptable.

Although DOD, as part of the "enhanced" post-deployment health assessment, now requires a blood sample be obtained from returning personnel no later than 30 days after arrival at their home station or demobilization site, DOD still relies on blood samples taken for human immunodeficiency virus (HIV) tests to fulfill the pre-deployment blood drawing requirement of PL 105-85. According to DOD procedure, deploying military personnel must be tested and found negative for HIV no more than 12 months before deployment on contingency operations. Although a specimen of serum used for this testing is stored at the DOD Serum Repository, the pre-deployment sample could be up to a year old, or older, and would, therefore, not be an accurate gauge of health immediately prior to deployment. This is unacceptable and should be re-evaluated.

According to DOD policy, commanders are responsible for ensuring compliance with and implementation of FHP programs and policies. In the fall of 2003, GAO reported on the Army and Air Force's compliance with DOD's FHP and surveillance requirements for personnel deploying in support of Operation Joint Guardian in Kosovo and Operation Enduring Freedom in Central Asia. GAO reviewed selected Army and Air Force bases, medical records of 1,071 service members (from a universe of 8,742) participating in these operations. GAO found noncompliance with FHP and surveillance policies for many active duty service members. This included required pre- and post-deployment health assessments, required immunizations and failure to maintain health-related documentation in a centralized location. Of the records reviewed, 38 to 98 percent were missing one or both of the pre- and post-deployment health assessments. The review also found that as many as 36 percent were missing two or more required immunizations. This is unacceptable and a disservice to these service members.

Additionally noted, many service members' medical/health records did not include health assessments found in DOD's centralized database nor did DOD maintain a complete centralized database of service members' health assessments and immunizations. GAO concluded the noncompliance problems it uncovered were the result of the absence of an effective quality assurance program at the Office of the Assistant Secretary of Defense for Health Affairs or at the Army or Air Force and reported that the centralized deployment database was missing information needed to track military personnel's movement in the theater of operations. As of July 2003, DOD's data center had begun receiving location-specific deployment information from the services and was in the process of reviewing its accuracy and completeness at the time GAO released its report. The American Legion is optimistic these corrections will be made, but believe timely verification is absolutely necessary.

As a result of its investigation, GAO recommended DOD establish an effective quality assurance program to ensure the military branches comply with the FHP and surveillance policies for all service members. DOD agreed with GAO's recommendation and informed The American Legion that it will create a Quality Assurance directorate under its Deployment Health Support Directorate. Its focus will be on ensuring compliance with FHP policies on pre- and post-deployment health assessments, immunization records and blood drawing for HIV and post-deployment assessments. Annual reports will be submitted to the Assistant Secretary of Defense for Health Affairs. The American Legion appreciates DOD's increased efforts to ensure its FHP policies and programs are fully and consistently implemented by each service; however, considering DOD's checkered history with respect to deployment health-related matters, The American Legion remains skeptical of its commitment. Continued noncompliance with required FHP policies will result in personnel deploying with health problems and or encountering delays and other problems in obtaining health care and VA benefits when service members return, not unlike problems experienced by the veterans of the first Gulf War. In order to avoid the problems of the past, DOD must make FHP a real priority and dedicate the resources necessary to ensure each service branch is in full compliance with all policies and directives.

Although military personnel participating in Operations Iraq Freedom and Enduring Freedom have not been exposed to chemical munitions fallout like their counterparts in Operation Desert Storm, some of the experiences have been similar. Once again, U.S. military forces have used

Depleted Uranium (DU) munitions. While exposure to DU fallout during Operation Desert Storm has not been definitively linked to Gulf War veterans' illnesses, it has not been definitively ruled out as a possible cause. The American Legion supports DOD's DU awareness training program. Avoiding DU fallout on the battlefield may be impossible, but informing troops about potential health hazards and instructing them to avoid unnecessary risks, such as entering an enemy vehicle destroyed by DU munitions, can help minimize potential health risk. It is vital that DOD conduct proper oversight to ensure that its DU education programs are being properly implemented by all of the military services.

The controversial anthrax vaccine continues to be an important part of the military's FHP program. The American Legion agrees with DOD's position to adequately protect military personnel against the threat of biological weapons attack, such as anthrax or smallpox. However, serious concerns with past problems associated with BioPort, the sole manufacturer of the vaccine, and the way adverse reactions are tracked and followed up by DOD, continue to worry The American Legion. Problems with BioPort's manufacturing facility caused a shortage of FDA approved vaccine, resulting in a slowdown of DOD's Anthrax Vaccine Immunization Program (AVIP). It has been two years since BioPort reestablished FDA approval. There continues to be a vaccine shortage resulting in only those service members on the ground in Southwest Asia for 15 days or more being vaccinated. The American Legion has long advocated a second manufacturer of the vaccine, as well as a newer vaccine, proven for efficacy and safety, and an inoculation period shorter that the current six shots.

The anthrax vaccine controversy has existed since the first Gulf War. Based on DOD's experience in tracking anthrax vaccinations, The American Legion is concerned. DOD claims, only 150,000 troops actually received the anthrax vaccine. Because of extremely poor record keeping, it can only verify vaccinations for less than 10,000. A similar controversy is emerging regarding the use of the anti-malaria drug Lariam. Several recent stories in the media about military personnel experiencing severe side effects, including depression and other psychological symptoms, after being prescribed Lariam. The military is obligated to follow strict protocol when administering Lariam, including counseling and documenting the drug in the service member's health record, service members have complained that such procedures have not been followed.

Lariam is only one of several anti-malarial drugs currently being used by the military; it is vital that its distribution is thoroughly documented to properly address and track side effects that may occur. If a service member suffers a chronic disability as a result of taking Lariam, but there is no documentation in the health record, proving service-connection becomes more difficult. This is especially true if the disability does not manifest, or was not identified, while the member was on active duty.

Due to the duration and extent of sustained combat in Operations Iraqi Freedom and Enduring Freedom, the psychological impact on deployed personnel is of utmost concern to The American Legion. The military has counseling available for those having difficulty coping with the aftermath of combat and other traumatic events. DOD needs to actively encourage troops to take advantage of such services. Counseling programs are useless unless service members feel that they can use them without adverse consequences to themselves and their careers. It is crucial for

commanders to publicly inform their troops that treatment and counseling for stress and psychological problems are okay and no adverse action will be taken against any individual seeking that care. Post Traumatic Stress Disorder (PTSD) often-manifest months or years after an individual has been removed from a traumatic event. There should be periodic follow up psychiatric evaluations for the active duty military and reservists upon return. The military should encourage treatment and counseling for those returning home. This is especially important for Reserve and National Guard personnel who are often quickly demobilized after returning from a deployment and do not have the same support system that is available to their active duty counterparts.

Military service is inherently dangerous and certain risks are to be expected. The American Legion believes the Federal government is obligated to provide health care and compensation to those who sustain chronic disabilities as a result of such service. Title 38, United States Code places the burden of proof in establishing a service-connected disability on the veteran and establishing service connection directly impacts the veteran's ability to access VA health care. VA's ability to adequately care for and compensate our nation's veterans depends directly on DOD's efforts to maintain proper health records/health surveillance, documentation of troop locations, environmental hazard exposure data, and the timely sharing of this information with VA.

The American Legion remains appalled at the numbers of Guardsmen and Reservists who were called to active duty and not deployable due to existing medical and dental conditions. Unquestionably, many Guardsmen and Reservists are included in that group of 40 million or more Americans who have no, or limited, medical coverage. Certainly, fault lies not only with Reserve Component commanders, but also active duty commanders for knowingly calling medically unready and non-deployable Reservists to active duty status.

For these reasons, The American Legion is strongly supportive of the Guard and Reserve Readiness and Retention Act of 2004, which would make all Guard and Reserve members and their families eligible for health coverage through TRICARE regardless of their mobilization status. Beneficiaries would pay a modest annual premium. This change would, we believe, improve individual and unit readiness and eliminate the need for Reservists and their families to change health care providers when mobilized. There should be a seamless transition from reserve status to active status and a seamless transition from DOD to VA. Also, during periods of mobilization, Reservists who opt to maintain private health care coverage, rather than TRICARE, would receive assistance in paying their health insurance premiums. This health care legislation would help with medical readiness for mobilization and pre-deployment, but it could also provide their post-deployment and post-deactivation health and dental care.

The American Legion strongly urges that Congress mandate separation physical exams for all service members, particularly those that have served in combat zones or have had sustained deployments. The American Legion believes this is essential because of oftentimes-inadequate medical record keeping and to ease accessing VA healthcare and applying for disability compensation and other veterans programs. DOD reports that only about 20 percent of discharging service members opt to have separation physical exams. Clearly, The American Legion believes separation physicals should not be optional. The American Legion understands

many of the reasons to opt out of a separation physical, but there is ample evidence to prove the importance these physicals or lack thereof plays in the VA claims process. Knowing the final health status of separating service members is also in the best interest of public health. During this war on terrorism and frequent deployments, with all their strains and stresses, this figure, we believe, should be substantially increased.

The American Legion strongly recommends that field hearings be conducted throughout the country to hear first hand accounts from those who served, including active, guard, reserve and family members to determine how FHP is working. Further, these hearings should not be held near large military installations.

Mr. Chairman, The American Legion thanks you again for the opportunity to discuss these important health care issues for the total force.