annual report

ADMINISTRATOR OF VETERANS AFFAIRS

1969

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Letter of Transmittal

January 19, 1970.

To the President of the Senate and the Speaker of the House of Representatives of the 91st Congress:

Pursuant to the provisions of 38 U.S.C. 214, I have the honor to submit the report of the activities of the Veterans Administration for the fiscal year ending June 30, 1969.

In a departure from previous years, this report describes the activities and accomplishments in all of the programs administered by the Veterans Administration, but does not present detailed statistical tables. A supplemental report containing such statistical information will be issued separately.

Respectfully,

DONALD E. JOHNSON,
Administrator.

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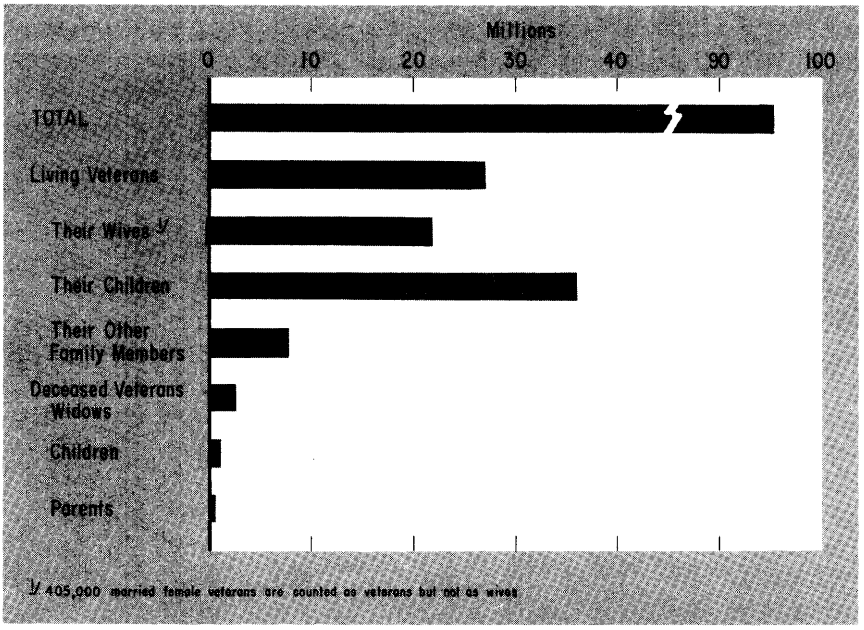
Meeting the Veterans' Needs

America's veteran population reached approximately 26,925,000 by the close of fiscal year 1969. These are men and women in civil life potentially eligible to receive veterans' benefits and services on the basis of service in the U.S. Armed Forces during a period of war, armed conflict, or in the "cold war" between January 31, 1955 and August 5, 1964. The veterans population today is 47 percent greater than it was immediately following World War II.

Veterans, their families, and deceased veterans' survivors account for 95.5 million of the total civilian population of just under 200 million. Thus veterans benefits and services are potentially available to 48 percent of the total population.

VETERANS AND THEIR FAMILIES, JUNE 30, 1969



During the year just ended approximately 940,000 servicemen were separated from the service. This number excludes 32,000 reenlistments. The influx of new veterans was offset in part by the death of about 288,000 already on the veterans rolls.

At both ends of this span the Veterans Administration plays a part. The newly discharged serviceman is potentially entitled to a variety of veterans benefits designed to speed his readjustment into civilian life and to help him in his future endeavors. The survivors of most deceased veterans are eligible for certain burial benefits including burial payments and flags. In addition, survivors may be entitled to insurance proceeds, to death compensation and pension benefits as well as educational assistance.

More than 3 million of the 27 million veterans are Vietnam era veterans. It is the needs of these young men and women that the Veterans Administration is most concerned with today.

One of the steps the VA has taken in attempting to accomplish this mission is to "go where the action is,"—to go to Vietnam. Representatives of the VA, men with long experience in the many benefit programs available to veterans, are actually stationed in Vietnam. Here they work closely with the Armed Forces TV and radio network which reaches more than half a million servicemen. They tell the serviceman in Vietnam about the benefits to which he is or will become entitled. Through personal interviews they help him prepare the proper applications and forms for obtaining these

Orientation in Vietnam

benefits. In the past year more than 475,500 servicemen in Vietnam were told about VA benefits and programs. Some 49,700 were given personal interviews.

Veterans Administration employees provided contact service throughout Vietnam, traveling by jeep, plane, helicopter and boat to remote forward areas. Two VA representatives were killed last October in a plane crash. Twenty-one servicemen also lost their lives in this accident.

Here in the United States stepped up efforts continue to acquaint the soon-to-be released serviceman with the benefits and services to which he may be entitled. Pre-separation group orientation sessions are provided at more than 300 military separation points throughout the United States. The aim is to reach the young serviceman about to be separated.

Under the military hospital program instituted in October 1966, interviews are conducted with servicemen awaiting separation because of disabilities incurred in service. VA personnel regularly visited 184 military hospitals. Over 80,100 personal contacts were made during the year. This is an increase of 30 percent over the previous year when 62,000 contacts were made at 115 military hospitals. As a result of these bedside interviews, 40,300 claims for compensation were filed and 27,700 servicemen requested vocational rehabilitation training.

All separatees are contacted by the Veterans Administration. A copy of each man's discharge from the Armed Forces is used to prepare a letter to the veteran. There are four basic type letters tailored to the veteran's education and disability status. Approximately 900,000 letters were dispatched during the fiscal year.

Periodic sampling indicates a response to these letters of about 38 percent. The sampling also shows an ever increasing interest in veterans benefits.

The United States Veterans Assistance Centers (USVAC's) were expanded from 21 locations to the 71 major cities in the country. These centers were established to provide recently separate veterans with an integrated Federal Agency assistance program on a one-stop basis. During the year, 325,000 interviews were conducted with veterans at these centers. Approximately 11,000 veterans were provided employment and over 190,000 applications for education, training or other benefits were filed.

In addition, telephone and personal visits were made to the new veteran to exhaust every possible means of acquainting him with his benefits, particularly his educational rights.

Special telephone service was extended to 37 communities. This special telephone service enables veterans and their families in cities where the facilities exist to pick up the telephone, dial a local number and, toll free, talk to a representative of the regional office many miles distant. One of the major advantages of this type of service is that it is available to those who cannot leave home or place of business to visit an office. Further, the veterans are in communication with the office actually adjudicating their claims

and where their individual records are maintained. During fiscal year 1969, there were 387,299 telephone discussions over these special telephone lines.

The main thrust of USVAC efforts is toward the educationally disadvantaged, although the service is available to all Vietnam era veterans. An "educationally disadvantaged veteran" is characterized as one without a high school diploma or an equivalency certificate. Since the inception of the program in February 1968, over 65,500 interviews have been conducted with educationally disadvantaged veterans. More than 44,400 applications have been filed by this class of veteran during this period. These statistics indicate the success of the program as a readily accessible focal point for action on the problems of the educationally disadvantaged veteran.

During the year social workers were assigned at five USVAC'S for a 60-day study to determine the extent of the need for social worker service in motivating the veteran and overcoming sociological or economic impediments to the pursuit of higher education. The tests indicated that this category of personnel could make a substantial contribution to the USVAC objective. Plans were made by year end for placing social workers in all larger USVAC operations.

In addition to the special efforts geared to assist the newer and younger veteran, the overall effort continued to be to assist all veterans. In the past year over 2.7 million interviews were conducted with individuals visiting contact locations and an additional 5.1 million persons were assisted through telephone calls.

The overall mission of the VA continued unchanged. Its mission since its establishment in 1930 was and is to administer, interpret and implement laws which relate to benefits and rights provided to veterans of the Armed Forces, their dependents and beneficiaries.

In the past year numerous bills and resolutions were introduced in Congress having a bearing on veterans benefits and services. At the request of Congressional Committees, the President and the Bureau of the Budget, 338 reports were prepared on such pending legislation. Analyses of the proposals, and other pertinent data and comments, were contained in the reports.

Several major pieces of legislation affecting the Veterans Administration were passed by the 90th and 91st Congress and signed into law.

Public Laws 90–429, and 432 increased the limitation on the amount payable for nursing home care from 33⅓ percent of the cost of hospital care in a Veterans Administration hospital to 40 percent of that cost; and the maximum per diem rates of Federal payments to State homes for eligible war veterans receiving hospital or domiciliary care from $2.50 to $3.50, and nursing home care from $3.50 to $5.00. The first year cost of these changes is estimated to be about $9 million.

Public Law 90–493 increased effective January 1, 1969 the monthly rates of service connected disability compensation payable for total disability (as well as higher statutory rates) by $100; for disability rated from 10

percent to 90 percent disabling by 8 percent and for those receiving additional compensation because of need of regular aid and attendance by $50. Cost estimates at the time of enactment of this law were placed at $235 million for the first year.

The educational assistance program was modified by Public Law 90–631 passed October 23, 1968. A maximum of 48 months of entitlement under two or more educational programs was provided for. Entitlement to educational assistance was increased for a period of 1½ months for each month of service, and 36 months of education assistance was provided to a veteran who had completed 18 or more months of active duty service after January 31, 1955. Another major provision was the extension of the war orphans' education program to the widow of any person who died of a service-connected disability or the wife of a person who has a total disability permanent in nature. Other provisions of the bill modified correspondence, farm training and flight training programs as to entitlement or payment basis. The modifications to existing laws allowed by this law are expected to increase the cost of these benefits by almost $15 million the first year and by $345 million over a 5-year period.

Public Law 91–22 extends the eligibility for grants for specially adapted housing to a new group of disabled veterans. It also increases the amount of the paraplegic housing grant from $10,000 to $12,500. The effects of these portions of the act on VA operations should be minimal. Other sections of the act increase the maximum amount of a direct loan from $17,500 to $21,000 and relax the first lien requirements for guaranteed home loans to permit guaranty of homes for veterans where basic financing requires first lien security for monthly charges to home purchases in "new town" developments. These latter two changes should have a beneficial effect on the direct and the guaranteed home loan programs.

To carry out its responsibilities the Veterans Administration has divided its main headquarters into departments (3) and staff offices (9). The departments in turn direct the activities of the various field stations. On June 30, 1969 there were in operation 166 hospitals, 16 domiciliaries, 202 outpatient clinics, 57 regional offices, 6 data processing centers and numerous miscellaneous installations. These field activities are located in every State, the District of Columbia, the Commonwealth of Puerto Rico, in the Philippines and Italy.

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Educational Benefits

The Veterans Administration has been sponsoring education and training programs since World War I. It began with a program to overcome the vocational handicaps of diseases and injuries suffered in military service during World War I.

Before World War II was over, a vocational rehabilitation program was again in effect. World War II also saw the beginning of education allowances to veterans who needed only military service to qualify. These programs were modified and reinstated in the Korean conflict and are currently in effect for the post-Korean period, including the Vietnam era.

About 13 years ago, a new departure was taken when orphans of those veterans who had died from service-connected causes were granted educational allowances. This program was later liberalized to include children of men who were permanently and totally disabled from service-connected causes. The program is designed to be of assistance in the child's period of life where education costs are high—the postsecondary education period.

Two innovations have recently been added to the Veterans Administration programs: The education benefits for certain wives and widows of veterans; and part-time vocational rehabilitation training. The first recognized the need for, and value of, education in preparing the wife or widow to supplement the family's income. The second was to encourage disabled veterans, presently employable, who couldn't afford to give up present earnings for full-time training. The part-time training would smooth the transition from present employment to a career compatible with a man's disability.

Educational Benefits for Veterans

When the post-Korean GI Bill became effective in June 1966 a "reservoir" of over 3 million qualified veterans existed. However, in the more than 11 years that had elapsed since February 1, 1955, most of these potentially eligible men had already obtained the education and training they required and had made their occupational choices. Thus, while some in this "reservoir" did participate after the law was passed, most did not and probably will not participate.

The situation is different with those discharged since the enactment of this legislation. Because the circumstances in this conflict are different from those of previous service periods, servicemen are being discharged at the end of

their service obligation rather than at the end of hostilities. As a result a number of veterans become eligible for educational benefits each month.

To assure that these separatees are made aware of the benefits available to them, computer-generated letters are sent to each recently separated veteran at his home address. There are four basic type letters tailored to the veteran's education level and whether or not he has a disability. (A sample of one of the types of letters used is shown.) With the letter is a post card by which the veteran can request detailed information on any of the benefits. Approximately 900,000 letters were dispatched during the fiscal year and the response indicated increasing interest in the benefits available.

VETERANS ADMINISTRATION

Letter to veteran who has less than high school education

Mr. Benny Fishiari
100 America Avenue
Bigtown, New York 10011

Dear Mr. Fishiari:

WE CAN HELP YOU ---

DO YOU WANT TO FINISH HIGH SCHOOL OR LEARN A TRADE?

GI BILL BENEFITS WILL HELP YOU TO DO SO.

DO YOU WANT A JOB?

THE LAW PROVIDES JOB PLACEMENT AND VETERANS PREFERENCE BENEFITS.

DO YOU WANT HELP IN BUYING A HOME?

DO YOU NEED DENTAL OR MEDICAL TREATMENT!

ASSISTANCE ON ALL THESE BENEFITS IS PROVIDED FOR VETERANS. IF YOU WANT MORE INFORMATION, CHECK THE BENEFIT(S) LISTED ON THE ENCLOSED POSTAGE-FREE CARD AND RETURN ...

OR ... CALL US AT ... 620-6501
(IF OUTSIDE OUR DIALING AREA, COMPLETE THE TELEPHONE INFORMATION ON THE CARD AND WE WILL CALL YOU.)

OR ... VISIT US AT ... VETERANS ADMINISTRATION ...
VETERANS ASSISTANCE CENTER
252 SEVENTH AVENUE
NEW YORK, NEW YORK 10001

Encl. VAF

Include Zip Code in your return address and give veteran's social security number.

Show veteran's full name and VA file number on all correspondence. If VA number is unknown, show service number.

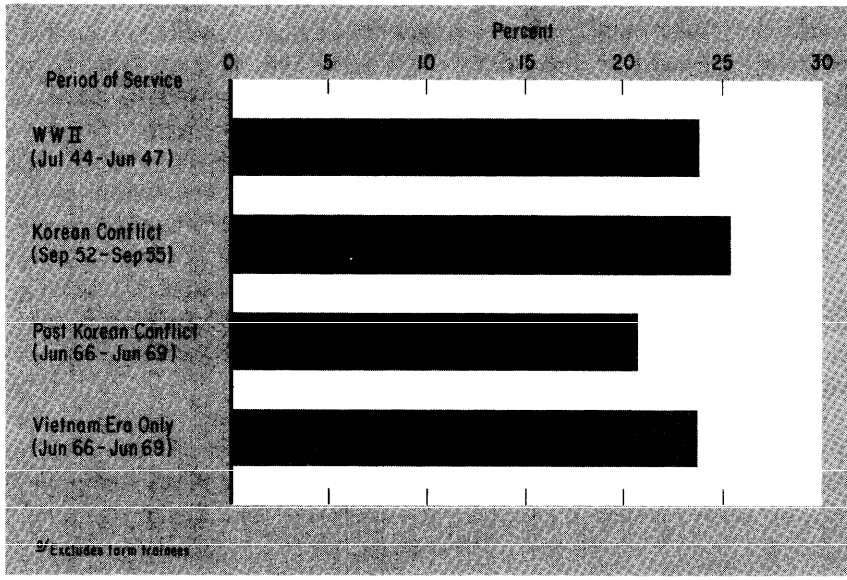
Letter to Vietnam Era Veterans

Since the inception of the current education program in June 1966 through the end of June 1969, more than 1,300,000 veterans and servicemen entered training, (90,000 were servicemen on active duty). Of this total, 57 percent were in colleges, including 11.4 percent in graduate work; 37.7 percent were in below college level courses consisting of business, trade, technical, flight training and high school courses; and 5.3 percent were in apprenticeship and other on-the-job training programs. Significantly, of the 90,000 servicemen who received training, only 28.5 percent were at the college level and 71.5 percent were in below college level training. Two out of three servicemen, or 60,000 out of approximately 90,000, have taken training through correspondence courses.

The most popular courses at both the college and below college level have been in the field of business and commerce. Approximately 20 percent of those taking college work have been in this field and 24 percent of those below college level. Another popular field of study at the below college level has been electrical and electronic courses. Over 103,000 veterans and servicemen took some training in this area. Although flight training has only been available since October, 1967, more than 38,000 veterans and servicemen have already had some flight training under the current G.I. bill.

The World War II and the Korean conflict G.I. bills provided for institutional on-the-farm training. With the changing nature of farming, increasing mechanization, larger size farms, larger capital outlays and decreasing farm population, there was no demonstrated need for institutional on-farm training and the current G.I. bill provides only for cooperative farm training.

EDUCATIONAL PARTICIPATION RATES



When the former type of farm training is excluded, meaningful comparisons can be made as to the participation rates after the first 3 years under each of the G.I. education bills. The participation rates were 23.9 percent for World War II, 25.4 percent for the Korean conflict, 20.7 percent for all the post-Korean conflict veterans, and 23.8 percent for those with Vietnam era service, i.e., service on or after August 4, 1964.

The need for vocational rehabilitation increased with the casualties from Vietnam. Participation rose by 35 percent. The disabled serviceman still in the military hospital is provided counseling by the Veterans Administration contact representative. He is motivated to begin his efforts as early as possible to overcome his disabilities. By the end of fiscal year 1969, 16,739 men in military hospitals had been counseled and 2,660 Vietnam servicemen had entered into rehabilitation training while still in a hospital status. Many more returned to their homes ready for immediate training commitments. Post-Korean and Vietnam era veterans accounted for 89 percent of the almost 19,000 in training.

A rather significant change in vocational rehabilitation training occurred during the year with the authorization by public law of subsistence payments for training pursued on a less than full-time basis. In April, a peak training month, almost 1,000 veterans were in training on a part-time basis.

Educational Assistance for Dependents

In the 13 years since the beginning of the educational assistance program for children, more than 211,000 applications for training have been received. Last year more than 40,000 received training under the program.

Effective December 1, 1968 the educational assistance program for dependents was expanded to include widows of deceased veterans and wives of permanently and totally disabled veterans. The Congress, with VA support, recognized the need of these widows and wives and, through Public Law 90–631, gave them an opportunity to achieve an improved standard of living. This additional education and training will, at the same time, contribute to the national pool of needed skills.

All of the eligible wives and widows were advised of the educational opportunities through information furnished with VA benefit payments as well as through public channels.

Over 7,000 widows and wives applied for training and 2,800 actually entered training by June 30, 1969. Of those who entered training 51 percent were in college and university level courses and the remainder in below college level courses.

A large percentage of the wives and widows entering training in the early months of the program were located in the Philippines. The rates of educational assistance payable to these wives and widows in the Philippines were, in many instances, higher than salaries earned by skilled professionals

in law, banking and medicine. This disparity apparently accounted for the high participation rate. Over 98 percent of these wives and widows were in below college level programs.

Vocational and Educational Counseling

The vocational and educational counseling activity has been a major contributor to the success of the education and training programs. Counseling was originally provided on the premise that disabled men needed skilled guidance in choosing occupations. Veterans with service-connected disabilities, needing rehabilitation, would thus be guided into training for jobs that would use their abilities, and not be infeasible because of their disabilities.

All applicants for vocational rehabilitation must receive counseling. The success of counseling in the rehabilitation program led to a similar requirement for orphans and children. Counseling is also required for obvious reasons, for veterans who have made unsatisfactory progress in their training, or who want to make more than one change in their program. It is available on request to all veterans, wives, and widows eligible for training.

It has been found that a very critical period in the life of a disabled veteran is the time of treatment and recuperation. During this time he must adjust to his disability and prepare himself for working and living with his disability. For this reason as previously stated, vocational counseling has been continued to hospitalized disabled servicemen before their discharges. Vocational counseling was provided 36,800 disabled veterans. In addition to these disabled veterans, 23,100 veterans were provided vocational counseling and assistance in selecting a program of education or training under the Veterans Educational Assistance Program.

A third group receiving counseling was the sons and daughters of deceased or permanently and totally disabled veterans who applied for educational assistance. During fiscal year 1969, counseling was provided 19,445 applicants for benefits under the dependents educational assistance program.

The importance of looking ahead and planning the secondary school course as a foundation for a program of subsequent education is brought to the attention of parents or guardians, when each eligible person reaches age 13.

Compensation and Pension

Recipients of the various compensation and pension programs administered by the Veterans Administration continued to increase. At year's end 3.2 million living veterans and the dependents of 1.5 million deceased veterans were receiving $4.9 billion in compensation or pension benefits. A year ago the recipients numbered 3.2 and 1.4 million, respectively, and the expenditures amounted to $4.5 billion.

Compensation for Veterans

Disability compensation is a benefit to living veterans, compensating them for the average loss of earning power for the average man caused by disease or injuries due to military service. These average losses are determined by applying an approved rating schedule to the findings of disability on physical examinations. The rating schedule is the product of half a century of experience with disabled veterans and has been revised many times. The schedule is currently undergoing an extensive economic validation study.

The study analyzes about 1,000 specific disability groups each made up of a representative sample of veterans who have the same service-connected disability rated at the same level. Information obtained is being used to compare the earnings and work experience of each service-disabled group with the earnings and work experience of a control group of veterans of similar age, level of education and area of residence who, however, do not have a service-connected compensable disability. Statistics on each disability group were gathered by the Bureau of the Census and furnished the Veterans Administration in June 1969. It is not expected that any indicated schedule revision will be made prior to 1971.

Disability compensation is paid to both wartime and peacetime veterans, but the disabilities due to peacetime service are compensated for at 80 percent of the wartime rates.

Wartime rates of compensation range from $23 for a 10 percent disability to $400 for a 100 percent rating. These basic rates can be increased by special rates for loss of limbs or organs, being housebound, or in need of aid and attendance, to a maximum of $1,000 per month. Basic rates for 50 percent or greater disability are increased by allowances for dependents.

The average monthly compensation payment per case can represent a high average degree of disability as with the Vietnam veteran or an unusual situation because of existing circumstances as with the Spanish-American

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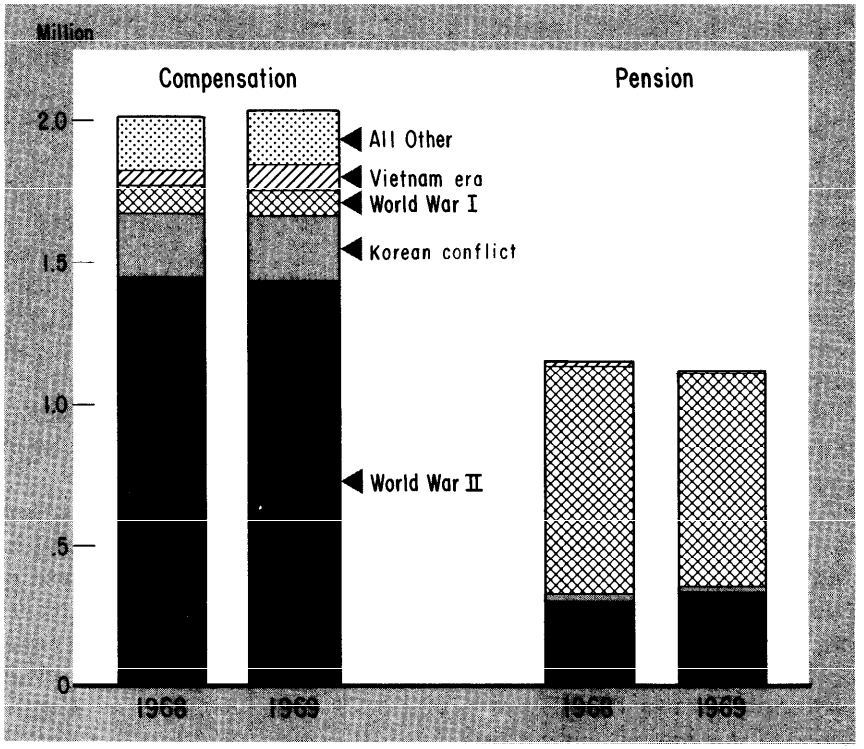
veteran. For example while some disabilities increase with age, it is also true that older war veterans often elect to accept pensions for totally disabling conditions not due to service when the pensions available exceed compensation benefits. The dropping of these lower rated veterans from the compensation rolls leaves the higher rated veterans on the rolls and distorts the average upward.

The disability compensation program is the largest direct benefit program in terms of beneficiaries (2,039,219) and in terms of dollars expended ($2.1 billion). It is an increasing program; the number of living veterans receiving compensation rose by nearly 30,000 last year. While there was a net increase in beneficiaries, the proportions of the various groups of veterans changed. The number of Vietnam era veterans more than doubled over the prior year (47,000 to 95,000) and their benefits more than tripled (less than $39 million to $118 million). While the Vietnam era veterans on the compensation rolls were increasing, World War I veterans declined 7,100, and World War II veterans had 17,500 fewer on the compensation rolls.

VETERANS RECEIVING COMPENSATION AND PENSION



Compensation for Dependents

Death compensation is a benefit paid to dependents of deceased veterans whose deaths were caused by conditions due to military service. It is based on flat rates paid to widows, children, and dependent parents. It has been largely superseded since 1956 by the Dependents Indemnity Compensation program.

Dependents Indemnity Compensation is paid to dependents of deceased veterans whose deaths were attributable to military service. It differs from death compensation in that the rates are based on the deceased veteran's pay grade and years of military service.

As with all programs, compensation for survivors of veterans undergoes continuous review with the aim of improving the services offered and tailoring the benefit programs to meet the needs of the beneficiaries. The Dependency and Indemnity Compensation program, as instituted by the Congress on January 1, 1957, was an improvement over the death compensation program. The DIC benefits, by being related to the pay grade of servicemen with the same rank as the deceased husband, compensated in greater part for the loss of income to the family unit resulting from the death of the veteran breadwinner. However, current studies conducted by the VA brought out disparities and inequities in the benefits resulting from this formula. Because military pay increases vary among grades, widows of the lowest enlisted grades received little benefit from each pay increase. One study concluded that the widows of veterans of the same pay grade should be treated alike without regard to the number of years of service and recognized the need for a cost of living increase.

The conclusions drawn from the study were recognized as being valid by the Congress, and were incorporated by it into legislation which was enacted as Public Law 91–96.

The cases of compensation for dependents of deceased veterans started to decline in 1960, but this trend was reversed in 1968 and in 1969. Last year nearly 477,000 dependents received almost $536 million in benefits payments.

Pension for Veterans

Disability pensions are paid to certain needy, totally disabled veterans of wartime service, to afford a measure of support when their incomes and available assets are below levels of adequate self support. This program obviously benefits more old than young veterans. That this is a substantial program of benefits is evidenced by the number of beneficiaries—over 1,120,000—and the dollars of benefits—over $1.3 billion.

Pension has historically been a benefit based upon need, with need measured by the income of the recipient. Income is too often not static and changes affect the ability of a pensioner to meet the necessary costs of living. Also, inequities have developed which reduced the beneficial effect of the program. One of the most important of these was the inadequacy in safeguarding the pensioner from a disproportionate loss of pension resulting

from a small increase in income. This impact was especially felt when social security benefits were raised, for in many instances a small increase in this benefit caused a comparatively catastrophic loss of pension to many VA beneficiaries.

A study was directed to devise a means for preventing such occurrences. It led to recommendations for providing safeguards against severe pension reductions resulting from increases in income. One recommendation adopted as a stop-gap measure was a provision in Public Law 89–730 prohibiting pension reduction due to an increase in retirement-type benefits until the end of the year in which the increase was received. A full PPB study recommended a restructuring of the pension program, expanding the three existing income levels to 18 and 28 for those without and with dependents respectively, and establishing pension rates for income levels. By this revision, a small variation in income would be reflected by a small change in pension. This proposal was adopted and became law effective January 1, 1969.

Pension for Dependents

The number of deceased veterans whose dependents received pensions went up from 1,075,000 in 1968, to 1,125,000 in 1969.

This program, like the veteran pension program, is based on a concept of need. Dependents of those wartime veterans who died of nonservice causes are eligible. Again, need is determined by the income and asset limitation provided by law. There are about 1,705,000 dependent beneficiaries in the 1,125,000 cases. The amount of benefits paid reached to nearly $850 million in fiscal year 1969.

The pension programs for living veterans and the dependents of deceased veterans have been made more flexible and more responsive to individual needs. The more than $2.1 billion dollars expended on all pensions in 1969 figured significantly in the economic security of more than 2 million veterans and their surviving dependents.

Guardianship

In addition to providing compensation and pension benefits, attention is given to administering the affairs of the mentally ill and minor beneficiaries. For the mentally ill who are incapable of administering their affairs, close supervision is given to estate administration, coupled with personal contacts to assure the beneficiary's well-being. The approach in cases of minor beneficiaries, while protective in nature, is primarily directed toward assurance of adequte provision for immediate needs, continuation of education through high school, and the development of an appropriate educational program thereafter.

Minor and mentally ill beneficiaries served totaled 746,806, an increase of 57,261 over the previous year. This increase is approximately 15,000 above the average annual increase for the past 5 years. Minors currently comprise 85 percent of the beneficiaries cared for on June 30, 1969.

Housing Assistance

Loans to Veterans

During the year, over 230,000 veterans were aided in the purchase of homes by VA guaranteed and direct loans. In aggregate, the loans amounted to about $4.2 billion. The number of veterans obtaining VA loans during the year was about the same as in fiscal year 1968.

The younger post-Korean veterans accounted for 68 percent of the loans, an increase of 14 percent over fiscal year 1968. Loans to World War II veterans declined by 47 percent from fiscal year 1968, and loans to Korean conflict veterans declined by 13 percent. These results in respect to World War II and Korean conflict veterans were a continuation of experience in recent years reflecting primarily the satisfaction of the credit needs of such veterans in the purchase or construction of homes.

About 68 percent of the homes purchased with the assistance of VA loans were previously occupied dwellings. A veteran purchasing a previously occupied home paid, on average, $17,651 and obtained a loan of $17,182. On newly constructed homes, the average price was $21,256, and the loan amounted to $20,754.

Nearly all homes purchased under the VA program were financed with guaranteed loans. Private lenders loaned $4.02 billion to 219,264 veterans to buy or build homes, with VA acting as the guarantor of the loans. In addition 11,162 veterans purchased homes with VA direct loans, amounting to $143.6 million, in rural areas, small cities and towns designated as housing credit shortage areas (comprising nearly 80 percent of the Nation's area and containing 20 percent of the veteran population), where private capital for guaranteed loans was not generally available.

Demand for capital in the Nation exerted strong pressures on the availability of funds for investment in residential mortgages. To keep pace with a consequent rise in interest rates generally, and to induce private lenders to invest in VA guaranteed loans, the maximum allowable rate of interest on such loans was increased, January 24, 1969, from 6¾ percent to 7½ percent. Concurrently, the interest rate on VA direct loans was also raised from 6¾ percent to 7½ percent.

The year was marked by two important milestones, the 25th anniversary of the program, and on November 14, 1968, the closing of the seven millionth GI home loan.

Seven Millionth GI Home Loan Closed

Substantive Improvements

In past years, a veteran was precluded from obtaining a VA loan if the purchase price of the property exceeded the VA appraised value. A new law approved in May 1968 (Public Law 90–301) was implemented to enable a veteran to obtain such a loan if he agrees to pay in cash any amount in excess of the appraised value.

Another change brought about by law (Public Law 91–22) permits loans to be guaranteed on properties in "new town" housing developments. Heretofore, such loans were not eligible for guaranty if liens superior to guaranteed loan liens would be created. In many "new town" developments, such superior liens, usually to ensure payment of community facility assessments, are created, prevented veterans from using the VA loan program to purchase homes in these increasingly popular types of developments. The new law permits the VA to disregard such superior liens.

In recognition of the continuing rise in the cost of housing, the maximum amount of a direct loan was increased to $21,000 from $17,500 by legislation. This same law also increased the maximum VA grant from a home specially adapted for a veteran who can't move about without the aid of a wheelchair, braces, or crutches. The previous maximum of $10,000 for a grant was raised to $12,500.

Liquidation and Funding

During the 25 year history of the GI loan program VA has underwritten over 7.4 million loans in an aggregate initial principal of $75 billion. In addition the VA has made 297,000 direct loans, amounting to $2.8 billion.

The veterans who obtained these loans have built an impressive record of meeting their obligations, as evidenced by the fact that since the beginning of the program less than 300,000 of these loans have resulted in claims for the guaranties or foreclosures.

For the third consecutive year, the number of defaults reported and guaranty claims paid declined substantially. Of the 3.5 million loans outstanding only 33,342 were in default, compared to 36,970 at the end of the previous year, and 43,561 at the end of fiscal year 1967.

The decrease in guaranty claims also resulted in a further decline in the number of properties acquired as the result of defaulted loans. At the end of the year VA owned fewer than 12,000 properties.

The money to pay guaranty claims and conduct property management operations is provided from a revolving fund established in 1961. This fund has been able to meet all such needs without appropriations.

The direct loan revolving fund provides money for making direct loans and meeting expenses and losses associated with such loans. Proceeds from the sale of direct loans and participation certificates and repayments on outstanding loans provide adequate funds for the operation of direct loan activities.

Grants for Specially Adapted Housing

During the year, 850 paralyzed veterans were declared eligible for grants to buy, build, or modify specially adapted homes. This was an increase of 250 over the previous year. Grants were made to 482 veterans during the year, bringing to 10,187 the number of veterans assisted by such grants since 1948, when grants were first authorized. The 482 veterans assisted during the year received $4.9 million, bringing the total disbursed since 1948 to $97.6 million.

Insurance Coverage

Programs

Insurance coverage for the Nation's servicemen and veterans is provided for under two separate types of programs: Those administered by the Veterans Administration and one supervised by the Veterans Administration but administered by a commercial primary insurer—The Prudential Insurance Co. of America. The insurance operation of the Veterans Administration is the third largest life insurance operation in the United States for all ordinary insurance coverage. The insurance program supervised by the Agency, called Servicemen's Group Life Insurance, covers more insureds than any other single group contract.

At the close of fiscal year 1969, the Veterans Administration was responsible for the administration of more than 5.6 million policies with a face value in excess of $38.2 billion under five separate programs:

(1) United States Government Life Insurance was established in 1919 to handle the conversion of World War I War Risk Term Insurance. Approximately 1,150,000 policies were issued and 207,278 remained in force at the end of the fiscal year, having a face value of $897 million. The program is self-supporting except for administrative expense and claims traceable to the extra hazards of military service. The program was closed to new issues after April 24, 1951. Policyholders are decreasing at the rate of about 5 percent a year.

(2) National Service Life Insurance was established October 8, 1940, to cope with the insurance needs of World War II servicemen. More than 22 million policies were issued, and 4.5 million remained in force at the end of fiscal year 1969. The face value of these policies is $29.7 billion. The program is self-supporting except for administrative expense and claims traceable to the extra hazards of military service. The program was closed to new issues after April 24, 1951.

(3) Veterans Special Life Insurance was available to veterans separated from service on or after April 25, 1951 providing an application for coverage was submitted within 120 days following separation. About 800,000 policies were issued and nearly 625,000 remained in force on June 30, 1969, with a face value of $5.5 billion. The program is self-supporting except for the administrative expense, and was closed to new issues after December 31, 1956.

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(4) Veterans Reopened Insurance was a limited reopening of National Service Life Insurance for certain disabled World War II and Korean veterans. Applications could be submitted from May 1, 1965, through May 2, 1966. Administrative expense is borne by the insured. Premium rates may be adjusted to meet the fund requirements. About 210,000 policies were issued of which about 197,000 remained in force at the end of the fiscal year with a face value of $1.4 billion.

(5) Service-Disabled Veterans Insurance is available to veterans separated from service on or after April 25, 1951, who are suffering from a specified service-connected disability, who are otherwise insurable, and who apply within 1 year after the date of the VA notice of the disability rating. These medically substandard lives are insured at standard rates, hence the program is not self-supporting and requires periodic appropriation. The Veterans Administration makes a special effort to assure the veteran does not overlook this valuable protection—it informs him of his eligibility for the insurance at the time of the disability rating and again 6 months prior to the delimiting date. For the totally disabled veteran the Veterans Administration takes the initiative where the veteran has not applied, by automatically issuing him a paid-up policy. Totally disabled veterans who do apply, also receive the premium-free policy. At the close of the fiscal year, over 81,000 policies were in force with a face value of $708 million. The SDVI program is the only one which remains open to new issues.

Applications for the Service-Disabled Veterans Insurance, in behalf of a mentally incompetent veteran, were formerly required to be made by a legally appointed guardian. The delays and costs that were encountered in the guardianship appointment prompted a change, which now permits anyone to apply for an eligible incompetent veteran when the latter also qualifies for premium waiver.

Applications for Service-Disabled Veterans Insurance were required to be submitted within 1 year of the date of the service-connected rating. To assure maximum eligibility for these disabled veterans, regulations were changed to permit submission of the application within 1 year from the date of the notice of eligibility, rather than from the date of the rating itself. Thus, if there should be any processing delay, this will have no effect on the veteran's eligibility period.

Policyholders under the Service-Disabled and the Veterans Reopened Insurance programs were granted liberalized reinstatement privileges, when the reinstatement application was made within 1 year from the date of lapse. The liberalization provides that any disability which was the basis for issuing the policy, including the natural progression of the disability, will be waived for reinstatement purposes.

Insurance coverage for present members on active duty in the uniformed services is provided by Servicemen's Group Life Insurance. This program was established in 1965. As stated previously, it is a Government-industry partnership by which, under a group contract with a primary insurer and the participation of 585 other commercial companies, members of the uniformed services are automatically insured for $10,000, unless they elect only $5,000 or not to be insured at all. Of the total 586 commercial companies enrolled, 20 companies participated during the fiscal year as converters only, and 566 as both reinsurers and converters.

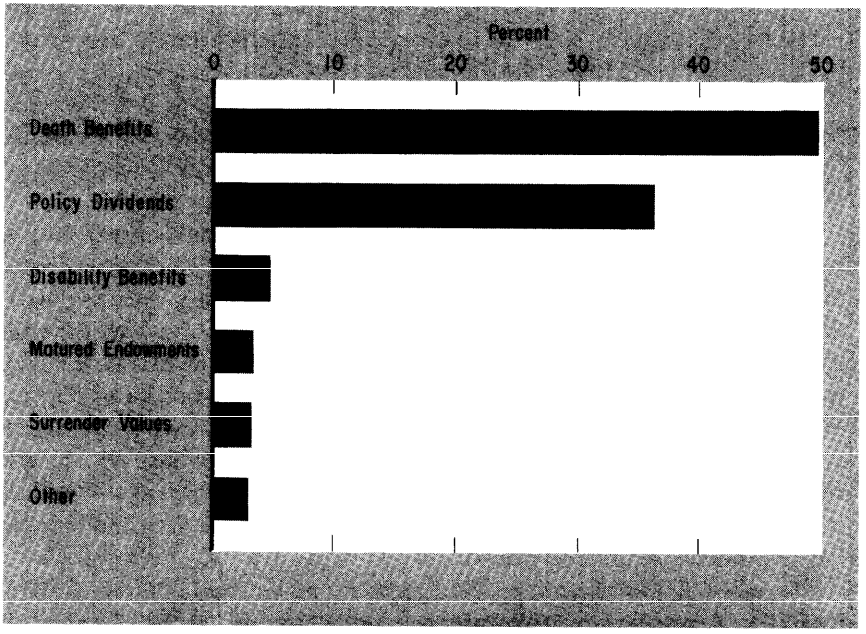
The program is administered by the primary insurer and is supervised by the Veterans Administration. The serviceman's monthly premium is $2 for $10,000, or $1 for $5,000. Coverage continues for 120 days following separation, without additional premium for that period, during which time the group coverage may be converted to an individual commercial policy with any of the participating companies, at standard rates irrespective of physical condition. The program is self-supporting except for those death claims attributable to the extra hazards of military service as specified by the law. The average insurance in force during the fiscal year covered 3.8 million members for $37.7 billion, including both those on active duty and those in the 120-day postseparation period.

The original implementing SGLI regulations imposed specific requirements for a serviceman to restore coverage when lost for such reasons as AWOL for 31 days or more. Extenuating circumstances were found to prevent some personnel from meeting all formal requirements so as to effect restoration of coverage prior to death. Therefore, the regulations were modified to take such circumstances into consideration when reviewing an individual case for determining the serviceman's intent.

Benefits Paid

Government-administered programs paid a total of about $408.8 million to policyholders during fiscal year 1969. Two of these programs are participating insurance, which means that the policyholder receives dividends from the gains, and savings derived from favorable mortality experience and excess interest earnings above reserve requirements. USGLI policyholders received $18 million in dividends while NSLI policyholders were paid more than $218 million in dividends. These payments represented $3 million and $10 million, respectively, more than was authorized in 1968. Other payments to policyholders were represented by matured endowments, cash surrenders and disability benefits. Beneficiaries received a total of $398.7 million during the fiscal year, which represented proceeds of the policy paid either by lump sum or installment payments. From the inception of the Government-administered programs through fiscal year 1969 cash payments to policyholders and beneficiaries have totaled about $22.4 billion.

BENEFIT PAYMENTS TO GOVERNMENT LIFE INSURANCE POLICYHOLDERS AND BENEFICIARIES



Servicemen's Group Life Insurance death claims are paid by the primary insurer, who is also responsible for determining to whom the proceeds are payable. However, questions as to whether the insurance is in force at time of death are resolved by the Veterans Administration. Fiscal year 1969 expenditures were nearly $200 million, and from inception of the program have amounted to more than $663 million. Death claim proceeds are payable in a lump sum or 36 equal monthly installments. At the current rate of interest, the monthly payment amounts to $296.40.

Health Care

The broadly stated purpose of the Veterans Administration Health Care Program is to provide medical care to eligible veterans. Efforts during the year advanced this purpose on several fronts.

Probably one of the most significant areas was in the treatment of patients in hospitals and as outpatients. Successful efforts were continued to increase both the quantity and the quality of medical service to eligible beneficiaries. Concurrently, the number of operating beds required was reduced. A number of factors contributed to the Agency's ability to treat more patients with fewer beds. Increased use of the prebed and posthospitalization treatment programs provided needed medical attention on an outpatient basis. It reduced the requirement for hospital beds as well as the cost and length of stay involved in the protracted hospitalization. In addition, the continuing transfer of patients with chronic or long-term illnesses to "extended care" beds released many hospital beds previously unavailable to patients with short-term acute conditions.

The progressive establishment of many specialized medical treatment services, such as open heart surgery centers, pulmonary emphysema units, and intensive and coronary units, resulted not only in providing a broader range of medical service to veterans but contributed to the Veterans Administration's ability to treat specific conditions more rapidly. Such treatment permits earlier return of the patient to his home and family.

The Veterans Administration, already a major contributor to the Nation's manpower pool of scarce-category health service personnel, expanded its medical education and training efforts. This extension of present training programs for medical residents, paramedical, and hospital administrative personnel assists in alleviating existing shortages in the health-science field. Pilot programs were established under the Exchange of Medical Information provisions of Public Law 89–785. These programs are designed to strengthen the nonmedical school affiliated VA hospitals located remote from medical school teaching centers.

And finally, the efforts made in the field of medical and prosthetic research continued to have an important impact upon the health care program. Program efforts during the year were directed at: improving diagnostic and treatment methods in the care of veteran patients; contributing to medical knowledge as a health service resource of the Nation; promoting research in the basic sciences of medicine that is essential to the completion of clinical

objectives; and aiding in recruitment, retention, and continued education of physicians and scientists in the Veterans Administration.

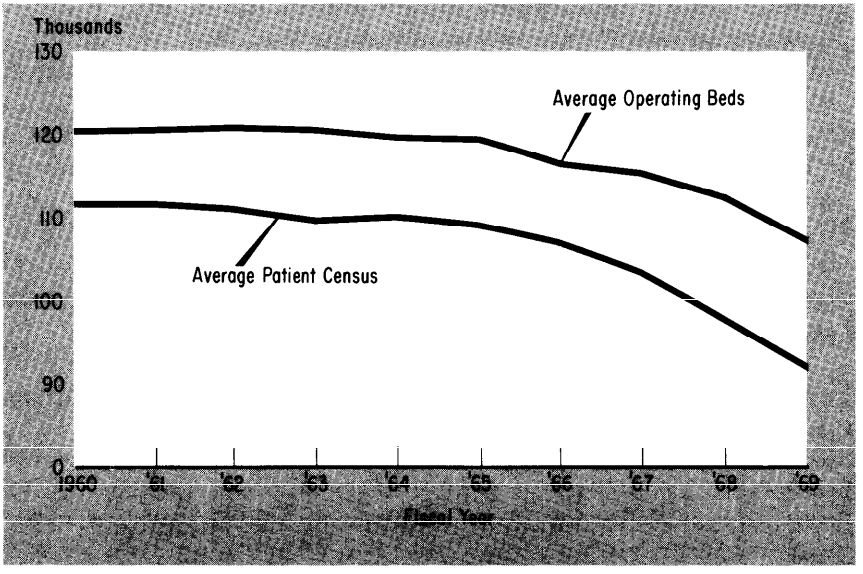
Inpatient Care

The care and treatment of veteran patents in VA hospitals is referred to as the inpatient care program. Contrasted to this is the extended care program which covers nursing home care, domiciliary care, and outpatient care. Both programs provide the highest quality medical care possible to eligible veterans.

Efforts continued in fiscal year 1969 to improve hospital bed utilization. A measure of the success of these efforts is apparent from an examination of the trend in the number of patients treated and in the number of beds required for treatment. Patients treated is a computed figure, derived by adding the number of patients discharged during the year to the number remaining in the hospital at the end of the year. During fiscal year 1969 there were 676,773 patients discharged and 99,541 remaining in hospitals at year's end for a patients treated total of 776,314. This was 13,888 above fiscal year 1968 and continued an upward trend that has been in effect the past few years.

The average number of operating beds used in the treatment of patients declined by 5,381 during the year. The 107,013 operating beds was the lowest number since 1950 when 106,012 beds were reported. Fiscal year 1969 marks the fourth consecutive year in which bed utilization improved. The increased bed utilization occurred in all type of bed sections, psychiatry, surgery, and other medical.

OPERATING BEDS AND PATIENT CENSUS IN VA HOSPITALS



Veterans with service-connected disabilities have first priority in receiving care in a VA hospital for a service-connected condition. Other veterans with nonservice-connected disabilities are cared for providing they cannot pay for their hospitalization and there are facilities available.

Once a year a detailed study is prepared on the composition of the VA hospital population (based on a 20 percent census sample). From it, information is obtained on the medical and demographic characteristics of the veteran population in VA hospitals.

In this study, there were 92,185 VA patients in hospitals on November 26, 1968, for whom the VA had responsibility. These patients were in a VA hospital or a non-VA hospital under VA authorization. Of this number, about 465 or 0.5 percent were nonveterans including some military personnel on active duty, Federal employees injured or disabled on the job and emergency cases. The VA requires reimbursement for these patients.

The remaining 99.5 percent of the patients may be classified into three broad eligibility groups as follows:

(1) 25.3 percent were veterans receiving care for service-connected disabilities. These veterans are unconditionally eligible for VA care.

(2) 11.4 percent were veterans with service-connected compensable disabilities who were receiving care for nonservice-connected disabilities. These veterans are eligible for VA care if a bed is available.

(3) 63.3 percent were veterans receiving care for nonservice-connected disabilities. These veterans are eligible for VA care if a bed is available and they sign an affidavit certifying their inability to defray the cost of hospitalization.

The number of patients with service-connected disabilities under VA care decreased by 2,625 to 23,240, since the previous annual census of November 30, 1967. A downward trend in the proportion of patients in the 1-day census who are service-connected has been observed since 1962 where it was 30.8 percent to the current (1968) figure of 25.3 percent. More than four-fifths of the patients identified as service-connected were under care for a psychiatric condition.

The number of patients receiving VA compensation for service-connected disabilities, who were under care for nonservice-connected disabilities only decreased by 490 since November 30, 1967. Forty-eight percent of the 10,490 patients in this group were being treated for psychiatric, neurological, or tuberculosis conditions.

Of the 58,455 patients (comprising 63.4 percent of the entire patient load) who did not have a compensable service-connected disability, approximately 31,260 (33.9 percent of the entire patient load), were receiving care for disabilities which may be classified as "chronic"; i.e., tuberculosis, psychosis, or some other condition that had already required 90 days or more of continuous hospitalization as of the day of the census.

The classification of the 707,969 patients discharged in calendar year 1968 into the same eligibility group shows the following:

(1) About 9,500, or 1.3 percent, were nonveterans, including some military personnel on active duty, Federal employees injured or disabled on the job, and emergency cases.

(2) 103,908 veterans, or about 14.7 percent of the discharges were treated for service-connected disabilities. About two out of five of these patients (40.2 percent) received their major care for a psychiatric condition.

(3) 114,133 veterans, or about 16.2 percent, were service-connected veterans treated for a nonservice-connected condition. About one-fifth of these patients received their major treatment for psychiatric, neurological, or tuberculous conditions.

(4) The remaining 480,438, or 67.8 percent, were treated for a nonservice-connected condition. About 14 percent of the nonservice-connected VA patient load discharged during 1968, or some 67,000 cases, were treated for a chronic condition, i.e., one which required 90 or more days of continuous hospitalization prior to discharge. Among the 413,481 other patients, almost one-half were receiving a pension or had applied for one.

Of the 707,969 patients discharged in calendar year 1968, over 38,000 were Vietnam era veterans. Twice as many Korean conflict veterans, and 10 times as many World War II veterans were discharged in the same period. The average age of the Vietnam veteran discharged was about 26.5 years. General medical and surgical conditions accounted for 70.5 percent of the discharges.

Going back to the hospital census data of November 26, 1968, there were 3,760 Vietnam era patients remaining among the total of 90,930 in VA hospitals. These patients were widely distributed throughout the hospital system. Eight VA hospitals had 75 or more such patients on the day of the census, and Long Beach, California, and New York City hospitals had 150 each.

The activation of specialized medical services continued at a fairly rapid pace during the years as space alterations, equipment, and staffing became available.

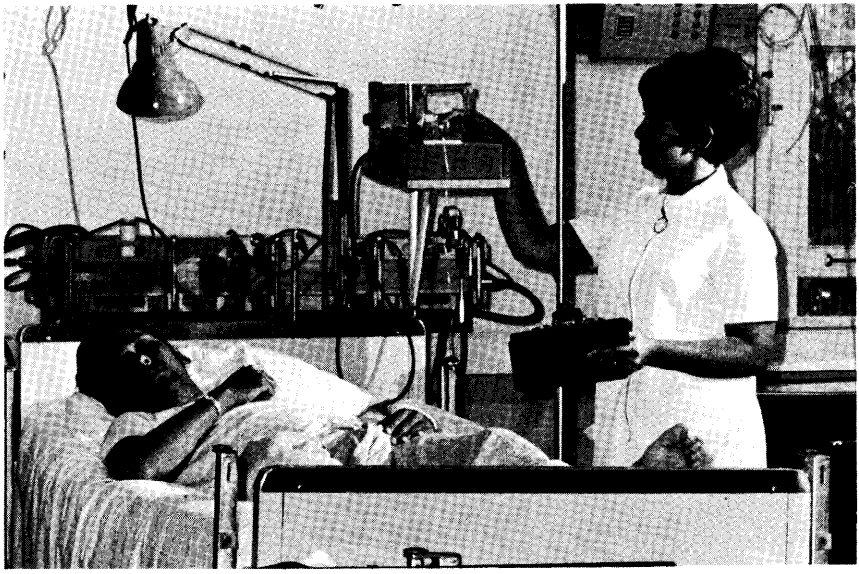
A pilot program for the treatment of alcoholic veterans was conducted in 27 VA hospitals. In 10 of these hospitals alcohol treatment units were established. About 360,000 days of patient care were provided. Alcoholism among the veteran population is estimated to be about 1.75 million. The peak incidence is in the age brackets of 35 to 55. This coincides with the predominant age group for all living veterans. Because of the general attitude toward alcoholism, medical facilities for the treatment and rehabilitation of alcoholics are generally inadequate. This VA program fills a serious need which has long been unmet. The units established in the 10 hospitals are staffed by a psychiatrist, a psychologist, a social worker, registered nurses,

and appropriate clerical personnel. Units average 30 beds. The eventual goal for this program is 60 alcohol treatment units.

The increase in disease and disability due to pulmonary insufficiency, chiefly emphysema, placed further emphasis on pulmonary emphysema units and the supporting laboratories. Sixty-eight special pulmonary emphysema treatment units were operating in VA hospitals in fiscal year 1969, and they were supported by pulmonary function laboratories located in 89 VA hospitals. The volume of work performed in the laboratories included not only work for patients with a primary diagnosis of emphysema but all other types of pulmonary function studies. Most VA surgeons request pulmonary function studies for their older patients so that surgical procedures can be planned which are within the tolerance of the patients' pulmonary function.

The use of cardiac catheterization and the injection of contrast media in performing diagnostic studies of arteries and veins continued to increase in demand during the year. The number of cardiac catheterization units in operation remained at 53. It is planned to activate additional facilities when building new hospitals or major modernizations of existing general medical hospitals in the future.

For patients with chronic renal (kidney) failure, the Veterans Administration has two major treatment programs. One is renal transplantation. This was first done in 1962. Since that time, over 300 kidney transplant operations have been performed in VA hospitals. In fiscal year 1969, 155 transplants were performed. The other treatment program is renal dialysis, which is a method that cleanses the blood by means of an "artificial kidney."



Dialysis Patient

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By the end of the year there were 30 renal dialysis units in operation. Workloads increased from 36,000 procedures in fiscal year 1968 to 41,000. With each patient receiving two to three dialysis per week, these procedures were performed for over 400 patients.

The Veterans Administration has been actively interested in home dialysis since 1966. During the last 3 months of fiscal year 1969, 39 patients were on home dialysis. Only a minority of these were supervised by VA renal dialysis centers. The majority were supervised by other personnel on a fee basis.

Organ transplants is an ever increasing field of endeavor. In addition to the 155 kidney transplants mentioned above, there were 10 liver transplants and three VA hospitals did one heart transplant each. The patients receiving the hearts lived from a few hours to several months.

With the national increase in the incidence of hepatitis which followed the use of pooled human plasma, the Veterans Administration prohibited its use in its own hospitals. Use of single donor human plasma is still permitted and the use of blood fractions encouraged. Further safeguards against serum hepatitis were also established.

A unified concept of facilities for the acute and intensive care of patients with spinal cord injuries was adopted during the year. The total bed capacity of these facilities which were designated "Spinal Cord Injury Centers," rose to 1,046 beds, and preparations were made towards a further expansion of the program to 1,122 beds.

The clinical application of radioisotope techniques to diagnosis and treatment is an important medical tool. During fiscal year 1969, seven radioisotope units were activated on a clinical basis, bringing to 75 the total number of clinical units. The program of broad licensing has gradually been expanded and 14 VA hospitals now operate under this plan. In effect, this program allows a local isotope committee to act for the Atomic Energy Commission in approving uses of radioisotopes, thus reducing delays necessary under the older specific licensing system. This broad medical licensing program will be extended to other larger radioisotope programs as the need develops.

During fiscal year 1969, the number of major nuclear medicine procedures increased approximately 50 percent over the previous year with very little increase in personnel. This was made possible in part by the procurement of more sophisticated "imaging" devices, predominantly scintillation cameras.

The sharing of medical resources between the Veterans Administration and other medical institutions is one of the very significant ways to better patient care. One of the major devices which the Congress has authorized VA to employ for this purpose, also under Public Law 89–785, is the sharing agreement.

In fiscal year 1968, this authority was used largely to lay the groundwork for VA participation as an integral member of total community medical resources in different localities. In fiscal year 1969, the program was notable for the size of its increase. In fiscal year 1968, 15 VA hospitals had sharing agreements, while in fiscal year 1969, that number more than tripled; but more importantly, the services actually furnished under the agreements were over four times greater, when measured in dollars, than those furnished in fiscal year 1968.

The scope of these agreements, moreover, is very broad, as a few examples attest: the pooling of organ (liver, kidney, and heart) transplantation resources, the sharing of renal dialysis and radiology facilities, and the furnishing of electroencephalogram and electromyograph services.

Besides these sharing agreements which are made under the authority of the sharing legislation, the Veterans Administration also has made cross-servicing arrangements under other legislation with Federal agencies. These involve diversified activities such as the ones related to procurement functions, civil defense and disaster planning, as well as services furnished directly for patients.

Hospitalization very often creates problems for the veterans' families or friends as well as for the veterans themselves, and therefore trained social workers are available from the point of admission to discuss how the ongoing and emerging problems may be most suitably met.

The trend toward shorter periods of hospitalization has led to greater involvement on the part of the social workers helping the patients in their posthospital living. This includes mobilizing available community resources to meet patients' needs, accompanying patients into their posthospital environment, and follow-up contracts with them to assure a "health" adjustment between the patients and his environment. In fiscal year 1969, special attention was paid patients and their families with stresses associated with hemodialysis, organ transplantation, and open-heart surgery. Emphasis on a fuller range of services to blinded veterans also grew. At selected outpatient clinics the social worker functions as the coordination-member of the visual impairment team and as such had responsibility for assessing the needs of visually impaired veterans in the vicinity served and for attempting to meet them by mobilizing and involving community resources.

Valuable as is the contribution of the millions of man-hours made annually by volunteers who assist many of the direct care services (e.g., nursing, dietetics, psychology, physical, medical, and rehabilitation) in the performance of their special tasks, this contribution does not reflect the significance of the role played—that of companionship. The compassion which underlies this role can only enrich the lives of the patients whom the volunteers selflessly serve.

Volunteer Serving Patient

This year special emphasis was given to the participation of high school and college student volunteers. Their participation was designed both to benefit the patients and expose the youth to career opportunities. For example, 40 psychology students from five colleges worked with patients in one hospital in an individual companionship—therapy relationship; and 30 physical education majors from one college worked with patients in another hospital in organizing sporting events, social games and ward parties. On another level altogether, the practice of enlisting youth planning for their own participation as volunteers was initiated at about 20 hospitals by forming Youth Councils as adjunct to the existing VA voluntary service committees.

The VA system seeks to meet the religious needs of its patients, no matter what their sect, by making available the services of chaplains and, in most hospitals, quiet chapels for worship by any denomination.

Because pastoral care, like any other formal disclipline, may be improved by study and training, the VA conducts courses for chaplains entering its service, and for graduate theology students who will become community clergymen. The first group of some 15 community clergymen completed a full academic year of clinical training in VA facilities.

A canteen service operates in all VA hospitals and domiciliaries. It is a self-sustaining operation and no appropriation is required to operate it. The canteen service furnishes at reasonable prices merchandise and services necessary to the comfort and well-being of veterans in the hospitals and domiciliaries. Reasonable selling prices for merchandise and fair charges for services are maintained on a uniform basis.

Over $1.145 billion was expended for the inpatient care program in VA hospitals in 1969, and $16 million for care of veteran patients in non-VA hospitals. This amount was above a year ago, when $1.088 billion was expended for care in VA hospitals, and 17 million for care in non-VA hospitals.

Another way to view the costs of the system is in terms of per diem costs. This cost is a computed figure and represents the expenditure needed to provide hospital care to one patient for one day. For all VA hospitals the per diem cost amounted to $34.16 this year compared to $30.53 in fiscal year 1968. The cost for providing hospital care in general hospitals increased by $3.32 a day; that for psychiatric hospitals by $2.86 a day.

Extended Care

The extended care program encompasses several types of health care for both inpatients and outpatients. Hospital patients who have received maximum hospital benefits but who still need skilled nursing care receive nursing home care. Domiciliary care is provided permanently disabled veterans who are incapacitated for earning a living and do not have adequate means of support. Restoration care is for the veteran in a VA domiciliary whose disability does not preclude him from reacquiring the capacity for independent living.

Extended care programs for outpatients include: The examination of applicants for admission to hospitals and domiciliaries; medical and dental care for veterans with service-connected disabilities; prebed and post-hospital care; examination of veterans applying for compensation or pension benefits; rehabilitation of blind veterans; radiology examinations; drugs and artificial aids (prosthetic appliances); speech pathology retraining; and hospital-based home care.

The Veterans Administration continued to expand the restoration care program to provide increases in operating beds and in average daily census. These increases allowed for more flexibility and a better balance in workload between domiciliary and restoree loads and resulted in an increasing number of patients being restored to society as useful and productive citizens. The number of veterans treated under this program has increased from 610 in fiscal year 1965, to 2,291 in the past fiscal year.

Of the almost 1,500 patients discharged, over 51 percent entered society in a restored and useful capacity, and another 17 percent returned to planned institutional living.

The motivation of veteran patients to perform some kind of work continued to receive emphasis in the domiciliary care program. Selected members are offered a special therapeutic work program which emphasizes the use of monetary remuneration in combination with such factors as achievement of status, increased responsibility, and recognition of member endeavor. During the year, 775 members were receiving this type of incentive therapy at the time of their discharge. As a consequence of this participation almost 50 percent of them were motivated to return to the community.

Domiciliary care is provided for in both VA facilities and in State soldiers' homes. Fifteen of the 16 VA domiciliaries are operated in conjunction with VA hospitals. During the year the average daily census of members in VA domiciliaries was 12,412. In addition, an average daily load of 7,140 was reported by the 34 State soldiers' homes, located in 29 different states.

There has been a decline in the patient load in both VA domiciliaries and in State homes in the past few years. This drop in patient load is in direct relationship with the increased load in nursing care facilities as these nursing facilities become more numerous and readily available to the veteran patient.

As mentioned previously the nursing home care program is designed for veterans who have obtained maximum hospital benefit, but who are too physically disabled for domiciliary living. These veterans have a need for nursing bed care, which for various reasons cannot be provided by the community.

The nursing home care program was initially authorized in fiscal year 1964. The program provides for the operation of 4,000 beds in VA hospitals supplemented by additional beds in State and community nursing homes.

The overall average nursing bed care census rose to 9,030 during the year, a gain of about 1,000 from fiscal year 1968.

The 4,000 operating beds located in 63 VA hospitals cared for the largest number of patients, 3,700. Efforts to make increased use of State and community nursing homes were also successful. The average daily census in State nursing homes rose by 358, and in community nursing homes by 373.

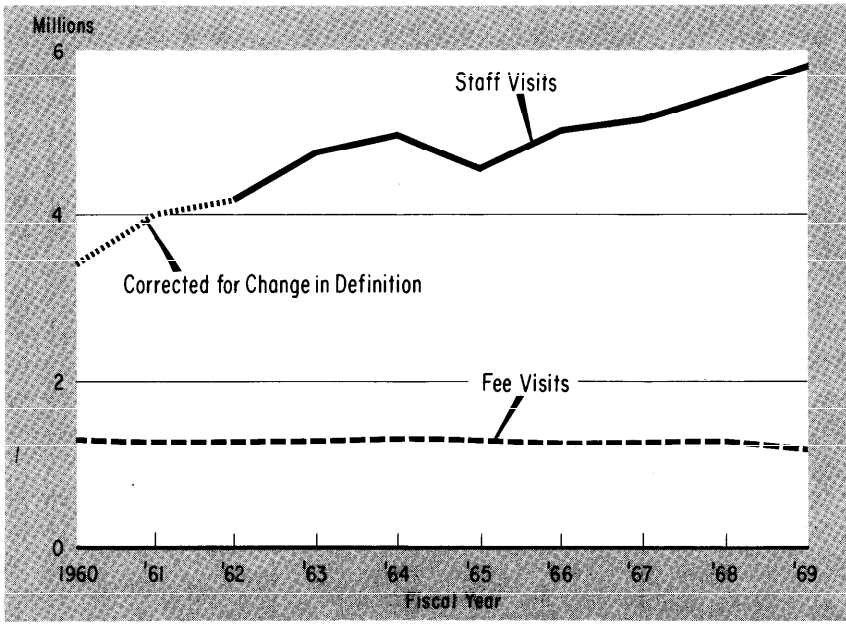
Recent legislation authorizing the Veterans Administration to increase the maximum per diem rate payable to community nursing homes placed the Agency in a competitive position for nursing home beds. Agreements are currently in effect with over 2,600 nursing homes throughout the country that meet prescribed standards.

The Veterans Administration provides outpatient medical and dental care for eligible beneficiaries in all of its hospitals and independent outpatient clinics. In addition, the services of private physicians and dentists are obtained on a fee basis to provide necessary and essential care where VA facilities are not readily available.

As was expected, a substantial increase occurred in the number of visits for outpatient medical care. The continued discharge of Vietnam era veterans to the care of VA, and the impact of new treatment methods within

the VA hospital system which decrease the patient's hospital stay and releases him for further treatment as an outpatient are the basic causes of these workload increases. Notification of recently discharged veterans by computer-generated letters (copy on page 8) of the availability of medical and dental care also boosted the overall demand for such care.

TREND IN OUTPATIENT MEDICAL VISITS



Visits for outpatient treatment comprised about 50 percent of all visits. Practically all visits made to private fee-basis physicians were for such treatment.

There are several other reasons for outpatient visits, besides outpatient treatment. The next largest categories are for determination of the need for hospital or domiciliary care, and for posthospital care. Both of these types of visits increased this year.

There were over 1,228,000 posthospital care visits, an increase of almost 140,000 from the previous year. Visits to determine need for hospitalization rose to 1,173,000, an increase of 82,000 from a year ago.

With the concept of comprehensive treatment for patients with psychiatric disabilities, mental hygiene clinics provide the continuity of total patient care required. About one-third of the outpatient treatment visits were made to the 68 VA mental hygiene clinics and the 36 day treatment centers for the care of psychiatric and neurological diseases.

Since the Korean conflict, by agreement with the Department of Defense, patients in service hospitals with eye conditions severe enough to meet the definition of blindness have been transferred to Veterans Administration hospitals for their rehabilitation at the earliest date possible. Since June 1966, approximately 157 Vietnam era veterans have been transferred.

To meet these needs, the Veterans Administration expanded its capabilities for rehabilitation. The Eastern Blind Rehabilitation Center at the VA hospital, West Haven, Conn., commenced operation in May. Two other clinics are in full operation. Eventually these three clinics will treat 70 blinded veterans.

Speech, language and hearing disorders are increasingly prevalent among veteran patients. Where speech pathology units have been established the treatment benefits have been quickly apparent.

Significant advances were made in the field of prosthetic and sensory aids during 1969. The Mauch S-N-S swing-and-stance control knee joint to help knee amputees avoid falling, descend stairs and hills smoothly, and walk gracefully, was accepted for routine distribution by the VA prosthetics center upon prescription by VA clinic teams.

The first seven of an order for 10 laser cases were delivered to the VA blind rehabilitation center, Palo Alto, Calif. Plans have been drafted for modifying the techniques used with the conventional long cane to take advantage of the special features of the laser cane—early warning of objects ahead or above the cane handle and of stairs, holes, or other major hazards in the ground surface.

There were 158,000 patient visits in audiology and speech pathology in fiscal year 1969, an increase of 17.7 percent over the previous year. These visits were made at 58 various hospitals and clinics.

Audiology examinations are done for assessment of social efficiency (tests for compensation or pension purposes), hearing aid evaluation and diagnostic purposes such as pre- or post-surgical procedure to note the effect of drug therapy.

Outpatient dental examination and treatment cases increased by 50 percent over a year ago, following much the same pattern as for outpatient medical treatment, and for the same reason, the returning Vietnam veteran. To expedite the administrative processing and authorization of treatment a new streamlined policy was adopted. This change eliminated the need for adjudicative action in most cases and permitted eligibility for service-connected treatment based upon a VA dental examination.

The extended care program began making greater use of dietitians. Besides overseeing 119 million meals in VA hospitals (served at a raw food cost of 37 cents a meal), dietitians this year began to improve dietary care in community nursing homes, foster homes, and multiple placement homes, by providing instruction to those involved with patient care in such homes.

Dietitian Teaching Patient To Select His Modified Diet

This program took two distinct directions. Foster home sponsors, community agency nutritionists, dietitians, and food service supervisors were invited into VA hospitals for orientation and training. Later VA dietitians visited the community or private homes to follow up on how the patients dietary needs were being met, and to advise on the food budget as well as on meal preparation.

Research and Education

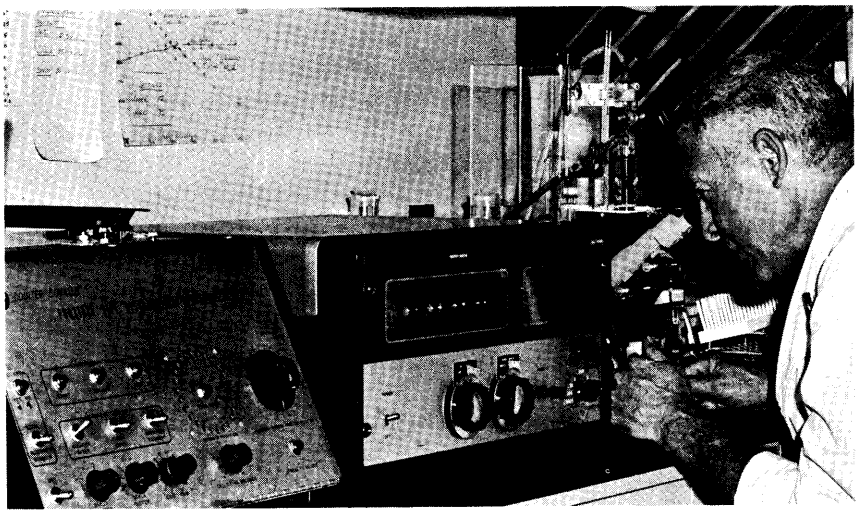
During fiscal year 1969, medical research programs were conducted at 145 VA installations, including 139 hospital or centers, four independent outpatient clinics, one domiciliary, and the VA central laboratory at the Armed Forces Institute of Pathology. A total of 5,654 investigators participated in 5,742 research projects. VA investigators contributed 3,934 articles to professional and scientific journals and presented 3,913 papers at scientific and professional meetings.

Research category	*Number of research projects fiscal year 1969*
Total	5,742
Cardiovascular and renal	488
Respiratory	248
Allergy and infectious	241
Hematologic	212
Metabolic and endocrine	342
Nutritional	22
Digestive system	204
Musculoskeletal and skin	96
Other (not elsewhere classified)	218
Surgery	941
Neural, psychiatric, psychology, and social work	1,520
Physical medicine and rehabilitation	96
Pathology	258
Nuclear medicine	317
Laboratory animal medicine, science and technology	52
Basic science	289
Dental	169
Spinal cord injury	29

Some examples of research projects by subject category are outlined below.

Treatment of Heart Disease.—The VA is meeting the problems of cardiovascular disease on a broad front—research with computers to assist in rapid and accurate diagnosis, research directly bearing upon organ rejection in heart transplantation, and basic research in many other complex facets of heart disease. The contributions of VA investigators are impressive, and have significantly advanced treatment and understanding of heart disease. For example, only 2 years ago VA researchers cleared up a medical controversy about proper treatment by establishing definitively that treatment of moderately high blood pressure prevented high-risk patients from developing serious blood vessel complications. Last year, the completion of an 8-year study at the VA center, Los Angeles, Calif., showed that blood cholesterol levels could be lowered by dietary means. And this year, dovetailing nicely with the dietary study, VA investigators clearly defined, for the first time, that dietary cholesterol, rather than cholesterol manufactured by the body, is responsible for the high levels of cholesterol in circulating blood; these high levels are associated with heart attacks and stroke.

Studies in Cancer—Significant improvements in the routine care and follow-up of surgical cancer patients have resulted from the extensive cooperative studies in cancer conducted by the Veterans Administration. In addition, the education and training of countless students, interns, residents, and physicians have resulted from the efforts put into these various cooperative trials.



Va Investigator Working on Research Project

The Surgical Adjuvant Cancer Chemotherapy Trials.—Using anti-cancer drugs in conjunction with surgery to prevent the spread of cancer cells—began in September 1957, and by December 1968, a total of 7,408 patients having surgical treatment for cancer (of the lung, stomach, and colon) had been accepted into the study. A total of 22 trials have either been completed or are currently in progress.

The VA cooperative urological research groups have clarified which treatments are the more beneficial ones for cancer of the prostate. In addition, the study had determined that some of the standard medical practices in treating cancer of the prostate are actually harmful. As a consequence, veteran and other patients are benefiting from this scientific approach to treatment.

Cause and Treatment of Alcoholism.—Why is alcohol addicting? Why does alcohol produce the effects known as drunkenness? The experimental work of VA investigators offers for the first time a plausible answer to these questions. VA researchers have developed techniques which enable them to determine some of the changes in metabolism caused by alcohol. Their experimental results indicate that alcohol during metabolism increases the formation of an aberrant breakdown product (tetrahydropapaveroline). This breakdown product is derived from a class of powerful body chemicals (biogenic amines) found in many body tissues including the brain. The aberrant product acts upon the central nervous system and enhances the sleep-producing effects of alcohol. In chemical structure, the product is only one step removed from morphine, and is an intermediate step in the production of morphine. These results strongly suggest that the formation of these aberrant products after alcohol ingestion may play a key role in pro-

ducing addiction, as does morphine. Morphine would also produce such signs of drunkenness as slurred speech, lack of muscle coordination, and finally sleep.

In spite of the high incidence of alcoholism in the Nation, very few large-scale studies have been done to evaluate the effectiveness of different drugs used in the treatment of the alcoholic during the withdrawal period. About 25 percent of all alcoholics undergoing treatment for alcoholism develop withdrawal symptoms that are severe and sometimes cause death (delirium tremens and convulsions). Since the advent of the newer drugs used in mental illness (reserpine, the phenothiazines, meprobamate and others), many of these drugs have been employed in an attempt to treat and decrease the severity of withdrawal symptoms. A VA cooperative study involving 537 patients in 23 VA hospitals has established that Librium (chlordiazepoxide) is the treatment choice in the prevention of severe withdrawal symptoms. In evaluating the effectiveness of four drugs, only 1 percent of the patients treated with Librium developed delirium tremens compared to 7, 8, and 12 percent for the other three drugs.

Behavior Projects.—VA research psycholgists have developed a technique that offers great possibilities for gaining information on how electrical discharges of nerve cells are related to behavior. A feat never before achieved, the technique consists of connecting very fine wires to 24 individual nerve cells in different brain structures in a single animal and recording the electrical discharge from these cells while the animal is active. Previously, only the electrical discharge from a single nerve cell could be measured. This work has important implications for the understanding of such conditions as sleep anesthesia, epilepsy, and certain kinds of psychoses.

Manic depressive psychosis is the second major mental illness whose origin is not related to physical causes. This illness characteristically affects productive, sensitive persons who have been well brought up. Although a relatively infrequent disorder, it causes great economic waste, human suffering, and even death. During fiscal year 1969, because of the availability of a new approach to the treatment of this crippling illness, the first joint VA-National Institute of Mental Health cooperative study was launched. Lithium carbonate, apparently specifically effective in the treatment of acute manic state and reputedly effective in the prevention of recurrences, is being tested under controlled conditions in 12 VA hospitals and six State and community psychiatric institutions.

Bone Disease.—Several different basic and clinical studies of bone metabolism are major areas of investigation. VA research has shown that in vitamin D deficient animals, the rates of bone formation are significantly reduced and the rate of mineral formation in the bone-forming matrix was about half normal. These and other findings are of importance in understanding bone disease because they provide previously unavailable information that very distinct changes occur in activity per unit length of bone surface. Knowledge obtained from such studies will provide very accurate

characterization of changes in bone disease such as osteomalacia and causes of rickets, and will hopefully provide the basic information essential for the best treatments of metabolic bone diseases.

Formation of Gallstones.—Based on their research, another VA team offered a new and reasonable explanation about how gallstones are formed. The significance of this work lies in the fact that a reasonable explanation of the mechanism of gallstone formation could lead to a rational treatment or preventive measures for this important disease and extremely painful condition.

Established during fiscal year 1968, the Office of Scientific Evaluation was assigned the task of reviewing all activities conducted at VA stations, with support from VA research funds, for the purposes of assessing their merit and arriving at appropriate levels of support. The institutional allocation for the station's general research support and development funds was designated as Part II funds. An Institutional Research Program Evaluation Committee reviewed Part II funded programs of 38 stations during fiscal year 1969, bringing the total accomplished to 55. This review continues, and plans are to complete the first review of the whole system by June 1971, and then to review all stations again in a continuing 5-year cycle.

During fiscal year 1969, new procedures were instituted by the Office of Scientific Evaluation for review of individual projects and programs by peer groups for performance and for progress in programs already supported when renewal of funding is sought, as well as for new programs. Funds for this portion, which includes the largest share of the institutional research allocation, are designated as Part I funds. Some 300 proposals for new research programs, or for renewal of funding for existing programs have undergone Part I review in the last 6 months of fiscal year 1969. Levels of funding appropriate to the merit of individual programs is based on the peer group's evaluations and recommendations.

The medical investigator program was initiated during this fiscal year. This program provides established successful investigators an opportunity to pursue research activities for a major percentage of their time, the remainder being spent in teaching and patient care. Competition for medical investigator positions is acute as evidenced by the fact that of 19 applicants only five were appointed.

The research and education traineeship program also was inaugurated during fiscal year 1969 to attract and retain in the VA large numbers of bright, young, capable physicians. Training programs in all medical specialties provide imaginative and innovative training not otherwise available. The trainee is not required to spend his entire effort on patient-care responsibilities, but is expected to participate in the specialty training program, a part of which will certainly encompass patient care needs as well as research methods and techniques. The traineeships are intended to produce physicians with special competence in teaching, research, and patient care. For fiscal year 1969, only six programs in gastroenterology were approved. Plans are

now being completed to initiate approximately 60 more programs in the early months of fiscal year 1970 in a variety of medical specialties.

Research in nursing followed two major lines. First, a 2-year project, "Teaching of Reality Orientation," emphasized the health team approach to restoring patients to their communities and even includes secretaries and patients' families as members of the team. Second, a scale to measure the effectiveness of nurses' performances was developed, and the data suggest that improved patient care may result from the improved performance of the head nurse.

In fiscal year 1969, a closer working relationship was introduced among the elements of patient care research and education in VA's physical medicine and rehabilitation service. In a few hospitals, clinical research, with assistance from the computer, saw more carry-over into patient treatment in areas such as functional evaluation of neuromuscular disability, the recording of normal and abnormal gaits, and electromyographic diagnosis. Also, history-taking via computer was adapted by one research group for use in rehabilitation medicine; the results were typed out automatically in good English prose.

A dynamic and closely integrated clinical and research program in prosthetic and sensory aids continued to provide improved devices and services to a constantly increasing number of disabled veterans. Beneficiaries now include, in addition to service-connected and hospitalized veterans, all nonservice-connected pensioners who are in receipt of aid and attendance allowances; totally and permanently disabled service-connected veterans who require prosthetic appliances, sensory aids, invalid lifts, or other therapeutic or rehabilitative equipment or supplies for nonservice-connected conditions; and military retirees where facilities are available. Through coordinated educational and training programs and widespread dissemination of information and interdisciplinary clinic teams, the benefits of these programs were made available not only to veterans but to all disabled people.

Education and Training.—The various accomplishments of the Veterans Administration in education and training represent collectively an accelerating contribution towards maintenance of high-quality VA patient care and towards increasing the scarce health manpower resources of the Nation. The momentum for the present expansions of VA education and training and the future utilization of its vast potential for the coming years arises from Public Law 89–785, enacted November 7, 1966. This legislation gives the Veterans Administration a mandate for large-scale health manpower training in order to carry out more effectively its mission of medical care for veterans. Correlatively, this law also has as an objective the fostering of "an environment of academic medicine" at all VA hospitals, through the wide exchange of medical information between the Veterans Administration and the medical community.

The intensified VA engagement in education and training is reflected in the increase of trainees in fiscal year 1969. There were 37,889 trainees in

1969 as compared with 31,759 in 1968. Prior to the enactment of this legislation 23,581 individuals received training. Thus, in 3 years the Veterans Administration has increased the numbers trained annually by 61 percent. In addition to the regular training activities of the Veterans Administration, VA facilities were used in fiscal year 1969 to provide health service training at novice levels and work experience to 11,513 persons enrolled in Federal economic opportunity and educational assistance programs.

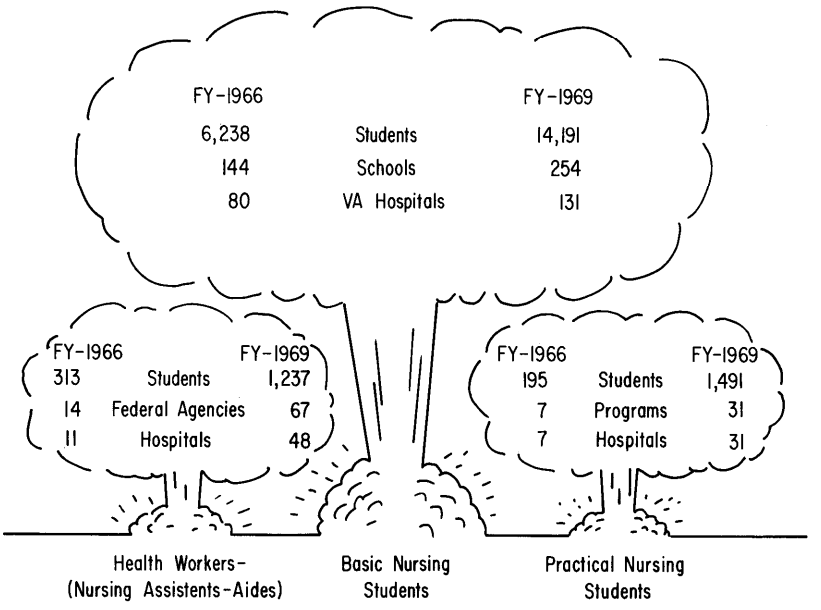
In the year 1900 one health worker in three was a physician. Today only one in 10 is a physician. The "team" approach to patient care has always characterized VA treatment; thus VA education and training is conducted in every hospital discipline—from the physician and dentist level, through the professional and technical levels to the aide level. The magnitude to the Nation's manpower need has been stated to be about 10,000 additional persons per month during the decade 1966–1975, that is about 120,000 persons a year. In providing training to 37,889 persons in 1969, with a goal set for about 87,000 trainees in 1975, the significant national role of the Veterans Administration in medical and allied medical training becomes clear. This role can be envisioned further in the following estimates of the VA share of all training presently conducted in the Nation in certain disciplines. VA training was provided to:

(1) Basic nursing students from 44 percent of all university programs; from 20 percent of all Associate degree programs; from 11 percent of all diploma programs.
(2) 20 percent of all nurses enrolled full-time in graduate study.
(3) 22 percent of all clinical social work students in recognized schools of social work.
(4) Residents in 21 percent of all approved dental residencies, and interns in 21 percent of all approved dental internships.
(5) 25 percent of all dietetic interns in approved internships.
(6) 20 percent of all graduating clinical and counseling psychology trainees at the Ph. D. level.
(7) 25 percent of all hospital pharmacy interns and residents.
(8) 12 percent of all medical residents in approved programs.
(9) 50 percent of all medical school graduates.

The education and training programs for nursing personnel not only serve the prime objective of improving patient care; they also serve as stimuli to these personnel to continue their education along the lines of their individual goals or needs. During the year, 1,253 nursing employees (including 823 professional nurses) enrolled in university programs during their off-duty hours.

The Veterans Administration has been associated for more than two decades with medical schools and other academic institutions for the cooperative education and training of health service personnel, discussed above. As

PROGRAM EXPLOSION—NURSING EDUCATION AND TRAINING PROGRAMS



the year ended, 94 VA hospitals were affiliated with 80 medical schools, and working relationships existed with 52 dental schools, 254 nursing schools, 29 pharmacy schools, 73 social work schools, and 74 graduate departments of psychology. In addition, programs are being developed jointly with many junior colleges, community colleges, and with newly created schools of allied health sciences. The intensity of cooperation is reflected in the fact that 1,946 VA physicians, 186 VA dentists, and 411 other VA staff hold faculty appointment at the cooperating schools.

In a recent study by the Committee on Allied Health Personnel, sponsored by the Division of Medical Sciences of the National Research Council, the need for new approaches to the delivery of health care was pointed out, including "identification of new types of skills required by modern medicine and adequate action to incorporate newly identified types of personnel . . . into education, training, and health-care programs." The committee recommended experimentation along these lines, concluding that "the Veterans Administration is suggested as a logical system in which such experiments might be tried."

Even prior to this recommendation, the Veterans Administration was taking the necessary measures. Coincidental with VA efforts to increase the numbers of trainees in traditional-type operations, the agency has been developing and initiating training for new types of subprofessionals such as

pathologist's assistant, autopsy assistant, and urologist's assistant, whose functions will permit the physician and others to have more time for professional duties. Other comparable programs, such as orthopedic assistant, mental health assistant, and radiotherapist assistant are in the process of development for the next fiscal year. The Veterans Administration is also analyzing the content of current training to assure the production at the end of the training period of health service workers who can do what is expected of them in light of the fast-moving technology of medicine. Plans are also underway to undertake research and development to devise fundamental changes in methods of delivery of health services. This is a long-range measure essential for the appropriate training of the health manpower of the future.

An outstanding development in fiscal year 1969, was the appointment of the first "Distinguished Physician" within the Veterans Administration, Dr. William B. Castle, Francis Weld Peabody Faculty Professor of Medicine at Harvard University. This position was established to bring physicians into the VA system who have made very significant contributions to medical science and have attained exceptional professional stature over long and distinguished careers. The distinguished physician serves on a VA-wide basis as a consultant, lecturer, or in other teaching capacities, thus providing scientific and educational leadership within the system on behalf of veterans' medical care.

Pilot programs authorized under the exchange of medical information provisions of Public Law 89–785 were for the most part related to electronic linkages and audiovisuals. However, several approved programs were different, with unique education implications. These are:

(1) A demonstration project by the Council on Social Work Education designed to assess whether and how specially developed programs of field experience for undergraduate social welfare students will make an important contribution to the social work manpower pool. Demonstration units encompassing different models of field experiences will be established at four different VA installations.

(2) The establishment of a complete and fully operational tumor registry, encompassing the patient populations of the University of Alabama Hospital and the four VA hospitals in the State. This includes automating and computerizing the registry mechanisms to achieve integration of all records and to carry out additional follow-up of patients. This project will be made available for teaching demonstrations and for structured training programs for practicing physicians, interns, residents, and medical students.

(3) At the 1969 annual meeting of the American Gastroenterological Association, a series of four self-administered examinations were presented by means of computer-linked teaching machines. This project, developed between the Veterans Administration and the University of Colorado Medical Center, was jointly sponsored by

the Veterans Administration, the American Gastroenterological Association, and Control Data Corp. Its objectives were to demonstrate the capability of a self-administered examination to attract, challenge, and satisfy participants, and to measure accurately their knowledge of a restricted professional area. As an extra dividend, this program yielded experience and knowledge applicable to the proper construction of a branching program examination, useable on a larger scale in the VA hospital system.

Management

The continually increasing complexity and needs of the medical care system confront top management with the problem of improving managerial capabilities at every level of the organization. During this reporting year a number of responses to this problem were made.

Studies were conducted in three areas: general administrative, data processing, and hospital construction.

Before this fiscal year, the Veterans Administration had developed work measurement standards for laundry, laboratory, social work, food service, supply, engineering, and housekeeping personnel. During the year, standards were also being developed for hospital ward and nonward administrative personnel. A concerted effort was initiated to develop standards for ward nursing activities. This study involves a multidisciplinary team of registered nurses, management engineers and analysts, industrial engineers, mathematicians and statisticians, and physicians acting as advisors. The initial phase encompassed 61 wards in 10 general hospitals. Data included the type of employee performing a task, time factors, and the frequency of nursing procedures performed for individual patients. The resulting nursing staffing requirements were expressed in terms of hours of nursing care per patient per day, abbreviated as HPD. Different HPD's were established for hospitals affiliated with medical schools and hospitals not affiliated with medical schools.

At the end of the year, the Veterans Administration was in the process of refining and validating the nursing staffing standards and installing in all its general hospitals a nursing care quality methodology of nursing care provided VA patients. The major objective of this methodology is to improve the nursing care of patients by means of a systematic examination of selected areas of nursing care. It is expected to provide (1) a uniform method for highly qualified professional nurses to evaluate selected areas of nursing care and (2) a means of communicating uniform management data relating to quality of nursing care to all concerned levels of management.

A study in progress at the end of the year attempts to determine the most efficient way of planning and operating hospital radiology services. This problem is being examined in terms of practices and use of facilities, equipment, and space under acceptance constraints (without sacrifice in the

quality of patient care) for a given hospital. VA also plans to conduct similar studies for its food service, physical medicine and rehabilitation service, and dental service.

The Veterans Administration's Management Information System is a sophisticated system of data collection and reporting, using mechanical and electronic methods through all stages. To obtain data more responsive to staff decision making needs, new outputs were designed and placed into effect during the year. Other studies in this area included a pioneering effort in a general purpose health information system involving a computer-based file of selected personal, demographic, and clinical data for each individual patient receiving inpatient care at VA expense; analysis of the causes of changes in veteran demands for care and alternative ways of meeting these demands; an improved cost accounting system which identifies all hospital bed sections or other types of care; and a project to determine the feasibility of accumulating detailed information about the costs of care for individual patients by day of hospitalization.

An ambitious project underway in a VA hospital, the Automated Hospital Information System, is visualized as a method of providing necessary, timely, integrated data to personnel within hospitals to improve use of existing patient care services and facilities. This system, which is based on automated data processing and electronic communication techniques, will collect, record, store, retrieve, summarize, transmit, and display its information primarily to assist the patient care team. The purpose of the system will be accomplished through the conceptual design of a "total" medical support system with selected subsystems made operational in phased implementation effort. Two selected subsystems have already been implemented. These are the admission and disposition subsystem, which provides master record formulation, patient controls, and bed controls; and the radiology subsystems, which provides a complete interface with the ordering point and the radiology service. Two additional subsystems are to be defined in the near future.

A major study in building technology is in progress to explore the feasibility of obtaining an integrated building system which will provide for VA construction requirements in shorter time and lower cost than conventional methods. The system involves obtaining building components that integrate the mechanical, electrical, architectural, and structural features. The expected benefits from this study are to obtain the most favorably balanced solution to several objectives, such as flexible and economic modular configuration, and reduction in design and construction time.

A major reorganization in the utilization of scarce professional psychological manpower has been effected by two actions. First, revision of the classification standards for nonsupervisory psychologists to provide for maximum utilization of professional knowledge and skills by the assignment of full responsibility for all psychological services provided to a designated section of the hospital, center, or clinic. Second, the establishment of psychology aids and technician positions to facilitate the efforts and extend the

capability of the professional psychologist in the delivery of comprehensive services by freeing him from the performance of purely technical functions.

The appearance of the first issue of "Newsnotes on Research and Education in Physical Medicine and Rehabilitation," in October 1968, marked a new medium for stimulating progress in the quality of patient care in physical medicine and rehabilitation. The first paper was so well received that the second issue had to be greatly enlarged and the distribution list increased fivefold to meet the demand. Its purpose is to highlight outstanding achievements by physical medicine and rehabilitation physicians and therapists to serve as a model and stimulus to others. Editorial policy emphasizes concern for vocational rehabilitation of veterans and closer relation with community resources to maintain the rehabilitation gains during hospitalization. "Newsnotes" is proving a significant link to improve communications between VA and academic efforts in this field.

A 2-week general review course was given by physical medicine and rehabilitation personnel at the VA hospitals in New York, N.Y., and Bronx, N.Y., to physicians in and outside the Veterans Administration in preparation for the "Board" examinations in this specialty. The results of the review were gratifying to the participants and further demonstrated, especially to non-VA phyciatrists, the high caliber of training and patient care in the Veterans Administration.

During the year, five regional courses titled, "Introduction to Physical Medicine and Rehabilitation Research," were given in various areas of the country. These courses which combine video and live presentations demonstrate that it is possible by this means to reach large groups with a minimum of faculty and expense. The intent underlying these presentations is to expose and stimulate latent talents in this important area, thereby constantly improving the quality of patient care.

One of the most striking aspects of the past year's activities has been the commitment of the VA nursing service to increase the involvement of professional nurses in direct patient care. New nursing care practices and innovations in the delivery of nursing services are reflected in the changing role of the professional nurse.

The hospital nursing service was reorganized with decentralization of authority to the nursing unit, thus allowing a greater degree of decision-making by professional nurses in their clinical practice.

At the same time various forms of the unit manager concept were established to relieve head nurses of the administrative aspect of ward management activities by placing them in the hands of a qualified nonprofessional.

In the community nursing home care program nurses now participate as members of the team to evaluate nursing homes; assisting in the selection of patients suitable for placement; making follow-up visits after patients are admitted to nursing homes; and insuring the provision of adequate, safe nursing care.

There was limited introduction of the unit dose packaging of medication during the year. Under this procedure the pharmacist dispenses the unit dose, individually packaged and labelled (by machine) for the patient directly from a copy of the physician's order or prescription. This system not only saves nursing time but, more importantly, improves the quality control of drug distribution in the hospital.

Unit Dose Packaging Machine

Another innovation was the adoption in one hospital, after a 2-year testing period, of a minimal cooking concept of food service, which involves the use of preprocessed and precooked foods to the extent of their availability. Other VA hospitals were also encouraged to adopt this type of food service whenever skilled workers, such as cooks, bakers, and meatcutters, leave the staff.

The test kitchen at the VA hospital, Washington, D.C., gave priority during the year to standardization of recipes for use in all VA hospitals. It also completed acceptability tests of 160 new convenience food items. Other studies conducted during the year concerned manpower requirements for assembling, delivering, and returning patient trays, and procedural use of new equipment such as mechanical trayveyors, warewashing systems, microwave and quartz ovens. A method was also tested for determining internal product temperatures of frozen foods at delivery time to ensure safe utilization of these products.

The evolving trend in surgery is toward a program of regionalization of hospitals based on geographic proximity, relative professional capabilities of the staff, and the grouping of disease entities in the regional hospitals concerned. In this way the type of surgical skill required will be available for

the patient. As an illustration, the VA hospitals at Marlin, Waco, and Temple, Tex., have had their surgical staffs and facilities regionalized. The Marlin and Waco hospitals are geared to emergency operations by local physicians while the Temple hospital serves its own surgical needs as well as cases transferable from Marlin and Waco.

At the end of this fiscal year, there were 20 such arrangements.

The physical environment of the patients requires the same kind of careful and thoughtful attention as does the care of patients themselves. There must be constant concern with not only the hospital structures themselves—e.g., repairing them, or altering them to meet changing demands—but with the grounds as well, for their attractiveness often has its own therapeutic value for many patients.

In connection with hospital structures one of the major concerns is with fire protection. The extent and effectiveness of this concern is reflected in the recognition given it by VA hospitals. This year, for the fifth consecutive year, the VA hospital in Coatesville, Pa., won the 1968 Grand Award in the Hospital Safety Contest sponsored by the American Hospital Association and the National Safety Council. Furthermore, five VA hospitals earned first place honors in their group; 27 hospitals and centers had perfect records; and 27 had the best records in their respective States.

Fires are still a challenge. There were a large number of small fires during the year—over 1,000 in fact—but the economic loss, which came to about $125,000, represented an encouraging drop from the previous year's figure which was three times larger.

Of the $125,000 loss nearly half was accounted for by a single fire; the balance consisted largely of small fires caused by smoking and matches. The relative smallness of this economic loss associated with smoking, however, was overshadowed by the accompanying loss of life—there were four patient fatalities.

This kind of tragedy may be eliminated by adoption of flame-retardant pajamas made of a synthetic material ("Nomex"). After successful tests, approximately 1,500 pairs of pajamas made of this fiber were bought for high smoking-risk patients. (The wearing quality of this fiber appears to surpass cotton: Nomex pajamas were washed 800 times with no sign of wear, while cotton pajamas averaged only 135 washings.)

The Veterans Administration has, in cooperation with the professional program directors, national professional organizations, and industrial leaders taken the lead in establishing requirements for safety in the field of electronics for medicine. A nationally recognized, basic specification has been developed which incorporates safety requirements for physiological monitoring equipment utilized in intensive care units. The U.S. American Standards Institute asked the Veterans Administration to participate with others in the development of national and possibly international standards for medical electronics.

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Construction

Major construction requirements provide for the building of new facilities and the modernization, alteration, and improvement of existing facilities. New facilities are required to replace temporary military hospitals built during World War II and older VA hospitals built prior to World War II. At the same time that obsolete facilities are being replaced, beds are also being relocated to geographic areas of greatest veteran population, based upon existing and anticipated migratory factors.

During fiscal year 1969, construction was substantially completed on a replacement hospital of 1,126 beds at Long Beach, Calif. At the end of the fiscal year seven projects under the replacement and relocation program were under construction. These seven projects will provide 4,803 beds at an estimated cost of $145.5 million. They are located at Columbia, Mo., Hines, Ill., Lexington, Ky., Northport, N.Y., San Diego, Calif., Tampa, Fla., and San Juan, P.R. Six additional projects have been authorized under this program and are in various stages of planning and development, but are not yet under construction.

During fiscal year 1969 construction was completed on 75 projects of all types with a construction cost of about $34.1 million. At the end of the fiscal year, 91 projects with a construction cost of about $186.3 million were under construction and 103 projects at $277.1 million were authorized and in various stages of development but not yet under construction.

In addition to the replacement and relocation program, construction effort has proceeded in the areas of modernization, nursing bed care, medical research facilities, and in a wide range of improvement projects such as air-conditioning and specialized medical units.

Total obligations incurred for all types of construction projects amounted to $105.6 million. With the exception of the $109.5 million obligated in fiscal

year 1964 the amount obligated this fiscal year is the highest for any year since 1950.

A brief history of the nursing bed care program from its start in fiscal year 1966 to date shows:

Fiscal year	Number of	
	Projects	Beds
Total	64	3,789
1966	27	1,344
1967	9	561
1968	26	1,653
1969	2	231

At the end of fiscal year 1969 projects at St. Cloud, Minn., and Chillicothe, Ohio, having 44 beds were under construction. One nursing bed care project having 120 beds at Miami, Fla., was in the working drawing stage.

Medical research is conducted at 145 VA installations, including 139 hospitals or centers, four independent outpatient clinics, one domiciliary and the VA central laboratory at the Armed Forces Institute of Pathology. Such research depends on the availability of animal, laboratory, and clinical facilities. During fiscal year 1969, construction on five medical research facilities projects was completed. These projects provides the additional space and facilities necessary for an ongoing research program. At the end of the year, seven more projects were under construction and 14 projects were in various stages of preconstruction development.

The hemodialysis program, which provides longer life for patients with kidney malfunctions, was initiated in fiscal year 1966. During the past fiscal year construction was completed on 11 hemodialysis projects, raising to 30 the number of such units in operation.

A special task force study indicated a need for 3,000 additional intensive coronary care beds during the 5-year period 1968 through 1973. Twenty-one projects with a total of 195 beds were completed during the past year and 37 projects for 462 beds were under construction. An additional 27 projects were in various stages of preconstruction development.

Congress appropriated $4 million in fiscal year 1969 for VA participation in the State Grant Nursing Home Care program. Fourteen States have been given tentative approval for 20 construction projects involving 1,989 nursing care beds.

Eleven research projects on building technology were in progress during the year. The majority of these studies are performed under contract with outside contractors. One of these studies explored the benefits to be derived from planning adaptability into the design and construction of VA hospital facilities to permit changes in space layout to be made after occupancy at a minimum of construction cost. Another studies the methods of approach for obtaining a total or partial systems solution to building hospital facilities. A second phase of this latter project is also underway.

The objectives of this second phase are to demonstrate the application of the systems integration design approach to the nursing tower portion of VA hospital facilities and to provide more effective solutions to the problems of cost, of total elapsed time from inception to occupancy of facilities and of responding to the rapidly changing needs of medical technology in terms of facilities.

Health Care Logistics

Facilities.—At the end of the fiscal year the following VA facilities were in operation:

166 hospitals with 104,771 operating beds
202 outpatients clinics
16 domiciliaries with 13,523 operating beds
6 restoration centers with 759 operating beds
63 nursing home care units with 4,000 operating beds

Staff.—Employment of personnel to operate the various health care programs totaled 154,797 on June 30, 1969. Full-time employees made up 85 percent of this figure with part-time workers accounting for the remainder.

Type of employee	Employment June 30, 1969		
	Total	Full-time	Part-time
Total	154, 797	132, 504	22, 293
Physicians	15, 561	5, 035	10, 526
Staff	6, 148	5, 035	1, 113
Residents and interns	4, 432	.....	4, 432
Consultants and attendings	4, 981	.....	4, 981
Dentists	1, 223	703	520
Staff	708	703	5
Residents and interns	122	.....	122
Consultants and attendings	393	.....	393
Nurses	16, 684	14, 915	1, 769
All other	121, 329	111, 851	9, 478

Costs.—Operating costs for VA's medical programs during fiscal year 1969 totaled $1,554 million, an increase of 7.8 percent over $1,442 million expended the previous year.

The operating costs of VA hospitals, domiciliaries, restoration centers, and nursing care units rose from $1,141 million in fiscal year 1968 to $1,205

million in fiscal year 1969, an increase of 5.6 percent. Legislated employee salary increases, and increased costs of communications and utility systems, drugs, medicines, etc., were primarily responsible for the increase.

Cost of operation of Medical programs—major activity totals [1] [2]
[Fiscal year 1969]

Activity	Cost
Medical administration	$11, 339, 342
Medical research	49, 431, 948
Prosthetic research	1, 314, 371
Postgraduate and inservice training	2, 117, 813
Exchange of medical information	899, 587
Inpatient care:	
VA hospitals	1, 145, 444, 675
Non-VA hospitals	16, 532, 232
Subtotal-hospitals	1, 161, 976, 907
VA nursing care	21, 187, 151
Non-VA nursing care	19, 604, 844
Subtotal—nursing home care	40, 791, 995
VA domiciliaries	35, 197, 156
State homes	8, 661, 611
Subtotal—domiciliary care	43, 858, 767
VA restoration centers	3, 478, 350
Total inpatient care	1, 250, 106, 019
Outpatient care	214, 926, 829
Miscellaneous benefits and services	20, 630, 732
Maintenance and operation of supply depots	2, 965, 760
Total	1, 553, 732, 401

[1] Net budgeted applied costs (including asset acquisitions) accumulated during FY 1969 regardless of fiscal year appropriated; therefore, not reconcilable to FY 1969 appropriations or obligations.

[2] Includes payments by employees for quarters, subsistence, and laundry in the amount of $3,403,529 for VA hospitals, $90,599 for VA domiciliaries, $37,096 for VA nursing, $2,089 for VA restoration centers, and $2,955,803 for miscellaneous benefits and services.

Cost of operation—Medical inpatient facilities

[Fiscal year 1969]

	Type of hospital			VA nursing care	Domiciliaries	Restoration centers
	Total	Psychiatric	General			
Professional and ancillary:						
Medical services [1]	$299,780,467	$61,846,153	$237,934,314	$3,938,149	$7,515,229	$1,093,707
Nursing service	331,528,801	107,925,643	223,603,158	10,311,472	968,454	320,683
Chaplain service	5,928,849	2,120,671	3,808,178	215,213	584,260	34,922
Dietetic service	124,470,420	42,574,398	81,896,022	4,978,346	11,447,722	928,015
Dental care	15,226,578	4,340,803	10,885,775	208,399	1,201,846	113,766
Audiology and speech pathology	1,036,086	9,148	1,026,938			
Direct care—Total	777,971,201	218,816,816	559,154,385	19,651,579	21,717,511	2,491,093
Administrative support	145,376,588	37,150,543	108,226,045	112,247	4,588,398	439,538
Building management [2]	61,278,971	18,793,352	42,485,619	1,400,205	1,580,914	128,540
Engineering operations	67,136,936	20,602,499	46,534,437		3,951,218	248,797
Engineering—Maintenance and repair	56,557,509	18,327,322	38,230,187		3,017,249	157,794
Asset acquisition	37,123,470	6,988,211	30,135,259	23,120	341,866	12,588
Support—Total	367,473,474	101,861,927	265,611,547	1,535,572	13,479,645	987,257
Total costs	$1,145,444,675	$320,678,743	$824,765,932	$21,187,151	$35,197,156	$3,478,350

[1] Professional medical services, laboratory, pharmacy, blind rehabilitation, clinical radioisotope, physical medicine and rehabilitation, social service, clinical psychology, radiology, medical illustration and library.

[2] Includes operation of laundry.

Other major increases occurred in the following programs:

(1) *Medical Research*—Costs increased by $5 million from $44 million in fiscal year 1968 to $49 million in fiscal year 1969. Expanded programs and new studies account for the difference over the previous year.

(2) *Exchange of Medical Information.*—Costs increased by $753,398 from $146,189 in fiscal year 1968 to $899,587 in fiscal year 1969. The lateness in the enactment of the initial funds for this program in fiscal year 1968 prevented their usage as originally planned. The establishment of programs which strengthen VA hospitals not affiliated with medical schools and those remotely located from medical school teaching centers was expedited during fiscal year 1969.

(3) *Outpatient Care.*—Costs for outpatient care in fiscal year 1969 totaled $215 million, an increase of $31 million or 16.8 percent over the previous fiscal year total of $184 million. The continued discharge of Vietnam era veterans, and the impact of new treatment modalities within the VA hospital system which decrease the patient's hospital stay and release him for further treatment as an outpatient, were the basic causes for this substantial cost increase.

As shown in the table below, there were increases in all types of per diem costs.

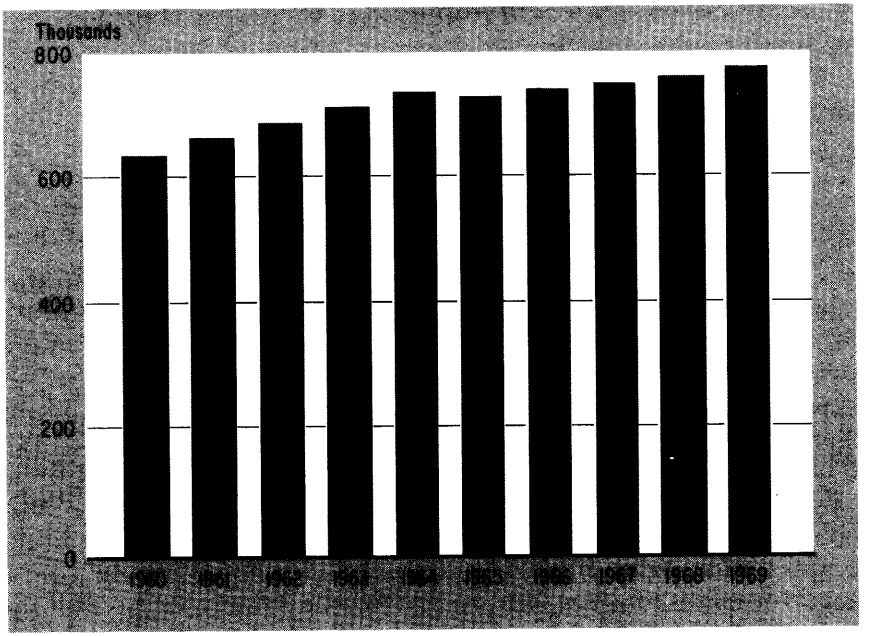
Type of station	Fiscal year		Change	
	1968	1969	Amount	Percent
All hospitals	$30. 53	$34. 16	+$3. 63	+11. 9
Psychiatric hospitals	19. 72	22. 58	+2. 86	+14. 5
General hospitals	39. 34	42. 66	+3. 32	+8. 4
Domiciliaries	6. 72	7. 77	+1. 05	+15. 6
Restoration centers	12. 51	14. 84	+2. 33	+18. 6
Nursing home care units	14. 99	15. 69	+. 70	+4. 7

Inpatient Care Workloads.—During fiscal year 1969 there were 1,120,437 applications for hospital care received by VA hospitals and outpatient clinics, approximately 65,700 more than the number receiving during the previous year. Sixty-three percent of all applicants were found to be medically in need of care and legally entitled.

Patient group	Admissions to VA hospitals during fiscal year	
	1968	1969
All patients	647, 241	667, 383
Patients 65 years of age or older	138, 964	127, 692
Patients under 65 years of age	508, 277	539, 691
With service since Korea, including Vietnam	55, 278	78, 277
All other	452, 999	461, 414

The number of patients treated in VA and non-VA hospitals during fiscal year 1969 totaled 800,012, the largest number in VA's history. The vast majority of these (776,314) were treated in VA hospitals.

PATIENTS TREATED IN VA HOSPITALS



Status of patients treated	Number of patients treated in VA hospitals	
	FY 1968	FY 1969
Total patients	762, 426	776, 314
Patients on VA hospital rolls, June 30	107, 743	99, 541
Remaining in hospital	91, 735	85, 909
On trail visit	11, 451	9, 389
On leave of absence or elopement	4, 557	4, 243
Patients leaving VA hospital rolls—during fiscal year	654, 683	676, 773
Discharged	610, 960	632, 632
Died	43, 723	44, 141

The Veterans Administration provided 34.1 million days of patient care for veterans at VA and non-VA hospitals during the year. This represents an average daily census of 93,547 patients, 91,878 of which was at VA hospitals. Nearly one-half (47.7 percent) of all VA patients in hospitals were occupying psychiatric beds.

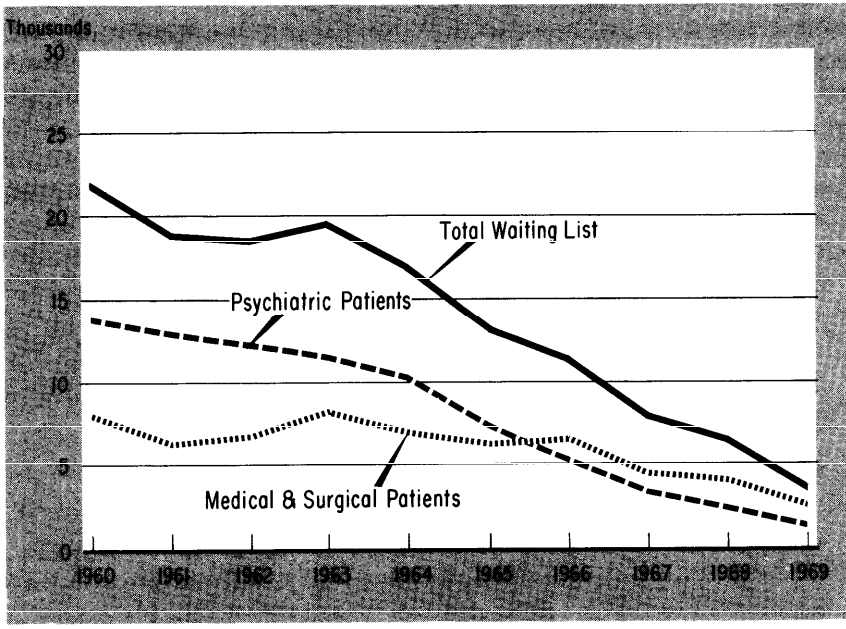
The turnover rate at VA hospitals increased from 56 to 61.4 percent in 1969. Increases in turnover occurred in all major bed sections.

Type of bed section	Average monthly turnover rate, fiscal year 1969			
	VA hospitals			Non-VA hospitals [1]
	Total	Psychiatric hospitals	General hospitals	
All bed sections	61. 4	15. 3	97. 4	110. 7
Psychiatric	18. 4	13. 0	44. 8	59. 0
Surgical	134. 1	56. 1	137. 7	167. 4
Medical	93. 7	36. 0	99. 7	155. 7
NP–TB	4. 7	4. 3	5. 9	.....
Tuberculosis	31. 7	33. 0	31. 7	.....
Non-TB, pulmonary	89. 1	4. 3	90. 3	.....
Intermediate care	14. 0	9. 7	14. 6	.....
Internal medicine	110. 7	43. 2	118. 1	.....
Neurological	60. 8	12. 6	72. 6	.....
Physical medicine and rehabilitation	41. 0	16. 0	43. 6	.....
Spinal cord injury	24. 6	.....	24. 6	.....
Intermediate care	13. 6	2. 8	13. 7	.....

[1] Data for non-VA hospitals is reported only by 3 major diagnostic categories: psychiatry, surgery, medicine.

The number of applicants on the waiting list for hospital beds totaled 3,975 on June 30, 1969. One of these applicants was awaiting care for a service-connected condition. Of the 1,214 patients awaiting care for a psychiatric condition 178 were receiving care in other public or private hospitals at no cost to the Veterans Administration.

HOSPITAL WAITING LIST



Extended Care Workloads.—Restorative care to eligible veterans is provided in six VA facilities which were operating 759 beds at year's end. During the year an average daily census of 642 restorees were cared for. There were 1,557 admitted, 1,489 discharged, and 2,291 treated in fiscal year 1969.

Domiciliary care is provided in 16 VA domiciliaries and 34 State soldiers' homes. The Veterans Administration operated 13,523 beds, and during the year cared for an average daily census of 12,412 members. The State soldiers' homes had a daily average veteran member load of 7,140.

Nursing home care patients average 9,030 during the year. Nursing home care units at 63 VA hospitals operated 4,000 beds and cared for an average daily census of 3,700. Community nursing homes provided care for an average daily census of 3,177. During the year over 10,500 veterans were placed in community nursing homes and 8,600 were discharged. Twenty-five State homes with 3,367 approved beds served an average daily census of 2,153 nursing home care patients during the year.

Outpatients made 6,947,000 medical visits of which 5,773,000 were to VA facilities and 1,174,000 were to fee basis physicians. Outpatient visits increased in almost all categories over last year.

Type of visit	Fiscal year		Percent of change
	1968	1969	
Total	6, 563, 787	6, 947, 074	+5. 8
Outpatient treatment	3, 352, 693	3, 458, 673	+3. 2
Posthospital care	1, 088, 906	1, 228, 570	+12. 8
Determine need for hospital care	1, 090, 904	1, 173, 117	+7. 5
Compensation and pension	302, 865	345, 408	+14. 1
Prebed care	88, 470	99, 388	+12. 3
Trial visit	120, 182	110, 907	−7. 7
Other	519, 767	531, 011	+2. 2

Applications for outpatient dental treatment rose from just below 105,000 in fiscal year 1968 to over 180,000 in fiscal year 1969. Examination cases completed increased by over 40,000 and treatment cases completed by 26,000.

Fiscal year	Examination cases completed	Treatment cases completed
1969	121, 508	92, 712
1968	79, 143	66, 507
1967	69, 217	58, 625
1966	58, 549	53, 687

Administration and Management

The support and management of the benefit programs of the Veterans Administration require the performance of many tasks. The changing composition of the veteran population and the resulting changes in direction and impetus of the various programs demand that these supporting tasks and services be viable and quick to respond to changing needs.

The enormity of these tasks can best be understood when it is realized that over $9 billion was expended for veterans benefits and services in the past year. Excluding a one-time special insurance dividend paid in 1950, fiscal year 1969 ranks as the high point in the expenditure of funds by the Veterans Administration, and this amount expended represents approximately 4 percent of all Federal budget expenditures. Only three Government departments—Defense; Health, Education, and Welfare; and Treasury, expended more.

Employment is another indicator of the size of the task. Veterans Administration employment on June 30, 1969 was 175,074. Only the Departments of Defense and Post Office had a greater number of employees on their rolls.

Management of the Agency includes many tasks. Accomplishment of the more vital ones is described in the following paragraphs.

Personnel Management

Employment.—The overall employment on June 30, 1969 of 175,074 included 3,678 temporary summer employees. Total employment was about 600 below that of a year ago. Over 88 percent of the employment was associated with the medical program. The remaining 12 percent covered all other programs.

Appropriations and other receipts versus expenditures cumulative through June 30, 1969

Title of appropriation or fund	Appropriations and other receipts			Expenditures	
	Total	Appropriation	Other receipts	Fiscal year 1969	Cumulative through June 30, 1969
Total	$202,972,300,219	$162,695,875,958	$40,276,424,261	$9,158,983,042	$191,732,504,410
General operating expenses	2,751,439,340	2,735,968,297	15,471,043	206,239,450	2,709,990,623
Medical administration and miscellaneous operating expenses	319,588,979	319,330,834	258,145	14,322,335	309,639,019
Medical care	16,092,322,056	15,976,572,915	115,749,141	1,464,103,543	15,921,569,610
Medical and prosthetic research	287,744,501	286,409,000	1,335,501	50,378,100	279,883,883
Construction of hospital and domiciliary facilities	821,386,617	820,822,862	563,755	46,102,621	655,696,261
Grants for construction of state nursing homes	14,500,000	14,500,000		1,769,335	3,736,851
Grants to the Republic of the Philippines	31,409,852	31,409,852		1,369,022	19,672,182
Compensation and pensions	74,701,184,469	74,698,538,000	2,646,469	4,939,409,724	74,693,765,170
Readjustment benefits	25,743,989,404	25,743,989,404		678,903,396	25,683,871,962
Veterans insurance and indemnities	325,992,413	318,837,036	7,155,377	12,629,094	325,049,190
Supply fund	2,344,232,859	53,623,882	2,290,608,977	123,347,401	2,289,947,277
Direct loans to veterans and reserves	4,072,963,284	1,730,077,996	2,342,885,288	208,546,050	3,327,879,846
Loan guaranty revolving fund	3,175,339,022	7,793,616	3,167,545,406	282,955,332	2,621,697,031
Insurance funds	29,999,769,484	4,250,000	29,995,519,484	1,065,598,058	21,602,176,464
General post fund	37,801,811		37,801,811	2,228,408	34,167,978
Personal funds of patients	913,268,008		913,268,008	59,188,590	860,403,602
Miscellaneous appropriations	36,540,063,117	35,981,149,203	558,913,914	1,686,538	35,670,044,377
Miscellaneous funds	4,799,305,003	3,972,603,061	826,701,942	206,045	4,723,313,084

Organization element	June 30, 1969	June 30, 1968	Change percent
Department of medicine and surgery	154, 665	155, 216	−0. 3
Department of veterans benefits	16, 715	16, 798	−0. 5
Department of data management	1, 486	1, 505	−1. 0
Staff offices	2, 208	2, 149	+3. 0
Total	175, 074	175, 668	−0. 3

Staffing.—During fiscal year 1969 the Veterans Administration hired more than 26,000 full-time employees and approximately 21,000 employees on a part-time or intermittent basis to staff essential positions. Recruitment for the health professions and supporting skilled occupations continued to be most difficult. There was also increased difficulty in recruiting at the entrance levels in large metropolitan areas for such positions as nursing assistant, food service worker, clerical worker, and craftsmen.

The following table illustrates the diversity of VA's work force by showing full and part-time employment in the more populous of the 335 occupational fields VA uses. Excluded from this table are intermittent employees, medical and dental residents and interns, consultants and attendings.

Occupation	*Approximate number June 30, 1969*
Nursing assistant	25, 150
Nurse and nurse anesthetist	16, 375
Food service worker	13, 025
Housekeeping aid	6, 950
Clerk-typist	6, 575
Physician	6, 000
Medical technician—miscellaneous	5, 350
Secretary	4, 375
Licensed practical or vocational nurse	3, 825
Clerk-dictating machine transcriber	2, 875
Mail and file clerk	2, 525
Clerk-stenographer	2, 520
Laundry worker—miscellaneous	2, 500
Cook	2, 350
Veterans claims examiner	2, 255
Therapist, occupational, physical, etc	2, 025
Social worker	1, 820
Supply clerk	1, 350
Claims clerk	1, 305
Plant operator, sewage, steam water, etc	1, 225
Loan and realty specialist	1, 100
Psychologist	1, 075
Dental assistant or technician	1, 025
Warehouseman	950
Dietitian	900
Contact representative	850
Laborer	825
Attorney	775
Dentist	725

The VA's unique personnel system for physicians, dentists, and nurses was improved and modified in order to attract and retain such personnel. More emphasis was placed on the use of part-time physicians and nurses.

Keen competition for the services of registered nurses continued to exist in many locations as salaries and fringe benefits rose in private and local community hospitals. As a result, it was necessary to increase or adjust entrance salaries, within statutory limits, at 29 hospitals and clinics to provide competitive salaries. Similarly, to obtain the services of interns and residents, stipend rates were adjusted at 99 hospitals to maintain comparability with rates paid within the local medical community.

Most significant among the steps taken by the VA to improve the recruitment, utilization, and retention of personnel during the fiscal year were:

- Improved promotion policies and guidelines and employee appraisal techniques which will provide more equitable consideration of employees for promotion and facilitate the identification of the best qualified employees.
- Restructured subprofessional positions which permit the shortage-category professionals to spend more of their time in strictly professional activities. This approach has been effective in the fields of social work, psychology, dietetics, and nursing.

VA Recruitment Pamphlets

- Revision of qualification requirements to provide more flexible and realistic recruitment standards and provide opportunities for the economically and educationally disadvantaged.
- Intensive on-campus recruitment at 990 colleges and universities by personnel-program official teams composed of field station and central office representatives.

Training and Development.—Training programs were specifically designed and utilized to upgrade the skills of VA employees and to open new career channels for the disadvantaged. With the objective of increasing the supply of the Nation's trained health workers, VA became increasingly involved as a center of training for the nonprofessional health occupations. A total of 11,513 enrollees in a wide variety of Federal economic opportunity and educational assistance programs received training and experience at 140 hospitals, domiciliaries, and outpatient clinics.

Coordinated Federal Wage System.—The Veterans Administration began implementing the Coordinated Federal Wage System (CFWS) for employees occupying trades, crafts, and manual labor positions. In cooperation with other Federal agencies, conversion to this system continued throughout the year and resulted in the development and application of wage schedules and the placing of employees under the CFWS at 70 VA stations. Fifty-eight additional stations were converted to transitional or interim wage schedules, pending their full conversion to CFWS. Both the CFWS and transitional wage schedules placed VA employees on a single wage system with wage rates comparable to those paid by other Federal agencies in the community.

Equal Employment Opportunity.—The VA's positive approach to Equal Employment Opportunity (EEO) follows three principal avenues: career development of minority group employees on VA rolls; continued recruitment of high quality and high potential minority group members; and identification and elimination of concealed or unintentional inhibitors to equal employment opportunity. During the past year, the number of minority group employees approached 30 percent of the VA workforce. Each VA station developed a "Plan of Positive Action," dealing with all aspects of equal employment, tailored to meet local needs.

VA continued, during the year, to be a major participant in the various economic opportunity and training endeavors in which Federal agencies may participate as "hosts." Again, as has been the case for the past several years, VA has hosted over 25 percent of the total number of enrollees associated with Federal agencies.

Special attention was given to ensure that regular VA employment is afforded, to the extent possible, to enrollees in the economic opportunity programs who successfully complete training under our auspices. During the last 6 months of the fiscal year, 112 former enrollees were employed in regular full-time VA jobs.

Employment of Women.—Women continued to be appointed and advanced to more responsible professional, technical, and administrative positions in the Veterans Administration.

As of June 30, 1969, there were 80,221 women employed in VA, constituting 45.8 percent of the agency's workforce—833 more than as of the close of the prior fiscal year.

Throughout the fiscal year, the number of women selected for higher level positions increased. At the close of the year, 2,165 women occupied positions in grades GS–12 and above or positions of comparable grades or salary. Of the total number of employees in higher level positions at the end of the fiscal year, 13.6 percent were women.

A significant "first" was the training and development of two women for assignments to assistant hospital director positions.

Continued progress was also made in the utilization of women in part-time positions. Approximately 68 percent of the 10,968 regular part-time employees are women.

Employment of the Handicapped.—At the end of the year there were 12,600 handicapped full-time employees on the rolls, more than 8 percent of the total workforce. Disabled veterans, with 10-point preference, constituted about 40 percent of the group.

Handicapped employees again demonstrated their performance capabilities with over 2,000 receiving grade promotions and an additional 400 receiving other salary advancements. These employees earned 763 awards for employee suggestions, 905 other awards, and 90 citations and commendations.

A highlight of the year was the selection of a VA employee, Miss Katherine A. Niemeyer as the "Outstanding Handicapped Federal Employee of the Year." Miss Niemeyer, who received her award from Vice President Spiro T. Agnew, is the dietitian in charge at the restoration center, VA Hospital, East Orange, N.J.

Employee-Management Relations.—VA employees are affiliated with 12 different employee organizations which hold 375 recognitions at 203 VA stations. Of these, 213 are exclusive recognitions and include representation for nearly 95,000 employees. Further, 85,000 of these employees are covered by 182 negotiated agreements dealing with their personnel policies, practices, and conditions of employment.

Employee Recognition and Incentives.—During the year national recognition was received by Miss Dorothy Starbuck, area field director, Department of Veterans Benefits. She was the recipient of the Federal Woman's Award. This was the fourth consecutive year that VA was honored by having a winner of this award.

To improve the effectiveness of the Incentive Awards Program, line officials, rather than committees, were delegated authority to approve awards. Although, as indicated in the following table, fewer employees submitted suggestions during the year, there was a significant increase in the tangible benefits realized.

Outstanding Handicapped Employee Award

Employee suggestions	Fiscal year		Change from 1968
	1969	1968	
Received	17, 561	19, 125	−1, 564
Adopted	8, 697	9, 220	−523
Tangible benefits	$916, 717	$791, 049	+$125, 668
Awards paid	127, 955	127, 934	+21

During this year the administrator's commendation certificate was presented to 16 contact representatives who had served voluntarily in Vietnam, where they provided information about veterans' benefits to servicemen. In addition, VA employees with outstanding records for service to the public were recognized at various organizational levels. Quality increases were awarded to 3,570 VA employees in recognition of their high level performance. This was 278 more than the previous year. In addition, 5,162 employees received awards in recognition of superior performance and for special acts or services.

Data Processing

ADP Equipment.—The administration of the many varied and complex veterans programs is greatly facilitated by the use of computers and auxiliary data processing equipment. The emphasis on the use of these tools and techniques has grown steadily over the past decade and will continue. At the end of fiscal year 1969, the VA ADP inventory included 52 small-, medium- and large-scale computer systems. Thirty-five are located in data processing centers, the majority of which are of the so-called "Third Generation" type (faster, larger memory capacity and far more operating versatility). Seventeen small scale computers are used by VA hospitals in support of a variety of medical research projects.

ADP Applications.—During the past 10 years, over 50 automated systems have been developed and placed in operation to assist in the processing of many program activities. Among the major systems are the following:

(1) *The Compensation and Pension ADP System.*—This system, formerly a manual-mechanical operation, was converted to a computer system in 1962. It maintains and services 4.7 million benefit payment accounts resulting in the disbursement of about 56.5 million checks annually in amounts totaling around $4.4 billion. Improvements in recent years have given the system increased flexibility to permit benefits to be adjusted automatically to meet the constantly changing provisions of new legislation.

(2) *Educational ADP System.*—This is an automated system which was developed to process payments representing educational benefits to veterans

and certain of their beneficiaries. It includes an automatic reenrollment feature which produces the necessary documents for students continuing their education at institutions of higher learning.

(3) *The Insurance ADP System.*—The conversion of Government life insurance accounts from a manual-mechanical system of maintenance to an ADP system was completed in 1962. Around 5.6 million life insurance accounts with a face value of $38.2 billion are maintained by this system and virtually all insurance actions and general ledger transactions are now processed automatically.

(4) *Personnel and Accounting Integrated Pay System.*—Every 2 weeks the system generates salary checks and earnings and leave statements for all employees and 46,000 savings bonds and notes. A master record, updated at regular intervals, is maintained on magnetic tape for each of the agency's 170,000 employees. In addition to personnel actions and employment reports, the system furnishes complete cost accounting information.

(5) *Automated Management Information System.*—This system encompasses all areas of management and operational reporting. The system employs a data bank storage and retrieval principle. The data base includes all quantitative data for VA medical and benefits programs.

In addition to these major operating systems, several data processing efforts achieved operational status in fiscal year 1969.

A standardized computer system for generating more complete management information for the engineering operation of hospitals was placed in operation. In addition to performance and cost data, the system automatically assembles maintenance repair costs for individual items of equipment and summarizes work order data.

An ADP Inventory Control System was installed in the VA Prosthetic Center in New York. The Center serves directly and through VA hospitals and clinics about 135,000 veterans residing in many parts of the country. An average of 400,000 requests for prosthetic or orthotic aids are serviced annually. This system encompasses inventory control stock replenishment, production control, and control of individual hydraulic units.

A new ADP Loan Guaranty System was developed and installed in June 1969 to maintain automatically the records for over 7 million guaranteed or insured home, farm, and business loans under the loan program. The system is designed to generate routine and special statistical reports and provide other required information for management purposes.

During fiscal year 1969 the "PLACE" Junior system (Property and Loan Accounting, Control and Evaluation) was expanded to a total of about 183,000 accounts. This is an interim computer system for maintaining loan accounting records. It automatically generates the monthly bills for borrowers and provides accounting reports and information on delinquencies and defaults.

An ADP system has been installed for the purpose of informing recently discharged servicemen by letter of the Federal benefits available to them.

Included in the letter is information on the Government educational programs. The system automatically selects and prepares one of four different types of letters, depending upon the educational background and the physical condition of the individual veteran. Letters also provide the address and telephone number of the U.S. Veterans Assistance Center nearest the veteran, the periods of time during which benefits are available and a postage-free post card for the veterans' use in obtaining additional information. The system also furnishes the veterans service organizations with the names and addresses of veterans for use in further informing the veterans of their rights.

A relatively new input device—an optical recorder—is now undergoing extensive tests at one of the data processing centers for use with the Government Life Insurance ADP System. With this equipment, various forms can be used as input to the computer instead of punched cards to update the master tape records. This device recognizes certain hand written, typed, or computer printed data on a form and, electronically, writes the information (data) onto the magnetic tape in machine language. The system is scheduled for installation in fiscal year 1970 and is expected to improve processing time and service to the policyholder at less cost to the Government.

The patient treatment file is a centralized computer-based system containing detailed data on individual treatment episodes for VA hospital patients. By the end of fiscal year 1969, about 118,000 in-house VA patients records were converted to the patient master record tape file and, eventually, this file will contain over 1 million records with about 700,000 records to be added to the history tape file each years. The system replaces the VA Inpatient Discharge Data System and the repository of data will serve as a source of information for management in planning and evaluating hospital and extended care programs.

Development of systems for monitoring critically ill VA hospital patients and for assisting clinical laboratories is underway with installation contemplated for the coming fiscal year.

Communications.—During the past fiscal year, several medically oriented data transmission systems requiring the use of the most modern communication devices and the application of sophisticated techniques were installed. Included are two communications systems designed to transmit laboratory test data and other medical information between the wards or clinical laboratories of VA hospitals at Boston, Mass., and Minneapolis, Minn., and remotely located computers which automatically process the data and quickly return the results back to the hospital wards or the laboratories. The computer for the clinical laboratory system at Boston is located within the hospital laboratory while the computer for the Minneapolis system is situated at the St. Paul data processing center.

Another communications system transmits electrocardiogram (ECG) data from VA hospitals at Durham, N.C., and West Roxbury, Mass., to the VA hospital, Washington, D.C., for computer processing after which

the ECG analyses are transmitted back to the hospitals where the results are printed out by teletypewriter.

A system installed at the VA hospital Togus, Maine, permits the transmission of electrocardiograms from the hospitals coronary care unit to the homes of staff cardiologist during off-duty hours for immediate interpretation. The results are returned to the hospital by voice transmission.

A similar system is in use between two VA hospitals at Durham and Fayetteville, N.C. When a cardiologist is not available at the Fayetteville hospital to interpret an ECG, the data are transmitted to the Durham hospital where an immediate analysis is made and the results returned via the Federal Telecommunications System.

The use of closed circuit television (CCTV) by VA hospitals was greatly expanded during fiscal year 1969. A total of 65 units were in use by the close of the year. One CCTV system connects the VA hospitals at Omaha, Lincoln, and Grand Island, Nebr., with the Nebraska Psychiatric Institute and the Nebraska State Hospital. This system will reach operational status in the early fall of 1969 and will be used for diagnoses (telediagnostics) and live consultation between physicians from remote locations (teleconsultation). A similar though smaller system has been developed for use between the Massachusetts General Hospital at Boston, Mass., and the VA Hospital at Bedford, Mass.

Management and Organization

Contract Compliance.—The equal employment practices and policies of more than 500 companies and corporations holding Federal contracts were reviewed under Executive Order 11246. These reviews were part of a continuing effort to assure that Government contractors fully understand and implement their contractual obligations to take affirmative action in providing equal employment opportunities for all persons regardless of race, religion, color, sex, or national origin. In addition, 161 surveys were conducted at VA construction sites to assure that contractors and subcontractors were complying with Executive Order 11246.

Regional conferences with Federal contractors were held in Cleveland, Philadelphia, St. Louis, San Antonio, and Chicago as an additional effort to emphasize the obligations of contractors and to assure the understanding and awareness needed to achieve voluntary orderly progress towards the goal of equal job opportunities for all persons.

Management Audits.—Audit efforts were concentrated on the effectiveness of management in meeting assigned responsibility. During fiscal year 1969, 25 audits were performed. The vast majority of these pertained to various health care activities, with 18 covering hospital or domiciliary management. Other benefit activities and supporting programs accounted for the balance.

Audits during the past year generated operational improvements permitting a reduction of costs by approximately $780,000 annually. Related audit

costs were $211,000 providing an audit benefit cost rates of over three to one.

Paperwork Management.—Year-end records holdings totaled 1.2 million cubic feet, an increase of 3 percent. Disposition actions during the year permitted the removal of 85,800 cubic feet of obsolete and inactive records from active files for destruction or transfer to low cost storage in Federal records centers of the General Services Administration. These records reduction actions are offset by the creation of 120,000 cubic feet of new records, largely long term, to document the medical treatment and monetary benefits provided.

An agency evaluation of service department induction and separation chest X–ray films determined that these films are disposable 20 years after the veteran's discharge from military service. A request for authority to destroy these films has been submitted to the Congress through the National Archives and also to the General Accounting Office. Such authority, when approved and applied to present holdings, will permit eventual destruction of 56 million X–rays occupying 120,000 cubic feet of records storage space and with a silver reclamation value well in excess of $500,000.

On June 30, 1969, there were 10,474 different VA forms and form letters in use of which 41 percent were standardized for VA-wide use. During the year, 183 standardized forms and form letters were eliminated as no longer necessary, 262 were created to meet new requirements, and 559 were updated and improved.

To increase correspondence production, alleviate backlogs, and achieve better manpower utilization, high-speed automatic typewriters were installed in central transcription units at 19 regional offices. In addition, expanded use was made of pattern paragraphs and letters to replace individually dictated correspondence of a routine and repetitive nature.

Management Improvement.—Actions taken during the year saved over 2,600 man-years and $46 million besides resulting in numerous other nonquantifiable improvements. For example, management improvements in two of VA's major centralized activities, the master index file and the claims folder locator file resulted in a savings of 14 man-years, despite a 25-percent increase in workload. Revision of the beneficiary travel process, utilizing a plastic patient data card and a streamlined paperwork process enabled hospital administrative offices to provide improved service at reduced cost.

Litigation Activities.—Tort claims were one of the most active areas in the field of important litigation. A total of 70 cases were closed during the year leaving a balance of 128 tort suits pending at the end of the fiscal year.

As with other Government agencies, violations of penal provisions of Federal statutes that are noted in carrying out the Veterans Administration's responsibilities are submitted to the U.S. Attorney or the Deparment of Justice for determination of criminal violation and possible prosecution. During the year 42 such cases were received and 69 disposed of, leaving 95 cases requiring action.

The most numerous type of civil litigation involved actions to recover debts due the United States. Out of a total of 1,724 cases, disposed of, 1,231 involved this kind of action.

Appellate Review

All questions on claims for benefits under laws administered by the Veterans Administration are subject to review on appeal. A Board of Veterans Appeals has been created by statute to provide this appellate review. The claimant is thus afforded a review independently of the operating elements responsible for initial adjudication. The appeals decision is, however, final and not subject to further review, except for insurance contracts.

An appeal is initiated by filing a "notice of disagreement." After then being furnished a "statement of the case" (résumé of facts, applicable law and regulations, and reasons for the decision) the appeal is completed by a "substantive appeal." A completed appeal must be certified to the Board of Veterans Appeals if the issue remains unresolved, but if the appeal is not completed, the case is closed without appellate review.

Appeals have been filed at a rate close to 40,000 annually over the past decade. In fiscal year 1969, 39,213 were filed. Of the total appeals filed, about 49 percent were settled in field offices without the necessity for consideration by the Board of Veterans Appeals. The following is a summary of the 40,458 cases disposed of during the year:

	Percent
Allowed	25.1
Closed, appeal not completed	27.7
Withdrawn by claimant	6.6
Denied or dismissed	40.6

At the end of the year, total time required from receipt of an appeal in field office to the final Board decision averaged 150 days. About three-fourths of this time was required in field offices and one-fourth in the Board of Veterans Appeals.

At the close of the fiscal year, there were 19,896 appeals pending—3,383 were on the Board's docket and 16,513 were in various stages of development in field offices.

The Board's rules of practice insure, among other things, the right of representation and the right of hearing.

Service organizations held power of attorney in 75 percent of the cases decided by the Board last year. Another 2 percent were represented by attorneys and agents. Vigorous and competent representation greatly assists claimants in perfecting their appeals and the Board in equitably deciding cases.

Hearings may be before the Board of Veterans Appeals in Washington, D.C., or before qualified personnel of the field office acting as a hearing agency for the Board. In addition, traveling sections of the Board visit field offices periodically to conduct hearings as a convenience to claimants and to bring the Board closer to those served. During fiscal year 1969 the Board

conducted 753 formal hearings, including 343 by travel sections in 26 field offices.

Supply

The Veterans Administration operates one of the major supply systems of the Federal Government. It supports its own medical and benefits programs. It also provides other Federal medical programs with a source for drugs, medical supplies and equipment, and nonperishable subsistence items. The supply program is conducted through a central procurement and distribution system for those volume purchases which are economically procured and distributed in this manner. There is a marketing center at Hines, Ill., and three medical distribution depots at Somerville, N.J., Hines, Ill., and Bell, Calif. Supply activities are located in each of VA's 166 hospitals and one domiciliary. They support the activity in which they are located as well as other VA facilities in the community. During fiscal year 1969, VA's supply system consumed $218 million worth of supplies and equipment and contracted for services amounting to $52 million.

A major change in connection with the Veterans Administration procurement of hearing aids occurred during the year. Contracting provisions now permit the release of test data obtained in connection with such procurement. This change allows the Veterans Administration to make public all or any part of the measurement and evaluation data in the manner, form and conditions deemed appropriate in the public interest.

A new depot computer system was installed in November 1968. The system serves as the basic source of input for fiscal processing of supply transactions at the three VA depots. It provides daily updating of data for depot management control and replaces a manual-mechanical operation. Coupled with conversion to central catalog files in the previous year, the system provides improvements in the VA station and other Government agency requisitioning process, marketing center replenishment process, and internal depot supply control operations.

The Inter-Agency Committee on Food Items for Federal Hospitals of which the Veterans Administration is a vital part, published the Federal Hospital Perishable Subsistence Guide (Program Guide G–1, VAPR) in October 1968. This is the first comprehensive effort at standardizing and disseminating to potential users a governmentwide guide in any commodity area. It showed result in improved economy and efficiency in selection and acquisition of perishable food. Supplemental data will be published later in 1969 which so far as the Veterans Administration is concerned will provide its individual hospitals with a comprehensive list of items, specifications, and characteristics, for all perishable food they use, including those they purchase in the local market.

Radio pager repair service has been established at the VA supply depot, Hines, Ill., in recognition of expanding agency needs with over 4,600 pagers currently in use at 87 VA hospitals. Service is offered at a flat price with re-

turn of the repaired pager to the field station within 7 days and is designed for optional use by stations finding local service unsatisfactory in cost or quality. Since November 1968, when this service became available over 600 pagers have been received for repair.

Changing techniques in patient care and treatment are being brought about by the increased use of disposables. Currently a total of 1,895 different disposable (one-time or one-patient) items are used in the VA hospital system. This number represents just about every hospital disposable item marketed. Over 600 of these are supplied through the national buying program. It is estimated that about $8 million annually is being spent for disposables. This expenditure is expected to increase as more and more hospitals find it more economical, or otherwise advantageous to increase their use of disposable items.

Byproducts recovered from exhausted operating supplies helped to reduce overall operating costs. Silver reclaimed from exhausted X-ray developing solutions and sales of X-ray film no longer needed for medical purposes generated income of $826,500. Mercury with a commercial market value of almost $89,000 was reclaimed from spent hearing aid batteries and reprocessed to obtain triple distilled mercury, which is issued to stations at less than 50 percent of its commercial value.

With new development of sophisticated medical equipment occurring at a rapid pace, there is a growing problem of keeping operation and maintenance personnel abreast of what to do, how to do it, and when to do it, to assure proper treatment and safety of the patient and maximum useful life of the equipment. Industry is cooperating in meeting agency needs by providing factory training for equipment specialists. Seminars on design, operation, and maintenance have been conducted at manufacturers' plants and at field stations. Knowledge gained by equipment specialists is passed on to hospital and clinic personnel through intra-agency training sessions, published guidelines, and maintenance standards.

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