Why Treat the Wounded? Warrior Care, Military Salvage, and National Health

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Because the goal of military medicine is salvaging the wounded who can return to duty, military medical ethics cannot easily defend devoting scarce resources to those so badly injured that they cannot return to duty. Instead, arguments turn to morale and political obligation to justify care for the seriously wounded. Neither argument is satisfactory. Care for the wounded is not necessary to maintain an army’s morale. Nor is there any moral or logical connection between the right to health care (a universal human right) and the duty to defend one’s nation (a local political duty). Once badly wounded, soldiers enjoy the same right to medical care as any similarly ill or injured individual. National health care systems grasp this point and offer few additional health care benefits to veterans. In the United States, however, lack of universal health coverage skews the debate to focus on special entitlements for veterans without considering the health care rights that other citizens enjoy.

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Treating critically wounded soldiers poses an abiding challenge for military organizations. Historically, the seriously wounded have not always received the best care available. Throughout the 19th century, when many assumed that the modern, liberal state would care for citizen-soldiers conscripted for war, those seriously wounded enjoyed little or no medical care. They certainly never had care commensurate with the best care available at the time. But fighting the Russians in 1904, the Japanese demonstrated that then modern medical care – vaccinations, hygiene, speedy evacuation and antiseptic treatment – could significantly conserve their fighting force. With that, the Western armies took notice and pursued military medicine with unprecedented zeal. In the 20th century wars that followed, military medicine would provide the means to “salvage” significant numbers of troops and return them to duty. Military medicine, however, did not always offer a rationale for saving those so seriously wounded that they could not return to duty. The goal of military medicine is caring for those who can fight, not saving the lives of those who cannot. As a result, military medical ethics has no ready answer for caring for critically wounded soldiers.

During WWII, for example, there were great disparities between the medical thinking of the American and German army. The American army devoted 8.7% of its personnel to providing medical care; the Germans just half that. Nevertheless, both sides returned similar numbers of soldiers to duty. The real difference lay, however, in the number of lives medical personnel could save. Among the Americans, only 24 of every 1000 wounded died of their wounds, but among the Germans the number was more than 3 times higher (Bellamy 1985). The Germans did not provide more comfort care to those who suffered serious abdominal, chest and head wounds.

In the aftermath of the war, some American observers declared that the Germans had a “lower moral conception of the medical mission” than American personnel did because, for the Germans, “a seriously wounded man, who could not fight again, even if his life were saved, was not worth bothering with” (Wiltse, 1965). But the morality of providing care to those who cannot return to duty is far from obvious, particularly when the manpower and personnel necessary for care of the critically wounded may more effectively aid the war effort in other ways. The inability to justify extensive medical care to the seriously wounded stems from a fundamental conflict between the prevailing principles of military medical ethics and those of medical ethics in general. Military medical ethics is guided by the principle of military necessity and driven by the principle of “salvage,” that is, the imperative to return soldiers to duty and maintain their health. Soldiers who cannot return to battle fall under the purview of nonmilitary or civilian medicine. Unlike military medicine, nonmilitary medicine is governed by the laws of medical need and focuses its efforts on saving lives and maintaining quality of life.

Paradoxically, then, the best way to insure care for the seriously wounded may be to disregard their status as soldiers and focus on their status as patients. It is no accident that in those nations that offer their citizens national health care, military hospitals have largely disappeared and the radical distinction between military and civilian medicine is an anachronism. When soldiers are fit to fight, military
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The mission of the AMEDD [Army Medical Department] is to conserve the fighting strength...Combat health support maximizes the system’s ability to maintain presence with the supported soldier, to return injured, sick, and wounded soldiers to duty, and to clear the battlefield of soldiers who cannot return to duty.” (Department of the Army. 2000, Paragraph 1.1 (d). page 1-1.)

Salvage, not saving lives per se, is the major function of battlefield medicine. Salvage is a criterion of medical care unique to military medicine and reflects a specific and objective measure of quality of life that is distinct from the patient’s own subjective evaluation. In military medical ethics, “quality of life” is not a patient’s own assessment about how he or she may feel and function in the future, but a strict evaluation by others about a soldier’s ability to do his or her job.

If the purpose of battlefield medicine is salvage, the purpose of non-battlefield medicine is to provide the routine medical care that maintains the fitness of a nation’s armed forces. On and off the battlefield, military medicine fulfills a “medical readiness mission” that tests and screens recruits, provides emergency medical treatment of service personnel involved in hostilities and maintains the “physical standards” of military personnel (Best 2007). In all cases, military necessity – the imperative to wage war justly and effectively – guides medical care. As medicine provides military organizations with the means to fight, the collective welfare of the armed forces overrides the rights and welfare of individual soldier/patients. As a result, soldiers, unlike ordinary patients, have no right to refuse standard medical treatment that keeps them fit for service (Moskop, 1998, Gross, 2006:101-136). The hard question arises when soldiers are no longer fit for duty, whether on the battlefield or off. No longer part of the war effort and released from the dictates of military necessity, we are left to ask how military medicine should care for those who suffer service-related injuries that make them unable to fulfill their military duties.

The number of critically injured who cannot return to duty is sometimes difficult to determine. Typically, the majority of the injured are the “walking wounded” who can return to duty within several days after receiving relatively minor medical care (Dupuy 1995:140-1; Swan and Swan 1996). Among the seriously wounded, however, return to duty (RTD) rates are generally low. The seriously wounded constitute approximately 15%-20% of those wounded or killed during battle. Of these, the RTD rate in Vietnam and the Arab-Israeli wars, for example, was about 15% (Koehler, Smith, and Bacaner 1994). Similar figures are reported in the Gulf War. Of the wounded transported to Germany for treatment, approximately 14% returned to duty in Iraq (Peake 2005).

The question about care for the critically wounded is sharply framed by considering the number of soldiers killed in action and those who died of wounds (DOW). In the major wars of the last century, 20% of soldiers hit were killed immediately (Dupuy 140-1). In Iraq, rapid evacuation and advanced blood clotting agents have reduced this number to less than 14%. As a result, however, DOW rates have increased. In previous wars, 88% of those soldiers who died were killed in action and 12% died of wounds. But in Iraq, 77% of those who have died were killed in action, while 23% died of their wounds (Holcomb et. al. 2006:401). This leads

2. In the American armed forces, service personnel refusing medical treatment that will keep them “fit” (that is, “able to reasonably perform the duties of his or her office, grade, rank or rating”) are subject to charges of “willful neglect” (Secretary of the Navy; 2002, paragraph 2085, 3413).

3. Of the more than 28,000 soldiers wounded in Iraq (through November 26, 2007), just over half (15,766) returned to duty within three days (Department of Defense 2007).
some observers to call on military planners to “to focus resources and research to aid these casualties (Holcomb et al. 2006:401).” If it is unlikely that these soldiers will ever return to duty, what moral principles govern the allocation of scarce resources on their behalf?

Often, two answers are given to this question. Commenting on the relative differences between German and American military medical care in WWII, Bellamy (1985, 410) concludes: “…there are other reasons for providing combat casualty care, reasons such as the morale of the soldier and the obligation of the nation to do all that is necessary to care for its defenders. Life saving surgery should be justified on these grounds, not because it conserves the fighting strength.” Arguments anchored in morale and, particularly, in the moral obligation to provide particularly good care to soldiers who defend their country enjoy widespread support. Nevertheless, there is room to question these arguments and instead subsume care for the seriously wounded under the general right to health care that all citizens should enjoy equally.

Morale, Political Obligation and Medical Care for the Severely Wounded

Since ancient times, kings and commanders have assumed that medical care boosts morale. In the Roman History, Livy suggests that medical care is necessary to prevent “the demoralization of the fighting line by the misery of the wounded” (Garrison [1922] 1970: 52). The Byzantine emperor Leo instructed his officers to “give all the care you possibly can to your wounded, for if you neglect them, you will make your soldiers timorous and cowardly before a battle” (Garrison [1922] 1970:80).

In spite of the intuitive appeal of the argument, there is much to suggest that morale, that is, the positive frame of mind necessary to undertake a dangerous or difficult task, is not directly related to the provision of medical care during war. There are too many counterexamples of armies that could not maintain morale despite superb medical care (the US Army in Vietnam or the Israeli Army in Southern Lebanon) and armies that maintained high morale despite poor medical care (guerrilla armies in North Vietnam and Communist China) to allow us to paint this relationship so simply. Instead, morale is a function of an entire range of support amenities that include good leadership and equipment, troop replacement, ideological fervor and medical care that an army must provide its troops. Together, these function to reduce risk and, at the same time, supply what Robert Rush (2001) has called “organizational cohesion.” Lack of medical care is not simply a health-related issue, but is often a symptom of a general collapse of military capabilities that will often presage defeat. When the system begins to falter, then medical care alone is insufficient to maintain morale. This was the case in the latter years of the Vietnam conflict. On the other hand, if an army can maintain organizational cohesion and supply reinforcements, materiel and leadership, then lack of medical care will not decisively cripple morale or an army’s ability to function. This was evident in the Peoples Army of [North] Vietnam (PAVN) during the Vietnam War and Mao’s 8th Route Army that fought the Japanese before WWII. Sophisticated medical facilities were not necessary to maintain morale; these armies soldiered on receiving only minimal care (Gross 2006, 81-83).

The question then remains: “How much medical care is necessary to maintain morale?” Two criteria suggest themselves: a minimal level of baseline care and, beyond that, a principle of distribution that offers critically wounded soldiers the same care that is generally available to similarly sick or injured compatriots. The first addresses the question of morale and the second concerns of social justice. Just as the German Army decided not to devote more than minimal resources to the care of the critically injured, guerrilla organizations could not offer anything approaching sophisticated care. Yet, German morale (at least in the early years of WWII) did not suffer: Nor did the relatively poor care that characterized some guerrilla organizations greatly undermine their motivation to fight (Dai, 2004). These armies could maintain morale because they offered “military” palliative care. Palliative care does not endeavor to cure an ill patient or extend his life, but to preserve dignity and self-esteem, and to relieve the pain and suffering that accompanies death. Its most important feature is evacuation from the battlefield, non-abandonment of the wounded, some measure of pain management, and respect for dignity. It is no accident that the first principle of the Army Medical Department’s mission is to “maintain presence with the supported [i.e. wounded] soldier.” Abandonment is probably more corrosive of morale than lack of sophisticated care. This seems to have been Livy’s concern. The cries of the wounded left on the battlefield were probably far more demoralizing for an army than anything the enemy could throw at them. Nothing, therefore, outrages the public more than to learn that critically wounded soldiers are abandoned and neglected. Neglect and abandonment roused public opinion in England during the Crimean War (1854-6) (Garrison [1922] 1970, 172) no less than it stirred up American public opinion in the wake of revelations of poor care in US military hospitals in 2007.

Off the battlefield, some observers raise concerns that volunteer enlistment will suffer as soldiers fear they may not receive superlative medical care if seriously wounded. But here, too, we ask the same question: What level of care for the seriously wounded is necessary to induce individuals to enlist? Must it be equal to or better than what others receive? “Relocating those with war wounds to Medicaid-level care would be considered a form of abandonment given that most people are well-insured and receive sophisticated care,” observes one commentator.4 As a result, potential recruits would be disinclined to enlist and, once in service, to fight with any enthusiasm.

If this hypothesis is true, then better care for any wounded soldier, even if she cannot return to duty, is justified because military organizations function better and more

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4. I thank an anonymous reviewer for this observation.
effectively with such an incentive in place. No data address this question directly. Medical care is not the chief incentive for those enlisting in the armed forces and does not show up on enlistment surveys. For most enlistees “patriotic adventure” (an opportunity for adventure, doing something for the country) is paramount and more important than “external incentives” such as money, education and job security (Sackett and Mavor 2003: 202-12; Griffith and Perry 1993; Moskos 2004). Still, we might speculate that enlistees simply assume they will receive adequate care. But “adequate” is the operative word. It may mean the best care money can buy, regardless of what is available to others, or it may mean care equal to what others receive.

Although public rhetoric sometimes favors the former interpretation, the latter, I think, best serves morale and social justice. The “best possible care” is reserved to maintain the health and fitness of those who can contribute to the war effort. Medical care, like any other aspect of a nation’s war making capability, often merits a disproportionate share of available resources. But this does not apply to those who cannot return to duty. What bothers us about Medicaid level care is that it falls short of what many others receive. Under these circumstances, soldiers will be justifiably angered by their relative deprivation and disinclined to serve, yet satisfied and ready to serve when they receive the same care as their fellow citizens. This is not only empirically true. Nevertheless, there is a strong inclination to argue for preferential medical care and to dedicate medical resources to the critically injured that are not available to others. The sentiment is widespread. When Henry Dunant, founder of the Red Cross, sought to convince European leaders to provide medical care commensurate with then contemporary medicine, he appealed to a special obligation between the state and its soldiers. “The soldier who receives a bullet in defense of his country,” wrote Dunant ([1862] 1986, 126–127), “deserves all that country’s solicitude.” The argument has resonated ever since. In the wake of revelations of substandard medical care in some of the US Army’s top medical facilities, President Bush declared: “This country has a moral obligation to provide our servicemen and women with the best possible care and treatment.”5 Morale justifies equal but not necessarily the best possible care. What then of political obligation? Does military service confer a right to receive (and the concomitant obligation of the state to provide) preferential medical care for the seriously wounded that is not available to others in similar medical straits?

**Political Obligation, Military Service and Medical Care**

It is difficult to establish a firm connection between a citizen’s duty to serve his or her country, and the state’s obligation to provide medical care to its citizens. One compelling theory is that these resources are necessary to provide the care so that healthy soldiers stay fit and the wounded can return to duty and carry on the fight. This claim is not controversial. The question is, however, whether military service entitles those who cannot return to duty to resources that are not available to civilians.

It is not unusual for a war effort to become all-consuming, devouring medical as well as other resources with little forethought. In WWII, for example, policy makers allocated 85% of the available stores of penicillin to the military while reserving 15% for the civilian sector (and here only for those cases that contributed to the war effort) (Adams 1989). The military used penicillin to treat the lightly wounded suffering from gonorrhea and the critically wounded suffering from serious abdominal and chest wounds. The former were treated and returned to duty, the latter often did not. Yet no one questioned the military’s claim to the lion’s share of resources, just as no one ever thought twice about the number of neurosurgeons sent to Vietnam or the number of doctors sent to Iraq. In a description of medical care in Iraq that is typical of the sporadic use of medical resources in most wars, one observer notes how “the far forward shock and resuscitation teams [in Iraq] bear the brunt of wide swings in activity. In some sites, two or more surgeons care for less than 15 wounded soldiers per month for months at a time, always needing to be ready for the possibility of being swamped for a few days.”

Does it ever make sense to ask whether one or more of these surgeons might do more “good,” that is, save more lives or provide more care elsewhere? Even though some of the soldiers they treat will not return to duty, many feel that these soldiers have a prior lock on medical care because they had risked their lives for their country. If this claim is less than airtight, as I will suggest it is, then there is room for a public debate about how to distribute medical resources to the seriously ill while disregarding the source of their injury. This debate, to my knowledge, has never taken place in time of war or peace. Should it matter that some have fallen wounded in the line of duty rather than injured in a work accident or laid low by disease? Should those seriously wounded as they defend others deserve first crack at available resources or must they share them on an equal basis?

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6. Personal communication, James Chandler, MD, Department of Surgery, University of Colorado Health Sciences Center, Denver Colorado, 19 December 2006.
with everyone else such as those who work in munitions factories or just stay home and take care of their children?

It is important to put the question in such stark terms because apart from the legal or contractual obligation an army has to provide its recruits with medical care, there often comes a special, moral obligation of the kind that President Bush describes. Members of a professional army in any country generally provide their services in return for a number of incentives that include, for example, a specific salary, educational benefits and medical care. Failure to provide any of these signifies a contractual lapse. But Bush and many others go much further than this: beyond the contractual obligation is a special, moral obligation for a nation to provide the best care it possibly can for those who are seriously disabled while serving and protecting others.

Do Severely Disabled Military Personnel Deserve Privileged Care?

To address these questions, it is instructive to look at the problem from a direction well known to bioethics and ask, “Do some individuals deserve less care because of their behavior?” Should alcoholics or smokers be pushed down (or off) transplant lists? Should bikers who don’t wear helmets or motorists who don’t wear seat belts get the last bed in the ICU on a busy weekend? These questions turn on the connection between a person’s deliberate actions and his right to health care. Just as irresponsible behavior (a vice) leads some to ask whether some patients forfeit their healthcare rights, it may be that exemplary behavior and defending one’s nation (a virtue) merits special rights.

In cases of irresponsible behavior, however, there are good empirical and moral grounds to resist any distinction between one person whose injury is no fault of his own and another whose injury follows from a less than reasoned decision. Empirically, it is difficult or impractical to determine the extent of an individual’s responsibility for his or her medical condition because it may be the (partial) result of genetics, addiction, disease and/or social norms. This applies to alcoholism, smoking, overeating and extraordinary risk taking. In each case, write Beauchamp and Childress (2004:359), “a denial of a person’s right to health care would be unfair if the person could not have acted otherwise, or could have acted otherwise only with great difficulty.” But apart from the empirical difficulty is a larger ethical issue. Is it right to deny health care to someone who has acted stupidly or recklessly (assuming we can make this determination with sufficient accuracy)? If health care is a human right, then the answer is no; it is not a right a person can forfeit. Instead, it seems fair, as Beauchamp and Childress suggest, to “require individuals who engage in certain risky actions that result in costly medical needs to pay higher premiums or taxes (360).” In which case, it is important to recognize that a tax does not change the distribution principle that governs the distribution of health care, it only increases available medical resources. The pie is bigger, but the fair distribution principle a society uses – medical need, quality of life years, etc. - is unaffected by a patient’s identity, his place in society, past behavior or other non-medical reasons that caused his condition.

It is useful to answer questions about seriously wounded soldiers in the same way we think about bike riders, first by considering the empirical difficulty of framing a clear class of those affected and, second, by asking whether members of this class deserve something more than others. Just as it is difficult to accurately assign individuals to the class of those responsible for their illness, it is difficult to assign individuals to the class of those taking part in war. It may not appear so at first, for the identity of combatants seems clear enough. But modern war is making this an increasingly difficult line to hold as the distinction between combatants and noncombatants is fading. The Red Cross, for example, is giving serious consideration to classifying those who direct computer network attacks from afar as combatants (ICRC 2005). Do they belong the pool of those entitled to privileged medical care for the severely wounded? What of civilians who work for weapons manufacturers, not just at home, but on the battlefield, or civilians who work for private military companies? What of civilians who indirectly aid military forces, a common occurrence in asymmetrical warfare? What medical care do these “quasi” combatants deserve? And, apart the growing class of civilians taking an active part in military operations, there are often calls for special compensation to victims of terror on the grounds that they, too, take a direct part in war. Do they deserve the same treatment as critically wounded soldiers?

Finally, consider that the same issue of personal responsibility noted earlier rears its head in the military. It has been estimated, for example, that a third of the head injuries in Vietnam occurred when soldiers failed to wear helmets because they were too hot and uncomfortable (Neel 1991, 55). Similarly, in Iraq, some soldiers refused to wear goggles because they were “too ugly,” and eye injuries only decreased when the “military bowed to fashion and switched to cooler-looking Wiley brand ballistic eyewear (Gawande 2004:2474).” Are head and eye wounds resulting from what appear to be grossly irresponsible decisions somehow less worthy of care? Certainly, if these soldiers will return to battle, the principle of utility trumps. It does not matter how a soldier was injured; the first concern is to return him to the line. But if the wounds are so serious that the soldier cannot return to duty, then the same question arises in the case of the bike rider who does not wear his helmet. Should past behavior affect medical care? Here, too, it seems the same logic should apply as in the forfeiture case: the right to health care is an unconditional, universal human right, guaranteed solely by virtue of one’s status as a human being and unaffected by merit or past contribution.7 The obligation to serve in the military, on the other hand, is a conditional, particular and political obligation incumbent upon a small part of the

7. “Everyone,” reads article 25 of the Universal Declaration of Human Rights, “has the right to … medical care… “without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”
population, namely sturdy young men and women, and under specific circumstances. Military service should not add to or detract from an individual’s right to health care.

War, nevertheless, strains health care resources. To fulfill a citizen’s right to health care during wartime, there is room to consider the analogy of the tax that risk-takers should pay as a source for additional resources for medical care. In Beauchamp and Childress’s scenario, existing medical resources are stretched thin if policy makers do not impose an additional tax on risk-takers. In these circumstances, the care of all will suffer if resources remain inadequate and risk-takers receive the same level care as those who act responsibly. Because it is not fair that one’s health care should suffer because others behave irresponsibly, we charge a tax and, rightfully, avoid having to ask whether the risk-taker should get less care than others. Once the tax is in place, the health care pie is bigger, but no member of any particular group is entitled to a bigger slice. The circumstances that strain a health care system in wartime are different. Those requiring extensive medical care do not act irresponsibly nor is the general population suffering unfairly because of someone’s irresponsible act. Nevertheless, caring for the severely wounded is going to affect the availability of health care resources unless taxes are raised or other expenditures are cut. As funding is increased, health care resources grow to meet the increased demand. Without it, resources will become increasingly scarce. Yet if citizens did not behave irresponsibly there are no grounds to think they should receive less than the prevailing distributive principle demands. All this raises a difficult dilemma of both caring for soldiers who suffer disability serving others and, at the same time, not harming those who are not at fault.

To illustrate the problem consider three individuals with similarly severe neurological injuries. One is a biker who wore a helmet but was hit by a drunk driver, another is a biker who refused to wear a helmet and was injured running a red light, and the third is a wounded soldier. If, for example, there are 10 units of medical care ordinarily available to care for these injuries, how ought we justly distribute them? There is no doubt that a soldier who has suffered significant loss of abilities while protecting his fellow citizens has a claim that can only be met if the government provides more medical care than is usually available in peacetime. To meet this claim, the policymakers impose a kind of reverse tax, that is, pay soldiers what they need to get proper care. Since the money is useless without a medical infrastructure to provide care, it is more likely that the government will simply use these funds to increase medical care and, in this example, raise the resources available to, say, 15 units. What do we do with the 15 units now available? One option is to deliver superlative care to the soldier (10 units) on the assumption that his contribution merits privileged treatment, and poorer care to the bikers (2.5 units). But this seems unfair: the bikers did nothing to merit harm, that is, less care than they would have normally received (5 units). The helmeted biker is entirely faultless and the unhelmeted biker paid his tax. Alternatively, one may distribute the resource equally and allow each patient 5 units of care. Here no one is harmed, but the soldier does not receive special consideration for his sacrifice. At best, a service related injury may help decide which of the injured is treated first, a feature common to national health care systems (below).

Considering the two distribution scenarios, the principle of not harming should trump one of not rewarding, that is, it is better, morally, that the faultless should not be harmed rather than the meritorious not rewarded. Equal distribution is, therefore, preferable to unequal distribution in this case. It should not go unnoticed that the first distribution scenario (10 units for the seriously wounded, 2.5 units for others) occurs when a nation builds a health care system dedicated to the care of wounded veterans and ignores vast segments of the nonmilitary population, while the second distribution scenario (equal distribution based on need) represents a national health care system.

Compensation and Entitlement for the Seriously Wounded

There is nothing in the foregoing discussion to suggest, however, that seriously wounded soldiers do not deserve special compensation. Compensation is a material benefit, usually money, that one earns relative to the dangers one faces and the subsequent harm one suffers. One might certainly compensate soldiers with more money or better housing or tax breaks when they suffer harm or injury as they fulfill their duty. In this way, they deserve more than others who fulfill less risky duties. Compensation, however, is not the same as entitlement. Compensation varies relative to the skill or risk necessary to perform a job. Entitlements are claims to scarce resources knowing that an entitlement offered to one person may come at the expense of another. In most cases, entitlements are offered on the basis of an equally applied criterion relative to the entitlement itself. Thus access to health care may be based on need, and access to higher education based on test scores. Special entitlements create hard dilemmas. There is a fierce debate about offering entitlements on the basis of past discrimination while harming those who had no part in the past injustice. But this difficult case is different from that which beheads care for the seriously wounded. While entitlements to correct past discrimination weigh one harm against another, health care for seriously wounded soldiers weighs harms to some against lack of preferential treatment for others. Conceived in this way, the latter is a less tangled dilemma and offers grounds for a national health care system rather than one that dedicates care to certain segments of the population.

8. There are other variations of this distribution scenario. The government or grateful nation may increase medical resources beyond 15 units. Under these circumstances, no one would be harmed if they continued to receive 5 units and soldiers receive something more. The question is whether there is a moral obligation to exceed the present standard of care. If that standard is low, then one might argue that nonmilitary personnel are harmed because they are denied a reasonable standard of care when resources are available. If that standard is already high, then it is not clear what is achieved when disabled soldiers receive more.
Coming home, the seriously wounded should expect to find a level of health care that meets their basic medical needs as well as it meets the needs of others. Inasmuch as wounded soldiers did not often receive medical care on par with what was available to most others, this alone would be a great step forward. The argument favoring preferential care or special entitlements for the wounded only gains traction in those nations, like the US, where there is no minimally mandated level of health care for all citizens. In such a hostile environment, it does indeed seem unfair if critically wounded soldiers returning from war are abandoned to fend for themselves (or relegated to Medicaid level care).

So, while most nations were beginning to think about national health care systems, the US was consolidating the Veterans Administration (1930) and expanding medical services for GIs returning from WWII (1944) (Perlin, Kolodner and Roswell 2004). Against the backdrop of no medical care whatsoever, it made sense to ask about the kind of health care that disabled veterans deserved (because, like anyone else, they certainly deserved something). As the years went by, the same question was addressed to various, ad hoc segments of the American population – the elderly (Medicare), the poor (Medicaid), children, etc. - but never to the populace at large. Focusing on the rights of discrete groups, rather than on the universal right to health care, however, distorts the debate in the US and gives way to the peculiar language of special entitlement.

National health care systems avoid this trap by simply asking about the right to health care that all their citizens should enjoy. Special interest groups, including veterans, lose their special entitlements but gain a measure of health care commensurate with what is best available, that is, what a particular nation is prepared to buy for all its citizens. Against this backdrop, recent charges of substandard military medical care in the United States afford a unique opportunity to refocus the debate on national health care. The first step, just outlined, is to question the connection between military service and medical care; the second is to consider the efforts of other nations to subsume health care for active service personnel and veterans under the care the state provides for all.

National Health Care, Military Health Care and Care for the Wounded

In most modern health care systems, the distinction between military medicine and nonmilitary medicine has collapsed. This is not true of battlefield medicine, of course. On the battlefield military medicine remains committed to salvation where the rules of triage and limited patient rights hold sway. During war, military medicine is subordinate to the dictates of military necessity and this demands the allocation of resources necessary to effectively wage war and protect national interests. While I cautioned above about over committing medical resources to military medical care during war, few complain if the emergency redistribution of resources reduces care available to civilians when medicines, machines and personnel are rushed to the front. Off the battlefield, however, a different paradigm takes hold: military and civilian health care merge. Not only is this true in practice – many national health care systems are closing down military hospitals – but it is an ethical imperative as well: once seriously wounded and unable to return to war, soldiers have the same right to health care as everyone else, no more and no less. Until the development of national health care, however, “everyone else” enjoyed very little health care, so it made sense to make some provision for military personnel. But the basis for this care, that is, the state’s obligation to care for its defenders, was only provisional and temporary.

Military health care in the United States is probably unique among the industrialized nations. While the various branches of the armed forces provide ambulatory and hospital care for active service personnel and their families, the Veterans Health Administration (as part of the Department of Veterans Affairs) provides care for those discharged with service (and, in some cases, non-service) related injuries.9 Spurred by charges of bureaucratic inefficiency and mediocrity, government planners gradually restructured veteran care from a “hospital” to a “health care” system. Beginning in 1996, outpatient facilities grew from 200 to 850, funding increased from 19 billion dollars in 1999 to 25 billion in 2003, while the number of veterans treated each year grew from 2.8 million to 4.9 million between 1996 and 2003 (Perlin, Kolodner and Roswell 2004).

In contrast to other developed nations, the United States built a comprehensive health care system for a very small segment of its population. By its very nature, this development tends to focus the debate on the special rights this segment should enjoy. Otherwise, it is difficult to justify a health care system for their use exclusively. But the trend elsewhere is much the opposite. In the UK, Sweden, and Norway, for example, the government no longer operates military hospitals.10 In Israel, health planners never built military hospitals, a rational decision when national health care is available at a nation’s inception. With the exception of local clinics on military bases, the national health care

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9. Health care coverage for active duty personnel, their dependents, retirees (veterans) and disabled veterans is complex. Various Tricare programs, a military medical insurance plan, cover active duty personnel, their families and retirees under age 65. Tricare and Medicare cover those over 65. The Veterans Administration provides care for those with service connected disabilities but will also make room for those “catastrophically disabled” or those with non-service related disabilities if they fall below a certain income level (Best 2007; Panangala 2006).

10. For the UK, see Harding 2006. For others I am grateful for personal communications from officers of their respective national medical association: Dr. Nina Tlainen, Finnish Medical Association (20 March 2007), Dr. Terje Vigen, Secretary General, Norwegian Medical Association (19 March 2007), Dr. Gunnar Lonnquist, Swedish Medical Association (20 March 2007) and Charlotte May, Deputy Head, International Department, The British Medical Association, 3 April 2007. The UK maintains dedicated military wards in some hospitals.
system in these nations provides care for veterans, military personnel and their families.

In Canada, veterans receive constitutionally guaranteed care directly from the federal government for their service related injuries. In many cases, this care replicates that which is available from provincial health care services, while in other instances veterans are eligible to receive additional benefits. These benefits include long-term care that covers medical expenses and room and board (nonveterans receive only medical expenses) and a “veterans independence program that includes rehabilitation care, housekeeping, personal care services and transportation (Canadian Ministry of Health 2005: 3, Veterans Affairs Canada 2006a:24, 2006b).

In Finland, where there is a large number of qualifying veterans relative to the population (2.0% compared to 1.6% in the US and 0.6% in Canada), veterans receive additional rehabilitation and dental benefits (Finland Ministry of Social Affairs and Health 2004, Social Insurance Institution of Finland (KELA), nda, ndb). Apart from these benefits, basic health care is the same for all citizens.

Representing a slightly different approach, the governments of France and Australia continue to maintain a small number of dedicated military health facilities. France operates a system of national health insurance (NHI) that covers all citizens with identical health care benefits that include a wide range of ambulatory and acute care. The NHI either pays for these services directly or reimburses patients for covered expenses (Rodwin, 2003). NHI is not a monolithic organization, but consists of several programs or “schemes” that provide insurance for different segments of the population including the military. Although France maintains a small number of military hospitals, military personnel receive primary and specialized care based on the same agreements with providers that the NHI uses to provide care for others. Health care benefits are therefore comparable across the population. In Australia the situation is similar. Active duty personnel often obtain specialized care outside the limited military medical health care system, while qualifying veterans receive care through the Department of Veterans Affairs (DVA). The DVA does not operate its own service infrastructure, but like Australia’s national health care system (Medicare) the DVA contracts care from health care providers and facilities.

Interestingly, the Australian health care system also makes a specific reference to special entitlements for veterans. “One of the ways that the Australian Government honours the service of veterans is by paying for their access to a wider range of health care services than is generally available...” declares the DVA website (DVA nd). This again raises the problematic link between military service and health care. The emphasis, however, is not on additional health benefits but on better “access” to those health care services that other citizens enjoy:

“In the main, DVA pays slightly higher fees to providers than Medicare. In return DVA clients are given priority of access, and they also receive a slightly higher standard of care, such as a private room, etc. Thus, the standard of health care is the same for all patients, but DVA clients will get it faster. For some items, such as orthopaedic procedures (like hip replacements), some Medicare clients have to wait many months for their operation; veterans will get their operation much more quickly. Veteran’s organisations also operate widespread networks of nursing home facilities, in which veterans get almost exclusive access. For other services, however, such as intensive care after motor vehicle crashes, the service would be exactly the same for veterans and civilians."

There does not appear to be much public opposition when veterans receive additional benefits of this kind. Quite the contrary, members of the public are probably happy to let veterans receive speedier care. But a veteran or critically wounded soldier does not usurp the right to health care of others or leave them with curtailed health care rights. Military status or past military contribution does not trump medical need, but operates as a “tie-breaker” criterion when there are many patients of equal need. This criterion, however, has no force when a patient of greater need requires care. One has to go to Britain’s National Health Service (NHS) to find the most coherent statement of the ethical principle governing care for seriously wounded soldiers:

NHS hospitals should give priority to war pensioners [disabled veterans], both as out-patients and in-patients, for examination or treatment which relates to the condition or conditions for which they receive a pension or received a gratuity (unless there is a emergency case or another case demands clinical priority). Priority should not be given for unrelated conditions (NHS Circular HSG (97) 31, 18 June 1997, emphasis added).

Privileged access for critically wounded soldiers is ethically defensible only when provided for service related injuries and only when no other patient with more urgent medical needs requires attention.

**Why Treat the Wounded?**

It is important to ask, “Why treat the wounded?” because, for so long, they received such poor care. While improved and effective medical care provide sound reasons to treat those who can return to duty and carry on the fight, military medical ethics, rooted firmly in the principle of salvage, can offer no compelling reason to care for those wounded so badly that they will never fight again. Shorn of military necessity, only “humanitarian” impulses, as Dunant quickly grasped, could ever convince others that these wounded deserve medical attention. In the absence of medical care, it was no less than barbarous to abandon the wounded and leave them to die on the battlefield. Dunant’s first principle of military medical care was, therefore, “non-abandonment,” the very same standard that drives the military medicine today. We attend to the seriously wounded

because it is their human right, not because of a special or overriding moral obligation we owe to those who risk their lives in our defense. Dunant was moved by their state of abject neglect, and they deserve their nation’s solicitude for no other reason.

Humanitarianism and the concern it evokes for human rights anchors every person’s right to health care. War creates a small class of conspicuous and horribly suffering individuals but one which is by no means unique. Recognition of the common cause seriously wounded soldiers share with others who suffer from similarly disabling disease and injury allows both to acquire better care. For the wounded, parity with nonmilitary patients provides the recognition of medical need and life saving care that military medicine, by its very nature, cannot justifiably provide. This recognition is crucial for their care and well-being. For nonmilitary patients, the care that developing health care systems may afford first to those injured in war can offer a model of effective medical benefits for all. But care for the seriously wounded cannot come at the expense of another’s basic human right to receive medical care. While national health care systems understand this, the peculiar nature of the American health care system skews this debate. Instead of declaring that the United States has a moral obligation to provide its servicemen and women with the best possible care and treatment, Bush should be saying, “This country has a moral obligation to provide all its citizens with the best possible care and treatment. They deserve it, and they will get it.”

REFERENCES


