PROPOSED VETERANS HEALTH LEGISLATION

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

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PROPOSED VETERANS HEALTH LEGISLATION

WEDNESDAY, SEPTEMBER 22, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND
HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9:33 a.m., in room 334, Cannon House Office Building, Hon. Roy Rowland (chairman of the subcommittee) presiding.

Present: Representatives Rowland, Long, Edwards of Texas, Clement, Filner, Tejeda, Gutierrez, Bishop, Kreidler, Brown, Smith, and Everett.

OPENING STATEMENT OF CHAIRMAN ROWLAND

Mr. ROWLAND. As you know, the President is launching his national health care reform proposal tonight, and we will hold a hearing on that subject next Thursday, September 30.

The road to far-reaching reform is likely to be a long one, and there remain other important issues before us. So we scheduled this session both to follow up on important oversight work this committee initiated several months ago as well as to take up a number of important legislative initiatives.

On June 29, we conducted a hearing on VA care of chronically mentally ill veterans. We learned that fully 40 percent of VA patients have psychiatric disorders, and almost half of those with schizophrenia—the most prevalent psychiatric diagnosis among VA patients—are service-connected for that disease. About 50 percent of all veterans hospitalized for psychiatric care receive that care from VA, yet care of these veterans has clearly been a poor stepchild in the competition for needed funding.

As a follow-up to our hearing, I wrote to express my concerns on this subject to Secretary Brown and asked that the Department address this issue in its testimony today. I am pleased, therefore, that the Secretary has recognized the problem and is committed to addressing it. I look forward to getting more detail this morning on precisely what that commitment will entail.

This morning's hearing will also take up a series of bills. Among those, H.R. 3082 aims to improve VA care to women veterans. Last November, the President signed into law a comprehensive health care bill, Public Law 102–585, which very substantially expanded the services and programs available to women veterans. H.R. 3082 would go further in order to remedy documented problems with VA's provision of care to women veterans. Two of our colleagues,

Lane Evans and Pat Schroeder, will testify this morning on behalf of similar purpose bills.

The bill I have drafted certainly builds on the oversight record Lane has developed, and includes several important elements from Pat's legislation, but in a number of areas, my bill goes further than these measures to remedy reported deficiencies relating to the quality of patient care and to ensuring patient privacy.

A second measure, H.R. 3081, is prompted by the expiration of special authority to provide certain care to veterans who may have been exposed in service to herbicides in Vietnam and to radiation. These special eligibility provisions were established in 1981 at a time when relatively little was known about the potential health effects of exposure to Agent Orange in particular. H.R. 3081 takes account of the considerable work that the National Academy of Sciences has done in this area, and specifically incorporates the Academy's recent findings with respect to the health effects of herbicides used in Vietnam. The bill would apply those scientific findings to both veterans exposed to radiation and to Agent Orange and would thereby identify certain specified diseases which, for treatment purposes, would be considered to be self-incurred.

We will also hear testimony on two additional bills, H.R. 3108, a bill expanding the scope of services provided veterans in Vet Centers, introduced by Chris Smith; and H.R. 3090, a bill to assist in the rehabilitation of the chronically mentally ill, introduced by Mike Kreidler. I would look to both Members for any remarks they would have on these particular bills, and at this time I want to recognize the ranking minority member, Chris Smith.

OPENING STATEMENT OF HON. CHRISTOPHER H. SMITH

Mr. SMITH. Thank you very much, Mr. Chairman.

It is indeed a pleasure to be here today as the subcommittee receives testimony on various bills which make important improvements to veterans' health programs. I want to commend you, Mr. Chairman, for your introduction of the Women Veterans' Health Improvements Act of 1993 and a bill to extend and expand Agent Orange and radiation treatment. As you know, I am an original cosponsor of both of these bills.

The Agent Orange bill will incorporate the findings of the National Academy of Sciences with respect to the health effects of certain herbicides used in Vietnam. The bill gives benefit of the doubt to the veteran by continuing to include diseases for which available studies are insufficient to permit a conclusion.

It is important to note that many of the studies reviewed by NAS included those which studied health patterns of agricultural and industrial workers. Presumably this population would experience high-level exposure to herbicides over a long period of time.

Our bill, H.R. 3081, presumes that the results of such studies are also pertinent to the Vietnam veteran who may have been exposed to the Agent Orange. I support this broad-minded approach. In addition, the bill adds priority for veterans exposed to Agent Orange to receive outpatient care, a priority they do not now have.

H.R. 3082, the Women Veterans' Health Improvements Act of 1993, expands on legislation enacted last year in Public Law 102–585. Public Law 102–585 enhanced the provision of health services

to women veterans and also authorized as a priority the provision of sexual trauma counseling for women. While not enough time has yet passed for the subcommittee to assess the full impact of this legislation, we do have evidence of the need to make improvements on certain aspects of the law. Those improvements are addressed in H.R. 3082 while at the same time preserving the role of the VA as the primary provider of women's health services.

This subcommittee has, for a long time, encouraged the VA to improve their health care services to women veterans. Testimony in this subcommittee has revealed that the VA is doing a better job but needs to continue the programs in this area.

The subcommittee will also address H.R. 3108, a draft bill which I introduced—and I appreciate the chairman for joining on as a cosponsor—to expand the role of Vet Centers to include certain health care services. Specifically, the bill gives authority to the VA to furnish preventive health care services, pre-admission screening, and referral services to veterans who are eligible for readjustment counseling and medical services.

This bill was drafted with the intention that the VA must become more accessible to veterans and more decentralized in its approach to health care if it is to be competitive under the national health plan. This bill is an incremental step toward that end based upon my belief that the Vet Centers will need time to incorporate this expanded mission while preserving its primary mission of readjustment counseling. Therefore, the authority is limited to treatment of only those veterans now eligible for Vet Center treatment.

Mr. Chairman, I thank you again for scheduling this hearing. We have a number of bills to get through and look forward to the testimony.

Mr. ROWLAND. Thank you very much.

Mr. Kreidler, do you have an opening statement about your legislation?

OPENING STATEMENT OF HON. MIKE KREIDLER

Mr. KREIDLER. Thank you, Mr. Chairman. First, I would like to commend you on your work on the Agent Orange issue and your effort to expand services to women veterans.

Tonight, as you pointed out, we are going to hear from the President regarding his plan to reform health care, and it seems quite clear, that we are going to see some significant changes to offer more primary and preventive services for men and women veterans. I look forward to hearing the discussion on that today.

Second, I am grateful for the opportunity to present legislation I introduced on compensated work therapy programs for chronically mentally ill veterans, H.R. 3090. On June 29, this subcommittee heard a great deal about the VA's failure to provide adequate services for the chronically mentally ill.

During that hearing, we had a discussion about the therapeutic residency and compensated work therapy programs. These programs have been brought to my attention by the staff of American Lake Veterans' Hospital in my district. American Lake is having great success with these services, which I believe can serve as a model for others around the country. The programs help veterans suffering from addictions and mental illness to learn social living

and work skills that will enable them to re-enter society as productive and self-sufficient citizens. But because the program is part of a Federal agency, it has limited ability to contract with private companies to seek private grants and work contracts.

My bill would allow the Secretary to authorize the establishment of a nonprofit corporation for the purpose of therapy at any VA medical center. This nonprofit corporation status will allow the programs to bid for work and grants in the private sector, bringing more diversity to the work experience patients gain and introducing them into the private sector where they will work after completing the program.

My bill also extends the therapeutic residency demonstration program from 1994 to 1997 and allows expansion from 50 to 70 sites by 1997. However, it limits the VA from spending more than $500,000 a year on housing properties.

Mr. Chairman, I believe these programs can help reintegrate into society veterans who have long been suffering from mental illness and do so in a cost efficient manner. I appreciate your interest in this legislation, and I look forward to hearing the views of our guests today.

Mr. ROWLAND. Thank you.

Are there any other Members who have opening statements?

Mr. Gutierrez.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you very much, Mr. Chairman.

First I would like, Mr. Chairman, to ask unanimous consent that questions by Mr. Kennedy be entered into the record, as his bill on insurance red-lining is having a full committee markup at 10 o'clock and he is unable to be here today.

Mr. ROWLAND. Without objection.

Mr. GUTIERREZ. Thank you very much, Mr. Chairman.

I am pleased that the subcommittee is focusing its attention on issues of such importance. I want to discuss some of the bills that I support to address these concerns, particularly in the area of veteran women's health care and treatment for Agent Orange and radiation veterans.

I recognize that members of the committee have different preferences about the bills designed to meet those needs. Although some of my comments might add fuel to that debate, please know that my goal is to do what I can to promote consensus. In fact, I think the range of opinions presented here today prove that members of the committee have given these problems some great thought. I hope that we can use this hearing and the upcoming markup as well as the ensuing period between them to make the best use of our shared commitment.

Let me first talk about Agent Orange and radiation veterans. I firmly support H.R. 2375, authored by Lane Evans, because it provides for long-term authorization. We were all educated by the results of the National Academy of Sciences study this summer that highlighted many of the health problems caused by Agent Orange. However, I have concerns that H.R. 3081 would limit treatment only to veterans suffering from those illnesses cited in that report. Authorization should not merely be extended to 1996. I hope that

we will be able to extend authorization to the year 2003, in keeping with the length of the Academy's plan for continued study. I am, however, enthusiastic about those provisions in H.R. 3081 that strike the sunset date for provisions of care to atomic veterans and enhance outpatient care.

To address the needs of women veterans, I have cosponsored two bills, H.R. 2797 and H.R. 2285 introduced by Congresswoman Schroeder. If our goal is to improve services, the VA must provide, as we have discussed many times, comprehensive coverage for women, and for coverage of women's health care to be truly comprehensive, it could not ignore the fact that women seek care for reproductive services.

All of us on this panel have committed ourselves to the survival of the VA health system. The survival of the system is predicated on its ability, I believe, to compete. Therefore, let us pay close attention to the standard benefit package as outlined this evening by the President. If the VA fails to meet any of those standards, including reproductive care, I think we are sacrificing the VA's ability to serve any veteran, male or female, young or old, in the future.

When we discuss improvement, we need to talk about the quality of services as much as quantity. With regard to mammography, for instance, I hope we will encourage the VA to apply strict standards to its own units, just as it will to private facilities with whom it contracts out for such care.

I am glad to see that H.R. 3082 does include provisions for sexual trauma counseling. However, I think that close attention should be paid to the provisions included in Congresswoman Schroeder's bill, H.R. 2285. In particular, I endorse her call to make such service gender neutral and to give these services a priority rating.

With regard to privacy concerns, Mr. Chairman, I am glad to see that H.R. 3082 addresses deficiencies in this area and will be considered under the VA's construction process. I would, however, like to expedite the resolution of such problems. I am worried that the construction process, while indeed worthwhile, would take far too long to complete. I would like to recommend that some temporary but immediate measures be taken at the VA facilities where women do not have sufficient privacy to receive care or examination. These would be temporary only until full construction could be undertaken. Again, I think we would all benefit from a real exchange of ideas. That is why, Mr. Chairman, I am grateful for this hearing and to you and your leadership and the upcoming markup.

Let me summarize again by saying that if we wish to make any improvements, let us do so by making real and progressive changes.

Thank you, Mr. Chairman.

Mr. ROWLAND. Mr. Filner.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman.

I join with my colleagues to thank you for calling today's hearing on these critical health matters facing our Nation's veterans. The fact that we are considering legislation on women veterans, PTSD,

and veterans exposed to Agent Orange and ionizing radiation is critical. I am pleased to see my colleagues—Mr. Evans and Ms. Schroeder—who have taken such a leadership role in these issues, and I thank them for being here today. Like my colleague, Mr. Gutierrez, I have also cosponsored Ms. Schroeder's legislation, H.R. 2797 and H.R. 2285.

Certainly, as we prepare for tonight's speech by the President on health care, we are assured that the Department of Veterans Affairs will have an integral role in the health plan. Certainly veterans deserve comprehensive care and quality standards now and under any reform. What we are looking at today is that significant deficiencies in health care services available to women veterans must and should be addressed now.

We have several different versions of legislation. I want to be looking, Mr. Chairman, at the availability of comprehensive benefits for women, mammography standards, gender neutrality in sexual counseling, and women's health research. That is what I expect in the piece of legislation that emerges from our markup.

So I look forward to working with you, with our colleagues on the committee, and with our colleagues testifying here today, and the various panels. Thank you again for your leadership here.

Mr. ROWLAND. Do other Members have opening statements?

Mr. Bishop.

OPENING STATEMENT OF HON. SANFORD BISHOP

Mr. BISHOP. Thank you, Mr. Chairman.

I, too, would like to associate myself with the remarks of my colleagues. I want to commend the chairman, the subcommittee, Mr. Evans, and Ms. Schroeder for the leadership that they have taken.

We have just finished the Congressional Black Caucus weekend, and I also want to especially commend Mr. Evans for his participation on issues of real concern to African American veterans with regard to their health care provision, and I want to take this opportunity to thank you for the contribution that you made in that regard.

I, too, support the committee's efforts and the legislation that has been offered with regard to Agent Orange, and in our hearings over the weekend and our brain trust, some very, very significant information came forth regarding VA health care for women, African American women in particular.

So I welcome these hearings, I welcome the legislation, and I am certainly supportive of this committee and the chairman and Mr. Evans and Ms. Schroeder in your efforts to move forward and to make sure that health care is provided adequately to the Nation's veterans, including Vietnam veterans and women veterans.

Thank you very much, Mr. Chairman.

Mr. ROWLAND. Thank you.

We are very pleased to welcome you this morning, Patricia. We know that you have been long involved as a member of Armed Services in these particular kinds of issues, and we look forward to hearing your testimony this morning.

I also welcome Lane Evans, a member of the committee, who has long been involved as well.

Thank you both very much for being here to testify this morning.

Mrs. Schroeder.

STATEMENT OF HON. PATRICIA SCHROEDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Mrs. SCHROEDER. Thank you, Mr. Chairman, and I realize you are undertaking a tremendous amount today, so let me ask unanimous consent to put my full statement in the record, because I would like to just summarize since there is so much for this committee to do and we have already gone into session.

First of all, I want to thank you for letting us come, and I want to thank you for introducing a bill that really does address the women's issues.

As you know, last year when we did pass this first bill, everybody got excited that, for the first time, the VA was looking at some gender-specific issues. But, our excitement was dampened rather rapidly when the inspector general's report came out in June showing us how tremendously neglectful the VA had been. When you looked at women's services in the VA, a lot of the facilities were really just finding a broom closet where they had shoved in some of the equipment for mammography or something, and that was considered the women's services area. That is not acceptable, and something must be done.

I was pleased to read that VA Assistant Secretary Vic Raymond testified here that the VA knew this and must speed up its process to start looking at all veterans, including women.

As I look at the 1.2 million women vets, I must say, the thing that has always made me the angriest about their neglect by the VA has been, most of them, a high percentage of them, were nurses who risked their lives to provide high quality care to our vets. When they came home, we ignored their specific health care needs, and I think that really is almost unconscionable.

When you look at the new Vietnam Women's Memorial it is very moving. It is women vets, but the nursing profession is front and center there. While viewing the memorial, one man said to me, "You didn't need this. Don't you women identify with the men?" and I said, "Well, if we had three women vets down here, would I ask you that question?" and he said that was unfair.

But I do think that when you look at health care needs, we ought to be looking at the health care needs of all our vets, no matter what their race, ethnicity, or sex, and that is what we have set out to do.

Congresswoman Lloyd and I developed our provisions in the Women's Health Equity Package, which some members of the subcommittee are backing, and the reason that I wanted to be here to testify about it. It is a little more comprehensive than the one that you introduced. I salute you, Mr. Chairman, on what you introduced, but we would like to make a plea that you go further. I don't have any quarrel with what you have in it, I only want to add more. We are very impatient and think in 1993 we shouldn't even be having this discussion, it should have happened long ago.

But the main differences that I see between your legislation and the one that the Congresswomen have been backing, and many other Members are backing, is that, first of all, we need desperately to include all services, primary and preventive care, and

it must include reproductive care. Our organs are interconnected just like male organs are, and it is very difficult to take private parts out and say, "Deal with that in some other sector."

As you look at women, you must look at the holistic group, we think. We think that is going to be the model for the President's health care, and I think if the VA doesn't follow that model or track that model, women are going to bale out of the VA system and go elsewhere. So, I think we need to make sure that they don't have any excuses for quartering off certain parts of women's bodies and saying, "We're not going to look at those, those must go elsewhere."

When you look at the statistics, most women's OB-GYN's are also their primary care providers, so women don't want to go from place to place to get care for different parts, and I think that makes all the sense in the world. So that would be the first thing.

The second thing that we feel very strongly about is that we must say women and minorities need to be in VA research and they need to be coded in VA research so we find out anything that might be specific in a gender fashion or specific in a minority fashion. You would think that this would be common sense.

I would also ask unanimous consent to put into the record the letter that many of us signed in June to the VA when we found out they were going to do their research on Gulf War veterans and how they reacted to chemicals they were exposed to, and they weren't going to gender code it.

(See p. 65.)

Mr. ROWLAND. Without objection.

Mrs. SCHROEDER. Okay. I would be more than happy to put that in, because I think many of you know about that, and what we want to prevent in the future. There should be gender coding. We all know there are very distinct metabolic differences and different metabolic states that women can be in, and it is very likely they could react differently to chemical substances or other such things.

We also know that women veterans have twice the incidence of cancer of people who weren't in the military, and I think they have the right to know why, and we also know there are those kinds of statistics for minorities.

Now I know the response to this. The response is always, "Oh, there you go micro-managing," and we bought that for about 5 years from the National Institutes of Health. We pointed out to them that they never have women or minorities in any of their research at the National Institutes of Health, that the norm was always a 180-pound white male; therefore, everybody else was abnormal, and we didn't look at it. They kept saying to us, "Oh, you're right, we did overlook that, and we'll take care of it." Well, 5 years later they hadn't taken care of it at all.

So we have determined the only way you can do this is to say, "You must do this," and after all of this has been going on for the last 10 years with the National Institutes of Health, to find out in 1993 the VA one more time was going to do their research without gender coding it, only says to me we need to be just as specific with the VA on research as we have been with NIH, and let's put that issue to rest.

I also think one of the big differences is the mammography quality provisions we have in ours. The Caucus has been very strong in saying you must have certification that the mammography is high quality. The only thing worse than not having a mammogram is having a bad mammogram. I think that is very essential. I think a lot of us have been very saddened by the ranking Member's wife's experience with that this very week. We all know about Edie Wilkie and how sad we are about that. I think that only underlines; we want high quality mammography or forget it. So let us make sure that we move on that.

Finally, I think the sexual trauma service—I am delighted you put it in there. I would just make a plea to make it gender neutral. I think that is an important part. We certainly hope that women don't move out and start preying on men, but if they do, they have every right to have that same kind of service. Therefore, I think it is a very important thing to do.

So that is a rapid-fire summary of where I think the bright line differences are, and I would certainly hope that as the committee moves to markup, maybe those could be added to the bill or something in that manner, because if we are going to do it, let's do it right, and let's finally be welcoming women into the fold of the VA and say, "We're going to treat you comprehensively across the board, as we are minorities and others, and we are going to end all the craziness that has gone on in the past." I also think it is the only way the VA survives long term.

I thank you for letting me be here.

Mr. ROWLAND. Thank you very much for your statement. Without objection, your entire statement will be made a part of the record.

[The prepared statement of Congresswoman Schroeder appears at p. 59.]

Mr. ROWLAND. Lane.

STATEMENT OF HON. LANE EVANS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. EVANS. Thank you, Mr. Chairman. I also want to thank you and Chris Smith for holding this hearing and allowing us to testify and the willingness of both of you to move on several important pieces of legislation.

Given the fact that Congresswoman Schroeder has just testified about legislation she has introduced, I want to limit my comments primarily to other measures being considered today, but I do want to say I strongly support her legislation.

Women veterans need quality health care delivered in a timely and appropriate manner, and they must also be included in research pertaining to veterans. Women should not be forced to accept inadequate care simply because the system is more accustomed to dealing with their brothers in arms, and I would like to propose that we follow the model that you set with the Persian Gulf legislation, the legislation that became a hybrid between Bob Clement's bill and my own, that I think really helped us improve the legislation that we both intended to introduce separately. That kind of model, I think, might work well in trying to work out some of the differences, and I would urge you to hold perhaps an infor-

mal meeting of the supporters of your bill and Congresswoman Schroeder's bill. I think it could be very helpful to us.

With regard to H.R. 3081, I support the elimination of the sunset date for the provision of care to atomic veterans, providing special eligibility for atomic veterans, and expanding the care provided on an outpatient basis. But I do have several concerns about other aspects of this legislation.

As you know, on June 10 I introduced H.R. 2375, a measure to extend for 10 years VA's authority to provide priority health care to veterans who were exposed to ionizing radiation or Agent Orange. Similar legislation was passed by the Senate committee shortly before the August recess. Unlike H.R. 3081, my legislation would not further restrict the provision of VA health care to veterans exposed to Agent Orange.

I also have reservations about the provisions of H.R. 3081 which would limit health care eligibility to those exposed whose illnesses were listed in the first three tiers of the NAS report on Agent Orange. Those provisions would be difficult to implement in the field and, even more importantly, possibly lead to the denial of health care services that some exposed veterans currently receive at this point. Given the NAS's conclusion that exposure to Agent Orange is harmful, exposed veterans deserve additional considerations rather than new restrictions.

I also believe that the VA's authority to provide health care to veterans exposed to Agent Orange should be extended through the year 2003 and appreciate the comments of Congressman Gutierrez. I think he outlined essentially what we wanted to do pretty well. Earlier this year, we received the first report wherein the NAS described a clear link between the exposure to Agent Orange and certain illnesses.

Based on these initial results and the longitude nature of the NAS review, VA's authority to provide health care to exposed veterans should be extended to at least throughout the duration of that review, the year 2003.

I believe we both want to provide the best care to atomic veterans and veterans exposed to Agent Orange, and I would hope we could work this out as well in developing legislation to provide exposed veterans with continuous high-quality health care.

Congressman Smith, I appreciate your efforts to expand the range of health care services provided in our Vet Centers. In fact, the legislation which both Senator Akaka and I have introduced dealing with the Vet Centers would include similar provisions. I would look forward to working with you on that legislation and appreciate your leadership, as always, on these issues affecting Vietnam veterans.

In addition to the expansion of health care services, my legislation would make all veterans eligible for the Vet Center services, and I think that is necessary given the fact that a lot of vets have been left out under previous legislation. It would make the Secretary's Advisory Committee on Readjustment Counseling a statutory committee and ensure the confidentiality of patient records.

I would also note that I intend to introduce legislation within the next week that would greatly expand the range of services available to veterans suffering from post-traumatic stress disorder.

Finally, with regard to the measure dealing with chronically mentally ill veterans, I question why Congress should authorize VA to establish nonprofit corporations. As an alternative, I would suggest that the VA be directed to contract out to community-based organizations for the coordination of therapeutic work for VA patients through compensated work programs. These community-based organizations have done outstanding work on helping homeless vets, and I think they have the resources and the networking skills to reach out to these veterans that need help.

Again, I want to thank you for your leadership on these issues, your willingness to hear us, and your willingness to work with us on these other issues. Thank you very much.

[The prepared statement of Congressman Evans appears on p. 54.]

Mr. ROWLAND. Thank you as well.

I have a couple of questions I would like to ask, and then we will move to some other Members.

Pat, you talk about research and the need for research in the VA. We all know research is extremely important to keeping a high quality of medical care available. We learned that the VA cut out $26 million in research from the VA budget and we had to work hard to not only get that money back in but additional money as well.

Your legislation proposes that the VA reimburse private physicians for care of women. Let me ask you this. Would this encourage women to go outside of the VA, necessarily reducing the pool of women that might be available for research? It is necessary to have a relatively large group of people if you are doing research in a specific area, people who have those specific kinds of problems. Would you address that for me, please?

Mrs. SCHROEDER. Sure. I don't think it would. First of all, you have about 1.2 million women vets that are potential, and there will be many areas because of the catchment problem, if that is defined in yours—where they may only be able to get quality care if they go outside. But I think if you have high quality care internally, you are going to attract a tremendous number of women to the VA, and that really is not a problem. Plus, the records could also be put as part of the group. As you now know, you can bar code everything and put it on a disc smaller than this for almost 500,000 people, so I don't think that that is problem.

Mr. ROWLAND. I guess we have got a little of a chicken and egg thing here.

Mrs. SCHROEDER. That is right.

Mr. ROWLAND. You need to have the personnel and the wherewithal present before you can attract the veterans to come into the hospital. As the GAO and IG reported, there are severe deficiencies within the VA itself in dealing with this. So I guess there is a problem in trying to get that kind of mechanism started. I personally would like to see the facilities provided by the VA and not do it outside.

Mrs. SCHROEDER. Well, I hear you, but until they do—and they have had such a bad track record—what do you do in the interim? I mean that is the real problem, and even just the basic things like privacy which many of the Members here mentioned. It is really

unbelievable. Maybe this would accelerate it. This puts a real push on them. If they don't get going, women can then go somewhere else and still be able to claim their benefits, and I think that is important.

Mr. ROWLAND. I yield to the gentleman from New Jersey.

Mr. SMITH. Thank you very much, Mr. Chairman.

Mr. Chairman, I have served on this subcommittee for 13 years, for the entirety of my tenure in Congress, and it has always struck me that it is one of those subcommittees that breaks its back in a bipartisan way to nurture, and to make sure that there is adequate health care with an emphasis toward healing for veterans, even though we often fall short on behalf of our veterans.

I am struck in listening to Mrs. Schroeder that she seemingly has glossed over one of the consequences of what her legislation, specifically the provision of comprehensive reproductive health care, would actually mean, and that would be the authorization of abortion on demand at the taxpayers' expense, whether in house—in other words, turning the 171 hospitals and 350 outpatient clinics potentially into the largest network of abortion mills in the country—or contracting out and paying the local abortionist for that abortion. There are no limits. These abortions could be done at any time during pregnancy. We are talking about methods from dismemberment, literal dismemberment, which is what is involved when the suction device hooked up to a razor blade literally rips that child apart, or poison shots, chemical poisoning, whether it be a saline abortion or some other poison that is employed, or the newest form of abortion, the DNX, which is being heralded by the National Abortion Federation as the answer to that dreaded complication, and that is the baby who survives a later term abortion. One doctor by the name of Haskell—and I have read his paper—boasts of having done 700 of these abortions whereby the baby is identified, the surgeon's hand literally makes its way to the baby's cranium after pulling the limbs out, and then the child's brain is aspirated, and sucked out, to ensure that no live baby results in that later term abortion. To me, this is the antithesis of healing.

Unless one construes a pregnancy and an unborn child to be a disease, it seems to me that we ought to be talking about healing and nurturing, prenatal care, maternal health care, all of which I would be very supportive of, even within the VA health care network, notwithstanding our limited dollars.

But it seems to me that to authorize and to force people like myself and others who find abortion on demand throughout the entire pregnancy to be objectionable has no place in this bill and has no place really. You know, in 1993, as you said earlier, we should be further along in defending and protecting and expanding women's rights and women's health care. There are two patients involved, it seems to me, in every pregnancy, mother and baby, and both ought to be given respect, deference and protection.

I would ask you, if you would respond, does your language authorize payments for abortions?

Mrs. SCHROEDER. Mr. Smith, I think it clearly authorizes exactly the same thing that is in the President's budget, and that is comprehensive reproductive services.

Mr. SMITH. Including abortions?

Mrs. SCHROEDER. I would also say the way that you phrased the question is not in a very healing way. If you look at the statistics, almost all abortions that are done are done in the very early trimester part, that women have gone in very early. I also think most people have great hope that eventually we will have less intrusive ways, such as RU–486 or whatever, and other such things.

But what about women who are exposed to dangerous chemicals that have caused all sorts of problems with the baby? What about all those kinds of things?

The law of the land says that this is a woman's right. Every country that has given that right to women has provided that kind of health care for women. We are not mandating that women do this. There is no mandatory thing, it is a part of a range of comprehensive services, and I think that to do anything less is not giving them their full constitutional rights, and we should respect that.

Mr. SMITH. What the gentlelady is mandating, though, is that the VA health care network, which has a mandate of caring for veterans with service-connected disabling diseases coming first, or anomalies—you are mandating that this health care network now become a provider or at least the payer for abortion on demand. There are no limits throughout the entire pregnancy.

You mentioned most of the abortions are done early in pregnancy, some time around the 8th, 9th, 10th week of gestation. Let me just say for the record, all the body systems of that baby are formed and working. Let me also add that in the second trimester there are approximately 180,000, much larger, much more mature babies, who are destroyed in this country every year. So the VA would become a party of that kind of destruction as well.

Again, you know, you say that my words perhaps are not healing. I am concerned about the lack of healing inherent in every abortion. It takes the life of the child, and the methods which are employed, which are always euphemistically referred to, are gruesome to behold. Dismembering a child, chemically poisoning a child, is not part of the healing arts. Our President said on January 22 he wants abortions to be "rare," and it just seems to me that to expand it, constantly look for additional providers, and subsidizing it by way of the VA and other health care providers will not lead to fewer abortions.

David Gergen, as you well know, said in U.S. News and World Report, in an article he wrote, that the President can't have it both ways; he can't say he wants abortions to be rare and to be doing everything to expand the provision of abortion by way of facilitation of Federal payments. Again, there are no limits in your bill; it is on demand.

Mrs. SCHROEDER. Mr. Smith, first of all, what my bill mandates is that women be given the same constitutional rights men are and that they be provided a full range of services, and that is where I think all veterans should. I don't think we are going to treat women in a lesser light than we are men.

Secondly, Mr. Smith, I hear in your comments——

Mr. SMITH. If I could interrupt one second——

Mrs. SCHROEDER. Well, I didn't interrupt you. If you don't mind——

Mr. SMITH. I just want you to answer comprehensively. Go ahead.

Mrs. SCHROEDER. Would you mind? I mean, let me finish.

Secondly, Mr. Smith, I would like to point out that your view is, it seems, that any woman, if given the option for an abortion, is going to be running down to the VA to have one. I find that a very offensive view of womanhood. This is an extraordinary procedure that very few women really want to go through. They hope they never have to go through it, and they weigh this—we do have brains and consciences—and they weigh this very heavily. This is not a lightly taken decision where suddenly everybody is going to go, "Oh, great."

Now the reason for comprehensive reproductive services is, if you find that the woman's life is in danger, if you find there is something wrong with the child, or whatever, you need to be able, as the medical provider, to discuss that with the woman and discuss her range of options, which then, I am sure, she weighs, and weighs very heavily, with her own ethical code, religious code, her family, and everything else.

But I am not mandating anything except that that woman have the full range of legal and constitutional services. What you are mandating is that she become a mandated mother and can't hear the full range of options as we learn more about what happens to children when they are exposed to chemicals, or this or that or the other thing, and I would hope that we would all work together to get better family planning, know much more about these decisions, and proceed on that.

But I want to assure you, you may know different women than I know, but I have gone to more women's meetings than, I bet, almost anyone in this room, and I have never had a woman come to me and say, "You must get me abortion services; that's what I'm going to use for family planning; I'm going to wait till the last trimester; I can't wait to do this." I don't know any medical doctor that has ever told me that either. This is something that people do take very, very heavily, and yet it is an important option in a range of options when sometimes everything has gone wrong. All I plead with you to do is, let's not mandate motherhood, let's not mandate anything, let's have a full, comprehensive range of reproductive services, or it doesn't work.

Mr. SMITH. Just let me say in response that it may be seemingly clever to say it is mandated motherhood, but, as ultra-sound has clearly shown us, once a pregnancy has begun, from the very earliest stages, it is not a matter of whether or not a woman is going to become a mother; she is a mother. Even Dr. Nathanson, who founded the National Abortion Rights Action League and was one of the leaders in the pro-abortion perspective for years, who finally changed over and became a pro-lifer, pointed out that if wombs had windows and if more women saw the ultra-sound prior to an abortion, they would realize that she is not carrying some inanimate object but a baby and she is already a mother. Then the question is whether or not the child will be healthy and hopefully will go to full term.

Mr. SMITH. Let me just say also, you used words like "exposed to chemicals." Your bill makes no such stipulation. Your bill would allow abortions on demand. It forces me and millions upon millions of conscientious objectors to have our tax dollars used to kill unborn children. We also happen to believe very strongly that there are two victims involved in every abortion, that the mothers do suffer tremendous trauma, I know this because I know many women who have had abortions. So it is not in a caring way to look out for her as well. So I think you are forcing all of us. You are mandating the taxpayer to foot the bill with your legislation.

Mrs. SCHROEDER. No. I am mandating that the taxpayer respect the woman's constitutional rights that she——

Mr. SMITH. And pay for it.

Mrs. SCHROEDER [continuing]. Put her life on the line to protect everyone else. She is over there protecting every American's constitutional rights, and your answer to her is, "Fine. Then when you come back, you only get a half of them," and I just think that—that's all I ask.

Mr. ROWLAND. The gentleman's time has expired.

Mr. SMITH. Thank you. I appreciate the chairman's providing that extra time for this exchange.

Mr. ROWLAND. Members will be recognized in order of seniority.

Mr. Clement.

Mr. CLEMENT. Thank you, Mr. Chairman.

Pat, your bill, H.R. 2797, would expand VA's fee basis authority. This expanded authority would be limited to the treatment of women veterans only and would far exceed what is currently available to service-connected veterans. Is it your belief that women veterans should be given a higher priority for fee-based care than service-connected veterans?

Mrs. SCHROEDER. No. My problem is that when we saw the inspector general's report in June, there are hardly any services for women vets even in 1993 in a very, very high percentage of our VA hospitals. I don't know about you, but I was stunned when I read that. I thought I knew, but the magnitude of it was so much greater than I anticipated; I was really stunned. This is only trying to correct that, because we have got a lot of changes that have to go on in a period of time, and I would hope that eventually we would lure all women back in because the services will be so great. But right now, when you read that, you would almost be counseling a woman in many regions to put her health in jeopardy to go into a VA hospital because the standards and the quality of care are so poor.

Mr. CLEMENT. How many women are we talking about?

Mrs. SCHROEDER. Well, there are 1.2 million veterans that are cited, which is a lot, and obviously we are going to see more and more coming along as the numbers increase. In fact, there may be more than that now, but we have been citing 1.2 million, I think, since about 1985.

Mr. CLEMENT. How many women do we have in the armed forces today? What percentage?

Mrs. SCHROEDER. The percentage in the armed forces today is about 10 percent and may be going up.

Mr. CLEMENT. I am in the National Guard, as you know, in the Army Guard, and this about what we have, too.

Mr. EVANS. Could I get a little bite on this apple? The legislation that the chairman has introduced I understand would also provide contracting out, and I think in both cases it is necessary. I have held hearings on women veterans issues since I became a subcommittee chairman—each Congress we have held hearings, at least—and the VA system is clearly inadequate at this time to deal with women veterans. So if we are going to get them involved in national health care reform, we are going to have to provide contracted out services, at least in the interim, to make sure that they are included in the pool of people using the VA. So we are asking for additional help for women veterans that isn't provided now, but we are not asking that they be treated differently, that they just get the same kind of treatment that they have gotten through the VA.

Mr. CLEMENT. Okay.

Mr. EVANS. That they haven't received, I should say.

Mr. CLEMENT. All right. Thank you.

Mr. ROWLAND. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman.

Ms. Schroeder, I think clearly you made the argument that we are talking about choice and not mandates. I appreciate your concern, your leadership, your outspokenness on this issue, and it is very moving to me. Thank you.

You have authored the Mammography Standards Quality Act.

Mrs. SCHROEDER. Absolutely.

Mr. FILNER. I share your concerns about making sure that the standards are consistent with the civilian situation.

I understand that the American College of Radiology is concerned that the provisions of H.R. 3082 will be inconsistent with the standards of your Act. Can you comment on those differences?

Mrs. SCHROEDER. Well, that is what I understand too, and that was my plea. Dr. Rowland probably understands this even more than we do, but I would certainly hope we would work that out, because I would like to make sure that what we passed in the mammography standards for the civilian sector would be exactly the same ones we would use, and I hope you could look at that and figure that out, because the radiologists are concerned.

Mr. ROWLAND. If the gentleman would yield on that point.

Mr. FILNER. Certainly.

Mr. ROWLAND. Pat, your legislation, does it require oversight by HHS?

Mrs. SCHROEDER. Yes, it does. It does require oversight by HHS in cooperation. They don't do absolute oversight, but they monitor it.

Mr. ROWLAND. Would the VA have to apply to HHS then for oversight?

Mrs. SCHROEDER. I believe that that is how that would be done, but I would hope that we do that just because it would then parallel what we have going on across the country everywhere else.

Mr. ROWLAND. Last year, we had a problem that came before the committee in reference to CLIA—that is, the laboratory standards—and whether or not there was going to be oversight by HHS

of the VA, and it was felt by the committee and the VA at that time that that was not something that we wanted to take place.

Mrs. SCHROEDER. I understand that, but my hope is that we have a more willing group to work together now. It seems like we all work under one flag and we are all supposed to be working for the same health care standards. Especially when it comes to mammography, I think it is very important that there would be the same kind of standards there.

Mr. ROWLAND. I thank the gentleman for yielding and yield back.

Mr. FILNER. I yield back to you.

Mr. ROWLAND. Has the gentleman concluded?

Mr. FILNER. Yes, Mr. Chairman.

Mr. ROWLAND. Mr. Tejeda.

Mr. TEJEDA. No questions, Mr. Chairman.

Mr. ROWLAND. Mr. Gutierrez.

Mr. GUTIERREZ. Thank you, Mr. Chairman.

I would just like to comment a moment, because I listened to my colleague, Mr. Smith, about the issue of choice, and I think that many times too many of us remain silent on both this panel and other panels when the issues come up, because they are difficult ones to deal with, and with the same degree of passion that Mr. Smith argued, I think it is important that we discuss sometimes just how it is we look at these issues.

We need to support the Constitution. That is what I took an oath to do, to support the Constitution of the United States. It is clear that the Supreme Court of the United States has passed *Roe* v. *Wade*. Women go and fight for this country to support that Constitution, to support this form of government, to support the separation of powers that we have.

We time and time again come before this committee and talk about veterans and about how they are the ones that maintain democracy and our freedom of choice and our freedom to be able to discuss and to dialogue, one with the other. So it seems that that is a decision that, number one, a woman needs to make, that it is fundamentally their body.

So as we discuss this issue, I would hope that the members of this committee, with the same enthusiasm, with the same courage, if they feel, discuss this issue of life and babies, would do the same thing when we talk about an earned income tax credit so that mothers, working mothers, and families can have more to give their children, because I think that is important, that we support programs like Head Start so we can educate children in our inner city neighborhoods and throughout this country, that we could support the vast array for the living, for the ones that are here, and obviously for medical treatment for women at every level.

I think that is basic and fundamental to America, that it is their choice, that they have fought to keep that choice available here in this country for all of us, and to disagree, and that we need to look at it that way. That is the way I look at it as I make that decision, that I am not going to impose my morality upon someone else, lest the Congress of the United States impose it.

Let me tell you, Mr. Smith, I have a district that is over 70 percent Catholic. I visit a different church in my district each and every Sunday, and the question gets brought up, and I talk to the

people in those churches, and I make it clear to them: "You would never come to my office—you would come to my office about Social Security, and I would understand why you would come and ask my counsel on Social Security. Maybe I am not the greatest after only being here 9 months, but I do the best I can, and I feel that at least I have an adequate staff to answer those questions. And you come to me about an array of Federal services."

I have yet to have a constituent come to my office, a woman or a man or a married couple, and ask me, "Congressman, what do you think? Shall we or shall we not have this baby? Here are the conditions under which we are working. Should we do that?" No one ever asks me that. No one has ever asked me that because they are smart and prudent people, and they know I am not the person to ask that question of. My wife and I might enter into that discussion, and that is a discussion that only she and I will enter into, and whoever else she decides to enter into a discussion about that issue with, I could respect her on that level. But no one asks me about that.

You know who they should ask? I tell them at every church meeting I go to, "You know who you ask? You ask that priest who is there, because he is a person who is qualified in your life to talk and to discuss those issues, not a Member of Congress, not a member of Government."

Mr. SMITH. Would my friend yield?

Mr. GUTIERREZ. Let me just finish. And I will protect the right of that priest and that pastor and those people to have those discussions.

Let me just finish by saying, you know, there are those of us on the issue of choice and freedom of choice that are for life, let me assure you of that, and to somehow construe that we all have a lesser sense of life is not true. We fight very hard in these halls of Congress for children and families day in and day out.

I have two wonderful daughters, a 14-year-old and a 5-year-old, and you know what? I understand the society in which they are going to have to finally engage themselves in life, and so I teach them to be independent. We give them all the best educational resources we can so that they can be the best they can be, so that they can fulfill themselves in terms of all that they can be, because I want them to go out into the world and be able to challenge that world. And you know what we tell them? Never take anything and accept it; always challenge the information that is before you so that you can change the world and you can better it.

I'll finish, Mr. Chairman. I know I am going at length.

But, Mr. Smith and members of this committee, how can I then turn around, after telling them to be independent, after telling them to challenge everything and to change the world, tell them, "Except, your father and the Congress of the United States are going to make sure that you cannot make decisions about your body"? No. "I have engrained in you and given you the best and highest moral standards, and I will protect your right to make that decision and to carry out your life." That is the way I see it. It would be a contradiction to do otherwise.

Mr. ROWLAND. The gentleman's time has expired.

Mrs. SCHROEDER. Thank you, Mr. Gutierrez. That was wonderful, and I appreciate it.

Mr. SMITH. Mr. Chairman, if I could just respond briefly.

Mr. ROWLAND. Briefly.

Mr. SMITH. Very briefly.

Just let me say that and I certainly respect the gentleman's opinion and views on this issue, as stated so articulately. But it seems to me that the care of children is a matter of public policy. While nobody has ever walked into my office either and said, "Should we have a baby or not?" that is their private matter. Once the child has been conceived and is growing and maturing it is a public matter. As modern science will tell us, birth is an event that happens to all of us, it is not the beginning of life. Preemies are surviving at increasingly lower ages every day of the week, that is just a matter of how technologically advanced we are. The real issue is the humanity of the unborn child. There are two bodies involved, the baby and the mother, and this is the point. When we are mandated to pay for abortion, I find it very objectionable. But I do appreciate the gentleman's comments.

Mr. ROWLAND. Mr. Bishop.

Mr. BISHOP. Thank you, Mr. Chairman.

On that point, I would just like to associate myself clearly with the remarks of Mrs. Schroeder, Mr. Gutierrez, and Mr. Filner. I have always believed very strongly in the sanctity of human life, but I very strongly believe that the matter of reproductive services and abortion is a decision that is rightly made by the woman, in consultation with her doctor and her god, and I do believe that we should uphold the Constitution in *Roe* v. *Wade*.

I wanted to explore another subject of gender bias with regard to the VA health care system, if I might shift the debate, Mr. Chairman, back to Agent Orange particularly.

During the hearings over the weekend, there was a complaint with regard to the Agent Orange studies and Agent Orange possible benefits for some African American nurses, and this highlighted to me a possible gender bias in the Agent Orange issue. They apparently feel that they are not being given proper consideration for Agent Orange benefits because they were not in the fields, they were not out where the Agent Orange was dropped, although they had to be exposed to it when they had to cut the uniforms off the servicemen that they treated in the Vietnam War in the hospitals, and to that extent I just wanted to highlight and lift up that issue for Mr. Evans and Mrs. Schroeder with regard to Agent Orange so that we could make sure that if there was that level of exposure, that women who served in the nursing corps and other areas where they did have exposure, it was not actually dropped on them, but because of their Army job as nurses they had to be exposed to it in the garments of the soldiers on whom they worked.

Mr. EVANS. If I could respond, Mr. Bishop, thank you for raising this point. It is something that I think is of great interest to this committee, because when the chairman and I were sworn in about 11 years ago, we received a briefing about Agent Orange from the VA, and at that time they indicated that the 55-gallon barrels/drums that Agent Orange was shipped over to Vietnam in were discarded by the military and in fact the Vietnamese used those

drums, being very resourceful people, for mo-ped fuel, and the residue of Agent Orange in the mo-ped fuel apparently was coming out of the exhaust of the motorcycles in downtown Saigon. So we have an array of problems.

The legislation we have passed and legislation we will be proposing says anyone in Vietnam who is suffering from these illnesses, there is a presumption that they were caused by exposure to Agent Orange and thus makes people eligible for treatment and compensation.

But I would bet, as we have had problems with minorities and women in the past with the way VA has handled these issues, and since we really haven't implemented the program at this point, just having had this study come out recently, that we are going to run into those problems. So I would be glad to work with the brain trust and yourself on these issues and make sure that, as this process opens up and veterans start to make claims, that they aren't excluded and that just a person's status is not the determining factor, because I think women and minorities were exposed in many other different areas of application of Agent Orange.

So I would be glad to work with you on that issue.

Mr. ROWLAND. Let me call attention to the legislation which I have introduced, which states that the term "herbicide exposed veteran" means a veteran who served on active duty in the Republic of Vietnam during the Vietnam Era and whom the Secretary finds may have been exposed during such service to a herbicide agent—that is, anyone who served in that theater.

Mr. BISHOP. I raise that question because it is my understanding that they were not considered to be exposed unless they were in a geographical location where they were able to establish that Agent Orange was actually dropped and disseminated as an herbicide. I don't know if that is accurate or not.

Mr. EVANS. I guess the legislation says the Secretary may determine, but I think the geographic area ought to be the whole of Indochina basically where Agent Orange was spread, and I would be glad to work with you on that issue.

Mr. BISHOP. Thank you.

Mr. ROWLAND. Mr. Kreidler.

Mr. KREIDLER. No questions, Mr. Chairman.

Mr. ROWLAND. Ms. Brown, any questions of this panel?

Ms. BROWN. Thank you, Mr. Chairman.

Mrs. Schroeder, all I could do was sit here and contain myself during that discussion that was taking place when I came in. I want you to explain for the subcommittee today your good bill to improve VA health services for women veterans. The VA must provide productive services, including abortion, to women veterans. Please explain to me and my subcommittee members why VA must provide a full range of health services, because these women, across the board, have not received the same kind of services as their counterparts, and that is what it should be all about, not how a Member of Congress feels about what kind of services a person should have and whether or not they should do one thing or another. That should be left to that woman who has served.

Mrs. SCHROEDER. Congresswoman Brown, I couldn't agree with you more, and that is exactly why it is in there, and it states it

very emphatically. These women signed up to protect everybody's rights at home, and when they return home they ought to have the same rights that they worked to fight for, for everyone else.

The other part is, when you look at women, about 90-some percent of them get all of their health care from an OB-GYN, so if you don't have comprehensive reproductive services where women can go for pap smears and birth control or whatever they need, why would they come? Obviously, you don't want to go treat one part of your body at one hospital in one service and one somewhere else. That is why I think the comprehensiveness of it is terribly important. Once you start bifurcating it and once you start micro-managing women's lives and saying we are going to treat women vets differently than we treat other people, I think that is absolutely wrong, and I think it is more unconscionable than anything else I can think of, because these are the women who went out and really did everything they could to try and preserve rights for America and work under the Constitution.

The whole basis of the Constitution is, as a government, trust individuals to make certain decisions, and once we break into that and start making those decisions for them, we have really crossed the line. So I thank you.

Ms. BROWN. Thank you.

I have real problems when men discuss these decisions when they don't have to make them one way or the other.

Mrs. SCHROEDER. Well, maybe we should do uterus transplants for men.

Mr. SMITH. If the gentlelady would yield on that——

Ms. BROWN. My next, follow-up question deals with the mammogram. I have a concern that in the VA bill it is not the same standard as that which we passed, and that would give women a false sense of security, which is worse than not having a test at all. Could you further elaborate on that?

Mrs. SCHROEDER. Absolutely.

As you know, the Congresswoman took a very strong stand on this a couple of years ago, and we had howls from all over America, because many cities found—my city found we had one place that was doing decent mammograms, and everybody else was screaming, "Oh, you're interfering, you're micro-managing, this is terrible." Well, let me tell you, the only thing worse than not having a mammogram is having a bad one. So we really toughed it out and have now developed these nationwide standards, and we would like to see exactly the same ones in the VA, because I think we should be all looking at the same kind of data as we make these very hard choices.

We all hope that we can find some way of digitizing mammograms and making them much clearer. No one has figured out how to do that yet. But at this point we would certainly like to have that all standardized as much as possible so that we make sure, when you go out for a second opinion, you are looking at the same kind of mammograms.

That is another thing I can't emphasize enough. People often think, "Well, gee, if we pay for these mammograms, women are just going to line up every day and have another free one." I don't think they have ever had one, because they hurt, and if I said to you,

Congresswoman Brown, "Here, I'll float all the mammograms you want to have," I don't think there is any incentive for you to go down and get it just because I am paying for it. They hurt, they are painful, women don't like them, they are very intrusive, when you get done you feel like you have nothing left of yourself, but at least if you are going to do and have to do it, let's make sure we do it right and that we can rely on it.

Ms. BROWN. Thank you.

Just in closing, I just had a procedure done, and I talked to my male physician and he said, "This is going to hurt." Later, a female physician gave it to me, and she said, "Well, he said that because he has never had it happen to him," and it was entirely different when the female gave the procedure, so you are right.

Mrs. SCHROEDER. A good tip.

Mr. ROWLAND. The time of the gentlelady has expired.

I want to thank both of you very much for coming this morning and for your testimony.

Before we begin the next panel, I want to recognize the AMVETS new National Commander, Don Hearom from the great State of Texas.

Mr. HEAROM. Thank you, Mr. Chairman. [Applause.]

Mr. ROWLAND. The next panel is: Dr. John Farrar, who is acting under secretary for health, Department of Veterans Affairs, and he is accompanied by Susan Mather, who is an M.D.—she is assistant chief medical director, Environmental Medicine and Public Health—and Ms. Barbara Gallagher, who is director of the Eastern Region; Dr. Paul Errera, director, Mental Health and Behavioral Sciences Services; Ms. Joan Sheldon, deputy assistant director for rehabilitation services, Mental Health and Behavioral Sciences Service; and Mr. Walter Hall, who is deputy assistant general counsel, Department of Veterans Affairs.

Ms. BROWN. Mr. Chairman, I missed my opening statement. Do I get a chance to put it in the record?

[The prepared statement of Congresswoman Brown appears at p. 53.]

Mr. ROWLAND. Without objection.

Mr. ROWLAND. Dr. Farrar, thank you very much for being here this morning, and all those who accompany you. You may proceed as you so choose.

STATEMENT OF JOHN T. FARRAR, M.D., ACTING UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY: SUSAN MATHER, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR, ENVIRONMENTAL MEDICINE AND PUBLIC HEALTH; BARBARA GALLAGHER, DIRECTOR, EASTERN REGION; PAUL ERRERA, M.D. DIRECTOR, MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE; JOAN SHELDON, M.S.W., DEPUTY ASSISTANT DIRECTOR FOR REHABILITATION SERVICES, MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE; AND WALTER A. HALL, DEPUTY ASSISTANT GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS

Dr. FARRAR. Thank you very much, Mr. Chairman.

Please enter my full statement into the record, and I would like to summarize it in the interest of time.

Mr. ROWLAND. Without objection.

Dr. FARRAR. Mr. Chairman, members of the subcommittee, it is a pleasure to be here today to discuss our plans to improve VA's program for treating chronically mentally ill veterans and to present the Department's views on legislation on your agenda intended to improve the VA health care system.

With me today are, on my right, Dr. Paul Errera, Director, Mental Health and Behavioral Sciences Service; Mr. Walter Hall on my far right, Deputy Assistant General Counsel; Dr. Susan Mather, between the two, Assistant Chief Medical Director for Environmental Medicine and Public Health; Ms. Barbara Gallagher, on my far left, Regional Director, Eastern Region; and Mrs. Joan Sheldon, on my left, Deputy Associate Director for Psychiatric Rehabilitation.

Mr. Chairman, following your June 29 hearing on our efforts to care for the chronic mentally ill, our Mental Health and Behavioral Sciences Service prepared, and our Planning Review Board has recommended for approval, a national plan for creating an effective and comprehensive continuum of care for treating veterans with severe psychiatric problems.

The plan applies state-of-the art treatment methods to helping intensive VA system users with severe mental illness make successful transitions to supported community-based living. I intend to initiate patient care, education, and research elements of this plan in fiscal year 1994; that is less than a month away. A detailed description of our plan is being sent to you as part of our response to your July 12 letter.

Mr. Chairman, our formal statement discusses each bill on today's agenda in some detail. As you have requested, I will summarize our views and then will be prepared, and our panel will, to respond to the committee's questions.

Mr. Chairman, we support your bill to extend and modify the so-called Agent Orange treatment authority to tie that authority to the findings of the National Academy of Sciences study released earlier this summer. However, we believe that we need to have discretionary authority to treat diseases and disorders that the National Academy of Sciences did not categorize in its study because there is no scientific literature related to them. We also want to be certain that our physicians have the authority to examine veterans who allege their ailments are due to exposure to herbicides so a diagnosis can be made.

We also support your proposal to modify and extend authority to treat veterans for disorders that may be related to exposure to ionizing radiation. Again, we want to make sure that our physicians continue to have authority to examine veterans and treat their symptoms, if necessary, prior to making a specific diagnosis.

We also support a final provision of H.R. 3081 that would authorize the VA to provide outpatient care and treatment for the disorders which may be related to exposure to herbicides or ionizing radiation.

Mr. Chairman, your bill, H.R. 3082, and two bills introduced by Congresswoman Schroeder, H.R. 2285 and H.R. 2797, are aimed at

making improvements in VA's programs for treating women veterans and treating veterans who experience sexual trauma during military service. We are extremely concerned that those women discharged before December 31, 1991, not lose eligibility for counseling at the end of this year, as would be the case under existing law. We strongly support eliminating that time limitation as well as other time limitations included in the current program. We also support the inclusion of male veterans within this program.

Mr. Chairman, H.R. 2285 would direct that we establish a new 800 number phone system to provide information about the Sexual Trauma Counseling Program. We agree with the intent of this provision. However, we believe the best approach would be for the VA to train our existing operators in the services available in the Sexual Trauma Counseling Program and allow them to serve the function contemplated by this provision.

Mr. Chairman, both your bill, H.R. 3082 and Congresswoman Schroeder's bill, H.R. 2797, are directed to improving VA's program for providing health care to women veterans. We support provisions of these bills that would improve our authority to provide outpatient care to women veterans and the requirement that VA establish quality assurance and quality control standards for mammography services that are at least as strict as standards to be developed by the Department of Health and Human Services.

We do not object to the provision in the bill to expand the requirements for a population study of women veterans authorized last year by Public Law 102–585.

Mr. Chairman, at this time we do not support the redefinition of the services available to women veterans contained in H.R. 2797. We are not currently prepared to provide obstetrical care and believe that that decision should be deferred until the impact of the national health care reform on the VA is more fully known.

We also ask that you reconsider two provisions of H.R. 2797 that would add additional detailed reporting requirements concerning the provision of care to women veterans and specify how we are to develop and implement a research strategy. Compliance with the additional reporting requirements, because they are so broad, would be extremely burdensome and expensive.

The second provision would expand and clarify the actions the Secretary must take to foster and encourage research involving women. We believe the requirements of the bill are too prescriptive and that research should be approved on the basis of the normal merit review processes.

We are also concerned about the provision of the bill that would specify the administrative support required for women veteran coordinators. We are committed to improving our programs that provide services to women veterans. Much progress has been accomplished during this year, and further program expansion is programmed for fiscal year 1994.

Mr. Chairman, H.R. 3090, a bill introduced by Congressman Kreidler would, first, authorize the VA to establish nonprofit corporations to help foster the compensated work therapy programs which operate in our medical centers throughout the country and, second, would extend and expand a demonstration program under which the VA operates transitional residencies for veteran patients.

The administration recommends deferring action on this bill at this time to allow further review of the effectiveness of current nonprofit corporation support of compensated work therapy programs and to allow completion of an evaluation of the effectiveness of our current Compensated Work Therapy Transitional Resident Program in rehabilitating veterans.

Another proposal on your agenda would authorize VA to use Vet Centers as sites for the delivery of limited outpatient services for veterans otherwise eligible for those services. We believe this provision is unnecessary since we currently have authority to provide outpatient services in Vet Centers.

Mr. Chairman, this concludes my summary, and I and my colleagues will be pleased to answer any questions you or your colleagues may have.

Thank you.

[The prepared statement of Dr. Farrar appears at p. 71.]

Mr. ROWLAND. Thank you very much, Dr. Farrar.

I would direct this question to you, Dr. Farrar. Public Law 102–585 directed the VA to encourage and foster research related to women's health problems, and I directed a similar question to Congresswoman Schroeder earlier. Doesn't the relatively small number of women veteran patients in the VA limit the extent to which the VA can practically carry out this research?

I am very strong on research, as you well know, and supported the reinstitution of the funding that we lost with some additional funding. But if Congress encouraged the VA to simply reimburse private physicians for treating women veterans rather than encouraging treatment through VA facilities, wouldn't that further retard the development of VA research on women veterans' health?

Dr. FARRAR. Let me answer it first, then ask Dr. Mather to add to it.

Our intent is to use the VA whenever possible for the treatment of veterans. We are making great progress, and we intend to make more progress, to make, as Congresswoman Schroeder said, our system very, very felicitous to women veterans. So we will try to use the VA for most of our studies.

Number two, we have in the past used our affiliated programs, our medical schools, to add women to some of our studies, when they are appropriate, in order to get enough people in our studies to have reliable results.

Dr. Mather, do you want to comment on the Congressman's question?

Dr. MATHER. Only that I think if the contracting authority were overused, it would certainly interfere with our ability both to serve women appropriately and provide them with the services that they have earned in their service to their country. It would also cut down on the pool of women who would be available for research studies with facilities, because while we do have between 1.1 and 1.2 million women veterans, they obviously don't all use VA. (Nor do all male veterans use VA health facilities.) If 25 percent of women veterans were to use our facilities, we would have a significant population for research studies.

But if the contracting-out authority is overused, I think that would interfere with that. We feel, though, that the contracting au-

thority can be used to provide equity between services and to provide services that are not feasible because of small numbers in certain locations.

Mr. ROWLAND. I believe that in order to have a good service, not only insofar as research is concerned but insofar as actually providing clinical care, there must be adequate utilization of that service, and if you do not have that, then you will not be able to provide high quality care.

Do you envision that what we would be putting in place in Representative Schroeder's bill would be detrimental to creating the kind of care that we would like to see created in house for women in the Department of Veterans Affairs?

Dr. FARRAR. I would not think so, Mr. Chairman. My view would be that we, as I said earlier, do most of what we do within the hospital, and there might be some at the affiliate. But I don't think it would be detrimental, as I could see it. I don't have a crystal ball.

Mr. ROWLAND. Let me ask you something else, Dr. Farrar. I understand that Secretary Brown has committed the Department to undertaking a number of new mental health initiatives to address the problems that we discussed here in June. Would you please detail the steps the VA will be taking in fiscal year 1994 and 1995 to improve care of the mentally ill and the level of funding support you will be providing for these initiatives for those fiscal years?

Dr. FARRAR. As a follow-up to our hearing in June—and we will detail this more thoroughly in the letter which you will receive, and I am sorry that OMB didn't clear our letter, and so we don't have it to you by now—we are planning—Dr. Errera may want to document this a little more explicitly, but we are planning in 1994 to take money out of my reserve as Acting Under Secretary in the amount of about $2 million to start up a new initiative on chronic mental illness, and in 1995 we are prepared to allocate $13.5 million to these new programs in chronic mental illness.

Do you want the details from Dr. Errera?

Mr. ROWLAND. I don't think so at this point. You could submit those for the record, if you will.

Dr. FARRAR. All right.

(Subsequently, the Department of Veterans Affairs provided the following information:)

In the immediate future we plan to create a new Special Committee for Seriously Mentally Ill Veterans which will report to the Under Secretary for Health. The special committee will:

1) monitor and evaluate the care provided to severely mentally ill veterans throughout the VA system;
2) identify and recommend fiscal incentives to support appropriate shifts in direction for VA mental health services;
3) identify specific facilities and programs that require special attention;
4) identify model programs that can be replicated throughout the VA health care system;
5) make facility-specific and system-wide recommendations to improve the quality of care provided to severely and persistently mentally ill veterans;
6) define the educational needs of clinicians involved in the delivery of care to seriously mentally ill veterans and propose appropriate activities; and
7) identify areas of research priorities relevant to the treatment of these patients.

We also intend to initiate two sets of clinical initiatives:

1) dissemination of Intensive Psychiatric Community Care (IPCC) modules. This community-based clinical approach is built around a case manager model to help seriously mentally ill veterans deal with their symptoms and teach them skills needed for day-to-day community living. In 1994, we plan to start four such programs and, in 1995, five additional ones.

2) establishment of Unified Psychogeriatric Biopsychosocial Evaluation and Treatment (UPBEAT) demonstration projects. This approach involves psychogeriatric evaluations and case management of high risk elderly inpatients on medical, surgical, and psychiatric wards where undiagnosed psychiatric illness or behavioral problems have led to repeated readmission or unnecessary lengths of stay. We plan to start one UPBEAT project involving three medical centers in FY 1994 and two others involving six medical centers in FY 1995.

Mr. ROWLAND. Ms. Gallagher, let me ask you a question. Under current law, eligibility for VA-reimbursed community-based treatment, the so-called fee-basis care, is severely limited. So, if a VA facility lacks the capacity to provide timely treatment, a veteran must seek it elsewhere or wait weeks or even longer.

We have heard concerns about the equity of expanding fee-basis care proposed under H.R. 2797. Do you have any problem, for example, with legislation that would authorize non-service-connected women veterans to receive outpatient treatment from private physicians for conditions relating to aging?

Ms. GALLAGHER. I think we would provide the same care for women. We might have to contract—we would do the same kind of contracting for men as well. I think we make every effort to keep the eligibility fair, or keep the access fair. There would probably be no special access because a woman is a woman whether it would be for whatever ailment: osteoporosis, Alzheimer's, whatever it may be.

I believe the VA, in the medical centers that I supervise, really makes a special effort to see that everyone gets equal access to care, and I don't see anything special—there would be no gender specificity there that I can point to.

Mr. ROWLAND. The gentleman from New Jersey.

Mr. SMITH. Thank you very much, Mr. Chairman.

My first question regards the Vet Center limits. As you know, H.R. 3108 would expand health services to Vets Centers. We do it in an incremental way, focusing primarily on those who are eligible for the services provided at the Vet Centers, who likewise be eligible for this kind of health care.

Do you support this incremental approach? Do you see any logic to it? Would it be helpful, as opposed to just allowing everyone to use the Vet Center, which potentially could overload the system? Though we may get to that point some day.

Dr. FARRAR. I think there is a problem with providing the kind of services that are suggested under this bill in the Vet Centers. To fundamentally change the unique nature of these facilities, I think may be a mistake. We can do it, but much of the success of the Vet Centers over the past 14 years can be attributed to the fact that they are not clinics providing traditional outpatient services. To introduce basic outpatient health care services into a mix of services now provided at the Vet Centers by social workers, by psychologists, and by groups that are dealing with the readjustment problems of Vietnam Veterans, might compromise the continued success of these facilities.

In our view, if we need to enhance our ability to provide limited services in small community-based facilities, we can do that under the existing authority by leasing space in the most appropriate location. It could be next to the Vet Center. But it would have to be bigger. It would have to have entirely new space, and it would change the character rather completely.

It should be pointed out also that because of national health care reform, we are thinking of establishing substantial numbers of community-based clinics in order to increase access to our system and make it more attractive to veterans to use our system for primary care.

Mr. SMITH. If I could just respond, I visited the Trenton Vet Center earlier in the year and in speaking to a number of veterans, saw a great deal of validity to expanding the mission. I am not convinced that this legislation would somehow injure the mission. It expands it. It makes it more attractive. It makes it more of a magnet for those veterans to utilize the Vet Center.

As a matter of fact, we have been trying to get a space adjacent to Trenton Vet Center that is absolutely amenable to this kind of usage, yet we still have not gotten any kind of answer back in contacting the VA. This situation is what primarily led me to go forward with this legislation. We all know that veterans complain en mass about traveling large distances, only to spend half the day going through a processing ordeal, when that could have been done prior to getting to that hospital.

So I would hope that you might revisit this with the thought that the expanded mandate would in no way be injurious, but would actually enhance and make the Vet Center more attractive.

Dr. FARRAR. I think that well might be the case, and I would like to go back and respond to you in detail. The difficulty with all of these things is that one Vet Center—if you have seen one Vet Center, you have seen one Vet Center, and there are a variety of differences. I think you may well be right, and I would like to look into it and ask Dr. Blank to consider your suggestion. We do want to give better service and we will review your proposal in this light.

Mr. SMITH. That is the bottom line.

Just so I understand your testimony correctly, is it your testimony that you oppose an expanded mandate requiring the usage of the VA for abortion?

Dr. FARRAR. No. What my testimony said was that we would like to put that on hold until VA's role and the contents of national health care reform are better known. If it is part of a basic health package and a veteran selects the VA as her source of care, then it isn't going to be necessary that we have a bill. It is going to be part of VA's basic benefit package, so we are not taking a position at this time.

Mr. SMITH. Would it be your advice to the chairman and myself and others who are pushing Dr. Rowland's bill that a provision not be added that would require or authorize the utilization of a network for abortion?

Because this legislation, obviously, will move, and we are hoping that it will move quickly.

Dr. FARRAR. I would very rapidly take the Fifth, Mr. Smith. I wouldn't respond to that at all.

Mr. SMITH. Why?

Dr. FARRAR. Just because I don't think that that is my position as Acting Under Secretary for Health to take a position on that today.

Mr. SMITH. I would appreciate it if you would get back to us. It would be helpful, because we will be moving towards markup and it would be nice to know what the VA would like done with this particular piece of legislation.

Dr. FARRAR. Well, our position is not to have this bill passed until we know what national health care reform will be. We don't know how we are going to play in that arena.

Mr. SMITH. Okay. Thank you very much.

Mr. ROWLAND. Thank you.

Mr. Filner.

Mr. FILNER. Just a brief follow-up on that last line of questioning. As I understand what the President is proposing, in the briefing that was given by your Assistant Secretary for Policy, the national health care reform plan includes a comprehensive standard benefits package that includes family planning and pregnancy-related services. And clearly, I think, we are in agreement with the fact that the veterans will be provided the same benefit package.

So, if H.R. 2797 proposes a comprehensive package, whereas H.R. 3082 does not, there is an inconsistency there that we couldn't possibly approve.

Dr. FARRAR. Dr. Mather, you want to comment?

Dr. MATHER. At this point we have to look at reproductive health care too as an equity issue, and we have not defined pregnancy as a disability. Neither pregnancy nor infertility is defined as a disability. They are conditions that, while a woman is the one who gets pregnant, in infertility there are two parties involved and the comprehensive reproductive package covers infertility too.

At this point, infertility services are not available to males in the VA health care system, and we would not, I think, favor a service that only looked at one-half of the reproductive picture; i.e., the woman.

So from the point of the complete reproductive package, it is not available to males in the system. So we have to look at that as an equity issue, I think, as well.

Mr. FILNER. Will the VA be providing, under your notion, the same benefit package for male and female veterans that Congress passes as a national health care package; is that right?

Dr. FARRAR. Yes. I think that is the assumption, although we have not officially seen the President's proposal.

Mr. FILNER. You are going to have to compete as a health care system.

Dr. FARRAR. Exactly. Yes, Mr. Filner.

Mr. FILNER. And so, whatever the debate here is and whatever the feeling of the members is on particular service, it seems that we would have to approve a package that is compatible, similar to, or identical to the benefits provided to people outside that system.

Dr. FARRAR. I haven't seen the full package. Our responsibility is to give the best possible care to veterans, and we will continue to do that and that will be the way we will have to function after national health reform.

Mr. FILNER. And I assume any legislation we report out of here would be consistent with the health care package that would be passed by the Congress.

Mr. ROWLAND. Well, you have alluded to the Department of Veterans Affairs hospital health care system. Based on what I know about the President's plan, it is going to have to be competitive in order to retain its independence. If it is not competitive, then, of course, there is great jeopardy.

Mr. FILNER. So you wouldn't want to propose any lesser set of benefits for the VA system, then, would you?

Mr. SMITH. If the gentleman would yield on that?

Mr. ROWLAND. Again, I think that——

Mr. FILNER. Whenever that comes out. We don't know yet.

Mr. ROWLAND. I think that we will have to wait and see, in fact, what is going to become law in the President's proposal before we will know where the VA is going to stand.

The gentleman controls the time.

Mr. SMITH. Will the gentleman yield?

Mr. FILNER. Yes.

Mr. SMITH. I think it would be unfortunate if the chairman's bill was held up to await something at some later date. If, for example, we lose, we being the pro-life side, which I don't think will happen, on so-called comprehensive reproductive services, which is a buzzword for abortion. Everything else but will be fine with me. That is the only thing I am concerned about.

But I think that issue will be the big, major fight on the floor of the House and the Senate when the national health care debate is engaged. If we lose that fight, it would obviously apply to the VA and every other agency of government. But to hold up this particular bill, which is silent on that provision, I think would be a mistake.

I would like to see this bill proceed on its own merits as introduced.

Mr. ROWLAND. I would hope that this bill would proceed on its own merits as well. Legislation which we passed last year and was signed into law provided for pap smears and breast examinations and mammography, but it did not include under this section infertility services, abortion or pregnancy care. We are silent, our bill is silent on this particular issue.

This is a bill that we want to move forward to address many of the problems that exist now in providing health for women. So that is what we are particularly interested in at this time.

Mr. FILNER. Clearly the context of this will be not only the health care plan, but the move of the VA toward providing services to dependents. Within that context, it obviously has an importance that we need to look at.

Mr. ROWLAND. We had a briefing by Vic Raymond, who worked on this committee for a number of years, just a day or so ago, to tell us exactly how the Department of Veterans Affairs expects to fit into the proposal by the Administration and that, of course, was part of that briefing, that dependents may well become part of the system in the Department of Veterans Affairs.

Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

Dr. Farrar, I want to see if I can pull you any deeper into this issue. If we were not faced with an impending health care reform, would the position of the VA be one of wanting to expand women's services in the area that we are discussing here, particularly reproductive services.

Dr. FARRAR. I think, again, the principle is one of equity, and the principle is that, if a woman veteran, as Congresswoman Schroeder said so eloquently, has defended the country and is service-connected, we have to give that woman whatever medical services we can as a part of our responsibility to her.

Mr. KREIDLER. No. I think you stated it quite well, and I think that really does answer the question of enhancement of women services in the VA system, as the VA is endeavoring to do currently. I think that, obviously, if health care reform were not going to be before us, we would see that program moving forward. But, of course, reform is going to involve a whole new initiative here if the VA is brought into it as envisioned.

Dr. FARRAR. Mr. Chairman, could Dr. Mather give you a 1-minute summary about what we have done in the past year to improve service to our women veterans?

Mr. ROWLAND. Of course.

Dr. MATHER. Well, I think there has been expansion of the area of reproductive health care. Traditionally, in the past we have not provided contraception. We are seeing increasing numbers of young women who come to our gynecology clinics wanting this service, and as a result we have provided funding to purchase gender-specific pharmaceuticals, including contraceptives and hormone replacement therapy as well as antibiotics for gynecologic infection. That has gone out to the field already. A policy saying that contraception and family planning can be considered a part of the routine health care that women veterans receive is in process.

We have funded, as you are aware, four comprehensive women's centers, one of which will be focusing on preventive health care. We are funding stress treatment teams in four centers. We are funding counselors for sexual trauma in our Vet Centers around the country. We have a national training program, and actually the National Training Program Steering Committee is meeting in Washington today and have come to this hearing to get some insight into what the Congress wants us to be doing in this area and are in the audience today.

We are also getting ready to issue guidelines for women veterans' health that will provide the primary care model for women veterans. I think Congresswoman Schroeder was right when she said a lot of women in this country get their health care from gynecologists. But I think that is true for healthy women. For sick women, for women with health problems, I think the primary care model is a much better model, because gynecologists are not very good at treating arthritis or diabetes or heart disease and we have lots of women veterans who have all these problems and who also need routine gynecology. They need pap smears and mammograms, but they also need their heart disease treated, their arthritis treated, that sort of thing.

So we are moving very fast into the direction of establishing primary care teams to provide women veterans health care in all VA

medical centers. We're also moving toward a goal of having women's health clinics in all the medical centers. They will look at the women as a whole, not as a reproductive system that also has some other organs connected to it, but a whole woman who has health care needs which include preventive medicine needs to prevent cancer or to detect it early, and needs health care providers to take care of all health needs, including those related to the reproductive system.

Mr. KREIDLER. If I could continue, Mr. Chairman.

Dr. Farrar, moving on to your testimony here that dealt with the IG's investigation of the VA's research program in relationship to the nonprofit corporations, I am curious if the IG is also taking a look presently at the nonprofits in the compensated work therapy area.

Dr. FARRAR. Ms. Sheldon.

Ms. SHELDON. To my knowledge, they are not. They are just looking at the research nonprofit corporations.

Mr. KREIDLER. Is there a reason? I mean you apparently have indicated here a desire to wait for that IG's report for the research program's nonprofits. I am curious why they weren't also taking a look here at the existing nonprofits that exist in the VA system in the compensated work therapy area? Is there a reason for that?

Ms. SHELDON. I am not sure there is a reason. Maybe because there are only a few associated with our CWT programs. I will say, though, that we have not had any problems with the nonprofit corporations that we work with in primarily California, American Lake and a couple of others. They were developed and have continually functioned strictly for the benefit of the CWT programs at the VA medical centers.

And not only that, but we do have annual audits of the nonprofits so that we can make sure that there aren't any other kinds of problems that would have any kind of negative bearing on our programs.

Mr. KREIDLER. You effectively moved on to my second question there by virtue of indicating that there are no current problems right now. Let me ask an additional question here. If, Ms. Sheldon, you could perhaps respond, and perhaps I could get a comfortable indication here too from Dr. Paul Errera on the questions of the kind of extension that I am proposing here of the CWT and TR programs. What are your personal feelings on the expansion of those programs, as opposed to, perhaps, the official line of the VA?

Ms. SHELDON. Personally, or even officially, our programs have been very successful. We have 20 new programs, 14 of which have been existing for about 2, 2½ to 3 years.

I would like to just tell you very quickly two major success stories because I happened to be visiting at one of the facilities and talked to some of the veterans. For example, we had one veteran who had been into the VA 18 times in substance abuse programs. He had 28 years of substance abuse. He had been incarcerated off and on for a total of 10 years. This man had almost been written off as being not treatable anymore.

He came into substance abuse about the time that we got our program started, and he was admitted into our program. He stayed in there approximately a year, while we worked with him, placed

him in supportive employment, and provided him with support. He was in therapy. He was also working 8 hours a day and learning responsibility.

He is now employed full time. He has been free of substance abuse for over 2 years. He is doing beautifully, and he is a supervisor. In fact, it is a Federal agency who hired him in spite of OPM's objections at the time.

We also had another veteran who was also having problems, had about 15 years of substance abuse , had been in and out of the VA, owed $10,000 in back taxes, and basically was doing nothing. He has now paid back about half of his taxes. He is going to college to be a computer programmer. He is working also full time in an agency where he was placed in supportive employment.

Overall, I can tell you that we have had approximately 720 patients in our program. Our success rate is very good. We are working very closely with our patients. They are working full time. They are learning skills that many of them had never had before.

So, in answer to your question, personally, absolutely I feel that we should extend our program. For the first time, and I have been in this program a long time, we have hospitals on a waiting list that would like to participate in this program.

Mr. KREIDLER. Great. Well, that reaffirms the experience I had in seeing what is happening out at American Lake Veterans Hospital.

Mr. Errera, would you——

Dr. ERRERA. I very much agree with Ms. Sheldon—that is why we teamed up—we both agreed as to the value of work therapy. I think the hesitancy which came from OMB is because they haven't yet received an evaluation of the CWT Programs. We have done an evaluation which confirms what Ms. Sheldon is saying. It is being finalized and will be sent in through channels. Within a month they will get it. Our prediction is that after they have gotten it they will like it and support these programs.

Mr. KREIDLER. Well, good. I am glad to hear that because I think your point is well taken. I think OMB came up with this IG's investigation of the nonprofits——

Dr. ERRERA. I am talking about work therapy, not the nonprofits.

Mr. KREIDLER. Right. Exactly. But I think OMB came up with this IG issue as a way of trying to defer taking a position on the nonprofits.

I would like to say that I have been particularly impressed with these two programs, and really feel that in the area of mental health they offer some tremendous opportunities. Given the VA hospitals' area of responsibility for mental health, it is a major undertaking in the VA hospital system, and this is a program with proven success.

Mr. ROWLAND. Mr. Kreidler.

Mr. KREIDLER. Yes, sir.

Mr. ROWLAND. The gentleman's time has expired. If you have additional questions, I will come back to you. I have two or three questions that I wish to ask. Do you have additional questions?

Mr. KREIDLER. I will defer to the chairman.

Mr. ROWLAND. Thank you.

Dr. Mather, I want to come back to what you were talking about a few moments ago. You were talking about services that were provided for women veterans, I suppose on an outpatient basis, reproductive, contraception, and services of this nature.

Isn't it true that under existing law and funding limits that the VA does not now provide comprehensive outpatient care to male veterans? And my question would be, are these Category I veterans that you are—that this kind of service is being provided to?

Dr. MATHER. You are talking about the primary care.

Mr. ROWLAND. Yes.

Dr. MATHER. The primary care model. These are eligible women veterans. These are not.

Mr. ROWLAND. These are those women who have service-connected disabilities or fit the criteria based on their economic resources.

Dr. MATHER. Or their economic resources.

Mr. ROWLAND. I see. The Department's testimony makes the point that there may be diseases and disorders that the National Academy of Science did not categorize in its study because there is no scientific literature related to them. Could you suggest some examples of diseases that NAS did not cover in its exhaustive study for which there is a positive biochemical basis to believe there could be an association with exposure to Agent Orange? This is for Dr. Mather.

Dr. MATHER. I am not personally aware of any diseases. I think the NAS was exhaustive. However, I am aware of anecdotes of veterans who have come to VA facilities and are receiving care under the authority. For example, the one I can think of is hypertension. The veterans' feeling is that the hypertension resulted from their exposure to Agent Orange in Vietnam. I don't know of any scientific reason to make that assumption, nor did the NAS feel that there is a scientific basis to look at a relationship between hypertension——

Mr. ROWLAND. Between what?

Dr. MATHER. Between hypertension and exposure to Agent Orange. There is no scientific basis for this that I am aware of. As I said, nor did NAS find a scientific basis for looking for an association between the two things.

But from my standpoint it appears that the National Academy of Science report is exhaustive as far as the conditions covered. However, there are also veterans who come with a number of skin conditions. As you know, skin crud was not unknown to people who were serving in Vietnam: Fungal infections, dyshidrosis, a lot of other problems. And the assumption on the veteran's part is that these skin problems may have been due to Agent Orange. The NAS did not cover an exhaustive range of skin problems.

And we are seeing veterans who come to us for care thinking that their skin problem, not chloracne, is related to Agent Orange.

Dr. FARRAR. Mr. Chairman, may I clarify. I think the Department's position is that we simply didn't want to bar the door to somebody who had symptoms of any sort who is a veteran until the diagnosis was made. Once the diagnosis was made, if it didn't fit under the National Academy's recommendations, we would not consider the person eligible for care.

Mr. ROWLAND. I appreciate it. Does anybody else have an additional comment relative to that?

I yield to the gentleman.

Mr. KREIDLER. Mr. Chairman, since I know we are going to have to run for a vote here in a little bit——

Mr. ROWLAND. The House is in recess at this moment.

Mr. KREIDLER. Oh, it is in recess?

Mr. ROWLAND. Yes.

Mr. KREIDLER. Oh, okay. Good. I didn't listen. I made an assumption.

Mr. ROWLAND. I believe the House is in recess until about 11:15. So, if you have additional questions now for the panel, please proceed.

Mr. KREIDLER. Well, with the idea that maybe we can proceed because I know there are two other panels here, I do have a number of questions, Mr. Chairman, but if I could submit them for the record?

Mr. ROWLAND. Well, we would appreciate that if you would submit those questions for the record.

Mr. KREIDLER. Thank you, Mr. Chairman.

(See p. 169.)

Mr. ROWLAND. I have one additional question for the panel. The legislation that I have authored to address the problems that we face with women's issues now, could you give me some indication from the Department of Veterans Affairs how you feel about moving that legislation forward, or do you have an opinion on that at this point?

Dr. FARRAR. Specifically which, Mr. Chairman?

Mr. ROWLAND. H.R. 3082.

Dr. FARRAR. We are generally in favor of that bill. Our formal statement discusses it in greater detail.

Dr. MATHER. My understanding is—I would like to be able to correct it, if my understanding of which bill we are talking about is wrong, for the record. But my understanding is that we favor moving that along.

Mr. ROWLAND. I want to thank the panel this morning for being here. We do appreciate your testimony very much.

Mr. ROWLAND. The next panel consists of Mr. John R. Vitikacs, Assistant Director, National Veterans Affairs and Rehabilitation Commission of the American Legion; Mr. Dennis Cullinan, who is Deputy Director, National Legislative Service, Veterans of Foreign Wars; Mr. David Gorman, Assistant National Legislative Director for Medical Affairs of the DAV; and Mr. Michael Brinck, Assistant National Legislative Director of AMVETS.

Gentlemen, thank you very much for being here this morning. And, Mr. Vitikacs, we will call on you first.

STATEMENTS OF JOHN R. VITIKACS, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; DENNIS M. CULLINAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS; MICHAEL F. BRINCK, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, AMVETS

STATEMENT OF JOHN R. VITIKACS

Mr. VITIKACS. Good morning, Mr. Chairman, and members of the committee. American Legion appreciates the opportunity to express our views on various VA health care matters.

Due to having received Congresswoman Schroeder's two women health care bills only as recently as Friday of last week, we request that our written response to those bills be submitted for the record. However, this morning I will summarize our response to those bills.

Mr. ROWLAND. Without objection.

[The information follows:]

Mr. VITIKACS. Mr. Chairman, the Veterans Health Care Act of 1992 included the Women Veterans Health Programs Act which authorized counseling to women veterans for sexual trauma and established priority care for that purpose, authorized specific health services for women, to include pap smears, mammography and general reproductive health care, excluding infertility services, abortions and pregnancy care except in cases where pregnancy is complicated by a service-connected condition.

It also mandated women veterans coordinators in the four VHA regional offices and imposed certain reporting requirements for sexual trauma counseling, health care and research. The legislative initiatives under consideration today seek to augment and strengthen these mandated programs.

Mr. Chairman, the American Legion supports legislation which will reinforce the efforts VA has made to implement provisions of Public Law 102–585 with regard to women veterans health care programs. We support parts of all three women veterans bills under consideration today.

We would like to see H.R. 3082 include provisions for VA to conduct specific female-related research activities. We believe that the specific women veterans health services proposed by H.R. 2797 should be worked out in the basic benefits package offered by VA in the context of national health care reform.

The Legion does not support any provision relating to the inclusion of pregnancy-related care and the management of infertility under existing fiscal and eligibility constraints. The American Legion, however, has no position on the provision of abortion services in VA. We do not involve ourselves in socio-medical decision-making with such powerful moral and ethical implications.

There must be continued efforts to ensure that women veterans receive all the care which is needed and for which they are eligible. VA should continue to utilize fee-basis care for service-connected women veterans in areas where it is not cost effective to provide that care through VA.

With regard to H.R. 3081, we believe the measure does not provide sufficient guidance as to which veterans under the Agent Orange Act of 1991 would be entitled to health care at VA facilities. Our concern is that the list referred to in the measure should not be used to restrict medical care to veterans exposed to herbicides. VA physicians must be provided a specific list of diseases in each of the three proposed categories. Provisions should also be made to provide health care for additional diseases caused by exposure to Agent Orange as determined by the Secretary and based on specific evidence.

We support the provision of H.R. 2375 which would expand through December 31, 2003, the authority for VA to provide health care to veterans who are exposed to ionizing radiation or to Agent Orange. We also support the draft proposals relating to expanding the mission of the Readjustment Counseling Service Vet Center program and the rehabilitation of chronically mentally ill veterans.

As noted in our written statement, the Legion encourages the subcommittee to include provisions of Senate bill S. 1226 regarding expanded entitlement of Vet Center eligibility and scope of services provided.

Mr. Chairman, that concludes the summary statement.

[The prepared statement of Mr. Vitikacs appears at p. 88.]

Mr. ROWLAND. Thank you, Mr. Vitikacs.

Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you very much, Mr. Chairman.

On behalf of the 2.2 million men and women of the Veterans of Foreign Wars, I wish to thank you for inviting us to participate in today's important hearing on a number of pieces of legislation intended to enhance the health care provided to this Nation's veterans by VA.

First under discussion today is H.R. 3082, which you, yourself, have introduced, Mr. Chairman, which is cited as the Women Veterans Health Improvements Act of 1993. In general, this legislation would reaffirm with greater specificity VA's existing statutory obligation to provide eligible women veterans appropriate gender-specific health care services in a timely and cost effective manner.

Without going into all the particulars of this bill, Mr. Chairman, it is in keeping with the VFW's ongoing position in favor of making the VA health care system available and user friendly for women and providing for their specific needs that we support this legislative initiative. We would only ask that the sexual trauma services also be made available to male veterans as well.

Next, we will discuss H.R. 3081, a bill to extend and expand the authority relating to Agent Orange and radiation exposure. In general, this initiative would authorize treatment for Vietnam veterans for any disease which the National Academy of Sciences finds to have some evidence or inconclusive evidence of an association with exposure to a herbicide.

We would support this so long as VA retains its authority to treat veterans suffering from disabilities that are not recognized by the Academy.

The bill would also provide for reassessment of the special authority relating to Agent Orange authority based on the National Academy of Science, due in July of 1995. While we have no objection to looking at specific disabilities, we do however support the extension of the overall authority to the year 2003.

The bill under discussion would also eliminate any sunset date for the provision of care to veterans who have been exposed to radiation, and it would provide special health care eligibility for radiation exposed veterans, and in the case of radiation and Agent Orange, expand the scope of authorized care to mandate any needed outpatient treatment for covered illnesses.

Once again, in keeping with the VFW's longstanding holding that the time for deliberation and delay with respect to caring for the needs of this Nation's radiation and herbicide-exposed veterans is long overdue. We support this bill.

Next under discussion is a bill which is to be introduced, as I understand it, which would authorize the Secretary of Veterans Affairs to expand the scope of services provided to veterans by Vet Centers. While the VFW is supportive of this proposal, we would ask that it be amended so that all veterans would enjoy access to the aforementioned services through Vet Centers.

The VFW views the provision of preventive health care services on an outpatient basis to be an essential component of modern medical practice and very much in keeping with maintaining a veteran's physical and the VA health care system's fiscal well-being. The VFW strongly holds that any eligibility criteria for VA health care should be modified to open up the system to all of America's veterans with a full continuum of services which it provides, including preventive health care.

While this draft proposal would provide certain of these crucial health care services on a limited basis through the utilization of Vet Centers, we believe that it should be made available to all veterans.

Also under discussion here today is a legislative proposal intended to improve VA's ability to provide continuity of care and the rehabilitation of chronically mentally ill veterans. Once again in keeping with our strong belief that VA should provide for the healing of mind as well as body those veterans in our Nation's service, we support this proposal.

Mr. Chairman, I will also discuss today the legislation which has been introduced by Congresswoman Schroeder. Although it is not part of our written testimony, I would like to comment on that as well.

H.R. 2797, which is entitled the Veterans Women Health Improvement Act of 1993, would among other things mandate VA health care for certain gender-specific disabilities for women regardless of service connection and would provide that such care may be provided on a fee basis. We would point that there is currently no equivalent for the provision of VA health care to veterans as if it were service-connected regardless of whether it is or not, so this would be unfair and contrary to the VFW's push to open up the VA health care system to all veterans.

We believe that veterans, male or female, should be treated equally. We would also point out that fee-based care is now se-

verely limited to service-connected veterans, and it would be doubly unfair to provide non-service-connected veterans, or certain non-service-connected veterans with this care only because they are women.

Mr. Chairman, this bill would also mandate inclusion of women and minorities in research studies. While we find the idea appealing, Mr. Chairman, we also realize that there are relatively few women within the VA health care system, and to mandate their inclusion in certain studies might indeed disincline certain health care researchers from undertaking such vital research, given that the protocols would become too cumbersome and restrictive.

I see my time is practically up, so I will conclude briefly. H.R 2285, another bill under discussion, would provide sexual trauma counseling for veterans. As we have already indicated, we would like to see such care provided to men and women alike.

Last under discussion will be H.R. 2375, which would provide the authority for the Secretary to provide priority health care to veterans who are exposed to ionizing radiation or to Agent Orange. Once again, we support this and we support the continuation of the overall authority until 2003.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Cullinan appears at p. 92.]

Mr. ROWLAND. Thank you.

Mr. Gorman.

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you, Mr. Chairman. Good morning.

I would say at the outset that the pieces of legislation that we received late on Friday we have not included in our written testimony. I will, however, be more than happy, if you wish us to try to respond to certain concerns or any concerns you may have regarding questions of those pieces of legislation.

Briefly, I think there is a wide and vast array of legislation before us today that do an awful lot of things for a lot of veterans, and I think in the main those are very positive things and very positive proposals. I would say that, in general, we are supportive of the concept of each and every one.

The draft legislation to provide for continuity of care for rehabilitation of the chronically mentally ill veterans proposed by Mr. Kreidler is certainly worthy of our support. I think it is often a forgotten population of veteran. The VA does a tremendously positive job, I think, in the treatment of the chronically mentally ill, and any tools that they can be given to improve their flexibility to be able to continue that are supported by the DAV.

We certainly concur with the intent, and we are fully supportive of the provisions contained in the draft legislation that would create an expansion of the Vet Center program.

It is our belief that the concept of providing certain health care services to eligible veterans at Vet Centers is long overdue. Unquestionably, such a program could only serve to have a positive effect on veterans and their overall health status.

Clearly, Vet Centers are well accepted by their user population. They have proven to be cost effective, and basically hassle free, and, importantly, in our opinion, exist in the community where vet-

erans reside and are therefore easily accessible and serve as an easy access point to the VA health care system.

In addition to the fully defined psychological needs of veterans seeking services at Vet Centers, it would seem that their existing physical disabilities will require the seeking out of medical care at some point. As Vietnam veterans age, it will be inevitable that the presence of additional disability and disease will manifest, and we can envision Vet Centers playing a significant role in the early detection and treatment of additional disabilities by means of having VA health care personnel present and immediately available to see those veterans.

Mr. Chairman, we don't necessarily share the VA's concerns that, number one, the mission of the Vet Centers would be diminished by providing these kind of additional services; we, in fact, believe they would be enhanced.

Secondly, the concept of already having the authority to provide outpatient services is foreign to us. We haven't seen that occurring in Vet Centers. However, we would be more than pleased to learn about it if it is occurring.

I think also the issue of being able to move forward with the leasing of satellite clinics, although there has probably been authority for VA to do that, they have not been able to do that for a number of reasons, primarily that of resources. I think the Vet Centers serve as an already existing physical plant that can be better utilized.

With respect to H.R. 3081, Mr. Chairman, we do have just one concern, and that appears to be what could be construed as a diminution of services that many veterans and their families have now come to rely on, that have been provided to them by the VA. At the very least, we would expect that veterans now availing themselves of that kind of medical care would be able to be grandfathered in for that care, and with such assurance I think we could be supportive of the measure.

With respect to H.R. 3082, Mr. Chairman, I would say that the DAV feels it is timely in addressing in a very positive way the continuing needs and issues facing women veterans. Although it was purely coincidental, the timing was such that last evening, I had the opportunity to be out in Bethesda and attend a focus group of women veterans conducted by a research firm and although there were only three women who were in that group, it was extremely revealing, and it went on for about 2½ hours.

They were all women veterans, service-connected, who were referred to as lapsed users of the system; they had used the system at one point in time, left the system, and are not now availing themselves of it. The reasons for that are many, but I think as we sit here and we discuss some of the more basic issues that we look at and consider in the treatment and the provision of quality medical care to women veterans, a lot of the concerns that were voiced by that group of women last evening were much, much more basic than that, and that is a feeling of not being considered to be a veteran when they walked into the VA, questions such as, "If you want to ask something about the status of your husband's care, you can go over to this desk," when, in fact, that was a woman veteran seeking health care herself. Clearly, the sensitivity that has to be

brought to bear on the VA, that it is a holistic system: a veteran is a veteran is a veteran, and they need to be treated in that way.

There are certain unique issues, no doubt, in dealing with privacy and gender-specific issues that need to be addressed. I think the VA has, since the enactment of legislation last session, moved in that direction. Clearly, they need to continue to move in that direction, and we are hopeful that they will.

With that, I will conclude my oral testimony and, again, be more than pleased to try to respond to any questions.

Thank you.

[The prepared statement of Mr. Gorman appears at p. 95.]

Mr. ROWLAND. Thank you.

Mr. Brinck.

STATEMENT OF MICHAEL F. BRINCK

Mr. BRINCK. Good morning, Mr. Chairman, and thanks for holding the hearing and having us here.

H.R. 3081 would expand treatment available to veterans exposed to radiation and Agent Orange, and we support the measure in its entirety. Having said that, as part of a compassionate society, we would hope that a way would be found to grandfather or extend the care they are currently receiving until the VA figures out what it is going to be doing under national health care. It would seem improper or inappropriate to throw them out of the door at this time and then possibly invite them back at some later period. It won't help the VA's image to do that.

As part of VA health care reform, VA must continue to improve its services for women. They are part of the potential patient base for which VA must compete, and it would not only be a bad business decision but, more importantly, a breach of trust with a growing portion of the veterans population not to try to improve those services.

Last year's women's health legislation finally provided the impetus for VA to begin concentrating on the female veterans population, which is now beginning to comprise a statistically larger share of the total population and now justifies increasing resources needed for their treatment. Therefore, we prefer the chairman's bill over H.R. 2797 on the grounds that H.R. 2797 will eventually prevent VA from expanding its in-house women's health care program by promoting an expansion of women's health care services and furnishing them through a strong reliance on fee-basis treatment.

We also object to eligibility for treatment that is gender based. VA's lack of focus on women's health care issues is largely a natural result of the gender of its primary population, not some Machiavellian plot to deprive women of quality health care. For the same reason, we object to mandating female participation in all VA research. First, VA cannot force women to participate in voluntary research protocols. Second, with the relatively small proportion of female patients, worthy research that has absolutely nothing to do with gender may lose funding.

AMVETS fully supports inclusion of female veterans wherever possible and increased emphasis on women's health research as clinically appropriate.

We also feel that we must once again ask that Congress not drag VA into the middle of the abortion debate. This morning's exchanges are a prime example of that. Over the last few years, the controversy generated by the well-intentioned supporters on both sides of the issue has stalled many worthwhile projects. Now is not the time to sacrifice VA reform on the altar of the national abortion debate. AMVETS' position is simple: VA should conform to the law of the land. If that law allows Federal taxes to fund abortions in all other Federal health care programs, then VA should be allowed to provide that service within VA. If the law does not provide such funding for abortions in other Federal programs, then VA should operate under the same restrictions.

Regarding H.R. 3082, AMVETS again supports the bill in its entirety. Quality care of any sort has many components: trained staff, proper facilities and equipment, and a critical mass of patients to keep the staff current. AMVETS suggests that the report required by the bill include demographic data corresponding to each deficient site to provide a frame of reference by which to judge future funding requests and VA progress, the special nature of sexual trauma demands, the special consideration for those subjected to that type of violence. Therefore, we support the extension of VA's authority to provide counseling through 1996.

We also agree with the provision to provide full-time status for those who are designated as women's health care coordinators. If a facility has a sufficient patient base to warrant such a staff member, then it is time to stop the hypocrisy and let them do the job.

Congressman Smith's bill, H.R. 3108, is similar in intent to Senator Akaka's S. 1226, and we support Mr. Smith's bill entirely. We merely ask that the committee consider opening up the Vet Centers to all veterans, because many of those who fought in World War II and Korea still experience problems connected with that service, and it is time to recognize that Vietnam veterans don't have a monopoly on PTSD.

AMVETS supports the bill because it will encourage the VA to move towards a more grass-roots structure in the delivery of health care. We feel strongly that there is a niche waiting to be occupied by VA in many geographic areas that will probably be ignored by the private sector as not cost effective. The bill will also make basic health services available to some of those who may not otherwise seek treatment. It makes good medical sense and fiscal sense to bring these veterans into the fold, and this bill will help make that happen.

We also like the fact that this is not a pilot program. The bill's objectives are valid. There is nothing new to study, and it is time to just do it.

Finally, we lend our support to the bill to improve VA's rehabilitation of the chronically mentally ill because provisions setting up nonprofit corporations should provide a flexible framework to improve management of work therapy programs.

Mr. Chairman, AMVETS would like to thank you for once again holding this hearing, and we look forward to your questions.

[The prepared statement of Mr. Brinck appears at p. 100.]

Mr. ROWLAND. I thank all of you very much. I do have a couple of questions that I want to direct to you.

Under current law and funding limitations, relatively few veterans are eligible for comprehensive care, and many are unable to gain access to timely treatment in the VA. Under these circumstances, does an expansion in the scope of women's health services and in access to fee-basis treatment as proposed in H.R. 2797 raise any concerns for you?

Mr. Vitikacs.

Mr. VITIKACS. Based on discussions that we had concerning that provision, the American Legion's view would be that this issue is not gender equal, and we would feel that women veterans be limited to the same eligibility constrictions that are in place now for male veterans.

In the future, as we examine eligibility, that may change, but at least in the short term we would support gender equality in that matter.

Mr. ROWLAND. Mr. Cullinan.

Mr. CULLINAN. Mr. Chairman, as I have already indicated, the VFW's position is similar. It comes down to a question of equity and resource allocation at this time. If the rules change in a day or two or in a while, then we will look at it again, but right now we feel that men and women have to be treated equally.

Mr. ROWLAND. Mr. Gorman.

Mr. GORMAN. As we indicated, Mr. Chairman, we think a veteran is a veteran is a veteran, and while the same set of eligibility rules can't always apply, in a broad sense they should, and I think in this instance they should.

The VA is going to have to position itself, in our belief, to compete in a new marketplace in a new era for health care, and to do so they are going to have to build a program within their own facilities to be able to take care of a different population mix, and that includes in large part, we believe, women. So they are going to have to concentrate some health care delivery within the walls of the VA, but on a parity with the eligibility rules for all, and that isn't to say that we think those eligibility rules are correct, because we certainly don't, but given the resources and the constraints, I think, again, there should be equality in the treatment.

Mr. ROWLAND. Mr. Brinck.

Mr. BRINCK. AMVETS would concur with the statements that have just been made.

Mr. ROWLAND. One other question. Regarding maintaining VA as an independent health care system, do you share my concern over the fact that section 4 of H.R. 2797 would have the Secretary of Health and Human Services regulate VA's provision of mammography services?

Mr. GORMAN. We think, Mr. Chairman, that, number one, the VA standards, whatever those turn out to be for mammography or any other provision of health care, should exceed that of any other delivery system, and we would be greatly troubled, as I think we have voiced in the past, by regulatory control by any outside agency of the VA. There is enough non-VA, nongovernmental agencies, looking at the VA as far as certification and overview that satisfies us that they are providing quality care.

Mr. CULLINAN. Mr. Chairman, the VFW is of a similar mind. We feel that if HHS's rules regarding mammography are the highest of the land, the VA should certainly abide by at least that level.

On the other hand, we have testified in the past against direct reporting requirements of VA to HHS. It arose once in the past regarding laboratory rules and regulations and procedures. We think it could just end up with a lot of trouble. VA should abide by the highest standard of care with respect to mammography but have no direct reporting requirement to another Federal agency.

Mr. VITIKACS. The American Legion has every confidence that the quality of services provided by VA will meet or exceed any other accrediting body's standards.

Mr. BRINCK. AMVETS would concur, and we feel that VA is fully qualified to set the standards, at least at the highest set nationally, and we are confident that they will exceed those whenever possible.

Mr. ROWLAND. You have already indicated that you believe that there should be some grandfather provisions in H.R. 3081. Would your organizations support this if the grandfather provision were included to protect veterans who have been receiving care under existing law?

Mr. GORMAN. Our concern, Mr. Chairman, is, a lot of veterans who have come to rely upon the VA, if the door is now going to be closed to them, they have no other place to go, and they are going to come into the VA in some other manner anyway.

I don't think we should, and we certainly won't, sit by while a clear reduction in services to veterans is proposed that translate to less or fewer than they are now receiving, and that has been our concern in the health care reform plan as proposed by the task force. With that assurance, I think that we are comfortable in supporting that provision, however.

Mr. ROWLAND. Mr. Vitikacs.

Mr. VITIKACS. The American Legion does support the grandfathering clause for those who have or now are receiving care. We support the bill and its intent. The only stipulation we have made is that there needs to be flexibility provided for any additional diseases determined by the Secretary to be linked to exposure to herbicides to be provided for future treatment.

Mr. ROWLAND. Thank you.

Gentlemen, I don't have any additional questions. I want to thank all of you very much for being here and your testimony this morning.

Mr. VITIKACS. Thank you, Mr. Chairman.

Mr. ROWLAND. I would like to call to the witness table now Mr. Terry Grandison, who is associate legislative director for the PVA, and Ms. Linda Schwartz, who is the Chair, Veterans Affairs and Women Veterans Committees for the VVA, and she is accompanied by Mr. Paul S. Egan, executive director.

Thank you very much for being here this morning, and we will proceed, Mr. Grandison, with you.

STATEMENTS OF TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND LINDA SPOONSTER SCHWARTZ, R.N., M.S.N., CHAIR, VETERANS AFFAIRS AND WOMEN VETERANS COMMITTEE, VIETNAM VETERANS OF AMERICA, ACCOMPANIED BY PAUL S. EGAN, EXECUTIVE DIRECTOR

STATEMENT OF TERRY GRANDISON

Mr. GRANDISON. Yes, sir. Good afternoon, Mr. Chairman and members of the subcommittee. On behalf of the Paralyzed Veterans of America, it is an honor to participate in today's hearing. PVA appreciates this opportunity to present our views and concerns regarding the various pieces of legislation being examined.

Mr. Chairman, I would like to request that my written testimony be included in the record.

Mr. ROWLAND. Without objection.

Mr. GRANDISON. Mr. Chairman, I will limit my oral testimony to the following draft bills: First, a bill to provide priority health care to veterans who were exposed to Agent Orange or ionizing radiation; second, a bill to extend and expand authority relating to health care services for women veterans.

PVA supports authorizing treatment for those diseases which the NAS has found sufficient evidence to conclude that there is a positive association between occurrence of diseases in humans and exposure to herbicide agents. Similarly, PVA endorses medical care for those diseases that the NAS also linked to exposure to herbicides based on suggestive and insufficient evidence. Although the current epidemiologic evidence is inconclusive in regard to a positive occurrence of these diseases in humans in exposure to Agent Orange, it does suggest that more research and study is needed to establish or negate an association between those diseases and Agent Orange. However, in light of the NAS findings, PVA supports the bill's presumption of providing medical care to veterans diagnosed with diseases classified under suggestive and insufficient evidence.

Based on current literature regarding effects of radiation exposure in the human population, PVA supports the bill's elimination of any sunset date for provision of care to veterans who may have been exposed to radiation. Moreover, PVA supports providing medical care to any radiation exposed veteran based on credible evidence of a positive association between disease occurrence and radiation exposure.

Mr. Chairman, PVA values legislation which advances the health care needs of women veterans. PVA fully endorses the VA's obligation to provide eligible women veterans timely, appropriate, gender-specific health care services.

In addition, PVA supports the bill's clarification that such services will be provided to women veterans directly from VA facilities. PVA believes that each VA facility should be adequately equipped to provide routine health care for women veterans. This is the only reasonable method in which VA can reasonably phase in comprehensive gender-specific health care services to women veterans. PVA supports the bill's remaining provisions in totality.

Mr. Chairman, at this time I would like to briefly comment on Representative Schroeder's bill, H.R. 2797. This bill would mandate that VA expand the contract authority to provide women's health care services to include outpatient and ambulatory care to women veterans regardless of service connection. PVA believes this measure would establish higher priority for one group of non-service-connected veterans as opposed to another. PVA recommends that a more even-handed and equitable policy be instituted, particularly in light of the current eligibility restrictions on outpatient care among non-service-connected veterans.

In addition, Mr. Chairman, PVA believes that continued focus on contract care is a disincentive to establishing quality health care services in house, so PVA strongly supports the VA's moving toward establishing in-house care for all veterans and specifically women veterans.

Mr. Chairman, this concludes my testimony.

[The prepared statement of Mr. Grandison appears at p. 106.]

Mr. ROWLAND. Thank you.

Ms. Schwartz.

STATEMENT OF LINDA SPOONSTER SCHWARTZ, R.N., M.S.N.

Ms. SCHWARTZ. Good morning, Mr. Chairman.

I would like to, as a way of introducing myself to you, say that I am a veteran and I do use the VA. I am probably one of the few women veterans that have come to the table today. I guess I have to say right from the get-go that some of the things that have been said here today are upsetting. I want to say that I am offended at the suggestion that the only reason a woman vet would come to the VA is for an abortion. I don't see that the VA is going to become a system of abortion mills. What I do see is that over the years women veterans, now more than ever, are coming to the VA, and some of them are coming for prenatal care.

I don't want to discourage the tenor of the bill, but one of the things that we have to consider is that when women come to the VA, they have a great expectation that they are going to actually be taken care of there. Some of them have had in their minds for many days and nights that if they need to come for any medical care the VA is going to take care of all of them and not just part of them.

One of the things that I would suggest, and I think is a realistic approach, is that the VA should not have to provide in-house care at every place. We have to look at what is cost effective; we have to look at the population of women veterans in the area. We also have to remember one thing, that in 1989 a study was done on disabled veterans across the board, 20 percent of the women who were service-connected said that they did not use the VA because the VA did not provide the services they needed for their disability.

I would also like to inform the committee that until 1975 pregnancy was a service-connected disability; and, in fact, I can tell you that because I was pregnant at the time. I did not leave active duty right away, but people who did were discharged with a disability. I don't think they went to the VA at that time, but I just want to say, when you are talking about these things, that there is some history to some of the things that need to be explained.

One of the things I would like to caution too is, some people raised the issue of fee for services. I have to tell, you, sir that one of the things that this Congress has got to be interested in is, how is the Government charged for some of these services? I really believe that there is some gouging. For example, one of our members went for a mammogram. They had a mobile mammography unit that went around the State. You just had to pay $50 for that. But when she got the bill from the same hospital that provided the mammography to her, at VA expense the bill was $176. So I think that if you are looking to fee for services as a way in which to take up the slack in the care of women veterans, you have also got to be aware of the fact that some people like to make a few dollars off the Government.

One of the other things I wanted to talk about is the bill that has something to do with the nonprofit corporations. I am very honored to be part of an excellent program at the West Haven VA in which I, as the president of the Vietnam Veterans Assistance Fund, wrote a grant with Dr. Laurie Harkness at the West Haven VA. We went out and competed for some State dollars to help homeless and disabled people, and we were able to bring a half-million dollars in to buy homes for homeless and disabled veterans. We did this because we had the partnership of a 501(c)(3) organization working with the VA.

One of the things that is a problem, but not really, was the fact that people thought the VA was buying the houses and, in fact, it was the nonprofit organization. I think that illustrates quite well how, in this day and age, there are many different kinds of funding that the VA could go out and compete for because of the kinds of services they provide, especially with the homeless and disabled.

One of the reasons I have this frog in my voice is that I was able to spend a weekend with 600 homeless veterans at our stand-down. I can tell you that the need is great, and if you ever have the opportunity to go there, you should, to get in touch with what is really happening in that veteran population.

Last of all, I would like to address the questions about research on women veterans. I was also honored to have the opportunity to address the National Academy of Sciences Committee—and I see my time is almost up, but I hope you will just let me finish this point. I addressed them on women and exposure to Agent Orange. The first thing I heard from them was that they had been told that women were not exposed to Agent Orange. Although they could have been in the same place at the same time as the men whom they were considering to be exposed, they did not consider women until my limited research, in which I found that women who were in Vietnam do, in fact, have twice the rates of cancer as civilian women of the same age and occupation.

I also found other diseases which are not mentioned in the National Academy of Sciences because I was the only person that addressed them on the issue of women. I found high rates of multiple sclerosis and anemias, hardening of the arteries, and I did find a significant level of skin lesions that were not classified as chloracne in women who were exposed to Agent Orange.

[The prepared statement of Ms. Schwartz appears at p. 110.]

Mr. ROWLAND. Thank you very much.

I do have a couple of questions, but before I start with those questions, I want to ask that those witnesses who are here from the VA—Dr. Farrar, there are some questions that would be submitted for the record and we are going to try to go to markup, so if you could have answers back by about a week from now, we would appreciate that very much.

Dr. FARRAR. Yes, sir, we will.

Mr. ROWLAND. Thank you.

[The questions and answers appear at p. 139.]

Mr. ROWLAND. Let me ask you this. Congress, last session, enacted legislation which directed the VA to foster and encourage research into women veterans' health. Do you share the view expressed by AMVETS that the key reason the VA doesn't do more research is the small number of VA patients, absent sufficient numbers of patients, to serve as research subjects? Wouldn't you agree that a mandate to do this in law is really essentially meaningless?

Mr. EGAN. May I address that question, Mr. Chairman?

Mr. ROWLAND. Yes, sir.

Mr. EGAN. What the legislation has said in the past and what is going on today in the VA is certainly important, and your question is legitimate, but we have to start thinking about health care in terms of a national health environment. If the VA is indeed going to be a competitor with the private sector, if it is indeed going to attract veterans who don't currently use the system as subscribers to this system, we have to understand that veterans, many of whom have families, are going to be concerned about their wives and their daughters and where their care is going to come from. So it seems fairly self-evident that, no matter what VA's current load happens to be, it needs to be preparing itself, either by referring dependents to hospitals or medical schools with whom they have an affiliated relationship or with other facilities, but the fact is that the VA is not going to compete well with other health providers in the private sector; it will not be able to attract veterans, whether they are currently using the system or not, unless it has the capacity one way or the other to provide those services that it currently does not provide. We have to start thinking of health care differently than we have thought about health care in the VA in the past.

Ms. SCHWARTZ. I would just like to comment on this because my research is an additional analysis of the National Vietnam Veterans Readjustment Study. The idea that we can't get a handle on the numbers of women veterans that are in the community at large and that there is no way to do research on them is a sad commentary.

First of all, we could draw conclusions from the sample of men, and I think we have the power and the numbers in the research of RTI to draw conclusions on the health of women. We have advocated at VVA for many years and in 1986, you, the Congress, said that there should be a study on the effects of herbicides on women who served in Vietnam. Although the study was never funded and there was a lot of controversy over the design of the study, that is no consolation to women.

I would just like to give you a reason why. It is a compelling reason, Dr. Rowland, because this happens to me continually. I received a telephone call from a woman in Indiana. It was 9 o'clock in the morning on a Sunday. She asked me if they had done anything about a study of the effects of Agent Orange on women who served in Vietnam. I said, "No; although Congress authorized it, it is still languishing on the drawing board." She said to me, "I just wondered, because I have had 13 miscarriages, I have cancer of the stomach, I have non-Hodgkins lymphoma, I have mitral valve prolapse, and now they have found that one of the tumors in my leg is cancerous, and I just wondered if that had anything to do with my service in Pleiku."

So I said, "What did you do with Agent Orange in Pleiku?" and she said, "Well, we used it to spray around the hospital perimeter, and then, when the barrels were empty, we cut them in half and used them for barbecue pits."

Were these people exposed to Agent Orange?

I think about them, and I think about their children. The point was made earlier that women may not have the same access to care because there has been no study on the effects of Agent Orange. But I really am now at the point where I think that we need a comprehensive study of women veterans so that the VA will know what kinds of care these women need. It would have to be in concert with DOD. You have a wonderful captive population here to do some studies on. It doesn't have to be just veterans who are using the system.

Mr. GRANDISON. Mr. Chairman, PVA supports and encourages research within the VA, particularly when it is in search of a scientifically relevant purpose, and also research which may affect particular populations of the veteran community, women and minorities, but we are of the opinion that those research studies should be, again, tempered with sound, scientific motivations. PVA does not endorse or foster a limitation on research in the VA, because a lot of things the VA does in a research capacity have broader applications to our general society. So as long as there is scientific merit we can support it, and to the extent necessary, even where it statutorily mandates it.

Ms. SCHWARTZ. I want to say too that I have suggested before to this committee that perhaps the most cost effective way to look at the health care of women veterans is on health studies of women, a national health study of women, to include questions about military service. Then you are looking at: Are military women different than other women in the population?

Mr. ROWLAND. You mentioned that you were on active duty in 1975 when pregnancy was declared a disability at that time.

Ms. SCHWARTZ. Yes.

Mr. ROWLAND. Under present law, except for such care relating to a pregnancy that is complicated or if the risks of complication are increased, then it is not considered to be a disability. Are you in favor of changing the law so that a routine pregnancy would be considered a disability in the VA?

Ms. SCHWARTZ. No. I think pregnancy in 1975 was a reflection of the thinking of the time, because there was a time if you were

pregnant in the Air Force—that was my service—you had to leave the service.

Because I use the VA, I am surprised that young women do come to the VA for their pregnancy care. These are women who might not think of other avenues, except they know the VA will take care of you: "I am a veteran, and that is what happens." They are lucky because sometimes there are agreements with teaching universities where they can access that care. But I was really surprised that this happens.

Mr. ROWLAND. That was in 1975.

Ms. SCHWARTZ. No, that is 1993.

Mr. ROWLAND. I'm sorry, I didn't understand. You were a little surprised that what happened?

Ms. SCHWARTZ. That women do come to the VA for prenatal care, that they think that is where they will get it.

Mr. ROWLAND. Is that very frequent, do you think, that that happens?

Ms. SCHWARTZ. On several of my visits I have encountered these women, and I really have to say, the last thing I thought the VA would be doing was getting into that business, but because of the younger population of women who are veterans now in the post-Vietnam era, that is one of their main needs.

Mr. ROWLAND. Is that a Category A veteran or any veteran?

Ms. SCHWARTZ. I'm sorry, I didn't see her ID card, but she was there for care.

Mr. ROWLAND. You wouldn't know offhand whether or not they were giving her prenatal care on an outpatient basis?

Ms. SCHWARTZ. No. All I knew was that was where they came. That would be the last place I would go.

One of the things is, and I just have to say this to you because I just experienced it this weekend: It isn't what the VA is, it is what they think it is, that creates this disparity and this feeling that, "We thought we would go there and be taken care of, and we're not." You know, women veterans are saying that, "We're not getting the care." It is not what the VA is, it is what they expect it to be.

Mr. ROWLAND. Do you think there should be some better understanding about what categories are eligible for what kind of care, and that would make it more clear to individuals who were coming? Perhaps it is not clear what is available based on category.

Ms. SCHWARTZ. Well, my comment on that is, you are right, for the first thing. The second thing is, as we go into the 21st century and we look at: Does VA want to be competitive? Do they want to provide the complete spectrum of care and compete with the private sector? some of this is going to have to change, and at the same time you and I both know that there are some veterans' organizations that are still advocating for the fact that a veteran is a veteran and the VA should take care of them. So that thought has not dissipated with time and not with the new military, it is still the VA. Maybe under the concept of our fathers or some people's grandfathers. You know, they said they would take care of them, and that is it.

Mr. ROWLAND. May I ask you something else? We were talking about mammography standards earlier. Do you support the provi-

sions in H.R. 2797 that would vest the Secretary of Health and Human Services with the authority to determine whether VA facilities could provide mammography services?

Mr. EGAN. Mr. Chairman, somebody has to police quality. Somebody has to assure standards. It isn't entirely clear that the VA is doing a particularly good job at assuring quality not only with regard to women's health services but with regard to a whole host of services. There has to be a reason why both the GAO and the Paralyzed Veterans of America estimated that if national health came, as many as 50 percent of VA's currently dependent users would leave the system. If added oversight above and beyond the VA assures quality, how can it be objectionable?

Mr. ROWLAND. Then I suppose what you are saying to me is that—we have always felt that there was a principle that the VA health care system should be independent, but once you put in place some oversight authority outside of the VA, it begins to lose some of its independence. Are you saying that you support its losing some of its independence, at least in that respect?

Mr. EGAN. I know that there is a sense throughout the organized veterans community that any monkeying around in a system that is collectively ours is inappropriate, but where quality of care is concerned, we need to get by some of this and assure that the quality that the VA is delivering is at least comparable to what is provided in the private sector.

I know there are all kinds of arguments over whether or not the VA is providing the same quality, the same product, that is provided in the private sector, but it would seem to me that the VA would welcome an opportunity to demonstrate that its quality, whether in mammography or any other health procedure, is as good as anything anywhere.

Mr. ROWLAND. Isn't that the case when the various hospitals throughout the VA health care system seek the accreditation of the Joint Commission on Accreditation of Health Care Organizations?

Mr. EGAN. Well, the Joint Committee on Accreditation of Hospitals certainly does oversee what the VA does. I suppose, though, with regard to this legislation and a provision to have HHS oversee quality control in mammography, if the Joint Commission on Accreditation of Hospitals had never been created, and the question today before us was whether or not the Joint Committee was going to be permitted to oversee VA, I am sure that we would hear the same thing: No, indeed, it should not. But the fact is that somebody has to assure quality. Somebody has to make sure that what goes on in a hospital meets minimum standards. That shouldn't be something that the VA or anybody else should be afraid of.

Mr. ROWLAND. I don't believe that the VA is since they do seek that accreditation and that is part and parcel of what private institutions do as well, is to seek that accreditation, and if they do not meet the proper standards then they are not accredited for that particular thing. So it seems to me somewhat superfluous to have HHS oversee this.

Anyway, I guess we could debate that point for a good while here.

I want to thank you for being here today and thank you for your testimony, and we stand adjourned.

[Whereupon, at 12:23 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CONGRESSWOMAN BROWN

Chairman Rowland, thank you for holding this hearing and for bringing forth bills which will improve veterans' health care. Mr. Chairman, I look forward to working with you on these bills, and on the role of the Department of Veterans Affairs in national health care reform. I mention health care reform because I don't believe that we can consider these bills today in a vacuum. Tonight, the President will make a speech to the nation outlining his national health care including a VA health care system that must be able to continue providing services that veterans are entitled to, and be competitive with other health care providers. This subcommittee will be taking up this subject on September 30.

I want to focus my remarks on the bills to improve VA health care services for women veterans. Those services should include comprehensive primary and preventive care, including reproductive services. Mr. Chairman, I commend you for including quality standards for mammography. But as you know, a mammogram of poor quality is worse than no mammogram at all because of the false sense of security that it gives to women. That's why I am strongly recommending that this legislation include the accreditation and quality standards set out in the Quality Assurance Mammography Act of 1992 which was passed by Congress last year.

We all know that VA Research is one of the strongest assets of the VA's system. Research on women's health, specifically substance abuse, reproductive health, and hazards related to military service should be a part of VA's research program and I would strongly suggest that this be a part of the bill. As a part of that research, the VA needs to conduct a population study of women veterans to identify any additional health care needs and concerns. Women and minorities should also be included in VA's general clinical research, where it is appropriate.

This legislation also sets out to improve the VA's sexual trauma counseling program. I would suggest that we make these services available for any veteran, man or woman.

Regarding the creation of full-time regional Women Veterans Coordinators to ensure women veterans receive quality medical care, I strongly support these provisions, however, these coordinators must have direct access to VA officials. If this overhaul legislation is going to be effective in providing women veterans with the same access to VA medical care as their male counterparts, the coordinators must be given clout and direct access.

Mr. Chairman, I want to work with you on this legislation. I know that you share my feelings that women who have served their country in the armed forces deserve the very best that the VA has to offer. Thank you.

Testimony Before the Subcommittee on Hospitals and Health Care

Rep. Lane Evans
(9/22/93)

Mr. Chairman:

Thank you for the opportunity to testify before your subcommittee today. Your interest in veterans' health care is commendable. And I applaud your willingness to move legislation benefiting Atomic Veterans, and veterans exposed to Agent Orange, women veterans, and veterans with post-traumatic stress disorder.

Given the fact that our distinguished colleague, Pat Schroeder, intends to testify on H.R. 2797, H.R. 2285, and H.R. 3082, I will limit my comments primarily to the other measures being considered today.

Let me say, however, that I strongly support the Congresswoman's legislation. Women veterans deserve high-quality care delivered in a timely and appropriate manner. And they must also be included in any research pertaining to veterans. Women should not be forced to accept inadequate care simply because the system is more accustomed to dealing with their bothers-in-arms. Accordingly, I would like to propose a meeting between the Chairman and the principal sponsors of H.R. 2797 and H.R. 2285 to discuss a reasonable compromise prior to the Subcommittee's mark-up.

With regard to H.R. 3081. I support eliminating the sunset date for provision of care to Atomic veterans, providing special eligibility for Atomic veterans, and expanding the care provided on an outpatient basis. Nevertheless, I do have several concerns about the other aspects of H.R. 3081.

As you know, on June 10th, I introduced H.R. 2375, a measure to extend for ten years VA's authority to provide priority health care to veterans who were exposed to ionizing radiation or Agent Orange. Similar legislation was passed by the Senate Committee shortly before the August recess. Unlike H.R. 3081, my legislation would not further restrict the provision of VA health care to veterans exposed to Agent Orange.

Mr. Chairman, I have reservations about the provisions of H.R. 3081 which would limit health care eligibility to those exposed whose illnesses are listed in the first three tiers of the National Academy of Science's (NAS) report on Agent Orange. These provisions would be difficult to implement in the field and even more importantly, possibly lead to the denial of health care services that some exposed veterans currently receive.

Given the NAS' conclusion that exposure to Agent Orange is

harmful, exposed veterans deserve additional considerations, rather than new restrictions.

I also believe that VA's authority to provide care to veterans exposed to Agent Orange should be extended through 2003, rather than 1996 as in H.R. 3081. As you know, the NAS has been charged the task of conducting a ten-year long examination of the health effects of exposure to Agent Orange. Earlier this year, we received the first report, wherein the NAS described a clear link between exposure to exposure to Agent Orange and certain illnesses.

Based upon these initial results and the longitudinal nature of the NAS review, VA's authority to provide health care to exposed veterans should be extended at least through the duration of the NAS review, the year 2003.

Mr. Chairman, I believe that we both want to provide the best care available to Atomic veterans and veterans exposed to Agent Orange. I hope that we can work together in developing legislation that would provide exposed veterans with continuous high-quality care.

Mr. Smith, I appreciate your efforts to expand the range of health care services provided in Vet Centers. In fact, the legislation which both Senator Akaka and I have introduced dealing with Vet Centers includes similar provisions. Accordingly, I look forward to working with you on these measures.

In addition to the expansion of health care services, my legislation would make all veterans eligible for Vet Center services, make the Secretary's Advisory Committee on Readjustment Counseling a statutory committee, and better ensure the confidentiality of patient records.

I should also note that I intend to introduce legislation within the next week that would greatly expand the range of services available to veterans suffering from PTSD.

Finally, with regard to the measure dealing with chronically mentally ill veterans, I question why Congress should authorize VA to establish nonprofit corporations. As an alternative, I would suggest that VA be directed to contract out to community-based organizations for the coordination of therapeutic work for VA patients through compensated work programs.

Thank you for the opportunity to testify today. I look forward to working with you and the members of this subcommittee on these important issues.

Statement of the Honorable Bob Clement
Before the Subcommittee on Hospitals and Health Care
September 22, 1993

MR. CHAIRMAN, THANK YOU FOR PROVIDING THIS OPPORTUNITY TO DISCUSS SEVERAL LEGISLATIVE INITIATIVES.

MR. CHAIRMAN - MR. EVANS, MR. KENNEDY, MR. GUTIERREZ, MR. BUYER, AND I RECENTLY HAD THE PLEASURE OF WORKING WITH YOU ON LEGISLATION TO PROVIDE PRIORITY CARE TO PERSIAN GULF VETERANS SUFFERING FROM AILMENTS LINKED TO THEIR SERVICE IN THE GULF.

THIS LEGISLATION WAS BASED ON THE SAME PRESUMPTION OF LINKAGE PRINCIPLE USED TO EXTEND TREATMENT TO VIETNAM VETERANS SUFFERING WITH DISEASES BELIEVED TO BE LINKED TO EXPOSURE TO HERBICIDES.

AS WITH THE PERSIAN GULF VETS, I BELIEVE WE OUGHT TO GIVE THE VIETNAM VETERANS THE BENEFIT OF THE DOUBT. IF THERE IS ANY POSSIBLE LINK BETWEEN EXPOSURE AND THE DISEASES,

TREATMENT SHOULD BE PROVIDED TO THESE VETS.

HOWEVER, LOOKING AT THE BILLS BEFORE US TODAY I HAVE SOME RESERVATIONS ABOUT THE PERIOD OF TIME THIS AUTHORITY SHOULD BE EXTENDED WITHOUT AT LEAST A PLAUSIBLE CONNECTION BEING MADE. THERE COMES A POINT IN TIME WHEN SCIENTIFIC EVIDENCE, OR LACK THEREOF, CAN NO LONGER BE IGNORED.

THE NATIONAL ACADEMY OF SCIENCES HAS BEEN COMMISSIONED TO REPORT TO CONGRESS ON THIS ISSUE. AS YOU KNOW, THIS REPORT COMES EVERY TWO YEARS. IT IS MY FEELING THAT THIS TWO YEAR PERIOD PROVIDES AMPLE TIME FOR THIS BODY TO MAKE ANY NECESSARY ADJUSTMENTS TO EXISTING AUTHORITY.

FURTHERMORE, I AM PLEASED TO SEE THIS COMMITTEE MOVING LEGISLATION TO IMPROVE WOMENS HEALTH CARE WITHIN THE VA. I HAVE WRITTEN BOTH, SECRETARY BROWN AND FORMER SECRETARY DERWINSKI, REGARDING THE NEED TO PLACE MORE OF AN EMPHASIS ON THE UNIQUE AND

SPECIAL NEEDS OF WOMEN VETERANS. HAVING TRIED UNSUCCESSFULLY TO GET A MAMMOGRAPHY MACHINE FOR MY STATES' LONE WOMEN'S CLINIC, I HAVE PERSONALLY SEEN JUST HOW FRUSTRATING IT CAN BE TO GET SERVICES IN A SYSTEM WHICH IS GEARED LARGELY TO MALE VETERANS.

I DO NOT INTEND TO IMPLY THAT WOMEN HAVE BEEN OR ARE CURRENTLY BEING EXCLUDED FROM THE SYSTEM DELIBERATELY BUT RATHER THAT THE CURRENT SYSTEM IS REFLECTIVE OF THE VETERANS POPULATION. HOWEVER, THE VETERANS POPULATION IS CHANGING AND WITH THE INCREASING ROLE OF WOMEN IN THE ARMED SERVICES THIS TREND WILL CERTAINLY CONTINUE INTO THE FUTURE. THE VA SYSTEM OF THE FUTURE MUST BE MORE EQUITABLE.

MR. CHAIRMAN, I KNOW THAT WE HAVE A GREAT DEAL ON OUR PLATE TODAY AND I FOR ONE WOULD RATHER HEAR FROM OUR WITNESSES. SO, HAVING SAID THAT, I AGAIN THANK YOU FOR HOLDING THIS HEARING AND YIELD BACK THE REMAINDER OF MY TIME.

TESTIMONY OF REP. PAT SCHROEDER (D-CO)
HOUSE VETERANS AFFAIRS SUBCOMMITTEE ON HEALTH AND HOSPITALS
SEPTEMBER 22, 1993

Mr. Chairman, I want to thank you for letting me testify today on behalf of women veterans. I am delighted that this Subcommittee is committed to moving forward on this issue and has illustrated that commitment by introducing H.R. 3082. What I would like to address today are issues that are of vital importance to women veterans that are not covered in H.R. 3082.

When Congress passed P.L. 102-585 last year, women veterans were thrilled that we had recognized some of their gender-specific needs. P.L. 102-585 established sexual trauma counseling programs at the VA and constituted a breakthrough for women who had been sexually assaulted. The law allows the VA to establish an 800 number for women veterans who were sexually assaulted during their military service, and permits the VA to offer women gender-specific health care including pap smears, mammographies, and menopause counseling. Finally, PL 102-585 mandates that the Secretary of the VA "shall foster and encourage research the initiation and expansion of research relating to the health of veterans who are women".

While these programs give women veterans great hope for the VA system, they are only a beginning. For instance, the law limits sexual assault counseling services to women who have been discharged within the past two years, and only makes such services available to veterans in need for one year. Common sense will tell you that these restrictions are counter-productive for sexual assault victims attempting to recover. Furthermore, under P.L. 102-585, women's health services remain discretionary, thereby leaving it up to individual VAMC Medical Directors if these services should be available. As the IG's June 17 Report of Inspection of Women Veteran's Health Care Programs revealed, the quality and quantity of women's health care services can vary

from full-service, easily accessible women's health care clinics, to archaic gender-specific equipment locked up in broom closets.

Obviously, there is a lot of work to be done to insure that women veterans receive equitable and effective care when they enter the VA system. I believe that the provisions outlined in H.R. 3082 to eliminate the restrictive time limits on sexual trauma services, to mandate women's health services through every VAMC, to establish mammography quality controls, and to create adequate privacy provisions for female patients are encouraging. Nevertheless, I am concerned that many other issues that are vital to women seeking services at the VA will remain unaddressed if H.R. 3082 is passed in its current form. As you know, many of the provisions I am concerned about have been included in H.R. 2797, the Veteran Women's Health Improvement Act, which I introduced on July 29, with Rep. Marilyn Lloyd, as well as the support of many members of this Subcommittee.

First, the VA must offer a primary and preventive package to women veterans. This package, as outlined in H.R. 2797, must include basic services like pap smears, mammographies, comprehensive reproductive health care, including pregnancy-related care, counseling and care for sexually transmitted diseases, counseling and care for menopause, osteoporosis, and other condition relating to aging, and finally, care for physical and/or psychological conditions relating to sexual assault. I believe that these quality services must be available through every VAMC, either in-house, through contract or on a fee-base arrangement, thereby giving women veterans the security of knowing the VA is capable of treating all their needs. Furthermore, I can not state strongly enough that these services are non-negotiable to any woman who is concerned about her health.

While some may argue that infertility care, treatment for sexual transmitted diseases, or pregnancy-related care should not be offered through the VA, I would like to remind you that as we

speak, President Clinton is putting his finishing touches on tonight's historic speech on health care reform. We all know that in health care reform, the VA will become a competitive provider and must provide the basic benefit package to all its clients. Furthermore, I understand that earlier this week, the VA Assistant Secretary for Policy Planning, Vic Raymond, indicated to this Committee that the VA realizes it must expand primary and outpatient care program and improve its women's health services in order to attract more patients. Furthermore, Assistant Secretary Raymond also indicated that however pregnancy-related care is ultimately defined, those services will be available to women seeking services at the VA. Finally, Mr. Raymond said that the VA will be willing to use money from the health reform revolving fund to seed expanding women's health programs at the VA. Therefore, I don't understand why the 1.2 million women veterans in our country must wait for health care reform if the VA can begin expanding women's health services now.

There is another provision in H.R. 3082 that concerns me. This provision states that, in essence, any VAMC with a certain number of women in its catchment area shall provide women's health services. I am a bit confused about this clause, as I don't quite understand how a catchment area will be defined. Will it be defined according to demographics, geography, how many women veterans have sought services at the VAMC in question, or some combination thereof? For instance, is the reason that 223 women visited the Miles City, MT, VAMC in 1992, while 5,595 women veterans visited the Albuquerque, NM, VAMC the same year due to the VAMC location, or a demographic calculation that there are less women veterans in Montana than in New Mexico? If a catchment area paradigm is established, will women veterans in Montana still be able to go to the VAMC in Miles City?

Women's health research is another issue that is very important to women veterans. With women veterans displaying up to twice the rate of cancer as their civilian counterparts, women veterans have the right to know why. The FY 1994 VA Appropriations Bill

includes $252 million for research, and the 1.2 million women veterans provide a unique study group that can be easily included in any research initiative. Integrating women and minorities in research, and coding that research for significant differences will save money by revealing important medical information quickly. H.R. 2797 includes language to include women and minorities in medical research where appropriate, and asks that medical research be coded for any potential differences. This language was modeled after language currently applied to the National Institute of Health, a world leader on medical research. H.R. 2797 also includes a list of gender-specific diseases that need our immediate attention.

Unfortunately, while including women and minorities in research trials may make good scientific sense, it is simply not happening at the VA. For instance, it was not until 1992 that the VA awarded a research grant to investigate the health status of women exposed to Agent Orange. A more recent example comes from Secretary Brown's response to a June 23 letter, signed by 34 members of Congress, inquiring as to the health status of the women who served in Desert Shield, which I would like to include in the record. Secretary Brown indicated that the VA Patient Treatment File the data received from the Persian Gulf Registry exams are coded for gender. Yet, despite significant anecdotal evidence from women who served in the Gulf who are displaying gender-specific problems, the VA is not conducting research on any of these problems.

On September 12, 1991, Dr. Holsinger, the VA Chief Medical Director, issued mammography guidelines for in-house and contracted mammography services. Like Dr. Hoslinger's memo, H.R. 3082 offers similar quality control standards for mammography machines. As the author of the Mammography Quality Standards Act (P.L. 102-539), which creates strict mammography quality standards for all mammography facilities, I am concerned that the standards in H.R. 3082 are not as strong as they could and should be. First of all, H.R. 3082, while calling for mammography

accredition from a non-profit agency, the bill in its current form side-steps the certification process which alerts patients that the mammography facility and the attending personnel have been certified to perform the service. Furthermore, while H.R. 3082 calls for random inspection by the Secretary of the VA, these inspections are only periodic and are not accompanied by penalties for non-compliance. Finally, since H.R. 3082 states that mammographies purchased under VA contracts must be in full compliance with the MQSA, it is possible that women securing mammographies on site at a VAMC may be receiving a poorer quality service than their contracted counter-parts. This situation can become very dangerous, since a bad mammography is worse than no mammography at all.

Before I finish, I would like to bring the Committee's attention to a few additional issues that I feel are important. For instance, while H.R. 3082 does improve the sexual trauma program currently offered through the VA, it still limits services to one year and prevents men who were sexually assaulted during service from accessing the program. In addition, while P.L. 102-585 authorized an 1-800 hotline for sexual assault survivors to initiate first contact with department regarding benefits and referrals, the hotline was never established, and many veterans who experienced sexual assault during their active duty time remain unclear as to their benefit opportunities. Furthermore, sexual assault survivors, even if they are receiving benefits to cover counseling services, often have difficulty receiving the services promptly.

My bill, H.R. 2285, to improve the VA sexual assault counseling program, which I introduced on May 26, makes the sexual assault program gender neutral, establishes the missing hotline, and grants veterans receiving sexual trauma services a priority rating and requires the Secretary to report to Congress on any difficulties in providing such ratings.

In conclusion, I want to once again thank this Committee for its commitment to women veterans. I do not have all the answers as to how we can provide the best services to women veterans, but I don have a lot of questions, and I look forward to working with you on this issue in the future.

Congress of the United States
House of Representatives
Washington, DC 20515

June 23, 1993

The Honorable Jesse Brown
Secretary of Veterans Affairs
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Brown:

As you know, many Persian Gulf veterans are reporting disturbing health problems possibly related to their service in Operation Desert Shield/Desert Storm. We support your efforts to work with the Department of Defense to establish Health Registries, and to contract with the National Academy of Sciences to research the unique health problems of these veterans.

We are writing to you in reference to the women who were in Operation Desert Shield/Desert Storm. Some of the 32,000 brave women who served in the Persian Gulf are reporting alarming gender-specific health problems, including chronic ovarian cysts and birth defects. We are concerned that these unique problems are not being properly recognized, researched, or treated.

We would like to know how the Department is cataloging the problems female Persian Gulf veterans report and what services are presently available to these women. We would also like to know what measures will be taken to research, and treat, any future health needs of these women and their children displaying distinctive health problems. Finally, we would like to know of any additional DVA programs specifically available to women who served in the Persian Gulf.

While the number of female Persian Gulf veterans reporting gender-specific health problems may appear to be minimal, it is crucial that the Department of Veterans Affairs not use this as an excuse to ignore the need for gender-specific research and services. Otherwise, we may miss an opportunity to clearly identify and treat these health problems. We urge you to code your Health Registry for gender specific symptoms, and to instruct the NAS and any prospective contractors researching the health status of our Persian Gulf veterans to do the same.

Sincerely,

Pat Schroeder

Rosa DeLauro

Lane Evans

Don Edwards

Joseph Kennedy

Henry Waxman

Maria Cantwell

Lucille Roybal-Allard

Marjorie Margolies-Mezvinsky

Leslie Byrne

Pat Danner

Jane Harman

Barbara Kennelly

Cynthia McKinney

Carolyn Maloney

Carrie Meek

Patsy Mink

Susan Molinari

Eleanor Holmes Norton

Barney Frank

Martin Meehan

Olympia Snowe

Jolene Unsoeld

Eddie Bernice Johnson

Karan English

Elizabeth Furse

Edward J. Markey

Karen Shepherd

Karen Thurman

Lynn Woolsey

Pat Williams

Nancy Pelosi

Louis Stokes

Anna Eshoo

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

AUG 10 1993

The Honorable Pat Schroeder
House of Representatives
Washington, DC 20515

Dear Congresswoman Schroeder:

Thank you for your letter in which you and your colleagues in the House expressed your concern about the women veterans who served in the Persian Gulf during Operation Desert Shield/Desert Storm.

Please be assured that I share your concerns about these veterans. I have personally committed the Department of Veterans Affairs (VA) to assuring equal access to health care for women veterans and to supporting women veterans' health care initiatives. VA certainly recognizes the contributions of Persian Gulf women veterans to the success of the military operation. VA is committed to serving their needs through a multi-faceted program which includes recognition of women veterans' health care problems, initiation of scientific research, identification/diagnosis of the illnesses suffered by these women, treatment of their medical problems, and provision of disability compensation for veterans with service connected illnesses. At my request, Veterans Health Administration officials have provided further information below regarding specific initiatives.

VA is sensitive to the needs of Persian Gulf women veterans who are suffering with health problems possibly related to their military service. Nearly a year ago, we established a Persian Gulf Registry medical examination program to gather information about Persian Gulf veterans with health difficulties possibly related to environmental hazards encountered in the Gulf. The data collected are consolidated and carefully analyzed to determine whether there are any unusual patterns or disease clusters. There is a gender indicator on the code sheet utilized in the registry to allow analysts to distinguish between problems diagnosed in women and men.

The VA Patient Treatment File also has a gender indicator as well as a Persian Gulf era indicator and is quite helpful in identifying medical problems of Persian Gulf veterans, in general, and Persian Gulf women veterans, specifically. To date, neither the registry examination program nor the Patient Treatment File has revealed unusual health patterns in Persian Gulf women veterans. Consequently, there is no hypothesis to test at the present time in a formal epidemiological study. We will continue to closely monitor all appropriate VA data bases to determine whether there is justification to design such a study in the future.

In addition to our medical examination program registry, VA offers medical treatment to eligible Persian Gulf veterans. In 1981, Congress enacted legislation to allow VA to treat veterans exposed to Agent Orange in Vietnam or ionizing radiation during atomic weapons testing in Japan, even though there was not definitive evidence that the disorders treated were related to the exposure. On June 21, 1993, I transmitted a draft bill to the Speaker that would extend this special priority treatment to Persian Gulf veterans who were exposed to toxic environmental and chemical contaminants during their service. While this authority would not be limited to Persian Gulf women veterans, it would clearly benefit them.

We are pleased that Persian Gulf women veterans are utilizing VA medical services available to them. While women accounted for approximately 6 percent of the forces in the Persian Gulf theater of operations, 9 percent of the outpatients and 7.6 percent of the inpatients seen in VA facilities who served in the Gulf have been women.

The Persian Gulf Family Support Program also was established to provide marriage and family counseling to Persian Gulf veterans. In the first six months of the program, 627 veterans were seen, 19% of whom were women.

Your letter mentioned that some women who served in the Persian Gulf have given birth to children with birth defects. This is a very troubling development. Be assured that we are closely monitoring this matter through our Registry Program.

A number of women veterans' health care initiatives have begun to help women veterans. While many of these efforts do not specifically focus on Persian Gulf veterans, the programs may benefit them substantially. Caring for the victims of sexual trauma is a major area of emphasis in the multi-year National Training Program on women veterans' health. Last year VA established a Women's Health Science Division devoted to research and education on the psychological impact of military service including traumatic stress on women veterans. VA is establishing four Women Veterans Post-Traumatic Stress Disorder Treatment Teams which will provide evaluation, diagnosis and direct patient care and treatment. VA Vet Centers are providing readjustment services as well to many women veterans. In addition, VA is establishing four Women Veterans Comprehensive Health Care Centers to provide a full range of services for women veterans in specific geographical areas.

Because we have not identified a unique medical problem among Persian Gulf women veterans, there is no standard treatment for these veterans. Rather, each veteran is provided treatment based on her particular health problem(s). If we become aware of a common medical condition or illness, we will develop a standard treatment methodology.

I hope this information is reassuring to you and your colleagues. A similar reply is being provided to each of the co-signers of your letter.

Sincerely yours,

Jesse Brown

Jesse Brown

JB/djr

STATEMENT OF

JOHN T. FARRAR, M.D.

ACTING UNDER SECRETARY FOR HEALTH

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

SEPTEMBER 22, 1993

Mr. Chairman and Members of the Committee:

I am pleased to be here to continue the discussion we began at the Subcommittee's June 29th hearing on the Department's efforts to care for veterans suffering from chronic mental illnesses. I will describe a national initiative the Department plans to implement which will help enhance our services to veterans with severe mental illness. Following that, I will present the Department's views on the seven different bills you are considering this morning, all of which concern VA health care benefits.

PROPOSED NATIONAL INITIATIVE ON CARE OF CHRONICALLY MENTALLY ILL VETERANS

Following your June 29th hearing on the subject of our efforts to care for the chronically mentally ill, our Mental Health and Behavioral Sciences Service drafted a national plan for creating an effective and comprehensive continuum of care for treating veterans with severe psychiatric problems. The plan was presented to the Veterans Health Administration planning review board in August. The intent of the plan was to improve VA services to the most under-served portions of the mentally ill veterans population within existing resources. The draft "National Initiative" would present a strategy for applying state-of-the-art

treatment methods to the task of helping intensive VA system users with severe mental illness make successful transitions to supported community-based living.

The Veterans Health Administration increased its focus on the seriously mentally ill in 1987 by funding Intensive Psychiatric Community Care programs (IPCCs) at twelve medical centers in the Northeast. The same year, Congress authorized and funded our Homeless Chronically Mentally Ill programs which now provide services in over 50 sites. These programs have laid the groundwork for the draft "National Initiative" for seriously mentally ill veterans.

Under consideration for inclusion in our "National Initiative," are: 1) strengthening VA's continuum of care in outpatient and community-based programs; 2) establishing a demonstration project for elderly veterans; 3) funding special Health Service Research and Development projects related to service delivery to seriously mentally ill veterans; 4) assigning additional medical expertise to psychiatric areas; 5) expanding efforts to provide vocational and employment rehabilitation.

We believe the final plan, once approved, will demonstrate our commitment to providing high quality, effective mental health care to all eligible veterans with severe and persistent mental illness.

We intend to involve all VA long-term psychiatric services in these efforts to redefine our programs for treating the chronically mentally ill.

Mr. Chairman, I will now turn to our views on the legislative initiatives before the subcommittee today.

H.R. 3081 -- REVISION OF AGENT ORANGE
AND IONIZING RADIATION TREATMENT AUTHORITY

Mr. Chairman, H.R. 3081 would make significant changes in our authority to provide veterans with care and treatment for disorders which are or may be associated with exposure to herbicides, and exposure to ionizing radiation. In 1981, Congress first authorized VA to begin furnishing such care and treatment even though there was no certainty that the disorders to be treated were associated with exposure to herbicides or radiation. Congress' view at that time was that VA should provide veterans with care and treatment during the period that it would take for the conduct of scientific research to determine what disorders might be associated with exposure. In the ensuing twelve years, much research did take place. Although we do not now have all of the answers, this bill represents an effort to associate the treatment authority more closely with the knowledge that has been gained through research.

Revision of the Agent Orange Treatment Authority

H.R. 3081 would completely revamp the so-called "Agent Orange treatment authority" and tie that authority to the findings of the National Academy of Sciences (NAS) in its study released earlier this summer. The bill would provide special health care eligibility for three categories of diseases identified in the study: first, those diseases for which the NAS found sufficient evidence to conclude a postive association with exposure to herbicides exists; second, those diseases for which NAS found suggestive evidence of an association with exposure; third, those diseases for which NAS found there is insufficient evidence of the presence or absence of an association with exposure. The bill does not provide special eligibility for a fourth category of diseases, those for which NAS found there is

limited suggestive evidence of no association, or for any other disease or disorder.

VA does not oppose the concept of associating the herbicide treatment authority with the state of scientific knowledge regarding herbicides. We are somewhat concerned, however, that this change would have the effect of limiting the authority the Secretary now has. There may be diseases and disorders that the NAS did not categorize in its study because there is no scientific literature related to them. We could now provide care for such disorders, but might not be able to under H.R. 3081. We would also point out that patients coming to a VA facility for the first time come with a set of symptoms. They generally do not, at least initially, have a diagnosed disease. We want to be certain that our physicians have the authority to examine veterans who allege their ailments are due to exposure to herbicides so a diagnosis can be made. At that point a determination can be made whether the veteran has a disease that is one identified in the NAS study.

Revision of the Ionizing Radiation Treatment Authority

H.R. 3081 would also revamp the Secretary's authority to treat veterans for disorders which may be related to exposure to ionizing radiation. The bill would authorize treatment for the specific cancers identified in section 1112(c)(2) of title 38, United States Code, for which VA grants presumptive service-connection. It would also authorize care for any other disease for which the Secretary determines, based on the advice of the Advisory Committee on Environmental Hazards, that there is credible evidence of a positive association between the disease and exposure to radiation.

As with the proposed changes in the Agent Orange treatment authority, we do not oppose tying the authority to the

current state of scientific knowledge. However, we have the concerns expressed above regarding limits on the Secretary's existing authority, and we want to make sure that our physicians continue to have authority to examine veterans and treat their symptoms if necessary prior to making a specific diagnosis.

Extension of the Agent Orange and Radiation Treatment Authority

H.R. 3081 would make permanent the Secretary's authority to provide treatment for disorders which may be associated with exposure to ionizing radiation, and would extend the herbicide treatment authority through September 30, 1996. Without these changes, both authorities would expire on December 31, 1993.

VA supports both of these proposed changes. Given the current state of knowledge about diseases related to exposure to radiation, permanent authority is warranted. With respect to the herbicide treatment authority, we understand the intent of the provision is to provide authority for care until after the Department receives the next report of the National Academy of Sciences in 1995, and has time to assess it. At that time, we will be better able to assess the need for further extension of the authority.

Outpatient Care

The final provision of the bill would authorize VA to provide outpatient care and treatment for the disorders which may be related to exposure to herbicides or ionizing radiation. VA supports this provision which will allow us to provide care in the most appropriate and cost-effective manner.

H.R. 2375 -- EXTENSION OF AGENT ORANGE AND IONIZING RADIATION TREATMENT AUTHORITY

Our existing authority to provide treatment for disorders which may be associated with exposure to Agent Orange or ionizing radiation expires on December 31st of this year. H.R. 2375 would extend the authority for ten years through the year 2003. As mentioned in my comments on H.R. 3081, we support making the radiation treatment authority permanent, and extending the Agent Orange treatment authority through September 30, 1996. We support H.R. 3081 as an alternative to this bill.

H.R. 3082 -- WOMEN'S HEALTH CARE

Provision of Gender Specific Health Care Benefits

H.R. 3082 would direct the Secretary to ensure that each VA health care facility is equipped to provide eligible women veterans with timely and appropriate gender related health care services, and general reproductive health care. Services must be available either in the VA facility, or through contractual arrangements. The services in question are those identified in legislation enacted last year, and include pap smears, breast examinations, mammography, and general reproductive care. General reproductive care does not, under the bill, include abortions, infertility services and obstetrics. The bill also provides that the Secretary need not ensure that services are available in the VA facility, as opposed to on a contractual basis, if there are insufficient numbers of women veterans in the hospital's catchment area, who have mandatory eligibility for VA hospital care, to make direct provision of services cost-effective.

We in the VA are committed to meeting the health care needs of women veterans. Over the last several years we have made

great improvement in our ability to provide women with needed gender specific services, and we will continue that effort. We intend to carry out the intent of this provision whether or not it becomes law.

Mammography Standards

H.R. 3082 would require that we prescribe quality assurance and quality control standards for the provision of mammography. The standards must be consistent with similar standards promulgated by the Department of Health and Human Services (HHS). Additionally, the bill would prohibit any VA facility from performing mammograms until that facility is accredited for that purpose by a private nonprofit accrediting body designated by the Secretary. Finally, we would have to ensure that any facility with which we contract for mammograms meets the HHS standards.

We support the requirement for mammography standards, and subject to one caveat, we support the accrediting requirement this bill would impose. We recommend that the bill be amended to provide for provisional certification of a facility to perform mammograms for up to nine months while the facility qualifies for accreditation. The Mammography Quality Standards Act of 1992 permits such provisional certification for private sector hospitals, and we believe our facilities should permitted this same provisional accreditation so they may provide mammography services during this initial accreditation process.

Sexual Trauma Counseling Program

Last year Congress provided us with authority to counsel women veterans who were victims of sexual trauma during service. That law authorizes us to provide such counseling services through December 31, 1995, and authorizes us to provide the services on a contractual basis through December

31, 1994. H.R. 3082 would extend each of those dates for one year. Additionally, the bill would delete a provision in the existing law which requires victims of sexual trauma to seek services within two years.

We strongly support this program. Indeed, we recommend that you permanently authorize the program, and not limit it to just one additional year, as this bill would do, or four years, as another bill before you today would do. Our task force on sexual trauma, and the Steering Committee of the National Women Veterans' Health Training Program, have advised us that a veteran's need for sexual trauma counseling often does not manifest itself until many years after the occurrence of sexual trauma. In addition, some victims of sexual trauma may be unable to seek counseling for many years, and some who receive counseling may need to return years later to deal with a recurrence of anxiety or other symptoms. To prevent veterans from being denied the counseling needed for sexual trauma which occurred while they were on active duty, we believe that all of the time limits on the program should be removed.

We are extremely concerned that those women discharged before December 31, 1991, not lose eligibility for counseling at the end of this calendar year, as would be the case under existing law. Thus, we strongly support abolishing that time frame as this bill would do.

Finally, we recommend that all references to "women" in the current law be deleted, thereby extending eligibility for sexual trauma counseling services to male veterans who suffer sexual trauma while serving on active duty. The next bill which I will discuss would do just that, and we support that provision. We see no reason to discriminate on the basis of gender in the providing of this benefit

Coordinators of Women's Services

H.R. 3082 would require that all of VA's regional coordinators of women's services serve on a full-time basis. It would also direct the Secretary to take appropriate steps to ensure that the coordinators in each facility are fully empowered to ensure women veterans receive quality care, and equal access to care. We agree that regional coordinators should serve on a full-time basis. At this time, we have full-time persons in two of our regions, and we are actively recruiting persons for the other two regions. We also concur with the policy that the Secretary to ensure that coordinators throughout the country have the authority to carry out their jobs. While we support the concept underlying these provisions, we do not support legislative requirements. Such requirements are inconsistent with the principles underlying a National Performance Review that are designed to let Federal managers manage their programs without unnecessary restrictions. We ask you to reconsider these provisions.

Patient Privacy

H.R. 3082 would direct the Secretary to conduct a survey of each VA medical center to identify deficiencies related to patient privacy afforded to women which might interfere with appropriate treatment. The Secretary would also have to ensure that plans are made to correct any deficiencies, and ensure that those plans are incorporated into the Department's construction planning processes. We support this provision which is consistent with existing VA policy.

H.R. 2285

Sexual Trauma Counseling

H.R. 2285 contains provisions aimed at improving the authority Congress provided VA last year to furnish

counseling to veterans who were victims of sexual trauma during service. As I stated above with respect to similar provisions in H.R. 3082, we support this program fully, and would like to see the authority for it made permanent.

As previously discussed, the law enacted last year authorizes us to provide sexual trauma counseling services through December 31, 1995. It also imposes strict time limitations on our authority to contract for such counseling, on the windows of eligibility for women veterans seeking these counseling services, and on the maximum length of time a woman veteran may receive sexual trauma counseling. This bill would extend both the program authority and the Secretary's contracting authority through December 31, 1998. It would also eliminate the time limitations relating to veterans' eligibility for sexual trauma counseling and repeal the time limitation regarding the period of receipt of counseling.

In my comments on H.R. 3082, I recommended that you permanently authorize this program by striking the sunset provision on both the program, and the contract authority. I make the same recommendation with respect to this bill. We support the other provisions of this bill which eliminate other time limitations included in the current program. We also support elimination of all references to "women" in the current law, thereby extending eligibility for sexual trauma counseling services to male veterans who suffer sexual trauma while serving on active duty. Finally, we support increasing the outpatient priority for care received by veterans eligible for sexual trauma counseling.

Coordinators of Women's Services

Another provision of this bill which is similar to H.R. 3082, would require that all regional coordinators of women's services serve full-time. We support the concept

behind this requirement and will continue working to meet it. We also support clarifying that the coordinator is responsible for facilitating communication between the coordinators in each hospital, and between the Under Secretary of Health and the Secretary. We will give full support to the coordinators working in the field both in terms of funding, personnel, clerical support and communications needs. These requirements, however, should not be legislated, as explained earlier.

Sexual Trauma Program 800 Number

H.R. 2285 would direct that we establish a new "800 number" phone system to provide information about the sexual trauma counseling program. We believe such a toll free number can be useful in conveying information about benefit programs, and to that end the Department already operates such a system with respect to all veterans benefits. We believe the best approach would be for VA to train our existing operators in the services available in the sexual trauma counseling program and allow them to serve the function contemplated by the provision of this bill. That would be considerably more cost-effective. Moreover, we would also be pleased to provide the Congress with any available information needed about the phone system use in lieu of fulfilling the reporting requirement contained in the bill.

Report to Congress

I want to express some concern with the final provisions of H.R. 2285 which would require a new report to Congress pertaining to the difficulties veterans encounter in obtaining service-connection for disabilities relating to sexual trauma. Developing and assembling such information would be difficult, and require significant resources which we believe could be better used for other purposes.

H.R. 2797

Provision of Gender Specific Health Care Benefits

As I mentioned in connection with H.R. 3082 above, Public Law 102-585, enacted last year, clarified that we have authority to provide various female gender specific services such as pap smears, breast examinations, mammography, and general reproductive health care. Moreover, that law specifically prohibited the furnishing of infertility services, pregnancy care, or abortion services. This bill, H.R. 2797, would change the law to authorize VA to specifically to provide "comprehensive reproductive health care, including pregnancy-related care." In addition, it extends the definition of women's health care services to include care for osteoporosis and other conditions related to aging.

To authorize VA to provide comprehensive reproductive care as described in the bill would be a significant departure from past practice. We are not now equipped to provide those services; we do not have staff or facilities to provide obstetrical care. Although we have not estimated the costs of providing comprehensive reproductive care, our assessment is that the cost would be considerable. More importantly, however, we are continuing to await the complete announcement of plans for national health care reform. To a great extent, new directions for VA will be governed by the approach the President and the Congress adopt with respect to reforming our Nation's health care system.

Fee Basis Outpatient Care for Women Veterans

H.R. 2797 would authorize us to contract for outpatient care for women veterans when we either lack the capability to provide the care in our own facilities, or cannot provide

the care economically in our facilities because they are geographically remote from the patient. We already have authority to contract for hospital care for women in those circumstances, and this provision would extend the authority to ambulatory care. We support this provision.

Report on Health Care and Research

Another provision in H.R. 2797 would add additional detailed requirements for a report VA must make on women's health care and research, a report required of VA by Public Law 102-585. Compliance with the additional reporting requirements, because they are so broad, would be extremely burdensome and expensive. Accordingly, we ask that you reconsider this provision.

Expansion of Research Relating to Women Veterans

H.R. 2797 also contains provisions which would expand and clarify the actions the Secretary must take to foster and encourage research involving women. Public Law 102-585 required the Secretary to "encourage the initiation and expansion of research relating to the health of veterans who are women." This bill would provide that in carrying out that earlier mandate, the Secretary must consult with various individuals identified in the bill, and it further suggests that research be conducted in some eight specific areas. Over the years, we have adamantly defended the position that the research we undertake should not be conditioned, but should be approved on the basis of normal merit review processes. This is the best method for ensuring that research funds are allocated to projects with the greatest merit. We therefore ask that this provision be reconsidered.

Inclusion of Women and Minorities in Research Studies

H.R. 2797 would direct the Secretary to ensure that in the conduct of VA research, women veterans, and members of minority groups are included as research subjects. The bill also would provide that such persons need not be used as subjects if it is inappropriate with respect to the health of the subjects, is inappropriate with respect to the purpose of the research, or is inappropriate for other reasons to be determined by the Secretary. VA supports this provision which is consistent with existing departmental policy.

Population Study

H.R. 2797 would expand the requirements for a population study of women veterans authorized last year by Public Law 102-585. We do not object to the measure. I would note, however, that we have not begun work on this study because the law provided that we could carry it out only if Congress specifically appropriated money to do it. No such appropriation has been made.

Mammography Standards

H.R. 2797 also contains a provision pertaining to mammography standards in VA. As I stated earlier, we support requiring VA to promulgate such standards. However, we strongly oppose the particular provision in this bill. H.R. 2797 would apply an existing law to VA which requires mammography standards for all hospitals. That law is administered by HHS. The effect of the provision would be that HHS would be regulating the VA. As an alternative, we support the provisions of H.R. 3082 which require that VA

prescribe standards which are equivalent to and consistent with the HHS standards.

H.R. 3090 -- WORK THERAPY PROGRAMS AND THERAPEUTIC TRANSITIONAL RESIDENCES

Nonprofit Corporations

H.R. 3090 would authorize us to establish nonprofit corporations to help foster the compensated work therapy (CWT) programs which operate in our medical centers throughout the country. The bill would authorize the corporations to both help arrange for therapeutic work for patients, and serve as funding mechanisms.

As you may know, nonprofit corporations commonly served as vehicles for VA to provide compensated work therapy prior to 1976. Changes in law that year authorized VA to do much of what the corporations were doing, and the need for them dwindled. However, Congress did permit existing corporations to continue operations, and VA still has arrangements with several such entities.

The Inspector General is currently reviewing the use of nonprofit corporations in VA's research program. We expect this review will contain several recommendations to improve financial accountability and program oversight. We would like to review the Inspector General's report before we consider using nonprofit corporations in the CWT Program. Accordingly, we ask that you reconsider this provision.

Transitional Residence Demonstration Program

The second part of H.R. 3090 would extend and expand a demonstration program under which VA operates transitional residences for veteran patients. Congress initially authorized the demonstration program through Fiscal Year

1994, and permitted the Department to operate up to 50 residences. This bill would extend the program through Fiscal Year 1997, and would permit VA to add up to five additional residences each year beginning in 1995.

The demonstration program assists many veterans with psychiatric or substance abuse related illnesses. The therapeutic facilities are acquired and operated primarily with donated funds which have been deposited in VA's General Post Fund. The cost for day-to-day operation is met entirely by rent payments made by the veteran residents. Patients earn funds in compensated work therapy programs and use the money to pay rent, and purchase food and other personal needs.

We are currently evaluating the effectiveness of this demonstration program to determine whether an extension or expansion of the program is warranted. This evaluation will be completed during Fiscal Year 1994. At that time, we will be better able to assess the need for a further extension or expansion. We ask that you reconsider this provision pending the outcome of the evaluation.

DRAFT BILL -- PROVISION OF LIMITED
ADDITIONAL SERVICES IN VET CENTERS

This draft bill would authorize us to use Vet Centers as sites for the delivery of limited outpatient services for veterans otherwise eligible for those services. It would permit us to furnish preventive health care services, services needed to prepare a veteran for hospital admission, and referral services for veterans needing specialized care. The bill would require a report to Congress one year after enactment describing implementation of the new authority.

Because this bill provides only discretionary authority, and does not mandate implementation, we do not oppose it.

However, the provision is entirely unnecessary. We could provide outpatient services in Vet Centers under existing authority if we thought that would be useful and appropriate. We generally do not believe it would be a good idea.

To provide basic health care services in Vet Centers would fundamentally change the unique nature of those facilities. Much of the success of Vet Centers over the past 14 years can be attributed to the fact that they are not clinics providing traditional outpatient services. To introduce basic outpatient health care services into the mix of services now provided in Vet Centers could compromise the continued success of those facilities. In our view, if we need to enhance our ability to provide limited services in small community based facilities, we can do that under existing authority by leasing space in the most appropriate location.

Mr. Chairman, this concludes my formal statement, I will be pleased to answer any questions you may have.

STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
SEPTEMBER 22, 1993

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to offer its views on several bills relating to veterans health care services. Each of these measures would reinforce and expand existing programs presently authorized by law.

H.R. 3082, the "Women Veterans Health Improvements Act of 1993", would improve health care services of the Department of Veterans Affairs relating to women veterans, and for other purposes. Section 2 of the measure would ensure that each VA medical center provide timely and appropriate health care services authorized in section 106 of Public Law 102-585, to any veteran described in section 1710(a)(1) of title 38, United States Code, who is eligible for such services. The measure also directs that each medical facility be adequately equipped to provide routine health care services, and shall provide, such services directly if the facility serves a catchment area with a sufficient number of women veterans to make it cost-effective to provide such services.

Mr. Chairman, The American Legion supports the objective of this measure and we believe that when it is more cost-effective to contract for veterans health care services, VA should be authorized to do so.

Section 3 of the bill would require that (1) a VA facility not perform mammograms unless it is accredited to do so by a nonprofit organization meeting standards established under law; (2) VA prescribe quality standards relating to VA performance and interpretation of mammograms and use of mammogram equipment consistent with the requirements set in the Public Health Service Act (42 U.S.C. 263 b(e); and (3) VA provide for periodic inspection of such equipment and ensure that contractors meet applicable quality standards.

The American Legion believes the proposed legislation adequately sets a quality framework for the provision of mammogram services to women veterans and we wholeheartedly support the proposal.

Section 4 would amend section 1720D(a) of title 38, U.S.C., to amend provisions of law enacted in P.L. 102-585, to (1) extend by one year VA's authority to provide counseling to women veterans associated with sexual trauma (without regard to adjudication of service-connection or income status); (2) repeal the requirement that a veteran must seek such counseling within two years after service (or before December 31, 1993, in the case of those discharged before 1992); and (3) provide that officials serving as regional women's coordinators shall serve in such a position on a full-time basis.

The Legion has previously supported the provisions contained in section 4 and has no objections to enactment of these measures.

Section 5 would amend section 108 of the Veterans Health Care Act of 1992 (P.L. 102-585), to require VA to take appropriate actions to ensure that the Coordinator of Women's Services at each VA health care facility is

empowered to carry out the responsibilities of that position, i.e., that women veterans receive quality medical care and, to the extent practicable, have equal access to VA health care facilities.

The Legion supports this measure and regrets that a legislative remedy is necessary in order that VA adopt this proposal as one of its highest priorities.

Section 6 would require VA to (1) survey each of its medical centers to identify deficiencies relating to the privacy of women patients; (2) ensure that plans to correct deficiencies identified in the planning processes are given high priority; and (3) compile an annual inventory of those deficiencies and remedial plans, and inform Congress annually through 1996 regarding the inventory, proposed corrective plans, and actual progress.

Mr. Chairman, the Legion has repeatedly called for VA to correct multiple facility infrastructure deficiencies with respect to the provision of VA health care services. In particular, the VA's Facility Development Planning (FDP) process was specifically designed to identify all urgent construction requirements and incorporate these proposals into each facility's five-year facility construction plan. Many of the FDPs have been completed, while additional funding is still required to complete the process. The Legion supports the provision of H.R. 3082 to conduct an inventory of physical plant deficiencies relating to the privacy of women veterans. Also, we recommend that VA review other equally important medical care delivery topics such as adequate ambulatory care facilities, including ambulatory surgery capability, the availability of acute inpatient and chronic long-term care beds, and skilled nursing home care beds. If VA is required to conduct a review of appropriate women veterans' privacy concerns, we think this review should be expanded to include other pertinent considerations. The development of the National Health Care Plan, presently being examined by VA, in conjunction with the Facility Development Planning process, is an excellent vehicle with which to incorporate women veteran privacy concerns, along with other necessary facility construction projects.

H. R. 3081 would extend and expand authority for VA to provide priority health care to veterans who were exposed to ionizing radiation or to Agent Orange. The measure would incorporate the findings of the National Academy of Sciences with respect to the health effects of herbicides used in Vietnam by authorizing treatment for Vietnam veterans for any diseases which the Academy has found (or subsequently finds) either some evidence of, or insufficient evidence to permit a conclusion as to, an association between occurrence of the disease in humans and exposure to a herbicide agent. The bill also provides that special authority relating to "Agent Orange" runs through September 30, 1996, to allow for reassessment in light of the next National Academy report due in July 1995.

The bill proposes to eliminate any sunset date for provision of care to veterans who may have been exposed to radiation. It also would provide special eligibility in the case of radiation exposed veterans for care of any diseases for which it is determined there is credible evidence of a positive association between disease occurrence and radiation exposure or for which Congress has established presumptive service-connection. In the case of radiation and Agent Orange exposure, the bill proposes to expand the scope of authorized care to mandate any needed outpatient treatment for covered illnesses and provide a higher priority to such treatment than assigned under existing law.

Mr. Chairman, The American Legion believes that H.R. 3081, section 1 (B) i, ii, and iii does not provide sufficient guidance to the Department of Veterans Affairs as to which veterans under the Agent Orange Act of 1991 would be entitled to health care at VA medical facilities. The authorization is far too broad and difficult to interpret. VA physicians must be provided specific lists of diseases in each of the three categories. Provisions should be made in this bill to cover health care for additional diseases caused by exposure to Agent Orange as determined by the Secretary of Veterans Affairs and based on specific evidence.

The American Legion adamantly opposes any bill which does not provide a grandfather clause to cover health care for Vietnam veterans presently or previously treated at VA medical centers for diseases caused by Agent Orange exposure. Further subsection (2) concerning the hospital and nursing home care expiration date of September 10, 1996 is unacceptable. The long latency period for cancer causing diseases and the age of Vietnam veterans dictates that Congress extend the authority for VA to provide priority care for veterans exposed to agent orange, with a provision for further extensions as the age of the veteran population increases.

H.R. 2375 would amend title 38, USC, to extend for ten years, to December 31, 2003, the authority for VA to provide priority health care to veterans who were exposed to ionizing radiation or to Agent Orange. The American Legion strongly supports this proposal.

The next bill is a draft proposal to authorize VA to expand the scope of services provided veterans in Vet Centers. The measure would authorize VA to use Vet Centers as sites to furnish preventive health care services, pre-admission screening, and referral services to those eligible for readjustment counseling and medical services.

Mr. Chairman, The American Legion recently testified in support of comprehensive legislation before the Senate Veterans Affairs Committee to enhance and expand the Readjustment Counseling Service Vet Center Program. Although the draft legislation under consideration today is not as extensive as the Senate bill, we support the measure. The legislation would allow VA to progressively expand the scope and services of the Vet Center program. The Readjustment Counseling Service has been a dynamic force in addressing the most pressing needs facing the veteran population it serves. The Legion encourages the Subcommittee to work with the Senate Veterans Affairs Committee to extend the reach of this draft bill to incorporate all provisions of the Senate bill regarding expanded entitlement of eligibility and scope of services provided by VA's Readjustment Counseling Service.

The last bill under consideration today is a draft measure to amend title 38, U.S.C., to improve the ability of VA to provide continuity of care in the rehabilitation of chronically mentally ill veterans, and for other purposes. The bill would authorize VA to establish nonprofit corporations to arrange for therapeutic work for VA patients through compensated work programs, based on current law authorizing VA to establish nonprofit research corporations; extend the demonstration program of compensated work therapy and therapeutic transitional housing authorized in section 7 of P.L. 102-54 through Fiscal Year 1997; and lift the restriction in existing law on VA's establishing more than 50 transitional therapeutic residences for veterans who are participating in compensated work therapy programs, to permit the establishment of up to five new sites each year through Fiscal Year 1997, subject to total expenditures for

acquisition, management, and maintenance not exceeding $500 thousand in any fiscal year after 1994 (such sums to be funded through VA's General Post Fund).

The American Legion has supported similar legislation on past occasions and strongly endorses this proposal. The measure would greatly assist homeless chronically mentally ill veterans to receive the rehabilitation support required to reenter the community and regain the self-worth and the dignity necessary to help overcome the conditions which have led to their health problems.

Mr. Chairman, that concludes our statement.

STATEMENT OF

DENNIS M. CULLINAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

HEALTH CARE RELATED DRAFT LEGISLATION

WASHINGTON, D.C. SEPTEMBER 22, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million men and women of the Veterans of Foreign Wars of the United States, I wish to thank you for inviting the VFW to participate in today's important hearing on several draft pieces of legislation intended to enhance the health care provided to this nation's veterans by the Department of Veterans Affairs. I also wish to extend to you the appreciation of the entire VFW membership for your demonstrated continuing concern for the health care needs of our nation's veterans.

First under discussion today is draft legislation to be introduced by Mr. Rowland, Chairman of this Subcommittee, which may be cited as the "Women Veterans Health Improvements Act of 1993." In general, this draft legislation would reaffirm with greater specificity VA's existing statutory obligation to provide eligible women veterans appropriate gender specific health care services in a timely and cost effective manner. This draft initiative would establish quality and accreditation standards regarding the provision of mammograms; extend and expand VA's authority to provide counseling to women veterans associated with sexual trauma; require VA to fully enable the coordinator of women's services to carry out the position responsibility; and, require VA to identify deficiencies relating to the privacy of women patients, take corrective action and inform the Congress annually through 1996 regarding actual progress. In keeping with the VFW's ongoing position in favor of making the VA health care system available and user friendly for women and providing for their specific needs, the VFW supports this draft legislative initiative.

Next under discussion today is a draft bill to extend and expand the authority relating to "Agent Orange" and radiation exposure. In general, this draft legislative initiative would authorize treatment for Vietnam veterans for any diseases which the National Academy of Sciences finds to have "some evidence" or "inconclusive evidence" of an association with exposure to a herbicidal agent; provide for a reassessment of the special authority relating to Agent Orange authority based on the National Academy Report due in July, 1995; eliminate any sunset date for the provision of care to veterans who may have been exposed to radiation; provide special health care eligibility for radiation exposed veterans; and, in the case of radiation and Agent Orange, expand the scope of authorized care to mandate any needed out-patient treatment for covered illnesses. Once again, in keeping with the VFW's long standing holding that the time for deliberation and delay with respect to caring for the needs of this nation's radiation and herbicide exposed veterans is long overdue, we support this draft legislative initiative.

Next under discussion today is a draft bill to be introduced by Mr. Smith of New Jersey which would authorize the Secretary of Veterans Affairs to expand the scope of services provided to veterans by Vet Centers. This draft proposal would authorize VA to use Vet Centers as sites to furnish preventive health care services, pre-admission screening, and referral services to those eligible for readjustment counseling and medical services. While the VFW in generally supportive of this proposal, we would ask that it be amended so that all veterans would enjoy access to the aforementioned services through Vet Centers. The VFW views the provision of preventive health care services on an out-patient basis to be an essential component of modern medical practice and very much in keeping with maintaining a veteran's physical and the VA Health Care System's fiscal well being. The VFW strongly holds that the eligibility criteria for VA health care should be modified to open up the system to all of America's veterans for the full continuum of services which it provides, including Page

preventive health care. But since this draft proposal would provide certain of these crucial health care services on a limited basis through the utilization of Vet Centers, we believe they should be available to all veterans.

Last under discussion today is a draft legislative proposal intended to improve VA's ability to provide continuity of care in the rehabilitation of chronically mentally ill veterans. In general, this draft legislative initiative would authorize VA to establish non-profit corporations to arrange for therapeutic work for VA patients through compensated work programs; extend the demonstration program of compensated work therapy and therapeutic transitional housing through fiscal year 1997; and, amend current law to permit the establishment of up to five new transitional therapeutic residences for veterans who are participating in compensated work therapy programs through FY 1997, as along as total expenditures in any fiscal year after 1994 do not exceed $500,000. In keeping with our strong belief that the Department of Veterans Affairs should provide for the healing of mind as well as body of those veterans injured in our nation's service, we support this draft legislative proposal.

Mr. Chairman, this concludes my statement, once again, thank you for including the VFW in today's important hearing. I would be happy to respond to any questions you may have.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
SEPTEMBER 22, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.4 million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, may I say how very much we appreciate the invitation to testify before the Subcommittee today.

In your letter of invitation, Mr. Chairman, our views were solicited on draft legislation to improve the ability of the VA to provide continuity of care in the rehabilitation of chronically mentally ill veterans; draft legislation to expand the scope of services provided veterans in Vet Centers; H.R. 3081, extending and expanding VA's authority to provide health care services to veterans exposed to ionizing radiation or Agent Orange; and, H.R. 3082, a bill to improve health care services relating to women veterans.

DRAFT LEGISLATION TO PROVIDE CONTINUITY OF CARE IN THE REHABILITATION OF CHRONICALLY MENTALLY ILL VETERANS, AND FOR OTHER PURPOSES

Mr. Chairman, the DAV is in general support of draft legislation directed at improving VA's ability to provide services of a meaningful nature, to chronically mentally ill veterans.

As we understand the draft legislation, the Secretary would be granted authority, via the creation of a new Section, 1718A, Title 38 USC, to establish at any VA medical facility a nonprofit corporation to:

1) Arrange for therapeutic work for patients of such facility or patients of other VA facilities pursuant to Section 1718, Title 38 USC, "Therapeutic and Rehabilitative Activities;" and

2) Provide a flexible funding mechanism that would achieve the purposes of Section 1718.

Additionally, the Secretary would be required to appoint a board of directors for any of the nonprofit corporations established. Such board would consist of the Director of the facility involved as well as other officials or employees of that facility, as well as individuals not employed by the VA.

Mr. Chairman, the corporation established would have authority to:

* Arrange with the VA to provide therapeutic work for VA patients;

* Accept gifts and grants and enter into contracts with individuals and public and private entities to carry out therapeutic and rehabilitative activities; and

* Employ such individuals as necessary for such purposes.

Authority would also be conveyed to deposit in or credit to, the Special Therapeutic and Rehabilitation Activities Fund any amounts of money in excess of that reasonably required to carry out the obligations of the corporation. Also, in

accordance with guidelines the Secretary would prescribe, the corporation would be permitted to retain funds derived from arrangements authorized by Section 1718A.

Mr. Chairman, we agree with the proposal to include the activities of the nonprofit corporation under the umbrella of VA programs and services subject to review by the Department's Inspector General.

Additionally, each corporation would be required to submit to the Secretary an annual report providing detailed statements of its operations, activities and accomplishments on a yearly basis. Additionally, the Secretary would be required to submit to the Veterans Affairs Committees an annual report on the number and location of corporations established and the amount of the contributions made to each such operation.

Mr. Chairman, based on the general intent of the therapeutic and rehabilitative activities authorized by Section 1718, Title 38 USC we view the proposed legislation in a very positive manner. It is our view that if the proposed legislation were enacted it would permit the Secretary a beneficial degree of increased flexibility in which to provide what we consider to be a very meaningful benefit and treatment alternatives to disabled veterans. Additionally, the scope of activities that patients could engage in would, we believe, be considerably broadened. For these, and other reasons, we are supportive of the creation of Section 1718A.

Mr. Chairman, we are also supportive of Section 2 of the draft legislation extending, through Fiscal Year 1997, the demonstration program of Compensated Work Therapy and Therapeutic Transitional Housing. Likewise, we are supportive of the incremental expansion, by 20 sites, through Fiscal Year 1997 of Transitional Therapeutic Residences.

DRAFT LEGISLATION TO EXPAND THE SCOPE OF SERVICES PROVIDED IN VET CENTERS

Mr. Chairman, the DAV concurs with the intent, and is fully supportive of, the provisions contained in draft legislation that would create an expansion of services provided by Readjustment Counseling Service (RCS), "Vet Centers" as authorized by Section 1712A, Title 38 USC.

Mr. Chairman, the draft legislation would add a new subsection, (h), authorizing the Secretary to provide, in Vet Centers:

* Preventive health care services;
* Medical services reasonably necessary in preparation for hospital admission; and
* Referral services to assist in obtaining specialized care.

The Secretary would be required to provide such additional services through health care personnel as determined appropriate by the Secretary.

It is our sincere belief that the concept of providing certain health care services to eligible veterans at Vet Centers is long overdue. Unquestionably, such a program can only serve to have a positive effect on veterans and their health status.

Clearly, Vet Centers are well accepted by their user population, they are cost effective, basically "hassle free" and, importantly, exist in the community where veterans reside and therefore are easily accessible.

In addition to the fully defined psychological needs of veterans seeking services at Vet Centers, it would seem that their existing physical disabilities will require the seeking out of medical care at some point. As Vietnam veterans age, it will be inevitable that the presence of additional disability and disease will manifest and, we can envision Vet Centers playing a significant role in the early detection and treatment of additional disabilities by means of having VA health care personnel present and immediately available.

Mr. Chairman, we would estimate no or relatively little additional costs would be incurred in such a venture. Medical staff from a nearby VA medical facility would be assigned to the Vet Centers as indicated by local need and within available resources. We envision physicians, nursing staff, physician assistants, dieticians, etc. all will have meaningful roles to play.

We are, therefore, totally supportive of such a concept being implemented, where appropriate, in Vet Centers.

H.R. 3081

Introduced by yourself, Mr. Chairman, H.R. 3081 proposes appropriate amendment to Section 1710(e), Title 38 USC, authorizing treatment for Vietnam veterans exposed to Agent Orange. As we understand, this measure intends to incorporate, in statute, the findings of the National Academy of Sciences report: "Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam" released on July 27, 1993.

H.R. 3081 proposes to continue the authorization for hospital and nursing home care for diseases the National Academy of Sciences has determined, or will determine in the future, when:

* there is sufficient evidence to conclude that there is a positive association between occurrence of the disease in humans and exposure to a herbicide agent;

* there is evidence which is suggestive of an association between occurrence of the disease in humans and exposure to a herbicide agent, but evidence is limited in nature; and

* available studies are insufficient to permit a conclusion about the presence or absence of an association between occurrence of the disease in humans and exposure to a herbicide agent.

Mr. Chairman, as concerns those veterans exposed to radiation, it is proposed they be eligible for hospital and nursing home care for:

* Any disease listed in Section 1112(c)(2) of Title 38; and

* Any other disease for which the Secretary, based on the advice of the Advisory Committee on Environmental Hazards, determines that there is credible evidence of a positive association between occurrence of the disease in humans and exposure to ionizing radiation.

Mr. Chairman, the removal of VA's authority to offer hospital or nursing home care -- sometimes vitally important care -- to a cohort of veterans with often times very serious and life threatening conditions, certainly appears to be a dimunition of services that many veterans and their families have come to rely on. At the very least, we expect veterans now availing themselves of VA medical care services to be able to continue to do so. We therefore view this as having an adverse

impact on the scope of health care services provided to veterans and we are unable to support this proposal.

Mr. Chairman, H.R. 3081 also proposes, for which we have no objection, extending the authority of VA to treat veterans exposed to herbicides through September 30, 1996, and removing any sunset date that veterans exposed to radiation may avail themselves of treatment.

Mr. Chairman, the DAV is supportive of the expansion of authority to provide ambulatory care services, via appropriate amendment to Section 1712(a)(1) to those veterans exposed to herbicides or radiation.

H.R. 3082

Introduced by yourself, Mr. Chairman, H.R. 3082, the "Women Veterans' Health Improvements Act of 1993" is timely and addresses, in a positive way, a number of issues facing women veterans.

Section 2 of the measure seeks to ensure that each VA health care facility and those facilities under contract with VA to provide services to women veterans, do so in a timely and appropriate manner with respect to the health care services authorized in Section 106 of P.L. 102-585 consisting of:

* Pap smears;
* Breast examinations and mammography; and
* General reproductive health care, including the management of menopause, but not including, unless necessitated by a service-connected disability, infertility services, abortions, or pregnancy care.

Additionally, each VA facility would be required to be adequately equipped to provide, and shall provide, such services directly if it is geographically situated in an area with a sufficient number of women veterans to render it cost effective to provide such care.

Section 3 would require that in order to provide mammography services each VA medical facility must be accredited by a private, nonprofit organization designated by the Secretary. Also, the VA would be required, in consultation with the Department of Health and Human Services to prescribe quality assurance and quality control standards relating to the performance and interpretation of mammograms and use of mammogram equipment. In order to comply with such standards, the periodic inspection of facilities and equipment would be required to be accomplished by VA. Finally, Section 3 would require the VA to ensure that those non-Federal facilities under contract with VA to provide mammography services also conform to the established quality standards.

Mr. Chairman, DAV is certainly supportive of Section 3 which only serves to ensure that women veterans are provided quality services. We would expect that the standards developed by VA would certainly be equal to and preferably higher than those utilized in non-VA facilities.

Section 4 of the measure proposes to extend, by one year, through December 31, 1996, VA's authority to provide counseling to women veterans as a result of sexual trauma. Also, the requirement that a woman veteran must seek such counseling within two years following her separation from service would be repealed.

Mr. Chairman, the DAV is supportive of this proposal. There has been a clearly identified and defined need to provide these types of services to women veterans. The provision of counseling services as a sequelae of sexual trauma/abuse is an

extremely sensitive issue and one that demands the full attention of VA.

It is our belief that VA has, since the enactment of Public Law 102-585, made significant strides in their policies affecting veterans who have been the victims of sexual trauma/abuse. Clearly, more needs to be done and we urge, in the strongest possible terms, that VA continue to devote their resources and expertise to this most important issue.

We are concerned, Mr. Chairman, with the perception that some women apparently hold that they are not, in a true sense of the word, veterans. In our view, every effort must be made to dissuade such feelings and, to the contrary, instill the belief in all women veterans that they certainly are and deserve to consider themselves veterans and most assuredly are on an equal plane with their male veteran counterparts. In this respect, we are hopeful that an aggressive outreach effort will be made to reach those women veterans entitled or potentially entitled to the many benefits and services offered by VA and who are not now availing themselves of such services.

Mr. Chairman, the DAV supports Section 5 which would require those individuals serving as a coordinator of women's services in each regional office serve in such a position on a full-time basis. Additionally, we support the concept of ensuring that the coordinator of women's services at each VA health care facility is able to carry out the responsibilities of such position to ensure that women veterans receive quality medical care and have equal access to VA facilities.

Finally, Mr. Chairman, Section 6 of the bill would require VA to conduct a survey of each medical center for the purpose of identifying deficiencies relating to patient privacy afforded women patients. After identifying such deficiencies, the Secretary would be required to ensure that plans for correction are developed and incorporated into the VA's construction planning process and given a high priority for completion. We are supportive of these requirements.

Mr. Chairman, this concludes my testimony and I would be pleased to respond to any questions you or members of the Subcommittee may have.

SERVING
WITH
PRIDE

STATEMENT

OF

MICHAEL F.BRINCK

AMVETS NATIONAL LEGISLATIVE DIRECTOR

BEFORE THE

HOUSE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

REGARDING

HR 3081, HR 3082

AND

DRAFT LEGISLATION CONCERNING VETERANS CENTERS
AND
CHRONICALLY MENTALLY ILL VETERANS

SEPTEMBER 22, 1993

A M V E T S

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Mr. Chairman, AMVETS would like to thank the committee for holding this hearing on a series of bills and draft legislation that would improve VA health care services to veterans.

HR 3081 would expand treatment available to veterans exposed to ionizing radiation and Agent Orange. AMVETS supports the bill in its entirety. We are especially pleased that you have included subparagraph (iii) that will continue to provide veterans with the benefit of the doubt concerning those diseases for which there is no definitive evidence of linkage to exposure to toxic herbicides.

We are pleased because the political and military pressures of wartime do not relieve the government of the subsequent burden of responsibility when using untried weapons or equipment.

The same may be said for those service members exposed to ionizing radiation. The one thing we know for certain is that radiation exposure is insidious in its manifestation. There are abundant stories about government coverups about veterans exposed to the effects of the bombs dropped on Hiroshima and Nagasaki and the later tests during the Cold War. It is time to finally pay for the rigged data and the poor or non-existent protective equipment. The costs, when viewed a portion of the total VA health care bill is relatively insignificant.

National health care reform will offer many challenges to VA. To survive, VA must restructure its organization and its philosophy of the way it delivers its services. It must become a more grassroots-oriented system. VA must reform its eligibility requirements to provide all veterans access to a full continuum of care. The reason is simple - VA must change or succumb to the competitive environment created by the new national health plan.

As part of the reform, VA must continue to improve its services for women. They are part of the potential patient base for which VA must compete and it would be not only a bad business decision but most importantly a breach of trust with growing portion of the veterans population.

Last year's women's health legislation finally provided the impetus for VA to begin concentrating on the women veterans population. It is an appropriate time because women are now beginning to comprise a statistically larger share of the total population which justifies increasing the resources needed to treatment them in the VA system. Therefore, AMVETS does not support HR 2797 on the grounds that it will prevent VA from expanding its women's health care program by mandating an expansion of women's health care services and providing for furnishing those services through fee basis treatment. We also object to eligibility for treatment that is gender-based. VA's lack of focus on women's health issues is largely a natural result of the gender of its population, not some Machiavellian plot to deprive women of quality health care. For the same reason, we object to mandating female participation in all VA research. First, VA cannot force women to participate in voluntary research protocols. Second, with the relatively small proportion of female patients, worthy research that has absolutely nothing to do with gender may lose funding. AMVETS fully supports inclusion of female veterans wherever possible and increased emphasis on women's health research as clinically appropriate.

We also feel that we must once again ask that Congress not drag VA into the middle of the abortion debate. Over the last few years, the controversy generated by the well-intentioned supporters on both sides of the issue has stalled many worthwhile projects. Now is not the time to sacrifice VA reform on the altar of the national abortion debate. AMVETS' position is simple: VA should conform to the law of the land. If that law allows federal taxes to fund abortions in all federal other health care programs, then they should be allowed in the VA. If the law does not provide federal funds for abortions in other federal programs, then VA should operate under the same restrictions.

Regarding HR 3082, a bill that would expand VA's authority for providing health care services for women veterans, AMVETS again supports the bill in its entirety. Quality care of any sort has several components: a trained staff, proper facilities and equipment, and a critical mass of patients to keep the staff current. While AMVETS fully expects an ever-increasing percentage of VA facilities to offer in-house treatment for women, we understand that for a time, higher quality care will be available through contracting or sharing arrangements because of physical

plant, staff and patent base limitations. We also fully expect the provisions requiring the Secretary to survey the system for deficiencies and report on plans to correct those deficiencies should provide the visibility for Congress to monitor progress in this area. AMVETS suggests that the report include demographic data corresponding to each deficient site to provide a frame of reference by which to judge future funding requests and VA progress.

AMVETS also supports the initial and recurrent certification of both staff and equipment used to perform and interpret mammograms done in-house and on a contract or sharing agreement basis.

The special nature of sexual trauma demands special consideration for those subjected to that type of violence. Therefore, we support extension of VA's authority to provide counseling through 1996. We are interested to hear VA's experience with this program, especially the size of the case load and the percentage of those seeking counseling for service-connected and non service-connected trauma. While we understand the reason for waiving adjudication of service-connection, it provides at least the appearance of inconsistency in the access to health benefits. It merely points out the crying need to radically reform the adjudication process so that veterans need not wait twelve months before being declared eligible for service-connected treatment.

We agree with the provision to require full time status for those who are designated women's coordinators. If a facility has sufficient patient base to warrant such a staff member, then its time to stop the hypocrisy and let them do the job. AMVETS suggests the Secretary provide a basic position description outlining the minimum duties and authorities for all those filling the position. We are also compelled to suggest that having the position filled with a dedicated, fully empowered full time employee is one way to help create the critical mass of patients necessary to quality care, and thereby help VA to compete locally and nationally.

The draft bill submitted by Congressman Smith is similar in intent with Senator Akaka's S 1226 in that it would expand the range of services at Vet Centers. While not opening up Vet

Centers to all veterans, the draft bill will make primary preventive treatment and screening available to those currently authorized access to Vet Centers. We ask the committee to open the Vet Centers to all veterans because there are still many of those who fought in WW II and Korea who still experience problems that could be helped by the services offered at the centers. We Vietnam veterans do not have a monopoly on PTSD.

AMVETS supports the bill because it will encourage VA to move towards a more grassroots structure in its delivery of health care. AMVETS feels strongly that there is a niche waiting to be occupied by VA in the areas that will probably be ignored by the private sector as not cost-effective. We feel VA must move towards a lesser reliance upon the traditional VA medical center approach to provide greater access to care. It will also make VA more competitive on a geographic basis. Basic marketing principles state that you must get your product in front of as many people as possible, and requiring your customers to drive hours for basic treatment will not help win the marketing wars about to begin.

The bill will also make basic health services available to some who may not otherwise seek treatment until more expensive inpatient treatment is required to correct their condition. It makes good medical sense to bring these veterans into the fold and this bill will help make that happen. We also like the fact that this bill is not another pilot program. The bill's objectives are valid, there is nothing new to study and it is time to just do it. We understand VA plans to move toward a more decentralized delivery model and this is a natural part of that process.

Finally, we lend our support to the bill to improve VA's rehabilitation of chronically mentally ill veterans. The provisions setting up nonprofit corporations should provide a flexible framework to improve the management of the work therapy programs. Since a major objective of the work therapy programs is the reintegration of veterans through the development of work and social skills, a "business" environment should help these veterans continue their adjustment, while being observed and guided through their transition. We fully support the oversight provisions and feel that inclusion of concerned local citizens as members of the board of directors will prove beneficial. We also fully support extending the transitional housing program through 1997 and expansion of the total number of transition homes.

Mr. Chairman, AMVETS would like to thank you and the committee once again for requesting our views on these bills, and we look forward to working with the committee in the future. That concludes our statement.

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

VETERANS HEALTH CARE DRAFT BILLS

SEPTEMBER 22, 1993

Mr. Chairman and Members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), it is an honor to participate in today's hearing. PVA appreciates this opportunity to present our views and concerns regarding the various pieces of legislation being examined. PVA will address the following draft bills: (1) A bill to provide priority health care to veterans who were exposed to agent orange or ionizing radiation; (2) A bill to extend and expand authority relating to health care services for women veterans; (3) A bill to authorize VA to expand the scope of services provided in Vet Centers; (4) A bill to improve the Department of Veterans Affairs' (VA) ability to provide continuity of care in the rehabilitation of chronically mentally ill veterans.

Veterans Exposed to Agent Orange or Ionizing Radiation

(a) This bill would codify the findings of the National Academy of Sciences (NAS) regarding the association between specific health problems and exposure to herbicides used in Vietnam. The bill would authorize treatment for Vietnam veterans for any diseases that the NAS has found (or subsequently finds) based on sufficient evidence, suggestive evidence, or insufficient evidence to permit a conclusion as to an association between occurrence of the disease in humans and exposure to a herbicide agent. The bill provides that the special authority relating to "Agent Orange" runs through September 30, 1996, to allow for reassessment in light of the next NAS report due in July 1995.

Mr. Chairman, as you know, the debate on Agent Orange has been a long ordeal for everyone. PVA has long contended that any new evidence or legislation concerning Agent Orange must be analyzed with exacting care by all of us in the veteran community. The efforts of many to establish a concrete link between exposure to Agent Orange and certain diseases have been met with extreme frustration. However, the recent release of the National Academy of Sciences (NAS) study, Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam, has revealed much needed epidemiological evidence on the association of certain health problems and Agent Orange.

PVA fully endorses this bill. PVA only supports authorizing treatment for those diseases which the NAS has found sufficient evidence to conclude that there is a positive association between occurrence of the disease in humans and exposure to a herbicide agent. Similarly, PVA endorses medical care for those diseases that the NAS also linked to exposure to herbicides based on suggestive and insufficient evidence. Although, the current epidemiological evidence is inclusive in regard to a positive occurrence of these diseases in humans and exposure to Agent Orange, it does suggest that more research and study is needed to establish or negate an association between those diseases and Agent Orange. However, in light of the NAS findings, PVA supports the bill's presumption of providing medical care to veterans diagnosed with diseases classified under suggestive and insufficient evidence.

(b) This bill would eliminate any sunset date for provision of care to veterans who may have been exposed to radiation. The bill would also provide special eligibility in the case of radiation exposed veterans for care of any diseases for which the Secretary determines there is credible evidence of a positive association between disease occurrence and radiation exposure or for which Congress has established presumptive service-connection. In the case of radiation and Agent Orange, the bill expands the scope of authorized care to mandate any needed outpatient treatment for covered illnesses and provides a higher priority to such treatment than assigned under existing law.

Based on the current literature regarding the effects of radiation exposure in human populations, PVA supports the bill's elimination of any sunset date for provision of care to veterans who may have been exposed to radiation. Moreover, PVA supports providing medical care to any radiation exposed veteran, based on credible evidence of a positive association between disease occurrence and radiation exposure.

While PVA supports this bill, we question the assigning of "priority" health care. As you know, PVA has advocated for eligibility reform for quite sometime now. The fundamental policy of eligibility reform is that once a veteran is determined eligible for VA health care that veteran should receive the full continuum of health care including inpatient, outpatient, noninstitutional, institutional and long term care. The current fractured and disjointed system of eligibility allows certain veterans access to medical services while setting up barriers to the full continuum of care for others. For example, the restrictions on outpatient care force VA providers to seek more expensive inpatient alternatives to avoid the ambulatory care eligibility roadblocks. Reforming VA's current eligibility rules would make prioritizing health care to veterans obsolete.

Health Care Services for Women Veterans

This bill would provide the following to women veterans: (1) provide eligible women veterans timely, appropriate gender-specific health care services; (2) health care services will be provided "in house" only if the VA facility serves a significant number of women veterans to make it cost-effective to do so; (3) require where routine gender-specific services are provided "in house" that the VA facility be adequately equipped to do so; (4) require that VA facilities do not perform mammograms unless they are accredited to do so by a nonprofit organization; (5) extend for one year VA's authority to provide counseling to women veterans associated with sexual trauma (without regard to adjudication of service-connection or income status); (6) repeal the requirement that a veteran must seek such counseling within two years after service; (7) regional women's coordinators serve on a full-time basis; (8) survey medical centers to identify deficiencies relating to the privacy of women patients.

PVA values legislation which advances the health care needs of women veterans. PVA fully endorses the VA's obligation to provide eligible women veterans timely, appropriate gender-specific health care services. In addition, PVA supports the bill's clarification that such services will be provided to women veterans directly from VA facilities. PVA believes that each VA facility should be adequately equipped to provide routine health care for women veterans. This is the only reasonable method in which VA can reasonably phase-in comprehensive gender-specific health care services to women veterans. PVA supports the bill's mammography provision in totality.

PVA favors the extension by one year VA's authority to provide counseling to women veterans who have experienced sexual trauma as a result of service in the Armed Services. PVA also supports the bill's authorization of full-time women veteran coordinators in VA's four regional offices. PVA notes, however, that pending reorganization of VA Administrative functions could alter the function of regional offices or eliminate them entirely. The Committee should amend the legislation to see that the services intended are provided in other ways at the field supervisory level. PVA is confident that this measure will expand dialogue between the VA and women veterans, and encourage them to seek assistance as soon as possible. The provisions outlined in this bill will make progressive inroads in counseling women veterans who suffered service-connected sexual trauma. For these reasons, PVA supports this bill.

Vet Centers Providing Certain Health Care Services

This bill would authorize VA to use Vet Centers as sites to furnish preventive health care services, pre-admission screening, and referral services to those eligible for readjustment counseling and medical services.

PVA emphatically supports this bill's utilization of Vet Centers for certain health care services. PVA has actively promoted the Vet Center approach for its future facility as an outpatient, community-based resource for all eligible veterans. This bill marks a significant step in the right direction.

The VA must reform its current byzantine eligibility criteria if it is to compete successfully within the context of a new national health care system. Eligibility rules must be constructed to offer the full continuum of care which includes inpatient, outpatient, preventive and long term care services for all eligible veterans. This can be accomplished efficiently provided VA realigns its service delivery models, shifting away from expensive inpatient treatment to more efficient outpatient care services. Such a shift will, in turn, require the system to expand its ambulatory capability at the medical center level as well as the community level to maximize patient access to these services.

Undeniably, as time passes, Vet Centers should experience a slackening of demand. As that happens, this valuable outpatient infrastructure, strategically located in 201 communities across the country, should not be a loss to VA for other needed services. Moreover, Vet centers should be given additional funding to support this additional activity. One of the reasons VA has been unable to expand its outpatient base is that annual appropriations have fallen short of the necessary level to support increasing outpatient demand. For these reasons, PVA supports this bill.

Continuity of Care in Rehabilitation of Chronically Mentally Ill Veterans

This bill would authorize VA to establish nonprofit corporations to arrange for therapeutic work for VA patients through compensated work programs. The bill extends the compensated work therapy and therapeutic transitional housing program. This legislation eliminates the restriction on VA's establishing more than 50 transitional therapeutic residences for veterans who are participating in compensated work therapy programs. Correspondingly, the bill permits the establishment of up to five new sites each year

through Fiscal Year 1997, total expenditures not to exceed $500 thousand in any Fiscal Year after 1994.

PVA supports the establishment of nonprofit corporations to provide therapeutic work for VA patients through compensated work programs. VA's compensated work programs have proven to be effective for veterans with psychiatric disabilities, neurological disabilities, or physical disabilities. This work-oriented approach to providing psycho-social rehabilitation offers veterans vital therapy at minimal cost. Therefore, the establishment of nonprofit corporations to provide therapeutic work for VA patients through compensated work programs greatly enhances veterans' access to these programs. This bill is an innovative approach for providing troubled veterans a "second chance" to regain their dignity and independence. For these reasons, PVA supports this legislation.

Mr. Chairman, that concludes my testimony. I will answer any questions you may have.

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Statement of

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Before the

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On Hospitals and Health Care

On

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Introduction

Mr. Chairman and members of the Subcommittee, Vietnam Veterans of America (VVA), is pleased to have the opportunity to present our views on the health care legislation being considered today. The seven bills before the Subcommittee represent timely intervention on the part of their sponsors to address several recurring problems with the VA health system, and give VA some legislative direction as to what its future role may be in the advent of national health care reform.

The VA's future role will depend upon its specialization in the problems which are distinct to veterans, such as the conditions and treatments addressed among others by these bills -- Agent Orange and radiation exposure conditions, PTSD treatment for veterans exposed to combat or sexual trauma, and rehabilitation programs for the chronically mentally ill. Each of these represent conditions for which it is often very difficult for veterans to obtain adequate non-VA care. Either private insurance will not cover service-connected conditions, or more often than not victims of these health conditions are not able to maintain employment and private health insurance.

In order to force VA preparation for national health care reform, Congress needs to encourage VA's manifestation of recognized specialty programs for those veteran populations the VA can most capably serve in the future. Extension and expansion of the VA authority to treat veterans exposed to Agent Orange or radiation is of utmost importance. In order to be even reasonably competitive with non-VA providers, VA will need to ensure that the growing population of women veterans receives adequate care either "in-house" or through contract or fee-for-service arrangements. Allowing Vet Centers to conduct preventive health care services and pre-admission screening is an excellent way to outreach many veterans who are not comfortable with the traditional VAMC setting, and may not currently be accessing health care services. And improving VA's capacity for rehabilitation programs for mentally ill veterans will dramatically improve the patients' quality of life, while at the same time reducing future VA compensation and health care dependence. Again, these bills emphasize VA's specialization in health problems that veterans face uniquely and to which there is not adequate treatment currently available.

We have addressed the legislation sequentially as follows.

H.R. 3081, Extend & Expand Agent Orange and Radiation Treatment
H.R. 2375, Extend Agent Orange Priority Treatment

While VVA supports the idea that VA should provide priority care for the diseases identified by the National Academy of Sciences (NAS) report as having evidence of an association between exposure and the veteran's contracting the disease, H.R. 3081 would in fact limit VA priority care to only the diseases cited. VVA was very encouraged by the initial NAS Report, and respects the unbiased format outline which listed diseases in the categories of compelling, limited-suggestive, insufficient or suggestive of no correlation between the disease and exposure, based upon the amount of empirical scientific evidence currently available. NAS did not conclude, as H.R. 3081 seems to suggest, that diseases not cited in the initial report are not service-related based upon herbicide exposure. NAS simply indicated that there is not enough evidence at the present time and encouraged further study. In addition, the eligibility restrictions proposed would be extremely unmanageable for those in the field tasked with implementation of the law.

These provisions of H.R. 3081, unfortunately represent an unacceptable effort to limit costs by limiting the numbers of veterans eligible for Agent Orange treatment to those cited in the first NAS Report. Current Title 38 language, as amended by P.L. 102-4, the Agent Orange Act of 1991, allows presumptive judgement of service-connection for any veteran seeking treatment for a condition related to herbicide exposure, who can prove service in the Vietnam theater and may have been exposed to dioxin or herbicides. While it is necessary to renew VA's authority to provide priority treatment for this class of veterans, as well as those exposed to ionizing radiation during World War II, it is undesirable to limit eligibility. We would recommend a simple authority extension, as proposed by Senator Daschle in S. 1094, and Representative Evans in H.R. 2375.

VVA does support the provisions of H.R. 3081 which authorize outpatient care for veterans exposed to environmental hazards, and also the language under Section 1(b)(E), which provides a permanent authorization for radiation-exposed veterans to receive priority care. The ideal legislation would incorporate these provisions, along with the aforementioned 10 year authority extension of H.R. 2375.

Even aside from ensuring that VA provides health care for victims of dioxin exposure, there is still more to be done on the Agent Orange issue. As we have indicated in the past, the service-connected health conditions of many of these veterans, whether adjudicated as such or not, have greatly diminished their quality of life, and have broken them financially because treatment has been so costly. Many are unable to work to support themselves, their families or to pay their medical bills. This bill will provide victims with health care services, but does nothing to ensure that compensation is provided to affected veterans or their families upon the veteran's death.

It should also be noted that men are not the only victims of Agent Orange-related health problems. It is apparent that women who served in Vietnam have a higher rate of reproductive cancers, miscarriages, stillbirths, and children with birth-defects. There has been no conclusive study of these gender-specific problems and, as the NAS review recommended, more independent study should be conducted on the effects of dioxin exposure to determine conclusively if the diseases categorized as "suggestive evidence", or "insufficient evidence" can be linked to dioxin. We have made recommendations that research be done in Vietnam, as it is the ideal laboratory. VVA suggests that the Subcommittee consider supporting further independent study, as recommended by the National Academy of Sciences.

H.R. 3082, Women Veterans Health Improvements Act of 1993
H.R. 2797, Veteran Women's Health Improvement Act of 1993
H.R. 2285, Sexual Trauma Counseling for Veterans

As each of these bills contain similar provisions, we will address them by issue.

Health Care Services for Women

As VVA and many other veterans advocates have cited, the VA has never and is certainly not currently receiving favorable reviews from women veterans who utilize VA health care. These women have serious concerns with the quality of care they receive, the availability of gender-appropriate equipment and services, and with patient privacy needs. Though many improvements have been made in the last decade due largely to the oversight responsibilities Congress has undertaken, VVA still notes continuing stories from horrified women veterans who vow never to return to the VA.

Because so few women veterans currently use the system, conclusive data does not exist regarding the specific health problems afflicting women veterans as distinct from the general population. We do know that current services are inadequate in many VA facilities, and unless system-wide improvements are made immediately, VA will never be able to accommodate the growth in the women veteran population as more women enter and leave the military. These are women who have served this nation and sacrificed, as we noted in the discussion of Agent Orange illnesses, in ways that have caused illness and disability similar to that of male veterans.

Many things can and need to be done to improve VA's service to women veterans. While some would argue that provision of the full range of gynecological care at VA hospitals would give women veterans preferential treatment, we disagree. VVA supports the language of Section 2(a) in Representative Schroeder's bill H.R. 2797, which details the gender-specific services the VA should provide to women veterans. Those opposed to providing this care ignore the fact that treatment is provided for similar gender-specific conditions of male veterans on a discretionary basis.

Non-service connected, low-income women veterans should have an equal right to access discretionary care where resources are available. In addition, with passage of eligibility reform, we are hopeful that VA will provide the full continuum of care to male and female veterans. That capability needs to be established now, in order that VA will be able to attract women

veterans in the advent of national health reform.

VVA also favors the language in Section 2 of Chairman Rowland's bill, which requires the Secretary to ensure that provision for women's health care services are made either within VA facilities, or through contract or other agreements, however we do not favor limiting the services provided to current law, as cited previously, and would prefer incorporating Representative Schroeder's language on this point. In addition, we are concerned as to who and how it will be determined under Subsection 2(b) of H.R. 3082, when the number of women veterans in a catchment area is "sufficient to make it cost effective to provide such services" within the VA. We recommend that this be clarified.

Sexual Trauma Counseling

While last year's Veterans Health Care Act of 1992 authorized counseling services for victims of sexual assaults and trauma associated with their military service, limitations to these services were quickly identified by those within the VA tasked with implementing the program. The introduction of S. 1030 by Senator Rockefeller and the companion H.R. 2285 introduced by Congresswoman Schroeder to improve the sexual trauma counseling for veterans and to improve the Women Veterans Coordinator positions within the VA are pragmatic and humane proposals which strengthen both programs and further affirm the intentions of Congress that America's veterans will receive the care they need.

By broadening the language to the inclusive "veteran" rather than suggesting that sexual trauma is only experienced by women, these bills allow for compassionate and sensitive treatment for any veteran -- man or woman -- who experiences these extremely violent and personal assaults. Lifting the time requirement on when a veteran can seek assistance from the VA, and extending the time constraints for care, are in keeping with accepted therapeutic approaches to treatment. The aftermath of sexual trauma does not conform to any legally imposed time schedule, nor does therapy for victims follow a specific trajectory or time limit. Because Congress has taken the initial steps to investigate and provide treatment for the casualties of sexual trauma, support for S. 1030 and H.R. 2285 will provide realistic expectations for outreach, treatment and assessment of the needs of this program.

While provisions of H.R. 3082 do remove the limitations requiring a veteran to seek counseling within two years following discharge, it maintains the restrictions as to length of care. For this reason, VVA supports the language of H.R. 2285.

Women Veterans Coordinators

Equally important are the provisions in the legislation for funding and support for the Women Veterans Coordinators program. Since 1982, VVA has expressed concern for the status of this vital service to women veterans. We still hear that there are problems with the present system of assigning this important responsibility as an additional duty. Many Women Veterans Coordinators have to stretch the limits of their time to attempt to provide adequate outreach and education programs. Particularly disturbing were their reports of trying to obtain even the most basic feminine hygienic supplies for hospitalized women veterans.

There was the distinct impression that these Coordinators exist with little to no clout or access to administrators to solve the identified problems and needs specific of women veterans The appointment of Women Veteran Coordinators with little or no time allocated for this responsibility is a cruel hoax, both to those assigned the duty, and to those they are assigned to serve. The efforts of these Coordinators reflect individual accomplishments rather than a system-wide level of service or commitment.

We believe that any serious efforts to apprise women of their rights as veterans will only come when there is a more structured approach. VVA continues to advocate for half or full time Women Veterans Coordinators in each Regional Office for a period not to exceed two years, to conduct more formalized outreach and educational initiatives. We believe that this pending legislation is an important step in providing a more formalized network which will ultimately better serve women veterans now and in the future.

On this issue, VVA prefers the language of Representative Schroeder's bill, because it

represents a stronger commitment of funding and resources. In addition, H.R. 2285 provides Regional Women Veteran Coordinators with the authority to communicate directly to the Under Secretary for Health and the Secretary.

Research on Women Veterans

Section 3 of Representative Schroeder's legislation, dealing with research on women veterans health conditions, a population study of women veterans and the inclusion of women veterans in VA general clinical research would truly improve the current law as passed in P.L. 102-585, the Veterans Health Care Act of 1992. VA Research is touted as one of the strongest assets of the system. VA could and should be a leader in research on women's health as well. The Subcommittee should seriously consider including these provisions in the bill it reports to the full Committee.

Patient Privacy

Patient privacy concerns have long been a sore point for women veterans, and the proposed language of Section 6, in H.R. 3082, will finally address this issue in a meaningful way. We have testified time and again that VA is still not capable of providing effective care to women veterans, because there are no private rest room and bathing facilities for women, nor even space to allow gender specific patient rooms in the physical make-up of many VA facilities. Again, as more and more women enter and exit the military, the VA will need to accommodate their needs, particularly if it intends to compete within a national health environment.

These provisions would require the VA not only to report to the House and Senate about deficiencies in this area, these considerations would have priority within the construction planning processes. We are pleased to endorse the provisions within Section 6, of Chairman Rowland's bill.

Mammography Standards

While we do not profess to be experts on the Public Health Service Act, nor current mammography technology, it does seem that H.R. 2797 would impose stricter quality standards on the VA, than would H.R. 3082. VVA's position on this issue as well as care of women veterans in general, is that the VA should be subject to the same quality and inspection standards as are private or public hospitals.

H.R. 3082 would apply to VA facilities only portions of the law currently covering non-VA hospitals. It is our view that requiring less stringent standards of the VA does not serve its self-preservation interests as VA will begin to compete for veteran patients under some form of national health reform. And more importantly, applying lower quality standards puts veterans in second-class citizen status, as those who use the system receive substandard care.

Draft Bill to Expand Services Provided in Vet Centers

Again, while we agree wholeheartedly with the intent of this legislation to meet the needs of veterans by making very basic clinical health care services available at Vet Centers, this bill as written does little to ensure that these changes will take place. VVA has endorsed S. 1226, legislation sponsored by Senator Daniel Akaka to expand Vet Center eligibility, and to establish a pilot project to evaluate the effectiveness of co-locating VA outpatient health clinics with Vet Centers. The Akaka bill sets goals and timetables for VA to complete these objectives. The draft bill before this Committee does not, and therefore is unlikely to effectively accomplish its objectives unless a specific appropriation is allocated.

S. 1226 recognizes the research already done on the issue of PTSD and embraces improvements in access to service and modalities of treatment. We have seen that many veterans afflicted with PTSD do not trust bureaucratic agencies of government, and therefore do not seek general health care services at the VA. This is especially troublesome because these veterans are often uninsured and cannot obtain health care elsewhere. Co-location of medical personnel with Vet Centers could greatly enhance veterans access to health services.

To meet ever increasing demand for PTSD mental health services in the community, VVA endorses an expansion of the existing Vet Centers program. Post Traumatic Stress Disorder is

perhaps the most common major contributor to chronic mental illness among veterans of any generation. According to the highly respected National Vietnam Veterans Readjustment Study (NVVRS), published in 1988 by the Research Triangle Institute, approximately 30 percent (830,000) of the veterans who served in Vietnam suffer significantly from PTSD, and nearly half a million men and women suffer from full-blown PTSD.

Although actual numbers vary by study and source, it is blatantly apparent that the VA is treating only about 10% of those veterans thus affected by their military service. We endorse legislation being proposed by Senator Paul Wellstone (D-Minn.) and Representative Lane Evans (D-Ill.), which is an updated version of the legislation introduced in the 101st and 102nd Congresses by former Representative Jim Jontz (D-Ind.). The proposed legislation would increase access for all war-time veterans to appropriate care within the VA by expanding and improving current specialized PTSD treatment units, and by providing additional research into modalities of treatment. Furthermore, this bill would encourage health professional specialization in PTSD under the VA Health Professionals Scholarship Program and allow VA provision of counseling services to veterans' families through the Vet Center program.

The legislation we advocate would phase in an expansion of the store-front "Vet Center" program by 40 "Vet Centers" over the course of four years; there are currently 202 sites. Authorization should also be included to provide for 76 additional staff at the currently existing Vet Centers, to meet the demand for service more adequately. Inpatient PTSD units operated by the VA, of which there are only 20 system-wide at present, would be increased in number by 30 such units over the same period. In addition to this, so as to assure proper treatment of PTSD in VA facilities lacking inpatient PTSD units or nearby "Vet Centers", the number of PTSD clinical teams (PCTs) would be increased by 50 over four years; there are currently 57 PCTs.

In addition to the increase in Specialized Inpatient PTSD Units (SIPUs) by 30 units over the next four years, the bill should provide authorization for an additional number of the smaller inpatient units that VA has designed to provide care for those awaiting openings in SIPUs (Evaluation and Brief Treatment Units; currently, there are 8-9 units) and post-SIPU adjustment (Residential Rehabilitation program; currently there are 10 units). The number of these units should be tripled with incremental steps stipulated over the same four year period.

Draft Bill Regarding Rehabilitation Programs for Mentally Ill

VVA supports this bill which would improve VA's capacity to provide a continuum of care for chronically mentally ill veterans, allowing VA to establish nonprofit corporations for the purposes of operating compensated therapeutic work programs. Existing work programs seem to be successful, and this legislation will encourage cooperation and coordinated funding between the Department of Veterans Affairs and outside entities. In addition, the expansion of the numbers of transitional therapeutic residences will allow VA to accommodate more demand for these rehabilitative services.

Upon initial reading of this legislation, we were concerned with the wide authority granted to the Secretary to establish these nonprofit corporations, but closer review indicates a well crafted bill with several protections to prevent the conflicts of interest VVA originally feared. In particular, we note the explicit oversight authority of the Inspector General, the Comptroller General and Federal laws and regulations regarding conflicts of interest. We are pleased to endorse this legislation.

Thank you, Mr. Chairman. This concludes our written statement.

WRITTEN STATEMENT

OF THE

BLINDED VETERANS' ASSOCIATION

PRESENTED TO

THE HOUSE VETERANS' AFFAIRS

SUBCOMMITTEE ON HOSPITAL AND HEALTH CARE

BY

THOMAS H. MILLER

SEPTEMBER 22, 1993

Mr. Chairman, and members of the Subcommittee, on behalf of the Blinded Veterans' Association (BVA), I want to express our appreciation for the invitation to participate in the hearing scheduled on 9-22-93 to consider several draft bills to improve VA health care delivery. Unfortunately, we will not be able to appear at the hearing but are grateful for the opportunity to present our views on these draft bills in this statement submitted for the hearing record. While BVA is always eager to have such opportunities, traditionally, we have limited our participation to those hearings or legislation which we believe we have some special interest in or expertise to offer. Clearly, the majority of the legislation under consideration in these draft bills does not apply directly to the majority of our membership, we do recognize the need for improvement in service delivery in the VA programs encompassed by these bills. All of the programs addressed in the proposed legislation should and must be available to blinded veterans across this nation and can provide extremely important benefits to any veteran in need of these services.

Generally, Mr Chairman BVA supports all four of these draft bills both in concept and content. Each bill confronts high visibility programs and services which are in need of improvement if VA is truly going to be competitive in the proposed managed competition approach to the delivery of health care services to our nations veterans. VA is uniquely qualified to provide the services mentioned in these bills except for women but VA must become qualified quickly if VA is to be competitive.

AGENT ORANGE

Without question, BVA endorses this legislation to extend the authority to VA to provide treatment to veterans exposed to Agent Orange or other herbicides used in Southeast Asia. We agree this authority should include all the diseases identified in the National Academy of Sciences (NAS) study of the health affects of exposure to Agent Orange. Any disease that was found to have even the slightest association to exposure to Agent Orange must be included in this authority and indeed, possibly no disease should be arbitrarily excluded at this point. NAS made very specific recommendations regarding the need for additional research in this area and especially in light of the long latency periods indicated in some cancers. Vietnam veterans should have every opportunity to receive treatment for such health effects and maximum effort must be made to further develop the Agent Orange Registry both in terms of numbers of subjects as well as the variety of diseases reported. Additionally, we support expanding the authorized treatment to include outpatient services. Certainly outpatient delivery is more consistent with preferred practices of medicine both from a preventive standpoint as well as cost effective. This authority is also more consistent with the managed care model of delivery as embraced in the proposed National Health Care Plan. Similarly, we support eliminating sunset dates for Radiation exposure and providing similar outpatient authority.

WOMEN'S HEALTH CARE SERVICES

BVA is pleased Mr. Chairman to endorse adoption of this draft legislation. We believe this bill contains several provisions vital to the delivery of quality health care services for our nations female veterans that have long been overdue. We concur that VA authority must be extended as well as expanded if VA is to have a realistic opportunity to compete in the new health care delivery environment. The provision which limits the expansion of services to those VA medical facilities serving areas with sufficient numbers of women veterans to make provision of gender specific services in house cost effective. All to often in the past new programs have been imposed on the VA with the best of intentions but without sufficient funding to ensure successful implementation. Consequently, either the new program is destined to fail or necessary funds are taken away from other programs already in place reducing their effectiveness. Again if VA is to be competitive in the new health care environment, comprehensive timely appropriate gender specific services must be available for our women veterans.

BVA feels increased availability of and access to such health care services will assist in identifying blinded female veterans previously unknown to VA simply because they have not sought care from VA believing services were not available or they had no eligibility. Often when women vets do come to VA they are referred out on contract for care and consequently are not picked up by non gender specific programs like those services VA offers for blinded vets. Extending and expanding authority therefore could have the additional benefit of assisting VA in identifying those female vets who have needs for special disability programs such as Blind Rehabilitation and other rehabilitative services which VA is uniquely qualified to provide.

Mr. Chairman, recent figures released by VA regarding the incidence of blindness in the U.S. based on 1990 census data indicate nearly 100,00 blinded veterans. With the increasing numbers of women serving in the military and the downsizing of our military forces, we believe there will be significant numbers of women veterans who will be experiencing severe visual impairment and blindness and in desperate need of the services provided by the VA. We understand the Rehabilitation Research and Development Center at VAMC Atlanta is exploring the possibility of doing research in the area of women veterans, a direction we fully support based on reasons sighted above. The provision to extend the authority to provide counseling for women veterans who have experienced sexual trauma is commendable. If our experiences with PTSD have taught us anything, we have learned that response to trauma whatever kind varies with the individual and does not confine itself to easy timetables or motivation for counseling. Women vets having such experiences must not be restricted unreasonably to arbitrary time frames for seeking help when indeed the resulting problems may not surface within the prescribed time frame. Access to such counseling will afford the women veterans greater access to health care services provided by VA.

BVA feels very strongly about the issue of regional women coordinators. It is absolutely essential these positions be full time if the program is to succeed. Our experience with the Visual Impairment Service Team Coordinator position has taught us much regarding this type of position. At the inception of the VIST program the coordinator was part time and it quickly became apparent that full time was necessary if just basic responsibilities of the position were to be met. We agree fully, the position of Regional Womens Coordinator must be full time and empowered to carry out the responsibilities of the position and the program. Surely anything less will only result in an ineffective program.

VET CENTERS

The bill to expand the scope of services offered at Vet Centers also make good sense to BVA. Having the authority to provide preventative services, preadmission services, as well as referral services for eligible veterans fits appropriately into the managed care concept of delivery.

REHABILITATION OF CMI VETERANS

Mr. Chairman, BVA also supports passage of the final draft bill that would improve the VA's ability to provide continuity of care in the rehabilitation of Chronically Mentally Ill (CMI) veterans. First BVA recognizes the value of the VA Compensated Work Therapy Program and how beneficial this program has been in the rehabilitation of CMI vets as well as other disabled veterans. In fact Mr. Chairman, while the chief of the Blind Rehabilitation Clinic at VAMC Waco Tx., I had an opportunity to utilize this program in conjunction with our blind rehab program for blinded vets enrolled in the blind rehab clinic. It was extremely effective in assisting blinded vets in improving and developing work skills but more importantly enhancing their self esteem and self worth by being productive.

We support giving VA the authority to establish nonprofit corporations, to arrange for therapeutic work for CMI patients and the opportunities such corporations would provide for VA to possibly secure additional funds to enhance this important program. When first hearing of this proposal however, we did have some concern regarding the extent of this authority. Two existing federal programs with special priorities feared new competition and a threat to their programs. We are speaking of the National Industries for the Blind (NIB) and National Industries for Severely Handicapped (NISH). After reviewing the draft bill, it does not appear that the VA nonprofit corporations will have any special priorities that would threaten NIB or NISH. Further the draft bill seems to have built in a number of provisions providing adequate management and oversight of the program.

Finally, Mr. Chairman, I would like to thank you and the Subcommittee for this opportunity to submit our views for the record. We commend you for conducting this hearing and introducing these important pieces of legislation. As always we are prepared to answer any questions you might have.

Testimony of the American College of Radiology
to
Subcommittee on Hospitals and Health Care
House Veterans' Affairs Committee
by
Karl K. Wallace, Jr., M.D.
Chairman, ACR Board of Chancellors
September 22, 1993

Thank you, Mr. Chairman.

The American College of Radiology is pleased to make comments on legislation to extend mammography quality standards to patients served by the Veterans Administration.

The draft legislation before this committee has been shared with us for our review. We believe that it is critical to adopt legislation that is consistent with the Mammography Quality Standards Act of 1992 and we are uncertain that the draft legislation will achieve this goal. To eliminate any confusion, we believe the language in the Schroeder Bill which was co-sponsored by several members of the Committee would provide that all patients will have mammograms provided in a manner consistent with the standards adopted by Congress last year. ACR was pleased to support the provisions for quality mammography contained in the Mammography Quality Standards Act of 1992. We support national standards for mammography. While we can recommend quality standards to our members and others, many will choose not to comply voluntarily. We agree that women should not be uncertain about the quality of the mammograms they receive. We also believe that standards should apply to all patients including those whose mammography is provided by or through the Veterans Administration Programs.

Currently there is no comprehensive oversight of mammography quality, there is a patchwork of law and programs. Mammography is being performed not just by qualified physicians, but also by a variety of other physicians, often with unqualified personnel acquiring images with little or no medical physics support and with equipment that is improperly used and inadequately maintained.

To this end, we believe that any legislation should provide for quality standards like those of the American College of Radiology. No standards should be allowed that are less than those that have been developed for the ACR Mammography Accreditation Program.

We hope that legislation can be written in a way to encourage the continuation of the progress made to date in enhancing quality in mammography nationwide. In addition to the voluntary efforts of physicians to improve quality, there has been significant pressure to improve quality from the public and from third party payors. We should build on this pressure to achieve our mutual goals.

The ACR has worked for several years with members of Congress to achieve coverage of quality mammography under the Medicare Program and we appreciate your efforts. Fortunately, the number of members interested in these important issues has grown substantially. We appreciate that the important issue of quality mammography has been brought to the attention of the Congress and the Nation.

The ACR looks forward to working with the Congress to address the issue of providing the highest possible quality mammography for all American women.

Submitted by: K. K. Wallace, M.D.
Chairman of the Board of Chancellors
American College of Radiology

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October 1, 1993

The Honorable J. Roy Rowland
United States Congress
2134 Rayburn House Office Building
Washington, DC 20515

Dear Dr. Rowland:

The American College of Radiology would like to thank you for your efforts and that of the sub-committee to clarify proposed legislation regarding quality standards and their applicability to mammography provided by the Veterans Administration. The ACR's major concern has been to assure that there is a national standard for mammography and that various programs operated by the Federal government have consistent requirements for the provision of mammography in the United States. We have reviewed the latest sub-committee draft which addresses some of our preliminary concerns over consistency and we believe that the latest draft meets those concerns.

Please accept our thanks for the work you have done on this issue. If we can be of further assistance please feel free to call on us.

Sincerely,

K. K. Wallace, Jr.

K.K. Wallace, Jr., M.D.
Chairman, ACR Board of Chancellors

KKW/pgm

cc: Representative Joe Kennedy
Representative Lane Evans
Representative Pat Schroeder
Ralph Ibsen

TESTIMONY CONCERNING HEALTH CONCERNS OF WOMEN VETERANS

HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

SEPTEMBER 22, 1993

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MR. CHAIRMAN, Members of the Committee: Thank you for inviting the National Women Veterans Conference (NWVC) to submit testimony on the subject of women veterans' health care in the VA medical system. The NWVC has requested me to speak for them. I am a Colorado attorney, who has worked with male and female veterans, regarding health care issues, for approximately fifteen years. I am a board member of WANDAS FUND, which also supports women veterans and endorses this testimony. The basis for my testimony on this subject is a review of the August 9, 1993 draft of Representative Rowland's bill, knowledge and experience gained through my law practice, information provided to me by women

12 veterans, veterans service officers, and documentation provided by
13 the National Women Veterans Conference. The plight of women in
14 the VA system is abysmal; and it is far worse than that of men.
15 Fundamental democratic principles are violated; and equal
16 protection of the law is denied by the VA medical system's current
17 handling of women veterans health care.

18 When a woman veteran seeks VA medical care, she finds that
19 negative attitudes and practices toward women, which she
20 encountered in the military have been carried over into the VA
21 system. [1] Often she literally, and figuratively speaking, cannot
22 get inside the door to obtain the care she needs and is entitled
23 to by law. Women currently report that they are still being met
24 with disbelief that they are veterans. They are required by VA
25 personnel to show papers proving their veterans' status, while men
26 who tell the same personnel that they are veterans are taken at
27 their word, no further proof required.

28 In the military, under the Feres doctrine, someone on active
29 duty has no right to compensation for injuries they receive, except
30 through service connection of their disability and military and
31 veterans pensions.[2] However, veteran's laws, including
32 Representative Rowland's bill, still do not treat women equally.

33 Over the years, sexual assault and harrassment have been a

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34 [1] The VA employs many veterans, most of whom are male. 1980 and 1987 U.S. Merit Systems Protection Board
35 (MSPB) studies indicate that the VA has the second highest incidence of workplace sexual harassment of 24
36 government agencies surveyed.

37 [2] United States v. Brown, 348 U.S. 110, 175 S.Ct. 141,99 L.Ed. 139 (1954); Brooks v. U.S., 337 U.S.
38 49, 69 S.Ct. 918, 93 L.Ed. 1200 (1949) and Feres v. U.S., 340 U.S. 135, 71 S.Ct. 153, 95 L.Ed. 152 (1950) are
39 the cases which deny a private right of action to active duty military personnel, based upon the need to
40 maintain military discipline; and based upon the belief that the claimant, who is already entitled to veterans
41 benefits and pensions would receive a double recovery. In actual practice this rule of law leaves the veteran
42 with no recovery at all, when the VA system does not provide what is needed.

43 risk of military service. As long as this shameful circumstance
44 exists, the VA medical system must be prepared to provide care and
45 treatment for women veterans who are victims of sexual assault.
46 Mandatory sensitivity training for VA staff must be a part of
47 women veterans healthcare. Progress for women has been too slow.
48 Since 1982 when the lack of care for women veterans was recognized
49 and all VA facilities were ordered to appoint Women Veterans
50 Service Coordinators, these positions have been inadequately
51 funded.[3] The Rowland bill is still attempting to fund these
52 positions.
53 The following comments are directed to Representative
54 Rowland's bill by page and line number:
55 MAMMOGRAMS: The mammogram program is not mandatory. If a
56 facility does not already have one, they could avoid this entire
57 provision. Funding for the program, which is also still
58 discretionary, does not appear to be in place. This means that
59 like other programs in the past it will be partly done, or not done
60 at all, with the excuse being, lack of funds.
61 The "reporting" requirement refers to plans only. Could it
62 require the Secretary to also report identified deficits which have
63 been remedied, along with "plans" to remedy?
64 PAGE TWO: Lines 1-13 "ensuring that they are able to
65 provide." It should simply state that they "shall provide", making
66 the requirement mandatory.
67 PAGE THREE: Line 2: "May not be performed. . ." If it is

68 [3] P.L. 98-160, November 1983, establishing Women Veterans Coordinators; in response to a 1982 GAO report
69 documenting deficiencies in women veterans care.

70 not mandatory to provide them in the first place, this phrase can
71 be interpreted to give the facility discretion not to do mammograms
72 at all, rather than obtaining and certifying the needed equipment.
73 Line 23: Standards and inspection do not have an enforcement
74 provision. What happens if they are not in compliance? Arguably
75 they could just stop the program and be in compliance.
76 SEXUAL TRAUMA, p. 5.
77 Line 1: The cutoff date is arbitrary. No cutoff date with
78 a determination of whether or not the trauma occurred in the
79 military would be more reasonable. Flexibility for proof of sexual
80 trauma in the military analogous to the presumptions extended to
81 Viet Nam era PTSD vets is needed. There should be:

82 - Continued care, with no arbitrary cutoff, such as two years
83 after discharge.

84 - Initial access to care based on occurrence of trauma in the
85 military, not without any arbitrary time limit.

86 - There should be no burden of proof required of women which
87 is greater than that required of men vets with PTSD after Viet
88 Nam. Delayed memory of sexual trauma is now more accepted
89 than in the past. Colorado recently amended its statute of
90 limitations for victims with delayed memory, as have other
91 states.

92 - There must be an 800 number for this.

93 WOMEN VETERANS SERVICE COORDINATOR, p. 5.: Line 13. Full time
94 status: It would protect the person appointed to require that this
95 be her only job. In the past, many women had this added to other
96 unrelated duties. Where possible this person should be a woman
97 veteran, and she should be accessible and visible to other women
98 who will use VA services.
99 PAGE SIX: LINE 2: "to the extent practicable, have equal
100 access to veterans facilities." This qualifier relieves the VA of

101 the duty to provide the same services to women as to men. If men
102 go for care that cannot be provided, they are referred elsewhere
103 and so should women. So long as they only get access, "to the
104 extent practicable", women will not get beds in these facilities.
105 It is recommended that this be worded as follows:

106 . . .ensuring that women veterans shall have equal
107 access to Veterans Administration facilities and to
108 medical care through the Veterans Administration.

109 LINE 6 Patient privacy. It is likely that privacy would be
110 effectively improved if the Secretary were required to report
111 corrections implemented to correct the deficiencies, as well as
112 "plans". A requirement that there be appropriate hospital beds and
113 clinic facilities for the number of women veterans in the area
114 served by the facility would do a LOT for privacy. Also a
115 requirement that the VA spend money on gender specific examining
116 materials and equipment for women would help.
117 ITEMS MISSING:
118 There should be geriatric care for women. There must be money
119 available to the women's coordinators so that they arrange for
120 needed care for the women with whom they work. It is necessary to
121 equate women's problems with other major illnesses studied and
122 treated and to equate a percentage of beds, dollars, and equipment
123 to the percentage of female vets in the area.
124 There must be medical research, especially for cancer in women
125 vets. They are an identified population with a higher incidence
126 of female cancers, for unexplained or inadequately explained
127 reasons. So far as I know there has been little serious research
128 done on women vets medical problems. Our entire population would

benefit from this. Women vets are a defined sample already there to be studied.[4],[5]

Reproductive care for women vets must be mandatory. It is not in the Rowland bill.

A mandatory provision for fee based medical care in the private community when the facility cannot provide the needed care is lacking. Without this, the money available will always go to the men first, leaving women uphill battles to get approval for their fee based care. A mandatory requirement that sexual trauma victims have qualified counsellors seems redundant; but I have often heard that in this area the counsellors are not qualified.

Current facts indicate that new legislation should provide equal quality of care to men and women suffering from mental and emotional illnesses arising out of military service. Male veterans have traditionally been cared for when they suffered "battle fatigue"[6], post traumatic stress disorder and dependency problems. The VA has routinely treated problems related to the male reproductive system; but has structured its care programs as if the female reproductive system does not exist! For example, Denver's VA has a urology staff member on its roster, but no one for gynecology. Men routinely receive prostate care, vasectomies and full exams; while gynecology services are available only 1/2 day

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[4] April 14, 1993, report on Health Care Services and Research Relating to Women Veterans to the House of Representatives Committee on Veterans' Affairs as required by P. L. 102-585.

[5] Cancer statistics, 1982 GAO/HRD-82-98, Actions Needed to Insure that Female Veterans Have Equal Access to VA Benefits, September 24, 1982, among others.

[6] A term commonly used to describe emotional problems suffered by veterans after the first and second World Wars.

157 per week and analogous procedures for women are often only
158 obtained after board review.[7] [8] One female, service connected
159 veteran who needed a hysterectomy, had letters recommending and
160 prescribing the procedure from her VA physicians and from other
161 physicians, but still required the assistance of an attorney; and
162 had to go through a medical board review process to have the
163 medically indicated procedure performed. At the same time, in the
164 same facility, her male counterparts received vasectomies as
165 routine care.

166 Women patients, who are military rape victims commonly report
167 that they feel unsafe in VA hospitals, which make no allowances for
168 gender differences; and require them to be hospitalized on
169 predominantly male wards.[9] They often report that there are no
170 pajamas for them, or only pajamas which do not fit; but they are
171 not allowed to wear other clothing.[10] One woman decompensated
172 severely when told that she would be required to wear pajamas on
173 a locked psychiatric ward. Another reported being required to wear
174 pajamas too small for her, which left her breasts exposed, when

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175 [7] It should be remembered that the VA hospitals around the country are adjuncts to medical schools
176 and are often staffed by physicians in training; and researchers. Little or no research is being done on women
177 veterans who are believed to suffer from cancer of their reproductive organs at twice the rate of female
178 civilians.

179 [8] The Denver VAMC, for example, has a urology service with twelve staff urologists who are board
180 certified and 3 resident slots. As of January 1, 1993, the ob/gyn clinic is only open 2 days per month. 3
101 ob/gyn physicians from the University of Colorado visit the clinic on a rotating basis. The pap smear clinic
182 is conducted by a nurse practitioner; and women report that nurse practitioners, not doctors, examine them.
183 No data is believed to be kept on numbers of women seen, procedures performed, etc.

184 [9] The Menlo Park, California facility for women veterans, including those suffering from PTSD after
185 serving in Viet Nam, was only opened within the last five years, although similar services for male Viet Nam
186 combat veterans have been provided for many years.

187 [10] Women referred to in this statement are not named. Complaints frequently are not seen as information
188 which gives opportunity for corrections and improvement. Instead, over the years, I have witnessed retaliation
189 toward those who complain in the form of cutting off of benefits, ridicule and hostility.

190 hospitalized on a predominantly male psychiatric ward. Another
191 woman complained of fear for her safety when hospitalized in
192 psychiatric wards; and received little or no reassurance from the
193 staff. She discharged herself and went without care, in order to
194 feel safe.

195 The lack of courtesy, privacy and common sense is appalling.
196 When women do receive care; they report crudeness and
197 insensitivity: pelvic exams performed in rooms where their feet
198 are positioned facing a door, which can be opened at any time; no
199 pajamas, or ill fitting pajamas, or gowns, designed for men;
200 uncertified mammography machines and examiners who comment that
201 they have never performed the exam in question on anyone with
202 breasts before. There is an ignorant, snickering attitude that
203 gynecology relates to the sexual act.

204 In summation, the changes listed below have been requested
205 many times in the past; but they are still desperately needed:

206 --Funding needs to be appropriated for programs in place;

207 --WWII women veterans need to be included in geriatric care;

208 --VA personnel should have mandatory sensitivity training;

209 --Fee basis services, including mental health services should
210 be available where there is no care; or only irregular care;

211 --Medical and Administrative Directors should be accountable
212 for implementing mandatory women veterans programs;

213 --Women Veterans Coordinator positions should be funded and
214 staffed by women veterans with authority and access to the
215 VAMC Director and Central Office.

216 --An Assistant Secretary for Women Veterans Issues should
217 be appointed; and women veterans should have an 800 line
218 dedicated to fielding complaints and providing referrals.

219 Medical research for women, including cancer research should
220 be required, and given the same emphasis and funding as

221 predominantly male programs.

222 Board certified physicians should see, or supervise physicians
223 on site, who see patients; and nurse practitioners should
224 not be used instead of doctors.

225 The time restrictions and proof requirements for
226 application for psychological treatment for sexual trauma
227 should be removed; and funding for appropriate treatment
228 and fee based treatment should be appropriated. (P.L.
229 102-585).

230 Thank you for extending me the opportunity to participate in

231 this important discussion.

Society for the Advancement of
WOMEN'S HEALTH RESEARCH

STATEMENT OF

PHYLLIS GREENBERGER

EXECUTIVE DIRECTOR

SOCIETY FOR THE ADVANCEMENT OF WOMEN'S HEALTH RESEARCH

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS' AFFAIRS

SEPTEMBER 22, 1993

Mr. Chairman and Members of the Subcommittee:

Thank you for allowing me the opportunity to testify today regarding H.R. 3082, the "Women Veterans Health Improvements Act of 1993." I would like to commend your commitment in seeking to improve the health care services afforded to our nation's 1.2 million women veterans.

The Society for the Advancement of Women's Health Research is the only national advocacy organization dedicated solely to the improvement of women's health through research. Founded in 1990, the Society brought to national attention the problem of the exclusion of women from major clinical research trials, and the need for greater federal funding for diseases and conditions prevalent in, and unique, to women. The lack of research has resulted in tremendous physical, emotional, and financial costs as the result of substandard treatment and diagnoses.

Women veterans have faced a particularly unresponsive health care system. A nationwide inspection of the availability of treatment facilities and programs for women veterans conducted by the Inspector General (IG), of which this subcommittee is familiar, documented a health care system which fails to provide women with routine gynecological care, privacy in VA hospitals, and inadequate and often unavailable gender specific equipment, such as mammographies. In addition, the VA failed to inform women of the availability of services that are offered to them.

While I am pleased that H.R. 3082 attempts to address many of the problems outlined in the IG report, I am concerned that it fails to address the critical need for research to identify the health care needs of women veterans. The health of these women will continue to be compromised until women are included in health research trials and until research is conducted on their unique health concerns. We know that women veterans experience twice the rate of cancer as compared to the rest of women, but we do not know why. There are reports of women experiencing gender-specific problems such as bearing children with birth defects and abnormal pap tests, who served in the recent Persian Gulf war, yet the VA has no plans to research this unique group of women. It was only recently that the VA awarded a research grant to study the health status of women exposed to Agent Orange.

In order to ensure that women benefit from VA research, I urge this Subcommittee to include the research provisions currently in H.R. 2797, the "Veteran Women's Health Improvement Act of 1993," introduced by Rep. Pat Schroeder and Rep. Marilyn Lloyd, to the Chairman's bill. The research language in the bill is identical to language applied to the National Institutes of Health which requires the inclusion of women in all medical research where appropriate. The bill also contains a vital provision that medical research be coded for any potential differences. In addition, the bill outlines a research agenda on the health concerns of women veterans including reproductive issues, mental health, menopause, substance abuse, sexual violence, and hazards relating to military service. For instance, sexual harrassment has been exposed as a serious problem in the military. Research in this area is urgently needed to determine the services and education needed which will have an impact on individuals and group morale. The VA must expand its knowledge of the unique medical and service oriented concerns of women veterans to ensure that quality health care services are provided.

I would also like to urge the members of this subcommittee to play an active role in seeking funding for the research provisions contained in Public Law 102-585, the "Veterans Health Care Act of 1992," which did not receive appropriations. These included a population study of women as well as funding to allow the VA to initiate new studies on women.

Thank you for allowing me the opportunity to comment. With your permission, I would like to include a fact sheet about the Society and our current activities and goals.

Society for the Advancement of
WOMEN'S HEALTH RESEARCH

The Society for the Advancement of Women's Health Research, launched in 1990, brought to national attention the problem of the exclusion of women from major clinical research trials, and the consequent need for greater federal funding for diseases and conditions experienced by women. Today, the Society is the only national advocacy organization whose sole mission is to improve the health of women through research.

GOALS: The work of the Society is guided by five basic goals. These goals include:

1. To identify those areas of research which will have an impact on the health of women
2. To promote and encourage financial support, both public and private, for women's health research
3. To effect changes in policies and behavior to improve the health of women based on research outcomes
4. To create a milieu for change by informing policymakers, the public, educators and other professionals on research outcomes
5. To advance women as leaders in the health professions with the intent of increasing research in women's health and improving the health of women

The Society has achieved notable success in its brief three-year existence. During the watershed year of 1990, the Society served as a catalyst for major advances in women's health including a Congressional initiative, the *Women's Health Equity Act*, and the creation of the Office of Research on Women's Health at NIH.

At its first annual Scientific Advisory Meeting in the Spring of 1991, the Society convened twenty-five medical and health specialty organizations to discuss research priorities for women's health. Using the meeting findings as a springboard for discussion, the Society subsequently held a series of regional roundtables in which health care providers and practitioners, community leaders, and female consumers sought to further refine the women's health research agenda for the 1990's.

Spring 1992, the Society launched its *Women in Academic Medicine and Health Science* initiative by dedicating the second Scientific Advisory Meeting to increasing the participation and advancement of women in the medical and health specialties. This meeting set the stage for a set of four regional roundtables which kicked off in New York on October 5, 1992 and convened leaders in academic medicine and health sciences -- deans, department chairs, administrators -- who will develop and implement the recommendations.

The third annual Scientific Advisory Meeting is planned for June 1993 and will focus on the impact of the environment on women's health. Researchers and environmental groups have increasingly observed possible links between exposure to environmental substances and women's health problems. More research is clearly needed to conclusively establish a link between environmental factors and women's health status. Such research findings could suggest ways to reduce or eliminate harmful exposures, thus improving women's health through disease prevention.

Continuing the positive momentum, the Society developed the following membership opportunities which seek both to sustain the recent gains and to further the dialogue:

Corporate Advisory Council: consists of representatives of health related corporations which provide a unique opportunity for dialogue and cooperation among leaders in women's health, medicine, science, public policy and government, and those in health care and health research industries;

Medical/Health Advisory Board: consists of representatives of professional medical societies, professional trade associations and related health professions professional societies which function to develop and facilitate ongoing, interdisciplinary dialogue, to target women's health research needs and to keep abreast of developments across specialties and disciplines; and

National Policy Task Force: consists of individuals who provide a national, leadership constituency which will undertake the requisite, hard-hitting advocacy, public education and outreach strategy to ameliorate gender-based inequities in research funding.

Society for the Advancement of
WOMEN'S HEALTH RESEARCH

WOMEN'S HEALTH FACT SHEET

- Women account for 52% of the U.S. population.

- Women make three-fourths of the health care decisions in American households and spend almost two of every three health care dollars (approximately $500 billion annually).

- Over 59% of physician visits are made by women, 59% of prescription drugs are purchased by women, and 75% of nursing home residents over the age of 75 are women.

Cardiovascular disease:

- Heart disease is the *number one* killer of U.S. women (28% of all deaths); death rates are highest for women of color.

- A long-term study (MR. FIT) examining the relationship of cholesterol and heart disease was conducted on 15,000 men, but *no* women.

- Women who are diagnosed with heart disease are typically ten years older and sicker than men with the same condition; a marked increase in incidence is observed after menopause.

- Hypertension -- a major risk factor in cardiovascular disease -- is 2 to 3 times more common in women than men and highest among African-American women. Drugs to treat hypertension have been tested primarily on white male populations.

Lung Cancer:

- If current trends continue, the death rate among women from smoking-related diseases will exceed that of men by early next century. Teenage women now smoke at higher rates than their male counterparts.

- Smoking lowers a woman's estrogen level and increases her risk for early menopause, pregnancy complications, and having a low-birth-weight baby. Women sustain more lung damage at an earlier age than their male counterparts. Some evidence suggests women find quitting more difficult than men do and that women smoke to be thin.

- Studies show doctors are more apt to give stop-smoking messages to male patients than to women, although such advice greatly increases the likelihood of quitting.

Breast cancer:

- Options for breast cancer treatment -- surgery, radiation and/or chemotherapy -- *have not appreciably changed over the last 30 years.*

- In 1992, an estimated 180,000 women were diagnosed with breast cancer, and 46,000 women died of the disease. Seventy percent (70%) of new cases are diagnosed in women who have *no known risk factors* for the disease. Women of color have poorer outcomes.

Ovarian, Cervical, and Uterine Cancers:

- There is no early detection method for ovarian cancer. Yet, there is a 90% survival rate even after 5 years when detected in Stage I (cancer confined to the ovary).

- In 1992, 21,000 new cases of ovarian cancer will be diagnosed; 13,000 women will die this year from this form of cancer. Women of color die from this form of cancer at disproportionate rates.

- Nearly one-third of all American women will have had hysterectomies by age 60; this is the highest rate in the world. Ovaries do not usually need to be removed, but doctors (lacking any alternatives) often remove them to prevent ovarian cancer.

- The incidence of this cancer is four times higher in postmenopausal women on estrogen-only hormone replacement therapy (HRT) than in women on combined estrogen and progestin therapies.

Menopause:

- Menopause, unlike menstruation, is often viewed by the medical profession as a disease rather than as a natural part of aging.

- There is little research data available for women seeking nonpharmacologic techniques and alternative methods for symptom management of menopause. Data on pharmacologic treatments is only marginally more available and is often conflicting.

Osteoporosis:

- Osteoporosis, a debilitating disease characterized by loss of bone mass, afflicts up to 50% of women over age 45 and 90% of women over age 75; this disease causes more than 50,000 deaths among American women annually.

AIDS:

- Women are the fastest growing demographic group affected by HIV infection. AIDS is the leading cause of death ages 15 to 44 in New York City and Newark, NJ and is expected to be the major cause of death among young women in the next decade.

We recognize that we have merely touched upon a few of the great number of diseases and conditions that adversely affect women. Our aim is to highlight several of the alarming gaps in knowledge which make effective preventive methods, treatments, and cures impossible.

By bringing these inequities in research to the public eye, the Society strives to bring much needed attention and resources to women's health research.

Statistics were compiled from the following organizations: Congressional Caucus for Women's Issues (Washington, DC); Jacobs Institute of Women's Health (Washington, DC); NIH Office of Research on Women's Health (Bethesda, MD); the National Institute on Aging (Bethesda, MD) and the Society for the Advancement of Women's Health Research (Washington, DC).

WRITTEN COMMITTEEE QUESTIONS AND THEIR RESPONSES

Chairman J. Roy Rowland
Questions Submitted for the Record
Department of Veterans Affairs
Subcommittee on Hospitals and Health Care
Hearings
September 22, 1993

Question 1): *Ms. Gallagher:* As a former hospital director, do you see any danger in a proposal such as H.R. 2285 that would direct VA to ensure that a particular hospital official have "sufficient clerical and communications support" to carry out his or her responsibilities? Aren't there VA hospitals which because of funding constraints, not only have insufficient clerical and communications support, but insufficient numbers of doctors and nurses? Would such a provision pose a troublesome precedent? What does "sufficient" mean.

Answer: The Medical Center Director should be allowed to determine the clerical and communications staffing needed to carry out his or her responsibilities. Funding constraints as well as other issues, such as ability to recruit, can impact the staffing levels of various types of personnel at VA Medical Centers. Many factors can influence the determination of how many constitutes a sufficient number of clerical and communications staff. Therefore, the Medical Center Director should be responsible for assuring that the Medical Center is staffed so that the mission can be met in a quality manner.

Question 2): *Dr. Farrar:* When can we expect to receive the approved national plan on mental health described in your testimony?

Answer: Since the National Initiative for Seriously Mentally Ill Veterans involves budgetary decisions involving Fiscal Year 1995, the plan cannot be approved until negotiations with the Office of Management and Budget are concluded in early 1994.

Question 3): *Dr. Farrar:* What do you think the term "conditions relating to aging," which is included in Ms. Schroeder's bill, H.R. 2797, includes? Wouldn't that term suggest such common and costly-to-treat diseases as Alzheimer's? Is VA able to provide prompt treatment for all veterans for a condition like Alzheimer's?

Answer: While Alzheimer's can occur as early as age 40, it reaches its peak incidence between ages 65 to 70. A patient has a life expectancy after onset of 2-6 years and those with an earlier onset tend to have a more rapid course. However, in the elderly almost half will develop signs and symptoms clinically diagnosable as Alzheimer's or a stroke and will become dependent on others to maintain the activities of daily living. This is the challenge that all health care agencies and society as a whole will need to deal with as more people live to be 85 plus.

Women still make up only 4 percent of the veteran population. There will be fewer than 500,000 women in the 65 plus age group until the year 2035. At present, there are approximately 333,000 in that age group. VA has the expertise and the appropriate facilities to care for people with Alzheimer's both male and female; however, VA currently can provide care only to veterans who are eligible and to the extent that resources are available.

Question 4): *Dr. Farrar:* You state that VA has developed a national plan to create a comprehensive continuum of care for treating veterans with severe psychiatric problems. Please provide more detail about the substance of this plan.

Answer: The plan addresses identified problems in six areas:

1. Strengthen VA continuum of care, particularly regarding outpatient and community-based programs. We propose dissemination of a number of Intensive Psychiatric Community Care (IPCC) programs, based on successful VA and non-VA experience with community-based intensive case management, as well as pilot programs in providing psychogeriatric expertise and case management for elderly veterans with psychiatric problems who are also high hospital users. The Under Secretary for Health has allocated $2 million in FY 1994 to initiate these programs.

2. Create an institutionalized source of sustained VA interest, advocacy, and activity to promote improved services to veterans with mental illness. We propose establishing a Special Committee for Seriously Mentally Ill Veterans, which will report directly to the Under Secretary for Health, similar to the Special Committee for PTSD that has provided leadership in that arena for a number of years.

3. Ensure that VA funding of Mental Health programs is spent appropriately and effectively. We propose to continue centralized tracking of special funds appropriated or otherwise allocated to specialized programs for the chronically mentally ill in order to insure that such funds continue to serve the veterans for which they were intended.

4. Improve the medical and surgical care of psychiatric patients. We propose to assign medical staff directly to psychiatric services rather than rely on the existing consultation system which has been insufficient in some instances.

5. Increase VA education and training regarding serious mental illness. We propose to establish special training for our clinicians in intensive case management, dual diagnosis, and general psychiatric techniques relying primarily on our Regional Medical Education Centers (RMECs). In addition, we propose increasing the numbers of psychiatric residency training slots, and the number of post-doctoral geropsychology training slots in order to prepare for increasing clinical demands in these areas.

6. Increase support for mental health research. We propose additional FTEE to allow selected VA academic psychiatrists and psychologists to devote time to supervise needed clinical research as well as a directed allocation to fund special Health Services Research and Development (HSR&D) projects related to service delivery to seriously mentally ill veterans.

Question 5): *Dr. Farrar:* Please explain how the elements of the draft national plan differ from VA's current approach in delivering care to mentally ill veterans and how they would address the problems discussed at the June 29th hearing.

Answer: The primary difference clinically is the plan's emphasis on providing intensive community-based case management services as well as supportive housing, vocational rehabilitation, and similar supportive services in the community. While VA as a whole has developed an enviable continuum of care for veterans with mental illness, as compared to non-VA mental health care systems, the VA traditional focus on hospital-bed based programs stands in sharp contrast to most state systems. Thus, there is a quantitative and qualitative gap in provision of community alternatives to hospital care both for older and younger veterans.

VA currently has no national group of mental health experts who maintain advocacy for the chronically mentally ill. Our proposed Special Committee for Seriously Mentally Ill Veterans can oversee activities, identify system and local problems and opportunities, and help integrate program evaluation and educational activities on behalf of seriously mentally ill veterans with a national, ongoing perspective.

Question 6): *Dr. Mather:* Since 1983, the law has required that each VA facility provide gender-specific care in-house or through sharing agreements with community or DOD facilities. In August 1991, you testified at a House Veterans' Affairs Committee subcommittee field hearing that all VA facilities were able to provide gynecology services through an existing mechanism. In September 1992, the Department again testified before House Members that gender-related health care was available in-house or through sharing agreements. It would seem to follow that fee-basis authority is not needed to provide gender-specific care. Please explain this change.

Answer: The fee basis authority would enhance the ability of VA to provide timely care to those veterans in geographically remote areas and in those instances where there may be temporary difficulty in replacing staff.

Question 7): *Dr. Farrar:* Please comment in detail on Ms. Schroeder's proposal that VA apply gender and minority group coding in the conduct of clinical research which includes women and minorities among the pool of participating research subjects as proposed in section 3(b)(3) of H.R. 2797. In the case of VA-conducted or supported clinical research, is such coding not now routinely done? If not, precisely what, if any, would be the nature of the administrative burden associated with such a requirement? Under what circumstances would such coding be likely to yield a valid analysis of whether the variables being tested affect women or members of minorities differently from others who are subjects of the research? With respect to the preceding question, please respond so as to differentiate, as applicable, between the situation for women, African-Americans, Hispanics, native-Americans, and other minority groups who might be research subjects in a VA clinical research study.

Answer: As we understand the requirements of section 3(b)(3) of H.R. 2797, (1) women and minorities are to be included in clinical research studies unless there are clear and compelling reasons not to, and (2) when women and minorities are included in a study, the design and analysis must be such that the relevance of gender and minority groups status to the variables under study can be determined. The first requirement is already part of VA policy (M-3, part I, chapter 14), and the second requirement is implied by the same policy. Most investigators would realize that it would be pointless to include subject subgroups unless members were sufficiently numerous to permit analysis of their status on study variables and unless such analyses were actually carried out.

It follows therefore that we would not expect that coding the requisite gender and race/ethnic group identifications would be an unreasonable burden insofar as such coding is relevant to study objectives. However, it is important to bear in mind that it would serve no useful purpose, and indeed would be a pointless burden to require such coding without a clear scientific rationale for doing so.

The requirement to include women, for example, in a given clinical study, means that if the study is to be conducted responsibly, sufficient numbers must be included to permit the identification of gender differences, if they exist, in the study outcome variable. However, unless there is some a priori reason to suspect such differences, the complication of the study design with its increased expense is not justifiable. The same point is valid for any other variable which could be used to stratify study samples.

Given the expense of clinical studies, especially multi-center clinical trials, it is important not to increase this expense further without clear justification. More expense means fewer studies, a trade-off that should always be considered carefully. However, this observation in no way implies that the office of Research and Development is unaware of the need to include diverse patient groups in its clinical studies.

Question 8): *Ms. Sheldon:* Please comment on Representative Evans' suggestion that VA "contract out to community-based organizations for the coordination of therapeutic work for VA patients through compensated work programs." Does VA have any such contracts? Has VA ever attempted formally or informally to solicit or otherwise explore such contracts? If so, with what results? Please comment on the practicality of the proposal. Would it represent an alternative to the establishment of nonprofit corporations, or simply another tool?

Answer: VA has enjoyed a strong relationship with community workshops in the past, although there is regional diversity based upon local economics and program resources. Most often this relationship is one of contract sharing, in which either the VA shares work with an organization, or vice versa.

In the past, VA has informally discussed and researched the concept of utilizing community services for our veterans, but have most often been told by these organizations that they could not even begin to accommodate additional clients into their systems; and that even if they could, they were not prepared to deal with a largely substance abuse/homeless type of client's needs.

We have also noted that with the decrease in monies allocated for community mental health programming, community organizations are being forced to utilize their resources to provide care for the most severely disabled individuals. This trend has also been noted in State Departments/Offices of Vocational Rehabilitation. The impact of this service delivery shift has been that the community organizations are no longer able to fulfill the terms of their contracts for a variety of reasons, including long turn around time, poor quality control, costs, or reliability. VA then takes these contracts, or portions of them, over. We also attempt to share work with community organizations, wherever possible.

We feel strongly that the utilization of community organizations, if available, would only provide VA with a minor portion of the benefits which are realized by having our therapists provide the necessary programming. Additionally, none of the benefits sought via nonprofit corporation status would be realized. While there is merit to this concept, it is as you have mentioned, merely another tool which needs to be used with the other modalities VA has at its disposal.

THE HONORABLE CHRIS SMITH
QUESTIONS SUBMITTED FOR THE RECORD
DEPARTMENT OF VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE HEARINGS
SEPTEMBER 22, 1993

Question 1:

Could VA maintain its primary Vet Center mission of providing readjustment counseling and provide basic health services such as: preventive health, pre-admission screening and referrals?

Answer:

Pre-admission and referrals would mean the introduction of primary care medical care into the vet centers, with doctors, nurses, and physician assistants. VA is opposed to such initiatives, which are better carried out in clinics. After 13 years of extraordinary success in the provision of outreach and readjustment counseling in the non-clinical framework of Vet Centers, we do not think this should be altered. Some provision of preventive health information, if carefully defined and if it specifically did not include the provision of medical care, might be possible, space permitting at some locations. However, in most locations, preventive health information is better provided at clinics.

Question 2:

Does VA's National Plan for health care utilize Vet Centers for the provision of community health services? If not, how will VA augment its community health services in order to become competitive with the private sector under the President's health plan?

Answer:

VA's National Plan does not deal specifically with Vet Centers. However, the VA is developing plans to provide non-institutional long-term care and expand access to outpatient care. Our proposal may include new convenient centers of access to provide primary care services in the community. Although the structural characteristics of the proposed new centers are unspecified, the plans call for maximum flexibility so that the type of facility and services offered can be tailored to community need.

Question 3:

How many women veterans received hospital care last year through fee basis? How many were for service-connected conditions?

Answer:

Due to sporadic reporting in FY 1992, VA is unable to accurately provide this information. Based on available information, 604 women veterans received hospital care last year through the fee basis program. Two hundred (200) of these women veterans were seen for service-connected conditions. Again I must emphasize that this information is not reliable. Program changes have been made to accurately capture this information for FY 1994.

Question 4:

How can contracting authority be strengthened to improve health care services to women and at the same time provide appropriate incentives for VA to develop in-house programs whenever feasible?

Answer:

VA is in favor of contracting authority for health care services in instances where VA cannot provide the required service, cost effectively, in-house. We would use the authority to assure that women veterans receive a level of care comparable to care provided male veterans. Special authority would be particularly useful in areas with small women veteran populations.

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THE HONORABLE CHRIS SMITH

Question 5:

Ms. Schroeder's bill mandates that women who are veterans be included as subjects in every clinical research project the VA supports or conducts. Isn't participation in research voluntary? Can the Secretary ensure participation of any veteran?

Answer:

VA has had a policy in place since 1991 which strongly encourages the inclusion of women and minorities in VA clinical studies whenever possible. All participation in human-subject clinical research is voluntary and only VA patients are eligible to participate. All volunteers must be fully informed of possible side effects and/or potential injury resulting from research participation and sign a statement of informed consent. Volunteers must meet criteria for inclusion prescribed by the reserch project protocol. The Secretary cannot, of course, ensure participation by women and minorities in every research project. However, the bill has sufficient flexibility to allow research projects to move forward in those cases.

Question 6:

Do you believe Congress should expand fee-basis contract authority for the provision of health services to Women veterans? Do you believe the greater authority and resources for fee-baiss treatment of women veterans would serve as a disincentive for the VA to initiate more in-house programs for women?

Answer:

VA is in favor of contracting authority for health care services for women in instances when VA cannot provide the required service cost effectively in-house. If used for that purpose, we do not beleive new authority will serve as a disincentive to establishing in-house programs.

Question 7:

Please tell us what the fiscal impact of expansion of fee-basis services to women veterans as proposed in Ms. Schroeder's bill would have on the fee-basis progam?

Answer:

We estimate that approximately 3 percent of women veterans seen in VA facilities will require fee-basis outpatient services at an average cost of $1,000 per patient. The total yearly cost would be approximately $7.2 million.

Question 8:

When will the draft "National initiative" for chronically mentally ill veterans be implemented?

Answer:

At the present time VA has not finally determined a timetable for implementation.

Question 9:

While using the disease categories specified by NAS, how can Congress ensure that VA physicians have the authority to treat veterans prior to making a diagnosis?

(Page 3)

THE HONORABLE CHRIS SMITH

Answer:

The most certain way to ensure that VA physicians have authority to examine veterans in order to diagnose one of the diseases in question would be to provide specific statutory authority.

Question 10:

In your testimony, you state your support for increasing the priority for outpatient care for services related to sexual trauma. Do you support this provision even in the absence of adjudication of service-connection? If so, isn't this position inconsistent with the Department's views regarding presumptions for other illnesses?

Answer:

We support the provision of priority sexual trauma counseling even in the absence of the adjudication of service-connection because of the difficulty victims have in proving sexual trauma for the purposes of service-connection. (These episodes rarely occur in public and are often not documented anywhere.) This authority is not inconsistent with other unique presumptions, i.e., medical care for Agent Orange exposure.

AMERICAN LEGION RESPONSE TO POST-HEARING QUESTIONS OF 9/22/93

1) Do you believe placement of health professionals at Vet Centers would augment the VA's ability to provide community health services and would have a positive effect on VA's competitiveness under the President's health plan?

Reply

The American Legion has testified before both the House and Senate Veterans Affairs Committees that we support the idea of using certain vet centers or veteran service organization posts to provide primary health care services to veteran beneficiaries. We think a program which would provide basic health care screening and preventive medical care, several days per month, should be piloted at several carefully selected locations.

The primary idea is to improve access to outpatient care for veterans residing minimally over 50 miles from the nearest VA health care facility. If VA is to be competitive under national health care reform, it will have to become more accessible to veterans. Each VA medical center can assess several possible locations within its primary service area to implement such a plan. With proper planning and the availability of space and services, medical center staff could visit several locations per month on a rotating basis. We think the costs for such a program would be less than than the current per vehicle cost of the mobile medical van program.

2) Do you believe it is necessary for the VA to institute a pilot program of providing health services at Vet Centers when VA already has a long history of successfully providing such services?

Reply

We are not certain what history of success is being referenced. VA has no history of providing health services at vet centers. We hope that no significant problems would occur through such a program. However, to simply mandate that vet centers carry-out such a program is risky. It could fail to meet its objectives if all potential problems are not identified before large scale implementation were to occur. Now is an excellent time to undertake such a pilot study, as there is still sufficient lead-time before the President's health care reform initiated is adopted and implemented.

As commented in Reply #1, we do not endorse implementing this pilot program at <u>all</u> vet centers. A successful pilot program would provide a means to develop permanent program criteria.

3) If VA focuses more effort and resources on contracting out rather than attempting to provide women in-house VA health services, will that have a negative effect on VA's competitiveness for women veterans under a national health plan?

Reply

We do not presume that all VA health care facilities should provide complete health care coverage to women veterans. It remains to be determined what services will be cost effective to provide in-house, based on historic and projected user patterns. VA facilities in densely populated areas would presumably be better able to offer complete in-house services. In either case, VA should plan on being able to meet women veterans health care needs through either in-house or contract coverage.

4) Do you believe Congress should expand fee-basis contract authority for the provision of health services to women veterans? Do you believe that greater authority and resources for fee-basis treatment of women veterans would serve as a disincentive for the VA to initiate more in-house programs for women?

Reply

The Legion believes women veterans should be limited to the same eligibility restrictions that are in place for male veterans. This includes fee-basis authority. We do not object to the provision incorporated in the Veterans Health Care Act of 1992, which entitled women veterans to mandatory treatment for sexual trauma. However, having made that concession, we can think of no other instance whereby women veterans should be entitled to special considerations for VA health care treatment.

Providing greater authority and resources for the fee-basis treatment of women veterans would, in our opinion, serve as a disincentive for VA to initiate more in-house treatment programs for women, and reduce the level of care and resources available to all veterans.

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RESPONSES OF DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
TO QUESTIONS SUBMITTED BY
THE HONORABLE CHRIS SMITH
AS A FOLLOW-UP TO THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE HEARING OF
SEPTEMBER 22, 1993

.) Do you believe placement of VA health professionals at Vet Centers would augment the VA's ability to provide community health services and would have a positive effect on VA's competitiveness under the President's health plan?

Yes. Not only would VA's ability to compete be enhanced by an expanded Vet Center role, but, more importantly, the opportunity for veterans to receive VA health care services would be significantly improved. It continues to be our view that by nature of the location of Vet Centers, in the community, veterans will be more likely to access VA for their health care needs. Certainly, the opportunity exists. The President's plan, with an emphasis on preventive and primary care, does not differ in concept from the "American Veterans' Health Care Reform Act of 1992," proposed by the DAV.

.) Do you believe it is necessary for the VA to institute a pilot program of providing health services at Vet Centers when VA already has a long history of successfully providing such services?

We are, frankly, unaware of VA's history or, for that matter, substantial involvement in the area of providing basic health care services in the Vet Center setting. While there may be isolated instances of this occurring, it is not, to our knowledge, done in a systematic, coordinated manner. Nevertheless, we do not feel the creation of a pilot program is necessary for this concept to be successfully implemented. We believe the resources exist that will allow, where appropriate and practical, medical centers and Vet Centers to work with each other in a professional manner in order to accomplish the shared goal of providing needed health care and related services to eligible veterans.

.) If VA focuses more effort and resources on contracting out rather than attempting to provide women in-house VA health services, will that have a negative effect on VA's competitiveness for women veterans under a national health plan?

VA should concentrate their efforts and resources on enhancing and/or establishing programs within VA medical facilities in order to recognize and substantially address the needs of women veterans. We believe, in order for VA to survive and flourish in an environment contemplated by national health care reform, changes need to be made by VA to the traditional way in which health care has been delivered. This will necessarily include the mix of patients VA treats. In order to meet the demands women veterans, and, perhaps, other women beneficiaries will place on the VA system, it would be short-sighted not to enhance their in-house treatment capabilities. This is a must if VA is to successfully compete.

(2)

4.) Do you believe Congress should expand fee-basis contract authority for the provision of health services to women veterans? Do you believe that greater authority and resources for fee-basis treatment of women veterans would serve as a disincentive for the VA to initiate more in-house programs for women?

As discussed above, we firmly believe VA must move in the direction of establishing a significant number, where appropriate, of in-house treatment capabilities directed towards meeting the needs of an expanding base of women patients. However, that is not to imply that VA should be constrained in authority to contract for needed services when they are not able, for any number of reasons, to provide such services. We believe current law permits sufficient authority and flexibility in this regard. Currently, we are unaware of a situation that is not able to be addressed under current law. It should be noted that the foregoing is based on DAV's belief that veterans with the same basic eligibility criteria need to be treated evenly concerning the manner in which services are delivered.

PARALYZED VETERANS OF AMERICA
Chartered by the Congress of the United States

Paralyzed Veterans of America:
Responses To Questions
Submitted by Rep. Chris Smith
In Regard to Hearings Of The
House Veterans' Affairs Subcommittee on
Hospitals and Health Care
September 22, 1993

1) **Question:** Do you believe placement of health professionals at Vet Centers would augment the VA ability to provide community health services and would have a positive effect on VA's competitiveness under the President's health plan.

Answer: As PVA stated in our testimony, and on many different occasions in testimony before the House and Senate Committees on Veterans' Affairs, the 200 strategically located Vet Centers are a valuable community-based resource for the VA health-care system. There is an important mission for many of these facilities beyond the provision of readjustment counseling or the treatment of post-traumatic stress disorder that can enhance VA's competitive position in a reformed national health-care system. Such activities include community-based ambulatory care or mental health services. PVA has endorsed the provision of these types of services in Vet Center facilities as long as it can be determined that: 1) the health care provided does not interfere with the mandated mission of the Vet Center Program and, 2) the VA is given appropriated funds to cover the cost of this expansion of services.

2) **Question:** Do you believe it is necessary for the VA to institute a pilot program of providing health services at Vet Centers when VA already has a long history of successfully providing such services?

Answer: A pilot program would be one way to ensure that the above criteria on cost and non-interference with traditional Vet Center functions are adhered to.

3) **Question:** If VA focuses more effort and resources on contracting out rather than attempting to provide women in-house VA health services, will that have a negative effect on VA's competitiveness for women veterans under a national health plan?

Answer: PVA does not believe that the source of specialized care provided for women veterans is as important to them as the availability and the quality of those services. If VA is going to be fully competitive in a reformed health care system, it will undoubtedly have to expand its health-care capabilities to meet the needs of greater numbers of women veterans as well as the potentially greater mix of services based on gender and age requirements, if services are to be offered to the dependents of veterans. There is no pat answer as to whether these unique health care services should be provided on a contract basis or within VA medical facilities. Such decisions should be made at the local level based on projections of health-care demand and cost-analysis of the most efficient way to provide care over a period of time.

4) **Question:** Do you believe Congress should expand fee-basis contract authority for the provision of health services to women veterans? Do you believe that greater authority and resources for fee-basis treatment of women veterans would serve as a disincentive for the VA to initiate more in-house programs for women?

Answer: The VA should have the authority and the resources to provide care in the most efficient and effective way it can for all veterans. For the VA to compete successfully in a reformed health-care environment, the system will also have to be given the flexibility to tailor the provision of health care to maximize quality, efficiency and cost-effectiveness to meet the needs of veterans at the local AHP level. Undoubtedly, this will require expansion of sharing agreements and contracts to provide some services currently not available or not appropriate to be provided in-house. In other instances, depending upon the mix of patients, or long range plans for a particular medical facility, this could also mean that a VA facility should make an investment to provide those specialized services in-house. Federal mandates such as statutory expansions of fee basis authority for health services for women veterans would not give individual VA medical centers the flexibility to fully develop their own potential and responsibility to provide the best care possible in the most efficient manner.

THE HONORABLE CHRIS SMITH
QUESTIONS SUBMITTED FOR THE RECORD
VIETNAM VETERANS OF AMERICA
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
SEPTEMBER 22, 1993

1. Do you believe placement of health professionals at Vet Centers would augment the VA's ability to provide community health services and would have a positive effect on VA's competitiveness under the President's health plan?

We believe the co-location of health services with Vet Centers or development of community-based clinics would assist veterans in getting preventive health services and screening and be vital to VA's competitiveness within a national health system. We are concerned, however, with the language of Representative Smith's draft bill because it does nothing to protect the integrity of the Readjustment Counseling Service (RCS) Vet Centers program as a distinct entity within the Veterans Health Administration (VHA).

The clientele of the Vet Centers are primarily PTSD-afflicted veterans who do not access general health care at the VA because they are distrustful of the bureaucratic agency. The "Help Without Hassles" motto is likely to be overrun by VHA if protections are not imposed. At the very least, the veterans' perception of too close a relationship between the Vet Centers and mainstream VHA bureaucracy could severely harm the success of this program. We have endorsed S. 1226, sponsored by Senator Daniel Akaka (D-HI), because it incorporates such protections.

2. Do you believe it is necessary for VA to institute a pilot program of providing health services at Vet Centers when VA already has a long history of successfully providing such services?

At this point, yes, we feel a pilot project is in order. Because we are unaware of a long history of successful integration of health services with the Vet Centers, and for the reasons cited in our answer to the previous question, we would prefer a pilot project of co-located health clinics. While some Vet Centers do utilize VAMC health care personnel on a part-time or one-day-a-week basis, we fear that a more institutional integration would truly detract from the Vet Center "Help Without Hassles" PTSD-counseling successes.

3. If VA focuses more effort and resources on contracting out rather than attempting to provide women in-house VA health services, will that have a negative effect on VA's competitiveness for women veterans under a national health plan?

Yes and no. The bottom line is, if VA is to compete for paying women clients it needs to have services available <u>at</u> the advent of national health reform. This is most especially true of women who are dependents of subscribers who are veterans. Given the current situation and the fact that it has taken the VA over 10 years to reach this inadequate level of preparedness for women veterans, it is unlikely that VA will be able to provide these services in-house initially. If VA doesn't provide proper care by out-sourcing these services, not only will women veteran patients be lost forever; male veterans hoping to enroll their dependents in the VA national health care package will choose another plan that accommodates the needs of female family members.

In the long run, it is important that VA begin to develop gender-specific care capabilities because VA plan subscribers may leave the system over time if they determine that it would be easier to enroll in a non-VA plan that is actually providing the care for women family members. The utilization of certified nurse midwives, nurse practitioners and physicians assistants would be a cost-effective method of providing quality care to women. We also suggest that the "start-up loans" and the revenue VA would be able to keep (from employer enrollment premiums, Medicare and third-party reimbursements) under the President's proposed health reform plan be utilized to bring health services for women in-house over time, as well as develop a broad network of community-based clinics to supplement the current tertiary care hospital system. VA should also develop its capabilities for serving specific populations it <u>will</u> be more competitive in serving, such as aging veterans, spinal cord injury veterans, vets needing blinded care and prosthetics, as well as the substance abuse treatment and mental health care benefits which will not be as comprehensive in non-VA health plans.

4. Do you believe Congress should expand fee-basis contract authority for the provision of health services to women veterans? Do you believe that greater authority and resources for fee-basis treatment of women veterans would serve as a disincentive for the VA to initiate more in-house programs for women?

For the reasons cited in our answer to the previous question, yes it is important that Congress provide broad authority for VA to enter into various kinds of arrangements with non-VA providers for health services to women <u>initially</u>. These may be fee-basis contracts, or less-costly sharing arrangements with teaching affiliations, DOD facilities, and/or community-based providers. Congress may impose time limitations on this authority and deadlines for VA to bring these services in-house in a cost-efficient manner to preclude this feared disincentive. With proper guidance and direction from the Congress, the VA could utilize the new funding sources proposed in the Clinton health package to greatly enhance its services to all veterans.

THE HONORABLE JOSEPH P. KENNEDY II
QUESTIONS SUBMITTED FOR THE RECORD
VIETNAM VETERANS OF AMERICA
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
SEPTEMBER 22, 1993

1a. Is your organization aware that provisions of H.R. 3081 will limit coverage for some Vietnam veterans exposed to Agent Orange that are currently eligible for VA health care?

In reference to language in H.R. 3081 that ties the VA's "Agent Orange treatment authority" to the findings of the National Academy of Sciences, the Department of Veterans Affairs states in its written testimony that it is "somewhat concerned... that this change would have the effect of limiting the authority the Secretary now has. There may be diseases and disorders that the NAS did not categorize in its study because there is no scientific literature related to them. We could now provide care for such disorders, but might not be able to under H.R. 3081."

It is foreseeable that grandfathering in those veterans who are currently receiving care could leave out some veterans whose illnesses due to exposure to Agent Orange emerge after an extended latency period.

VVA is keenly aware of the provisions within this bill that would erase tenets of current law which give veterans the benefit of the doubt in obtaining VA treatment for conditions suspected to be associated with Agent Orange exposure. Given the NAS recognition of the fact that scientific data currently available on the correlation of many diseases is inconclusive and recommendation of further study, it is completely unacceptable to impose such limitations on which veterans with which diseases may receive VA care for Agent Orange exposure. The addition of a grandfather clause, as Representative Kennedy indicates, would still not address the problems of veterans contracting Agent Orange-related conditions after enactment which are not listed in this legislation. We are adamantly opposed to these provisions, and frankly, were disappointed that some of the other veterans organizations did not express concerns.

1b. Would you support striking these provisions of H.R. 3081 to remedy the exclusion of this group of veterans?

Absolutely. While we admire Chairman Rowland's proposal to authorize VA to provide outpatient care to veteran victims of Agent Orange exposure, we cannot support the aforementioned eligibility restriction provisions of H.R. 3081.

1c. If these restrictions limit eligibility to specific diseases, would the provision called for in H.R. 3081 be difficult to implement since veterans come to the VA with a set of symptoms rather than a disease?

Yes. It would be extremely difficult to implement. Additionally, since national health reform will open VA eligibility to all veterans, it is illogical to impose this restriction during the interim.

2. Is your organization aware of any sexual assault cases where male veterans were the victims? Would your organization be supportive of providing VA sexual assault services to both men and women, irrespective of gender?

Yes, we are aware that sexual assault and harassment do not effect only women, and we support the inclusion of men in these service programs. It is important to make these services available to all veterans regardless of gender, just as it is important to make general health care services available to all veterans in an appropriate manner regardless of gender.

3. The Mammography Standards Quality Act of 1992 (P.L. 102-539) establishes thorough quality standards and oversight mechanisms to ensure that mammography equipment and materials meet strict standards and those who perform and interpret mammograms are certified to do so.

In testimony submitted by the American College of Radiology, Dr. Karl Wallace raises concerns that the provisions of H.R. 3082 are uncertain to bring the VA's mammography services into compliance with the Mammography Quality Standards Act of 1992 (P.L. 102-539). A 1992 GAO report, VA Health Care for Women, revealed that a key problem with VA Medical Center inspection of mammography equipment was with the frequency of the inspection. The report found that "15 of 19 medical centers (79%) did not meet at least one of the American College of Radiology (ACR)-recommended time periods for inspecting items of the mammographic equipment." GAO also found that "VA does not monitor VA medical centers' in-house mammography programs to ensure compliance with ACR quality standards."

According to the Massachusetts Breast Cancer Coalition, mammographic screening is the only technical method for the early detection of breast cancer, and annual mammography can reduce the mortality rate of women over 50 years of age by thirty percent. A mammogram of poor quality is worse than no mammogram at all because it leaves the patient with a false sense of security.

Do you share concerns that the same quality standards required under P.L. 102-539 may not be prescribed by the VA under the provisions of H.R. 3082 and the same inspection procedures called for under P.L. 102-539 are not required of the VA in H.R. 3082?

VVA most definitely shares these concerns. We advocate applying the same quality and staff certification standards to VA facilities as are required of non-VA providers. It is vital that quality standards be judged at the same level if VA is ever to compete effectively for paying veteran patients within a national health reform environment. This is especially true of women veterans who already perceive VA care to be substandard.

To cite an example of this mammography quality problem, one of our women veteran members was given a clean bill of health after a VA mammogram, only to discover three years later when a follow-up screening was conducted that the previous test was interpreted incorrectly. This woman had a tumor growing in her breast all during the three year period because the VA was not subject to the same quality standards.

4. Do you believe that research carried out by the VA should benefit all veterans? If so, do you believe that veteran-related research should be coded for race and gender?

Yes. To truly be an effective research institution, VA must account for differences in health effects among genders and races. For example, rates of heart disease differ among caucasians and blacks. There are certainly gender-specific effects of diseases and treatments that need to be accounted for in order to give appropriate care to all veterans.

It should be noted that this is not a problem only in VA research. Some of our nation's finest research institutes, such as the Centers for Disease Control (CDC) and the National Institutes of Health (NIH), also need to do a better job of accounting for women and different races in health studies.

5. Knowing that the VA is going to be a competitive provider under health reform and will have to offer comprehensive benefits to women vets and dependents, what suggestions would you have for VA to ready itself for that mission?

What consequences, if any, do you think the VA will face if preparation for health care reform doesn't begin now?

Assuming that health reform will become law in a form closely resembling the plan proposed by President Clinton, the VA will need to have the same basic benefits and services available as non-VA providers to even participate within the Health Alliances as an optional health plan for veterans. This is true of services to both women and men. If VA is to be competitive in attracting paying women clients it needs to have gender-appropriate services available at the advent of national health reform, especially to interest veterans with women dependents. Given the fact that it has taken the VA over 10 years to reach the current inadequate level of preparedness for women veterans, it is unlikely that VA will be able to provide these services in-house initially. If VA doesn't provide proper care by out-sourcing these services, not only will women veteran patients be lost forever -- male veterans hoping to enroll their dependents in the VA national health care package will choose another plan that accommodates the needs of female family members.

VA should develop in-house gender-specific care capabilities over time, however, because VA plan subscribers may leave the system if they determine that it would be easier to enroll directly in whichever non-VA plan is actually providing care for women family members. We suggest that the "start-up loans" and the revenue VA would be able to keep (from employer enrollment premiums, Medicare and third-party reimbursements) under the President's health reform proposal be utilized to bring health services for women in-house over time, as well as develop a broad network of community-based clinics to supplement the current tertiary care hospital system. VA should also develop its capabilities for serving specific populations it will be more competitive in serving, such as aging veterans, spinal cord injury veterans, vets needing blinded care and prosthetics, as well as the substance abuse treatment and mental health care benefits which will not be as comprehensive in non-VA health plans.

Congress should impose time limitations on VA's authority to arrange non-VA care for women and deadlines for VA to bring these services in-house in a cost-efficient manner. With proper guidance and direction from the Congress, the VA could utilize the new funding sources proposed in the Clinton health reform proposal to greatly enhance its services to all veterans. If VA does not adequately prepare for the effects of national health reform, we will likely see the demise of the VA health system.

REPRESENTATIVE JOSEPH P. KENNEDY, II
QUESTIONS SUBMITTED FOR THE RECORD
DEPARTMENT OF VETERANS AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HEARING
SEPTEMBER 22, 1993

WOMEN'S HEALTH SERVICES

Question 1a: How many women veterans seek gynecological care at the VA? How many women veterans receive this care at the VA? Please provide this information in terms of the numbers that fall into the respective eligibility categories.

Answer: In FY 1992, 27,586 women received GYN (gynecological) or reproductive health care services through VA, as was reported in the 1993 annual report on women veterans care. The majority of these women received this care in VA. Eligibility categories of 14,111 women veterans receiving care in VA GYN clinics during FY 1992* follow:

Eligibility Category		# Women Veterans
Service-connected	0%	957
Service-connected	10%	1269
Service-connected	20%	612
Service-connected	30%	697
Service-connected	40%	445
Service-connected	50%+	2220
AA/House bound		135
Nonservice-connected, Pension		713
Nonservice-connected		7014
Domiciliary Patient		49
Total		14111

There is no data available to determine if the gynecological care was provided for a service-connected disability.

*These figures are not exact, as they are based upon those VA facilities with established GYN clinics and do not include women provided gynecological services through other outpatient clinics.

Question 1b: How many women veterans have a service-related disability that is gender-specific?

Answer: The number of women veterans with a primary gynecological disability for FY 1992 is 7,333 and as of June 1993 is 8,042.

Question 2a: Under P.L. 102-585, the definition of women's health care is limited to pap smears, mammographies, and menopause care. The law specifically exempts pregnancy related care and reproductive care unless the pregnancy is complicated by a service-related disability.

Answer: Under current law, women veterans will not be entitled to hospital care for pregnancy and parturition unless it is complicated by a pathological condition. Obstetrical care is not provided to veterans because pregnancy is not a medical disability, as it is considered a physiologic state. General reproductive health care including management of menopause may be provided to women veterans.

Question 2b: How are these exemptions processed, and how long does this procedure usually take?

Answer: To determine if pregnancy and parturition is to be provided by VA, a VA Medical Center physician medically determines if the pregnancy is complicated by a pathological condition. The length of time it would take to make the medical determination could vary depending upon the patient's symptoms, disability, etc. Some medical determinations could be accomplished immediately while others may require special diagnostic tests or referral to a specialist. An approximate range to make a decision of this nature could be from a few minutes to as long as 14 days.

Question 2c: Has there ever been an exception made under this clause? If so, please provide specifics of the case(s).

Answer: Women have been provided pregnancy and parturition care when complicated by a pathological condition. This determination is made on a case-by-case and facility-by-facility basis. There is no national registry of this information; therefore, specifics are not readily available.

Question 2d: Has a patient, or a doctor ever requested an exemption and been consequently denied? If so, what were the circumstances of that case(s)?

Answer: VHA is not aware of any such cases. There could be cases in the initial appeal stage that have not been forwarded to the Board of Veterans' Appeals' (BVA). Data of this nature would only be available at the medical center level. The Board of Veterans' Appeals' records indicate that in calendar year 1992 they have had no appeals related to any such denials.

Question 3: In July 1992, the VA Advisory Committee on Women Veterans issued a report offering several recommendations to improve the quality of women's health care at the VA and to incorporate the needs and concerns of women veterans into VA sponsored research. These recommendations included implementing a standardized physical examination for women veterans, VA monitoring of women's health providers and facilities, specific treatment for osteoporosis, and facilitating research ties between the VA and the Office for Research on Women's Health at the NIH. Has the VA responded to any of these recommendations? What is the status of the Advisory Board, and when is it scheduled to reconvene?

Answer: The Report of the Advisory Committee on Women Veterans has been sent to all the offices with interest in or responsibility for the issues raised in the report. The responses of these offices have been collated and were sent to the Chairman of the Committee on February.8, 1994. The Advisory Committee held two meetings in 1993. The first was in San Antonio in June 1993. The last meeting was held November 1993 in Washington, DC. The Committee is working on the next report which will go to the Secretary of Veterans Affairs for transmittal to Congress in July 1994.

Question 4: In June 1993, the Inspector General issued a report on women's health care services. One of their recommendations included reallocating staff and resources at Central Office to facilitate women's health programs through the VA system. At the time of the report, the VA did not offer any specific plan to satisfy the recommendation. What is the VA's current plan to incorporate this recommendation in Central Office's priorities?

Answer: VA has incorporated this recommendation into Central Office's priorities. A full-time position has been added to the VACO staff in the Office of the Women Veterans Program.

Question 5: In testimony submitted by the American College of Radiology, Dr. Karl Wallace outlines concerns that the mammography standards set out in H.R. 3082 are uncertain to bring the VA's mammography services into compliance with the Mammography Quality Standards Act of 1992 (P.L. 102-539).

How would the VA ensure quality assurance in mammography services? What are the current quality assurance procedures and standards currently implemented by the VA? Please explain how the VA has taken steps to address the quality assurance concerns raised by the GAO in its 1992 report, VA Health Care for Women.

Answer: Quality assurance for mammography services in the VA will be ensured by setting policy and standards and oversight requirements that meet or exceed the forthcoming standards to be issued by HHS. Current quality assurance procedures and standards require VA facilities to follow the American College of Radiology Quality Control Manuals for Mammography. In response to the quality control and quality assurance concerns raised by the GAO in its 1992 report, the VA implemented oversight of compliance in this area by making it a reporting requirement of each facility as part of the OMB Circular A-123 process.

Question 6: If the VA is willing to live up to standards equivalent to mammography standards established by the Department of Health and Human Services as included in P.L. 102-539, why is the VA reluctant to affording HHS its oversight responsibilities?

Answer: VA prefers to have control and policy oversight over its own health care facilities in keeping with our status as a separate Cabinet Level Department.

Question 7: In your written testimony, you recommend that amending language be offered with respect to mammography standards to "provide the provisional certification of a facility to perform mammograms for up to 9 months while the facility qualifies for accreditation." Such provisional certification is provided for under the Mammography Quality Standards Act of 1992 for private sector hospitals. Since you support the VA coming under the standards of P.L. 102-539 for provisional certification, does it follow that you would support compliance with other requirements of that Act?

Answer: As indicated in the testimony, the Department would support an amendment that would provide Department facilities with the same provisional certification which is afforded private hospitals under the Mammography Quality Standards Act of 1992 (the "Act"). However, we would object to the Department being subject to the Act. VA will implement mammography quality standards which are equal to or greater than those provided for by the Act. We merely want to ensure that VA is able to apply its standards on a provisional basis to new programs.

Question 8: Your testimony indicates that H.R. 3082 does not go far enough in certain areas. In your written testimony, the VA supports many measures of H.R. 2797 and H.R. 2285 and made recommendations for modifications to H.R. 3082. For example, in your written testimony, you recommend permanent authorization of the sexual trauma program and support provisions of H.R. 2285 which would make these services gender neutral and available on a priority outpatient care basis. You also state that the establishment of a sexual trauma hotline would be "useful." Further, you state that you support H.R. 2797's provision for fee basis outpatient care for women veterans.

Please expand on necessary modifications to H.R. 3082 based on the aforementioned testimony.

Answer: Last year, Congress provided VA with authority to counsel women veterans who were victims of sexual trauma during service. That law authorized the Department to provide such counseling services through December 31, 1995, and authorized the Department to provide the services on a contractual basis through December 31, 1994. H.R. 3082 would extend each of those dates for one year. The bill would also delete a provision in the existing law which requires victims of sexual trauma to seek services within 2 years from release or discharge from active service.

As we testified, we strongly support this program. We recommend that H.R. 3082 permanently authorize the program, and not limit it to just one additional year. Our task force on sexual trauma, and the Steering Committee of the National Women's Health Training program have advised us that a veteran's need for sexual trauma counseling often does not manifest itself until many years after the occurrence of sexual trauma. In addition, some victims of sexual trauma may be unable to seek counseling for many years, and some who receive counseling may need to return later to deal with a recurrence of anxiety or other symptoms. To

prevent veterans from being denied the counseling needed for sexual trauma which they incurred while they were on active duty, we believe that all of the time limits on the program should be removed.

We strongly support abolishing that time frame, as H.R. 3082 would do.

Finally, we recommend that all references to "women" in the current law be deleted, thereby extending eligibility for sexual trauma counseling service to male veterans who suffer sexual trauma while serving on active duty.

Question 9: With respect to your testimony on H.R. 2285's reporting requirements on difficulties of establishing service connection for sexual trauma-related disabilities, is it VA's position that this useful information should not be included just because it would be "difficult" to assemble?

Answer Veterans Benefits Administration (VBA) assumes that the thrust of the testimony presented at the September 22 hearing concerned the collection of data to identify disability claims for sexual trauma-related conditions. In that regard, VBA does not presently have an effective method of identifying competed claims involving sexual trauma. With few exceptions unrelated to sexual trauma, our automated data systems are designed to capture disability information characterized by the resulting disability rather than by cause of the disability. Therefore, our research would be limited to pending claims, which would require claims folder review for identification.

On a prospective basis, we could track future claims involving sexual trauma. But, at this time, we have no reason to believe that the number of such claims would be large enough to provide a basis for meaningful analysis.

Question 10: Many have noted that as many as 50% of veterans would choose a health care provider other than the VA if they had the choice. In national health care reform, the VA will be placed in direct competition with private providers. Many veterans, particularly special populations of veterans including women, have much more confidence in private providers, largely based on VA's past record. What actions does the VA plan to undertake to ready itself for its mission of serving women veterans, who will likely be joined by additional women dependents accessing VA health care under family plans, in national health reform?

What consequences, if any, do you think the VA will face if preparation for health care reform doesn't begin now?

Answer: VA is planning for national health care reform and exploring possibilities for more women to use VA facilities to ameliorate some of the issues which are inherent in providing services to minority or special populations. Women veterans currently make up only 4 percent of the veteran population and even if most eligible women veterans used the system, women would still be a small minority. In order to overcome some of the problems which may arise for women veterans in accessing and feeling comfortable in the VA system, guidelines have recently been issued for women's health care based on the primary care model. Each woman veteran in the system will receive most of her care from a primary care provider with special interest in women's health. Referrals for specialized care will be made by the primary care provider and the patient will return to the primary care provider for ongoing care. This will improve both continuity of care and patient satisfaction. At the same time, VA is planning and instituting enhanced gender specific services.

Obviously, planning must begin now if VA is going to be in a position to provide care for those who need the special services available in VA facilities when national health care reform is instituted. Planning must be flexible enough to respond to changes in the reform package as well.

Question 11: With respect to your written remarks on H.R. 2797's provision on the Report on Health Care and Research, the inclusion of information on women's health services and the amount and type of these services

provided would provide the VA with crucial data in order to meet its health care mission for women veterans. Why would the VA oppose the inclusion of such valuable information?

Answer: Compliance with the additional reporting requirements would be burdensome and expensive. The resources required to collect and monitor this data would be better spent on providing care.

WOMEN IN VA RESEARCH

Question 1: On June 23rd, 34 members of Congress sent a letter to Secretary Brown inquiring into the health status of women who served in the Persian Gulf. Secretary Brown's response to the letter indicated that due to minimal amount of female veterans displaying gender specific symptoms, "there is no hypothesis to test ... in a formal epidemiological study." How many Persian Gulf veterans have reported gender-specific problems? Please describe the VA's plans to investigate whether gender-specific illnesses have resulted and any plans to determine the cause, diagnosis, and treatment of these diseases.

Answer: As of June 1993, 88 of 381 women Persian Gulf veterans treated in VA hospitals had gender specific medical conditions (see attached table). VA plans to continue its health surveillance activities using the in-patient treatment records among the Persian Gulf veterans and medical data collected in the Persian Gulf Registry. As the attached table indicates, there appears to be no significant difference between women Persian Gulf veterans and era veterans in the proportion of women treated in VA hospitals for gender specific conditions.

The number of women veterans who were diagnosed with gender specific conditions in the registry is still too small on which to base any assessment. Of the 400 women who participated in the registry examination, 39 women were diagnosed with medical conditions specific to women. Of course, we will continue to monitor literature and our own health data. When there is a hypothesis to test, an epidemiologic study will be designed and carried out with all appropriate scientific rigor.

The gender specific conditions observed among Gulf veterans are not unique to those women. Therefore, there is no inherent problem with diagnosis and treatment of these conditions providing that VA hospitals are staffed with appropriate medical specialists.

Question 2: It is my understanding that the VA has issued an internal guidance requiring all VA-sponsored research include women and minorities where appropriate. Please provide the Subcommittee with a copy of this guidance. How is this guidance being enforced? Has the VA encountered any problems in satisfying these requirements? Does this guidance cover cooperative research agreements with the VA and other private or public agencies?

Answer: The guidance is attached (M-3, Part 1, Chapter 14) inclusion of Women and Minorities in Clinical Research.

The primary mechanisms for oversight of investigator compliance are (1) local review of proposals by the Research and Development Committees, and (2) review by Merit Review Boards in Central Office. We have carefully instructed both review groups to attend to the inclusion of women and minorities, and, we believe that they are very much aware of the issue and seek to deal with it responsibly. The low prevalence of women patients in VA medical center treatment populations does make it difficult to include women in many studies.

Question 3: The Omnibus Reconciliation Act of 1986 (P.L. 99-272) authorized a "Study of Effect of Vietnam Experience on Health Status of Women Vietnam Veterans" to identify any gender specific health problems as a result of Agent Orange exposure. A contract for a modified study design was awarded in October 1992. What is the status of this study?

Answer: The contract for the conduct of Phase I of the Study of Reproductive Health Outcomes Among Women Vietnam Veterans was awarded to Innovative Training Systems (ITS) effective November 1, 1992. Following the award a protest was filed with the GAO by Klemm

Analysts Group (KAG) and a stop work order was issued to ITS pending resolution of the protest. VA responded to the protest by proposing to the GAO that the contract be reopened for further negotiations. The GAO agreed with the proposal and VA informed ITS that the award to them of November 1, 1992, was terminated. Subsequently, VA reopened negotiations with all offerors in the competitive range and requested another round of best and final offers with the objective of awarding the contract to the offeror whose offer proved to be the most advantageous to the Government. The new contract was awarded to KAG effective June 9, 1993. Following the award ITS filed a protest with GAO. On October 19, 1993, GAO dismissed its protest. On November 1, 1993, KAG was informed to proceed with the contract and the study is now underway.

Question 4: Section of the Veterans Health Care Act of 1992 (P.L. 102-585) states that "the Secretary should foster and encourage the initiation and expansion of research relating to the health of veterans who are women." What steps are being taken to fulfill this clause?

Answer: A research proposal has been developed for a Health Services Research and Development (HSR&D) Service Directed Research project to study the special needs or problems faced by women veterans seeking breast cancer care in the VA health care system. Principal Investigators for this study will be Dr. John Feussner and Dr. Denise Hynes at the Durham VA Medical Center. This study will serve as the pilot phase for a subsequent study to evaluate current primary and secondary prevention practices and rehabilitation therapy for breast cancer among women veterans in the United States, especially women veterans who are eligible for VA health care services. The research proposal has undergone a rigorous peer review and has been approved for scientific merit; initiation of the project is planned for FY 1994.

Plans have begun for establishment of a consortium of HSR&D field programs to specifically develop a program of research on women's health care issues. The proposed mission of the consortium will be to improve women veterans' health care through a coordinated effort of research and information dissemination. Although the primary objective of the consortium will be to conduct and coordinate health services research to address the needs of women veterans, the consortium will also provide information and expertise to other researchers, managers and policymakers both within VA and within other federal and non-federal agencies and institutions. The HSR&D field programs in Durham, North Carolina; Houston, Texas; Chicago (Hines), Illinois; and Bedford, Massachusetts will participate in this consortium in FY 94.

Coordinated through the HSR&D Management Decision and Research Center, the HSR&D Service is working closely with the Associate Chief Medical Director for Environmental Medicine and Public Health to design and implement a series of evaluation studies to be conducted in conjunction with clinical initiatives in women's health care. This effort will be led by Dr. Nelda Wray at the Houston VA Medical Center.

In addition to the research planned in health services research, VA was mandated by the "Veterans Health Care Act of 1992" to conduct a population survey of women veterans and women on active duty to determine their needs for health care services. The VA Office of Policy and Planning has been tasked with this responsibility for implementation in FY 1994. In FY 1992 Medical Research Service spent approximately $2 million to support research initiatives related to the health needs of women veterans. VA investigators received an additional $6 million from extra-VA sources to conduct research on this topic. Altogether, 90 research projects were supported relevant to women's health issues. As an example of VA research accomplishments in this area, one investigator found that the absence of the female hormone estrogen leads to excessive production of bone scavenger cells (osteoclasts), which quite literally bore holes into the bones of women, leaving them with a weakened skeletal frame. The identification of this hormonal imbalance paves the way for pharmacologic therapies which can reduce, and quite possibly, eventually eliminate this disease.

Medical Research Service plans to increase its emphasis on research relevant to women, especially on breast cancer in FY's 1994 and 1995, providing the research appropriations permit such initiatives. Since 1985, approximately 200 studies have been conducted in breast cancer.

In summary, VA has made progress in developing plans for enhancing and expanding upon current research efforts in the area of women's health care. These include HSR&D Service Directed Research, an HSR&D consortium for research on women's health care, systematic evaluation of clinical initiatives in women's health care, and a needs assessment study of women veterans and active military. Full implementation of these plans is contingent on availability of funds in upcoming fiscal years.

PRIVACY PROVISIONS

Question 1: What actions are being taken to remedy the patient privacy deficiencies identified by the GAO in Actions Needed to Insure That Female Veterans Have Equal Access to VA Benefits and VA Health Care for Women? Are Women Veteran Coordinators involved in these remedies?

Answer: Significant progress has been made during the last three fiscal years in providing additional privacy for female veterans in VA health care facilities. Correction of existing privacy deficiencies is an ongoing process and current Veterans Health Administration directives require quarterly reporting of the status of all planned and funded projects to make these corrections. Special considerations have been incorporated into the methodologies used in scoring and prioritizing the Non-recurring Maintenance and Minor Construction projects. In addition, space and planning criteria have been carefully reviewed to assure that these criteria fully support the need for female privacy. Thus any new construction which is undertaken by the VA fully meets those needs. The following is a summary of construction funding during the last three fiscal years which has served to measurably improve female accessibility:

Program	Projects	Cost ($000)
Station Level	18	105
Nonrecurring Maintenance	51	10,000
Minor Construction	189	142,300
Major Construction	22	868,243
Total	280	1,020,648

It should be noted that the female privacy is a component part of major construction projects which correct patient ward and outpatient deficiencies. While all of these construction projects will contribute to increase accessibility, every VA medical center has the capacity to adequately accommodate female veterans. Current directives require that the medical center Women Veterans Coordinator, or the medical center Women Veterans Advisory Committee, be included in the review and approval process for facility construction and renovation.

Question 2: Are there interim steps that can be undertaken to address privacy needs prior to a construction phase? If so, how does the VA plan to take action on such interim steps?

Answer: A number of interim steps such as the provisions of privacy shielding in outpatient examination rooms, additional dressing rooms, and changes to communal toilets and/or showers accomplished locally with instituted under the guidance of the Women Veterans Advisory Committee.

AGENT ORANGE AND IONIZING RADIATION TREATMENT AUTHORITY

In reference to language in H.R. 3081 that ties the VA's "Agent Orange treatment authority" to the findings of the National Academy of Sciences, you state in your written testimony that the VA is "somewhat concerned...that this change would have the effect of limiting the authority the Secretary now has. There may be diseases and disorders that the NAS did not categorize in its study because there is no scientific literature related to them. We could now provide care for such disorders, but might not be able to under H.R. 3081."

Question 1a.: Given the fact that there may be additional disorders not acknowledged by the NAS because there is no scientific literature to date; that some disorders, including cancers, have long latency periods; and that veterans may still make their first contact with the VA on Agent Orange-related disorders, do you agree that striking this provision from H.R. 3081 would alleviate these concerns?

Answer: Yes, we would agree that striking that particular provision in H.R. 3081 would alleviate those noted concerns. Otherwise, there may be diseases and disorders that the National Academy of Sciences did not categorize in its study because there is no scientific literature related to them. We could now provide care for such disorders, but might not be able to under H.R. 3081. We point out that patients coming to a VA facility for the first time come with a set of symptoms. They generally do not, at least initially, have a diagnosed disease. We want to be certain that our physicians have the authority to examine veterans who allege their aliments are due to exposure to herbicides so a diagnosis can be made.

Question 1b.: Does the VA agree that grandfathering those Vietnam veterans in who currently receive care would not adequately address the group of veterans that you reference may be reporting their illnesses to the VA for the first time?

Answer: VA recognizes that H.R. 3081 does not fully address the specific health concerns of Vietnam veterans reporting possible Agent Orange-related conditions for the first time at VA health care facilities. However, this does not preclude such veterans from applying for service-connected recognition, with associated compensation and health care benefits, based on their military service including any service in the Vietnam theater. VA is hopeful that subsequent scientific reviews conducted by the NAS, in accordance with the provisions of Public Law 102-4, will provide further answers to the complex health care issues of concern to some Vietnam veterans.

Question 1c.: If these restrictions limit eligibility to specific diseases, would the provision called for in H.R. 3081 be difficult to implement since veterans come to the VA with a set of symptoms rather than a disease?

Answer: VA recognizes that it may be more difficult to implement the provisions of H.R. 3081 for veterans presenting symptoms rather than a disease. As noted in VA's testimony on H.R. 3081, the Department believes it would be preferable to retain authority to continue to provide health care for veterans presenting symptoms/conditions possibly associated with exposure to herbicides. In the meantime, and until such time as subsequent Academy findings on the effects of exposure to Agent Orange and other herbicides are released, Vietnam veterans who meet normal health care eligibility criteria will still have an opportunity to have their symptoms diagnosed and when appropriate, provided with the necessary health care.

Attachment to Question #1
(Women in VA Research)

Distribution of Gender Specific
Diagnoses for 381 Women Persian Gulf
Veterans and 684 Era Veterans Treated
in VA Hospitals on an Inpatient Basis

Diagnoses (ICD9)	Persian Gulf (a) Number	Persian Gulf * Percent	Era (c) (b) Number	Era (c) Percent
Breast Cancer (174)	1		3	
Cervix Cancer (180)	0		6	
Ovary Cancer (183)	0		1	
Disorders of urinary tract including infection (597-599)	25	6.6	37	5.4
Benign dysplasia and other disorders of breast (610-611)	10	2.6	24	3.5
Inflammatory disease of female pelvic organs (614-616)	28	7.3	47	6.9
Other disorders of female genital tract (617-629)	58	15.2	113	16.5

*percent of women in each group with the specific conditions

(a) 88 Persian Gulf veterans contributed a total of 122 gender specific conditions

(b) 163 Persian Gulf era veterans contributed 231 specific conditions

(c) Era refers to veterans who served from August 2, 1990 to present, but did not serve in the Persian Gulf theater of operations.

Attachment to Question #1
(Women in VA Research)

Distribution of Gender Specific
Diagnoses for 400 Women Persian Gulf
Veterans on the Persian Gulf Registry

Diagnoses (ICD9)	Women Veterans	
	Frequency	Percent
Carcinoma in situ of breast (233)	1	
Neoplasm of uncertain behavior of GU organ (236)	1	
Disorder of urinary tract including infection (597-599)	8	2
Benign dysplasia and other disorders of breast (610-611)	5	1.3
Inflammatory disease of female pelvic organs (614-616)	1	
Other disorders of female genital tract (617-629)	17	4.3

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CHAPTER 14. INCLUSION OF WOMEN AND MINORITIES IN CLINICAL RESEARCH

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CHAPTER 14. INCLUSION OF WOMEN AND MINORITIES IN CLINICAL RESEARCH

14.01 PURPOSE

This chapter provides VHA (Veterans Health Administration) policy regarding the inclusion of women and minorities in clinical research. Such inclusion is needed to assure that research findings can be of benefit to all persons at risk of the disease, disorder, or condition under study.

14.02 SCOPE

a. VHA policy applies to all applicants for VA (Department of Veterans Affairs) Central Office support for clinical research, e.g., all applicants for funding from:

(1) Medical Research Service.

(2) Health Services Research and Development Service.

(3) Rehabilitation Research and Development Service.

b. Since similar policies exist for other funding sources, e.g., National Institutes of Health, it is appropriate that applicants for extra-VA funding familiarize themselves with all relevant policies.

14.03 POLICY

a. Applicants for VA Central Office research support will include minorities and women in their study population whenever possible and scientifically desirable.

b. Special efforts will be made to include members of minority groups and women in studies of disease, disorders, and conditions that disproportionately affect such groups.

c. If women or minorities are excluded or inadequately represented in a proposed clinical research study, particularly in a proposed population-based study, an exception to the policy must be approved by the Associate Chief Medical Director for Research and Development, or designee.

14.04 BACKGROUND

The policy stated in this chapter results from a Congressional directive "that VA make every effort to provide for adequate representation of women and minorities, within the constraints imposed by the characteristics of the population served by the VA, in VA-funded medical research projects, and to develop a policy to ensure such representation." *(Ref: Report 101-474 from the Senate Committee on Appropriations, p. 21.)*

14.05 PROCEDURES

a. Medical center Directors will ensure, through their research offices, that all potential applicants for clinical research support are familiar with the policy stated in this chapter.

b. Research and development committees and human studies subcommittees will review all proposals for compliance with this policy.

c. Scientific peer review groups, in VA Central Office, will evaluate all applications for clinical research support for compliance with this policy.

d. Projects that do not comply with this policy will not be funded by:

(1) Medical Research Service.

(2) Health Services Research and Development Service.

(3) Rehabilitation Research and Development Service.

14.06 DEFINITIONS

Clinical research includes human studies of the etiology, treatment, diagnosis, prevention, or epidemiology of diseases, disorders, or conditions, including but not limited to clinical trials.

Congressman Kreidler to Department of Veterans Affairs

Question # 1

First, I understand that CWT programs existed prior to the beginning of the TR demonstration program. I am wondering if the introduction of the TR program increased the number involved with CWT? And what are the total number of veterans involved with the programs are today?

Reply:

CWT Programs, or Veterans Industries (VI) was authorized by PL 94-581 in 1976 (38 USC Section 618). In 1990, PL 102-54 authorized the TR demonstration program, and expanded VI's contracting authority to include federal entities (38 USC Section 1718). The addition of the TR programs provided practitioners with a much needed clinical component, a "next step" in transitioning homeless veterans and those with substance abuse problems from acute care to self sufficiency in the community. There has been a very definite increase participation in VI programs. In FY 1990 there were 49 VI programs. This increased to 62 in FY 1993; currently there are 76 VI programs in operation, with another 4 requesting start up training. During the first 30 months of operation, 299 veterans were provided services by the VI/TR program, and an additional 17,100 veterans were provided treatment in CWT. Adjusting for the increase in program size, there are approximately 750 to 1,000 veterans participating in these programs at any one time.

Question #2

As I understand it, the VA makes the initial purchase of the housing facilities, but that the continued maintenance is paid through profits generated from CWT and rent paid by the veteran. But, is the program truly self-sustaining?

Reply:

Yes, most definitely. In fact, this was a primary consideration in the design of this program. A detailed amortization schedule, utilizing 2, 5, 10 and 15 year periods was developed so that each program would be able to project costs of repair and replacement, and charge rent accordingly. Additionally, the costs of utilities, etc. were worked into a monthly "rent" figure. Currently, over $280,000 is available for repair/replacement purposes. CWT has always been self sufficient; the costs of equipment and supplies necessary for its operations must be developed as a by-product of the bidding process.

Prior to implementation of either of these programs, new staff members are provided intensive training. One point that is consistently made is that these programs have a dual identity, both as a business and as a therapeutic program. The ability to provide therapy is contingent upon maintaining a viable business.

Question #3

I believe the VA has already purchased 37 residences for the program and that you are currently working on the purchases of the remaining 13. When do you expect to have this completed?

Reply:

At this time 37 residences have been purchased and renovated to meet

appropriate codes. Another 12 are in varying stages of the purchase process. The one remaining site is being held in anticipation of the designation of a special site in Somerville, New Jersey. This process is lengthy due to title searches, reviews of covenants, meetings with zoning boards and local officials, pest and radon inspections, etc. It is difficult to precisely predict when a purchase will be consummated. Assuming that there are no significant obstructions to the currently planned purchases, and renovations proceed in a straight forward fashion, we would anticipate the remaining sites to be owned by the end of this year.

Question #4

Now, the work the veterans perform in the program, is this mostly in the programs sheltered work-shops?

Reply:

The type of work in VI varies from site to site, according to the needs and types of local industry, the average length of stay of participants, and the technical and environmental capabilities of the program itself. Usually, during the initial evaluation and work hardening period, new veterans will begin working in a traditional sheltered workshop setting. In this manner, extensive clinical support and supervision can be provided in a well controlled setting. As the veteran's clinical condition and ability to withstand the demands of work improve, (s)he is moved into more demanding projects, with less immediate supervision. Finally, the veteran will move into supported employment at an industry worksite. Because veterans must be able to handle the stress of work, and earn a significant income, they are usually required to be able to sustain an eight hour workday in VI prior to placement in the TR program.
In some cases, veterans will remain in a sheltered setting while in the TR program, for one of two reasons - either they are actively seeking competitive employment, and need to be available for job seeking activities; or they are involved in technologically sophisticated work which pays well, but has a significant learning curve.

Question #5

What kind of wages are the veterans earning in this work?

Reply:

In FY 1993, participants in VI were paid $7.2 million. The average pay per hour was $4.61. This figure, of course, includes earnings of highly functioning individuals as well as much more seriously disabled veterans. Some stations have been concerned about creating financial disincentives to transitioning into competitive employment because of high rates of pay. The monies earned in VI, while taxable, are not subject to FICA withholding. As a rule, TR participants earn considerably more than other, more severely handicapped veterans with multiple neuropsychiatric handicaps. When one takes into account that the veteran participant must earn sufficient monies to (a) develop a community reentry fund, (b) purchase their food and clothing, (c) pay off past debts to clear credit history, and (d) pay full operational costs of the TR facility, it becomes obvious that the work developed must pay accordingly. Rates are generally higher in supported employment settings, running between $4.50 - $7.00 per hour.

Question #6

What benefits would these programs have by becoming non-profit corporations?

Reply:

By in large, our programs are quite flexible. The ability to assume such a non-profit identity would provide several additional program variants which will enhance the scope of clinical activities within VI. Programs would be able to compete for grant monies normally reserved for non-profit corporations, private, and state programs, thereby enhancing treatment and community-cooperative job training opportunities, etc. This status would also allow the programs to purchase equipment and supplies, and, finally, to take on additional support staff (as employees of the non-profit corporation) which would supplement the VA's clinicians.

Question #7

In the few existing programs with non-profit status, has there been any problems with the administration of the corporations?

Reply:

There have been no problems with currently viable non-profit programs. Current VHA program policy provides for fiscal oversight. The current legislative proposal, HR 3313, provides additional oversight to this, by including the facility director on the board of directors. It also requires that fiscal controls, reporting requirements and mechanism toprotect against conflicts of interest be developed. Based upon this, and the fact that VI's track record for fiscal compliance has been excellent, we do not foresee difficulties with this status.

Question #8

I was told that the some veterans in the program are volunteering in their communities. Can you tell me about this?

Reply:

Yes, these activities were initiated to preclude "NIMBY syndrome" (Not In My Back Yard); to inculcate a sense of community responsibility; and to decrease the attendant social isolation often seen in this clinical population. Each site provides its community with some visible service. Examples of this include shoveling snow and lawn maintenance for elderly neighbors, planting gardens,

PARALYZED VETERANS OF AMERICA
Chartered by the Congress of the United States

PARALYZED VETERANS OF AMERICA
RESPONSES TO QUESTIONS
SUBMITTED BY
REPRESENTATIVE JOSEPH P. KENNEDY II
IN REGARDS TO HEARINGS OF THE
HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE
SEPTEMBER 22, 1993

QUESTION 1(a): Is your organization aware that provisions of H.R. 3081 will limit coverage for some Vietnam veterans exposed to Agent Orange that are currently eligible for VA health care?

ANSWER: The current construction of H.R. 3081 is ambiguous to the extent that it does not expressly include or exclude health care for those diseases not categorized by the NAS study. Therefore, H.R. 3081 on its face could be interpreted to limit coverage for some Vietnam veterans exposed to Agent Orange that are currently eligible for VA health care.

CONTINUATION OF QUESTION 1(a):

In reference to language in H.R. 3081 that ties the VA's "Agent Orange treatment authority" to the findings of the National Academy of Sciences, the Department of Veterans Affairs states in its written testimony that it is "somewhat concerned... that this change would have the effect of limiting the authority the Secretary now has. There may be diseases and disorders that the NAS did not categorize in its study because there is no scientific literature related to them. We could now provide care for such disorders, but might not be able to under H.R. 3081."

It is foreseeable that grandfathering in those veterans who are currently receiving care could leave out some veterans whose illnesses due to exposure to Agent Orange emerge after a extended latency period.

QUESTION 1(b): Would you support striking these provisions of H.R. 3081 to remedy the exclusion of this group of veterans?

ANSWER: As stated in our written testimony, PVA fully endorses H.R. 3081. Moreover, PVA only supports authorizing treatment for those diseases which the NAS has found sufficient evidence to conclude that there is a positive association between occurrence of the disease in humans and exposure to a herbicide agent. Similarly, PVA endorses medical care for those diseases that the NAS also linked to exposure to herbicides based on suggestive and insufficient evidence. Although, the current epidemiological evidence is inclusive, PVA supports the bill's presumption of providing medical care to veterans diagnosed with diseases classified under suggestive and insufficient evidence.

QUESTION 1(C): If these restrictions limit eligibility to specific diseases, would the provision called for in H.R. 3081 be difficult to implement since veterans come to the VA with a set of symptoms rather than a disease?

ANSWER: H.R. 3081 would not be difficult to implement because it identifies certain diseases for medical treatment. Moreover, the bill should not be interpreted to deny a veteran a full and thorough examination for a particular symptom believed to be caused by herbicide exposure.

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Question 2: Is your organization aware of any sexual assault cases where male veterans were the victims? Would your organizations be supportive of providing VA sexual assault services to both men and women, irrespective of gender?

Answer: The consequences of sexual assault affect both men and women. VA should be prepared to provide counseling for both.

Question 3: Do you share concerns that the same quality standards (for mammography equipment, materials, performance and interpretation) required under P.L. 102-539 may not be prescribed by the VA under the provisions of H.R. 3082 and the same inspection procedures called for under P.L. 102-539 are not required of the VA in H.R. 3082?

Answer: The Department of Veterans Affairs should not have to be under the regulatory scrutiny of the Department of Health and Human Services in order to maintain the quality of care provided to the veteran population. VA health care services of every variety, including mammography, should meet or exceed national standards, not only to ensure uniform quality throughout the system, but to instill confidence in the system among the veteran population.

Certain provisions in H.R. 3082 would have authorized standards for mammography that would not have met the criteria required for the rest of the nation's health care providers by the Mammography Quality Standards Act of 1992. We believe VA should establish standards that are, at a minimum, no less than the national standard. We understand the Committee has reached tentative agreement to amend the legislation to raise the level of quality standards and inspection provisions for mammography procedures and equipment to a level equivalent with the federal standards. We understand that the standard adopted will be on a par with those monitoring standards recommended by the American College of Radiology. PVA fully supports this initiative.

Question 4: Do you believe that research carried out by the VA should benefit all veterans? If so, do you believe that veteran-related research should be coded for race and gender.

Answer: Research on diseases and disabilities conducted by the Department of Veterans Affairs health-care system has the potential of improving the health and well-being of all human beings suffering from those diseases - both veteran and non-veteran alike.

PVA understands that VA already has the ability to code and track the race and gender distribution of those individuals selected for research protocols. We do not believe that a statutory requirement mandating such procedures would be necessary. PVA has maintained that the Congress should not interfere in the ability of science, scientists and the peer review process to determine the best course for VA research in order to maximize results to the benefit of veterans and non-veterans alike. Certainly it is appropriate for the Committees on Veterans' Affairs and the Congress to set broad parameters for VA research which would highlight areas of investigation significant to the veteran population. In this regard, encouraging VA research planners to promote research into the health concerns of women veterans would be appropriate and of benefit to women veterans and all American women. However, we believe the Congress should avoid specific mandates, earmarks and research setasides to maximize the excellent product that has historically come from researcher self-initiated peer reviewed research.

Question 5: Knowing that VA is going to be a competitive provider under health reform and will have to offer comprehensive benefits to women vets and dependents, what suggestions would you

have for the VA to ready itself for that mission?

What consequences, if any, do you think the VA will face, if preparation for health-care reform doesn't begin now?

Answer: Health care reform will require VA to compete for a broader patient base. In doing so, the health-care system will have to expand its expertise and sensitivity in meeting the needs of increasing numbers of women patients - women veterans, and potentially, dependents and survivors of veterans. How the system provides these services - in-house or by contractual agreement - should be based on local determination of projected demand and health care capability, not by national mandate. VA should be given the resources to support such initiatives including the establishment of adequate privacy standards, personnel and equipment to meet the increasing health care of female VA patients. However, the ultimate determination on site-of-service selection for services for women patients should not be based on cost alone, but on where best to ensure the quality of the services provided. The quality as well as the patient's perception of the quality, along with the VA systems ability to provide those services in an efficient and effective manner, will be paramount factors in determining whether VA can attract and sustain a stable patient base.

The Department of Veterans Affairs Health Care System has suffered over 6 years of budget shortfalls that have constrained the ability of the system to provide necessary care, weakened the morale of the employees within the system who provide that care and generally undermined the ability of VA medical facilities to offer a health-care product in the most efficient and effective manner. /The VA's fractured eligibility system has joined budget constraints as a problem of equal, if not greater magnitude./ Most veterans currently seeking VA care do so without entitled access to the full continuum of modern health care they might potentially need. The "swiss cheese" of eligibility rules and regulations describing which veteran can receive what services, are an anachronism in modern medicine, confusing to the veteran patient, and an inefficient means of practicing health care.

These problems will continue to exist in varying degrees whether or not VA is launched immediately into the reorganization required by the competitive processes of health care reform. The system will continue to take a pounding from a yearly funding shortfall in excess of two billion dollars in operating funds and needed medical equipment. As part of the reform package VA will require funding to overcome these historical budget shortfalls as well as additional funds to reorganize and expand delivery systems. On the eligibility front, the reform plan would provide the "basic package" of services for all veterans, core group and non-core group, who elect VA as a provider. In doing so it would alleviate many of the inequities currently experienced by veterans in the present eligibility system through the blanket provision of additional outpatient and preventive health services. However, to what extent the end-product basic package remains sufficiently comprehensive under the examination of a cost-conscious Congress remains to be seen. Costs have already forced the Administration to sidestep the full continuum of care for veterans by ignoring almost completely entitlement to the most basic service required by an aging veteran population - long term care.

While certainly not perfect, the Administration's announced health care reform initiative gives the VA health-care system, the Congress and other policy makers the opportunity to address many of the systems ills, both financial and structural. The Administration has made it plain that VA will be tied to this process. PVA has been willing to accede to this process as long as it has been clear that players on all sides were sincere in

their commitment to do the most for, and what is best for, the VA system (and as long as it appeared there were no realistic alternatives). Without health care reform, however, or if protracted debate delays enactment of the reformed package, the Congress should move immediately to disencumber the VA from national health care reform and proceed to address the problems of health care eligibility, budgets and financing on a unilateral basis. These problems are not new. Budget shortfalls and eligibility reform have been key concerns of PVA and all major veterans service organizations for years. Correcting these problems have been the main health-care policy objectives of eight published "Independent Budgets."

Reinventing VA within the context of health care reform is not a perfect solution. But ignoring the lingering problems facing the VA if health-care reform were to languish in a protracted political debate would eventually destroy the system. One way or another these problems need to be addressed and corrected as soon as possible.

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