

DEPARTMENT OF THE AIR FORCE

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Mister Chairman and members of the Committee, it is a pleasure to be here. When we last met, I described how our transformation efforts were saving lives during combat operations in support of the war against terrorism. The week before my testimony, we had just begun combat operations in Iraq. Now, a year later, major combat in Iraq has ended, but the mission and danger continue. Although many of my comments here today address the Air Force Medical Service's contribution to combat operations, I assure you that the care we provide to families and retirees is still of great importance. It continues to improve even as we are engaged in operations around the globe.

And, of course, we truly *are* engaged around the globe. Like our sister services, every step in our transformation is to advance our ability to operate worldwide with lightning speed. This is reflected in the Air Force's six Concepts of Operation, or CONOPS. CONOPS are a statement of our desired end result, or effect, that the Air Force brings to the battle. The first three are Global Mobility, Global Strike, and Global Response. The others are Nuclear Response, Homeland Security and finally Space and Command, Control, Communications, Computers, Intelligence, Surveillance and Reconnaissance. That's a mouthful, so we refer to it as Space-C4ISR. The medics provide fundamental support to all six.

Global Mobility, Strike, and Response CONOPS require the AFMS to provide medical care anywhere at any time to support humanitarian and warfighting operations. This demands that our medics travel fast and far, so they pack light, very light. Some of our Expeditionary Medical System medics travel with just a 70-pound pack. One small 5-person team carries enough to perform 10 life-saving surgeries in the field under battle conditions. And our aeromedical evacuation capabilities permit us to quickly fly into

hostile environments, pluck injured members from the field, and fly out, often providing critical care in flight.

The Air Force's Nuclear Response CONOPS provides a deterrent umbrella under which our conventional forces operate. Medics support this CONOP by ensuring that commanders can rely on the medical and psychological health of the human element of the nuclear force. We also develop plans for the care of casualties and refugees in a radiological event of a terrorist or national origin. We assess health hazards and provide recommendations to protect responding personnel or our combatants within any hazardous zone.

The Homeland Security CONOPS recognizes that if someone attacks our homeland again, Air Force medical personal will be an invaluable asset bringing a wealth of manpower and expertise to the crisis. In such a contingency, our base clinics and hospitals become part of the local health care disaster network. They offer their ability to help local authorities detect and identify chemical, biological, and nuclear weapons, and we aid in the treatment of those exposed to them.

The final CONOPS, Space-C4ISR, serves to integrate the other five. Simply put, it is the network of intelligence, sensors, satellites, and communications that allow us to orchestrate our forces worldwide. Every unit and every function of the Air Force is tied into this capability. Each contributes information to it and uses information from it. Air Force medics use this capability to monitor health threats worldwide, to coordinate care from combat to CONUS, and to maintain visibility of our patients no matter where they are within the joint medical system.

We have now been in Iraq over a year. The AFMS has used this time to review its performance there through a Capabilities Review and Risk Assessment -- a process that drives a hard look at our performance -- from this process we learn what we did right; and what we can do better. These lessons learned help to hone our four central AFMS capabilities of:

- Ensuring a fit and healthy force
- Preventing illness and injuries
- Providing care to casualties
- And enhancing human performance.

1. **Ensuring a Fit and Healthy Force**

The first capability we provide the Air Force is that of ensuring a **fit and healthy force**. Unhealthy troops cannot deploy. A commander who is short of troops cannot fight; cannot win. We keep troops healthy so commanders can do both.

While providing a fit and healthy force is ultimately every commander's responsibility, the AFMS plays a critical role in defining what is fit, what is healthy . . . how do we get them that way, how do we keep them that way.

One recent step is the implementation of the Air Force Chief of Staff's revised fitness program -- a significant change in fitness standards and how we monitor them. The program is now based upon push-ups, sit-ups, and a mile-and-a-half run. To this we add body composition measurements and a strong focus on unit exercise programs. This model includes the Guard and Reserve who must meet the same standards as their active duty counterparts.

The program is only a couple months old, but we know airmen accept and appreciate it. They must like it -- I find it much harder lately to find an open weight bench at the gym, so I know first-hand that our troops are enthused about the program.

Fitness results will be available on the Air Force's secure web to commanders and leadership, allowing them to know in near real-time what percentage of our troops are fit to fight.

Of course, our dedication to health goes far beyond a yearly fitness test. We employ a life-cycle approach to care. We surround troops with continual health monitoring and evaluations from the day recruits first put on an Air Force uniform, during every visit to the in-garrison or expeditionary clinic or hospital throughout their career, and especially during their transition to veteran status. We honor our commitment to our retirees; we are there.

An important tool of ensuring a fit and healthy force has been our Preventive Health Assessment program. It ensures that *at least* once a year, every Airman has an assessment for changes in his or her health and for needed health screening or immunizations, and has the opportunity for a medical exam, if needed.

Additionally, preventive health assessments are provided before members deploy and immediately upon their return. Such screenings were an interest item for both the DoD and Congress last year. We are pleased to report our success. For the 61,000 Air Force personnel deployed from March 1 through December 31, 2003,

- 99% completed their post-deployment health assessment--which included a face-to-face appointment with a medic--and

- 97% had serum samples collected for submission to DoD repository

The medical information from all screenings and appointments is captured in an innovative information system called the **Preventive Health Assessment and Individual Medical Readiness** program, or PIMR. PIMR data, like that of our new fitness program, are available on the web to Air Force leadership worldwide.

The next version of the Composite Health Care System--CHCS II--is another computer information system that will provide significant benefit to the AFMS as well as the entire DoD health care. Even in its current decade-old form CHCS is an amazing system. It captures every visit, prescription, lab result, and procedure provided to every patient.

We first deployed CHCS in the late 1980s when computer screens were black and white and a mouse on your desk was cause for alarm. The upgraded CHCS II will have the look and feel of a web site. It will also be faster and easier to learn. More importantly, CHCS II will interface with the numerous other programs that have come on line since it was first introduced. CHCS II marches us down the path toward an electronic medical record that will solve many problems for us, including that of lost or fragmented medical records. Additionally, CHCS II will be deployable, so it will be the same program used in the field and at home.

CHCS II, like its predecessor, will be deployed worldwide, accessed by thousands of users simultaneously, and contain the patient records of up to 8.8 million eligible beneficiaries. It is the largest health information system in the world . . . and an invaluable tool in keeping our troops -- and their families -- healthy.

Once we have assured that only fit healthy troops are sent to the area of operations, we take great effort to ensure they stay that way. This falls to our next capability, that of preventing casualties.

2. Preventing Casualties

We are experiencing unparalleled success in the prevention of illness and injury during Operation Iraqi Freedom. A telling example of this success is our **low Disease Non-Battle Injury Rate** -- we call it the "D-N-B-I rate" for short. The DNBI rate describes the percentage of troops who become sick or hurt from things other than enemy activity; things like dental problems, car accidents, the flu, broken bones, etcetera.

Historically, more troops are removed from battle because of accidents or illnesses than from enemy fire. In Operation Desert Storm, the DNBI rate was about 6 percent. During the current Iraqi conflict, only 4 percent (DoD rate) of illnesses and injuries were non-combat related. This is the lowest DNBI rate in history. We seek ways to make it lower yet. One of our doctors in Iraq jokingly suggested that if we were to cancel intramural basketball games in theater we could eliminate many sprained ankles and drop that DNBI rate another percent. The important point is that we continue to address all the challenges -- including sports injuries -- that reduce our combatant capabilities.

Much credit for the low DNBI goes to the preventive health assessments and pre-deployment screenings I mentioned. These allow us to identify personnel with pre-existing or uncontrolled medical problems; conditions that would worsen under the stress of deployment. These folks -- if allowed to deploy -- are a huge source of DNBI. By pulling them out of the deployment line and caring for them back home in-garrison, we not only

decrease the DNBI rate, we also ensure these members get the health care they need to make them worldwide-qualified in the future.

The **Deployment Health Surveillance** program is another critical piece of preventing casualties. Before airmen arrive in large numbers to establish a base in foreign territory, a special team of medics -- called the Preventive Aerospace Medicine, or PAM team -- has already been there. They have surveyed the environment for biological and environmental threats, and have stood up surveillance equipment to detect and identify such threats.

When it comes to total "battlespace awareness," PAMs and another EMEDS team called the Biological Augmentation Team, or BAT team, are invaluable. These teams take on the same importance as the radar, intelligence, and security specialists whose mission it is to detect, identify, and deter enemy attacks. In the same manner that a radar operator surveys the skies for threats, our medics survey the environment with equipment to detect chemical, biological, radiological or nuclear--CBRN--threats. In combat, speed counts. That radar operator must detect the presence of an airborne object and then quickly identify it -- friend or foe. The sooner that operator can do both, the faster we can react -- the safer our people are. In the same way, our teams and their equipment act quickly to detect, identify, and counter CBRN threats.

For example, it used to take up to a week to detect and confirm the presence of dangerous biological and chemical weapons -- too long. Imagine a biological agent loose in one of our bases in Iraq for a week before we were able to identify and contain it. Even the most conservative estimates predict that 30 percent of our troops would become seriously ill or worse.

With RAPIDS technology, we eliminate the deadly delay between the time a pathogen is released and when we become aware of its presence. The aptly named RAPIDS stands for the Rapid Pathogen Identification Systems; a fielded and proven system that can determine the identity of pathogens within a few hours; much better than 4-to-7 days it used to take. Using new genome-based technologies, we hope to reduce the time even further.

Another tool in the Air Force Medical Service toolbox is the Global Expeditionary Medical System, or GEMS. This rugged, laptop-based system serves as a deployable, electronic medical record for every patient encounter in the combat zone. To date, it has logged nearly 107,000 patient encounters in Afghanistan and Iraq. But it does more than that. It also tracks chemical, physical, and radiological hazards and even tracks the results of food inspections and living conditions in the field. GEMS provides commanders a theater-wide overview of the health of their forces. Its sophisticated epidemiology tracking features allow it to identify potential disease outbreaks very early in the courts of outbreaks or a chemical or biological attack.

I have described systems and processes we have in place that ensure oversight of our airmen's health before they deploy, while they are in the field and even after they return. But we must remember that combat is inherently dangerous. In spite of our best efforts to prevent it, some of our troops will fall ill, and some will be wounded. Thus the critical need for our third capability; that of restoring the health of the sick or injured -- casualty care.

3. Casualty Care

We have completed the conversion of our large-footprint field medical facilities into small, rapidly deployable Expeditionary Medical System--or EMEDS-- units. Our performance in Iraq validates that the EMEDS concept works. It saves lives.

These units can be found throughout the area of operations. They often provide care from the point of injury, at tented facilities removed from the front, and during aeromedical evacuations as they transport the patient from the theater entirely. When the UN Building in Baghdad was car bombed last August, killing 20, EMEDS surgeons and their staff were only minutes away, and cared for numerous injuries on the spot.

Shortly before the start of combat operations in Iraq we added a new capability to EMEDS; hoping against--but preparing for--Iraq's potential use of chemical weapons, we created EMEDS Supplemental NBC Treatment Modules--or NBC pallets, as our troops call them. Each module contains 25 ventilators and medical supplies to care for 100 radiological, biological, or chemical casualties. I find it extraordinary that it took only 30 days for these packages to mature from the concept stage until the first pallet was loaded onto an aircraft for delivery.

While NBC pallets provide the tools to treat NBC casualties, the EMEDS' hardened tents and infrastructure offer a protective shelter in which our medics can render that care. Each can be equipped with special liners and air handling equipment that over-pressurizes the tents' interiors. Clean, filtered air is pushed in; contaminated air is kept out. Protected water distribution systems work the same way, ensuring a safe, potable water supply even in contaminated environments.

I continue to be impressed with the enabling technologies that permit the development of things like Push Pallets or advanced air and water-handling systems.

During operations in Iraq we have relied on these and other technical marvels, like a laptop sized ultrasound machine, a ventilator unit the size of a football, and a chemistry analyzer that--during Desert Storm--required its own tent; now it fits in the palm of your hand. Our people are saving lives with these technologies around the globe as we speak. There are EMEDS operating in Iraq and 11 other countries in support of Air Force operations.

Operation Iraqi Freedom also validated our new aeromedical evacuation concept of operations. A significant advancement in this mission is our ability to take advantage of back-haul aircraft, which has tremendously accelerated the aeromedical evacuation process. This has eliminated the need for patients to wait days for a designated C-9 or C-141 aeromedical evacuation mission to pass through their area. Patient Support Pallets -- or PSPs -- make it far easier to turn any Air Force mobility aircraft into an aeromedical evacuation platform. PSPs are a collection of specially packed medical equipment that can be installed into cargo and transport aircraft within minutes. The plane that just landed to deliver weapons is quickly converted to carry wounded patients.

Let me share with you an example of PSPs work . . . in Baghdad, a 5-year-old, deathly ill Iraqi girl was brought to one of our allied locations. She was scheduled to fly to Greece for medical treatment. Her condition was so poor that upon arrival at the clinic she was placed on a ventilator. Doctors determined she was too ill to survive and she was removed from the flight. One of our nearby medics heard of the situation. He determined that leaving that little girl behind to die was simply not an option. He, and other members of his Aeromedical Evacuation team, grabbed one of our PSPs--we have 41 of them strategically placed around the globe--and within an hour had converted a section of the

Greek aircraft into a small critical care bay. Their precious cargo was loaded--with her ventilator--and she was flown to Greece to receive care. We are the only country in the world that can do this on a regular and sustained basis for our military personnel.

This demonstrates that PSPs allow us the flexibility to convert not only our own aircraft into AE platforms, we can also take advantage of our allies' aircraft. This dramatically increases the availability of aeromedical evacuation opportunities to our troops. It's like one of our medics told me: "If it flies, and we have elbow room, we can do our thing. Our thing is saving lives."

The medic I spoke of is a member of one of our Critical Care Air Transport Teams. We call them CCATS. These CCAT teams are comprised of a physician, a nurse, and a cardiopulmonary technician. They are specially trained to work side-by-side in the air with our aeromedical evacuation crews to provide critical care under the extremely difficult environment of flight.

Recently, one of our aeromedical evacuation crews augmented by a CCAT team flew into Baghdad on a C-130, under black-out conditions and while taking fire to retrieve three severely wounded soldiers. These troops, too, needed ventilators to help them breathe. They were quickly loaded and even before the aircraft could take off again, our CCAT teams were providing life-saving care to their patients. While in the air, the aircraft was diverted to Talil where U.S. forces had come under attack. Two more men were critically wounded there and needed immediate aeromedical evacuation. Both of these troops also required ventilators.

All five soldiers were flown that night to an Army medical facility in Kuwait. The Air Force medics on that mission are proud of their accomplishment--never before, or

since, has there been a combat AE mission in which a team cared for five patients on ventilators in one aircraft. I'm proud of them, too. Without the AE concept and the skills our medics brought to the theater, each of those five soldiers would have succumbed to their injuries.

Another enhancement to our aeromedical evacuation capabilities is the placement of an AE cell in the Air Operations Center. This permits the smooth integration of our actions with all other DoD or allied air operations in the theater. The story of Private Jessica Lynch's rescue provides a famous example of how all these assets--the AE cell, aeromedical evacuation crews and CCATS, patient support pallets, and the use of backhaul aircraft--all come together in a successful operation. Following her retrieval from the Iraqi hospital, Army medics, Air Force Aeromedical Evacuation troops, and Special Operations members transported her thousands of miles, used three different aircraft, and provided care in the air during her entire journey until she reached the safety of an Army hospital in Landstuhl, Germany. All this was accomplished in less than 15 hours.

Like so many of our missions, Jessica Lynch's AE mission could not have been accomplished without the near-seamless integration of our sister services. Medical and AE operations serve as the perfect example of the joint application military capabilities.

I also must give praise to the backbone of our AE capability, our Guard and Reserve. Fully 87 percent of our AE structure is Air Reserve Component members. They have assisted their active duty counterparts in transporting over 13,700 patients from OEF and OIF, of which about 2,300 were urgent or priority missions.

As I hope I have made clear, EMEDS capabilities span the geography of operations from the farthest forward immediate surgical capability, throughout the area of operations,

to include aeromedical evacuation to facilities around the globe. EMEDS has vastly improved how we care for casualties, but we still face challenges. Perhaps one of the most significant of which is caring for victims of weapons of mass destruction.

Although this country has recently seen two bio-chem attacks -- the anthrax attack two years ago, and the fortunately unsuccessful ricin scare of January -- we have yet to experience a large scale Weapons of Mass Destruction attack. Therefore, we can never know just how successful our response to such an attack will be. I guarantee our response would be superior to any other nation's on earth--but we always strive to expand the envelope of our nation's capability.

To enhance our response even more, AFMS personnel are implementing Code Silver. Code Silver is a program that offers tabletop exercises emphasizing biological and chemical warfare responses by our medical facilities. We will focus on how our facilities interact and relate to the rest of the base and with the local civilian community. Forty Air Force medical facilities and the communities surrounding them will participate in Code Silver exercises in 2004.

The fourth and critical capability we bring to the warfighter is the enhancement of human performance.

4. Enhance Human Performance

As the size of our military decreases and the capability of each individual platform increases, the relative importance of every individual also increases. Today's airman receives superior training so that they can maintain and operate the most sophisticated equipment and weapons systems in the world. But the stress and exhaustion of combat

operations leads to fatigue. Fatigue dramatically erodes the Airman's ability to react quickly and think clearly. It eliminates the intellectual and technological advantages we bring to the battle.

Commonly used methods of combating fatigue involve careful studying of our airmen's mission schedules, their diets, sleep patterns, even their biorhythms, to mitigate the impact of drowsiness upon their missions. These are all important to maintaining wakefulness, because at the very least, fatigue degrades mission performance. At the very worst, it kills. In battle, fatigue is a deadly enemy.

We also find we can enhance human performance by enhancing vision. We do so through corneal refractive surgeries--commonly known as PRK and LASIK. These procedures are provided to non-flying and non-special duty airmen. We began offering them after an exhaustive literature review and extensive expert conference conclusions revealed that the operations are, indeed, safe, effective, and potentially cost-saving. In the near future these procedures will be offered to some aviators and special duty members. We continue to study corneal refractive surgeries to see what the effects of time or the stresses of the cockpit -- like pressure changes and jarring -- have on our flyer's eyes. The results thus far are highly encouraging. One thing is for sure, they are very highly desired by our troops.

Good eyesight is, of course, critical to our forces. An enemy who can temporarily or permanently blind one of our troops will have succeeded in removing that Airman from combat. One method for inflicting such an injury is through directed energy, or lasers. In the little-more-than 40 years since the laser's invention, it has grown from something found only in a few science labs and an occasional James Bond movie, to a technology so

common that one can find lasers in every supermarket scanner, in DVD players; and I have even seen them sold as cat toys. Lasers are also weapons -- and are capable of injuring or destroying eyesight. The proliferation of lasers poses a growing threat to our pilots and troops.

In response to this challenge, we have created protective eyewear and faceplates that absorb and deflect laser light. The devices save our pilots from damaging and potentially permanent eye damage from these weapons. We continue to study ways to detect the presence of lasers in battlespace and methods for protecting our men and women against them.

Another challenge we encounter in enhancing human performance is our need for ever-increasing amounts of information and communication; especially that which flows between our EMEDS troops on the ground, our aeromedical evacuation crews in the air, and our medics in permanent facilities who receive patients from the area of operations. Our success at converting any transiting mobility aircraft into an aeromedical platform outpaced our ability to create the information systems to track the patients using them. It is difficult to keep oversight of the location and condition of thousands of patients on a worldwide scale.

Fortunately, the U.S. Transportation Command Regulating and Command & Control Evacuation System or TRAC2ES [*Tray-suhs*] is helping us overcome that challenge. TRAC2ES is a DoD information system that allows us to track the location and status of patients from the moment they enter the aeromedical evacuation system in the theater of operations, as they fly to a higher level of care, until they are safely back in a garrison medical facility.

I have described some of what we learned during current operations in Iraq, but before closing, I would like to mention a few our successes here on the home front.

The Home Front

We are always developing avenues to provide great and cost-effective care. One way to do so is to seek out partners who share our dedication to the care of patients and can join us in a better way of doing business. We continue to strengthen just such a relationship with our partners at the Department of Veterans Affairs. Of the seven current Joint Ventures between the DoD and VA, four of them are at Air Force medical facilities: Elmendorf in Alaska, Travis in California, Kirtland in New Mexico, and Nellis in Nevada.

These are not the only locations in which the VA and DoD work together to provide care. We are pursuing several additional Joint Venture locations and already have nearly 140 sharing agreements between the Air Force and VA throughout the United States. These are great examples of partnering with the VA.

We are also developing the exciting possibility of expanding the traditional concept of Joint Ventures to other major healthcare institutions. For example, we believe that a unique three-way joint venture between the DoD, VA and the University of Colorado Hospital will be a cost-efficient way of caring for all our beneficiaries. This concept is receiving not only strong support from DoD leadership and local VA officials, but also all of the Colorado Veterans organizations and the Colorado state congressional leadership.

Next Generation TRICARE Contracts

We are passionate about our mission and confident of continued success, yet there are some uncertainties in the future that warrant mention. As you know, the DoD is in the process of fielding new contracts to replace our original TRICARE contracts. This transition is the focus of a great deal of management attention. Our ability to smoothly change contractors and governance will be closely watched by our stakeholders. Not only will there be just three TRICARE regions, revised financing will be expanded nationwide.

This is a methodology to place the entire costs of a TRICARE enrollee's care in the hands of the local Medical Group Commander. She pays the private sector care bills as well being responsible for the direct care system -- that care we provide to our enrollees in our Air Force clinics and hospitals. Revised financing has proven to be an effective tool in those regions where it is currently being used. This is an important advance, leveraging what we've learned in allowing the Commander to select the most effective and most efficient location for health care. So, the dollars allocated to the direct care system are critical, but just as critical are the dollars allocated for revised financing. With this in mind, two-way flexibility between the private sector care and direct care accounts is necessary for revised financing to function successfully. The Air Force appreciates the congressional intent to protect direct care funding, but we recommend that the FY 2005 Defense Appropriations Act language remove the separate appropriation for Private Sector Care to allow the flexibility to move funds to wherever care is delivered without a Prior Approval reprogramming.

Budget

For FY 2004, the Congress's budget adequately funds our direct care system.

However, we do have challenges with the private sector care budget -- the health benefits purchased from civilian providers for our TRICARE beneficiaries. The TRICARE Management Activity (TMA), not the Services, manages all of these funds to include those for Revised Financing.

Two issues will pose significant fiscal challenges as we try to estimate what our private sector care costs will be.

The first issue is the increased use of TRICARE. TRICARE offers a very comprehensive benefit. With civilian healthcare plans raising co-pays and cutting back on benefits, more retirees are dropping their civilian healthcare and are relying exclusively on TRICARE. As more people opt for our health care program, costs for the entire TRICARE benefit rise. Correctly forecasting this cost is crucially important and placed pressure on the Department to handle these increases.

In addition to the enhanced TRICARE benefits the Department of Defense offered to activated Reserve Component members and their families during FY 2003, the National Defense Authorization Act of FY 2004 included even more new benefits. Because the new reserve health program is temporary, it offers us the ability to assess the impact of these benefits after the trial period. We will review the effects of these programs on reservists and their families as they transition to and from active duty and look at the overall effect on retention and readiness. We have concerns that health care benefits will be enhanced permanently before a full assessment of the impact can be completed, as well as concerns over the potential cost of new entitlements for reservists who have not been activated.

Consideration must also be given to the impact on the active duty force if similar health care benefits are offered to reservists who are not activated. OMB, DoD and CBO are working together to develop a model and a resulting five-year cost estimate to price the proposal to expand TRICARE health benefits for all reservists without regard to employment, medical coverage, or mobilization status as proposed in the Reserve and Guard Recruitment and Retention legislation. Preliminary results indicate that this could range from \$6 billion to \$14 billion over five years. Final scoring of this proposal should be completed by the end of March.

The influx of retirees and their families and of increased Guard and Reserve beneficiaries have greatly increased private sector care costs, which DoD will meet with internal reprogramming actions.

These bills are a must-pay, and they affect far more than our ability to provide the right care at the right place in the most efficient manner. Care for our military families is not just a medical issue -- readiness is inseparable from family health. It is unmeasurable, but undeniable, that an Airman's physical and mental fitness to deploy is tied to the well-being of his or her family. We must provide our troops piece-of-mind that in their absence their loved ones will have their social, mental, and health care needs met.

A final challenge we encounter in providing care is that of the recruitment and retention of our active duty and reserve component medical professionals, especially physicians, dentists and, nurses. The civilian health care environment offers significantly more attractive financial incentives than the Air Force, and we appreciate your support of recruitment and retention bonuses, special pay programs, and critical tools such as the

Health Professions Scholarship Program and the Health Professions Loan Repayment Program. These are vital to our ability to attract qualified professionals and keep them in the Air Force.

Summary

No other military in the world has the expertise, willingness to devote the resources, or the capabilities of the United States when it comes to caring for troops and their families, in times of war or in peace.

One of our medics -- a surgeon -- just returned from four months in Baghdad. He was asked, "What one word sums up your experiences there?" He said, "Satisfied . . . I was caring for people who put their lives on the line for this country. I know that I made a difference. That is satisfying."

It truly is satisfying to make a difference. We do. And we are proud to bring the special skill of Air Force medics to the service of our warriors -- both present and past -- and to their families. I thank you for your continued support of our medical service and our Air Force. We are proud to make a difference, and we are anxious to answer the call again.