



UNITED STATES GENERAL ACCOUNTING OFFICE  
WASHINGTON, D.C. 20548

HUMAN RESOURCES  
DIVISION

B-207364

SEPTEMBER 24, 1982

The Honorable Daniel K. Inouye  
United States Senate

Dear Senator Inouye:

Subject: Actions Needed to Insure That Female Veterans  
Have Equal Access to VA Benefits (GAO/HRD-82-98)

In response to your April 24, 1981, request, we reviewed the Veterans Administration's (VA's) efforts to provide benefits to female veterans. As agreed with your office, we focused on their medical needs. Specifically, we sought to determine whether VA was (1) equipped to provide them medical care, (2) planning for the anticipated increase in their demand for care, (3) informing them of available benefits, and (4) addressing their psychological problems related to service in Vietnam.

We visited 13 VA facilities, contacted another 32 facilities, and interviewed VA central office officials and representatives of veterans' service organizations. (Our objectives, scope, and methodology are detailed in enc. II.)

VA has made progress in insuring that medical care and other benefits are available to female veterans. However, because women make up only 2.5 percent (742,000) of the total veteran population, VA has not adequately focused on their needs. Yet, women have some unique needs, particularly medical, that must be addressed.

Action is needed to insure that

- men and women have equal access to VA treatment programs and medical facilities,
- women treated in VA facilities receive complete physical examinations,
- needed gynecological care is provided,
- sufficient plans are made for the anticipated increase in female veterans, and
- female veterans are adequately informed of their benefits.

The primary mission of VA's medical care system is to provide care to veterans with service-connected disabilities. In addition, to the extent that staff and facilities are available, VA facilities can provide care for nonservice-connected disabilities to veterans who are unable to defray the cost of care elsewhere. VA facilities have traditionally been sized and staffed to provide care to both service-connected and nonservice-connected patients. In past reports, we have questioned whether VA should be sizing facilities to serve both categories of veterans. However, as long as VA continues to do so, it should insure equal access to care for female veterans.

Because of the lack of privacy in older VA facilities, women could not benefit from some specialized medical care. For example, women could not participate in certain treatment programs at 2 of 6 VA psychiatric facilities contacted and were not admitted to 10 of the 16 domiciliaries. In addition, although the medical-surgical facilities could generally handle the number of female patients they had, the problem of insuring patient privacy at older medical centers inconvenienced patients and staff.

Although encouraged to do so by VA's central office, only one of the seven medical centers we visited had monitored physical examinations to insure that female patients received pelvic and breast examinations. That facility found that pelvic examinations had been documented for only 27 percent of the female patients, breast examinations for only 40 percent, and pap smears for none. Medical staff at two additional facilities told us that pelvic examinations were not routinely given.

Complete gynecological and obstetrical care were often not available. VA medical centers and independent outpatient clinics used various methods to provide gynecological care. While most were satisfactory, the reliance of many facilities on the fee-basis program--reimbursements to private health care providers--resulted in treatment being denied to women with nonservice-connected conditions. Eight of the 30 medical centers and independent outpatient clinics contacted depended primarily on the fee-basis program to provide gynecological care. However, VA can reimburse private sources for outpatient care only if the veteran is service-connected or has an emergency condition.

Thus, facilities that did not have outpatient gynecological services available and relied on the fee-basis program could not provide care to women with nonservice-connected, nonemergency gynecological problems. This was inequitable because the facilities treated virtually all outpatient medical needs of nonservice-connected males. For example, at the San Francisco medical center, 10 women were denied outpatient care for nonservice-connected

gynecological problems during the first 5 months of fiscal year 1982, while the medical needs of men with nonservice-connected problems were routinely met.

VA does not provide care for normal pregnancy and childbirth, even if the veteran was pregnant when discharged from the military or is unable to pay for hospital care. Officials at six of the seven medical centers we visited said that female veterans had requested, but were denied, care for normal pregnancies.

VA has not adequately assessed its ability to meet the future needs of female veterans. VA's long-range planning has not (1) identified programs currently unable to accept women or (2) projected the number of service-connected and nonservice-connected female veterans expected to seek care. VA has also not insured that renovation projects were planned so as to increase female patients' access to care.

Although VA is required to provide outreach services to veterans and measure the services' effectiveness, VA's outreach efforts have not been directed toward female veterans. VA has not (1) routinely disseminated information on benefit changes to service organizations with predominantly female memberships; (2) targeted outreach to female veterans, as it has for other categories of veterans; (3) adequately informed female veterans of statutory changes in their eligibility; or (4) measured female veterans' awareness of benefits, as it has for male veterans.


The Veterans' Readjustment Counseling Program was, however, specifically addressing female veterans' needs. Staff from 108 of the 126 veteran counseling centers had been trained in counseling female veterans. The centers were also collecting statistics on the women treated, and some were performing outreach specifically toward female veterans.

Enclosure I details the results of our review. We are making several recommendations to the Administrator of Veterans Affairs to insure that (1) female veterans have equal access to VA medical programs, (2) they receive needed gynecological care consistent with VA policies on providing care to nonservice-connected veterans, (3) their needs are considered in future planning for construction and renovation projects, and (4) they are adequately informed of available benefits. (See pp. 15 and 16.) VA agreed with most of our recommendations. (See enc. III.)

B-207364

As arranged with your office, we are sending copies of this report to the Administrator of Veterans Affairs; the Director, Office of Management and Budget; and other interested parties. Copies will also be made available to others who request them.

Sincerely yours,



Gregory J. Ahart  
Director

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### ABBREVIATIONS

DOD	Department of Defense
VA	Veterans Administration
WASP	Women's Airforces Service Pilot

ACTIONS NEEDED TO INSURE THAT FEMALE  
VETERANS HAVE EQUAL ACCESS TO VA BENEFITS

In an April 24, 1981, letter, Senator Daniel Inouye requested that we review the adequacy of the Veterans Administration's (VA's) efforts to meet the needs of female veterans. Our review was performed in accordance with generally accepted governmental auditing standards as contained in the Comptroller General's "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions." Our objectives were to determine whether VA was

- equipped to provide medical care to female veterans,
- effectively planning for the anticipated increase in their demand for medical services,
- adequately informing them of the benefits available, and
- addressing their psychological problems through its Readjustment Counseling Program for Vietnam era veterans.

We visited 7 medical centers, 1 psychiatric hospital, and 5 veterans' readjustment counseling centers. We contacted another 23 medical centers and independent outpatient clinics, 5 psychiatric hospitals, and 4 domiciliaries. Further, we interviewed VA central office officials and representatives of veterans' service organizations. Our objectives, scope, and methodology are detailed in enclosure II.

BACKGROUND

As of September 1981, there were about 742,000 female veterans. While representing only 2.5 percent of all veterans, the female veteran population is growing significantly. Women made up only 2 percent of the military strength before 1975, but under the all-volunteer force, the percentage rose to nearly 6 percent in 1977 and is expected to reach 12 percent in 1984. According to a 1981 VA Professional Services Letter, the increasing female veteran population is already appearing in some geographical areas and in such medical programs as nursing homes and intermediate hospitals. Further, the letter states that "changes in the roles women are currently assuming in the military will impact the nature and kind of injuries they receive and the medical care they will require."

Veterans are eligible for a wide variety of benefits, including (1) assistance for education or training; (2) home loan guarantees; (3) medical services (including hospitalization, outpatient care, dental care, nursing home care, and drug and alcohol treatment); (4) compensation for service-connected disabilities;

and (5) pensions for needy veterans who are permanently and totally disabled from nonservice-connected causes.

Although women have served in the military since at least World War I, they have not always received recognition as veterans and VA benefits equal to those given to male veterans. For example, women who served in the Women's Airforces Service Pilots (WASPs) during World War II were not legally eligible for VA benefits until 1979.

Even when women were recognized as veterans, they were not given the same benefits as male veterans. For example, until 1972, married female veterans received smaller education allowances under the GI bill than did married male veterans. In the 1960s, VA did not consider a woman's income equal to a man's for the purpose of qualifying for home loan guarantees.

Although these inequities have been eliminated, VA health care programs have typically been oriented to male health care needs because most veterans are male. The need to plan for and provide medical care that meets the special needs of female veterans is becoming more important in view of the increasing numbers of service-connected female veterans coming into the system now and anticipated in the future. Women require care for breast diseases, gynecological disorders, and pregnancy that may not be routinely available at VA hospitals. Privacy must also be provided in bed and bath facilities if male and female patients are to have equal access to VA treatment programs.

The primary mission of the VA medical care system is to provide care to veterans with service-connected disabilities. In addition, to the extent that staff and space are available, VA facilities can provide care for nonservice-connected disabilities to veterans who are unable to defray the cost of care elsewhere. Veterans with nonservice-connected illnesses are eligible for outpatient care only if the care is needed to obviate the need for hospitalization.

Veterans can also get care outside a VA facility. Veterans with service-connected disabilities can obtain both inpatient and outpatient care from private sources on a fee-for-service basis if VA facilities cannot provide the needed services or are geographically inaccessible to the veterans. Veterans with nonservice-connected disabilities are not generally eligible for fee-basis care. However, because some VA facilities cannot accommodate women, VA facilities can authorize fee-basis inpatient care for nonservice-connected female veterans.

Although nonservice-connected veterans are entitled to care only on a space-available basis, VA facilities have traditionally been sized and staffed to provide care to both service-connected

and nonservice-connected patients. In 1980, about 89 percent of VA inpatient veterans were treated for nonservice-connected disabilities.

Past studies of VA programs and veterans have not adequately addressed the effectiveness of VA's programs in meeting the needs of female veterans. For example, a 1977 National Academy of Sciences' study 1/ of the VA health care system specifically excluded female patients because the female veteran population was so small. Similarly, major studies of Vietnam veterans have not included women, although women served in Vietnam. 2/ Furthermore, although some women have had Agent Orange examinations, the data compiled in VA's Agent Orange registry do not distinguish between male and female veterans. Thus, we could not readily determine the number of female veterans who have received these examinations or the incidence or type of medical problems they have experienced.

Similarly, other Federal sources of data on veterans have not included information on female veterans. Although the Bureau of the Census has collected data on male veterans regularly since 1910 and published such data since 1950, it did not collect data on female veterans until 1980. The National Center for Health Statistics has also published statistics on the size and characteristics of the veteran population but compiled data only on male veterans.

#### FEMALES' ACCESS TO PROGRAMS LIMITED BY PRIVACY PROBLEMS

Because of the lack of privacy at older VA facilities, women, including those with service-connected disabilities, could not obtain some specialized medical care. Although staff and patients were sometimes inconvenienced, medical-surgical facilities were generally able to handle the current number of female patients. However, psychiatric facilities and domiciliaries were not.

#### Psychiatric facilities

Women could not participate in some treatment programs at two of the six psychiatric facilities we contacted. VA's director of mental health said that the six facilities were representative of other VA psychiatric facilities and that VA's older psychiatric hospitals are not suited to integrated treatment of men and women. He did not know how many of VA's psychiatric programs did not accept women.

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1/"Study of Health Care for American Veterans," June 7, 1977, submitted to the Senate Committee on Veterans' Affairs.

2/Data on the number of females who served in Vietnam were not available, but estimates ranged from 1,100 to 7,500.



Women were not admitted to the Intermediate Rehabilitation Unit or the New Directions Program at the Brentwood, California, VA medical center because they could not be insured adequate privacy. According to Brentwood's chief of psychiatry, privacy is inadequate in the sleeping areas, and VA cannot staff the units 24 hours a day to adequately supervise a sexually mixed population.

The Intermediate Rehabilitation Unit housed inpatients who no longer needed the structure of an acute psychiatric ward but who still needed treatment before returning to the community. Brentwood's chief of psychiatry estimated that annually about 15 to 20 women who could have benefited from the program remained in the acute psychiatric unit because they could not be accommodated in the rehabilitation unit. Because of this, the women could not benefit from (1) the less intensive supervision and (2) the emphasis on improving daily living skills, such as balancing checkbooks and finding housing, provided in the unit. However, according to the chief of psychiatry, in May 1982 Brentwood made the necessary staffing changes to permit women to be admitted to the unit.

Brentwood's New Directions Program, a highly structured, long-term treatment program for veterans with personality disorders, often compounded by drug or alcohol abuse, provides a restrictive environment emphasizing peer confrontation. According to the chief of psychiatry, from two to five women a year have been denied access to the program because VA did not have enough staff to supervise a sexually mixed psychiatric group. Women who could have benefited from the program were treated in either a general psychiatric ward or a substance abuse program, neither of which, according to the chief, were as effective in treating their personality disorders.

The chief of psychiatry said that the fee program could be used for female psychiatric patients who cannot be accommodated in VA programs. However, he said that there were no programs in California comparable to the New Directions or Intermediate Rehabilitation Unit programs.

The North Chicago VA medical center did not accept women in some of its psychiatric treatment programs. For example, a geriatric unit for frail elderly psychiatric patients who had complicating medical problems did not admit women because it could not provide adequate privacy to female patients. According to North Chicago's chief of psychiatry, about 10 female patients who could have benefited from the program's specialized nursing were being treated in other units. Similarly, a research unit that treated patients with tardive dyskinesia, a neurological disease that occurs more often in females than males, did not accept women. According to the chief of psychiatry, the unit did not provide adequate privacy in the sleeping areas, and because the facility had many more men than women with the disease, the women were

treated in other psychiatric units. He said that about 20 women were therefore unable to benefit from the specialized nursing services and patient monitoring available in the research unit.

### Domiciliaries

Neither service-connected nor nonservice-connected female veterans were admitted to 10 of VA's 16 domiciliaries because of a lack of privacy in sleeping and toilet facilities. Domiciliaries provide care to ambulatory veterans disabled by age, disease, or injury who need care less intensive than hospital or nursing home care. VA has recognized the problem and has required domiciliaries that do not accept females to include, in their 5-year renovation plans, modifications designed to accommodate women. Until renovations are completed, women needing domiciliary care may apply either to 1 of the 6 VA domiciliaries that accept women or to 1 of 38 State veterans' home domiciliaries in 30 States.

However, the nearest facilities that accept women may be too far from the veterans' homes to be reasonable alternatives. For example, VA's Wadsworth, California, domiciliary, which does not accept female patients, is 400 miles away from the nearest alternative facility. Wadsworth officials estimated that each month five female veterans inquire about admittance to the domiciliary, which serves the second largest concentration of veterans in the United States. They are directed to the three nearest domiciliaries that accept women: Temple, Texas, 1,500 miles away; White City, Oregon, 700 miles away; and Yountville, California, a State veterans' home domiciliary 400 miles away. VA officials said that most women do not pursue the alternatives because of a reluctance to move so far from their family and friends. In addition, the State domiciliary has a 5-year California residency requirement that some applicants may not meet. Both service-connected and nonservice-connected males can be accommodated at Wadsworth with little or no delay.

### Medical-surgical centers

Five of the seven medical-surgical centers we visited had problems accommodating female patients. In some, particularly older facilities with large open rooms, special procedures were required to accommodate females. The two newest facilities we visited, San Antonio and San Francisco, had no significant problems of this nature.

Problems in insuring privacy at older medical centers created concerns for female patients and inconvenienced the staff. Wards in older facilities have many 8- to 16-bed rooms and frequently have communal shower and toilet facilities. Because there often are not enough female patients to fill large rooms,

females compete with isolation patients for the hospitals' limited number of private rooms.

Staff at five of the seven medical centers visited expressed concern regarding female patients' privacy either because of large open sleeping areas or communal baths or toilets. Five medical centers visited had bedrooms for 8 to 16 patients, and four of these had communal bathing areas. Concerns expressed by staff included:

- Staff at three of the five facilities said that problems occurred when men had to be moved from private and semi-private rooms to make the rooms available for female patients. Problems mentioned included extra time demands on nurses making the moves, delays for women waiting to be admitted, and resentment on the part of the men being moved.
- Nurses at Palo Alto said that, because women were admitted whenever possible to private rooms, originally intended as isolation rooms, they competed for these rooms with critically ill patients.
- Staff at all five facilities cited problems with communal toilet or bathing facilities. When a female patient needed to bathe, nurses cleared the areas, then stood guard to insure privacy. Toilet facilities sometimes had to be similarly secured, and nursing units at two facilities resorted to providing women portable commodes.

In addition, female patients were not always placed in the most appropriate medical ward. For example, a female alcoholism patient at Houston said that it took her 2 weeks to get transferred to a room on the alcohol treatment unit originally intended as a female patient's room. In the meantime, she was placed on the psychiatric ward and required to conform to that unit's more restrictive environment. She, therefore, felt that she was not treated the same as the male patients. Also, the fact that she had to make several complaints before she was moved put her in an adversary position with medical and administrative staff.

FULL GYNECOLOGICAL AND OBSTETRICAL  
CARE NOT ALWAYS PROVIDED

Women require some unique medical care, including pelvic examinations and gynecological and obstetrical care. However, physical examinations at the facilities visited did not always include pelvic examinations, women with nonservice-connected disabilities could not always get gynecological care, and women with normal pregnancies could not obtain obstetrical care.

Physical examinations

A January 1981 VA Professional Services Letter stated that:

"A pelvic exam is a routine part of the physical examination for any female patient and should be required and monitored by each medical center's internal review program."

According to a VA gynecologist, pelvic examinations and pap smears are important techniques for detecting cancer in women. However, only one medical center we visited, Syracuse, had reviewed patients' medical charts to monitor the completeness of female patients' physical examinations. This facility found that, in May and June 1981, pelvic examinations had been done for only 27 percent of the female patients; breast examinations for only 40 percent; and pap smears for none. These findings were provided to the hospital staff along with guidance on when such examinations are warranted. The hospital guidance stated that a breast examination should be done on every admission and that pelvic examinations and pap smears should be done annually unless there are specific indications to the contrary. A followup review is planned for 1982.

At six of the seven medical centers visited, medical staff said that pelvic examinations were left to the physicians' discretion. At the other facility, the staff believed that pelvic examinations were always done, but said that there had been no monitoring of physicians' practices. Medical staff at two facilities, Houston and San Francisco, said that pelvic examinations were not routinely done, although men generally received rectal examinations to detect prostate cancer.

Gynecological care

VA medical centers and independent outpatient clinics used various methods to provide gynecological care. While most facilities satisfactorily served female patients, many relied on the fee-basis program to provide gynecological care, which resulted in their denying treatment to nonservice-connected female outpatients. One method the facilities could use to provide this care to nonservice-connected veterans is sharing agreements with military hospitals.

Six of the seven facilities we visited had arranged to provide gynecological care to both service-connected and nonservice-connected outpatients:

--The Manhattan VA medical center had a part-time gynecologist on its staff.

--The Denver and San Antonio VA medical centers had sharing agreements with local universities to provide gynecological care.

--The Palo Alto, Syracuse, and Houston medical centers had gynecology consultants under contract. Houston also had a gynecologist on its staff to see outpatients.

However, the San Francisco medical center relied exclusively on the fee-basis program for gynecological care and could therefore provide outpatient gynecological care only to service-connected patients or those with emergencies--the two categories of veterans permitted to receive outpatient fee-basis care under Federal law. As a result, 10 women were denied outpatient care for nonservice-connected gynecological conditions at San Francisco during the first 5 months of fiscal year 1982. According to the medical center's administrative assistant for ambulatory care, some of the women had serious gynecological problems, but because they were nonservice-connected and did not need immediate hospitalization, they were denied care. San Francisco officials said that this reliance on the fee-basis program resulted in women being treated inequitably because virtually all outpatient medical needs of nonservice-connected male veterans were treated in VA's outpatient clinics to obviate the need for hospitalization.

To determine whether other facilities were relying on the fee-basis program to serve female veterans, we made a telephone survey of 17 randomly selected medical centers and all 6 independent outpatient clinics. Seven of these facilities indicated that they depended primarily on the fee-basis program to provide outpatient gynecological care. Because of restrictions on the availability of fee-basis care, nonservice-connected women are not eligible for outpatient gynecological treatment at these facilities even if the treatment is needed to obviate the need for hospitalization.

We have long encouraged sharing of Federal medical resources between VA and the Department of Defense (DOD) as a way to better use Federal facilities and thus reduce health care costs. Such sharing is now authorized under the Federal Interagency Medical Resources Sharing and Coordination Act of 1981 (Pub. L. No. 97-174). Because DOD hospitals have traditionally provided care to spouses and dependents, they are more attuned to the needs of female patients. Accordingly, we believe VA could expand its ability to meet female veterans' needs through sharing agreements with DOD hospitals. The San Francisco medical center was considering such a sharing agreement with a nearby military hospital to provide gynecological care.

In April 1982, legislation was introduced (S.2385) that would authorize VA to provide certain outpatient care--pre- or post-

hospitalization care and care necessary to obviate the need for hospitalization--on a fee-for-service basis for nonservice-connected disabilities of female veterans when VA is unable to provide care for their gender-related disability. According to the Chairman of the Senate Committee on Veterans' Affairs, he introduced the legislation to meet the needs of female veterans who cannot receive needed medical care because VA is not equipped to provide gynecological and other services they require for gender-specific conditions.

Female veterans cannot receive  
care for normal pregnancy

Under a VA regulation, female veterans are not eligible for medical care for normal pregnancy and childbirth, even if they were pregnant when discharged from the military or are unable to defray the cost of hospital care. The regulation was recently upheld in the U.S. Court of Appeals for the District of Columbia, but further litigation is possible. In the event that VA must eventually provide obstetrical care, we have identified several ways to provide such care without expanding VA facilities.

VA is required by law (38 U.S.C. 610) to provide hospital care to any veteran with a service-connected "disability" and, if space is available, to a veteran with a nonservice-connected disability who is unable to defray the cost of hospital care. However, VA considers normal pregnancy a physiological condition, not a disability. Accordingly, a VA regulation (38 CFR 17.48(e)) states that VA will not provide care for pregnancy unless it is complicated by a pathological condition. VA officials at six of the seven medical centers we visited told us that female veterans requested hospital care for normal pregnancies and were refused treatment. We did not obtain information on whether pregnant veterans had requested care at the seventh facility.

The VA regulation was challenged by a veteran, who claimed that childbirth is a disability within the meaning of the law. In 1981, the U.S. District Court for the District of Columbia ruled, in Kirkhuff v. Cleland, that the regulation was inconsistent with the intent of the law and was therefore invalid. However, on July 20, 1982, the U.S. Court of Appeals for the District of Columbia overturned the lower court's decision, 1/ stating that the regulation was sufficiently reasonable

"\* \* \* in light of the legislative history, the wide-ranging responsibility and discretion of the Veterans Administration on matters dealing with benefits for

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1/Now Kirkhuff v. Nimmo.

veterans, and the long-standing, consistent, and widely publicized nature of VA's interpretation \* \* \*."

As of August 30, 1982, the veteran had not appealed the decision.

VA has argued that it would have to expand VA facilities at great expense to provide obstetrical care; however, alternatives exist. VA provides hospital care for pregnancies with complications through arrangements with other facilities (for example, affiliated university hospitals) or through the fee-basis program. These alternatives, as well as sharing agreements with DOD hospitals, could be used to provide care for normal pregnancies.

VA PLANNING EFFORTS NOT ADEQUATELY  
CONSIDERING FEMALE VETERANS

VA has not adequately considered the increasing female veteran population in long-range planning for construction and renovation projects or in designing facility renovations. In developing data for VA's 5-year construction plan, VA medical centers did not identify the factors limiting female veterans' access to facilities and programs or project the number of service-connected and nonservice-connected female veterans expected to seek VA care. Furthermore, when detailed plans were developed for renovation projects, medical centers did not insure that the planned renovations would provide females adequate privacy.

A 1981 VA Professional Services Letter stated that because of the "increasing numbers of women veterans coming into the system \* \* \* it [is] important to plan for and implement health care programs \* \* \* tailored to the special needs \* \* \* of women veterans." It suggested that "each medical center review its approach to female patients and determine what changes and adjustments may be needed."

However, VA planning has not identified medical programs that cannot accommodate female veterans. In October 1981, VA established a Medical District Initiated Program Planning process to develop 5-year plans. The initial phase, completed in March 1982, required medical centers to identify factors limiting service delivery. Although female veterans do not have access to some VA facilities and treatment programs, none of the 28 medical district submissions identified any factors limiting females' access to VA medical centers or treatment programs.

Furthermore, VA had not quantified the expected increase in female veterans' demand for VA services. To identify expected increases or decreases in demand for services, VA directed medical districts to include, in their January 1982 submissions, data on the current and projected veteran population to be served.

However, the data submitted by the medical districts reflected total veterans without a breakdown by sex. One medical district recognized the need for data on female veterans, but indicated that such data were not available.

Without projections on the female population likely to seek VA health care, VA cannot determine if its facilities can accommodate future demand. As stated on pages 5 and 6, older VA facilities frequently use their few isolation rooms for female patients. As the number of female patients increases, these facilities may not be able to adequately accommodate female veterans.

VA's privacy standards do not insure that female patients are provided privacy in shower facilities. The standards, which are used in designing facility renovations, discuss how to provide privacy in communal and private bath facilities, but do not require separate facilities for male and female patients. As a result, facilities that are renovated to provide more patient privacy still may not be able to accommodate female veterans.

For example, the Syracuse medical center developed renovation plans--approved by VA's central office--that could give women access to more patient rooms but did not give them adequate access to shower facilities. Syracuse planned to divide the medical center's 16-bed rooms into smaller rooms equipped with toilets and sinks, but did not plan to subdivide existing communal showers or provide more private showers. Syracuse officials said that they had not recognized the potential future problem of shower privacy during the planning process. After our visit, they revised the plans to include private showers in some rooms to accommodate female patients.

Similarly, part of the domiciliary at the Hampton, Virginia, medical center was renovated in 1977-78 to improve privacy in sleeping quarters, but no change was made in the communal bathrooms. Because there are no private bathrooms for female veterans, the domiciliary did not accept females even after the renovations.

VA's domiciliary coordinator said that if renovations do not specifically address females' needs, the increasing number of retirement-age female veterans will place an additional burden on the six domiciliaries that accept women.

VA OUTREACH NOT DIRECTED  
TO FEMALE VETERANS

VA has not effectively informed female veterans of their benefits or assessed their awareness of those benefits. Specifically, VA has not (1) routinely disseminated information on



benefit changes to service organizations with predominantly female memberships; (2) targeted outreach to female veterans, as it has to other groups of veterans; (3) adequately informed female veterans of statutory changes in their eligibility for benefits; or (4) measured female veterans' awareness of benefits.

VA is required to conduct outreach to inform veterans of available benefits and services. To do this, VA

- sends veterans letters a few months after discharge;
- distributes public service announcements and news releases to television networks, radio stations, newspapers, and magazines;
- operates veterans' assistance centers in VA regional offices to provide information on VA benefits to veterans who inquire; and
- distributes information to veterans' service organizations for dissemination to their members.

VA relies heavily on recognized service organizations to inform female veterans of VA benefits, but neither VA officials nor the service organizations knew how many women belonged to the organizations. All of the 90 VA-recognized service organizations have predominantly male memberships, and one of the major ones, the Veterans of Foreign Wars, did not admit women as members until 1978. VA automatically informs all VA-recognized service organizations of changes in benefits or in eligibility requirements, whereas nonrecognized organizations must request specific information. VA had made no special effort to get predominantly female veterans' groups, such as the Women's Overseas Service League or Women's Auxiliary Army Corps, to apply for recognition.

Although VA has targeted certain groups of veterans in its outreach program, it has done no special outreach toward female veterans. VA has made special efforts to inform educationally disadvantaged, aging, and incarcerated veterans of their benefits. For example, in fiscal year 1980, VA provided information on its services to over 600 local agencies serving aging Americans and conducted presentations at senior citizen centers, nursing homes, and congregate meal sites.

In addition, VA was not effectively notifying women of statutory changes in their eligibility. Although VA did outreach for one benefit change, it did not notify women of another major eligibility change and provided misleading information on a third change.

In 1975, VA did extensive outreach notifying female veterans of a change in GI bill education payments. VA notified female

veterans of retroactive adjustments, going back to 1966, that equalized the benefits paid to married female veterans with those paid to married males.

In another instance, however, VA made no attempt to inform female veterans of a change specifically affecting them. Under the Equal Credit Opportunity Act of 1975, lending institutions are required to give the same weight to women's income as they do to men's when considering applications for home loans. Although VA was aware that lending institutions had been discriminating against females in processing home loan guarantees, it made no special efforts to inform female veterans that lending institutions could no longer discriminate on the basis of sex or require women to submit statements on their use of birth control.

Although VA recently attempted to inform several groups of newly recognized female veterans that they were eligible for VA benefits, it did not contact all members of the groups or provide accurate information. Several groups of women who provided services to the Armed Forces in a civilian capacity during World War II were judged by DOD to have served in an active duty military capacity and therefore became eligible for veterans' benefits. The two largest groups, the WASPs and the Women's Auxiliary Army Corps, recognized as veterans in 1979 and 1980, respectively, have an estimated current membership of over 7,000.

To become eligible for veterans' benefits, a member of these groups must apply to DOD for an official service discharge. Neither DOD nor VA has attempted to notify the women who have not applied for a discharge that they may be eligible for veterans' benefits. As of September 1981 about 2,500 of the 7,000 had applied for veterans' status.

VA has sent the same form letter that it sends to all recently discharged veterans to most of the 2,500 women who have received a service discharge. VA said that a specially designed and carefully worded letter and pamphlet were prepared to advise the newly recognized female veterans of benefits to which they may be entitled, but that the wrong letter was initially mailed to female veterans by mistake. According to VA, the specially designed letter has been sent to the 859 female veterans recognized since September 1980. The approximately 1,600 female veterans recognized before that time were sent a form letter informing them that they were eligible for all VA benefits. However, the members of the two groups were not eligible for all those benefits. For example, they were not eligible for the GI bill education benefits, certain dental benefits, or job preference benefits. According to an official from the WASPs, because of this misinformation, some female veterans were confused about what benefits they were eligible for.

Although VA is required to assess the effectiveness of its outreach services, it has not measured their effectiveness in reaching female veterans. In 1980, VA issued the "1979 National Survey of Veterans," a major study of male veterans' awareness and use of VA benefits. The veterans in the study were selected from Bureau of the Census data, which identified only male veterans. The study showed that many male veterans were not aware of VA benefits. For example, of the selected male veterans,

- 78 percent were aware of VA hospitalization benefits,
- 46 percent were aware of VA outpatient care, and
- 89 percent were aware of the VA home loan guarantee program.

Although VA is now studying female veterans' use of certain benefits, it has not studied their awareness of benefits and, therefore, does not have data to assess how well it is meeting its responsibility to inform all veterans of benefits.

VETERANS' READJUSTMENT COUNSELING PROGRAM  
ADDRESSING FEMALE VETERANS' NEEDS

The Readjustment Counseling Program for Veterans of the Vietnam Era, a program established in 1979 to provide counseling to veterans having difficulty readjusting to civilian life, was specifically addressing female veterans' needs. The veteran counseling centers (vet centers) were training staff on female veterans' readjustment problems, compiling statistics on female veterans seeking help, and performing outreach to female veterans.

According to the program's director, vet center staff at first did not consider women who served in Vietnam to be combat veterans. He said that, because of the small number of women who served in Vietnam and the different roles that men and women generally played, female veterans' readjustment needs were not initially recognized. However, training provided to vet center staff now recognizes the needs of female veterans. As of May 1982, the women's director of Vietnam Veterans of America and VA staff had trained staff from 108 of the 126 vet centers in counseling female veterans.

Of the five outreach centers we visited, two (Denver and Oakland) specifically targeted outreach to female veterans, one (Houston) publicized that the program served both male and female veterans, one (San Antonio) planned to do outreach to females, and one (Manhattan) did not discuss both male and female veterans in its outreach.

Despite the actions VA has taken to address female needs in the vet centers, women still face problems gaining acceptance at

some centers. According to the director of the Readjustment Counseling Program and the coordinator of the program's western region, vet centers vary in their awareness of female veterans' needs. The director said that a vet center's attitude toward female veterans will reflect community values because both the staff and clients generally come from that community. According to the women's director of the Vietnam Veterans of America and several female veterans in California and Oregon, female veterans still encounter negative reactions from some VA staff and veterans.

### CONCLUSIONS

Because of the high proportion of male veterans, the VA health care system has traditionally been oriented toward male needs. Although the primary mission of the VA health care system is to meet the needs of service-connected veterans, VA facilities have generally been sized and staffed to accommodate both service-connected and nonservice-connected veterans. Thus, male veterans can generally obtain needed care from a VA facility regardless of service connection. The same is not true for female veterans because of problems in insuring privacy in older facilities and variations in the availability of gynecological care. We have, in the past, questioned whether VA should size its hospitals to accommodate nonservice-connected veterans. However, as long as VA continues to do so, it should insure that male and female veterans have equal access to facilities and treatment programs.

VA needs to increase its staff's awareness of female veterans' unique medical needs and do more to address those needs. This is becoming more important because of the increasing numbers of female veterans and the increasing proportion of them who are expected to have service-connected disabilities. Without a concerted effort by VA to identify and address female veterans' needs, neither short-term renovation projects nor long-term facility planning will substantially increase their access to VA medical care.

### RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator, through the Chief Medical Director:

- Improve female veterans' access to outpatient gynecological care and other care not available at VA facilities by (1) negotiating sharing agreements with DOD or other Federal hospitals, (2) contracting with private gynecologists, or (3) developing in-house capability.
- Revise privacy standards and insure that future construction or renovation projects correct privacy limitations that limit women's access to VA facilities and treatment.

--Instruct VA medical facilities to identify all treatment programs that cannot accept female patients and develop alternative ways to provide the care, such as sharing agreements or increased use of the inpatient fee-basis program.

--Develop projections on the numbers of service-connected and nonservice-connected female veterans expected to seek care from VA and use such data in planning future construction and renovation projects.

We also recommend that the Administrator, through the Chief Benefits Director,

--evaluate female veterans' awareness of benefits,

--establish procedures to insure that female veterans will be notified of major changes in benefits that affect them, and

--expand outreach efforts to include veterans' organizations with predominantly female memberships.

AGENCY COMMENTS AND  
OUR EVALUATION

VA agreed with our recommendations to improve female veterans' access to medical care, but did not agree that the primary mission of the VA system is to provide care to veterans with service-connected disabilities. VA also did not agree that there is a need for (1) an assessment of female veterans' awareness of VA benefits or (2) special efforts to notify female veterans of changes in their benefits.

Primary mission of VA  
medical care system

VA said that section 4101(a), title 38, United States Code, states unequivocally that "the primary function of the VA Department of Medicine and Surgery is to provide a complete medical and hospital service \* \* \* for the medical care and treatment of veterans." (Emphasis added by VA.) VA also stated that, although nonservice-connected veterans are not eligible for all the medical care for which service-connected veterans are eligible and priority is usually given to service-connected over nonservice-connected veterans, one of VA's primary functions is to provide medical and hospital services to all eligible veterans.

The language cited by VA was added to 38 U.S.C. by the Veterans Omnibus Health Care Act of 1976, whose principal purpose was, according to the Senate Report, to "redirect care and expenditures

to the system's primary beneficiaries--veterans with service-connected disabilities." The report also stated that:

"The VA hospital system, since its establishment more than 50 years ago, has had as its primary mission the provision of first-class medical care to service-connected veterans. Its secondary mission has been to provide care for nonservice-connected veterans, but only to the extent that facilities are available so as to bring about a patient population size which could promote efficient utilization of resources."  
(Emphasis added.)

Improve female veterans'  
access to care

VA said that it will develop guidelines to help all VA health care facilities improve female veterans' access to out-patient gynecological care and other care not available to them at VA facilities.

Revise privacy standards and  
insure that construction projects  
correct privacy limitations

VA said that, as guidelines and instructions for interim construction are revised, sensitivity to the special facility needs of female veterans will be highlighted and encouraged. According to VA, a forum will be developed through medical center engineering officer conferences and conference telephone calls to share successful local solutions to female patient care and privacy problems. VA said that health care facility construction will provide the special facilities needed to treat female veterans when VA's health care programs require these facilities. However, VA said that, because of existing physical constraints and limited resources, interim solutions are often necessary even though they require a compromise in program scope and staff convenience.

Develop projections on  
female veterans

VA said that it will prepare estimates which reflect the age, county of residence, and other statistics regarding the female veteran population. According to VA, the estimates will be used in conjunction with current age-specific utilization data to project future use.

Evaluate female veterans'  
awareness of benefits

VA said that our recommendation could be quickly implemented but questioned the need for or value of such information. According to VA, female veterans are, "first and foremost, veterans" and as such, have access to the full range of benefits information and assistance provided to all veterans. VA said that the assistance available to all veterans includes toll-free telephone service in all 50 States and access to any regional office for a personal interview.

Having access to information on available benefits does not mean that a veteran is aware of those benefits or of the availability of benefits information. Although male veterans have access to the toll-free telephone lines and regional offices, VA studies have shown that male veterans are not aware of many of their benefits. We believe female veterans' awareness should be measured because (1) women have not been included in past VA studies and (2) they have not always received the same information and benefits as male veterans.

Notify female veterans of  
changes in veterans' benefits  
specifically affecting them

VA does not see a need to subdivide veterans by sex because (1) the same benefits are available to all veterans and (2) training at military separation points, briefings, and benefits orientations are all designed to disseminate comprehensive information regarding VA benefits and services. VA believes that separate procedures for female veterans are unnecessary and duplicative of ongoing procedures.

Benefits changes do not necessarily apply to all veterans. For example, legislation has been introduced to authorize fee-basis outpatient care for nonservice-connected female veterans when VA is unable to provide care for a gender-related disability. (See pp. 8 and 9.) If that legislation, or other legislation specifically affecting female veterans' benefits, is enacted, VA should insure that female veterans are notified of the changes. While training at military separation points would disseminate such data to newly separated veterans, it would not disseminate data to the 742,000 female veterans previously separated.

Expand outreach to predominantly  
female veterans' organizations

VA agreed with our recommendation and said that action will be taken to ensure that veterans' organizations with predominantly female memberships are included in outreach efforts.

OBJECTIVES, SCOPE, AND METHODOLOGY

Female veterans are increasing in both numbers and as a percentage of the total veteran population. Senator Daniel Inouye requested that we determine whether VA was (1) equipped to provide medical care to female veterans, (2) effectively planning for the anticipated increase in their demand for medical services, (3) adequately informing them of the benefits available to them, and (4) addressing their psychological problems through its Readjustment Counseling Program for Vietnam era veterans. Our study was conducted primarily at the following VA facilities in four States.

## VA medical and psychiatric centers:

- San Francisco, California
- Palo Alto, California (including nursing home)
- Brentwood, California (psychiatric center)
- Denver, Colorado
- Houston, Texas (including nursing home)
- San Antonio, Texas
- Manhattan, New York
- Syracuse, New York (including nursing home)

## Veteran readjustment counseling centers (vet centers):

- Oakland, California
- Denver, Colorado
- Houston, Texas
- San Antonio, Texas
- Manhattan, New York

The facilities in California, New York, and Texas were selected because of the large numbers of female veterans living in those States. The Denver medical center and vet center were selected because a VA central office official indicated that they were particularly attuned to the concerns of female veterans.

ASSESSMENT OF MEDICAL CARE  
PROVIDED TO FEMALE VETERANS

To assess the capability of VA facilities to provide needed medical care to females, we determined whether (1) VA medical facilities and treatment programs were accessible to women, (2) gynecological care was available, (3) thorough physical examinations were given, and (4) obstetrical care was available.

To determine if women had access to all VA medical facilities and treatment programs, at each medical center visited we interviewed VA personnel, including management and administrative personnel, nurses, physicians, and staff from the ambulatory care, psychiatry, and engineering services. We also toured all facilities to see whether they offered adequate privacy in the bed and bath areas.



Because psychiatric facilities were cited in the 1977 National Academy of Sciences study of VA health care as lacking adequate patient privacy, we visited the psychiatric facility at Brentwood, California, and contacted the chiefs of psychiatry at the Coatesville, Pennsylvania; Murfreesboro, Tennessee; North Chicago, Illinois; Fort Meade, South Dakota; and Salisbury, North Carolina, psychiatric hospitals to ascertain whether all treatment programs accepted women. According to the VA Director of Mental Health and Behavioral Sciences, the facilities contacted were representative of VA psychiatric facilities nationwide.

To determine whether women had access to VA domiciliaries, we spoke with VA's program coordinator for domiciliaries and officials at four domiciliaries (Wadsworth, California; Bath, New York; Hampton, Virginia; and Martinsburg, West Virginia).

To obtain information on VA policies and additional information on whether female veterans have access to all VA medical programs, we spoke with numerous VA central office officials from the Nursing, Medical, Professional, and Medical Administration Services; the Office of Administration; the Evaluation and Analysis Office; the Board of Veterans Appeals; the Reports and Statistics Service; the Extended Care and Patient Treatment Services; and the Inspector General's office.

To determine whether and how gynecological and obstetrical care were provided at VA facilities, we (1) spoke with the medical staff at each of the 7 medical centers visited, (2) conducted a telephone survey of 6 independent VA outpatient clinics and 17 randomly selected medical centers, (3) reviewed VA regulations and policies, (4) reviewed legal briefs concerning care for pregnancy, and (5) interviewed VA central office officials.

#### EVALUATION OF VA'S PLANNING FOR INCREASE IN FEMALE VETERANS

To determine whether VA was adequately considering existing facility limitations and numbers of female veterans in developing construction and renovation plans, we (1) interviewed VA central office officials in the Facility Planning Service, Health Systems Information Service, Office of Program Analysis and Development, Office of Construction, and Health Systems Planning Service; (2) reviewed all 28 VA medical districts' initial submissions for the 1982 medical district initiated planning process; and (3) spoke with planners in two medical districts and with engineering and administration officials at the seven medical centers visited.

#### ASSESSMENT OF VA'S OUTREACH SERVICES TO FEMALE VETERANS

To assess the adequacy of VA's outreach to female veterans, especially outreach informing them of statutory changes affecting

them, we spoke with VA officials and examined VA outreach material. At VA's central office, we (1) spoke with officials from the Office of Public and Consumer Affairs, Reports and Statistics Service, Department of Veterans Benefits, and Education and Loan Guarantee Services and VA's Federal Women's Program Manager; (2) viewed VA public service announcements distributed to television networks; (3) examined VA benefits brochures; and (4) reviewed VA studies on veterans' awareness of benefits.

To determine the effectiveness of veterans' service organizations as a vehicle for informing female veterans, we spoke with officials of veterans' groups, including the American Legion, Disabled American Veterans, Veterans of Foreign Wars, Vietnam Veterans of America, American Veterans Committee, Women's Overseas Service League, and WASPs.

At the medical centers, we spoke with staff about their perceptions of female veterans' awareness of benefits.

#### EVALUATION OF CARE PROVIDED TO FEMALE VETERANS BY READJUSTMENT COUNSELING PROGRAM

To determine whether the veteran readjustment counseling centers (vet centers) were addressing the needs of female veterans, we met with the program's director, the coordinator of the program's western region, and the women's director of Vietnam Veterans of America and visited five vet centers and spoke with their directors.

#### REVIEW OF NONMEDICAL BENEFITS

During the initial phase of our review, we spoke with VA officials about the availability of nonmedical benefits to female veterans. At the VA central office, we spoke with the Chief Benefits Director, Department of Veterans Benefits, as well as officials from the Education Service, Loan Guaranty Service, and Veterans Assistance Service. We also reviewed VA regulations on benefits, including the education, home loan, and compensation and pension programs. At VA's San Francisco Regional Office, we spoke with the Regional Director and Loan Guaranty Officer about the regions' roles in providing benefits. In addition, we contacted some female veterans identified as having concerns about benefits to determine whether they believed they had been discriminated against.

Based on our initial work, we found little indication of inequitable practices in these programs; therefore, we focused on the health care programs.

Office of the  
Administrator  
of Veterans Affairs

Washington, D.C. 20420



**Veterans  
Administration**  
SEPTEMBER 3 - 1982



Mr. Gregory J. Ahart  
Director, Human Resources Division  
U.S. General Accounting Office  
Washington, DC 20548

Dear Mr. Ahart:

My comments on the findings and recommendations in your July 21, 1982, draft report, "Actions Needed to Insure that Female Veterans Have Access to VA Benefits," are enclosed. Thank you for the opportunity to review this report.

Sincerely,

A handwritten signature in cursive script that reads "Everett Hoare".

ROBERT P. NIMMO  
Administrator

Deputy Administrator - in the absence of

Enclosure

VETERANS ADMINISTRATION (VA) COMMENTS ON THE GENERAL ACCOUNTING OFFICE (GAO) JULY 21, 1982, DRAFT REPORT, "ACTIONS NEEDED TO INSURE THAT FEMALE VETERANS HAVE ACCESS TO VA BENEFITS"

The following statements reflect my position on the recommendations in the subject report.

GAO recommends that I, through the Chief Medical Director:

- Improve female veterans' access to outpatient gynecological care and other care not available at VA facilities by (1) negotiating sharing agreements with DoD or other Federal hospitals, (2) contracting with private gynecologists, or (3) developing in-house capability.
- Instruct VA medical facilities to identify all treatment programs that cannot currently accept female patients and identify alternative ways to provide the care such as sharing agreements or increased use of the inpatient fee basis program.

I concur. VA Central Office staff will develop guidelines to assist all VA health care facilities in improving female veterans' access to outpatient gynecological care, and other care not available at VA facilities.

- Revise privacy standards and insure that future construction or renovation projects correct privacy limitations that limit women's access to VA facilities and treatment.

I concur, and health care facility construction will provide the special facilities needed for the treatment of female veterans when the VA's health care programs require these facilities. As a result of existing physical constraints and limited resources, interim solutions are often necessary even though they require a compromise in program scope and staff convenience. As guidelines and instructions for interim construction are revised, sensitivity to the special facility needs of female veterans will be highlighted and encouraged. A forum will be developed through medical center engineering officer conferences and conference telephone calls to share successful local solutions to female patient care and privacy problems.

- Develop projections on the number of service-connected and nonservice-connected female veterans expected to seek care from VA and use such data in planning future construction and renovation projects.

I concur in this recommendation and estimates will be prepared which reflect the age, county of residence, and other useful statistics regarding the female veteran population. These estimates will be used in conjunction with current age-specific utilization data to project future use.

GAO also recommends that I, through the Chief Benefits Director:

- Evaluate female veterans' awareness of benefits.

This recommendation could be quickly implemented but I question the need for or value of this information. Female veterans are, first and foremost, veterans. As

such, they have access to the full range of benefits information and assistance provided to all veterans, including toll-free telephone service in all fifty states and access to any regional office for a personal interview.

--Establish procedures to insure that female veterans will be notified of major changes in veterans benefits that affect them.

Again, I see no need to subdivide veterans by sex. The same benefits are available to all veterans. Additionally, training at military separation points, briefings, benefits orientations, etc., are all designed to disseminate comprehensive information regarding VA benefits and services. Establishing separate procedures for female veterans is unnecessary and duplicative of ongoing procedures.

--Expand outreach efforts to include veterans organizations with predominantly female memberships.

I concur in this recommendation and action will be taken to assure that veterans organizations with predominantly female memberships are included in outreach efforts.

#### OTHER COMMENTS

Page 2 of your letter addressed to Senator Inouye and pages 3 and 23 of Enclosure I contain the statement that the primary mission of the VA medical care system is to provide care to veterans with service-connected disabilities. This is not an accurate statement. Section 4101(a), title 38, United States Code, states unequivocally that the primary function of the VA Department of Medicine and Surgery is to provide a complete medical and hospital service . . . for the medical care and treatment of veterans. (Emphasis added.) Although nonservice-connected veterans are not eligible for all the medical care for which service-connected veterans are eligible, and priorities are established which generally place service-connected ahead of nonservice-connected veterans, one of the primary functions of the VA is the provision of medical and hospital services to all eligible veterans.

Page 4 of the letter to Senator Inouye and pages 10, 14, and 15 of Enclosure I which discuss VA denial of care for normal pregnancies should be amended due to the recent D.C. Court of Appeals' decision in Kirkhuff v. Nimmo (No. 81-1770, D.C. Cir. July 20, 1982) which was favorable to the VA. The analysis of the alternative courses of action available to the VA can be deleted.

The statement on page 21 concerning form letters sent to newly recognized female veterans who had received a service discharge is misleading because it implies that the wrong form letter was sent in all cases. Initially, some incorrect letters were released in error. When VA receives verification of service, a specially-designed letter and VA Pamphlet 20-67-1 are mailed to these female veterans. The letter is carefully worded to advise the newly classified veteran of benefits to which she may be entitled. It was first mailed in September 1980 to 767 women. Ninety-two letters have been sent since the initial mass-mailing.

GAO note: Page references in this enclosure may not correspond to page numbers in the final report.