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Access to Care for Women Veterans: Delayed Healthcare and Unmet Need

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RESEARCH HIGHLIGHTS:

- There is a rapidly increasing number of women veterans, however they are less likely to utilize Veterans Affairs (VA) healthcare compared to men. Prior research shows there are both general and women veteran-specific access barriers to healthcare, but not how these factors impact receipt of needed care
- Nineteen percent of women veterans had perceived unmet healthcare needs. Women with unmet healthcare needs tended to be racial minorities, uninsured, disabled and without health insurance and/or a regular care provider. Veteran women with unmet healthcare needs tended to be in a high priority group for VA enrollment, and were more likely to have experienced military sexual assault.
- About 41% of women veterans cited being unable to afford medical care as a primary reason for their unmet health needs. Other barriers to care faced by women veterans included inability to leave work, transportation difficulties, work schedules incompatible with VA care hours and caregiver responsibilities.

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ABSTRACT:

"Background: Timely access to healthcare is essential to ensuring optimal health outcomes, and not surprisingly, is at the heart of healthcare reform efforts. While the Veterans Health Administration (VA) has made improved access a priority, women veterans still underutilize VA healthcare relative to men. Eliminating access disparities requires a better understanding of the barriers to care that women veterans' experience.

Objective: We examined the association of general and veteran-specific barriers on access to healthcare among women veterans.

Design and Participants: Cross-sectional, population-based national telephone survey of 3,611 women veterans.

Main Measure: Delayed healthcare or unmet healthcare need in the prior 12 months.

Key Results: Of women veterans, 19% had delayed healthcare or unmet need, with higher rates in younger age groups (36%, 29%, 16%, 7%, respectively, in 18—34, 35—49, 50—64, and 65-plus age groups; p<0.001). Among those delaying or going without care, barriers that varied by age group were: unaffordable healthcare (63% of 18—34 versus 12% of 65-plus age groups); inability to take off from work (39% of those <50); and transportation difficulties (36% of 65-plus). Controlling for age, race/ethnicity, regular source of care, and health status, being uninsured (OR=6.5; confidence interval [CI] 3.0—14.0), knowledge gaps about VA care (OR=2.1; 95% CI 1.1—4.0), perception that VA providers are not gender-sensitive (OR=2.4; CI 1.2—4.7), and military sexual assault history (OR=2.1; CI 1.1—4.0) predicted delaying or foregoing care, whereas VA use and enrollment priority did not.

Conclusion: Both general and veteran-specific factors impact women veterans' access to needed services. Many of the identified access barriers are potentially modifiable through expanded VA healthcare and social services. Health reform efforts should address these barriers for VA nonusers. Efforts are also warranted to improve women veterans' knowledge of availability and affordability of VA healthcare, and to enhance the gender-sensitivity of this care."

Implications

FOR PRACTICE

Since barriers to healthcare access for women veterans vary by age, work status and other population characteristics, there is no one remedy to address access issues completely for women veterans. Because age plays a role in the way in which women veterans enter VA care, for example, through women's health or geriatric clinics , interventions may be successfully implemented by designing them according to age groups. This study found that women veterans under the age of 35 often found healthcare unaffordable, which also served as a major barrier for those ages 50-64. Those under age 50 also faced the barrier of being unable to take time off from work for treatment, and for those ages 64 and over transportation difficulties represented a major issue. Solutions for these obstacles to care include the implementation of VA after-hours care, expanded transportation services provided by the VA, tele-medicine and other off-site alternatives to provide accessible care for women veterans. The VA should also engage in marketing campaigns to improve veterans' knowledge of service availability and affordability, including social networking and peer support to reach as many veterans as possible with this information. These initiatives should be linked with training caregivers in gender sensitivity and gender-appropriateness, especially when treating veterans with a history of military sexual assault, a barrier to care found across all age groups.

FOR POLICY

The policy implications of this research center mostly on eligibility and access to VA healthcare for women veterans. Some women veterans do not meet eligibility requirements for VA healthcare, or opt out of VA care, choosing to obtain care from the private sector instead. Those who are uninsured are at risk of not receiving needed care, and even those opting for private sector healthcare may not receive coverage that addresses both general health needs and needs specific to the veteran population, such as post-traumatic stress disorder (PTSD) and military sexual assault treatment programs. Non-VA care may also lack personnel and procedures addressing re-integration issues, and coordination of obstetrical and mental healthcare, which is important for veteran women. Policy makers should focus on healthcare reform policies that mandate coverage for veteran-specific needs in non-VA health plans, for veterans who choose to go this route instead of VA healthcare. Women veterans from the Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) conflicts have higher VA market penetration than women veterans from other eras, so there is widespread need for health plans that are responsive to these women veterans' needs, both in and outside of the VA health system.

FOR FUTURE RESEARCH

Because this study did not focus on the health consequences of delays in healthcare, this is a potential direction for future research. Researchers in future studies can compare the seriousness of conditions, length of delays in care and any potential health consequences of delays in care among participants. A separate category should be included as well for more significant delays, perhaps any longer than 12 months, and whether these delays resulted in health issues that could have been prevented by access to prompt care. Another area for future research includes addressing the variety of caregiver responsibilities that served as obstacles for veteran women seeking healthcare. In this study, there was no differentiation between childcare and elder care responsibilities. Further research should assess the differences in these kinds of care, including the proportion of veteran women engaged in each and the various ways in which they affect women veterans' ability to access care. Studies focusing on non-VA users and populations with significant access barriers, including rural veterans and those without a telephone, could contribute significant information for future programs and interventions increasing access to care. Finally, it would be beneficial to explore women veterans' perceptions and navigation of the clinical sites that serve as entry points into the VA health system, including post-deployment clinics, women's clinics, primary care clinics and mental health clinics.

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