A fundamental principle of design in any public-policy program can be found in the ancient Hippocratic Oath: “First, do no harm.” This should be especially true of policy toward veterans. Having already taken risks in uniform to protect our society, they should not be exposed to risks from government policy or private philanthropy which could harm them after their service.

Unfortunately, many policies directed toward servicemembers and veterans recovering from wounds of various sorts violate this fundamental rule. While created out of an intention to help the wounded warrior, they often combine to create a perfect storm of disincentives that can cause individuals to become passive dependents during a season of acute distress. Temporary dependency, if improperly managed, can become permanent dependency. Veterans unintentionally robbed of self-sufficiency lose crucial abilities to take part in all that American society has to offer.

Maj. Daniel M. Gade, who holds a Ph.D. in public policy from the University of Georgia, teaches in the Department of Social Sciences at the U.S. Military Academy. He served as a platoon leader and a company commander in Iraq in 2004 and 2005, where he was wounded in action twice and decorated for valor. Despite losing his right leg at the hip, he won his category at Ironman Arizona in 2010, and in 2012 he completed the “Race Across America” cycling race, covering the 3,000 miles from San Diego to Annapolis in eight days as part of a four-man team.
This problem is far-reaching, entrenched, and serious, and I encourage philanthropists and nonprofit organizations to take it into account when designing or participating in programs for helping veterans. Philanthropists should assess opportunities for giving with a gimlet eye: Compassion is no excuse for carelessness. Perverse incentives and moral hazards can corrode veterans as much as anyone else. As with most recipients of aid, the best help is generally that which speeds the beneficiary toward the point where help is no longer needed. Givers who fail to separate fact from fiction, and emotion from reality, may actually create additional burdens for veterans at a vulnerable point in their lives.

How Misconceived “Help” Can Harm
For the sake of argument, let us examine a fictional soldier, Adam, and the forces that affect his reintegration into society.

Adam is from a small town in Kentucky. Although he dropped out of college after his first year, he is the first member of his family to attend college at all. He joined the Army for several reasons: If you ask him, he might say he did it because “they attacked us.” Personal desires for life experience, adventure, college money, and structure all played into his decision.

Adam’s first tour overseas as an infantry soldier was scary: In Iraq, the insurgency was still very active and dangerous. Although he wasn’t wounded, he had a friend killed, and still has occasional nightmares about that day. His second tour, this time in Afghanistan’s Nuristan province, was a different story. Four months into his deployment, an improvised explosive device destroyed his Humvee, killing two other soldiers and seriously injuring Adam. He woke up at Walter Reed National Military Medical Center after two weeks of unconsciousness with a mild brain injury, amputation of his lower right leg, and minor shrapnel wounds to his remaining leg, arms, and face.

At first, Adam is just happy to be alive: although he is in some pain, his medical care is excellent and he feels confident that he will recover fully. He has headaches from the mild brain injury, and his shrapnel wounds are taking a while to heal, but his mother and girlfriend are there to nurse him back to health, and he is grateful. He can’t wait to learn to walk on his new prosthetic so that he can get back to Kentucky, get out of the Army, and go on with his life.

Adam has an interesting life: the President pinned on his Purple Heart, a Congressman and Senator came by to see him just last week, and the quarter-

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1. While “Adam” is fictional, neither his medical condition nor his experiences are in any way atypical. His education, background, family history, post-service course, and challenges are all common to veterans who served in the post-9/11 war on terror.
back of his favorite team came by with an autographed jersey. He was invited
to join Faith Hill on stage at a concert where 10,000 people gave him a stand-
ing ovation. He really likes taking his girlfriend to the festivals, cycling trips,
and fancy dinners that are offered to him. As a matter of fact, Adam is begin-
nig to feel like a bit of a celebrity; he may even think, despite the occasional
nightmare, that “this rehab gig isn’t so bad after all.”

After six months, Adam can run again on his new prosthetic leg. A year after
his injury, he starts his medical board process so that he can separate from military
service, and eight months later he is a civilian. He goes to an advocacy group for
disabled veterans for help filing his disability claim, and they insist that he apply
for disability based not just on the lower leg amputation (which, in truth, is more
of an inconvenience at this point), but also for the shrapnel wounds, mild traum-
atic brain injury (TBI), and for his bad dreams, which they call post-traumatic
stress disorder (PTSD). Fortunately, his claim is handled rather quickly, and the
government gives him a disability rating of 40 percent for the leg, an additional
10 percent for the scarring, plus 30 percent for the PTSD.

Compassion is no excuse for carelessness.

He is also offered the chance to go to vocational rehabilitation, or back to
college on the greatly expanded new G.I. Bill. On the other hand, his counsel-
or from the Department of Veterans Affairs says that he qualifies for something
called “Individual Unemployability.” I.U. is a program where someone like
Adam, whose disabilities don’t add up to 100 percent disabling, can receive
compensation at the 100 percent rate as long as he doesn’t work. Adam feels
like he could work, but the difference between compensation at the 80 per-
cent rate and the 100 percent rate is significant (about $1,000 per month), and
he wouldn’t have to make all the adjustments involved in going to work every
day, so he applies for I.U. and receives it.

Adam is deserving of the praise, support, and love of his fellow Americans.
In some ways, it is a natural impulse to give him whatever he needs or desires.
Nobody is criticizing Adam, nor do I intend to be the first. In fact, it is useful
to compare Adam’s case with two other soldiers, also fictional but also based
on real people: Bill and Chris.

Bill is a hard-charger, and a member of the U.S. Army Special Forces (a
Green Beret). When he was hurt by small-arms fire in Iraq in 2006, his injuries
were serious: as a matter of fact, his leg was amputated below the knee like
Adam’s. However, Bill has many characteristics that give him advantages over Adam: he is happily married with children, already had completed his bachelor’s degree, and, most importantly, has a reservoir of self-reliance and drive that gets him through tough times.

The upshot: Bill not only puts his injury behind him but elects to continue on active duty, and has even returned to combat. Bill, and the many soldiers like him who have stayed on duty in the military or launched successful civilian careers despite serious injuries, will need some helping hands along the way. It is simply not accurate, however, to call Bill “disabled.” Nor is he a particularly good target for either government transfer payments or private charity.

Chris, on the other hand, needs all the help he can get. He was a sergeant in the infantry and was serving proudly in Afghanistan when he was hit by an IED and suffered penetrating trauma to his head, leaving him severely disabled. He has crippling headaches, poor mobility, and poor cognition. He is dependent on others for daily activities like cooking, transportation, and many elements of self-care. Chris is a perfect fit for lifelong disability payments and extensive ongoing treatment.

Both Bill and Chris are exceptions. In social science terms, these men are outliers, in the “tails of the distribution.” Bill has an exceptionally good outcome, mostly because of internal character traits. Chris has an exceptionally bad outcome, despite his own character strengths. His injuries are simply too devastating. Bill and Chris represent small slices of the total population of wounded, ill, and injured veterans of Iraq and Afghanistan.

Adam, on the other hand, is a much more common case. His situation is thus the one we will examine most closely as a normal baseline to inform the assistance offered to veterans. Both public policy and private charity should be crafted around population norms, not extreme cases (while retaining a degree of flexibility to address those veterans with exceptionally bad outcomes for reasons outside of their control).

Cut Off from Healthy Work and Self-support
It is indeed true that there are many Adams today who end up him permanently and totally “disabled.” But not because of their injuries. Instead, they are being disabled by well-intentioned charity and governmental support that works as a massive impediment to their reintegration into mainstream society. Let us examine several of these forces.

Financial: Due to his injury, Adam receives $50,000 in Traumatic Service-men’s Group Life Insurance. This money is intended to serve as a bridge to
rehabilitation. During his recovery, Adam lives in lodging provided free of charge. He can eat for free at the hospital or other Army dining facilities. He also receives his full salary and other benefits.

Once he leaves the Army, Adam will receive a portion of his military retirement pay and all of his disability benefits from the Department of Veterans Affairs. Because he chose to apply for I.U., he will receive compensation from the V.A. at the 100 percent rate (around $2,800 per month). Depending on where and when he applies, he might qualify for Social Security Disability Insurance as well. SSDI is worth around $800 a month for someone like Adam. All told, his benefits package from the government might be worth in excess of $4,000 per month, most of which is tax-free. Considering that the national median earnings of 20- to 24-year-old males who work full time is $1,908 before taxes, he is doing well. It is in this environment that Adam must make a decision about whether to work or not: because he loses his I.U. benefit and his SSDI if he begins to earn above a minimal amount, he faces a stiff financial penalty for beginning a job. Considering that he has only one year of college, it will initially be difficult to replace that income, much less exceed it.

**Psychological:** When considering the nature of disability, it is important to consider the difference between diagnosis and impairment. For someone like Adam, his diagnosis was serious at the beginning, but his residual impairment might be mild. So how “disabled” is Adam? From one perspective, he is not disabled at all: He is bright, strong, walks with a slight limp, and only occasionally has headaches or a sleepless night due to his TBI. On the other hand, Adam has just spent more than two years proving to the federal government that he is disabled, and not one but two federal programs have labeled him as “disabled.” It is relatively easy to imagine that he may begin to label himself disabled as well, with all of the negative psychological outcomes that can bring.

**Social:** A person’s work is a huge portion of how he relates to society, and a key part of his identity. Although each of us has many identities, our work-related identity is typically near the top of the list. Because Adam is labeled disabled by two federal programs, he decides not to get a job. As a result he meets fewer people. In fact, he is pretty isolated at home, and has a much smaller social network than someone who goes to work every day. He is involved in fewer social activities, and more likely to become depressed and experience

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2. Not all disabled veterans receive SSDI. SSDI is unlike V.A. compensation in that it is “all or nothing.” Normally, those on SSDI are seriously disabled. It is entirely possible that Adam would qualify based on his multiple conditions.

People value those things for which they strive, and tend to devalue those things that are given to them.

Other social dysfunction. More fundamentally, he doesn’t have the meaning and purpose that comes with work, even when it taxes us.

Charitable: Many charities have been formed in the last decade to assist veterans and wounded warriors, and many existing charities have formed subsidiaries or programs for the same purpose. Someone like Adam might be touched by a half-dozen or more groups providing him things: tickets to events, sporting equipment, cash, dinners, vacations, clothing, a place to live or housing services, and many more. Each one of these types of support is provided with the best of intentions. If there isn’t some correlated effort to help Adam enter productive, self-supporting society, however, the downside is that these gifts can cumulatively sap the recipient’s willingness to earn those things for himself. It can be difficult for well-meaning donors to accept that this really does happen, but the reality matches the intuition: people value those things for which they strive, and tend to devalue those things that are given to them.

Obviously not every veteran responds to these various incentives in the same way. Some people will take their disability payments and job re-training and make dramatic successes of themselves. Rep. Tammy Duckworth, Wounded Warrior Project board president Dawn Halfaker, Sen. John McCain, and many others have done just that. It’s critically important to realize, though, that the men and women who are able to resist the siren song of gifts, charity, and disability payments are often exceptional, and the system should be designed not to harm those who might be lured astray by poorly constructed incentives.

Understanding Disability
The concept of “disability” is a key starting point for helping injured veterans navigate their recovery processes. At least two major models of disability exist, the first of which is the so-called “medical model.” The medical model is an attempt to classify a disease or impairment and control its effects. The medical model of disability says that an amputee is “disabled” because of his limb loss.

A more modern approach is the broader “social model of disability,” which assumes that a physical ailment is only the first element of disability. The social model adds environmental and personal factors to the physical diagnosis. For example, a wheelchair user has much less mobility impairment in an environ-
ment free of wheelchair barriers (curbs, stairs, etc.). Similarly, personal factors at the individual and family level strongly affect the degree of disablement that a person will exhibit at the completion of their medical course of treatment. Many families are able to find “a new normal” after a family member becomes disabled; some are not. Some individuals are resilient in the face of daunting challenges; some crumble.

As a society, the United States has begun to shun the medical model in favor of the social model. The 1990 passage of the Americans with Disabilities Act reduced physical barriers in the built environment and required reasonable accommodation in the workplace. New prosthetic, computer, and drug technologies have had some revolutionary effects. Societal attitudes have changed.

The World Health Organization (WHO) also has adopted a social model of disability in its International Classification of Functioning, Disability, and Health.4 Most human-resources managers in businesses, government, and non-profit agencies now apply a social model of disability.

We’ve become accustomed to seeing amputees pass us on the ski hill. Children with disabilities are often put into “mainstream” classrooms. Adults with disabilities are accommodated at many kinds of jobs. Lots of us have watched co-workers find new employment niches with the help of retraining, computerized equipment, or other accommodations. Our views of what is possible and “normal” have been altered dramatically over the last generation.

A key concept for understanding disability today is appreciating that there is a difference between capacity and performance. Capacity is the best that an individual can be expected to do in a specific area of life. Performance is what that person actually does.

The goal of any program relating to persons with disabilities should be to narrow the capacity-performance gap. In some areas, technology is decisive: A computer that reads materials aloud for a person with dyslexia, for example, may eliminate the gap between capacity and performance entirely. Some prostheses can significantly narrow gaps in mobility, appearance, or performance, if not close them. Alternatively, the gap between capacity and performance may be widened by human behavior. Bullying or negative attitudes toward disability could pull a disabled person’s performance far below what he is capable of.

Many government programs acknowledge the social model of disability. For example, most disability employment programs run at the state level require some version of an Individualized Education Plan as part of the re-employment process. These plans take into account the particular strengths and weaknesses

of the candidate before placing him into a tailored program of rehabilitation, education, or training in independent living.

Writing Checks Versus Re-integrating into Work and Society

Unfortunately, several major U.S. government programs rely on a medical model rather than a social model. The Department of Veterans Affairs disability-compensation program is one. The V.A.’s statutory requirement (found in U.S. Code Title 38) is to compensate for disabilities based on “average loss of earnings” that would be expected in a worker with that particular diagnosis. The V.A.’s compensatory scheme thus relies on two abstractions—a diagnosis, and an estimate of the average loss of earnings of previous persons with that diagnosis. Note that this definition does not take into account personal qualities, or family support, or educational potential, or other factors affecting how much residue of disablement an injury will leave behind.

What this means, in essence, is that the V.A. doesn’t base its compensation on disability at all, but rather around a diagnosis. By this definition, those athletes you see sprinting and swimming at the Paralympics, and the wounded veterans now working in many Wall Street banks, are “totally disabled.” Some injured servicemembers who remain on active duty and return to what they did before their injuries will, bizarrely, be labeled “totally disabled” once they leave the service. Clearly, the medical model leaves something to be desired.

The Department of Defense has its own separate disability-rating system that superficially resembles the V.A. system. The DoD rates disability based on whether the person in question can still perform his assigned military duties or can be re-assigned to something more in line with his residual capacity. There are dozens of amputees who have returned to service after rehabilitation, and at least one completely blind soldier who continued his Army career after losing sight in 2005. The DoD paradigm is a better example of the “social model.” By eliminating barriers and restructuring work requirements, it allows persons with disabilities to continue to contribute usefully to the DoD’s work.

The reason that disability systems and supports must be carefully designed is simple: The process of applying and proving that one is “disabled” can trigger a powerful set of social constructs in the disabled person, his family, and his community. Applicants can start to rely routinely on others. Personal aspiration can dry up. Passivity and dependence can become normal.

The modern military is both healthier and more educated than society at large.
The person with a disability may experience a change in “locus of control.” Instead of believing that he is responsible for his own outcomes in life (internal locus of control), the person may believe that other people or the environment are responsible for his outcomes (external locus of control). Similarly, the community may begin to view the person with a disability, consciously or not, as an object of pity rather than as a citizen with full standing. Charitable giving which accidentally creates disincentives to work can serve to hasten the onset of displaced locus of control in the person who receives the charity.

In their recent book *The Declining Work and Welfare of People with Disabilities*, economists Richard Burkhauser and Mary Daly study two massive federal programs—Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)—and find that despite the last generation’s many new legal protections and forms of assistance for the disabled, their employment rates are at an all-time low, support rolls are rising, and household income among persons with disabilities is stagnant. The design of these programs makes work both “less attractive and less profitable” than passively receiving benefits. The positive effects of the Americans with Disabilities Act and other efforts at mainstreaming and integration, the researchers conclude, have thus been considerably nullified by carelessly designed entitlements.

Astonishingly, there are more Americans of working age receiving government disability checks today (more than 12 million) than there are paid workers in our entire manufacturing sector.\(^5\) Through our Social Security system alone, cash payments to individuals classified as disabled totaled $135 billion in the latest fiscal year. It isn’t just cold-blooded economists who have noticed this. *New York Times* opinion writer Nicholas Kristof recently acknowledged the problem. “This is painful for a liberal to admit, but conservatives have a point when they suggest that America’s safety net can sometimes entangle people in a soul-crushing dependency.”\(^6\)

The disability system for veterans is bedeviled with this problem. Benefits are predicated on an individual first proving a work-related disability or handicap, causing individuals to become economically and emotionally invested in their condition as a barrier. And the primary focus is on cash assistance, rather than on helping the individual get rehabilitated, retrained, and reoriented so he can

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engage in productive labor. The many psychological, social, and financial benefits of work are thus often lost to recipients.

Because systems giving cash to the disabled are filled with perverse incentives, Burkhauser and Daly suggest enhancing employment and offering other mainstreaming services, instead of just writing checks. They offer a series of reforms using the Dutch model of rewarding and thus incentivizing work. While their recommendations adhere to the particular nature of the SSI and SSDI programs they are writing about, the parallels between the deteriorating trends they review and the veterans disability system are striking. Despite improved technology, deepened legal protections, and greater acceptance in public opinion, V.A. disability enrollment has exploded, the number of different medical conditions claimed by recipients has mushroomed, and the official rates of functional impairment among V.A. clients have essentially remained stagnant over the last several decades.

Despite the many assets of today’s young veterans, there are reasons for serious concern in current dependency trends.

The unfortunate incentives identified by Burkhauser and Daly may actually be worse for wounded warriors than for private-sector workers. Not only does the individual face the moral hazard of being tempted to substitute a cash entitlement for daily labor, but there is also a greater moral hazard for the employer. The Department of Defense bears no burden when an employee exits the military with a disability settlement, since the V.A. handles the caseload, and taxpayers pay the tab. The normal risks of simply cutting checks rather than undertaking the work of rehabilitation and integration are thus actually worsened by the nature of public employment.

A New Generation of Veterans
The post-9/11 generation of veterans has borne heavy burdens accumulated during more than a decade of war. Deployments have been unusually long and unusually frequent. Fortunately this generation of servicemembers has many strengths and assets that have helped them meet these demands.

First, the modern military is composed solely of volunteers. And rather than being a random cross-section of society they are, as a statistical fact, both healthier and more educated than society at large. (See “Vital Statistics” at the end of this book.) With very few exceptions, they are high-school graduates
or have GEDs, and many even in the enlisted ranks have college experience. More than 80 percent of officers have bachelor’s degrees, and many have graduate degrees. Most of the veterans of Iraq and Afghanistan are young—still in their 20s—and because our current military’s medical and physical fitness standards are relatively rigorous, veterans are both physically and mentally healthier than the population at large. A final demographic difference is that the Afghan and Iraq wars involved record levels of Reserve and National Guard forces, who are typically somewhat older, even more educated than the active force, and more fully integrated into civilian life in other ways.

Second, the combat experience of today’s veterans is markedly different than most previous counterparts. With a few exceptions (the initial invasion of Iraq, the first and second battles of Fallujah, isolated pockets of the fighting in Afghanistan, and a few other episodes), today’s veterans have faced conflicts characterized by chronic, low levels of violence rather than dramatic, high-intensity battles. At the same time, they have largely operated in theaters with no front lines and with civilians mixed in with combatants. This means they have often been exposed to civilian suffering and also been unsure of their adversaries.

Third, the social and economic environment experienced by veterans after their service is much different today than for some previous generations. By and large, the civilian world is now accepting of its veterans and thankful for their service. In some circles this is called the “Sea of Goodwill”7 and encompasses not just grateful citizens, but employers, community leaders, government officials at all levels, academics, health care professionals, and others. There are hundreds of major charitable programs and thousands or tens of thousands of minor programs and donors who have stepped up to provide a welcoming environment for returning soldiers and recently discharged veterans.

Finally, although the number of veterans to be re-integrated is high, it is still dramatically less than in previous wars. Fewer than 2.5 million veterans have served in Iraq or Afghanistan since 9/11.8 That is less than served in

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7. This phrase was coined by Adm. Mike Mullen in a 2008 Memorial Day speech, and is the title of a DoD white paper, “The Sea of Goodwill: Matching the Donor to the Need.”
8. DoD reports that 2,443,927 individuals had been deployed to Iraq or Afghanistan as of June 30, 2012.
Vietnam, and only a fraction of the 16 million Americans who served in the military during World War II.

The upshot of all of this is that, contrary to some conventional wisdom, it is a serious mistake to look at veterans overall as victims, or as a problem class. Both the earnings and the overall income of veterans in this country are higher than those of non-veterans. Among all males, for instance, year-round workers averaged $51,230 in 2009 if they were veterans, and $45,811 if they were non-veterans. The advantage for veterans is even bigger among women. And when the measure is “income” (including not just earnings but also pensions and entitlements), veterans fare even better.

Given their educational and health advantages outlined above, Iraq and Afghanistan veterans are likely to be a valuable asset to America’s economy and society over the coming decades. It is not all veterans who need help, but just particular veterans working through transitions to civilian life, or struggling with specific personal burdens, who may need assistance from fellow citizens.

Dramatic Increases in Compensation

Despite the many assets of today’s young veterans, there are reasons for serious concern in current trends. A staggering 45 percent of Iraq and Afghanistan veterans are currently seeking compensation for service-connected disabilities. They are applying at more than twice the rate of troops who served in the 1990s Gulf War. Currently, about a third of all new veterans are being granted some level of disability. And the number of disabling medical conditions claimed by the average applicant has soared from 1 or 2 among post-World War II veterans, and 3 to 4 among Vietnam veterans, to 8.5 medical conditions per claimant among veterans who served in Iraq and Afghanistan.

Those are shocking numbers. They are influenced, however, by many inducements in today’s system, including V.A. procedures. The definition of

9. Because this figure does not take into account the selection effects of the high initial enlistment standards, this difference would be slightly less if we compared people who served with those who could have served but chose not to. Nevertheless, this simple figure illustrates that veterans are doing quite well on average.


11. For a brief layman’s summary of Department of Veterans Affairs data, see http://news.yahoo.com/ap-impact-almost-half-vets-see-disability-16065648.html. For a more thorough academic treatment, see http://costsofwar.org/sites/default/files/articles/52/attachments/Bilmes_Veterans_Costs.pdf.

disability in the V.A. system is such that most of these veterans are not “dis-
able” in the commonly used sense of the term. More accurate terminology
would describe them as “having a service-connected condition.”

The most prevalent service-connected condition in the V.A. system in
2011 was tinnitus (ringing in the ears), and the second-most prevalent was
hearing loss. Of the nearly half-million post-9/11 veterans receiving disability
compensation in 2011,16 percent were granted 10 percent disability, 38 per-
cent were given 20–40 percent disability, 42 percent were paid for 50–90 per-
cent disability, and 4 percent were compensated for 100 percent disablement.\textsuperscript{13}

Some small part of the jump in medical conditions per claimant may be
explained by the happy fact that some servicemembers whose injuries would
have killed them in previous wars are now saved by improved trauma care. But
that is a minor factor. Keep in mind that out of the 2.7 million servicemem-
bres who have served in Iraq or Afghanistan, less than 14,000 were wounded
in action seriously enough to merit evacuation from the theater.

The old saying about giving a man a
fish versus teaching him to fish applies
in veterans philanthropy as much as
anywhere else.

It is appropriate for the nation to spend whatever it takes to help seriously
injured servicemembers recover their capacities. Thankfully, catastrophic inju-
ries are less common among post-9/11 veterans than generally imagined. For
example, there are about 1,700 amputees. Approximately 250 Iraq-Afghan-
istan veterans are blind. About a hundred suffered spinal-cord injuries. And
penetrating brain injuries total 4,174.

PTSD is the affliction most mentioned in popular discussions. It is a syn-
drome covering a very wide range of complaints, and estimating its prevalence
is complicated by the fact that there have been at least two major policy
changes in PTSD diagnosis and treatment. First, the V.A. no longer requires
proof that a traumatic incident occurred. (Indeed some advocates argue that
there need not be any precipitating incident, that PTSD can occur simply
from an accumulation of occupational pressure.) Second, the V.A. actively
seeks patients instead of just accepting them when they come. This latter deci-

September 23, 2012.
sion gets more veterans into treatment, but also makes the total number much higher. Among Iraq and Afghanistan veterans, the Department of Veterans Affairs reported 217,082 cases of diagnosed PTSD as of the first quarter of the 2012 fiscal year, a significant increase in prevalence compared to previous generations of combat veterans.14

The Department of Veterans Affairs is also loosening rules for qualifying for benefits on the basis of traumatic brain injury. In December of 2012 the agency unveiled new regulations that will make it easier for thousands of veterans to receive benefits for five additional diseases, basing the expansion on a 2008 Institute of Medicine study which found “limited or suggestive” evidence that these diseases may sometimes be linked to TBI.15 Incidentally, only a small fraction of the 250,000 cases of TBI diagnosed among servicemembers since 2000 are combat related. The vast majority stem from vehicle crashes, training accidents, or sports injuries.16

**Categories of Assistance and Their Pitfalls**

A returning service member or recent veteran in need may benefit from assistance in areas like medical care (physical and/or psychological), education or training, or employment. Obviously much depends on circumstances—whether the service member is headed for redeployment by his unit, repatriation to civilian life, or rehabilitation from a significant trauma.

A rich network of services would first treat acute and chronic medical needs, then provide rehabilitation services as needed, and finally help veterans gain and maintain useful employment, all roughly in that sequence. At each stage, the needs of the soldier or veteran can be met by federal programs, by assistance from state or local government, by nonprofit groups of various stripes, or by individuals—family members, neighbors, church congregants, or donors.

When services are being offered to individuals, dangers can arise in the area of perverse incentives or unintended consequences. This is a well-known phenomenon in economics—well-intentioned policies or programs often create side-effects that are not at all what the program’s creator desired, but which can be as pronounced as (or even stronger than) the intended good


It is a truisms of public policy that “if you want more of something, subsidize it.” If the thing being subsidized carries downside risks, recipients may be hurt as well as helped.

This trend is visible in the stark growth of disability programs of all types over the last several decades. After reviewing the 19-fold explosion of disability claimants since 1960, Washington Post columnist George Will warns that “gaming . . . of disability entitlements” has made work “neither a duty nor a necessity”—which is one major reason why the male labor force participation has plummetted from 89 percent in 1948 to 73 percent today. Federal agencies like the Government Accountability Office have called repeatedly for serious reform of incentives in disability programs, warning that “low return-to-work rates may be due, in part, to the timing in which certain supports are offered to beneficiaries.”

Programs for veterans are no exception to this problem. Compensating individuals for their disabilities will result in more people lining up to be declared disabled, just as unemployment programs invariably increase the time that people in receipt of compensation remain jobless. It makes policymakers and taxpayers queasy to think that programs designed for good can be crippling to intended beneficiaries if incentives are misaligned. But it’s clear that poorly designed compensation programs can serve as a “headwind” that holds back veterans from long-term success, rather than an aid.

This isn’t just a risk with government entitlements. Some charitable programs designed to honor veterans can also have negative effects. One troubling trend in charitable giving has been the growth of programs offering large gifts to veterans based on service-connected disability. For example, there are several programs offering free homes to veterans who have been declared disabled. Such programs, while heart-warming in the short run, may serve as a chilly headwind in the long run if they decrease a veteran’s desire to participate in the labor force. It isn’t particularly hard to balance out the negative incentives in such generous gifts—via sweat-equity requirements like those

17. For example, a recent New York Times article discussed how the global carbon-credits market had the effect of causing factories in China and India to overproduce a certain polluting chemical so that they could sell the carbon credits earned when its byproducts were destroyed.
19. For an excellent summary of this ongoing problem, see GAO Report 03-119, January 2003.
Poorly designed assistance for veterans—governmental or charitable—can actually hurt and disable the intended beneficiary.

used by Habitat for Humanity, financial co-pays, and concrete expectations of employment after the recipient moves in—but those important details are currently lacking in most programs, at least in part because the charities that do this type of work generally haven’t developed the will and capability to provide the required oversight.23

Principles for Doing Good without Doing Harm
Neither today’s federal programs for veterans nor the thicket of charitable offerings to the same population are in any way intended to harm veterans. Yet it is quite possible for them to drag down recipients during their transition from service to civilian life. How, then, can donors and charities interested in caring for veterans provide crucial support without creating disincentives to full recovery and reintegration? Here are some helpful principles:

1. **Always take incentives into account, including negative ones.** Veterans are simply people, and they respond as rationally as they can to the incentives they are offered. The old saying about giving a man a fish versus teaching him to fish applies in veterans philanthropy as much as anywhere else. Does the program that you are considering creating or donating to provide for veterans, or does it help them integrate into society and assist them in providing for themselves? Paradoxically, a program that offers benefits to a veteran only as he enters work might be better for him than one that subsidizes him in his unemployment, even though the unemployed veteran is more miserable.

2. **View veterans as resources, not damaged goods.** The percentage of veterans who leave the service totally and permanently

23. The Repair Corps program run jointly by the Home Depot Foundation and Habitat for Humanity has thought through some of this. It provides improvements to the homes of disabled veterans—not only wheelchair ramps and widened doorways, but also roofing, electrical, plumbing, insulation, and structural repairs. A combination of volunteer labor from Home Depot employees (trained by Habitat volunteers), plus $2.7 million of funding from the Home Depot Foundation recently allowed the program to expand. But the repairs are not a gift. Participating families agree to repay a zero-interest loan to cover the costs of the remodeling, and the repayments are put into a revolving fund to assist other families.
disabled is tiny. The percentage who need or could use some help is moderate. The majority of veterans need no special help at all. Efforts to help veterans should start by appreciating and valuing all that they can bring to an employer or community, and should focus on moving veterans from the category of needing some help to the category of self-sufficiency. Offering them independence is the biggest favor one can do.

3. Don’t reinvent the wheel. Some existing charities and rehabilitation efforts are excellent and can serve as a model for further efforts. If your contributions are large enough to change the ways that programs operate, then reinforce the ones that create healthy incentives for self-reliance, and push other well-intended programs away from negative incentives they may have unintentionally created. Insist on these things as a condition of your support.

4. Every human success is a victory. It is not necessary to change the lives of all veterans for the better. If you try, you will likely frustrate yourself with failure. Instead, focus on concrete, attainable goals, and change even a few lives for the better.

The warnings we’ve posted here—that poorly designed assistance for veterans, governmental and charitable alike, can actually hurt and disable the intended beneficiary—are rarely spoken, partly because they can so easily be attacked for demagogic purposes. But these are hard realities, ones I have observed both through years of academic specialization in this area and through personal experience. I was wounded twice in Iraq. The second time I nearly lost my life, did lose my entire right leg, and ultimately required more than 40 operations before I could return to self-supporting work and family life.

During my year at the Walter Reed medical center, I saw many, many soldiers who had been moderately wounded, like Adam, get sidetracked from their reentry into productive society by overly generous or poorly targeted programs. One soldier, a below-knee amputee from the 2nd Infantry division, used his traumatic injury settlement of $100,000 to buy not one but two new luxury cars. That money could have changed his life for the better had it been devoted to job training, a starter fund for a small business, or the purchase of a home.

I myself was offered forms of help along the way that could have sidetracked my quest to regain independence. I was also blessed by wiser offers
from generous helpers at hundreds of points along the way, and by a supportive and loving family. But far too many veterans are disabled by poorly designed incentives and programs before they even get out of the starting gate.

I want to emphasize that the cautionary spelled out in this text is only half the story. The other part of the tale is that the vast predominance of charitable assistance offered to veterans today does wonderful things, for men and women who deserve support. And most of the individuals who have served our country in uniform will respond well to wise incentives, and end up as highly productive civilians.

But as you read this book, and feel inspired to create or expand a philanthropy for veterans, servicemembers, or their families (which I certainly hope you will consider), do so in smart and hard-headed ways. The flip side of avoiding bad incentives is the imperative to offer smart incentives. Donors who do so can dramatically increase the opportunities for today’s veterans to participate fully in the American dream without headwinds or handicaps.