

The Perpetual Struggle for Access Within Reformed Veterans' Health Systems

Daniel Park

Westview High School, 13500 Camino Del Sur, San Diego, CA, 92129, United States

ABSTRACT

Veteran healthcare in America exposes the disparity between policy change and lived experience. Though promising legislation like the Veterans Access, Choice, and Accountability Act (2014), VA MISSION Act (2018), and Honoring Our PACT Act (2022) were proposed, implementation of these reforms has been inconsistent. This paper examines the structural, logistical, and social barriers that still complicate providing equitable care to millions of veterans. Despite the Department of Veterans Affairs (VA) operating one of the largest healthcare systems in the United States, veteran patients—especially those in rural areas, minorities, or those with complex mental health or disability needs—often experience delayed appointment access as increased unidentified staff shortages plague care coordination across care networks. The Government Accountability Office has drawn attention to numerous inconsistencies and deficiencies in these facets identified in oversight reports. The inclusion of geographic and racial inequities alongside systemic ambiguity when federally funded programs overlap demonstrates how these issues significantly complicate access to care. These reports have exposed the consequences of missed and inconsistent treatment. Although reforms have increased eligibility and somewhat improved treatment outcomes, they have equally worsened disparities within an already under-resourced system. This paper argues that true progress is not solely through policy but through aligning legislative ambition with effective implementation: attention to recruitment of providers, enforcement of oversight, and the establishment of a culturally competent veteran-centered healthcare system to help veterans serve as advocates for themselves. Ultimately, bridging the gap between policy and practice will deliver the healthcare our nation's veterans deserve.

Keywords: Veterans; Healthcare; Policy; Access; Disparities; Equity

INTRODUCTION

Veteran care has long been a bipartisan issue with both parties supporting policies aimed at improving

the lives of our nation's veterans. However, there is an enormous chasm between what is passed into law in Washington D.C. and the actual experiences of veterans at the local level (1). While landmark legislation is celebrated during hearings and press releases for the impacts they will have, the reality is that the benefits of these laws are rarely seen by the veteran waiting in line at a rural Montana clinic for a mental health appointment or traveling hours for routine screening (2, 3). This seemingly perpetual dissonance between policy

Corresponding author: Daniel Park, E-mail: danielpark2026@gmail.com.

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design and care delivery defines the primary problem of veteran healthcare today.

Despite numerous attempts through federal legislation to improve access and eligibility to care for veterans, many veterans still experience delays and barriers to obtaining timely and quality care. The causes of these delays and barriers do not come from a lack of intent behind the laws being passed but from administrative bottlenecks, workforce shortages, fragmented care networks, and entrenched inequities affecting rural, disabled, and marginalized veterans. The result is a system where reforms often broaden rights on paper faster than the healthcare infrastructure required to deliver those rights in practice (1, 4).

The Department of Veterans Affairs (VA) is the largest single integrated healthcare system in the United States, providing healthcare services to more than 9 million veterans each year at over 1,200 locations (1). Despite this, Government Accountability Office (GAO) oversight continues to expose the problems associated with delayed appointments, inconsistent referral processes, and uneven enforcement of care standards throughout the VA's healthcare delivery system (5, 6). When the VA offers to provide care at a non-VA facility, veterans are faced with conflicting and confusing eligibility requirements that often create confusion rather than meaningful choice (1, 4).

This paper examines the policy-implementation gap in veteran healthcare by examining federal legislation, the administrative capacity, and on-the-ground outcomes. By drawing upon federal documents and testimonies from veterans, it argues that meaningful change to the healthcare delivery system cannot

occur simply by increasing the number of services provided to veterans, but by creating and sustaining the infrastructure necessary to deliver those services. For many veterans, the difference between policy and practice is not theoretical; it determines whether care comes in time, or too late.

HISTORICAL CONTEXT AND LEGISLATIVE INTENT

Over the past decade, three major reforms have shaped the modern VA: the Veterans Access, Choice, and Accountability Act of 2014, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, and the Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022. Each sought to address the system's recurring crises of long wait times, provider shortages, and inequitable access, yet each introduced its own set of new challenges (Table 1).

The Veterans Access, Choice, and Accountability Act of 2014 was enacted following a national scandal at VA medical centers, where investigations found that 84% of veterans waited more than 14 days for primary care appointments and some waited an average of 115 days, far beyond clinically recommended standards (7). This act created the VA Choice Program, allowing eligible veterans to receive care from non-VA providers if VA waits or travel distances exceeded federal thresholds (7). While the law aimed to relieve pressure on VA facilities, its implementation highlighted challenges in eligibility verification, reimbursement processes, and provider participation (8).

Table 1. Major Veterans' Health Reform Acts (2014-2022)

Year	Legislation	Key Provisions	Intended Goal	Observed Limitations
2014	Veterans Access, Choice, and Accountability Act	Created VA Choice Program allowing private care for eligible veterans	Reduce excessive wait times and alleviate facility strain	Complex eligibility, billing confusion, uneven provider participation
2018	VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act	Replaced Choice Program; created Community Care Program; expanded caregiver support	Permanently integrate public-private care options and increase flexibility	Provider shortages, fragmented coordination across VA and private networks, privatization concerns
2022	Honoring Our Promise to Address Comprehensive Toxics (PACT) Act	Expanded presumptive coverage for toxic exposure and simplified claims	Remove burdensome proof barriers and expand access to benefits	Workforce strain, processing backlogs, uneven outreach

In 2018, Congress attempted to address these shortcomings through the VA MISSION Act. This act replaced the Choice Program and established the Veterans Community Care Program, expanding access to private-sector providers and introducing new urgent care benefits and caregiver support (9). Early data from Congressional Research Service (CRS) Report R45390 showed a 26% increase in community care appointments between 2017 and 2018, reflecting strong demand for expanded options (9). However, these gains exposed underlying structural constraints, particularly in rural and underserved regions where provider shortages limited the effectiveness of expanded eligibility (2, 3, 4).

The Honoring Our PACT Act of 2022 marked one of the largest expansions of veterans' health benefits in recent history. By presuming eligibility for certain cancers and respiratory illnesses linked to toxic exposure from burn pits, Agent Orange, and radiation, the PACT Act aimed to remove burdensome proof requirements that had historically delayed treatment and benefits (10). Within its first year, more than one million claims were approved and over \$5.7 billion in benefits were disbursed (10). While widely regarded as a significant moral and public health milestone, the surge in claims intensified demand on a VA workforce already operating under capacity constraints (10, 11).

These reforms are overseen by multiple congressional committees. While the House and Senate Committees on Veterans' Affairs lead most legislative activity, oversight often intersects with committees governing healthcare financing, labor, and regulatory standards. According to the CRS, this overlapping jurisdiction can elevate attention to veterans' healthcare, but it may also fragment accountability and complicate consistent implementation across the national system (1).

Together, these laws reflect a pattern of expanding eligibility and benefits faster than the system's administrative and clinical infrastructure is strengthened to deliver them. This gap between intent and capacity forms the foundation for the implementation challenges examined in the following section.

IMPLEMENTATION FAILURES AND STRUCTURAL BARRIERS

While major reforms have aimed to expand access and improve care delivery, many veterans continue to experience the system as confusing, fragmented, and inconsistent (4-6). Much of this stems from how the VA

interacts with parallel programs such as TRICARE and Medicare Advantage. TRICARE primarily operates as an insurance network for active-duty personnel, retirees, and eligible dependents, granting access to civilian healthcare providers (12). VA, meanwhile, functions as a centralized healthcare system serving over 9 million enrolled veterans annually across more than 1,200 facilities (3). Although both systems exist to support military-connected populations, they operate in parallel rather than in coordination. Veterans transitioning from TRICARE to VA care (or attempting to use both) face incompatible referral systems, conflicting eligibility rules, and lack of shared medical records (12). The GAO has repeatedly documented that these misalignments lead to prolonged referral times and inconsistent standards for community care wait times (5, 8).

These gaps are exacerbated by the increasing reliance on private community providers under the VA MISSION Act. Advocates argue that outsourcing expands choice, but expanding access without building oversight structures has intensified fragmentation. Community providers often lack familiarity with military cultural trauma, discharge histories, or VA documentation systems, and VA facilities lack the staffing capacity to coordinate complex cross-system care (4, 11, 13). A 2025 GAO report noted that community care utilization rose from 1.1 million veterans in 2014 to 2.8 million by 2023 (4), but this growth occurred without proportional increases in oversight, leading to delays, billing complications, and inconsistent follow-up (4, 14). Even beyond TRICARE, inefficiencies continue within Medicare Advantage: between 2018 and 2021, private insurers collectively received nearly \$44 billion in payments for veterans who primarily received care through the VA, despite the VA being unable to bill those insurers (14). The result is a system where responsibility is distributed across multiple programs, but accountability is diffuse, leaving veterans to navigate the gaps on their own.

Workforce constraints further limit the system's ability to meet increased demand. The VA is the largest integrated healthcare system in the United States, employing more than 371,000 staff (11), yet persistent shortages—particularly in mental health, rural care, and specialties requiring military cultural competence—continue to hinder timely access (11, 13). GAO investigations have shown that efforts to expand Community Care networks have been undermined by staffing vacancies and insufficient administrative

guidance (11). These systemic vulnerabilities were magnified in early 2025, when the Trump Administration terminated 2,400 VA employees, including Social Science Assistants (SSA) who support the Veterans Crisis Line. At a Senate hearing, former responder Marcia Blane described SSAs as “on the same level as 9-1-1 operators,” responsible for tracing calls and coordinating emergency response for veterans in crisis (15). Their removal, she testified, left responders “supporting up to fifty crises at once,” creating dangerous lapses for those most at risk (15). The infrastructure to support expanded access, in other words, exists in legislation, but not yet in practice.

Even once veterans enter the system, their experience is shaped by geography rather than need. Internal VA audits reveal that mental health referral follow-up varies widely across facilities (16), and the VA's risk management systems have struggled to keep pace with the complexity of hybrid public-private care networks (6). This leads to inconsistent care plans, repeated testing, and treatment gaps that disproportionately affect veterans already facing trauma, disability, or instability. GAO reports also underscore the persistence of bureaucratic inertia, where overlapping administrative layers delay reform implementation even when authority and funding have been granted (6, 16, 17).

The core issue is not a lack of reform, funding, or stated commitment. It is the structural misalignment between policy design and delivery capacity. Legislation has expanded eligibility and benefits more rapidly than the system designed to administer them has been strengthened. The consequence is predictable: veterans are promised more than the current system is able to consistently deliver. Passing a law is the *beginning*, not the fulfillment, of care. For too many veterans, the distance between eligibility and actual access remains the defining barrier (4-6, 8).

EQUITY AND THE MARGINALIZED VETERAN

While recent reforms have expanded eligibility and broadened access on paper, their benefits are not yet realized equally among all veterans. Structural inequities—shaped by race, mental health vulnerability, disability status, and geography—continue to influence who receives timely, continuous, and culturally competent care. These disparities compound one another, reinforcing unequal outcomes within a system already strained by capacity and coordination challenges. The root causes are systemic: privatization

incentives fragment accountability, administrative bottlenecks delay coordination across agencies, and persistent provider shortages limit continuity of care (11). These disparities are not accidental; they stem from the design of reform laws that prioritize access through privatization rather than investment in internal capacity (4, 6). Together, these forces transform well-intentioned legislation into uneven outcomes.

Race and Ethnicity

A 2023 GAO analysis showed that between 2010 and 2020, Black veterans had lower initial disability claim approval rates (61%) compared to White veterans (75%), and more recent data indicates that the gap persists across several major diagnostic categories (18). These disparities extend into treatment access: both Black and Hispanic veterans experienced longer wait times for community care referrals in the years following the VA MISSION Act (19). Because the act delegated more care to external providers without standardizing oversight, veterans in under-resourced areas faced additional administrative steps to access care (4, 6). Oversight of contracted providers also remains decentralized across regional VA networks, meaning enforcement of equity standards and accountability varies widely (6). While the VA's Equity Action Plans have called for improved demographic data collection, cultural competency training, and expanded outreach partnerships, recent reversals of internal equity protections risk undermining this progress, particularly for LGBTQ+, female, and rural veterans (21, 21, 22).

Mental Health

Mental health remains one of the most urgent challenges affecting veterans, especially those who served post-9/11 (23). Veterans are 1.5 times more likely to die by suicide than non-veteran adults (24), yet the availability and follow-up of mental health referrals vary widely across VA facilities (16). Peer-based initiatives, such as the American Legion's Buddy Checks, have helped connect isolated veterans, but they reach only a small fraction of those in need (25, 26). Fragmented referral standards and high staff turnover rates weaken the handoff between crisis lines, VA hospitals, and community care providers, producing preventable gaps in treatment (16). Veterans' accounts underline how thin that margin can be: as Air Force veteran Trevor Smith reflected, “Even with the best care, you can still get to a point where you have a gun to your head” (27). This stark reality highlights persistent gaps as he offers

a blunt warning: “We’re fucked” (27). His words expose the human cost of system inconsistency: when follow-up lapses, mental-health crises become lethal. Without consistent continuity of care, untreated mental health conditions can escalate into homelessness, substance use disorders, and long-term instability (23, 24). The importance of reliable, culturally competent mental health care cannot be overstated.

Geographic Access

Nearly one quarter of veterans live in rural communities (2), where shortages of primary care clinicians and mental health providers are most severe (3). While the VA MISSION Act was intended to expand access through community care networks, in many rural regions there are few or no participating providers available (2, 3). The VA reimburses community providers at lower rates than private insurers, discouraging participation and perpetuating shortages (4). These shortages persist because reimbursement levels and administrative burdens make rural participation economically unsustainable for many providers. This privatization incentive leaves rural veterans with theoretical options but practical scarcity (2, 3, 4). One rural veteran captured the frustration plainly: “It’s a whole day just to get to the doctor and back” (28). The result is that “choice” often exists in policy, but not in practice. Travel burdens, limited appointment availability, and inconsistent coordination make access contingent on location rather than need (2, 3).

Toxic Exposure and Disability Claims

The PACT Act dramatically expanded presumptive eligibility for cancers and chronic illnesses linked to burn pits, Agent Orange, and radiation exposure, marking one of the largest benefit expansions in VA history (10). Yet veterans in rural and underserved communities are less likely to receive screenings or individualized claims support (2, 3). Without proactive outreach, expanded entitlement frameworks risk reinforcing existing inequities instead of alleviating them. Administrative complexity, multiple agencies managing different exposure registries, has also delayed coordination, illustrating how overlapping authority can dilute accountability (6). Without a unified case-management system linking these registries, veterans must navigate multiple portals, producing duplicative paperwork, inconsistent eligibility determinations, and delays in treatment (6).

Comparative Insight

In contrast, the United Kingdom’s National Health Service (NHS) Veterans Programme delivers care through a single integrated structure that links general practitioners, mental-health specialists, and social-care services under one oversight body (29). Similarly, Australia’s Department of Veterans’ Affairs coordinates benefits and medical treatment within one agency, ensuring consistent eligibility standards and data sharing (30). The U.S. system’s hybrid public–private model, by comparison, disperses responsibility across the VA, TRICARE, Medicare, and private contractors, producing the very fragmentation that undermines equity (4, 6, 14).

Acknowledging Progress

Reforms such as the VA MISSION Act and the PACT Act have yielded meaningful improvements for many veterans, particularly in areas with robust provider networks (2, 9, 10). Yet as long as eligibility expands faster than the system’s administrative and clinical capacity, disparities will persist as structural outcomes rather than exceptions. The work ahead lies not in passing new legislation alone, but in ensuring that the care promised in policy becomes care delivered in practice. As one veteran put it, “They’re my lifeline. I wouldn’t be here without the VA” (27). This reflection reiterates both the necessity and fragility of the system, a reminder that policy reform achieves its purpose only when it reaches those most in need.

POLICY RECOMMENDATIONS AND THE PATH FORWARD

Laws such as the Choice Act, VA MISSION Act, and PACT Act were meant to help expand access and repair a system long criticized for abandoning its veterans. Yet there remains a stark chasm between legal text and clinical context. Policies can claim commitment to care, but claims are not healing. Without adequate staffing to meet demand, oversight to ensure consistency, and culturally competent providers who understand the essence of service, reform risks becoming another headline rather than a solution.

Even the most recent effort in June 2025—the House’s passage of the first FY2026 appropriations bill fully funding veterans’ health care and benefits—follows this pattern (31). The legislation represents a significant investment, but its true impact will depend on whether resources are translated into timely

appointments, consistent mental health support, and equitable care for all veterans. The next step is not another statute. It is implementation: eliminating staffing shortages, streamlining referrals, and investing in veteran-centered models that integrate mental and physical health. It is only when implementation matches ambition that the country will fulfill its commitment to those who served: not in principle, but in practice. The FY2026 bill offers an opportunity for the nation to uphold that promise.

Systemic barriers to veterans healthcare delivery are not individualized, but interconnected inequities that exist based upon staffing deficits, inconsistent and fragmented implementation of existing policies, and a lack of equity in the delivery of care. Race, disability, mental health status, and geographic location create barriers to accessing quality care for veterans. Black veterans have historically experienced lower rates of approval for disability claims, 61%, compared to 75% of White veterans during the period from 2010 to 2020 (18). Rural veterans continue to travel hours to receive care from providers, or they experience delays in receiving appointments of months (18). All of these inequities have been exacerbated by chronic under-resourcing, including the recent termination of 2,400 VA employees, leaving crisis line responders without critical support (15). Former service members remain 1.5 times more likely to die by suicide than non-veteran adults (24), a sobering reminder of what is at stake when care is delayed or denied.

In order to bridge the gap between reform and reality, several policy steps need to occur:

1. Establish common data dashboards across the Department of Veterans Affairs (VA), Department of Defense (DoD), and the Centers for Medicare and Medicaid Services (CMS) to track wait times, claims processing, and referral backlogs in real-time to strengthen inter-agency collaboration and accountability.
2. Develop performance metrics that focus on the outcomes of policy initiatives, not on the amount of money spent or the number of claims processed. Metrics should focus on specific goals, such as having 90% follow up for mental health referrals within 7 days of discharge and tracking veteran satisfaction across service regions.
3. Increase VA infrastructure in rural areas by expanding the use of telehealth to cover a larger percent of rural zip codes, providing incentives to encourage rural provider participation through

grants, and increasing travel stipends for veterans living in remote regions until the level of access to care is fairly equal among rural and urban populations.

4. Recruit and retain healthcare workers to the VA by providing loan forgiveness programs and rural service incentives to clinicians, with the goal of filling 95% of the VA's authorized medical and mental health positions within 3 years, while maintaining a turnover rate of less than 10%.
5. Require all clinical staff to complete annual equity and cultural competency certifications to develop culturally and linguistically competent providers who are aware of the experiences and needs of the diverse population of veterans being treated by the VA and in the community.

Together, these steps move reform from aspiration to action, making access not a promise, but a guarantee.

Reforming legislation alone is insufficient to eliminate the deep-seated inequities that veterans experience unless implementation directly addresses the structural and social realities veterans face each day. *"They're my lifeline"* (27). Behind every policy statistic stands a life waiting to be sustained, and a promise still waiting to be kept.

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CONFLICT OF INTERESTS

The author declares that there are no conflicts of interests related to this work.

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