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Report to the Chairman, Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

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VA HEALTH CARE FOR WOMEN

Progress Made in Providing Services to Women Veterans

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The Honorable Cliff Stearns
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) is required to provide health care to men and women who have served in the U.S. military. Because male veterans account for 95 percent—24.3 million of the total veteran population and VA's total outpatient workload (29.4 million visits)—it has been difficult for women veterans to obtain health care services, especially gender-specific care, within VA medical facilities. By 2010, however, women are expected to represent over 10 percent—over 2 million of the projected 20 million veterans—compared to about 5 percent in 1997.

In response to past criticisms, VA has taken a number of steps to improve its accommodation of the special health care needs of women and plans to continue its efforts. For example, last April, we testified on VA's efforts to provide counseling services to women who had been sexually traumatized and found that, as a result of VA's efforts, women veterans were increasingly using these services.[1]

Concerned about women veterans' access to other, more general services, you asked us to review the current status of the women veterans' health care program. Specifically, you asked us to (1) describe the progress VA has made in removing barriers that may prevent women veterans from obtaining VA health care services and (2) determine the extent to which VA health care services, particularly gender-specific services, are available to and used by women veterans.

To conduct our work, we interviewed officials at VA's Readjustment Counseling Center (Vet Center), medical centers, and Center for Women Veterans in the Office of the Secretary; the Veterans Health Administration (VHA); and two Veterans Benefits Administration (VBA) regional offices. In addition, we reviewed and analyzed VA's health care plans for women, patient utilization data, and prior reports and studies on women veterans' health care programs. (For a complete description of our scope and

[1]See Women Veterans' Health Care: VA Efforts to Respond to the Challenge of Providing Sexual Trauma Counseling (GAO/T-HEHS-98-138, Apr. 23, 1998).

methodology, see app. I). We performed our work between September 1998 and December 1998 in accordance with generally accepted government auditing standards.

Results in Brief

VA has made considerable progress in removing barriers that prevent women veterans from obtaining care. For example, VA has increased outreach to women veterans to inform them of their eligibility for health care services and designated women veterans coordinators to assist women veterans in accessing VA's health care system. VA has also improved the health care environment in many of its medical facilities, especially with respect to accommodating the privacy needs of women veterans. However, VA recognizes that it has more work to do in these areas and plans to address concerns about the effectiveness of its outreach efforts and privacy barriers that still exist in some facilities. In addition, in response to women veterans' concerns, VA has begun to assess its capacity to provide inpatient psychiatric care to women veterans.

With regard to gender-specific services, VA's efforts to emphasize women veterans' health care have contributed to a significant increase in the availability and use of all services over the last 3 years. The range of services differs by facility; services may be provided in clinics designated specifically for women veterans, or they may be provided in the overall medical facility health care system. More importantly, utilization has increased significantly between 1994 and 1997. For example, gender-specific services—pap smears, mammograms, and reproductive health care—grew from over 85,000 to more than 121,000. During the same time period, the number of women veterans treated for all health care services on an outpatient basis increased by about 32 percent or 119,300.

Background

Women represent a small but rapidly growing segment of the nation's veteran population. In 1982, there were about 740,000 women veterans. By 1997, that number had increased by 66 percent to over 1.2 million, or 4.8 percent, of the veteran population. Today, women make up nearly 14 percent of the active duty force and, with the exception of the Marine Corps, 20 percent of new recruits. By 2010, women are expected to represent over 10 percent of the total veteran population.

Like male veterans, female veterans who serve on active duty in the uniformed services for the minimum amount of time specified by law and who were discharged, released, or retired under conditions other than

dishonorable are eligible for some VA health care services. Historically, veterans' eligibility for health care services depended on factors such as the presence and extent of service-connected disabilities, income, and period and conditions of military service.

In 1996, the Congress passed the Veterans Health Care Eligibility Reform Act (P.L. 104-262), which simplified the eligibility criteria and made all veterans eligible for comprehensive outpatient care. To manage its health care services, the act requires VA to establish an enrollment process for managing demand within available resources. The seven priorities for enrollment are (1) veterans with service-connected disabilities rated at 50 percent or higher[2]; (2) veterans with service-connected disabilities rated at 30 or 40 percent; (3) former prisoners of war, veterans with service-connected disabilities rated at 10 or 20 percent, and veterans whose discharge from active military service was for a compensable disability that was incurred or aggravated in the line of duty or veterans who with certain exceptions and limitations are receiving disability compensation; (4) catastrophically disabled veterans and veterans receiving increased non-service-connected disability pensions because they are permanently housebound; (5) veterans unable to defray the cost of medical care; (6) all other veterans in the so-called "core" group,[3] including veterans of World War I and veterans with a priority for care based on presumed environmental exposure; and (7) all other veterans. VA may create additional subdivisions within each of these enrollment groups.

With the growing women veteran population came the need to provide health care services equivalent to those provided to men. Over the past 15 years, GAO, VA, and the Advisory Committee on Women Veterans have assessed VA services available to women veterans. In 1982, GAO reported that VA lacked adequate general and gender-specific health care services, effective outreach for women veterans, and facilities that provided women veterans appropriate levels of privacy in health care delivery settings.[4] In 1992, GAO reported that VA had made progress in correcting previously identified deficiencies, but some privacy deficiencies and concerns about

[2]VA assigns disability ratings to compensate veterans for physical or mental conditions incurred or aggravated during military service. These ratings are assigned in increments of 10, ranging from 0 to 100 percent, and are used to determine compensation for service-connected conditions.

[3]"Core" refers to World War I and Mexican-border veterans, veterans solely seeking care for disorders associated with exposure to toxins or environmental hazards in service, and compensable 0-percent service-connected veterans.

[4]Actions Needed to Ensure That Female Veterans Have Equal Access to VA Benefits (GAO/HRD-82-98, Sept. 24, 1982).

availability and outreach remained.[5] In response to concerns about the availability of women veterans' health care and to improve VA's delivery of health care to women veterans, the Congress enacted the Women Veterans Health Programs Act of 1992 (P.L. 102-585). This act authorized new and expanded health care services for women. In 1993, VA's Office of the Inspector General (OIG) for Health Care Inspections reported that problems—such as women veterans' not always being informed about eligibility for health care services as well as VA's lack of appropriate accommodations, medical equipment, and supplies to treat women patients in VA medical facilities—still existed.[6]

In December 1993, the Secretary of the Department of Veterans Affairs, established VA's first Women Veterans' Program Office (WVPO). In November 1994, the Congress enacted legislation (P.L. 103-446) that required VA to create a Center for Women Veterans to oversee VA programs for women. As a result, WVPO was reorganized into the Center for Women Veterans. The Center Director reports directly to the VA Secretary.

In compliance with the Government Performance Results Act, VA has a strategic plan that includes goals for (1) monitoring the trends in women's utilization of VA services from fiscal years 1998 through 2001, (2) reporting on barriers and actions to address recommendations to correct them, and (3) assessing progress in correcting deficiencies from fiscal years 1999 through 2001. VA's performance plan also includes goals that target women veterans currently enrolled in VA for aggressive prevention and health promotion activities to screen for breast and cervical cancer.

VA Has Reduced Many Barriers to Care

VA has taken several actions to remove barriers identified by GAO, VA, and women veteran proponents over the years that prevent women veterans from obtaining care in VA medical facilities. First, VA has increased outreach efforts to inform women veterans of their eligibility for benefits and health care services. However, it has not evaluated these efforts, so it is not known how knowledgeable women veterans are about their eligibility for health care services. VA has also designated coordinators to assist women veterans in accessing the system.

In addition, VA has identified and begun to correct patient privacy deficiencies in inpatient and outpatient settings. VA has surveyed its facilities on two occasions to determine the extent to which privacy

[5]VA Health Care for Women: Despite Progress, Improvements Needed (GAO/HRD-92-23, Jan. 23, 1992).

[6]Office of the Inspector General for Health Care Inspections, Report of Inspection of Women Veterans' Health Care Programs, 3HI-A99-129 (Washington, D.C.: Department of Veterans Affairs, June 1993).

deficiencies exist. In fiscal year 1998, VA spent more than $67 million correcting deficiencies and has developed plans for correcting remaining deficiencies. However, VA continues to face obstacles addressing the inpatient mental health needs of women veterans in a predominantly male environment and has established a task force to look at this and other issues.

Efforts Increased to Inform Women Veterans of Services, but Effectiveness Unknown

Over the last few years, VA has increased its outreach efforts to inform women veterans of their eligibility for care in response to problems highlighted by GAO, VA, and veteran service organizations between 1982 and 1994. We and others reported that (1) women veterans were not aware that they were eligible to receive health care in VA and (2) VA did not target outreach to women veterans, routinely disseminate information to service organizations with predominantly female memberships, or adequately inform women of changes in their eligibility. To address these concerns, VA has targeted women veterans during outreach efforts at the headquarters, regional, and local levels.

At the headquarters level, a number of outreach strategies have been implemented. For example, the Center for Women Veterans, as part of its strategic and performance goals for 1998 through 2000, is placing greater emphasis on the importance of outreach to women and the need for improved communication techniques. Since the inception of WVPO and the Center for Women Veterans, VA has held an average of 15 to 20 town meetings a year, along with other informational seminars. The Center also provided informational seminars at the annual conventions of the Women's Army Corp and the Women Marines; American Legion; American Veterans of World War II, Korea, and Vietnam; and Disabled American Veterans. The Center also provided information on VA programs for women veterans and other women veterans' issues at national training events for county and state veteran service officers and their counterparts in the national Veterans' Service Organizations. Further, the Center established a web site within the VA home page to provide women veterans with information about health care services and other concerns as well as the opportunity to correspond with the Center via electronic mail.

At the regional and local levels, VBA regional and benefit offices, VA medical centers, and Vet Centers display posters, brochures, and other materials that focus specifically on women veterans. They also send representatives to distribute these materials and talk to women veterans during outreach activities, such as health fairs and media events, that are used to publicize

the theme that "Women Are Veterans, Too." The VA facilities we visited were conducting similar activities. For example, the medical center in New Orleans directed its Office of Public Relations to work closely with the women veterans coordinator to develop an outreach program. The New Orleans Vet Center women veterans coordinator told us that she expanded her outreach efforts to colleges with nursing schools in an effort to reach women veterans who do not participate in veteran-related activities.

In addition, VBA regional offices coordinate with the Department of Defense to provide information on VA benefits and services to prospective veterans during Transition Assistance Program (TAP) briefings. In addition to providing information to active-duty personnel who plan to separate from the military on how to transition into civilian life, TAP briefings provide information on the benefits they may be eligible for as veterans as well as how to obtain them.

Although VA has greatly increased its outreach efforts, it has not yet evaluated the effectiveness of these efforts. Women veterans organizations have acknowledged the increase in VA's outreach efforts directed at women veterans but continue to express concern about whether women veterans are being reached and adequately informed about their eligibility for benefits and health care services. Several women veterans we talked with during our site visits said they found out by chance—during casual conversations—that they were eligible for care. Women veterans and agency staff acknowledged that "word of mouth" from satisfied patients appears to be one of the most effective ways to share information about various benefits and services to which women veterans may be entitled.

In March 1998, the Advisory Committee for Women Veterans, the Center for Women Veterans, and the National Center for Veterans Statistics provided specific questions for inclusion in VA's Survey of Veterans for Year 2000 to address the extent to which women veterans are becoming more knowledgeable about their eligibility for services. This survey should allow VA to assess the effectiveness of its outreach to women veterans.

Women Veterans Coordinators More Effective in Assisting Women Veterans in Obtaining Care

Women veterans coordinators assist in obtaining care, advocate for women veterans' health care, and collaborate with medical center management to make facilities more sensitive to women veterans. This role was established in 1985 because women veterans did not know how to obtain health care services once they became aware of their eligibility for these services. However, in 1994, VA's OIG reported that these

coordinators often lacked sufficient training and time to perform effectively; many women veterans coordinators performed in this capacity on a part-time basis.[7]

VA has since provided women veterans coordinators training and more time to carry out their roles and help them provide better assistance to women veterans in accessing VA's health care system and obtaining care. In an effort to make them more effective in this role, in 1994, VA implemented a national training program designed to increase women veterans coordinators' awareness of their roles and familiarize them with women veterans' issues. The program is administered by a full-time women veterans' national education coordinator and staff at the Birmingham Regional Medical Education Center. In addition, the women veterans coordinators at VA's medical centers in Tampa and Bay Pines developed a mini-residency training program for women veterans coordinators. This program, approved in 1995, is the only training program of its kind and is offered for newly appointed women veterans coordinators.

To allow women veterans coordinators more time to perform their duties, in 1994, VA established positions for additional full-time women veteran coordinators at selected VA medical centers and four full-time VBA regional women veterans coordinators. As of January 1998, about 40 percent of the women veterans coordinators in VA medical facilities were full-time. According to VA's Advisory Committee on Women Veterans, the women veterans coordinator program has proven to be one of the most successful initiatives recommended by the committee.

VA Is Addressing Privacy Deficiencies, but Barriers Remain

Patient privacy for women veterans has been a long-standing concern, and VA acknowledges that the correction of physical barriers that limit women's access to care in VA facilities will be an ongoing process. Between 1982 and 1994, GAO and VA's OIG reported that physical barriers, including hospital wards with large open rooms having 8 to 16 beds and a lack of separate bath facilities, concerned women veterans and inconvenienced staff. Female patients had to compete with patients in isolation units for the limited number of private rooms in VA hospitals. Also, hospitals with communal bathrooms sometimes required staff to stand guard or use signs indicating that the bathroom was occupied by female patients.

[7]Office of the Inspector General for Health Care Inspections, Report of Inspection of Women Veterans' Health Care Programs, Privacy Issues—Part II, 4HI-A19-042 (Washington, D.C.: Department of Veterans Affairs, Mar. 1994).

As required by section 322 of the Veterans' Health Care Eligibility Reform Act of 1996, VA conducted nationwide privacy surveys of its facilities in fiscal years 1997 and 1998 to determine the types and magnitude of privacy deficiencies that may interfere with appropriate treatment in clinical areas. The surveys revealed numerous patient privacy deficiencies in both inpatient and outpatient settings. The fiscal year 1998 survey also showed that 117 facilities from all 22 Veterans Integrated Service Networks (VISN) spent nearly $68 million in construction funds in fiscal year 1998 to correct privacy deficiencies. Another 91 facilities from 20 of the 22 VISNs used a total of 130 alternatives to construction to eliminate deficiencies. These alternatives included actions such as initiating policy changes that would admit female patients only to those areas of the hospital that have the appropriate facilities or issuing policy statements that gynecological examinations would only be performed in the women's clinics or contracted out. In addition, VISN and medical center staff developed plans for correcting and monitoring the remaining deficiencies.

Although the 1998 survey showed that VA has improved the health care environment to afford women patients comfort and a feeling of security, the survey also revealed that many deficiencies still exist. (See table 1.) Of those facilities with deficiencies, the most prevalent inpatient deficiency was a lack of sufficient toilet and shower privacy, and the most prevalent outpatient deficiency was the lack of curtain tracks in various rooms.

Table 1: Prevalent VA Patient Privacy Deficiencies and the Number of VA Medical Facilities Where Deficiencies Still Exist as of October 1, 1998

Patient privacy deficiency	Facilities having deficiency	
	Number	Percent
Inpatient unit[a]		
Lack of sufficient, appropriate bedroom privacy	42	24
Lack of sufficient toilet and shower privacy	63	36
Lack of sufficient, private, handicapped-accessible shower facilities	58	34
Lack of privacy curtain tracks in patient bedrooms, examination rooms, and other types of rooms	40	23
Ambulatory care (outpatient)[b]		
Lack of privacy curtain tracks in various rooms[c]	63	10
Lack of toilet rooms adjacent to gynecological rooms and urinary clinic changing rooms	53	9
Inappropriate location of existing toilet rooms[d]	51	8
Lack of designated changing areas for women in diagnostic and day surgical areas, clinics, mammography, and other imaging areas	26	4
Inappropriate location of changing areas for women in certain areas that are near general waiting areas or common hallways	22	4
Lack of a private examination room in or near the emergency or urgent care area	14	2
Lack of a private intake interview room in the admission area	45	7
Lack of personal hygiene dispensers in toiletrooms in clinics and other patient areas	23	4

[a]Percentages for facilities with inpatient deficiencies are based on VA's 173 hospital facilities as defined in VA's 1998 survey.

[b]We used 612 as the denominator in computing these percentages: 173 hospitals, 37 nonhospital-based clinics that reported having deficiencies, and 402 clinics that did not report a deficiency.

[c]Includes examination rooms (gynecological and nongynecological), procedure rooms, emergency and urgent care rooms, treatment cubicles, ambulatory surgery patient holding and recovery areas, and other cubicles and rooms.

[d]Requires women patients to pass through general waiting areas to access this room from a nongynecological examination room.

Source: Department of Veterans Affairs, Veterans Health Administration, Women Veteran Patient Privacy Survey Results, 1998 Data (Milwaukee, Wisc.: National Center for Cost-Containment, Sept. 1998).

Consistent with VA's strategic plan for fiscal years 1998 through 2003, a task force with representatives from VHA and the Center for Women Veterans was established to identify, prioritize, and develop plans for

addressing five major issues related to women veterans' health care, one of which was patient privacy. Further, VA plans to assess the progress made in correcting patient privacy deficiencies on an annual basis between fiscal years 1999 and 2001. VA requires that each facility have a plan for corrective action and a timetable for completion; VA has also directed each VISN to integrate the planned corrections into their construction programs.

To correct the remaining deficiencies, VA projects it will spend $49.3 million in fiscal year 1999 and $41 million in fiscal year 2000. Over this same period, medical centers are estimated to spend approximately $647,000 more in discretionary funds to make some of these corrections. Beyond fiscal year 2000, VA projects it will spend an additional $77 million in capital funds; six facilities in VISNs 6 and 7 account for 58 percent of the total projected spending for beyond fiscal year 2000.[8]

Task Force Is Assessing VA's Ability to Provide Inpatient Psychiatric Care to Women Veterans

While correcting privacy deficiencies has allowed VA to better accommodate women veterans' health care needs, VA faces other problems accommodating women veterans who need inpatient mental health treatment. In the summer of 1998, VA established a task force of clinicians and women veterans coordinators to assess mental health services for women veterans and make recommendations by June 1999 for improving VA's capacity to provide inpatient psychiatric care to this population. This task force is chaired by the Director of the Center for Women Veterans.

VA data show that in fiscal year 1997, mental disorder was the most prevalent diagnosis—26.4 percent—for women veterans hospitalized. While inpatient psychiatric accommodations are available in VA facilities, in most instances the environment is not conducive to treating women veterans. In 1997, VA's Center for Women Veterans reported that women veterans hospitalized on VA mental health wards for post-traumatic stress disorder, substance abuse, or other psychiatric diagnoses are often the only female on a ward with 30 to 40 males. This disparate ratio of women to men discourages women from discussing gender-specific issues and also makes it difficult to provide group therapy addressing women's treatment issues. Women veterans also noted that they were concerned about their safety in this environment. These concerns included male patients engaging in inappropriate remarks or behavior and inappropriate

[8]VA's survey shows that the correction of patient privacy deficiencies in facilities identified in VISNs 6 and 7 will require renovation and modernization of wards and other conversions. The age of these facilities, among other factors, contributed to the costs involved.

levels of privacy. During our site visits, two women veterans expressed similar concerns.

VA has inpatient psychiatric facilities that have separate psychiatric units for women veterans within five areas: Battle Creek, Michigan; Brockton-West Roxbury, Massachusetts; Central Texas Health Care System; Brecksville-Cleveland, Ohio; and Palo Alto, California, Health Care System. Women veterans often do not want to or are unable to leave families and support systems to travel to one of these facilities for treatment. Staff at one of the medical centers we visited in Florida told us that a few of their women patients who had been sexually traumatized would be better served in an inpatient setting, but the nearest suitable inpatient facilities were those in California and Ohio, and the patients did not want to go that far from home.

Availability and Use of Services Have Increased for Women Veterans

VA's greater emphasis on women veterans' health has resulted in an increase in both the availability and use of general and gender-specific services, such as pap smears, mammograms, and reproductive health care. Some VA facilities offer a full complement of health care services, including gender-specific care, on a full-time basis in separate clinics designated for women. Others may only offer certain services on a contractual or part-time basis. According to program officials and the women veterans coordinators at the locations we visited, the variation in the availability and delivery of services is generally influenced by the medical center directors' views of the health needs of the potential patient population, available resources, and demand for services.

The increase in the availability of services and the emphasis on women veterans' health have contributed to increases in the number of women veterans served and visits made, with the exception of inpatient care.[9] Between fiscal years 1994 and 1997, the number of gender-specific services provided to women veterans increased about 42 percent, from over 85,000 to over 121,000. The total number of inpatient and outpatient visits made during this same period increased nearly 56 percent, from about 893,000 to almost 1.4 million.

[9]This decline is consistent with the general reduction of inpatient services throughout the VA health care system and mirrors the trend in health care in the private sector to deliver services in outpatient settings where feasible rather than in hospitals.

VA Has Modified Its Health Care System to Better Accommodate Women Veterans

Over the past 10 years, GAO, VA's OIG, and VA's Advisory Committee on Women Veterans reported that VA was not providing adequate care to women veterans and was not equipped to do so. These organizations found that VA (1) was not providing complete physical examinations, including gynecological exams for women; (2) lacked the equipment and supplies to provide gender-specific care to women, such as examination tables with stirrups and speculums; and (3) lacked guidelines for providing care to women. As a result, VA began to place more emphasis on women veterans' health and looked for ways to respond to these criticisms.

For example, to ensure equity of access and treatment, VA designated women veterans' health as a special emphasis program that merited focused attention. In 1983, VA began requiring medical centers to develop written plans that show how they will meet the health care needs of women veterans. At a minimum, these plans must define (1) that a complete physical examination for women is to include a breast and gynecological exam, (2) provisions for inpatient and outpatient gynecology services, and (3) referral procedures for necessary services unavailable at VA facilities.

VA also procured the necessary equipment and supplies to treat women. In addition, VA established separate clinics for women veterans in some of its medical facilities. The locations with separate women's clinics that we visited had written plans that contained the required information and the necessary equipment and supplies to provide gender-specific treatment to women. Also, we found evidence that women veterans coordinators were monitoring services provided to ensure proper care and follow-up.

VA is more able to accommodate women patients than they were prior to the early 1990s. In 1997, VA provided inhouse 94 percent of the routine gynecological care sought by women veterans, even though its number of women's clinics fell from 126 in 1994 to 96 in 1998. Some VA facilities closed their women's clinics because of consolidation or implementation of primary care. Others are phasing their women's programs into primary care, especially the facilities that had limited services available in the women's clinic. This is consistent with VA's efforts to enhance the efficiency of its health care system. For example, since September 1995, VA has or is in the process of merging the management and operations of 48 hospitals and clinic systems into 23 locally integrated systems.

Services for Women Are Available but Vary by Facility

While women veterans can obtain gender-specific services as well as other health care services at most VA medical facilities, the extent to which care, especially gender-specific care, is available varies by facility. Some facilities offer a full array of routine and acute gender-specific services for women—such as pap smears, pelvic examinations, mammograms, breast health, gynecological oncology, and hormone therapy—while others offer only routine or preventive gender-specific care.

Of the five sites we visited, two—Tampa and Boston—are Women Veterans' Comprehensive Health Centers,[10] which enable women veterans to obtain almost all of their health care within the center. Generally, these centers have full-time providers who may also be supported by other clinicians who provide specialty care on a part-time basis. For example, the Tampa Women Veterans' Comprehensive Health Center, which provided care to about 3,000 women in 1997, is run by a full-time internist, who is supported by another internist, four nurse practitioner primary care providers, a gynecologist, a psychologist, a psychiatrist, and other health care and administrative support staff. The Tampa center as well as the Boston center provide their services 5 days a week.

Other facilities offer less extensive services than those offered within the comprehensive centers. For example, the VA medical center in Washington, D.C., offers only routine or preventive gender-specific care by a nurse practitioner about 4.5 days a week; acute or more specialized gynecological care is only offered one-half day a week with the assistance of a gynecologist and general surgeon through a sharing agreement with a local Department of Defense facility. Other health care services are available within the medical center.

The range of services provided by VA's nonhospital-based clinics varies as well. Some nonhospital-based clinics, like the one in Orlando, may provide services almost comparable to those provided by the medical center or comprehensive center. Other centers, however, offer services on a more limited basis. For example, the nonhospital-based clinic associated with one of the medical centers we visited only offers gynecological services once a week. According to the women veterans coordinator, the average waiting time to get a gynecology appointment at this clinic is 51 days. She explained that if the situation is urgent, arrangements are made to have the patient seen in the urgent care clinic or at the medical center.

[10]VA has a total of eight Women Veterans' Comprehensive Health Centers. The other six centers are located in Chicago, Illinois (Chicago Area Network); Durham, North Carolina; Minneapolis, Minnesota; Philadelphia, Pennsylvania, and Wilmington, Delaware (Southeast Pennsylvania Network); San Francisco, California; and Sepulveda and West Los Angeles, California.

Variation in services at VA medical facilities may be attributable to one or more factors, such as medical center management's views on the level of services needed, funding, staffing, and demand for services. The specific services offered and the manner in which they are delivered within VA facilities are left to the discretion of medical center or VISN management. Most VA facilities did not receive additional funding to establish health care programs for women and had to provide these additional services while maintaining or minimally affecting existing programs. Initially, VHA provided additional funding for the comprehensive centers, which was supplemented by funds from the medical center's budget. VHA also provided some additional funding in 1994 to help VA facilities obtain resources to counsel women veterans who had been sexually traumatized.

The women veterans coordinators at the five medical center locations we visited told us that the medical center directors have a strong commitment to providing quality health care to women veterans and that without such support, it would be difficult to meet women veterans' needs or improve the women's health program. Some women's programs had to be established and operated using the medical center's existing funding and resources, which included no provisions for these services. Although the Tampa and Boston centers received VHA funding to establish a comprehensive health center, they still had to obtain additional funding from the medical center, which required management's support.

The availability of gender-specific services may also be influenced by the demand for these services. At two locations we visited, the women veterans coordinators told us that when they first opened their women's clinics, they operated on a very limited scale—one-half to 1 day a week. However, the demand was so overwhelming that they increased their operations to 5 days a week. On the other hand, the women veterans population in some areas is small and may not generate a high enough demand for gender-specific services to provide them in a separate women veterans' health care program or within the medical center on a full-time basis. In such instances or if a very small number of female veterans have historically availed themselves of the services, it may not be cost-effective to provide these services in-house, as pointed out by VA's OIG in 1993.[11] Instead, it may be appropriate to contract out for these services.

[11]Office of the Inspector General for Health Care Inspections, Report of Inspection of Women Veterans' Health Care Programs.

Women Veterans' Use of Health Services Has Increased

In the 1990s, women veterans' utilization of gender-specific services has increased significantly. Outpatient and inpatient visits among women veterans at VA facilities increased more than 50 percent between fiscal years 1994 and 1997. Based on VA's survey of its medical facilities, the number of women veterans receiving gender-specific services increased about 42 percent from more than 85,000 to almost 121,200 during the same period. (See table 2.)

Table 2: Gender-Specific Health Care Utilization by Source, Fiscal Years 1994 Through 1997

Source	Pap smears	Mammograms	Reproductive health	Total
Fiscal year 1994				
In-house	30,654	11,943	25,632	**68,229**
Referral	454	623	556	**1,633**
Contract	1,357	12,174	2,233	**15,764**
Total FY 1994	32,465	24,740	28,421	**85,626**
Fiscal year 1995				
In-house	35,491	15,110	[a]	**50,601**[b]
Referral	335	696	[a]	**1,031**[b]
Contract	1,270	12,542	[a]	**13,812**[b]
Total FY 1995	37,096	28,348	[a]	**65,444**[b]
Fiscal year 1996				
In-house	40,115	15,537	23,405	**79,057**
Referral	216	609	[a]	**825**[b]
Contract	2,521	14,657	4,053	**21,231**
Total FY 1996	42,852	30,803	27,458	**101,113**[b]
Fiscal year 1997				
In-house	49,799	17,539	28,233	**95,571**
Referral	255	412	663	**1,330**
Contract	2,867	18,483	2,928	**24,278**
Total FY 1997	52,921	36,434	31,824	**121,179**
FY 1994-1997 increase	**63.0%**	**47.3%**	**12.0%**	**41.5%**

[a]Reproductive health data were not collected for these reporting periods.

[b]Excludes reproductive health services.

Source: Department of Veterans Affairs, Veterans Health Administration, Health Care Services and Research Related to Women Veterans as Required by P.L. 102-585, as amended by P.L. 104-262. Reports for fiscal years 1994 through 1997.

Between fiscal years 1994 and 1997, the number of pap smears and mammograms provided to women veterans increased dramatically. In fiscal year 1997, almost 53,000 women veterans received pap smears, a 63-percent increase over fiscal year 1994. Similarly, in fiscal year 1997, about 36,400 women veterans received mammograms, a 47-percent increase over fiscal year 1994. Reproductive health care services, which cover the entire range of gynecological services, were provided to over 31,800 women veterans in fiscal year 1997, 12 percent more than in fiscal year 1994. According to VA, the pap smear and mammography examination rates among appropriate and consenting women veterans in 1997 are 90 percent and 87 percent, respectively. VA has set goals to increase the mammography and pap smear examination rates from their current base rates to 92 percent and 90 percent, respectively, by fiscal year 2003.

Women veterans have also used more health care services in general, consistent with VA's goal to meet women veterans' total health care needs. With the exception of inpatient care, the number of women veterans who use VA health care services and the frequency of their usage continue to increase. For the 5-year period between fiscal years 1992 and 1997, the women veteran population increased only slightly, from about 1.2 million to 1.23 million. However, between fiscal years 1994 and 1997, the number of women veterans who received outpatient care increased 32 percent, from about 90,000 to more than 119,000, and the total number of outpatient visits increased 57 percent, from nearly 870,000 to over 1.3 million. (See table 3.) During this same period, the number of women veterans who received inpatient care decreased about 5 percent, from about 14,350 to 13,700, which is consistent with VA's—and the nation's—current health care trend to deliver services in the least costly, most appropriate setting.

Table 3: Outpatient and Inpatient Care Provided to Women Veterans in VA Facilities During Fiscal Years 1994 Through 1997

	Outpatient care		Inpatient care		Total inpatient and outpatient visits
Fiscal year	Unique patients[a]	Total visits	Unique patients[a]	Total visits	
1994	90,182	869,567	14,342	23,802	**893,369**
1995	100,445	1,043,316	14,821	24,533	**1,067,849**
1996	107,344	1,210,839	14,554	23,783	**1,234,622**
1997	119,312	1,369,085	13,679	23,070	**1,392,155**
Percent change	**32.3**	**57.4**	**(–4.6)**	**(–3.1)**	**55.8**

[a]VA counts unique visits by facility. Since some patients may visit more than one facility, they may be counted as a unique more than once. Therefore, VA's reported number of uniques may be more than the actual number of uniques.

Sources: VA outpatient treatment files (1994-1997) and Department of Veterans Affairs, Veterans Health Administration, Health Care Services and Research Related to Women Veterans as Required by P.L. 102-585, as amended by P.L. 104-262. Reports for fiscal years 1994 through 1997.

Concluding Observations

VA's health care program for women veterans has made important strides in the last few years. VA has made good progress informing women veterans about their eligibility for services and the services available, assisting women veterans in accessing the system, correcting patient privacy deficiencies, and increasing health care services for women veterans. Most importantly, VA's efforts are reflected in the increased availability of services and utilization by women veterans.

While progress has been made, the importance of sustaining efforts to address the special needs of women veterans will only increase, as their percentage of the total veteran population is projected to double by 2010. Coincident with these demographic changes, VA is making changes to the way it delivers health care, including integrating and consolidating facilities while maintaining quality of care and implementing eligibility reform. VA will need to be especially vigilant to ensure that women veterans' needs are appropriately addressed as it implements these overall changes.

Agency Comments

In its comments on a draft of this report, VA agreed with our findings that progress has been made in serving women veterans through the Women Veterans' Health Program but that additional work is required to improve outreach to women, rectify privacy issues, and improve inpatient

environments for women undergoing inpatient psychiatric treatment. VA also provided some technical comments, which we have incorporated as appropriate. VA's comments are included as appendix II.

Copies of this report are being sent to the Secretary of Veterans Affairs, other appropriate congressional committees, and interested parties. We will also make copies available to others on request. If you have any questions about the report, please call me or Shelia Drake, Assistant Director, at (202) 512-7101. Jacquelyn Clinton, Evaluator-in-Charge, was a major contributor to this report.

Sincerely yours,

Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

Contents

Abbreviations

OIG	Office of the Inspector General
TAP	Transition Assistance Program
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPO	Women Veterans' Program Office

Scope and Methodology

To determine the barriers to women veterans obtaining care within VA, we talked with officials in the Center for Women Veterans, within the Office of the Secretary; VHA; two VBA regional offices; and Readjustment Counseling Centers (Vet Centers) in Tampa, Florida; St. Petersburg, Florida; and New Orleans, Louisiana. We also reviewed Women Veterans Advisory Committee reports and talked with women veterans and VA program officials in five medical centers: Bay Pines, Florida; Boston, Massachusetts; Tampa; New Orleans; and Washington, D.C. These medical centers were selected because they offered different levels of health care services to women veterans.

To determine the availability and use of gender-specific care, we discussed women veterans' health care services with officials at VA's Central Office and the five medical centers we visited. We reviewed VA medical centers' women veterans health care plans, relevant VA policy directives, and women veterans health care utilization data. We also reviewed quality assurance plans, annual reports, minutes of Women Veterans Advisory Committee meetings, outreach materials, and other written documentation and materials.

Comments From the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
ASSISTANT SECRETARY FOR POLICY AND PLANNING
WASHINGTON DC 20420

JAN 1 1 1999

Mr. Stephen P. Backhus
Director, Veterans' Affairs and Military
Health Care Issues
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Backhus:

We have reviewed your draft report, ***VA HEALTH CARE FOR WOMEN: Progress Made in Providing Services to Women Veterans*** (GAO/HEHS-99-38) and are pleased to provide these comments. We appreciate GAO's recognition of the progress the Department of Veterans Affairs is making in serving women veterans through the Women Veterans' Health Program (WVHP). Like GAO, we recognize that additional work is required to improve outreach to women, rectify privacy issues, and improve inpatient environments for women undergoing inpatient psychiatric treatment.

Increasing national outreach efforts to women veterans has been and continues to be a major goal of the Center for Women Veterans. We believe that one measure of the effectiveness of outreach is the number of eligibility reform enrollment applicants in relation to the number of veterans who use VA and the number of veterans in general. The most recent data available indicate that 4.9 percent of the veteran population are women. Women who use VA are 4.39 percent of our population and the percentage of women veterans who have enrolled with VA is 4.5 percent. We believe these numbers indicate that VA is reaching an appropriate number of women veterans in relation to the entire veteran population. In addition, customer service surveys of ambulatory care indicate that women veterans and male veterans are equally satisfied with the service they receive from VA.

As part of its new benefits package, VA offers expanded services to women veterans, including reproductive health services. We expect that these services will be attractive to new, younger women.

We continue to hold monthly Women Veterans Coordinators (WVCs) conference calls with Women Veterans Health Program (WVHP) Deputy Field Directors. These conference calls provide WVCs with ongoing education about changes to the program. The Veterans Health Administration (VHA) is directing efforts during FY 1999 to have a network level representative who will serve as a liaison with WVHP national and field

2. Mr. Stephen P. Backhus

staff. VHA is also requesting that each network assign a "lead" WVC to improve communication.

Although VHA has accomplished much to improve privacy needs, we recognize GAO's concern that the environment in some facilities for inpatient psychiatric care for women is not ideal. Although the use of inpatient services is declining system-wide due to the availability of alternative treatment approaches, there will still be a need for inpatient care for veterans suffering from serious mental illnesses. For women veterans whose mental disorder is so severe that inpatient care is required, the privacy and security afforded by an inpatient site that is specifically designated to meet their needs can be an invaluable aid to recovery. Women Veterans Health Program Deputy Field Directors work in concert with VISN and facility staff to address these problems and meet the needs of women veterans for inpatient psychiatric care. Contract care also remains a viable option. As noted by GAO, VHA does offer segregated inpatient psychiatric care to women veterans in five facilities nation-wide. A work group was created in 1998 to explore options in this area and their work will continue into 1999. We also plan to continue with established plans to correct other privacy deficiencies in both inpatient and outpatient settings.

The enclosure contains several detailed edits that we believe would enhance the overall picture the report presents on VA's response to the health care needs of our nation's women veterans. We appreciate the opportunity to comment on your report.

Sincerely,

Dennis Duffy

Enclosure

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