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

FOR RELEASE ON DELIVERY  
Expected at 9:00 a.m., est  
March 3, 1983

STATEMENT OF  
ROBERT A. PETERSON  
SENIOR ASSOCIATE DIRECTOR  
HUMAN RESOURCES DIVISION



120736

BEFORE THE  
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE  
COMMITTEE ON VETERANS' AFFAIRS  
HOUSE OF REPRESENTATIVES

ON

FEMALE VETERANS' ACCESS TO VETERANS  
ADMINISTRATION HEALTH BENEFITS

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss our September 1982 report<sup>1</sup> on female veterans' access to Veterans Administration (VA) health benefits.

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 female veterans coming into the system now and anticipated in the future.) While representing only about 3.8 percent of all veterans, the female veteran population is growing

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<sup>1</sup>/"Actions Needed to Insure That Female Veterans Have Equal Access to VA Benefits" (GAO/HRD-82-98, Sept. 24, 1982).

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significantly and women are expected to make up 12 percent of the military strength in 1984.

#### INPATIENT CARE

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.

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. Five of the seven medical centers visited had bedrooms for 8 to 16 patients, and four of these had communal bathing areas. Because there often are not enough female patients to fill large rooms, females had to compete with isolation patients for the hospitals' limited number of private rooms.

Women could not participate in some treatment programs at two of the six psychiatric facilities we contacted. For example, women were not admitted to two specialized treatment programs at the Brentwood, California, VA medical center because they could not be assured adequate privacy. According to Brentwood's chief of psychiatry, staffing changes were made in May 1982 to permit women to be admitted to one of the two programs. VA's director

of mental health told us that, in general, VA's older psychiatric hospitals are not suited to integrated treatment of men and women.

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. 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 the 6 VA domiciliaries that accept women or to the 38 State veterans' home domiciliaries.

#### GYNECOLOGICAL AND OBSTETRICAL CARE

Women require gynecological and obstetrical care. However, women with nonservice-connected disabilities could not always get gynecological care, and women with normal pregnancies could not obtain obstetrical care.

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. At two other facilities, Houston and San Francisco, medical staff acknowledged that pelvic examinations were not routinely done.

At six of the 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.

VA medical centers and independent outpatient clinics used various methods to provide gynecological care. While most facilities satisfactorily served female patients, 7 of 23 VA facilities contacted 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 were not eligible for outpatient gynecological treatment at these facilities even if the treatment was 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. One method the VA facilities could use to provide care to nonservice-connected female veterans is sharing agreements with military hospitals. Such sharing is now authorized under the VA and DOD Health Resources Sharing and Emergency Operations Act (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.

## FACILITY PLANNING

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 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.

Further, data submitted by the medical districts on the current and projected veteran population to be served reflected total veterans without a breakdown by sex. Without projections on the female population likely to seek VA health care, VA cannot determine if its facilities can accommodate future demand.

Facilities that are renovated to provide more patient privacy still may not be able to 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. For

example, 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.

#### READJUSTMENT COUNSELING

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.

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.

#### RECOMMENDATIONS AND AGENCY ACTIONS

We made several recommendations to correct the deficiencies I just discussed and have been encouraged by the actions VA has initiated.

In a January 1983 circular, VA directed each medical center and outpatient clinic to develop and submit to central office

by June 30, 1983, a written plan for the care of female veterans. The plans are to address, at a minimum:

- the definition of a complete physical examination for a female as including breast examination and pelvic examination;
- provision of inpatient gynecologic services for hospitalized female veterans as well as those in VA nursing homes and domiciliaries;
- provision of outpatient gynecologic services to both service-connected and nonservice-connected veterans; and
- referral procedures so that female veterans can receive necessary services currently unavailable at the medical center because of privacy considerations.

The circular also directs the facilities to review their current method of providing outpatient gynecological services and upgrade those needing improvement by June 1, 1983. The circular specifically states that reliance on fee basis care alone is not adequate.

Finally, the circular directs each medical center to examine admitting areas, outpatient clinics, and bed services to identify physical barriers, such as lack of privacy or bath facilities, that limit access of females to any program. Plans for correction of barriers are to be incorporated in the 5-year construction plan for fiscal years 1985 through 1989, unless the necessary renovations or new construction are underway prior to fiscal year 1985.

We believe the actions taken by VA, if effectively implemented, should significantly improve female veterans access to VA health care.

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Mr. Chairman, this concludes my statement. We will be happy to respond to any questions you or members the Subcommittee may have.

Summary

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FEMALE VETERANS' HEALTH BENEFITS

GAO has reviewed the Veterans Administration's (VA's) efforts to provide health benefits to female veterans. Although progress has been made in insuring that medical care is available to female veterans, 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, and
- sufficient plans are made for the anticipated increase in female veterans.

Actions VA has taken to implement our report recommendations should, if effectively implemented, significantly improve female veterans access to health care.

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