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Native American Vietnam-era Veterans' Access to VA Healthcare: Vulnerability and Resilience in Two Montana Reservation Communities

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Abstract As a growing segment of the military, Native Americans are expected to increase enrollment in Department of Veterans Affairs (VA) healthcare. Currently, 20% of Native American veterans are aged 65–74, which means they served during the Vietnam era. This study explores the experiences of rural American Indian veterans from two Montana reservations with accessing VA health services. Utilizing detailed data obtained in focus group and individual interviews, we examine the experiences, attitudes, barriers and needs of rural Vietnam-era veterans. Analyses indicate that while Native American Vietnam-era veterans experienced a poor reception returning to the US after military service, they had more positive receptions in their home reservation communities. However, reintegration was often impeded by poor local opportunity structures and limited resources. As they have aged and turned to the VA for healthcare, these veterans have encountered barriers such as lack of information regarding eligibility and services, qualifying for care, excessive distances to health services, the cost of travel, and poor quality of assistance from VA personnel. Despite variations in their resources, tribal community efforts to honor veterans have begun to facilitate better access to healthcare. Focusing on the roles and importance of place–based resources, this study clarifies challenges and obstacles that Native American Vietnam-era veterans experience with accessing VA health services in rural, reservation communities. Additionally, findings show how tribal efforts are facilitating access as they begin to implement the 2010 agreement between the VA and Indian Health Services to better serve Native veterans.

Keywords Barriers to healthcare access · Native American · Vietnam-era veterans · Rural communities

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Introduction

As of 2012 there were over 22,000 American Indians and Alaska Natives on active duty, [1] and as a growing minority segment of the military, their enrollment in the VA healthcare system is expected to increase [2]. Currently, 20% of Native American veterans are aged 65–74, which means they served during the Vietnam era. States vary in their veteran populations, with states in the Midwest and West having more rural and Native-American veterans [3]. In Montana 50,553 veterans were enrolled in the VA health system in 2014 [4]. Thirteen community-based outpatient clinics, four vet centers and one VA hospital offer services to Montana veterans. Much of Montana is highly rural, with an average of 6.8 persons per square mile compared to a national average of 87.4 [5]. American Indians comprise almost 7% (or about 67,000) of the state population, [5] almost 3000 Native-Americans are veterans, [3] and a substantial number live in rural reservation communities.

Recent research indicates that rural veterans experience challenges in accessing the healthcare they need [6–8] and Native American veterans have different care seeking patterns than non-Natives [9, 10]. A useful perspective for examining rural, Vietnam-era veteran experiences is suggested by studies showing that health is not only affected

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by one's daily physical habits and socioeconomic conditions, but also by what public health scholars call "social determinants of health." This view asserts that the place in which a person is born and lives is central to understanding health and illness above and beyond genetic predisposition and individual behaviors [11–14]. Indeed, research has empirically demonstrated the importance of stable communities for promoting better public health outcomes than less stable communities [15].

A focus on local communities is important for several reasons. First, communities provide the context for much of human behavior in terms of resources, opportunities, and constraints, and have been considered as inextricably linked with individual well-being [16, 17]. Second, according to a variety of sources, [18] the experiences of Vietnam veterans returning to their communities was a much more negative experience than veterans of previous wars. However, while American Indian veterans generally experienced negative treatment upon arrival home, many also had a more positive reception in their home communities [19, 20]. These veterans, in turn, have provided stability for recent veterans by, for example, making sure they receive a better welcome.

Third, despite strong ties to community-based social networks which rural veterans believe they can call on for help, [21] many experience barriers to reintegrating into their communities. Such barriers mediate the ability of rural veterans to gain access to needed healthcare [8, 21] and often promote "individual and social vulnerability factors [which] influence the development of PTSD" beyond the traumatic event itself [22]. Above and beyond recognizing mediating structures within a community, recently scholars [23, 24] have called for more research on the social, cultural, personal, and environmental aspects of community that influence rural residents' ability to adapt to postwar conditions.

The purpose of this study is to understand the experiences of American Indian veterans from two Montana reservations with accessing health services of the Department of Veterans Affairs (VA). Specifically, this research focuses on the experiences of Vietnam-era veterans, identifying strengths of and gaps in existing services. Additionally, this study contributes new understandings of the use of VA health services and local contextual factors that may affect residents' access, such as distance, cultural norms and practices, community resources, and personal attitudes regarding seeking help.

Methods, Participants and Research Sites

The literature on healthcare access among rural veterans and community residents calls for understanding barriers to care from their point of view [8]. Focus groups are well suited for unexplored, complex topics because they provide more details and a greater depth of understanding [25]. They include persons with relevant knowledge and experience [26], affording them opportunities to offer insights, opinions, and perspectives. For this study, rural veterans clarified the meanings of their experiences as well as their attitudes toward accessing health and mental health services, views of the quality and quantity of health and mental health services received, barriers and problems with access or use of services, unmet needs, and ideas for improvement of services. In semi-structured individual interviews researchers explored the responses of individual research participants. The use of both individual and group interviews addressed the preference of some participants for individual over group interviews, thus increasing participation and representation. The results presented here draw on data from focus groups and interviews conducted from 2010 to 2015 involving 47 American Indian veterans, with approval by the BYU Institutional Review Board and with appropriate approvals obtained in each tribal community.

Study Participants

Participants were identified through contacts with local veterans and community members at each reservation. Meetings with veterans occurred in locations that allowed for open discussion but also protection of participants' privacy and confidentiality. Quotes presented from interviews with Vietnam-era veterans from the two reservation communities are designated as A and B with a number for each study participant.

Background data collected show that Vietnam-era participants were over 61 years of age, about 54% served in the Army, and 38% served in the Marine Corp. The majority of participants completed high school as well as some type of post-secondary education. More than half (54%) were retired, 15% were employed and 31% indicated other statuses (e.g., unemployed, student, disability). Almost half were married, 31% were divorced, and the remaining participants were widowed or single.

Information on the social and economic conditions helps to contextualize the situations that many American Indians face in reservation communities [27]. For example, important population characteristics include that in 2013 the average age of American Indians was 13 years younger than the state population; 73% completed a high school diploma or higher (slightly higher than the US average but less than the 92% of all Montanans), and the median household income was $7000 less than the US average [28].

Additionally, the Montana Department of Labor and Industry report [28] indicates that the unemployment rate among American Indians is higher than the

average for the state, which is reflected in their lower wages and income levels. For example, American Indian median household income was a little more than half that of majority group Montana residents, which can be attributed in large part to the higher unemployment rate among American Indians in 2008–13. The Montana Department of Labor and Industry report also shows variation among reservation communities, with Fort Peck having the lowest rate (<5%) and the Crow reservation having the highest (25%), compared to a little more than 6% for the state. Unemployment rates for the remaining five reservations ranged from about 10% to as high as 20%. Although unemployment rates were much higher than the state, the rates in 2013 showed declines from the previous year for some reservation communities while several others experienced increased unemployment. Typically, the reservations overall have not experienced the increased employment that the state saw as a whole since 2011.

Finally, the distribution of economic activities in reservation communities is very different from the state: while government jobs comprised about 3% of jobs for the state overall, the percentages among the reservation communities ranged from 35 to 83% in 2013. Conversely, the percentage of jobs in the private sector ranged from 9 to 65%, compared to 81% for the state. Importantly, recent drops in real wages in the public sector has resulted in lower wages for a substantial proportion of jobholders in reservation communities. Among private sector jobs, healthcare and education are the primary sources of employment, which is typical of other areas of the state.

As suggested by this contextual information, the rural reservation locations of a substantial proportion of American Indian Montana residents means that veterans often face problems with employment as well as equitable wages and income. Additionally, distance from health services presents challenges affecting their access to needed health information and healthcare. Data collected for this study occurred in two of the seven reservations, one of which is characterized by somewhat better socioeconomic conditions and access to healthcare than the other.

Study Results

In the following sections important themes related to veterans' experiences and perspectives are presented. First, results are presented on the transition to civilian life followed by discussion of major themes on access to and use of healthcare services.

Making the Transition to Civilian Life

In the focus groups veterans described their reasons for entering the military and experiences with returning home. For example, veterans reported that while they were treated poorly when they first arrived in the US, they received more respect in their tribal communities. They also discussed what service meant to their family.

> All of [my family] way back, many generations to our great great grandfather… all went to the service. … all of my cousins, we all went to Vietnam…America really didn't want us, but the good thing is that our tribe welcomed us back. I think they saved a lot of us. (A-4)

Remembering their experiences with returning from Vietnam, some veterans in each reservation community recalled their negative experiences. For example, two veterans' comments illustrate what many felt: "It was more, hide the fact that you were a veteran because the Vietnam war wasn't over yet. You were a 'baby killer' and so you didn't even talk about being in the military" (B-3). A Northern Cheyenne veteran explained: "These veterans [now], they go to the airport and have ceremonies …but the older [veterans]… had a bad welcoming. People spit on us… It just hurts because there are a lot of veterans like that on the reservation" (A-6).

The transition to civilian life has been difficult for many Vietnam veterans. As one veteran expressed it, "It took time just to get used to being me again. I wasn't me" (B-1). Looking back on their experiences with returning home and considering the needs of veterans who have arrived recently, Vietnam veterans in one reservation organized a Talking Circle where all veterans can gather to share experiences and support each other.

Today, veterans in each reservation have important roles in the community and are honored for their military service. As one veteran explained, "Without war veterans our ceremonies couldn't continue…there's really no other tribe that I know of …that [has] sacred covenants like we do" (A-4). In community B, the names of veterans were placed on a new Veterans memorial in 2011.

Veterans also discussed how they feel now about their military service. Most have concluded that it was an important part of their lives. As one community A veteran stated, "You know, I've talked to a lot of veterans and said, 'If you had to do it again, would you do it?' And most of them say, 'Yes, but I don't want my kids in there' (A-3). In community B, veterans described how military service changed their lives. As one veteran explained: "I look at this … where would I have been in life? I'll tell you honestly …I'd be in a joint now… today, if the military didn't take me" (B-4).

Barriers to Accessing Healthcare

Veterans in this study experienced a wide range of physical and mental health issues resulting from their service in the military: injuries sustained during deployment, exposure to Agent Orange in Vietnam, and post-traumatic stress. Veterans also dealt with other health issues associated with aging such as diabetes, heart conditions, and strokes. They also experienced a range of barriers to accessing healthcare services to meet these needs. Importantly, healthcare needs that are unrelated to military service typically are not covered. Consequently, veterans with new or changing health needs as they get older are unclear about the types of care they are eligible to receive from the VA. This confusion is illustrated by the comment from a veteran in community B: "If you get hurt or shot while in service, then fine. But if you get in a car wreck, they don't want to deal with it" (B-6).

The following sections present major themes from interview data about the types of obstacles veterans encountered when seeking VA healthcare.

Qualifying for VA Care and Accessing Medical Records

One concern expressed by virtually all veterans related to qualifying for VA benefits. Not all realized that their eligibility was related to having a service-related health condition. At the end of their deployment, military personnel go through a de-briefing process of exit interviews and a health evaluation. Some veterans assumed they would automatically be enrolled in the VA system. Although in both communities a local VA representative is available to help, many veterans do not know about or access these services.

Our analyses indicate bureaucratic restrictions were the most commonly cited obstacles to accessing VA health services. Many veterans reported that they needed copies of their service records but could not obtain them from VA facilities in St. Louis because they were either misplaced or destroyed in fires. Consequently, Vietnam veterans in both communities A and B without records could not establish eligibility for healthcare. One veteran in community A described his experience: "They lost my records, they couldn't find them … The VA told me, 'You don't exist.' They said, 'We have no record of you. You have to reapply in the state of Montana'" (A-3).

Some focus group participants reported that veterans had to get government officials (or legislators) to help overcome eligibility obstacles. Although it took a great deal of time and effort, veterans in these communities eventually learned how to get copies. For example, a veteran in community B explained: "Somebody told me they couldn't find records or anything; said they were burnt up. He said he went through [Senator] Baucus… [the VA rep] could help you get them out of Helena" (B-2).

Other veterans expressed concerns about the difficulties that veterans faced in qualifying for services and the effects of this process, especially for veterans who needed mental health services. As one veteran stated: "If you're seeking something for mental [health needs], it's almost like you've got to prove you're nuts or something" (B-2).

Furthermore, older rural veterans on fixed incomes who did not know how to qualify for VA care were inclined to delay treatment for both minor and serious illnesses. Although they expected to be able to qualify for VA care these veterans often encountered difficulties in getting care from the VA. The following comments illustrate the obstacles older veterans face:

> If you need surgery, they won't do it. People just go without… people going to them as a diabetic caused by Agent Orange, and they want you to pay the supplies and medication. It makes me mad. (B-6)
>
> But the ones that are really suffering are the ones that stay home and don't know how to get benefits. When they do go someplace, they are turned down. The VA usually turns them down right away. (A-6)

Some veterans from each reservation community found that when they do qualify, they do not get the amount of services they need or receive the treatment they expect.

> I was asking my VA doctor; I said, "You're telling me that Agent Orange causes prostate cancer…too bad; you're just going to die because it's a slow acting cancer." … Medicare came out with a thing saying I could only have one treatment a year. And the VA said the same thing. (B-6)
>
> I got hurt in Vietnam. So I lost my hearing. I lost my knee. And they did my surgery in Fort Lewis, Washington. And they didn't do a really good job on me. They didn't test me for anything, like Agent Orange (A-2)

This type of experience led some veterans in both reservation communities to conclude that the VA is not there to serve them. As one veteran explained: "The main thing we keep hearing is this adversarial role of the VA" (B-6). Other veterans reported the hurdles they encountered that produced great frustration.

> When I went to the Vets I found out that it wasn't as easy as they made it sound. It seemed like every time I turned around there were hurdles… everywhere you turned everybody thought of all kinds of reasons why you shouldn't rather than should. (B-4)
>
> With the Vietnam veterans like myself, I don't really give a darn about the VA or anybody else because

> they didn't care when we came home. I had a hard time getting the help that I needed (A-6)

The inability to clearly establish service-related health needs is particularly problematic for veterans whose health issues fall into the gray areas. Health concerns that are indirectly related to service may not qualify for treatment. The strain and rigor of military life in general can have physical effects later on, but veterans must qualify for coverage. However, several veterans expressed their reluctance to establish eligibility. For example, one veteran in community B had postponed applying for services because he expected to have to fight to qualify: "I'm putting off having to deal with some really serious health issues simply because once I sign those papers, I've really got to be ready for a battle" (B-2). A community A veteran resisted enrolling in the VA because he did not believe that the government understood his needs: "For a long time I didn't want anything to do with government… There was no help for the veterans coming out of war a long time ago…They didn't understand PTSD" (A-4).

Waiting for Appointments and Referrals

Once eligibility is established, long waiting periods (as long as 6 months) can impede rural veterans' access to appropriate healthcare, as the following interview comments illustrate.

> I don't know how they say instantaneous healthcare. Even if you go to [the VA in] Helena, you can't get in. If you're having psychological problems, you wait 90 days. And you're like, I'm having a problem today, I can't wait 90 days! (B-2)
> When you miss it, they say you're going to have to make another appointment that's going to take another several months, or maybe a year. (A-7)

Distance from Healthcare

Another obstacle identified is the distance to healthcare facilities. Some participants indicated that the long travel had a decidedly adverse effect on their use of VA services; they are restricted to using the closest clinics or hospitals. While some care is available in hospitals or clinics located within a 1–2 hour drive, specialized care is typically much farther away, often on the other side of the state. The distance is a greater problem for those without transportation or who cannot drive. Additionally, transportation is seasonally affected. As one veteran explained, "In the winter months, especially when the roads get bad, everybody is kinda immobile" (B-4). However, when one veteran in community A did not have transportation to VA services in Billings, he made the round trip by foot. When asked why he walked, this veteran replied: "No ride, no way of getting home, no place to stay over there" (A-5). Additionally, many veterans did not know they could get reimbursed for mileage when traveling to VA appointments and, therefore, did not request this help.

Responsiveness of VA Staff and Quality of Services

Some veterans reported that the VA staff, including doctors, was not always responsive to their specific needs. The veterans' opinions were that staff outlook and procedures tended to favor cost saving measures rather than facilitating quality care. For example, one veteran was concerned about VA doctors who wanted to cut health services and save the VA money: "That woman advertised the fact that she's a hatchet woman …she came there to change the program and toughen it up. Too many people getting money for PTSD… I know veterans that won't go there anymore" (B-6). Another veteran observed that VA clinic staff appeared to change the rules to be less responsive to the needs of veterans.

Additionally, veterans pointed out regional differences in services. One veteran described experiences with services in an urban east coast area that were more responsive compared to rural Montana, and another veteran found that in an urban Washington area he could receive greater benefits than in his Montana reservation community.

In contrast to these experiences, veterans who had qualified for and received VA healthcare had positive reports about the medical services they received. Additionally, veterans appreciated the quality of the VA's substance abuse treatment program: "I had a few friends go there related to alcohol treatment stuff and end of life stuff … and I would say he was getting good care at that time" (B-1).

Elements of Reservation Community Contexts Relevant to Veteran Adjustment

When soldiers are discharged from the military and they return home to the reservation, the problems they face with addressing health needs, as well as the transition to civilian life, are complicated by the social vulnerability and instability of reservation communities. The limited opportunity structure and lack of resources create barriers for adjustment to civilian life. For example, one interviewee described veterans' experiences with getting a job: "Talking to a civilian employer…they say, 'Well, what can you do?' and you're like, 'Well, I killed people,' and they don't have anything like that for you to do" (B-6).

Another veteran discussed the racial minority aspect of veterans' experiences adjusting to civilian life, especially interacting with non-Indians.

> And it doesn't matter if you served in the military. When you come back here, you're still an Indian. Non-Indians say, "Oh you served in the military, thank you, thank you!" But as soon as you take off your uniform, you're an Indian. (B-FH6)

For many American Indian veterans, returning to their community means dealing with both VA and local reservation social dynamics, such as few job opportunities:

> A lot of the things we've been talking about revolve around the community itself, and [the lack of resources] it has to offer veterans. And it seems like reservation communities are struggling anyway, with employment and similar issues. (B-6)

Similarly, community A veterans did not find much opportunity when they returned home: "There was nothing there when we got back home, except drinking" (A-7).

Resilience in Reservation Communities

Despite the lack of resources and opportunities, tribal healthcare agencies in both communities have worked to address veterans' needs. Important differences between the two reservation communities relate to the range and amount of resources from which they could develop solutions. In 2013, the director of tribal health services in community B provided support for a new tribal veteran advocate position designed to assist veterans get the healthcare they need, such as establishing eligibility, arranging for services and applying for travel reimbursements. These actions were directly related to implementing provisions of the 2010 Memorandum of Understanding between the VA and Indian Health Services (IHS) for improving coordination between the agencies and services to Native American veterans. As a result, there has been in an increase of at least 30% in local enrollment in the VA healthcare system. Veterans who worked with the new tribal veteran advocate described their experiences with this source of help:

> Well, it's tough. That [VA staff person] called me on the phone and asked me questions I didn't know…so I gave her [the Tribal veteran advocate's] number and I asked [him] if he would talk to that lady from Helena. …[The VA personnel] are not doing anything, and I think that's one of the reasons they created that job for him…to help veterans. (B-2)

Another veteran summed up his experience with the Tribal veteran advocate: "He's on my side. He's somebody I can trust" (B-3).

Advocacy for veterans in community A has developed differently than in community B. Until recently, veterans reported they needed more assistance in getting access to VA care. Comments like the following were typical: "We really need to get somebody that is going to advocate for the veterans" (A-4). Another veteran commented: "There's no help here…We travel to Billings and there's a lady there that helps us. It's a VA outreach and that place is really good" (A-6).

Since these interviews, however, a new VA tribal representative, who is also a veteran, is located at the IHS clinic. His outreach and work with veterans have begun to increase their interest in accessing VA benefits and services.

Discussion and Conclusions

This research underscores variation in the role of tribal health services in these two contexts, representing important community resources differences. However, veterans in both reservations faced common limitations in the range of healthcare services available in rural areas. This suggests that both Native veteran groups experienced the vulnerabilities associated with resource and opportunity constraints in rural areas. However, sources of resilience emplaced in these communities included both the informal assistance provided by veterans' groups and individuals and tribal commitments to honor and assist veterans. Nevertheless, resources in community B provided for additional advocacy and assistance, which generated greater resilience among veterans as they confronted barriers to accessing services from a significant external source, VA healthcare. Taken together, these findings suggest that the place-based social, cultural and economic conditions of these reservation communities mediated the ability of individual veterans to adapt to postwar circumstances. Furthermore, this research underscores the importance of understanding pre-war social characteristics of soldiers and their communities which may reduce or enhance successful post-war adaptation to the consequences of military service-related experiences.

In conclusion, results of this exploratory study reinforce the call of researchers [13, 16, 17] who emphasize the importance of understanding the relationship between communities of residence and individual well-being. Indeed, such research demonstrates that health is as much a function of socio-cultural factors, resources and conditions as it is of biological factors. By adopting a more holistic approach, policy makers, researchers, and healthcare practitioners will be better attuned to the local needs of veterans. As in the case of the research presented, they may become better prepared to deliver timely and culturally appropriate healthcare services.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

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