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Exploring the Experiences of Australian Veterans with Accessing Healthcare: A Qualitative Study

RESEARCH

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ABSTRACT

Service in the Australian Defence Force (ADF) can be associated with health consequences. Poorer physical and psychological health and health-related quality of life of Australian veterans are frequently reported in the literature and government inquiries, with little evidence of improved health outcomes. The purpose of this study is to gain a greater understanding of how Australian veterans experience healthcare, with the ultimate intention of highlighting the challenges faced when navigating the civilian healthcare system, and to provide possible strategies to improve Australian veterans' experiences of healthcare. Qualitative data were collected between August and September 2019 via a purpose-built online survey (N = 82) and semi-structured interviews (N = 11) with Australian veterans who had accessed the civilian healthcare system after discharge. Participants were recruited Australia-wide via social media advertising and ex-service organisations. Data were analysed using an inductive thematic approach to describe participant experiences and perspectives. Participants (aged 24–80 years; 88% male) had served between 1 and 49 years in the ADF. Five key themes were produced through analysis. When accessing healthcare, veterans described systemic issues, difficulties finding appropriate clinicians, additional load on veterans, difficulties with transition from military to civilian healthcare, and feeling disregarded. Based on this analysis, and recommendations from participating veterans, strategies to improve healthcare access could include case co-ordination, access to knowledgeable providers, improved system navigation, and continuity of care from ADF to civilian care and the Department of Veterans' Affairs.

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Due to the unique nature of service in the Australian Defence Force (ADF), ex-serving ADF personnel (hereafter referred to as veterans) may have healthcare needs, experiences, and challenges that are different to the general Australian population (Australian Institute of Health and Welfare, 2020). As a condition of ADF service, military personnel have immediate access to a comprehensive level of health and medical services. This quick and responsive health system is vastly different to navigating the Australian healthcare landscape as a civilian.

Accessing and navigating the healthcare system is of crucial importance for veterans. A large body of evidence demonstrates poorer physical and psychological health and health-related quality of life in Australian veterans compared to the civilian population (Forbes et al., 2016; Hawthorne et al., 2013; Hawthorne et al., 2014; O'Toole et al., 1996a). Military service (from deployment to domestic work) can result in experiences leading to trauma and physical health issues and can affect social networks and psychological health (Lawrence-Wood et al., 2019). Increasing combat exposure, repeated deployments, length of posting, and exposure to potentially traumatic events (e.g., injuries and death) are also likely to have an impact on veterans' health status (McFarlane & Van Hooff, 2017). Psychological symptomology can be higher in veterans 20-plus years after combat exposure (McKenzie et al., 2004), indicating complex and ongoing healthcare needs. Deployed veterans with diagnosed posttraumatic stress disorder (PTSD) also tend to experience more physical comorbidities (e.g., cardiovascular and sleep disorders) than those without PTSD (McLeay et al., 2017).

More recently, research has demonstrated the psychological and physical difficulties of ADF personnel involved in peacekeeping missions (Davy et al., 2012). Compared to civilians, peacekeeping personnel have higher rates of PTSD, major depressive episodes, substance abuse, anxiety, and suicidal ideation (Forbes et al., 2016). Younger veterans (<45 years), those with more severe symptoms, and those who are unemployed or with total or permanent incapacity status are more likely to have attempted suicide (Kerr et al., 2017). Data show that suicide rates are lower amongst current serving ADF personnel than in the general population, but higher for former serving ADF members (Australian Institute of Health and Welfare, 2019). With prolonged exposure to physical and psychological trauma, a possible outcome of repeated deployments, veterans will remain a population with increased and unique healthcare needs (Abouzeid et al., 2012; Ikin et al., 2004; Kelsall et al., 2004; Kerr et al., 2017; O'Toole et al., 1996b).

While medical services are provided to ADF personnel as a condition of service, upon discharge from the military, veterans are required to access the Australian civilian healthcare system. As Australians, veterans have access to the private and public (Medicare) healthcare sectors, and to the Department of Veterans Affairs (DVA). DVA is the Australian Government department responsible for providing support, services, and information for veterans and their families under various legislative acts. Support and services available to veterans include financial support, health care for approved conditions, transition services, rehabilitation, and mental health care (including Non-Liability Health Care (NLHC); where access to treatment is provided without the need to establish certain conditions were caused by military service). To access DVA-funded healthcare (with no out-of-pocket costs), veterans who hold White Cards are required to have DVA accept certain conditions and their treatment (i.e., conditions have to be deemed to be service-related by DVA, except for mental health which is covered by NLHC), whereas veterans who hold Gold Cards are provided with clinically required treatment for all medical conditions. Overall, in Australia, substantially more younger veterans hold White Cards than Gold Cards (108, 675 compared to 10, 163 < 55 years of age), while veterans over 70 years old are more likely to hold Gold Cards than White Cards (75, 460 compared to 21, 248; Department of Veterans' Affairs, 2022).

Veterans describe accessing healthcare in the military as vastly different compared to navigating the relatively complex, unstructured, and unfamiliar healthcare system as a civilian (Burkhart & Hogan, 2015; Maguire et al., 2022). In Australia this may entail registering for Medicare and finding practitioners in the community. Many veterans struggle with the transition from military to civilian life (Romaniuk & Kidd, 2018), and may experience difficulties with accessing and utilising DVA-funded and veteran-specific healthcare services in the community. Barriers for veterans accessing healthcare may include financial, social, geographical, and socio-demographic factors (Wright et al., 2018). Government inquiries and media reports suggest that younger Australian veterans have significant challenges accessing appropriate and DVA-funded medical care, but research among Australian veterans, and particularly young veterans, is needed to better understand these experiences.

The purpose of this study is to gain greater understanding of Australian veterans' experiences accessing the healthcare system upon discharge from the ADF. The ultimate intention is to highlight barriers and challenges faced while navigating the civilian healthcare system and to identify possible strategies to improve the experience of healthcare for Australian veterans.

MATERIALS AND METHODS

To address the study aims, we conducted a descriptive qualitative study using a purpose-built online survey design combined with semi-structured interviews with a purposive sample of survey participants. The study was approved by The University of Queensland and the Department of Defence and Veterans' Affairs Human Research Ethics Committee.

PROCEDURE

Demographic and qualitative data were initially collected online between August and September 2019 using a custom-built open text survey as part of a larger study. Subsequent semi-structured interviews with a purposive sample of consenting survey participants were conducted to obtain more in-depth data. The sample was selected to ensure representation across younger veterans (<65 years). The initial open text survey methodology was chosen to explore the experiences of veterans accessing the healthcare system, as surveys facilitate engagement of a large number of participants and encourage free expression of opinions due to their anonymous nature (Punch, 2003).

Semi-structured interviews were chosen to collect more in-depth data (to complement the survey) and allow probing for more information and clarification of responses, thus enabling exploration of attitudes and beliefs regarding complex and potentially sensitive issues (Barriball & While, 1994). Questions were designed to elicit veterans' experiences with, and recommendations for improving, access to healthcare. Interviews were conducted via telephone at Vanguard Health (Brisbane, Australia) and audio-recorded with participants' consent. Recruitment ceased when there was sufficient repetition and depth of thematic content of the data relevant to the research aims (Braun & Clarke, 2021).

PARTICIPANTS

Individuals aged 18 and over who had served in the ADF and engaged with the Australian healthcare system after discharge were eligible for the study, provided they had sufficient English language to provide informed consent and complete the online questionnaire (N = 82) and interview (N = 11). Participants were recruited from the general community via advertisements on social medial (Facebook, Twitter), veteran-specific organisations and communities (e.g., Mates4Mates, Soldier On, Young Veterans, Australian Peacekeeper and Peacemaker Veterans' Association) and word of mouth. A purposive sample of survey participants who agreed to be contacted for the subsequent interview were invited to participate in the interview to ensure data collection from a diverse range of participants.

DATA ANALYSIS

Data were analysed with inductive thematic analysis (Braun & Clarke, 2013). Inductive analysis means that the research team avoided imposing pre-existing theory on the analysis; rather, the data drove the findings (Braun & Clarke, 2013). The objective was to analyse the perspectives of ADF veterans in the healthcare context. The analysis involved iterative and partially overlapping steps. In Step 1 we independently read the entire dataset and made informal notes relevant to the research question. In Step 2 the first author re-read the entire dataset, manually coding participant responses (including veterans' recommendations to improve access to healthcare) into a data management software and developing provisional themes. Provisional themes and recommendations were then discussed to agreement. The complete dataset was then coded into the data management software and refined (Step 3). In Step 4 provisional themes were discussed with all members of the research team (and Vanguard Health) to map veterans' recommendations to improve access to healthcare on to the relevant themes. The final stage, conducted by the first author, was to integrate all perspectives into final themes, subthemes, and associated recommendations for reporting.

RESULTS

DEMOGRAPHIC CHARACTERISTICS

A total of 103 participants responded to the survey, with 82 meeting all eligibility criteria and completing the survey. Survey participants were between 24–80 years of age, 88% male, serving between 1 and 49 years in the ADF (see Table 1 below). Participants who completed the interview (N = 11) had a median (range) age of 50 (27 to 74) and were all male.

EXPERIENCES ACCESSING HEALTHCARE

Five themes (with a total of 14 subthemes) and four key recommendations were identified during analysis of the open survey responses and interview data (see both Table 2 and Table 3 below): DVA systemic issues, load on veterans, finding appropriate clinicians, transition from military to civilian, and feeling disregarded. Each theme, subthemes, (indicated by italic font), and recommendations suggested by veterans to improve access to healthcare are discussed herein. Survey participants are distinguished by a number (e.g., P16) and interview participants by a pseudonym.

CHARACTERISTIC	SURVEY PARTICIPANTS
Age, mean (*SD*), range	51 (13.1), 24 to 80
Gender, *n* (%)	
Male	72 (87.8)
Female	10 (12.2)
Years in the ADF, mean (*SD*), range	14.9 (9.5), 1 to 49
Years since discharge, mean (*SD*), range	17.3 (13.4), 0 to 52
Reason for discharge, *n* (%)	
Completed National Service	3 (3.8)
End of term	3 (3.8)
Administrative	4 (5.1)
Voluntary	7 (8.9)
Career progression/opportunities	8 (10.1)
Family reasons	10 (12.7)
Retired > 15 years service	11 (13.9)
Medical	33 (41.8)
Number of active deployments, mean (*SD*), range	1.5 (2.6), 0 to 19
Duration of longest active deployment (in months), mean (*SD*), range	5.3 (6.1), 0 to 36
Place of residence, *n* (%)	
Metropolitan/urban	35 (49.3)
Regional	32 (45.1)
Rural/remote	4 (5.6)
Living situation, *n* (%)	
Parents	1 (1.3)
Children	2 (2.5)
Alone	11 (13.9)
Partner and children	32 (40.5)
Partner	33 (41.8)
Household income, *n* (%)	
>$150, 000	11 (13.4)
$125, 000–149, 999	10 (12.2)
$100, 000–124, 999	6 (7.3)
$75–99, 999	13 (15.9)
$50 000–74, 999	19 (23.2)
$25 000–49, 999	15 (18.3)
$0–24, 999	4 (4.9)
Highest level of education completed, *n* (%)	
Primary school	2 (2.6)
University degree	14 (17.9)

(Contd.)

CHARACTERISTIC	SURVEY PARTICIPANTS
Post-graduate study	15 (19.2)
Trade certificate	23 (29.5)
High school	24 (30.8)
Current work status, *n* (%)	
Working casually	1 (1.3)
Out of workforce	1 (1.3)
Unable to work – other reasons	1 (1.3)
On benefits	3 (3.8)
Working part time	5 (6.4)
Retired	17 (21.8)
Working full time	24 (30.8)
Unable to work/service-related health issue	26 (33.3)
Relationship status, *n* (%)	
Single/never married	6 (7.5)
Divorced/separated	8 (10)
Married/de-facto	66 (82.5)

Table 1 Demographic Characteristics of Survey Participants (N = 82).

THEME	DESCRIPTION OF THEME
Systemic issues	The systemic issues participants described in relation to their experience accessing healthcare as an Australian veteran.
Unclear processes	
Rigidity	
Time to approval	
Finding appropriate clinicians	Finding appropriate clinicians who understood their needs was difficult for veterans when navigating civilian healthcare.
Clinicians who see DVA clients	
Finding providers who understand	
Geographical issues	
Load on veterans	Factors participants described as increasing the loads on veterans about accessing healthcare.
Added stress	
Cost of time	
Monetary costs	
Transition from military to civilian	Participants expressed issues when transitioning from the military to civilian in relation to accessing healthcare.
Unprepared	
Alone	
Lack of continuity	
Feeling disregarded	Feeling disregarded, disbelieved, or discredited and worthless was a persistent discourse throughout participants responses.
Disbelieved or discredited	
Feeling worthless	

Table 2 Themes and Subthemes Identified in the Qualitative Analysis.

RECOMMENDATION	DESCRIPTION
Case co-ordination	• Rehabilitation consultant/case managers and support people who understand DVA • Peer support system (veterans involved in providing guidance for other veterans)
Access to providers with DVA/veteran specific knowledge	• A list of service providers who accept DVA clients and/or specialise in managing veterans • Education/training for civilian service providers regarding veteran specific healthcare • More specialists in remote areas • No charge for veteran healthcare when recommended by treating specialist • Healthcare facilities for veterans • Increase fees paid to health practitioners/reduce payment gap
Improved system navigation	• Clearer process for accessing services available to veterans • Education for medical practitioners in relation to DVA requirements and procedures/processes • Automatic eligibility for gold card^ healthcare with war-like service • Revise claims assessment procedures • Reduce paperwork required for accepted claim (i.e., set up like private health card)
Integration and continuity of care	Information regarding veteran access to healthcare covered as part of ADF discharge procedures Defence medical practitioners involved in assessment of injuries/illnesses for compensation Provision of white card^^ with all accepted conditions and services at the time of discharge as part of the process List of services available to veterans for each card level (services, number of appointments, whether a referral is required) Veterans informed of what health services are available to them at the time of discharge

Table 3 Veterans' Recommendations for Improving Access to Healthcare.

Note: ^ Veteran Gold Card is a treatment card that provides eligible veterans (e.g., those who meet age or permanent impairment criteria) with medical treatment for all medical conditions.

^^ Veteran White Card is a treatment card that can provide veterans with medical treatment for accepted service-related injuries or conditions and all mental health conditions (for veterans with continuous full-time service or certain reserve service; see Department of Veterans' Affairs, 2023).

Theme 1: Systemic Issues

Many participants mentioned that systemic issues were a significant barrier to accessing and receiving DVA-funded healthcare. Issues that veterans described under this theme primarily related to having claims accepted by DVA, resulting in difficulties being compensated for healthcare. The process of accessing DVA-funded healthcare was described as complicated, confusing, adversarial, and inconsistent. For example, participants frequently expressed that DVA *processes were unclear* for veterans with one participant reporting, "I think that the doctrine or the legislation that they work to is just being patched up here and there and changed. And it just doesn't make sense; it just makes it so difficult for people" (Greg, male, 37). Participating veterans also stated that the system and processes were often complicated and adversarial, and at times led them to avoid accessing DVA-funded services (which could delay care).

> When I asked for psychiatrist details in my area the DVA rep laughed at me and told me to find one myself. The treatment was vile and disgusting—I ended up using Medicare and my own money for the treatment. (P32, female, 56)

Participants reported that the classification system was *rigid*, leading to difficulties with injuries being recognised as service-related, with delayed *time to approval* leading to delays in accessing treatment. As one participant explained, "That's where the holdup seems to be, is getting people getting the recognition that yes, you have an injury. Yes, we will cover you. That seems to be where the major holdups are" (Ian, male, 50).

Some veterans indicated that they had given up trying to have conditions recognised so that they were able to access healthcare. For example, "Getting a condition recognized is the biggest stumbling block most veterans face and many give up on trying as it becomes 'too hard'" (P10, male, 63). Veterans expressed frustration and despair about the time it took for injuries to be accepted as service-related, so that DVA-funded healthcare could be accessed. The process was described as "slow" and many veterans discussed the effects of these delays in terms of the added stress (discussed further in Theme 3: Load on veterans). One participant claimed, "They need to speed the process up within dealing with veterans with their injuries and acceptance. The timeframes are just way too long, and it plays a major role in mental health and the wellbeing of ex-veterans" (Ethan, male, 41).

Other participants (fewer) said they did not have any issues with accessing DVA-funded healthcare, particularly once injuries and conditions had been recognised. For example, one participant said their experience was "Fairly straight forward once eligible service was acknowledged" (P34, male, 69), others described their experiences as "generally very good" and some indicated that their experiences have improved in recent years: "Experiences have been better in the past couple of years, verse when I was first discharged" (P101, male, 45).

Ways in which veteran access to healthcare could be improved in relation to systemic issues focused on two key areas: *case management and co-ordination* (i.e., case managers and support people [e.g., peer support workers] who understand DVA systems and processes) and *improved system navigation* (i.e., clearer process for accessing services being made available to veterans and education for healthcare providers in relation to DVA systems/processes). For more information, please see Table 3 (above).

Theme 2: Finding Appropriate Clinicians

Many participants said that finding appropriate *clinicians who will accept DVA clients* was a significant barrier to accessing healthcare as a veteran, that they had received no help to find such clinicians, and it felt like there was a reluctance or refusal from clinicians to see them (this was related to systemic issues). In this theme, veteran card holders with an entitlement to treatment described difficulties accessing services. For example, one veteran described it as:

> All too hard and complicated. Doctors and specialists even refuse to accept DVA as payment is so low and system too complicated … [they also] refuse to complete DVA forms and reports because they are too complicated and time consuming. (P55, male, 53)

Finding clinicians who understand the DVA systems and processes and *clinicians who understand* military service and the experiences of veterans was also reported to be difficult. Some reported trying multiple providers before finding a clinician who understood military service:

> I had to go through four different people before I found somebody who had a military history, or military understanding; that I can say, "This is what I saw, this is what I did. Is it me? What's going on?" And he was able to help me out. (Jake, male, 50)

Some participants also described reluctance and hostility from health service providers due to their veteran status.

> There was a lot of reluctance for them to sort of take you on … they would always pass comments that they weren't paid on time or the rate at which they were paid wasn't adequate … they really are hesitant to want to help you because they feel that they're risking themselves not being paid. So, they seem to treat you with a lot of hesitation. (Ethan, male, 41)

A small number of veterans described how finding clinicians who understand the difficulties they face made accessing and utilising healthcare easier and a more positive experience overall. For example: "I was fortunate in that my psychologist at the time was ex-military. So, he understood everything that I'd been going through. He'd personally experienced a lot of what I was going through" (Ian, male 50).

Some veterans mentioned that *geographical issues* exacerbated existing barriers to accessing appropriate clinicians for DVA-funded healthcare. Veterans in regional and remote areas said that at times they had to either travel significant distances or wait significant amounts of time before they were able to access a clinician who would accept DVA clients. As one participant recalled, "My only difficulty has been my initial diagnosis for PTSD. I was located in a regional area and access to a psychiatrist was difficult. I had to wait for several months, during which time I was experiencing increasing problems" (P06, male,

65). Veterans discussed how this exacerbated already existing difficulties relating to lack of health professionals in rural areas.

Veterans' suggestions relating to the process of finding appropriate clinicians focused on two key recommendations: *access to providers with veteran specific knowledge* (i.e., a list of service providers local to the veteran who accept DVA clients and/or with specialist experience managing veterans) and *improved system navigation* (see Table 3).

Theme 3: Load On Veterans

Veterans reported that trying to access healthcare services and the difficulties experienced at times (i.e., delays in receiving approvals and/or access to healthcare) put them and their families under *added stress*. Some veterans said these difficulties significantly affected their mental and physical health. Participants shared that "Veterans are really struggling in dealing with the DVA and getting the assistance they require and that's affecting their mental health as well" (Ethan, male, 41), and that "when you're feeling like you're perhaps suicidal, you want someone right now, not to see a psychiatrist in two weeks, it's too long" (Harry, male, 38). Veterans described the introduction of NLHC for mental health as a positive step: "the best thing [DVA] did in the last 10 years was the non-liability mental health, that's a great initiative" (Greg, male, 31). Additionally, veterans discussed experiencing additional stress due to the *time* it took for claims to be accepted for DVA-funded treatment and/or when prior approval was required before treatment could begin. For example, one veteran said, "that's where the hold-up seems to be, getting the recognition that yes, you have an injury, and yes, we will cover you" (Ian, male, 50). Veterans said that additional time spent waiting for claims to be accepted by DVA first had led to further delays than expected in seeing a healthcare professional. This is impacted by the overall workforce shortage of health professionals**,** particularly access to mental health professionals, in Australia.

Further, veterans said that *monetary costs* of health services out of pocket, either when claims are rejected or when the full amount is not covered by DVA (i.e., when current provider rates are higher than the DVA fee schedule pays), put them under significant financial stress or led to avoiding treatment due to inability to pay. Veterans indicated that the schedule of fees payable by DVA was significantly less than the cost from the service provider charged, and that at times this prohibited them from accessing and receiving required health services. For example:

> If DVA only pays to the item number, if their base charge is more than that, then DVA doesn't cover, or won't pay for it, so people won't see you. It's very difficult when you need a procedure done and you can't find anyone to do it … I ended up having to go somewhere myself, and I think [I was] about a few thousand out of pocket. (Adam, male, 48)

Despite legislation prohibiting treatment "gap" payments, veterans described having to "sometimes avoid treatment due to inability to pay for the treatment gaps" (P15, male, 26) when the health provider does not accept the DVA rate.

This was not always the case. A smaller number of veterans with Gold Cards and those able to independently incur the financial costs of healthcare described a more positive overall experience accessing healthcare as a veteran:

> Luckily, my civilian university qualifications got me a well-paid job shortly after transitioning from the ADF to civilian life. Due to that I've managed to pay for any medical or surgical procedures and thus far there have been no difficulties. (P10, male, 63)

Even with Gold Cards alleviating the *financial stress* of conditions not being recognised by DVA as service-related, some participants described difficulties finding providers who would accept DVA clients. One veteran reported, "All services accessed through Gold Card have been paid, however, I had to seek out services that would accept Gold Cards" (P40, male, 66).

Recommendations across the four key areas for improving veteran access to healthcare were all related to managing (or reducing) the additional loads (both emotional and financial stress) placed on veterans' when navigating the civilian healthcare system (see Table 3 above).

Theme 4: Transition from Military to Civilian

Many participants described the transition from Defence to civilian healthcare as poorly managed, identifying that they felt *unprepared* to access healthcare as a civilian and that at times, this contributed to deterioration of health conditions. Veterans described having difficulties initiating contact with knowledgeable health professionals independently (i.e., without the help of Defence at the time of discharge) and how navigating the civilian healthcare system *alone* as a veteran was a difficult process without someone to help them.

For instance,

> At the beginning it was quite daunting and pretty much I had to find my own way which was scary. I thought that a rehab provider/case manager is

> supposed to help with this, yet I never had that. Trying to find out what you need to ask for (as defence is different) and most of the time advising providers how DVA works rather than discussing your situation. At times not knowing how DVA works made it hard as I really didn't know what was required of me. (P43, female, 40)

This was not always the case. Some participants said they had a rehabilitation coordinator, an advocate, or a GP who was able to help them with the process. As one veteran shared, "Having an advocate and GP who were able to source doctors/specialists who accept DVA cards helped enormously" (P35, male, 50). Others said they relied on family support to navigate the healthcare system: "My wife understood how Medicare worked and the relationship Medicare has with private health funds" (P97, male, 64), and "I had to ask my very new boyfriend how to find a doctor and a dentist, [I] didn't know I needed a Medicare card and struggled with getting sick certificate" (P56, female, 44).

Many participants mentioned that *the lack of continuity* of providers from within ADF-funded healthcare, to accessing healthcare as a veteran, was a significant issue. Some participants said they were given their medical files upon discharge, but this was not always the case. Many veterans said that reliving their experiences with new practitioners was a significant issue and that it would be helpful for civilian practitioners to have better access to their medical history.

> I haven't spoken to him really about historical medical issues. I've got my medical files on disc. I've got that new electronic health record; it'd be great to be able to put it on that, or whether I could give it to my GP and he could upload all of the information. Because it would be nice if he actually knew what my medical history was. (Greg, male, 37)

Veterans suggested several ways the transition from ADF to civilian healthcare could be improved, and these were primarily related to the key recommendation *integration and continuity of care* (see Table 3 above). For instance, participants suggested that information regarding access to civilian healthcare was covered as part of ADF discharge procedures, and that they were individually informed of what health services would be available to them (based on their eligibility) at the time of discharge.

Theme 5: Feeling Disregarded

A sense of feeling disregarded underpinned all themes. This was most prevalent when participants had tried to have a claim accepted by DVA so they were able to access healthcare that would be funded by DVA. Veterans described feeling *disregarded*, *disbelieved,* and *worthless*. Many participants said they felt they had to fight to prove they had service-related injury or illness and they were scrutinized. This could be associated with inadequate documentation relating to veterans' medical conditions, amounting to negative veteran experiences of accessing DVA-funded healthcare. As one participant shared,

> They really make it feel like, even though you had it all recorded through your medical files, and it is very easy to see, they'd make it feel like you were not worthy of it. They really scrutinized you, which put a lot of pressure on your mental health. To be scrutinized and made to feel like you're almost lying, even though it's all documented, is quite a traumatic experience. (Ethan, male, 41)

One participant said that they "had never been made to feel so worthless" (P44, male, 45) when they tried to have a claim accepted and another said they felt "isolated with little to no assistance available" (P56, female, 44). This was not always the case and some participants described overall positive experiences accessing and utilising healthcare as a veteran, mostly related to their interactions with health providers. For example, "Civilian general practitioners are normally very sympathetic to treatment and support of the ongoing health problems associated with military service" (P30, male, 60).

All four key areas of recommendations (see Table 3 above) suggested by veterans were related to *feeling disregarded*. Case coordination, knowledgeable providers, improved system navigation, and integration and continuity of care may improve access to and the experience of accessing healthcare for Australian veterans.

DISCUSSION

This study aimed to identify how Australian veterans experience healthcare, including highlighting veteran-reported challenges around the transition to the civilian healthcare system and possible strategies to improve Australian veteran healthcare. The transition from military to civilian life is a critical period and social health matter. Individuals are required to navigate many changes across the social determinants of health including economic stability and employment, location (housing) and neighbourhood, social and community contexts, as well as access to healthcare. Veterans can struggle significantly with reintegrating into civilian life (Romaniuk & Kidd, 2018)

and the current study exemplifies how such difficulties extend to the transition from military to civilian healthcare. The ADF provides healthcare services to personnel as a condition of their service (Australian Institute of Health and Welfare, 2018), which means that following discharge, ex-serving personnel (now veterans) may have limited experience with independently navigating the less structured Australian public and/or private healthcare system, outside of the ADF.

The current findings are in line with transition and reintegration difficulties that have been documented in the literature, including that veterans can experience civilian life as unstructured, unsupported, and overwhelming (Romaniuk & Kidd, 2018). Our analysis suggests that the transition to civilian healthcare is worsened by perceived systemic issues around processes and approvals, and difficulties with finding healthcare providers who accept DVA clients and understand the needs of veterans. As a result, veterans can experience stress and negative emotions in relation to accessing healthcare, which may present a barrier to engaging with healthcare providers and accessing much needed healthcare services. There is comparable literature from other contexts (e.g., workers compensation) that illustrates individuals feel disregarded and scrutinised if they have to prove the existence of medical conditions, and this degrades interactions (Kilgour et al., 2015). There may be opportunities to bolster positive interactions between veterans and DVA by improving continuity of care and access to veterans' ADF medical records. The current results are also comparable to a recent interview study with veterans in the United Kingdom (Gordon et al., 2020), indicating that the identified perceived barriers are not limited to the Australian context. Veterans in the UK also reported difficulties with navigating "uninviting" healthcare services and feeling that clinicians do not understand their military service and experiences (Gordon et al., 2020).

Health and mental health services are difficult for veterans to access in the community due to a lack of service coordination, which differs to the more coordinated system in the ADF (Forbes et al., 2018). Veterans who are transitioning from a military environment to civilian life may perceive this change as particularly difficult. As well as highlighting the difficulties Australian veterans experience during this transition, this study captures veterans' recommendations and elucidates potential strategies for improving veteran healthcare in the community. Continuity of care from the ADF to civilian healthcare, supportive case management, improved access to practitioners who understand military culture as well as DVA processes and simplifying systematic processes for better service coordination emerged as key areas for improvement.

These veteran-identified recommendations are in line with DVA initiatives that are underway. Since data collection in 2019, DVA have made further modifications to systems and processes, which address some of the concerns raised by Australian veterans in this study. For example, a single digital system for DVA staff to access information, digitising records to speed up claims processing, and information sharing between Department of Defence and DVA (The Department of Veterans Affairs, 2020) have since been introduced. Veteran Support Officers are also now available at many ADF bases to provide support and guidance on the transition/discharge process (including submitting claims prior to discharge) and all eligible veterans are now issued a White Card upon discharge from the ADF (The Department of Veterans Affairs, 2020). In addition to NLHC and access to Open Arms for mental health services, the Provisional Access to Medical Treatment trial (which enables eligible veterans to receive medical and allied health treatment on a provisional basis for 20 of the most commonly accepted conditions while DVA is considering their claim) has been extended (The Department of Veterans Affairs, 2021). Coupled with improvements to the website (e.g., for ease of navigation) and ongoing changes to correspondence for readability, DVA is making positive changes to improve the experience of accessing healthcare for Australian veterans. Further strategies veterans have recommended DVA should look to addressing include a review of the fee schedule for providers (to match current provider rates), procuring lists of providers who accept and specialise in managing veterans, and developing and implementing educational resources for community practitioners about providing veteran specific healthcare (e.g., such as those provided by Open Arms covering common service-related injuries and PTSD awareness training).

Despite the convergence of the current findings with previous literature, there are some methodological considerations pertaining to this study. First, data were collected in 2019, and as such, readers should interpret participant quotes in this context. New initiatives and strategies appear to be in place that aim to address some of the participant concerns highlighted in this study. We are unable to account for how these changes are perceived or the effect, if any, of initiatives introduced after data were collected. Future research should aim to examine veteran perceptions following the introduction of the above discussed initiatives, and other initiatives that are underway in Australia.

The current findings are representative of veterans who participated in this study. While the sample size of 82 is a small fraction of the estimated veteran population, and as such, findings cannot be generalised to reflect

the experiences of all Australian veterans, it is likely that these insights might be relevant to similar veterans. However, participants who have strong opinions (positive and negative) may be more inclined to participate in qualitative research. Almost half of the sample (46.9%) reported discharging for medical and administrative reasons, which may be experienced differently than discharging voluntarily (e.g., for family or career reasons). This may have impacted the participants' experiences and perspectives. Future research should include participants with varied reasons for discharge to include a more representative sample. An additional limitation is that few female participants took part in this study and their experiences may not be represented. Nonetheless, there is limited available data on Australian veterans' use of healthcare services (Australian Institute of Health and Welfare, 2020), and this study presents the perspectives of Australian veterans; in addition to identifying what Australian veterans perceive to be the key barriers to health service utilisation and presenting practical strategies to address such barriers in the future. Veterans can experience more health challenges than the general population and is important to streamline processes to improve their healthcare.

CONCLUSIONS

The five themes and subthemes identified in this study are consistent with findings of previous reports and inquiries into Australian veterans' access to healthcare once discharged from the ADF. Based on this study, recommendations for future research include examining veteran perspective following the introduction of new initiatives, including a more representative veteran sample (more female participants, varied reasons for discharge), and collecting data from international contexts for comparison. Findings from this study highlight areas for improving systems and processes for Australians to access civilian healthcare. Importantly, participants provided several feasible and practical recommendations that could improve Australian veteran healthcare, related to enhancing case coordination, accessing providers with specialist knowledge, making the system easier to navigate, and integrating and improving continuity of care.

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COMPETING INTERESTS

The authors have no competing interests to declare.

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