

THE ROLE OF THE VA IN AN EVOLVING HEALTH CARE SYSTEM

Position Paper

of the

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INTRODUCTION

The Veterans Administration (VA) operates the largest single health care system in the United States. Its 172 medical centers, 100 nursing homes, 16 domiciliary facilities, and 53 independent or satellite clinics throughout the United States and Puerto Rico provided care directly in 1983 for 1.3 million inpatient and over 16 million outpatient visits (Table 1) (1). In addition, the VA paid for care on a fee basis for 90,000 inpatient and almost 2 million outpatient medical visits. The VA has affiliations with over 1,000 American health care professions schools. Almost 100,000 students and trainees per year receive supervised clinical and administrative experience in VA medical centers. The VA employs over 197,000 people, including approximately 11,500 physicians. In FY 1984, the VA budget was in excess of \$8 billion, and for FY 1985 its budget is estimated to exceed \$8.5 billion.

Since colonial times the American people have recognized an obligation to provide care for indigent and disabled war veterans. The Continental Congress provided pensions for disabled Revolutionary War veterans. In 1811, the US Naval Home in Philadelphia was authorized. In 1865, Congress established a series of national homes and asylums for disabled soldiers. The return of large numbers of disabled World War I veterans suffering from combat injuries coupled with veterans' marches on Washington, D.C. prompted Congress, in 1924, to establish a formal system of hospitals and other facilities to provide health care directly and without cost to eligible veterans. Establishment of a separate system reflected the gratitude of the nation for the sacrifices of those who served in the military during time of war and represented a national commitment to assure that all eligible veterans would receive needed health care.

The VA system was begun in a spirit of optimism in the United States during a period of an expanding economy. It was designed to furnish priority medical care to veterans with service connected disabilities, while also providing medical care for needy non-service connected (NSC) veterans. Congressional action, in 1930 (during the Great Depression) and after World War II, the Korean Conflict, and the war in Vietnam reaffirmed the national policy commitment to provide a complete medical and hospital service of high quality for eligible veterans. Benefits and coverage were expanded and facilities were constructed and renovated.

As the size of the system grew, its needs increased for well-trained health professionals and for mechanisms to assure that high quality care was provided. Consequently, the VA also began to play a major role in medical education and research.

As the largest national medical specialty society, representing over 60,000 general internists and allied subspecialists who are professionally committed to serving the medical needs of adults and adolescents, the American College of Physicians strongly supports the VA in its efforts to assure high quality health care for the nation's 28.3 million war veterans. The College recognizes that the VA has unique missions: 1) to serve eligible veterans; 2) to provide special services required for veterans with war-related injuries; 3) to care for widows and orphans of veterans; and 4) to act as a medical care backup to the Department of Defense in case of war or national emergency.

SUMMARY OF POSITIONS

1. The fundamental goal of the VA health care system must remain the delivery of high quality health care services to eligible veterans. Highest priority in the allocation of VA resources should continue to be given to veterans with special needs stemming from active military service. Unless some practicable alternative emerges, the VA will also need to continue to commit substantial resources for the care of veterans with non-service connected (NSC) disabilities, including long-term care for increasing numbers of dependent elderly veterans.
2. Continuing national pressures to restrain health care costs mandate that VA resources be integrated -- without loss of VA identity -- with other available health care resources.
3. The strengths and weaknesses of each individual VA facility should be assessed in the light of total community health care resources. VA planners should be prepared to modify local facilities so as to emphasize those needed services that can be provided most effectively. Access of the veteran to non-VA facilities and of non-veterans to the VA should be facilitated where appropriate to provide timely and effective medical care. The administrative structure of the VA should be streamlined to enhance overall flexibility and local autonomy.
4. The VA has emerged as an integral component of the national health professions educational and biomedical research enterprise. Therefore, when changes in national public health policy are contemplated, it is essential that the impact on these important VA functions be taken into account.

POSITION

1. The fundamental goal of the VA health care system must remain the delivery of high quality health care services to eligible veterans. Highest priority in the allocation of VA resources should continue to be given to veterans with special needs stemming from active military service. Unless some practicable alternative emerges, the VA will also need to continue to commit substantial resources for the care of veterans with non-service connected (NSC) disabilities, including long-term care for increasing numbers of dependent elderly veterans.

RATIONALE

The VA performs many functions including the provision of a wide range of health care services for eligible veterans. Because of the increasing number of elderly veterans, the VA has also assumed a major new role in geriatrics. However, the primary purpose of the VA health care system must still be to assure that eligible veterans of all ages receive needed health care services of high quality. VA policies should continue to be guided by this fundamental goal.

In 1982, there were 3.5 million veterans who were aged 65 and over. By 1990, the number of elderly veterans is expected to more than double to 7.16 million, and by the year 2,000 it is projected to be approximately 9 million (2,3). The number of veterans age 75 and over, the age group that requires the greatest amount of resources per capita, is expected to increase even more rapidly from approximately 750,000 in 1982 to about 4 million by the year 2000. Veterans over age 85, whose utilization of services is also extensive, will increase correspondingly from about 300,000 to approximately half a million. These dramatic increases reflect the aging of the cohort of veterans of World War II (11 million) and the Korean Conflict (5.3 million), who in 1983 comprised more than three fourths (77%) of all civilian males age 60-64 (1).

Within the VA, a complex maze of statutorily defined priorities exists for admission to non-emergency hospital, nursing home, ambulatory, and domiciliary care facilities. As an example, Appendix 1 shows VA regulations for outpatient services. In general, highest priority is given to treatment of veterans with service-connected disabilities. Medical services are provided by contract with other health care facilities for a qualifying spouse or child of a totally disabled or deceased veteran with a service-connected disability and for surviving dependents of those who died while on active duty.

During FY 1983, almost 1 million inpatients were treated and discharged from VA medical centers. Slightly more than 10% of these patients were veterans receiving care for service-connected disabilities; another 20% were veterans with service-connected disabilities who required care for other illnesses. The remaining 70% were predominantly non-service connected (NSC) veterans with disabilities (1).

Substantial VA services are provided to elderly veterans who are eligible for VA medical care regardless of financial need. Approximately 25% of veterans aged 65 and over use some form of VA health care annually (4), and approximately 30% of all VA health resources are expended on the elderly (5). Yet, aging, in itself, is not related to military service, and the health care needs of aging NSC veterans are not very different from those of non-veterans. In light of the availability of Medicare coverage for nearly all elderly veterans, it is appropriate to question whether the VA should continue to provide such coverage. At present, for most NSC veterans eligible for Medicare, this question does not arise; they can afford to obtain care elsewhere and do not use the VA.

On the other hand, NSC veterans who depend upon the VA for health care services are predominantly those who have low incomes, lack other insurance, and are geographically or otherwise isolated from other health care providers. The VA provides for many veterans an alternative to accepting Medicaid. Furthermore, many NSC veterans have assumed that the VA would provide for their health care needs and have made no provision to assure care from other sources. Unless the VA provides for these veterans, either other governmental programs will have to assume the burden for their care or many veterans will be unable to obtain needed health care services.

Because the VA requires no copayments or deductibles, it is reasonable to expect that as Medicare copayment requirements increase, more veterans will apply for VA care. Older veterans are exempt from having to sign a "poverty oath" to qualify for VA medical care, but they must still meet medical need criteria, and they have no priority over others with NSC illnesses. In addition, demographic changes, alone, will dictate that the VA also devote extensive resources to long-term care services for the elderly.

Institutional facilities operated or supported by the VA offer to eligible veterans long-term care services that are generally in short supply outside the VA. Non-institutional services too, such as ambulatory care, home health care, adult (geriatric) day care, and hospice care provided by the VA will become increasingly in demand, because they, also, often are not covered by other public programs or by private insurance. Even within the VA, however, these services are often inadequate. Without proper planning to meet increased future needs, they certainly will become inadequate.

POSITION

2. Continuing national pressures to restrain health care costs mandate that VA resources be integrated -- without loss of VA identity -- with other available health care resources.

RATIONALE

It is a certainty that as the veteran population ages, health care needs and demands for services will increase. Consequently, VA facilities will serve patients with more complex problems requiring additional care,

more staffing, and more resources. However, not all elderly veterans entitled to VA coverage will require health care services, and not all of those requiring care will utilize the VA.

Any reduction of coverage or benefits outside the VA system is likely to increase the proportion of eligible veterans who enter the VA system. Changes in Medicare coverage and benefits, or even in public perceptions of changes in the quality or accessibility of services under Medicare, could influence materially, the degree to which veterans rely upon the VA. Utilization of the VA could also be affected by cost containment pressures resulting in alteration of benefits by other payers, changes in employment with consequent changes in health insurance coverage, and the aging of the population. The impact on the VA of the new Medicare prospective payment system, which bases payments on diagnosis-related groups (DRGs), has yet to be determined, but this innovation can be expected to have some influence. Changes in Medicaid coverage and eligibility requirements can also affect the number of requests for VA services.

The VA is a major purchaser of medical and surgical care furnished by non-VA providers when services are not obtainable at local VA facilities. As medical care continues to become more complex and more costly, the interdependence of the VA with the rest of the health care system will intensify.

The VA has long been aware of the impending increase in demand for services by elderly veterans and has sought to improve efficiency. Efforts have been made to increase coordination of VA services with other community resources. Emphasis has been given to outpatient care and to providing hospital-based home care, adult day health care, residential care, hospice care, and a variety of other support services. Current VA plans call for significant increases in VA nursing home, extended care, and outpatient facilities. Historical and projected VA medical care expenditures by type of care are illustrated in Table 2. The VA ambulatory and extended care strategy seeks to establish non-institutional capacity that will enable it "to provide essential health and supportive services to eligible veterans of all ages, emphasizing a full array of health care services...to decrease the need for hospital treatment to the maximum extent consistent with high quality" (3).

In light of the projected health care needs of aging veterans, rising national health care costs and a national surplus of acute care hospital beds (both within and outside the VA system), the question has often been raised as to whether a separate VA health care system should be maintained. Indeed, in 1977, the National Academy of Sciences completed a 3-year, \$6 million study (6) containing some 37 recommendations, 7 of which were concerned with the integration of VA and community health care resources. The Academy advised phasing out the VA and fully integrating facilities and services with community resources. Recent studies have also emphasized a need for greater integration of VA facilities with those of the community (2,7). Without question, any proposal for the dissolution of VA health care services will encounter stiff political opposition. Regardless of these pressures, such a drastic step would entail monumental

shifts in resources, not only for medical care but also for medical research and education.

POSITION

3. The strengths and weaknesses of each individual VA facility should be assessed in the light of total community health care resources. VA planners should be prepared to modify local facilities so as to emphasize those services that can be provided most effectively. Access of the veteran to non-VA facilities, and of non-veterans to the VA should be facilitated where appropriate to provide timely and effective medical care. The bureaucratic structure of the VA should be streamlined to enhance overall flexibility and local autonomy.

RATIONALE

The VA is often criticized for being a ponderous, hierarchical, centrally controlled bureaucracy poorly responsive to rapidly changing local needs. It is argued that administrative and legislative rules and regulations impede rather than facilitate innovation. The federal budget process provides incentives to spend all that is budgeted before the close of each annual period, thus discouraging long range planning. Budgetary rigidity also prevents VA installations from making needed changes at the local level.

In an effort to repair this deficiency the VA devised the Medical District Initiated Program Planning (MEDIPP) process to encourage experimentation and cooperative community planning. However, some innovative recommendations generated and approved locally have been vetoed at higher levels of the VA bureaucracy.

Entitlement protections prevent any restriction of services, even though resulting savings might mean that more patients could receive care. Thus, in times of fiscal stringency, NSC outpatients cannot be asked to share in the cost of treatments by purchasing their prescribed medications; they must either be provided with total ambulatory care or discharged. Legislation adopted in 1982 (PL 97-72) requires the VA to maintain and operate no fewer than 90,000 hospital and nursing home beds (1), regardless of need.

The VA's ambulatory care system is seen by some to be undersized and underfinanced (8). Attempts since 1976 to control ambulatory and hospital care costs have reduced access to ambulatory care at VA hospitals and at some clinics. Access to long-term ambulatory care has also been diminished for many veterans without service-connected disabilities. These restrictions appear to run counter to the intent of Congress and medical planners to minimize the need for more costly hospitalizations.

Other bureaucratic impediments to cost-effective patterns of practice are said to include payment policies that compensate medical centers and pharmacies more for having a patient return for a number of separate visits than for scheduling multiple appointments on the same day, restrictions on

the size of ambulatory care staff based on inappropriate inpatient staffing ratios, slowness to modernize facilities, and administrative inertia that causes inordinate delays in obtaining proven technologies and equipment (e.g., many VA acute care medical centers with intensive care units still lack CAT scanners). Although the VA has made more progress in providing continuity of care than much of the rest of the health care system, its ability to assure such care for NSC veterans is seriously impeded by its imprecise and confusing eligibility regulations. As the veteran population continues to age, the VA will need to expand its ability to perform functional assessments and case management for the coordination of a full range of community based services. Furthermore, because it deals almost exclusively with older males and cannot effectively provide care for spouses or other family members, the VA often discourages community care or home care that would serve the needs of family units. This fragmented support by the VA often leads to suboptimal efforts on the part of other agencies in the community. At times even well-recognized cost-efficient services such as "meals on wheels" may be withheld.

Another recognized weakness of the VA system has been its inability to adjust its compensation policies to reflect local job market differences and changing needs for health care professionals and administrators. Special pay provisions were established for the VA to enable it to recruit and retain qualified physician staff. However, adjustments in VA physician salaries often have not kept pace with compensation changes outside the VA system. Salary ceilings tied to politically sensitive Congressional salaries cause the VA difficulties in attracting and retaining senior level physicians. Limitations on the applicability of special pay provisions deter physicians from entering top administrative positions. Civil Service rules and compensation policies have also caused difficulties for some VA facilities in filling certain nursing positions. Increased efforts are needed to make VA salaries parallel more closely local market conditions.

Advocates for the VA maintain that it has pioneered in delivering high quality health care on a limited budget. They note that the private sector is only just beginning to face the challenge of providing services within budgetary restraints and could benefit from some of the methods used by the VA (e.g., greater use of triage and geriatric evaluation units). Conversely, examination and application of some of the recent cost containment strategies developed in the private sector may lead to improvement in the delivery of VA care.

An objective appraisal is needed for both VA and non-VA community facilities. Effective planning requires data on the strengths and weaknesses of each VA facility in conjunction with local and regional health care resources. Once needs and available resources are clearly identified, innovative and flexible approaches should be encouraged to utilize all facilities. Statutory provisions impeding local VA autonomy and hindering efficient management should be revised. Restrictions limiting use of VA facilities will also need to be changed to allow the VA, when capacity and resources permit, to serve reasonable community needs and to receive appropriate compensation for the use of VA facilities and services.

Efforts to restrain rising health care costs without impeding the delivery of services should encompass all aspects of health care, including the VA system. The recent surge of innovation and experimentation in both the private and public sectors should be examined for applicability to both VA and non-VA facilities.

POSITION

4. The VA has emerged as an integral component of the national health professions educational and biomedical research enterprise. Therefore, when changes in national public health policy are contemplated, it is essential that the impact on these important VA functions be taken into account.

RATIONALE

The VA has affiliations with over 1,000 health professions schools throughout the United States and Puerto Rico. Some 99,684 students and trainees received all or part of their supervised clinical and administrative experience in VA medical centers during 1983. Of these, 22,517 were medical students -- nearly one-third of the nation's total undergraduate medical school enrollment and double the number similarly participating a decade before. There were also 26,307 graduate medical students (35% of the nation's total) participating in approximately 7,700 VA supported full-time equivalent medical residency training programs at 134 VA medical centers affiliated with 100 medical schools (1).

The ability of the VA to deliver high quality care depends to a large extent on its affiliation agreements with medical schools. A loss of affiliation agreements would jeopardize not only the VA's educational and research programs, but also would deprive the VA of its major guarantee of high quality care and seriously impair opportunities to recruit and retain the best professional personnel (4). It is essential that the VA maintain a balance of services, including acute, long-term and home care facilities.

Research activities of the VA are extensive. Approximately \$155 million were appropriated for VA medical and prosthetic research in FY 1983, \$219 million for FY 1984, and \$193 million were requested for FY 1985. High priority areas of VA medical research include schizophrenia, alcoholism and other substance abuse, aging, spinal cord injury, delayed stress, and the long-term effects of nutritional and other health impairments of former prisoners-of-war. Research is also directed toward health problems prevalent among veterans including cancer, diabetes, chronic heart diseases, and chronic pulmonary disease. The VA also encourages studies that emphasize practical applications for medical care such as prosthetics and sensory aids to help the disabled as well as and health services research to promote cost effectiveness.

Particular emphasis is given to health care problems related to aging, and the VA is acknowledged to be a major force in the field of geriatrics.

Much VA research is conducted in ten Geriatric Research, Education and Clinical Centers (GRECCs), centers designed to foster teaching and research on aging in a clinical context. Resources are concentrated at each specialized GRECC to encourage advances in medical knowledge in geriatrics and gerontology and to translate advancements into the delivery of patient care. Over 600 health professionals have received formal training in geriatrics through the GRECCs (9). One of the major achievements of the program has been the development of geriatric evaluation units which provide intensive inpatient diagnosis and therapy, provide consultations, and enable the VA to determine patients' functional abilities and needs. These activities could be enhanced with the establishment of satellite centers to assist in the dissemination of services and knowledge.

The extent and high value of VA programs in medical education and research have made the VA an integral part of the nation's medical educational system. Major changes in the VA health care system would undoubtedly produce significant repercussions for academic medical centers. By the same token, changes in the medical education system (e.g., reduction of medical school class size or elimination of schools) would likewise affect the VA. Therefore, proposals for significant change in VA health care should be evaluated prior to implementation to determine possible effects upon the national medical education enterprise and vice versa.

Changes in national policies affecting health care and the VA must not be made in isolation. Development of new policies must include recognition of interrelationships among health care systems and the ramifications that policies directed at any one system will have upon the provision of medical care provided throughout the nation.

The American College of Physicians supports efforts aimed at streamlining and improving the delivery of VA medical services and stands ready to work with Congress, the VA, veterans' organizations and others dedicated to the provision of optimal health care for our nation's veterans.

REFERENCES

1. Administrator of Veterans' Affairs, Annual Report 1983. Washington, DC: Veterans' Administration, June 1984.
2. Health Care of the Aging Veteran: A Report of the Geriatrics and Gerontology Advisory Committee, EW Busse, MD, ScD, Chairman. Washington, DC: Veterans' Administration, April 1983.
3. Caring for the Older Veteran. Washington, DC: Veterans' Administration, July 1984.
4. Custis DL, Chief Medical Director, VA Department of Medicine and Surgery, Statement before the House Committee on Veterans' Affairs Subcommittee on Hospitals and Health Care, 14 July 1982.
5. Haber PA. "Geriatrics and extended care in the VA", The Aging Veteran Population: Interorganizational Relations, Social Work Service, Veterans Administration Medical Center, Coatesville, PA; June 1982.
6. National Academy of Sciences National Research Council. Study of Health Care for American Veterans, submitted to the Senate Committee on Veterans' Affairs. Washington, DC: US Government Printing Office (Committee Print No. 4); June 1977.
7. Broberg M. "Conclusion", the Aging Veteran Population: Interorganizational Relations, Social Work Service, Veterans' Administration Medical Center, Coatesville, PA; June 1982.
8. Inui TS, et al. "Patients, clinicians, and problems in the VA's ambulatory care system" VA Practitioner, March 1984.
9. Worthen D. "Scope of VA/DM&S educational affiliations and programs during fiscal year 1982," Presentation to the VA Administrator's Staff Conference, April 1983.

Table 1

Veterans Administration
Annual Operating Statistics
FY 1983 and FY 1982

Item	FY 1983	FY 1982	Percent Change
Facilities operating at end of year			
Medical centers	172	172	
Hospital care	(172)	(172)	
Outpatient care	(172)	(172)	
Nursing home care	100	99	+ 1.0
Domiciliary care	15	15	
Independent or satellite clinics	53	53	
Independent domiciliary	1	1	
Employment (net full-time equivalent)	197,352	195,251	+ 1.1
Obligations (in millions)	\$8,053	\$7,369 ¹	+ 9.3
Medical care	\$7,817	\$7,155	+ 9.3
Research in health care	\$ 161	\$ 137	+17.5
Medical administration and miscellaneous operating expenses	\$ 62	\$ 57	+ 8.8
Other medical programs	\$ 13	\$ 19	-31.6
Inpatients treated	1,401,018	1,357,547	+ 3.2
VA facilities	1,311,008	1,272,151	+ 3.1
Other facilities	90,010	85,396	+ 5.4
Average daily inpatient census	103,955	102,601	+ 1.3
VA facilities	80,693	80,467	+ 0.3
Other facilities	23,262	22,134	+ 5.1
Outpatient medical visits	18,509,552	17,808,977	+ 4.0
VA staff	16,617,485	15,861,687	+ 4.8
Fee-basis	1,892,067	1,947,290	- 2.8
Prescriptions dispensed	41,263,062	40,650,610	+ 1.5
Lab procedures (unit count)	252,919,000 ²	232,035,884	+ 9.0
Radiology examinations	5,457,957	5,266,166	+ 3.6

1 Total does not add due to rounding

2 Estimated

Source: Administrator of Veterans Affairs. Annual Report 1983
Washington, DC: Veterans Administration (June 1984).

TABLE 2

VA MEDICAL CARE EXPENDITURES 1973, 1982, AND FUTURE YEARS ASSUMING
CURRENT POLICIES AND CURRENT AVERAGE LENGTH OF STAY (In billions of
1982 dollars)

Types of Care	Actual Cost		Projected Cost ^{a/}		
	1973	1982	1990	1995	2000
VA Hospital	1.75	4.38	6.28	7.23	8.26
Nursing Home	0.11	0.47	0.71	0.90	1.08
VA	N/A	0.28	0.41	0.52	0.62
Community	N/A	0.17	0.24	0.31	0.37
State	N/A	0.03	0.06	0.07	0.09
Domiciliary	0.06	0.10	0.13	0.14	0.14
VA	N/A	0.09	0.11	0.12	0.12
State	N/A	0.01	0.02	0.02	0.02
Outpatient	0.44	1.38	1.70	1.96	2.02
Other Costs ^{b/}	N/A	0.85	1.02	1.04	1.07
Total	2.70	7.20	9.85	11.30	12.60

SOURCE: Congressional Budget Office; Veterans Administration, Administrator for Veterans' Affairs, Annual Report 1982 (June 1983), Tables 12 and 13.

Printed in: Congressional Budget Office; Veterans Administration Health Care: Planning for Future Years (April 1984), Tables 2 and 5.

- a. Costs include direct patient care, administrative, and support costs, but exclude construction costs and capital costs. The costs are based on the average per diem costs of care for VA patients.
- b. These costs include the costs of other medically related programs -- contract hospital care, medical care for dependents of service-disabled veterans, education and training, research, and miscellaneous administrative costs.

N/A = Not available.

APPENDIX

PRIORITIES FOR OUTPATIENT CARE AND SERVICE Section X - VA Departmental Manual October 7, 1982

GENERAL

The initiation and continuing care of eligible patients in an outpatient status will be effectively managed according to priorities established in this section.

POLICY

a. Those persons with emergent conditions requiring immediate medical attention will be provided emergency care without regard to priorities.

The initiation of care in an outpatient program or the continuation of care after its initiation will be based on a professional determination of the need for care, and the applicant or patient will be scheduled and/or seen according to the following priorities and in the sequence indicated within these priorities.

c. Priorities I (a,b and c), II (a and b) and III are mandated by 38 U.S.C. 612 (i). Priorities IV through VII are established by departmental policy.

PRIORITY I

a. Veterans requiring care for service-connected disabilities or for disabilities incurred in line of duty for which they were released or retired from the active military, naval or air service. (This category also includes Spanish-American War veterans requiring care for any disability.)

b. Veterans with a service-connected disability or disabilities rated at 50 percent or more.

c. Veterans with service-connected disabilities or retired for disabilities incurred in line of duty, requiring care for non-service-connected disabilities (including any veteran requiring examination to determine the existence or rating of a service-connected disability).

(NOTE: Veteran entitled to a rehabilitation program and the medical services required are determined necessary for continuation in the program are categorized in either priority I (a), (b) or (c), as appropriate.)

PRIORITY II

- a. Veterans who are former prisoners of war.
- b. Veterans who are receiving care for conditions possibly related to exposure to Agent Orange, other hazardous substances or ionizing radiation.

PRIORITY III

Veterans in receipt of increased pension or special allowance based on the need of regular aid and attendance or by reason of being permanently housebound, or who, but for the receipt of retired pay, would be in receipt of such increased pension or special allowance, and veterans of the Mexican border period or World War I.

PRIORITY IV

Beneficiaries receiving authorized examinations for VA pension, dependency and indemnity compensation or examinations for insurance purposes.

PRIORITY V

- a. Non-service-connected veterans requiring post-hospital care (OPT-NSC).
- b. Non-service-connected veterans requiring pre-bed care (OPT-PBC).

PRIORITY VI

- a. Non-service-connected veterans requiring care to obviate the need for hospitalization.
- b. CHAMPVA beneficiaries receiving care at VA facilities.
- c. Former members of the armed forces retired from the service on the basis of length of service who are to be provided outpatient care as beneficiaries of the armed forces.

PRIORITY VII

- a. Persons authorized examination or treatment under approved sharing agreements.

b. Beneficiaries from other Federal agencies, except as described in priority VIc.

c. Veterans of Nations allied with the United States in World War I or II receiving medical care under the authority of VA Regulation 6045(E).