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Intersecting Contexts: Understanding Rural Utah Veterans' Experiences with Accessing VA Health Care

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Abstract Since the passage of the Rural Veterans Care Act of 2006 research has focused on health care provider issues with less attention given to individual and contextual factors that contribute to the remaining service gap. Adopting the health care user's viewpoint, we focus on two questions: How do health care users perceive access to health care, and which contextual factors are relevant to explaining the failure of recent efforts to increase access by rural veterans? We collected detailed data through focus groups and individual interviews involving veterans and knowledgeable community members in four rural areas of Utah. Framing the analysis of interview data using the sociospatial approach reveals key dimensions of several contexts that affect rural veterans' access to health care: the historical period of military service that influences attitudes toward use of Veterans Administration health care and access to specialists, regulations of regionally and locally organized insurance coverage that affects access to and coordination of health care, and local social aspects of rural communities that inform use of specific health care sources. These dimensions provide new insights into the conditions that contribute to variations in the vulnerability of rural Utah veterans.

Introduction

Since the passage of the Rural Veterans Care Act of 2006, hundreds of studies, many funded by the Veterans Administration (VA), have documented both improvements to and challenges for rural veterans in accessing health care (CAMH 2015). Despite the contributions of recent research, complete understanding of the persistence of critical service gaps has been elusive. Scholars have recently suggested the need for more attention to the health care user's perspective and consideration of the social contexts that affect access to health care in rural communities (e.g., Cully et al. 2010; S. Sanders et al. 2015). For

example, despite the networks of social ties rural veterans believe they can call on for help (Erickson, Yorgason, and Call 2012), many experience barriers to accessing the health care they need. Additionally, although increased access to tele-health facilities and local VA-contracted service providers has helped close the service gap, rural veterans report they continue to face obstacles in meeting their health and mental health care needs (CAMH 2015; Cully et al. 2010; Liu et al. 2008; Weeks et al. 2008). Cully et al. (2010) note that the social acceptability of services is a relevant dimension of access although its importance is not well understood. Recently, S. Sanders et al. (2015) called for more research on the social and cultural factors that affect rural residents' access to health care (see also Xue et al. 2015). In this article, we answer that call with evidence from an ethnographic study that suggests the relevance of several overlapping social contexts to the persistence of poor access to health care among rural veterans. Recent studies have highlighted important systemic or institutional sources of problems that affect veterans' access to and satisfaction with VA service delivery (e.g., CAMH 2015). The analysis presented here extends that research by focusing on rural veterans' experiences and by using the sociospatial approach (Gottdiener and Hutchison 2010) to frame and interpret relevant social dynamics. Thus, this ethnographic study provides the opportunity to explore how the intersection of multiple relevant contexts may affect rural residents' experience with uneven distribution of and access to needed resources, a central concern of the study of rurality.

Unique Concerns for Rural Veteran Access to Health Care

A larger percentage of veterans live in rural areas than their urban counterparts (Montgomery 2012). Rural veterans also tend to be older and have less access to social capital resources, although they do have stronger bonds with those in their network (Montgomery 2012). These differences require a shift in focus to the different needs of older veterans, the more complex nature of their health concerns, and the resources they have to advocate for their needs. For adults under age 65 the primary barrier to health care access is lack of insurance. In contrast, older adults are more likely to face challenges with transportation to health care services (Fitzpatrick et al. 2004). First, the farther a veteran is from the appropriate health care facility, for either in-patient or out-patient care, the less likely he or she will be to actually travel (Burgess and DiFiore 1994; Mooney et al. 2000). Understanding the social perceptions of distance is important because rural

veterans are more likely to bypass local health care providers due to perceived limitations in care capabilities (Liu et al. 2008). S. Sanders et al. (2015) suggest that socioeconomic characteristics and community attachment of rural residents are also important factors in their decisions to bypass local primary care physicians, especially among aging residents. Furthermore, newer cohorts of older adults may have fewer informal supports in later life, such as children living close by who could help with transportation (Ryan et al. 2012). Erickson et al. (2012) found that veterans and nonveterans were similar in their expectations that friends and family (i.e., "social convoys") would be available to help with health care and other needs. However, older residents and those most attached to their community differed in the levels and sources of help they preferred.

Several descriptive studies indicate that rural veterans experience higher rates of physical co-morbidities and lower levels of health-related quality of life (Rehman et al. 2005; Weeks et al. 2006). Other studies have identified social and institutional factors that prevent aging veterans from using needed services. For example, G. Sanders, Fitzgerald, and Bratelli (2008) examined barriers such as attitudes of older adults, physical and cognitive limitations, and lack of knowledge among service providers. In addition to distance from services, other barriers include inadequate assessment and prescription for treatment, lack of funding or appropriate allocation of resources and personnel needed to provide for quality VA health care services, and the complexities of overlapping insurance coverage (CAMH 2015; G. Sanders et al. 2008).

Care for eligible rural veterans is further complicated because the VA is often the primary or sole source of physical and mental health care (Hynes et al. 2007). However, many veterans also utilize a combination of health care sources (CAMH 2015). Importantly, rural areas have a large proportion of older adults with specific health problems, such as diabetes and hypertension (G. Sanders et al. 2008), that are experienced by veterans as well. According to Kramer et al. (2009), the three most frequent diagnoses for veterans overall include posttraumatic stress disorder, hypertension, and diabetes. The last two conditions are particularly prevalent among aging veterans. Veterans generally tend to have more health problems than civilians, and about 50 percent of veterans are age 65 or older (CAMH 2015).

The type of health care needed by older rural residents is also more complex. According to West et al. (2014:36), "Among the older population in 2008, only 8 percent had no chronic conditions, compared with 51 percent who had one or two, and 41 percent who had three or more

chronic conditions." Further complicating matters, veterans who served the longest also tend to experience more rapidly declining health as they age than civilians, an outcome that is especially true for Vietnam veterans (Wilmoth, London, and Parker 2010). Indeed, Teerawichitchainan and Korinek (2012:1996) specifically note that "the societal conditions in which American veterans of the Vietnam conflict were embedded, that either facilitated resilience or vulnerability, aid in understanding how war and military service relate to health outcomes later in life."

While the quality of the available services in rural areas has improved due to mobile, satellite, and virtual clinics (Weeks et al. 2008; Workman et al. 1997; Wray et al. 1999) and is comparable to VA services in urban sites (Weeks, Yano, and Rubenstein 2002), rural veterans still seek care—especially mental health services—at a much lower rate than their urban counterparts (Cully et al. 2010). In seeking to understand the reasons for the difference in health care use among rural veterans, previous research on rural health care has emphasized either the setting or the service providers—rarely the service user (Cully et al. 2010; Weeks et al. 2008). Focusing on the perspectives of rural veterans and community members, this study offers a more nuanced examination and interpretation of health care access and use. Specifically, we use concepts grounded in interview data from rural Utah communities as well as relevant health and community literatures to elucidate the relevance of local, regional, and national contexts to the dilemmas rural veterans face in accessing health care. The conceptual framework we propose suggests the utility of three overlapping contexts: (1) national historical conditions that affect perceptions of military service, available benefits, rules regarding eligibility for care, and identity; (2) the unique challenges associated with navigating access to regional and local overlapping sources of health care; and (3) cultural and social dimensions of rural communities that shape veterans' context-specific perceptions of distance and access to health care services.

Intersecting Contexts: Framework for Interpretation of Interviews with Rural Veterans

Over the past several decades professionals and researchers have conceptualized health care using different paradigms. However, two elements have remained consistent across these approaches: patient characteristics (e.g., preexisting health conditions, patient demographics, and health perceptions) and availability of services (e.g.,

location and resources that enable individuals to receive the care needed). The interplay between these two elements constitutes the patient's ability to access available services and shapes patients' perceptions, interactions, and the strategies employed to manage their health care (Anderson 1995). Although it has been used most frequently in the analysis of metropolitan social phenomena, the sociospatial approach is also useful for conceptualizing how individuals and systems interact in rural contexts. The sociospatial approach asserts that the quality of life varies across different types of settlement spaces in relation to the distribution of resources (e.g., social, political, and economic opportunities) and the actions and interactions of people of different social statuses (e.g., race, gender, age, and social class) (Gottdiener and Hutchison 2010). Additionally, uneven development resulting from both investment practices and government policies across settlement areas contributes to the spatial concentration of social problems, such as poverty and social isolation, in specific places. The resulting conditions are not static, however, as local, regional, national, and global social and economic processes continue to influence settlement spaces differently. Thus, both history and place matter in understanding the experiences of people residing in different types of settlement spaces. Importantly, the effects of historical events, policy changes, and shifts in investments made in infrastructure and resources also create generational differences in the experiences of residents in different locales (Gottdiener and Hutchison 2010).

According to the National Center for Veterans Analysis and Statistics (Montgomery 2012), geographic isolation of rural areas generates different challenges for rural residents than urban residents. Rural-urban distinctions include demographic composition, social ties and social capital, culture, and infrastructure and institutional support. Importantly, such distinctions have been shown to shape susceptibility to unique risks faced by veterans (e.g., Beck 2002; Murray 2015) as well as vulnerabilities that undermine health and healing (e.g., Frey-Wouters and Laufer 1986; Teerawichitchainan and Korinek 2012). Although the sociospatial perspective has been utilized for the study of uneven development in urbanized areas, we propose that it provides sensitizing concepts relevant to rural areas as well. Specifically, sociospatial concepts, such as the uneven spatial distribution of and access to resources, help frame our results by focusing attention on the perspectives, experiences, and contexts of rural veterans as they attempt to gain access to and utilize the VA and other health care systems. Such an approach supports a more

nuanced sociological interpretation of the issues identified by veterans with accessing health care resources, highlighting how local, regional, and national contexts influence their levels of risk and vulnerability.

For these rural veterans, three contexts shape and inform their needs and actions. The first context involves the era in which veterans served in the military and related military norms. Important aspects of this context include military experience and the identities developed in specific historical periods, which influence whether or how much veterans use VA health care (Damron-Rodriguez et al. 2004; Harada et al. 2002; Harada, Villa, and Reifel 2005), especially as their needs change or increase. The dominance of specialists in the American medical system typically facilitates access to specialized care. However, changing VA rules related to eligibility for and use of specialized care may mean that needed and available specialist care remains out of reach.

A second context involves the complexity of sources of health care that veterans may use—a combination of private care, VA service networks, and other government health care programs (e.g., Medicare). The vast majority of veterans' health care needs could be met through these programs. Yet many refrain from accessing the whole range of sources available because overlapping coverage is too complex to pursue. Additionally, coordination among regional and local service providers, which can ensure high-quality care, introduces another layer of coordination that can be challenging.

A third context is the rural community or locale in which veterans seek care. An important social dimension is "contextual distance," which differs from previous conceptions of distance in studies of the "bypass" phenomenon. In this analysis, local residents' perceptions of distance involve use of a distinct cognitive map influenced not only by their needs but also by local community culture and social relations. In essence, contextual factors shape veterans' perceptions of what is the "right" health facility to use.

Research Sites and Methods

Research Site and Participant Selection

Given the purpose of this ethnographic study to make an inductive contribution to research on rurality, focus group interviews provide a particularly useful method for addressing complex topics related to rural health care access (Bender and Ewbank 1994; Berg 2008). We used the Rural Utah Community Study, a random sample survey of residents

from 24 rural Utah communities conducted in 2008,[1] to formulate questions for the focus groups about health care access as well as to identify ideal research sites. Based on these survey data, we then used GIS technology to select relevant rural communities for conducting focus groups.[2] We conducted six focus groups with residents from rural areas in four geographic areas of Utah: central, southeastern, northeastern, and southwestern. Key sources included members of local veterans organizations and local military units who helped provide access to individuals interested in participating in the study.

Focus group members represented a range of characteristics and reflect the diversity of experiences of residents, their concerns, and their needs. Six focus groups, conducted between 2010 and 2012, ranged in size from 3 to 15 individuals. In all, 38 rural veterans and community residents participated in the focus groups, generating 247 pages of interview transcripts. Most groups were structured to include veterans or community members knowledgeable about local veteran health needs and health care in order to create an environment conducive to open discussion about relevant issues. We conducted additional individual interviews with veterans and community representatives who could not, or did not wish to, participate in the focus groups. Individual interviews with 18 additional veterans, community members, and service providers produced more contextual information for understanding the service needs and experiences within each rural community research site.

Participants in each focus group were recruited because they had relevant knowledge and a range of experiences with accessing VA services,

[1] The Rural Utah Community Study (completed in 2008 by Brigham Young University community sociologists) provided information for selecting research sites and provided data relevant to the study, e.g., where respondents go for primary health care and for specialized care and reasons for going outside their community, where they get prescriptions filled, which branch of the military veterans served in and dates of service, and use of VA services. An analysis of these survey data indicated that substantial proportions of the rural community respondents left their communities for primary health care, but even larger proportions left for specialized care. The main reasons for leaving their rural communities for primary health care included the need for better quality care, the most frequent response, and limitations on the services available. For specialized health care, the main reasons were reversed, with limited services being the most frequent response followed by the need for better quality care. These survey data informed the development of interview questions needed to obtain greater detail about the experiences of rural veterans and community members.

[2] We used maps and county-level data for identifying four large geographic areas of Utah: central, southeastern, northeastern, and southwestern. The communities in these areas had relatively larger proportions of veterans, which facilitated recruitment of participate for the study. The Rural Utah Community Survey data indicated that veterans in these rural areas had served in the military primarily prior to 1990, with only a few respondents indicating they had served in the 1990s or more recently.

which is crucial to collecting relevant and credible data. These participants typically shared gender and veteran statuses but differed in other areas, such as income level, employment, political views and experience, or contact with the VA. Because rural community residents tend to know each other and the participants were recruited, in part, through local networks, it was important to have some understanding of the degree of familiarity. Although participants were assured about the confidentiality of the information, focus group dynamics often include some censuring. Therefore, participants were invited for follow-up interviews in which they could express their views in more detail.

Research Participant Characteristics

A short survey administered to the focus group research participants obtained information on general background characteristics. Key information particularly relevant to this article's themes include that two-thirds of the participants were male, and 68 percent were veterans. The majority were seniors, although 31 percent were between 41 and 60 and 16 percent were under age 40.[3] The vast majority (81 percent) were married or cohabitating and identified as Caucasian (94 percent). Education levels were on average lower than national averages, but consistent with rural and veteran percentages: 24 percent indicated that they had attended some college, and equal percentages had completed high school as their highest level (13 percent) and vocational training (13 percent). Additionally, 24 percent had received a graduate degree, 18 percent had a four-year college degree as their highest level, and 2 percent had not finished high school. More than a third (37 percent) were employed on a full-time basis while a smaller percentage (10 percent) worked part-time. Consistent with their ages, almost half were retired and 8 percent were unemployed.[4] A substantial proportion of participants (92 percent) had insurance while 8 percent had no insurance. The primary sources of insurance included employment (29 percent), military (16 percent), and private plans (13 percent). Medicare (8 percent) and military and Medicare combined (8 percent) accounted for the remaining forms of insurance.

[3] The percentages do not add to up 100 percent because missing or "Other" responses were not listed. The percentages presented were not intended to be exhaustive or add up to 100 percent; the intent was to provide some selected descriptive statistics about the participants.

[4] The responses related to employment and retirement were not mutually exclusive. The percentages presented were not intended to be exhaustive or add up to 100 percent; the intent was to provide some selected descriptive statistics about the participants.

Nearly half (45 percent) had lived in their community for more than 16 years; 16 percent for 11 to 15 years; and 10 percent for 6 to 10 years. Individuals who spent less than 5 years residing in their communities accounted for 21 percent of the respondents.

Coding and Data Analysis

Analyses of qualitative data collected in the focus group and individual interviews required coding in stages, as suggested by Corbin and Strauss (2008) and Berg (2008). The first phase involved open coding, which is designed to create basic categories that capture the nature of the comments, views, and experiences expressed by research participants. Subsequent, more detailed coding created subcategories that reflect multiple dimensions of the views expressed in the group interviews. Ongoing coding of the interview data helped to ensure that interview procedures captured concepts and themes grounded in the interview data. We determined the salience of the concepts and themes identified by the importance and attention given to them in the focus group discussions and interviews. Comparisons of coding by multiple team members and refinement of codes ensured the validity and reliability of coding (Berg 2008).

Research Findings

Consistent with other studies we found that some barriers persist despite numerous efforts to address them. Similar to veterans in other locales (CAMH 2015; Carter and Kidder 2013), veterans in this study reported issues related to qualifying for and accessing health care services within their local communities. Specifically, veterans identified problems such as long wait times for appointments and referrals at the VA and limited access in satellite or local clinics due to a quota system. Additionally, many veterans still perceive that the VA is more interested in lowering cost or denying service than providing needed care. At least part of the reason for this perception is that rural veterans were often unaware of programs designed to help them, which further increased their frustration and provided "evidence" that the VA did not want them to use the facilities. Finally, distance remains a problem, but not for the reasons often suspected.

The persistence of barriers to accessing care, despite the effort that has been expended to address them, indicates the importance of understanding veterans' decisions and actions within several relevant contexts, which interact with the systemic issues identified in relation to VA health care service delivery. In the following sections we discuss

findings related to the three key contexts and related dimensions, previously outlined, that potentially constrain veterans' access to health care.

Service Era and the Legacy of Military Rules and Norms

Historical Era and Conditions

Historical conditions are important because they include events as well as sociocultural conditions that affect generational and geographic groups in different ways. For example, compare the perceptions of the military and the experience of war among veterans of different eras. Initially supplied by active duty military personnel and reactivated World War II veterans, recruits for service in the Korean War eventually involved the draft. Support for the war was generally positive in the beginning with more than 65 percent of Americans supporting the war effort (Crabtree 2003). More importantly, military members of this era understood their relationship to the VA in a very positive light. These perceptions of their service now have implications for veterans' willingness and ability to seek and obtain care.

The older rural veterans in this study regard their military service both as a personal duty and honor. Military service was central to their identity and to their reasons for accessing VA health care. Specifically, as members of the armed forces they believed they earned the right to receive at least adequate care. In fact, as one veteran pointed out, VA benefits were just an extension of insurance provided to them during their tenure in the military:

> As far as the VA, that's something that's been offered for the veterans for years and years, . . . of course it's government run, but it is a veteran's benefit, I feel, from your years of service in the military. . . . So that's where, you have the insurance while you're in the military; it's more or less just a continuation of that after you're out of the military, I think.

Such sentiments can be contrasted with attitudes expressed by some Vietnam-era veterans who experienced President Lyndon Johnson's troop increases when only 25–40 percent of the population supported the war, and only 34 percent supported the government in general (Newport 2012). Although the context for entering the military varied dramatically, the majority were drafted, and morale was low. Powerful antigovernment attitudes still persist among some veterans of the Vietnam War that affect their perceptions of access to VA benefits today. Additionally, negative sentiments regarding the role of the federal government have developed in some rural communities where many

veterans perceive VA benefits as welfare. For these veterans the benefits related to military service were only to be accessed if you had no other resource on which to rely. Such attitudes were especially pronounced in the southeastern area of Utah where the interviewees expressing this view were younger ($\geq$30 years of age) and currently employed. The contrast between this view and those of some older veterans in the same community is evident in the statement from one interview: "I think in the rural communities there's been a little bit of a stigma about using government benefits. Whether they don't want to be on welfare, they consider it welfare, or what, I don't know. I think if somebody was a little bit more proactive of contacting these guys and helping them know what they're eligible for, that maybe they would use them more." However, these perceptions were not only related to age; they also reflect emplaced social conditions. In areas with exceptionally strong libertarian views and, more specifically, where veterans adopt libertarian views, this same attitude appears to persist. In northeastern Utah, research participants strongly expressed similar attitudes; in fact, even older members of the community expressed concern about accessing services viewed as government intervention or welfare benefits.

Differences in attitudes about use of VA health care reported by research participants suggest the relevance of how VA care is understood, or how its meaning is framed, by different groups and communities rather than simply the systemic problems with program operation previously identified. Regardless of the VA's attempt to address needs, the public discourse surrounding the care provided has an impact. If the veterans' understanding of VA benefits is not clear prior to their entering or leaving military service, substantial numbers of veterans—many with significant untreated mental health issues—may remain untreated and will present a destabilizing force within their communities. The increased animosity toward government intervention, a decade of war, and higher unemployment rates among veterans may affect their willingness to access VA services.

Norms and Unrecognized Military Injuries—the Paradox of Specialized Care

An important consideration is that the VA is not intended to be the primary health insurance for all veterans. VA benefits were initially designed only to address injuries related to their military service. However, with changes in the contexts of war over the years, the types of eligible care now cover significantly more than immediate, life-threatening injuries as well as long-term health needs related to military

service injuries (CAMH 2015). Also, as veterans age they may experience new health problems that result from their earlier military experience (see Davison et al. 2006). Importantly, the increased specialized care needs of many veterans are colliding with the realization that not all military injuries manifest themselves immediately, nor are all injuries related to veterans' specified jobs. These realities combine in unique ways to deny or limit needed specialized care.

Currently the VA health care system is primarily concerned with definitive injuries received and documented while in service (CAMH 2015). Without these "qualifying events," a veteran's access to health care may be severely limited. The veteran interviews indicated that they experienced a wide range of physical and mental health issues resulting from their service in the military. However, only those injuries that were manifested and documented while in service and recognized as military-service-related injuries are covered. Injuries sustained during deployment and training exercises (including exposure to radiation, nerve damage, shrapnel wounds, hearing damage, and posttraumatic stress) were regularly denied coverage because of poor linkages between the rules of engagement in specific eras or conflicts and service members' job descriptions.

Research participants noted that soldiers generally are reluctant to report injuries or health concerns because they do not want to risk jeopardizing their status within the military. Apprehensions such as these were particularly true for those individuals interested in pursuing a military career, as suggested by the statement of one veteran: "I know there was some hesitancy from the guys who planned to stay in to put down any problems, because they thought, 'This might ruin my chances to continue my service.' And there was no counseling about that." For other veterans, the cultural norms of the military supported their coping with injuries the best they could and then getting back to work. One Vietnam veteran spoke about his treatment for illness and sunburn: "And of course in the service, during my time, it was you 'cowboy up.' It was almost, if you get hurt doing something, you're almost in some cases disciplined and ridiculed. So you don't . . . say what you did, you just do it."

Beyond the fear of reporting, many recent veterans indicated that nearly everyone felt obliged to work through injuries of some type because they were at war and their "battle buddies," who were continuing to fight, were relying on them. Their absence, even for legitimate injuries, made life not only more difficult for their friends but also significantly more dangerous. Their reliance on each other to do specific jobs and their tight bonds led to many injuries going unreported. These unspoken "policies" and prevalent attitudes, which certainly serve a

purpose in times of war, resulted not only in nonreporting of injuries but also absence of the necessary paper trail for addressing health needs at a later time. Missing records occurred for other reasons as well.

A number of older rural veterans experienced the absence of records for reasons other than military culture. Service records housed at VA facilities were either misplaced or destroyed in fires, and many veterans do not possess personal copies. In one instance, a research participant was informed that his records were classified and he is uncertain about qualifying for VA benefits following his retirement. "I went to the internal medicine and they ran some blood tests to see, because she wanted to see what I had," he said. "I think I had, my memory, and I would love to have my health records, but I don't even know how to get that. . . . I'd like to see what they really classified."

An important consequence for veterans unable to obtain their records is the denial of treatment. The lack of paperwork documenting their medical history is particularly problematic for veterans whose health issues may fall into the gray areas. Because of the VA's narrow range of coverage, health concerns indirectly related to service may not qualify for treatment. The strain and rigor of military life in general can have physical manifestations later on (e.g., back pain and long-term effects of hepatitis, sunburn, etc.). Even when exhibiting symptoms that are outcomes of specific military operations, some older rural veterans have been refused treatment. For example, one veteran described his exposure to radiation during a training exercise that has led to prolonged health issues. He has not been able to receive any treatment because the VA cannot locate the necessary documentation—in part because the records are classified and the U.S. military had a policy in the past of denying such nuclear tests. He said,

> I have got a letter here dated September 12, 1974 [nearly 20 years later], and it says, "We realize that you have been waiting a long time for a decision on your claim. We regret the delay, but we have been unable to locate your service medical records and need them in order to process your claim." Well, I can't get them either. . . . Well, they told us that they burned up in a fire back in Missouri. And we have no way to, you know, whether that's true or whether it's not. It seems awful convenient.

Another way that care may remain inaccessible is highlighted by one research participant's efforts to access care. Shortly after his military service in Vietnam ended this veteran developed hearing loss and reported it to the VA. His claim was denied because, according to his medical

records and military position description, his work was not near any large guns or loud equipment. Therefore, his loss could not be service related. Although technically correct, this denies the realities of his service. His desk job was located in an office next to a runway that he had to cross several times a day to communicate with staff in offices on the other side. However, despite the fact that he was required to be outside frequently near the jets, he did not have ear protection.

The current definition of service-related injury creates a paradox of care. The VA has increased access to specialized doctors to meet the demand for the broad range of care for veterans needs. However, this increase only addresses part of the problem. When specialized injuries intersect with arcane coverage rules that do not apply to the realities experienced by soldiers, or when these injuries are the result of classified missions, all of the specialized care provided by the VA will not close the gap in care for many veterans.

Although veterans have the option of appealing any VA decision, not only are most veterans unaware of this possible action, the process also appears to be arbitrary. The veterans in this study had a wide range of experiences with the appeal process. Although one veteran's petition to have his records released was rejected repeatedly, other veterans have been able to claim partial VA benefits despite the loss of service records. Importantly, veterans who persisted and were able to qualify for benefits perceived the VA to be accommodating to their needs and concerns. One said, "Well, I tell you as far as I'm concerned the Veterans program is pretty good all right. But you've got to take the first step; they're not going to do it for you. They don't know you from Adam." Additionally, veterans who had utilized VA health care services indicated that the overall quality was good. One commented, "Yeah, I believe in the Veterans Administration. They've treated me really good. I've been going over there since, oh, about 2000. When I retired from the sheriff's office, I didn't have any insurance . . . so I thought I'd better get over there and sign up for it."

Regional and Local Health Care Regulations—the Paradox of Too Much Care

Confusing, Overlapping, or Limited Coverage

Not only do veterans need to utilize their own personal insurance if they have it, they may use Medicaid if they are below the poverty threshold, employment-related insurances, the VA, and, as they age, Medicare (CAMH 2015). Each has its own set of complex rules that must be navigated within the regional or local service area in addition to coordinating

the care received at each physician's office. The complexity of rules often leads to confusion as well as delayed, overlapping, and expensive care. It also contributes to an environment that encourages veterans to delay seeking needed services until the need is critical. When coordination took place the care was sufficient to meet the needs. The lack of coordination contributed to the perceptions of disorganization.

Coordination of Care

VA resources are also structured and provided on a regional basis through 21 Veterans Integrated Service Networks, which in theory allows for oversight that is better attuned to the localized risks and vulnerabilities faced by veterans. However, VA policy does not allow for the transfer of eligibility across states or regions, requiring veterans to re-qualify for their benefits. One veteran said, "So the VA, even though it's a national service—the military is United States—the VA is still divided into district areas. So when we moved from south Texas and came up here, I had significant problems. . . . They wouldn't see me here because I was enrolled in the south Texas VA system. Refused to see me." Such requirements disproportionately increase the vulnerability and risk faced by some veterans who need immediate access to health care. Additionally, rural veterans on fixed incomes who face limited access to health care are inclined to manage uncertainties by delaying treatment for both minor and serious illnesses, expecting to ultimately qualify for VA care. One interviewee described this situation: "Well, you got to realize that Medicare only pays 80 percent. So if they have a real problem, they have to come up with 20 percent of the cost of treatment. The Veterans Administration is free. And so on a limited income, you can see where they're coming from and why they are hoping for VA to give them the care they need." Another reason that the VA is an attractive option is because it ensures that the veterans are reimbursed for transportation expenses incurred in visits to the VA hospital (for example, the distance from southwestern Utah to the VA Medical Center in Salt Lake City is about 300 miles, with travel time of about 4.5 hours in good weather). As noted, for aging veterans the care provided by the VA tends to be less expensive than Medicare (which only covers 80 percent of the costs).

Finally, in some areas the VA has been efficient in coordinating veterans' care with civilian doctors. One veteran related his experience in this regard: "Being I lived so far away they just sent me out here to the regular therapist here at the hospital. I don't think he was affiliated with the VA at all. They made all the arrangements and did everything. It really helped me."

The latter instance suggests the benefits of the VA working more closely with non-VA primary care providers to take care of the arrangements rather than requiring the patients to take that responsibility. Where coordination occurred the veterans tended to express positive attitudes toward the VA. Where coordination was lacking veterans' negative attitudes toward the VA persisted, a factor that may contribute to the vulnerability of veterans who need specialized care or increased access. Well-coordinated care was more likely to be provided when it involved a permanent family physician who advocated for the needs of the individual regardless of the type of insurance veterans used. Exceptionally vulnerable veterans include those recently returning home to poor job markets and who are older than 26 and ineligible to be included on their parents' insurance (due to a change in the health care law) as well as aging veterans who lost their jobs during the economic downturn. These vulnerable groups have been in particular need of mental health care, but they may not have the personal resources necessary to negotiate with the VA for their health care.

Individuals assisted by advocates within the medical community, family, or even veteran service organizations reported more coordinated care. Services that work well seem to do so by happenstance, however. Rural interviewees typically did not identify efforts to train primary care physicians about veteran care, inform family members and enlist their support, or advance the agenda of advocacy groups to ensure that members are aware of coverage.

Rural Communities—Local Resources, Limitations, and Social Constraints

Context-Specific Perceptions of Distance

Numerous studies (e.g., Burgess and DeFiore 1994; Liu et al. 2008; Mooney et al. 2000) have demonstrated that distance decreases veterans' access to needed services. Because distance is a recognized barrier, the VA began adding contract clinics in rural areas. Despite these changes, the veterans in our focus groups indicated that distance remains a problem. Our data suggest a new way to conceptualize distance that helps to explain why local clinics do not appear to reduce the distance barrier as much as expected. We refer to this as "contextual distance," or context-specific perceptions of distance, which considers not only the actual distance to a facility but also the distance to the *right* facility. Specifically, we examine distance as a function of care needed as well as sociocultural perceptions of the facility's location. In part, our research supports the

research findings by Liu et al. (2008) regarding the bypass pattern of rural residents. However, the sections below identify some additional dimensions of access related to community context.

Distance to the "Right Facility"

It does not matter how close a facility is if the services provided are not the services needed. Similar to previous research, veterans in this study would bypass three or four local clinics on their way to a VA hospital because the required appointment or care could not be accommodated by the local facility. Bypass of local clinics was more likely to occur for most specialized treatment and assessments.

In southeastern Utah veterans and service members related a need to address posttraumatic stress disorder (PTSD) and self-medication. They hoped the local clinic would offer help in these areas but were disappointed by the results. No information on the services offered was available to them, nor was it clear who was in charge. Without knowing who was supposed to be in charge, veterans did not act on needs they saw within their community. The VA offers tele−mental health counseling services for those suffering from PTSD at several locations throughout Utah. However, many did not know this was an option available to them, or how to begin to register, or where they would even go to use such facilities. The focus group discussions were the first time many of these veterans had heard of such a service.

Consideration of whether to use a facility is one of the most important themes discussed by veterans in relation to mental health services. Male veterans tended to perceive mental health issues as detrimental to military service. Such issues were seen as a weakness, incongruous with a military culture that valorizes bravery and strength. Additionally, the shame attached to mental health issues can prevent veterans from seeking the necessary treatment, especially in rural communities where confidential access to service is difficult. Some veterans believe they can manage on their own without professional intervention; as one said,

> I know that's what a lot of guys tell me. And then I know another guy that he was hesitant to go get help … and he didn't know what it would do to his career. But it got to the point where he couldn't function day-to-day working. And it was probably five years after he'd been home that it got to that point, he'd been trying to deal with it for five years on his own.

Perceptions of Community Health Care Services and Locations

The impact of community loyalties, conflicts, and biases on the choice of health care resources is demonstrated in one rural area by an ongoing dispute, which concerned two competing health care facilities only thirty minutes apart from each other. Each community supported its own institution, believing that the region could not support more than one. Residents were reluctant to visit the other town's health care facility for fear of giving it the advantage. Thus, the location carried specific meanings in the communities. Additionally, according to focus group participants, because American Indians frequented the clinic where a VA office was located, this clinic was perceived to be for American Indian veterans, a fairly substantial population, rather than for white veterans. Research participants in this rural area expressed the view that American Indian use of local government facilities and resources was detrimental to their community.

Not everyone had these views, of course; some had more positive perceptions of the availability of services at the new hospital:

> This new hospital and the new Navajo health program has kicked in and done well. Why, it's up and functioning and we have doctors that meet our needs and provide services and we get to choose. . . . There's not a whole lot of give and take between them, but I think it is slowly getting better, you know. My doctor was . . . in the [one] clinic until he died, and I switched down to this other one and I've been treated very well there and I think the needs are there.

Finally, when considering local resources it is important to understand how information travels in rural communities. Simply put, everyone knows everyone's business. In story after story rural community members recounted the specific details of other community members' experiences. Communities learn where and for what these facilities are used, and this knowledge can significantly enhance or hamper effectiveness. Consider one tele-health clinic that was placed at the front of an office with glass windows so that anyone visiting the facility could immediately identify any patient in the tele-health center. Any use of this facility would immediately breach confidentially. Consequently, there was little use of it.

Addressing the needs of veterans who have experienced PTSD, one community member provided the following assessment of mental health care services:

> Based upon my experience if there is one hope that I would have, it is that the VA would give veterans access to qualified, experienced mental health professionals that understand PTSD and trauma and can help our veterans heal from the experiences they have during wartime that continue to haunt them, long after they return home. When I heard that going to a group counseling session was part of the standard of care for veterans, I was horrified. This would be an almost impossible task to ask of victims suffering from PTSD. There is so much guilt and shame involved in dealing with PTSD, that it is a challenge to discuss traumatic events one-on-one, much less in a group setting with a group of strangers.

Discussion and Conclusions

In response to the calls for research that represents the perspectives of rural veterans on health care access and use (Erickson et al. 2012) and identifies social and cultural influences relevant to their experiences (Cully et al. 2010; S. Sanders et al. 2015), the qualitative study presented here focuses on health care experiences of residents of several Utah rural communities, including veterans of different ages and eras of military service. The age distribution of research participants, and veterans in particular, is typical of the rural veteran population in general (CAMH 2015; Montgomery 2012). Focus group and individual interviews were well suited for exploring complex topics related to health care access and use because they provide greater detail and depth of understanding. While the results confirm that rural veterans, like veterans in other locales (CAMH 2015), continue to experience barriers to health care access, interview data also suggest new concepts that facilitate greater understanding of the challenges rural veterans face in accessing VA health care. These findings extend previous research that identifies institutional barriers to VA service access and delivery by focusing on how veterans' experiences with the challenges of accessing health care are affected by multiple, overlapping contexts.

The analytic framework for the research presented emphasizes the intersection of veteran perceptions and actions within several contexts and sociocultural conditions. We have shown that specific historical contexts, such as the era of military service, affect military identity and veterans' decisions to access VA care after discharge. For example, although veterans of the Korean War experienced more positive societal attitudes toward the military, veterans of the Vietnam War faced negative attitudes that shaped their postwar experience and reluctance to

access VA benefits and services. These older veterans now face important complications related to the needs for more specialized care, some of which are related to unrecognized and undocumented health problems that were created by particular military rules and cultural norms at the time they served. Additionally, a number of older veterans reported difficulties with establishing eligibility related to documentation that was missing or lost by the military (or VA), which has resulted in the denial of treatment.

An important theme that emerged in the study is that although most veterans believed that health care is a benefit related to their military service, many rural veterans have not sought VA benefits because of their aversion to using government services, which they perceived to be similar to welfare. Other veterans who want to access VA benefits, however, have found that qualifying presented serious challenges and some did not realize they could appeal negative decisions about eligibility. Qualifying for mental health services is particularly difficult for veterans in remote, rural areas since evaluations were performed at the VA hospital and often involved travel for multiple appointments over a lengthy period. As they have aged and their health care needs have changed, veterans must now navigate a new context involving multiple types of coverage (e.g., private, VA, Medicare) and learn how to access and coordinate different sources of local or regional health care services.

Overlapping with these contexts are features of the local community context such as limited information on health care services, distance to VA health care, and local perceptions of the appropriate sources of care for veterans to use. Not all veterans are familiar with the VA services available and new alternative delivery approaches, such as mobile clinics and tele-medicine. The lack of information on and confidence in these new services and technology limits veterans' use of these resources. Many veterans do not understand clearly the role of the VA nor do they have sufficient information about qualifying for health and mental health services. Similarly, veterans and community members across rural areas in Utah faced common limitations in the range of health care and mental health services available. While local primary care was often perceived as adequate or good, specialist care was perceived to be quite limited. Distance to health care (especially specialized care), a problem identified in previous studies, continues to be a barrier for rural veterans wanting to access VA services. However, another important interview theme suggests that local contexts can increase the complexity of overcoming distance. Specifically, perceptions of distance to health care services for some veterans involve not only calculations of physical distance (including road and

weather conditions) but also consideration of the socially appropriate (or "right") facilities for specific groups of veterans to use. Rural veterans' experiences with the social calculations of distance add an important dimension to our understanding of the "bypass" phenomenon reported in other studies.

These findings suggest that clarifying the challenges faced by rural veterans in accessing health care is improved by conceptualizing their experiences and perspectives within overlapping contexts, or sets of social conditions, that are also affected by the institutional resources and limitations of VA health care services. Identifying key features of these contexts, veterans' perceptions of them, and how the contexts relate to each other allows for assessment of the ways in which rural veterans may experience higher levels of risk and vulnerabilities. For example, veterans with "unrecognized" injuries related to their military service may not only face challenges in qualifying for VA care, they may not be able to access the specialized treatment they need within their rural community. Such difficulties are exacerbated if information about establishing eligibility and services is limited or travel to needed sources of care is constrained by local social dynamics such as community loyalties. Importantly, understanding the specific configurations of rural veteran identities, statuses and needs, and the access barriers associated with overlapping contexts also provides the VA, as well as other service providers, opportunities to address challenges related to coordination of care and improve service access and delivery.

Despite the contributions this ethnographic study makes to a more sociological understanding of the experiences and challenges of rural veterans with accessing health care, there are several limitations. The focus on rural communities in several sites across Utah, for example, provided for exploring some important elements of rural contexts in a large western state. However, this analysis does not address the relevance of the study findings to veterans in other settings. Specifically, while prior studies also have identified the challenges associated with institutional issues such as qualifying for VA health care, overlapping coverage, and coordination of care for urban veterans (CAMH 2015; Carter and Kidder 2013), the relationship of urban or suburban community contexts to veterans' experiences with these phenomena is less clear. Thus, comparative research that includes veterans in urban and suburban locales would help to assess the utility of the findings of this study and identify other key features of context. Similarly, although the relevance of our findings to other rural communities may be argued, the small size of the study population does not provide for generalization to other states in the West or the larger population of rural veterans.

Finally, other areas of inquiry are suggested by the study findings. Future research should seek to understand veterans' perceptions of recreancy, the perceived failure of "specialized organizations to execute properly responsibilities to the broader collectivity with which they have been implicitly or explicitly entrusted" (Freudenburg 2000:116), specifically as it relates to the Veterans Administration and access to quality health care. Also important to examine are the experiences of rural veterans with using different types of insurance and how health care can be coordinated among health care providers, options available to aging veterans and rural community members as they plan for and enter retirement, and how family members and other caregivers can assist rural veterans to access the care they need. Importantly, new research (Child, Hicken, and Ward 2015) on a recent VA initiative, Veteran Community Partnerships, suggests that the extent and nature of local health care provider coordination are important factors for increasing access by veterans and their families to the care they need. Finally, an important question to pursue concerns the impact of greater attention by the VA to the needs for and timely delivery of appropriate mental health services.

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