The Financial Legacy of Iraq and Afghanistan: How Wartime Spending Decisions will Cancel Out the Peace Dividend

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Introduction

After every war
someone has to clean up.
Things won't
straighten themselves up, after all.

Someone has to push the rubble
to the side of the road,
so the corpse-filled wagons
can pass.

… Photogenic it's not,
and takes years.
All the cameras have left
for another war.[1]

Wislawa Symborska, Nobel Laureate in Literature 2006

The history of war is a cycle of people destroying and then repairing. Fighting, killing, exhausting armies, depleting treasuries, razing buildings … followed by burying the dead, taking care of the wounded, replenishing stockpiles, repaying war debts, and rebuilding. The repercussions of war persist for years and decades after the last shot is fired.

The inevitable legacy of this well-worn path is debt; promises and commitments that extend far into the future. As the combat phase of the Iraq and Afghanistan wars draws to a close, the years of conflict have left a war-weary America still burdened with heavy costs. These include the immediate costs of paying for medical care for the wounded, as well as the accrued liabilities for providing lifetime medical costs and disability compensation for those who have survived injuries. Long-term costs also include structural increases to the military personnel and health care systems; depreciation on military equipment and weaponry, restoring the military, Reserves and National Guards to pre-war levels of readiness, and maintaining a long-term military and diplomatic presence in the region. There are also far-reaching social costs, including the costs of

[1] Wislawa Szymborska, "The End and the Beginning"

quality of life impaired, families damaged and careers terminated; as well as economic costs and financial costs, that have been estimated (with Joseph E. Stiglitz) in previous writings. [2]

The single largest accrued liability of the wars in Iraq and Afghanistan is the cost of providing medical care and disability benefits to war veterans. Historically, the bill for these costs has come due many decades later. The peak year for paying disability compensation to World War I veterans was in 1969 – more than 50 years after Armistice. The largest expenditures for World War II veterans were in the mid 1980s. Payments to Vietnam and first Gulf War veterans are still climbing. The magnitude of future expenditures will be even higher for the current conflict, which have been characterized by much higher survival rates, more generous benefits, and new, expensive medical treatments. The US has also expanded veteran's programs, made it easier to qualify for some categories of compensation, and invested in additional staff, technology, mental health care, medical research and other services designed to improve the situation of newly returning veterans. The percentage of service members who have required medical care from the Pentagon and VA systems, and claimed benefits from the VA, has risen to unprecedented levels. Yet the accrued wartime liabilities – which have already been incurred but not yet paid – are not recorded anywhere in the US accounting system.

This paper updates previous estimates for the care of Iraq and Afghanistan veterans based on actual reported data through year-end 2012 reports. It also estimates additional costs that were not considered in previous estimates, including costs incurred by the Department of Veterans Affairs (VA) that are related to the conflict; costs for active-duty service members, Reservists, Guards and their families who have been using the department of defense health care system (TRICARE) and including those who are wounded and being treated in military facilities; and costs to the Department of Defense for personnel, retirement, health care and military replenishment costs related to decisions made during the past decade. This paper demonstrates that the decisions we have made during the past decade, including commitments to veterans, active service members, families, service branches, and foreign governments, are substantial, and can reasonably be expected to preclude any serious windfall or "peace dividend" from the end of combat. The paper does not recalculate previous estimates of the economic costs of the impact on human life, nor the extensive impact inside of Iraq, Afghanistan and the region, which if included would bring the costs much higher.

I. VETERANS COSTS

Approximately 2.5 million service men and women have served in Operation Iraqi Freedom (OIF), Operation New Dawn (OND), and/or Operation Enduring Freedom (OEF) in Afghanistan to date, with 6658 fatalities as of March 2013. As of September 2012, some 1.56 million troops

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[2] Joseph E. Stiglitz and Linda J. Bilmes have written extensively on the long-term costs of war. See: *The Three Trillion Dollar War: The True Cost of the Iraq Conflict (Norton, 2008)*; and "Estimating the costs of war: Methodological issues, with applications to Iraq and Afghanistan" in *the Oxford Handbook of the Economics of Peace and Conflict*. (Eds. Michelle Garfinkel and Stergios Skaperdas, Oxford University Press: 2012).

had returned home and left active duty, thereby becoming eligible for veterans medical care and benefits.[3]

There are two main types of costs associated with veterans: medical costs, which are appropriated through the discretionary budget in the Veterans Health Administration (VHA); and disability benefits, which are a mandatory authorized entitlement once granted, and administered by the Veterans Benefit Administration (VBA). In 2008 Stiglitz-Bilmes predicted[4] that costs of both medical care and disability benefits for recent war veterans would grow enormously. We predicted that by 2012, some 46% of new veterans would be enrolled in the VA health care system and that 43% would have applied for disability benefits. But our estimates were far too low. The actual number of Iraq and Afghanistan veterans receiving government medical care has grown to more than 56% of the total. One out of every two veterans from Iraq and Afghanistan has already applied for permanent disability benefits[5].

The costs are high due to the level of physical and mental suffering that has afflicted the troops from these wars. One-third of returning veterans are being diagnosed with mental health issues, suffering from anxiety, depression, and/or post-traumatic stress disorder (PTSD). The suicide rate in the Army has more than doubled, with many failed suicides suffering serious injuries that require lifetime care. The mental health epidemic will increase both immediate and long-term costs. In addition to the spending for mental health clinics, hiring psychiatric personnel and paying higher disability benefits, research from previous wars has shown that that these veterans are at higher risk for lifelong medical problems, such as seizures, decline in neurocognitive functioning, dementia and chronic diseases[6].

The VA has processed millions of unique application claims but is still facing a substantial backlog. As a result of increases in workload, benefits and attempts to meet demand, the VA's

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[3] There are two cost streams associated with "service-connected" veterans: (a) the medical costs of caring for them over their life spans, and (b) the cash compensation and other benefits (such as housing loans and home and physical rehabilitation) that are awarded to eligible veterans and their survivors. Some of these benefits are payable to all veterans regardless of their disability status, including five years of free medical care in the veterans health care system upon their discharge from active duty. Veterans can qualify for a range of compensatory benefits and stipends on approval from the medical and administrative apparatus of the VA. Additionally, veterans may be eligible to receive assistance from other government agencies, such as supplementary disability compensation from the Social Security Administration if they can no longer work.

[4] *The Three Trillion Dollar War*, *ibid*.

[5] "VA Benefits Activity, Veterans Deployed to the Global War on Terror" through September 2012, VBA Office of Performance Analysis and Integrity, November 2012

[6] See Hoge, C.W. *et al*., "Mental disorders among US military personnel in the 1990s: Association with high levels of health care utilization and early military attrition," *American Journal of Psychiatry*, 159(9):1576-1583; see also work from the Veterans Health Research Institute. See also: Daniel Bertenthal, Beth Cohen, Charles Marmar, Li Ren and Karen Seal, 2009, "Association of cardiovascular risk factors with mental health diagnoses in Iraq and Afghanistan war veterans using VA health care," *JAMA* 302 (5):489-492.; and Boscarino JA, 2008, "A prospective study of PTSD and early-age heart disease mortality among Vietnam veterans: implications for surveillance and prevention," *Psychosomatic Medicine,* July, 70(6):668-7; Boscarino, JA, CW Forsberg and J Goldberg, 2010, "A twin study of the association between PTSD symptoms and rheumatoid arthritis," *Psychosomatic Medicine*, June 72(5):481-6 . In the latter, a study of twin pairs showed that the highest PTSD sufferers were 3.8 times likely to have rheumatoid arthritis compared with the lowest sufferers). Spitzer has also shown increased incidence of angina, heart failure, bronchitis, asthma, liver and peripheral arterial diseases among PTSD sufferers). See also Judith Andersen, *et al.*, 2010, "Association Between Posttraumatic Stress Disorder and Primary Care Provider-Diagnosed Disease Among Iraq and Afghanistan Veterans," *Psychosomatic Medicine 72.*

annual budget has risen, in real terms, from $61.4 billion in FY 2001 to $140.3 billion in FY 2013[7]. This reflects huge investments in personnel, clinics, programs, benefits, mental health, IT, women's health care, claims processing, expanded disability pay, and the decision to provide five years of free health care coverage to all newly returned veterans.

Veterans Medical Costs

The US has spent $23.6 billion during the period FY 2001 through FY 2013 in providing medical care to OIF/OEF/OND veterans. [See Table 1].

Table 1: Veterans Medical, Disability and Related Spending FY 2001-2013

	Total-Cum	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
VA Medical	23.6		0.1	0.2	0.2	0.4	0.8	1.1	2	2.9	3.8	3.6	4.1	4.4
SS Disability	4.4					0.1	0.25	0.38	0.45	0.5	0.6	0.7	0.7	0.7
VA Disability	34.9		0.1	0.3	0.5	1.2	1.6	2.4	2.9	3.5	5.3	5.3	5.7	6.2
VA other	71.5	0.0	0.0	0.0	0.0	0.0	0.0	4.7	5.3	8.9	11.7	12.8	13.6	14.5
Totals	134.3	0.0	0.2	0.5	0.7	1.7	2.7	8.6	10.6	15.7	21.4	22.4	24.1	25.8

- The Veterans Health Administration (VHA) has already treated 866,181 (56%) of OEF/OIF/OND veterans for a wide range of medical conditions. The most common diagnoses include diseases of the musculoskeletal system (principally joint and back disorders), mental health disorders, central nervous system and endocrine system, as well as respiratory, digestive, skin, and hearing disorders[8]. Of this group, 29% has been diagnosed with post-traumatic stress disorder (PTSD). Most veterans have been treated for a variety of different conditions. There is virtually no difference between the former active duty service members and Reservists/Guards; with 56% of active duty and 55% of Reservist/Guards having obtained VA health care.

- The costs of VA medical care include the direct costs of providing care to these individuals, through the extensive network of VA clinics, hospitals and contract medical support, as well as the costs of medical programs that the VA has initiated in recent years in response to specific health concerns from the recent conflicts. These include initiatives for studying, treating and monitoring PTSD among Iraq and Afghanistan veterans, and spending related to prosthetics for amputees, and traumatic brain injury (TBI).

- The present value of the expected total medical care for OEF/OIF/OND veterans already committed to be delivered over the next forty years is projected to be $288 billion[9].

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[7] See Table 1, "Historical Budget Authority for the Department of Veterans Affairs in Constant 2011 Dollars, FY1940 - FY 2012", Congressional Research Service, February 5, 2013 and FY 2013 VA Budget

[8] "Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) Veterans, (October 1, 2001 -September 30, 2012), Epidemiology Program, Veterans Health Administration, Department of Veterans Affairs, January 2013

[9] The costs described here include the cost of veterans based on administrative records obtained from the VA. It does not include Vet Center data -- which would increase the numbers if we had it. The evidence from previous wars shows that the cost of caring for war veterans rises dramatically over time as veterans get older and their medical needs grow. This does not include the cost of veterans beyond age 67, who will also be covered through Medicare, TRICARE for Life and other systems.

Veterans Disability Costs
The US has spent $28.9 billion for disability benefits for OIF/OEF/OND veterans from FY 2001 through FY 2012. Including the projected costs for FY 2013, the total amount to date will be $35 billion from the VA. [See Table 1]

- As of September 2012, some 783,623 of OIF/OEF/OND veterans (50%) have filed disability claims with the VA, of whom 671,299 have been awarded service-connection so far, and 15,521 have been denied. (The rest are pending in the VA system)[10].

- These applications are complex, with an average requesting compensation for eight or more disabling conditions. The complexity of the claims is one of the factors that has led the VA to invest in more personnel and technology to attempt to process the claims more efficiently.

- An estimated $4.4 billion has been paid out to severely disabled veterans through Social Security Disability Insurance. More than 30,000 OIF/OEF/OND veterans have been awarded 100% service-connection, which makes them automatically eligible to receive supplemental disability compensation from the Social Security system (SSDI)[11]. There are more than 145,000 veterans who are 70-90% service-connected, many of who also qualify for SSDI.

- The present value of the expected total veterans disability benefits already accrued for OEF/OIF/OND veterans and payable over the next forty years is projected to be $424.5 billion[12].

Other Costs to the Department of Veterans Affairs (VA)

Certain portions of the cumulative growth of the VA budget from ($61bn in 2001 to $140bn 2013, in constant dollars) is the result of specific decisions, initiatives, programs, benefits and investments that are directly related to serving Iraq and Afghanistan veterans. This includes:

- Expenditures directly related to recent veterans, including readjustment counseling, fast-track processing for OIF/OEF/OND disability claims, hiring of thousands of new mental health

[10] "VA Benefits Activity, Veterans Deployed to the Global War on Terror" through September 2012, VBA Office of Performance Analysis and Integrity, November 2012.
[11] *Ibid*. Social Security provides disability compensation (SSDI) for individuals who cannot work due to disability. Veterans can receive both VA disability compensation and SSDI. Veterans who are service-connected at the 100% level automatically qualify for SSDI. Most veterans who are 90% service-connected, and many who are 70-80%, would also qualify for this compensation.

[12] This does not include veterans education benefits under the GI Bill.

professionals to staff clinics for veterans suffering from PTSD and other items serving the needs of recent veterans[13].

- Expenditures which have been undertaken largely due to the current conflict, but which will benefit all veterans. The most costly of these are investments in benefits claims processing, including automating the disability claims process and hiring additional personnel to process disability claims. Congress has appropriated this money due to the VA's inability to cope with a huge influx of disability claims from both recent and earlier veterans[14]. The backlog has been the subject of numerous congressional hearings, GAO investigations, lawsuits and media attention. The VA spent $1.8 billion in 2010, $2.1 billion in 2011, $2.0billion in 2012 and $2.2 billion in 2013 "to support improved benefits processing though increased staff, improved business processes and information technology enhancements". This spending is *in addition* to over $3.3 billion per year for each of the past four years to "for a reliable and accessible IT infrastructure, a high-performing workforce, and modernized information systems"[15].

- In total VA has spent a cumulative sum of $71.5 billion on these war-related initiatives since 2001. Some of the spending will add to the structural base of the VA, particularly the costs related to additional personnel.

Table 1A: Total Projected Veterans Medical and Disability Costs Already Spent/Accrued

	Spent to date	PV 2014-53
VA Medical	23.6	287.6
SS Disability	4.4	42.3
VA Disability	34.9	419.7
VA Related	71.5	86.6
	134.3	836.1
Total $ Bn		970.4

[13] These are discussed in detail in the FY 2009 through FY 2013 VA budgets, and summarized in the "VA Budget Fast Facts" issued with the budget each fiscal year.

[14] It is reasonable to attribute this spending to the Iraq and Afghanistan wars, which have produced a huge upsurge in the number and complexity of disability claims. The VA has expanded eligibility, granted more presumptions to the veteran, increased outreach, liberalized the PTSD stressor definition, and consequently, it has received more than 1 million claims per year during the past three years (from all veterans, of which approximately 30-40% have been newly discharged). If not for the outrage among veterans, and the public awareness of the war situation, it is unlikely that the VA would have been able to secure appropriations for this amount of funding at a time of rising deficits and austerity in most of government. These estimates also do not include VA capital investments, such as the construction that will serve all veterans but are primarily targeted toward those returning from Iraq and Afghanistan.

[15] See VA Budget "Fast Facts", FY 2009-FY 2013

II. PENTAGON PERSONNEL AND MEDICAL COSTS

The costs of veterans are only a portion of the total accruing personnel associated with the Iraq and Afghanistan wars. Since 2001, the Pentagon base budget (excluding money appropriated for war spending) has increased cumulatively by more than $1.3 trillion in constant dollars above the levels that were planned prior to 9/11. Much of this increase can be attributed to spending that was related directly or indirectly to Iraq and Afghanistan and the Global War on Terror (GWOT), and much of that is linked to expenditure patterns and decisions regarding personnel, pay and medical care.

Personnel and Health Care

The cost of military pay and allowances, along with those for military health care, make up about one third of the Department's budget and have been growing rapidly in recent years – up almost 90% since FY 2001 while active duty end strength has grown by less than 3%.

Military members and their families are eligible for health coverage through the TRICARE system. TRICARE includes the troops who are injured while serving in the war theatre (before they are discharged into the veterans system), and their families. TRICARE spending is likely to reach $56 billion in 2013, up from $18 billion in 2001, and accounting for nearly 8% of the total US defense budget. TRICARE is now the fastest growing federal health program -- growing at a faster rate than Medicare, Medicaid, or VA health care.

Table 2: Annual Growth Rate of federal health care programs 2001-2011

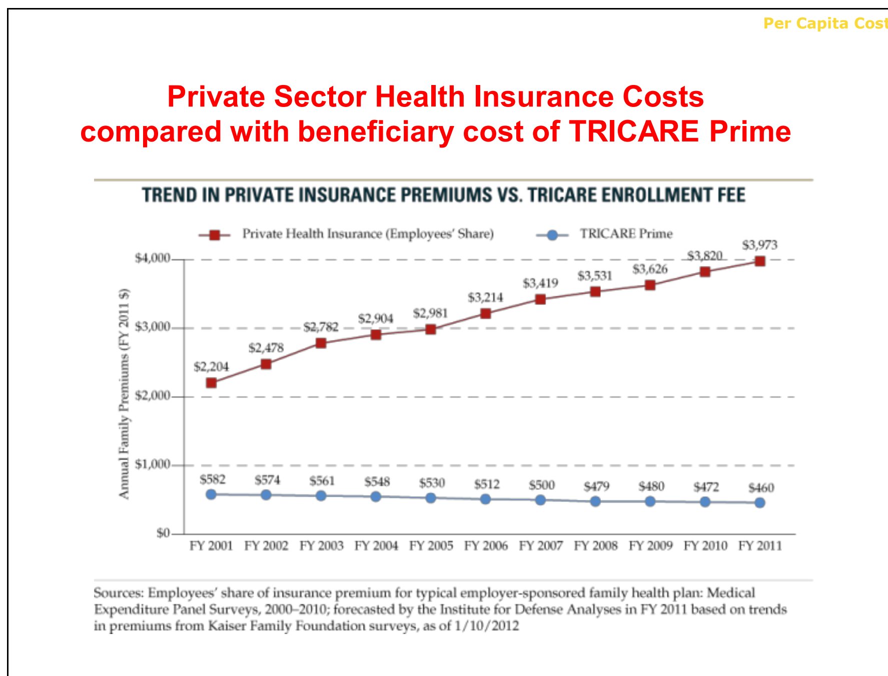
$ Billion	2001	2011	Compound Annual Growth Rate (CAGR)
Medicaid	$130	$276	7.8%
Medicare (net)	$217	$485	8.4%
Veterans Medical	$21	$50	9.1%
DoD Medical	$18	$54	11.4%

There are several reasons why much this growth can be attributed to the wars in Iraq and Afghanistan. These include:

1. Increase in TRICARE participation
2. Increase in TRICARE utilization
3. Expansion of TRICARE to Reservists/Guard
4. High profits of TRICARE providers
5. Expanded programs for retirees

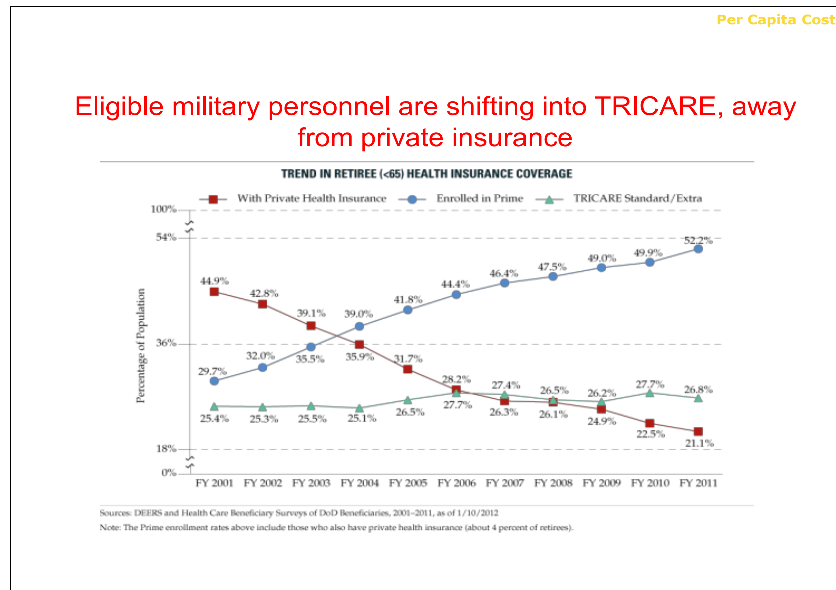
First, the Pentagon kept the costs associated with TRICARE (co-pays, enrollment fees, deductibles, etc) artificially low between 2000 and 2012 due to reluctance to raise fees during wartime. Before the wars, the co-pays for TRICARE were scheduled to be increased; but that was canceled every year. The out-of-pocket amount paid by TRICARE recipients remained $250 per year ($460 for a family four) throughout the period -- actually less in real terms than the amount paid in 2011. [See Table 3]. Individuals and families could purchase health insurance in TRICARE for a tiny fraction of the private sector rate. During the past decade, the market price of health insurance increased steeply, so the *differential* between the paying for private health coverage compared with TRICARE increased from less than 3.7:1 to nearly 9:1. Consequently, the amount that TRICARE was subsidizing increased, and unsurprisingly, the participation rate among eligible active duty military and family members rose from 29% to 52%, while the percentage that carried private health insurance fell from 45% to 21%. [See table 4][16]. Although there has been a very small increase in fees during FY 2013, there was substantial congressional opposition to this increase and it is unlikely that fees will go up again anytime in the near future.

Table 3: TRICARE Prime premiums vs. Private Insurance 2001-2011



[16] "Evaluation of the TRICARE Program: Access, Cost and Quality", FY 2012 Report to Congress, US Department of Defense

Table 4: Increased Participation in TRICARE and decrease in Private insurance enrollment

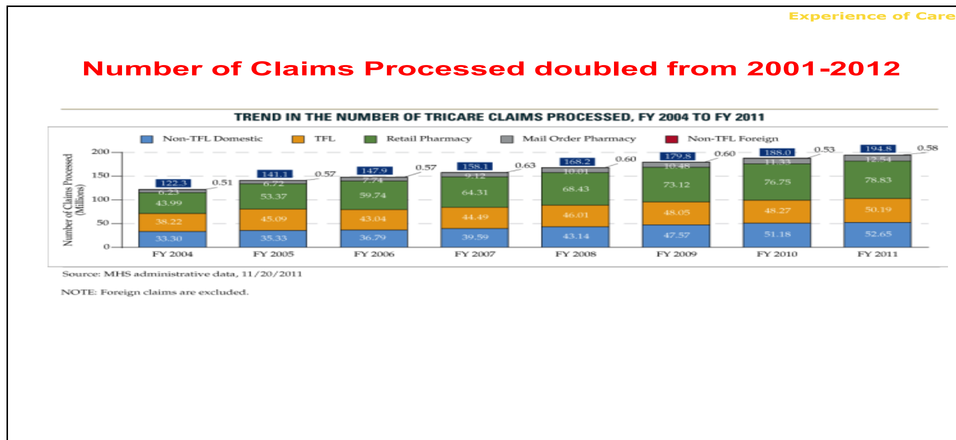


Second, the number of enrollees, and the volume of medical visits, procedures and claims increased. Overall TRICARE added 400,000 new beneficiaries between 2004 and 2011 and the number of annual claims processed grew steadily from 112 million in 2004 to 195 million claims in 2011.[17] Many of these claims were directly war-related, with much higher utilization by the active duty services and families. For example, since 2004, behavioral health counseling for troops/families rose 65% and counseling for children of troops rose by 45%. Medical visits from active duty troops due to joints and musculoskeletal problems grew from 2.8 million in 2005 to 3.9 million by 2009.

The estimated costs for those who are still serving are large and growing. This includes service members who are wounded on the battlefield and treated within the military medical system, (for example in battlefield medical centers or military hospitals such as Walter Reed National Military Medical Center in Bethesda). The worst casualties of the entire period have occurred during the Afghanistan surge - with the Marines suffering the highest toll.[18] In the past year alone, dozens of NATO troops have been killed or wounded by members of the Afghan forces (or attackers wearing their uniforms) in so-called "green on blue" attacks. The Walter Reed National Military Medical Center in Bethesda, Maryland is treating hundreds of amputees and severe casualties from the past two years alone.

[17] Military Health Service, TRICARE 2012
[18] For example, 25 Marines died and more than 180 were wounded, including many with multiple amputations, from a single battalion in the Fifth Marine Regiment out of Camp Pendleton, California, while it was deployed to Helmand Province in 2010.

Table 5: Increase in TRICARE claims processed 2001-2012



Third, TRICARE was expanded to the Guards and Reserves who had served in the war, establishing a new program called "TRICARE Reserve Select (TRS)". This was a direct response to the fact that a large percentage of those who have served in OIF/OEF/OND have been drawn from Reservists and Guards. Of those who have already been discharged, 43% (674,688) are Reservists/Guards and 882,338 (57%) are active duty[19]. The TRS program was originally designed for Reservists and Guards who lacked a civilian option, but it has become a default plan for many. The participation rate (and the cost) is likely to increase further when the mandates in the Affordable Care Act take effect. RAND Corporation recently produced a study projecting that this program will grow significantly in the next two years, as TRS will become by far the cheapest option for those able to take advantage of it. Currently, some 30% of reservists are Guards are not insured, and TRS premiums will be a cheaper option than purchasing health insurance in the private market, through state subsidized health exchanges or paying a penalty for not having insurance[20].

Fourth, the private health insurance companies that comprise TRICARE have benefitted from the conflicts -- enjoying large increases in revenues and profits. Taken together, the three companies that have administered TRICARE (Humana, Health Net and TriWest Health Care[21]) would rank as the 6th largest contractor for the Department of Defense -- bigger than KBR, and just below the biggest contracting names such as Lockheed, Northrup Grumman and Boeing. These firms account for some of the highest profits earned by any company in the war, for example,

[19] "Analysis of VA Health Care Among OEF/OIF/OND Veterans, January 2013, Epidemiology Program, Post-Deployment Health Group, VHA" *ibid*.

[20] Hose, Susan D.. Healthcare Coverage and Disability Evaluation for Reserve Component Personnel: Research for the 11th Quadrennial Review of Military Compensation. Santa Monica, CA: RAND Corporation, 2012. http://www.rand.org/pubs/monographs/MG1157.

[21] Last year, TRICARE decided to shift its $20.5 billion contract for western states from TriWest to UnitedHealth Group Inc. (UNH), the nation's largest health insurer by revenue. This will take effect starting April 1, 2013

Humana's TRICARE premium fee revenues increased from $2.8 billion to $4.2 billion between 2001 and 2010, as the company shifted a larger percent of its operations into the government sector[22].

Fifth, the Pentagon expanded benefits for military retirees, in part because the wartime climate helped the department persuade Congress to agree to a number of longstanding requests. These included adding "concurrent receipt" – an expensive benefit that permitted working age military retirees who also qualify for VA disability benefits to accept both. TRICARE also expanded the "TRICARE for Life" (TFL) Program, which was enacted in 2001, to augment Medicare for military retirees. Military service members are eligible to retire after 20 years, and TFL is a popular benefit that has grown rapidly. Unlike Medicare, TRICARE can negotiate for higher rates to pay its providers (regardless of Medicare rates), so there is less likelihood that providers will choose not to accept TFL patients. Both of these decisions will increase the base Pentagon budget permanently and continue to grow quickly as the demographics of the population shift more people into these categories.

Personnel Costs

The second main area of increase base cost is in pay and benefits. When the Army and the Marines, (who were carrying the brunt of the casualties), faced recruiting difficulties in 2004, the Pentagon made a number of changes to boost recruiting to the all-volunteer force. These included relaxing some standards for education and fitness among recruits, increasing the number of recruiters, and increasing pay. Congress also authorized pay raises above Pentagon request levels.

A key decision was to adopt higher pay scale indexing. Previously pay increases were linked to the employment cost index (ECI). The new method was to link pay scales to the ECI *plus 0.5%.* This pay enhancement tool was made possible by the overall surge in war spending, but it was not funded through wartime appropriations and it has added another layer of cost to the DoD base. For the past two years, the Pentagon has asked Congress to roll back these benefits, but they are politically untouchable.

Another important cost was the activating reservists and Guards and paying them on a full-time basis. This was an *extra, incremental* expense. Because these troops were on average five years older and with families, they were in most cases entitled to receive higher levels of special adjustment pay, combat pay, parental and other benefits. Many of these costs contributed to the 30% growth in personnel cost during the period, but were not covered by war appropriations.

Of course, there are excellent reasons why the nation should support better benefits for those who are fighting wars and their families. But from a budgetary standpoint, these have been hidden costs of the war, in which cumulatively hundreds of billions of dollars have been spent on expanding military health care, pay, recruitment, service and retirement benefits, without any discussion about how to pay for them.

Another upcoming issue is the military retirement pension system. The US now pays over $100 billion annually for a military retirement system that only benefits those who have served for 20

[22] EDGAR (SEC Company database) filings and research.

years or longer. In the Iraq and Afghanistan conflicts, more than 85% of the troops will not serve for that long[23]. Therefore they do not receive any kind of pension or stipend for their service. This places additional pressure on the veterans disability claims system - -which in effect, provides the only small stipend for many veterans who have suffered from minor to moderate injuries and who will leave the military long before 20 years. The current system was designed after World War II and is ill-suited to today's veterans. But when the topic is reopened in the future, it will likely require additional long-term expenditures for the Defense department.
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OTHER DEFENSE DEPARTMENT COSTS

Throughout the war effort, the base budget has been padded with war expenditures, at the same time that the war budget has funded many items that should have been paid for through the regular budget. It is difficult to disentangle these two streams. In this analysis, some $780 billion of Pentagon base budget increases have been attributed to the indirect costs of Iraq and Afghanistan operations, which includes health care costs, personnel, recruitment, overheads related to the procurement, monitoring, legal costs, evaluation costs and other costs related to these programs, as well as depreciation that of ordinary equipment that has been damaged, or consumed during the wars more rapidly than its peacetime life rate, or that is too expensive to bring back home. This depreciation has not been adequately accounted for in the war appropriations and should in most part be attributed to the original budget through which most of these items were purchased. There are maintenance, repairs and upgrades charges beyond what has been included in war appropriations, particularly for helicopters and trucks, which have been consumed several times the peacetime rate.

Looking ahead, the US has pledged to help support the Afghan police and army for the next decade – expected to run to $8 billion dollars a year or more. The US is maintaining a vast diplomatic presence in Iraq, including at least 10,000 private contractors providing support in security, IT, logistics, engineering and other occupations. In addition, the US has made extensive commitments to Afghanistan beyond combat. For example, we have pledged to train and equip 100,000 new Afghan soldiers and 100,000 new policemen by 2013. Given that Afghanistan is one of the poorest countries in the world, it is widely expected that the US will continue to pay for the upkeep of this army and police force for the foreseeable future.

III. IMPACT OF BORROWING FOR THE WARS

The US has already borrowed some $2 trillion to finance the Afghanistan and Iraq Wars – a major component of the $9 trillion US debt accrued since 2001. Today as the country considers how to improve its balance sheet, it could have been hoped that the ending of the wars would provide a peace dividend, such as the one during the Clinton administration that helped us to invest more in butter and less in guns. Instead, we are left with the legacy of poor decision-making from Afghanistan and Iraq.

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[23] "Reforming Military Compensation: Addressing Runaway Personnel Costs Is a National Imperative" Lawrence J. Korb, Alex Rothman, and Max Hoffman May 2012, Center for American Progress

Studies of the budgetary impact of a war (like the Iraq war) that is funded largely by borrowing naturally focus on the interest costs: anyone who buys a house or car on credit knows that the interest payments may easily be far larger than the purchase price. But critics say to include the interest costs is double counting. One simply wants to know the (expected) present discounted value of the payments, i.e. converting future payments into present dollars.

If it were costless to raise money, then imposing future costs on the budget through borrowing (necessitating raising more tax revenues in the future) would be of no concern. The timing of financing would be irrelevant. But in reality the costs can be substantial, so that there is a "distortionary" cost associated with these future budgetary payments. The magnitude of these costs depends, on the magnitude of the distortions associated with a country's tax system[24].

CONCLUSIONS:

The legacy of decisions made during the Iraq and Afghanistan conflicts will impose significant long-term costs on the federal government. These costs include medical care and disability benefits for war veterans, increases to the military base budget, and debt servicing costs. The cost of providing veterans disability and medical care and related services will approach $1 trillion, and could even surpass that amount if the number and complexity of claims continue to exceed estimates.

The large and rapidly-growing cost of the TRICARE health care system, the supplementary military pay raises enacted during the war years and the diversion of defense budget dollars to support the requirements of veterans will dominate future defense spending. These commitments have already cost in the order of $700 to $800 billion, and are set to continue, unless there is a significant reversal of current policies.

Additional funds will be taken up by the need to replace large quantities of basic equipment destroyed in the wars and to support ongoing diplomatic presence and military assistance in the Iraq and Afghanistan region.

Finally, the large sums borrowed since 2001 to finance operations in Iraq and Afghanistan will impose substantial long-term debt servicing costs. As a consequence of these wartime spending choices, the United States faces severe constraints in funding military operations, new initiatives, research, development and diplomacy over the next decade and beyond. In short, there will be no peace dividend. The legacy of the Iraq and Afghanistan wars will be costs that persist for decades to come.

[24] Linda J. Bilmes and Joseph E. Stiglitz
Chapter 12: "The Long-term costs of conflict: The case of the Iraq War", in the *Handbook on the Economics of Conflict*. Eds. Derek L. Braddon and Keith Hartley, Edward Elgar, 2011