McMaster University | HEALTH FORUM

Rapid Evidence Profile

Understanding the health-system context and evidence-support system assets for decision-making about the health and well-being of military personnel, Veterans and their families in the Five Eyes countries

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Context

- Defence and Veterans' affairs departments, as well as armed forces, are required to make many decisions related to the health and well-being of active and reserve military personnel, Veterans and their families.
- These decisions include, among others:
  - what programs, services and products are covered
  - how and where military personnel, Veterans and their families can access them
  - who delivers them
  - how the right programs, services and products get to those who need them.
- These decisions are made in a specific health-system context, ideally by leveraging key assets available in the evidence-support systems operating within and across the Five Eyes countries.
- Understanding the health-system context and evidence-support system assets in each of these countries is a first step in improving how evidence is used in improving the health and well-being of military personnel, Veterans and their families.

Questions

- How do features of the health system differ for military personnel, Veterans and their families across the Five Eyes (i.e., Australia, Canada, New Zealand, U.K. and U.S.)?
- What evidence-support system assets are available to inform decisions related to the health and well-being of military personnel, Veterans and their families in each of these countries?

High-level summary of key findings

- Across all Five Eyes countries, the national government (through their defence department) and armed forces oversee the health-system arrangements for military personnel, which includes the provision of healthcare services, supports for health-related military readiness, and health workforce training, as well as preparing medical standards and developing appropriate policies and procedures. The key responsible entities are Australia's Joint Health Command, Canadian Forces Health Services, New Zealand's Defence Health Services, U.K's Defence Medical Services, and the U.S. Defense Health Agency (within the U.S. Military Health System).
  - Similar categories of healthcare services – such as emergency, primary care, community and social services, preventive health and specialist care – are funded for active military personnel across the Five Eyes countries, with covered services typically itemized in countries like Canada (with Spectrum of Care) and the U.S. (with TRICARE) that operate with a health-insurance plan model for their civilian populations.
  - Most services are delivered by military personnel (or by military personnel working alongside civilian healthcare workers), in military-owned facilities and using military-procured infrastructure, including an electronic health record (EHR) specific to military personnel. Some countries have service contracts with a healthcare organization that is not part of the military.
  - Funding and delivery arrangements for reservists and for families may work similarly or differently than for military personnel.

- Additional details are available in the 'What we found' section for care by sector (e.g., primary care) and for priority conditions (e.g., mental health), treatments (e.g., prescription drugs) and populations (e.g., women and 2SLGBTQ+ individuals).

- In three of the Five Eyes countries the national government has a designated department that oversees Veterans' affairs (Australia, Canada and the U.S.), in one Veterans' affairs is a branch of the defence force (New Zealand), and in another Veterans' affairs is located within the Cabinet Office (U.K.). The entities for overseeing the health-system arrangements for Veterans are: 1) Australia's Department of Veterans' Affairs, with its own minister and assistant minister; 2) Veterans Affairs Canada with its own minister; 3) Veterans' Affairs New Zealand, one of four branches of the New Zealand Defence Force but with its own minister for Veterans; 4) the U.K. Office for Veterans' Affairs, which is an office within the Cabinet Office but with its own secretary of state (minister for veterans' affairs); and 5) the U.S. Veterans Health Administration (VHA), which is led by the under secretary for health and is part of the Department of Veterans Affairs (VA), which in turn is led by secretary of veterans affairs.
  - In three of the Five Eyes countries these entities primarily play a role as a funder of services for eligible Veterans (Australia, Canada and New Zealand) with non-funded services handled through civilian health systems, in one the entity relies primarily on the civilian health system (U.K.), and in another the entity oversees an integrated delivery system focused on Veterans (U.S.).
  - Healthcare funding and delivery arrangements for families are typically the same as for other civilians, although in Australia and New Zealand dependents may be eligible for some forms of healthcare coverage.
  - Additional details are available in the 'What we found' section for care by sector and for priority conditions, treatments and populations.

- One of the Five Eyes countries has a description of a military- and Veterans-focused evidence-support system (Canada), and another published a framework for putting evidence at the centre of government decision-making for Veterans' matters (U.K.).
  - We found nine sources of global evidence that can be drawn upon in providing timely, demand-driven evidence support, including key sources like the Continuum of Evidence (from the Clearinghouse for Military Family Readiness) and the VA Evidence Synthesis Program.

Box 1: Approach and supporting materials

We identified evidence addressing the question by searching Health Systems Evidence, Social Systems Evidence, and PubMed. All searches were conducted on 13 June 2023. The search strategies used are included in Appendix 1. We identified jurisdictional experiences by hand-searching government and stakeholder websites for information relevant to the question from each of the Five Eye countries (i.e., Australia, Canada, New Zealand, U.K. and U.S.).

In contrast to synthesis methods that provide an in-depth understanding of the evidence, this profile focuses on providing an overview of key insights from relevant documents.

We appraised the methodological quality of evidence syntheses that were deemed to be highly relevant using AMSTAR. AMSTAR rates overall quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality. The AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to evidence syntheses pertaining to delivery, financial or governance arrangements within health systems or to broader social systems.

A separate appendix document includes:
1) methodological details (Appendix 1)
2) details about each identified synthesis (Appendix 2)
3) jurisdictional scans about features of health systems for military personnel and their families in each of the Five Eyes countries (Appendix 3)
4) jurisdictional scans about features of health systems for Veterans and their families in each of the Five Eyes countries (Appendix 4)
5) sources of global evidence that can be drawn upon in providing timely, demand-driven evidence support (Appendix 5)
6) jurisdictional scans about evidence-support system assets that enable informed decisions related to the health and well-being of military personnel, Veterans and their families (Appendix 6)
7) documents that were excluded in the final stages of review (Appendix 7).

This rapid evidence profile was prepared in the equivalent of five days with a 'full-court' press' by all involved staff.

- We found few searchable sources of existing domestic evidence that can be rapidly drawn upon, perhaps because such sources have not been compiled in a way to make them easily retrievable or because searchable databases have not been made publicly available.
- We found several searchable sources of existing domestic recommendations that can be rapidly drawn upon, the most important being the U.S. clinical practice guidelines for military personnel and Veterans.
- We found many sources of domestic research studies and other types of information; however, they are typically not organized by form of evidence or recommendations, which makes them very difficult to use on short (e.g., one- to five-day) timelines.
- Additional details are available in the 'What we found' section.

- Note that key links from this document that may be helpful to those providing evidence support related to the health and well-being of military personnel, Veterans and their families have been made available on a dedicated webpage – Resources specific to military and Veterans – under the 'Find global evidence' tab on the McMaster Health Forum website.
- Note also that we welcome additions, corrections and updates to this document, particularly when publicly accessible webpages and reports can be linked to for those who want to learn more.

Frameworks to organize what we looked for

- Priority populations
  - Military personnel
  - Family members of military personnel
  - Veterans
  - Family members of Veterans
- Health-system features
  - Governance arrangements
  - Financial arrangements
  - Delivery arrangements
    - Workforce
    - Infrastructure
  - Sectors
    - Home and community care
    - Primary care
    - Specialty care
    - Rehabilitation
    - Long-term care
    - Public health
- Priority conditions
  - Chronic diseases
  - Chronic pain
  - Mental health and addictions
- Priority treatments
  - Prescription drugs
  - Devices and other assistive technologies
- Priority sub-populations
  - 2SLGBTQ+ (two spirit, lesbian, gay, bisexual, transgender, queer or questioning, and additional sexual orientations and gender identities)
  - Indigenous peoples
  - Women
- Evidence-support system assets

- Frameworks that guide evidence use, or, in their absence, structures and processes on the evidence-demand side to 1) incorporate evidence use into routine advisory and decision-making processes (enablers), 2) build and sustain an evidence culture and 3) strengthen capacity for evidence use
- Evidence-demand coordination mechanisms (including any priorities and priority-setting processes for evidence)
- Evidence-supply coordination mechanisms (including any 'general contractor' roles and contracting approaches, including performance standards)
- Evidence sources that can be drawn upon in providing timely, demand-driven evidence support, including: 1) global evidence; 2) domestic evidence; 3) domestic recommendations; 4) domestic research studies and other types of information (and units producing them, particularly timely, demand-driven evidence-support units); and 5) domestic research priorities and supports
  - Other sources drawn upon in providing timely, demand-driven support for decision-making, including: 1) complementary processes (e.g., jurisdictional scan, horizon scan, key-informant interviews and deliberative processes); 2) approaches to and standards for expert groups; 3) approaches to and standards for stakeholder and citizen engagement; 4) approaches to elicit people's lived experiences; and 5) approaches to incorporate Indigenous ways of knowing

What we found

We did not identify any highly relevant evidence syntheses but we did identify four evidence syntheses that we deemed to be moderately relevant. All evidence syntheses were from the U.S. and provided background information about the health systems for military personnel and Veterans, including:

- the use of pay-for-performance as a financial arrangement for Veterans care
- denial of coverage for Veterans
- the use of mental-health apps for Veterans
- the quality of care delivered in Veterans Affairs health facilities.

Key findings from a jurisdictional scan about how features of the health system differ for military personnel and their families across the Five Eyes

Governance, financial and delivery arrangements in health systems for military personnel and their families

Across all Five Eyes countries, the armed forces and national government (through their respective defence departments) oversee the health-system arrangements for military personnel, which includes the provision of healthcare services, supports for health-related military readiness and health workforce training, as well as preparing medical standards and developing appropriate policies and procedures. The key responsible entities are Australia's Joint Health Command, Canadian Forces Health Services, New Zealand's Defence Health Services, U.K's Defence Medical Services, and the U.S. Defense Health Agency (within the U.S. Military Health System).

Similar categories of healthcare services – such as emergency, primary care, community and social services, preventive health and specialist care – are funded for active military personnel across the Five Eyes countries, with covered services typically itemized in countries like Canada (with Spectrum of Care) and the U.S. (with TRICARE) that operate with a health-insurance plan model for their civilian populations. Most services are delivered by military personnel (or by military personnel working alongside civilian healthcare workers), in military-owned facilities and using military-procured infrastructure, including an electronic health record (EHR) specific to military personnel, such as in the U.S. under one of the TRICARE health plans and using the MHS GENESIS EHR (and its accompanying patient portal). Some countries have service contracts with a healthcare organization that is not part of the military. For example, Australia's Joint Health Command has a contract with Bupa Health Services to deliver healthcare to military personnel. The UK's Ministry of Defence is piloting a contract with NHS general practitioners to serve both a garrison and the local community.

Healthcare funding and delivery arrangements for reservists and for families may work similarly to or differently from military personnel. For example, in Canada, reservists may be eligible for the same healthcare services as military personnel depending on their class of reserve service and whether an injury or illness is attributable to the performance of duty, whereas families and ineligible reservists must access healthcare through their provincial or territorial health system. In Australia, ineligible reservists must access healthcare through their civilian health providers. In the U.K., families and reservists primarily access healthcare through the National Health Service. In the U.S., families and reservists can access the U.S. Family Health Plan or a TRICARE plan, much like how others living in the U.S. access employment-based insurance coverage directly or through a family member. Given the many nuances involved in care for reservists and families, we focus below on military personnel.

Care by sector

Home-care services can be provided for eligible military personnel, with the details of coverage varying by country (e.g., Canada and the U.S.). These services can include professional services (e.g., provided by nurses, occupational therapists and physiotherapists), personal support services (e.g., bathing and dressing support provided by a personal support worker) and homemaking services (e.g., cleaning and making meals). They can be delivered 'in quarters' or in a private residence.

Primary-care services can be obtained through entities with varying names, such as care-delivery units in Canada (staffed by both military and civilian healthcare workers) and Defence Health Centres in New Zealand, and with varying specificity of the most-responsible provider (e.g., primary-care managers in the U.S.). Primary-care services typically include dental care, and may include other services such as mental-health services. Same-day primary-care visits may be provided through a dedicated 'sick parade.' Primary-care services for rostered military personnel may be supplemented by helplines, such as the helplines in Australia, one of which is the telephone helpline called 1800 IMSICK. Military personnel are typically discouraged from accessing healthcare routinely from non-military primary-care organizations and other health organizations without approval or a referral.

Specialty-care services requiring hospitalization may be accessed through military-specific facilities where a critical mass of military personnel are serving (e.g., in large U.S. 'markets'), in a military-specific facility to which severely injured and ill military personnel are sent (e.g., Royal Centre Defence Medicine at the Queen Elizabeth Hospital Birmingham in the U.K.) or in a civilian facility (e.g., a private, not-for-profit hospital in Canada) that may or may not have specific beds set aside for military personnel. In addition, member countries of NATO work together to ensure sufficient speciality services are available to military personnel while deployed. Specialty-care services provided in an outpatient setting may be provided in military primary-care facilities (e.g., mental-health or occupational-medicine specialists working alongside primary-care providers), in military-specific secondary or tertiary facilities or in civilian secondary or tertiary facilities. Military specialists, such as those in the U.K., may hold joint appointments in civilian health systems to maintain their clinical skills and adhere to other professional requirements.

Rehabilitation care can be provided both in primary-care facilities (primary rehabilitation care) and in secondary- or tertiary-care facilities (which are often organized regionally), both for injuries and illnesses attributable to the performance of duty and for those that are not (e.g., conditions requiring general or orthopedic surgery, after which some form of rehabilitation is needed). Typically rehabilitation care continues to be covered as needed when an injury or illness is attributable to the performance of duty, with responsibility typically transferring from the armed forces to the Veterans-responsible entity if military personnel leave service (e.g., Australia).

Less information is publicly available about coverage for long-term care, presumably because those requiring it are likely to have transitioned to Veteran status. Stays in long-term care homes appear to be covered in both Canada and the U.K., and a long-term care insurance program is available for enrolment by U.S. military personnel (and Veterans).

For public health, military personnel typically benefit from the public-health programs available to the jurisdiction where they are based (e.g., health surveillance and population-based strategies for health protection, injury and disease prevention, and health promotion) and they are sometimes deployed in the context of such programs (e.g., emergency preparedness and response) or benefit from parallel programs (such as the Armed Forces Health Surveillance Division and more generally the Defence Health Agency's public-health centres and programs in the U.S.). Individually targeted services (as opposed to population-based strategies) for disease prevention and health promotion are often called 'force health protection' or 'medical force protection,' and in the case of the U.S. 'medical and dental care preventive care fitness' is one of eight dimensions of force fitness and nested within a population-health management approach.

Care for select priority conditions

Mental health is often featured as a priority condition on military health webpages, such as with Australia (with both programs and online resources), the U.K., and the U.S. (with the Psychological Health Center of Excellence and many resources targeting mental health and burn-out and the Defence Suicide Prevention Office and many resources targeting suicide prevention). Mental-health services may be available as part of primary care (and related helplines) as noted above, in stand-alone mental-health programs and through partnerships with the civilian health system (e.g., in the U.K. for in-patient mental-health services).

Chronic pain is also sometimes featured as a priority condition for which dedicated initiatives and extensive resources exist for military personnel, such as the Defense and Veterans Center for Integrative Pain Management and the main pain-management resources (including a pain-management toolkit) available to military personnel in the U.S. We were not able to find much information on how care is delivered for key chronic diseases.

Care using select treatments

Coverage of prescription drugs for military personnel is explicitly connected to an approved drug-benefit list in Canada and to an approved drug formulary in the U.S. (with higher cost-sharing for non-formulary drugs), whereas coverage follows the same eligibility rules for free prescriptions as the general population in the U.K. Eye glasses and contact lenses, hearing aids and other devices and assistive technologies may also be covered or partially covered, as they are in Canada and the U.S. (for vision care and durable medical devices).

Care for priority sub-populations

Women serving in the military, as well as conditions specific to women like pregnancy and experiences that are more common in women such as being affected by sexual misconduct, are sometimes a specific focus, such as in Canada (with the Women's Physical Wellness and Fitness Program and Sexual Misconduct Support and Resource Centre), the U.K. (with their pregnancy and maternity guidelines), and the U.S. (with women's health programs including well woman examinations and screenings, contraceptive care, pregnancy and reproductive health, and sexual trauma). For 2SLGBTQ+ individuals, specific programs are sometimes available, such as with the New Zealand Defence Force's Directorate of Diversity and Inclusion programs focusing on gender equality and LGBTTIQ+ (lesbian, gay, bisexual, transgender, takatāpui, intersex and queer/questioning, and other identities not captured in the letters of the acronym), such as OverWatch. Specific services may also be covered, such as TRICARE in the U.S. covering hormone therapy and mental-health services for individuals diagnosed with gender dysphoria. We found no publicly available information on healthcare services for Indigenous people serving in the military.

Key findings from a jurisdictional scan about how features of the health system differ for Veterans and their families across the Five Eyes

Governance, financial and delivery arrangements in health systems for Veterans and their families

In three of the Five Eyes countries the national government has a designated department that oversees Veterans' affairs (Australia, Canada and the U.S.), in one Veterans' affairs is a branch of the defence force (New Zealand), and in another Veterans' affairs is located within the Cabinet Office (U.K.). The entities for overseeing the health-system arrangements for Veterans are: 1) Australia's Department of Veterans' Affairs, with its own minister and assistant minister; 2) Veterans Affairs Canada with its own minister; 3) Veterans' Affairs New Zealand, one of four branches of the New Zealand Defence Force but with its own minister for Veterans; 4) the U.K. Office for Veterans' Affairs, which is an office within the Cabinet Office but with its own secretary of state (minister for Veterans' affairs); and 5) the U.S. Veterans Health Administration (VHA), which is led by the under secretary for health and is part of the Department of Veterans Affairs (VA), which in turn is led by secretary of Veterans affairs.

In three of the Five Eyes countries these entities primarily play a role as a funder of services for eligible Veterans (Australia, Canada and New Zealand) with non-funded services handled through civilian health systems, in one the entity relies primarily on the civilian health system (U.K.), and in another the entity oversees an integrated delivery system focused on Veterans (U.S.).

In Australia, funded healthcare services depend on whether Veterans and eligible family members hold a Veteran Gold Card (e.g., aged 70 and older and have qualifying service or receive disability compensation), Veteran White Card (e.g., have an accepted service-related injury or condition or have a mental health condition, cancer or pulmonary tuberculosis) or Veteran Orange Card (e.g., have qualifying service from the Second World War) and whether the healthcare provider accepts the card or, in some cases, is approved by the Department of Veterans' Affairs to accept the card for the service being sought.

In Canada, funded healthcare services depend on whether Veterans hold a Veterans Affairs Canada (VAC) health card, the requirements specific to any of the 14 'programs of choice' (11 of which are described in 'benefit grids' and with the other three including medical services, dental services and prescription drugs), and in some cases pre-authorization. Veterans who hold a VAC health card receive disability compensation or are eligible to receive homecare services to remain at home, long-term care payments or a war veteran's allowance. Service claims are processed through a contract with Medavie Blue Cross, and registered service providers can submit claims directly so patients do not have to pay out of pocket.

In New Zealand, funded healthcare services – grouped into treatment (e.g., physician visits, diagnostic X-rays and scans, and prescription drugs), mental health treatment and hearing aids – depend on qualifying service (and holding a treatment card) and having a condition related to qualifying service, and are typically accessed in the first instance through a family physician. Access to and coordination of services may be supported by a case manager.

In the U.K., Veterans access healthcare services directly through the National Health Service (NHS). The NHS supports a variety of specialty and other services as well, such as RESTORE (Veterans Physical Health and Wellbeing Service) to provide specialty care to Veterans who have physical health problems as a result of their service, as well as Op COURAGE (Veterans Mental Health and Wellbeing Service for Veterans and their families who have mental-health problems), and the NHS independently or in partnership with other entities supports Veterans living with a disability.

In the U.S., Veterans access healthcare services through the largest integrated health system in the U.S., with 172 VA medical centers and 1,138 VHA outpatient clinics – organized into 18 Veterans Integrated Service Networks – delivering care to over 9 million Veterans enrolled in the VA healthcare program. Veterans face different co-pay rates depending on the type of service and a variety of other factors, including disability, income, service record and priority group.

Healthcare funding and delivery arrangements for families are typically the same as for other civilians, although in countries like Australia and New Zealand, dependents may be eligible for some forms of healthcare coverage. Financial and other forms of support may be available for caregivers of Veterans, such as in the U.S..

Care by sector

Home-care services can be covered for Veterans – with the details of coverage varying by country (e.g., Australia with an array of home-care services, Canada with 'programs of choice' that include nursing services and aids for daily living, and the U.S. with its 'home healthcare' program) – or provided through the civilian health system. These services may be complemented by community-based services (e.g., U.S. Vet Centers that provide counselling) and housing support (e.g., accommodation, including assisted-living facilities, in Australia).

Primary-care services are typically obtained through civilian family physicians, with fees from Australian general practitioners (GPs) typically covered for Veteran Gold Card and Veteran White Card holders, fees linked to a disability benefit covered in Canada by another 'program of choice' (medical services), fees from New Zealand GPs typically covered for service-related conditions, no fees for U.K. GPs just as for civilians seeking care in the National Health Service, and subsidized fees from U.S. VA community-based outpatient clinics (with co-pays covered by Veterans). In Australia, all Veterans are eligible for a free one-off or annual Veterans' Health Check. In the U.K., GPs can note Veteran status in the medical record (to help with referrals to specialist Veteran healthcare services if needed) and some family practices are considered 'Veteran-friendly' GP surgeries. In the U.S., Veterans can access home-based primary care when needed.

Specialty-care services requiring hospitalization may be accessed in the U.S. through Veteran-specific facilities (VA medical centers) where a critical mass of Veterans are located, and in other Five Eyes countries typically through civilian facilities (e.g., a private, not-for-profit hospital in Canada and NHS hospitals in the U.K.). Specialty outpatient services are typically funded similarly to primary-care services.

Rehabilitation services (e.g., medical, physical, occupational and social) can be provided at the primary-care level (e.g., allied health treatment cycles in Australia and 'related health services' in Canada) and at secondary- and tertiary-care facilities levels (e.g., inpatient rehabilitation for complex trauma). More extensive coverage typically applies to those with a service-related disability (e.g., Canada). The U.K. has many NHS, Ministry of Defence and charity services (including Disablement Service Centres) dedicated to providing support and treatment to Veterans with disabilities. The U.S. has a VA Rehabilitation and Prosthetic Services area focusing specifically on rehabilitation.

Coverage for long-term care is highly variable, with some assistance in accessing residential aged-care facilities available in Australia, some financial support for long-term care homes available in Canada, for care homes in the U.K., and for nursing homes in the U.S.. As noted in the section about care for military personnel, a long-term care insurance program is available for enrolment by U.S. Veterans.

For public health, military personnel typically benefit from the public-health programs available to the jurisdiction where they are based.

Care for select priority conditions

Mental health is often featured as a priority condition – with an array of targeted supports available – on Veteran health webpages, such as with Australia (which includes Open Arms for Veterans and family counselling), Canada, the U.K. (which includes Op COURAGE as described above) and the U.S.. Specific coverage provisions are typically in place for mental health, such as in Australia, Canada and New Zealand. Suicide is a focus of Australia's Royal Commission into Defence and Veteran Suicide.

Chronic pain is sometimes featured as a priority condition for which dedicated initiatives and extensive resources exist for Veterans, such as in the U.S.. A list of interdisciplinary pain-management clinics is maintained by the Michael G. DeGroote Institute for Pain Research and Care.

We were not able to find much information on how care is delivered for key chronic diseases.

Care using select treatments

Coverage of prescription drugs for Veterans is explicitly connected to an approved drug formulary in Canada, New Zealand and U.S., whereas coverage follows the same eligibility rules for free prescriptions as the general population in the U.K. Eye glasses and contact lenses, hearing aids and other devices and assistive technologies may also be covered or partially covered, as they are in Australia, Canada, New Zealand and U.S..

Care for priority sub-populations

Women's health is less frequently featured as a priority on Veteran health webpages. U.S. Veterans have access to Women's Health Clinics, U.K. women who experienced sexual trauma or harassment while serving in the military can access support from Salute Her UK, and Australian Veterans may see healthcare improvements arising from the Department of Veterans' Affairs gender equity action plan.

For 2SLGBTQ+ individuals, specific programs are sometimes available, such as a hotline in Canada for those with unreported service-related injuries and special programming in the U.S..

Key findings about evidence-support system assets available within the Five Eyes to inform decisions related to the health and well-being of military personnel, Veterans and their families

We found a description of a military- and Veterans-focused evidence-support system for only one of the Five Eyes countries (Canada), which include enablers, culture and capacity considerations on the evidence-demand side, evidence-coordination mechanisms at the interface between the demand and supply side, and evidence sources that can be drawn upon in providing timely, demand-driven evidence support. We found a framework for putting evidence at the centre of government decision-making for Veterans' matters in a second country (U.K.), which supports alignment between evidence and policy and the coordination of the research agenda, knowledge mobilization and partnerships (within the U.K. and beyond) to reduce duplication and streamline evidence-support efforts. Note that we did not include in the assets below ones that were specific to COVID-19.

We found nine sources of **global evidence** that can be drawn upon in providing timely, demand-driven evidence support.

Sources of global evidence	Scope (jurisdictional and/or substantive)	Focus (military personnel, Veterans and families)
Continuum of Evidence (from the Clearinghouse for Military Family Readiness) – 'level' of evidence available about program effectiveness	U.S. lens	Families
VA Evidence Synthesis Program – evidence syntheses prepared to support VA leaders (with a separate tab for ones in progress)	U.S. lens	Veterans
McMaster Health Forum – evidence syntheses prepared in response to requests from DND and VAC	Canada lens	Use filter for military and Veterans (as a topic of interest)

ACCESSSS – evidence syntheses meeting minimum quality criteria (when the 'review' filter is applied)	Clinical programs, services and products	Add search terms to limit to military or Veterans
Health Evidence – evidence syntheses with a quality appraisal	Public-health programs and services	Add search terms to limit to military or Veterans
Health Systems Evidence (HSE) – evidence syntheses with a quality appraisal and 'best' filter	Health-system arrangements and implementation strategies	Use filter for military and Veterans (as a population of interest)
Social Systems Evidence – same as HSE	Sectors other than health	Same as HSE (and note that 'Military' is also a filter under 'Public safety and justice')
Evidence Aid – evidence syntheses	Humanitarian emergencies	Add search terms to limit to military or Veterans (little available)
PubMed – evidence syntheses (when the 'systematic review' filter is applied after running a search)	Health	Add search terms to limit to military or Veterans

We found few searchable sources of existing **domestic evidence** that can be rapidly drawn upon, perhaps because such sources have not been compiled in a way to make them easily retrievable or because searchable databases have not been made publicly available.

Sources of domestic evidence, by form of evidence and jurisdiction	**Focus (military personnel, Veterans and families)**
Data analytics	
• Australia – Australian Defence Force – Data analytics related to service, which draws on the Defence census	Military
• U.S. – Veterans Affairs – National Center for Veterans Analysis and Statistics, many reports from which are available at VA Open Data	Veterans
• U.S. – Veterans Affairs – VA Information Resource Center (to support those engaged in data analytics)	Veterans
Modeling	
• None identified with a focus on health	
Evaluation	
• Armed Forces Covenant Trust Fund – Evaluations of programs it has funded, some of which pertain to health and well-being	Military
Behavioural/implementation research	
• U.S. – Department of Defence – Implementation Science Branch (no searchable content)	Military
• U.S. – Veterans Affairs – Quality Enhancement Research Initiative (QUERI and its network of centres; no searchable content)	Veterans
Qualitative insights	
• None identified with a focus on health (for research studies that may include qualitative designs, see below)	

We found several searchable sources of existing **domestic recommendations** that can be rapidly drawn upon, only one of which specifically targets military personnel and Veterans.

Sources of domestic recommendations, by form of evidence and jurisdiction	Focus (military personnel, Veterans and families)
Guidelines	
• Canada – Canadian Armed Forces' members provide input to immunization recommendations and travel-related health advice	All citizens
• U.K. – National Institute for Health and Care Excellence (NICE) provides guidance, advance and quality standards about health and social care	All citizens
• U.S. – Veterans Affairs and Department of Defence – Clinical practice guidelines	Military and Veterans
• NATO – Medical Intelligence Expert Panel (no link found)	Military
Health technology assessments	
• Australia – Four groups undertaking health-technology assessments, include Therapeutic Goods Administration, Medical Services Advisory Committee, Pharmaceutical Benefits Advisory Committee, and Prostheses List Advisory Committee (however, there is no searchable database of all health technology assessments)	All citizens
• Canada – Canadian Agency for Drugs and Technologies in Health (sometimes turned to by the Canadian Armed Forces and Veterans Affairs Canada)	All citizens
• U.K. – See NICE above	

We found many sources of **domestic research studies and other types of information**, but they are typically not organized by form of evidence or recommendations, which makes them very difficult to use on short (e.g., one- to five-day) timelines.

Sources of domestic research studies and other types of information, by jurisdiction	Focus (military personnel, Veterans and families)
Australia – Department of Defence – Military Health Outcomes Program	Military
Australia – Department of Defence – Mental Health Research and Evaluation	Military
Australia – Department of Veterans' Affairs – Health and social research studies	Veterans and their families
Australia – Australian Military Medicine Association – Journal articles	Military, Veterans and their families
Canada – Canadian Institute for Military and Veterans Health Research – 'Heat map' of primary studies (no link found)	Military, Veterans and their families
Canada – Defence Research and Development Canada – Research reports (with most focus on innovations, not evidence ready for application)	Military
Canada – Veterans Affairs Canada funded centres • Atlas Institute for Veterans and Families – Knowledge hub • Canadian Institute for Military and Veteran Health Research (CIMVHR) – Reports, journal and stakeholder reports • Chronic Pain Centre for Excellence for Canadian Veterans – Publications	Military, Veterans and their families
U.K. – Forces in Mind Trust (FiMT) Research Centre – Knowledge repository	Veterans and their families

U.K. – King's Centre for Military Health Research – Publications	Military, Veterans and their families
U.K. – National Institute of Health Research – Policy research units	All citizens (health policy research)
U.S. – Veterans Affairs (VA) Health Services Research and Development – Studies and implementation projects (undertaken by VA HSR&D centres)	Veterans (health services research)
U.S. – Veterans Affairs (VA) Office of Research and Development – Cooperative studies program focused on large, multi-centre evaluations (e.g., randomized controlled trials)	
U.S. – VA Health Services Research and Development – Funded research consortia focused on key priorities (access, pain/opioids, suicide prevention, virtual care)	Veterans (health services research)
U.S. – VA Mental Illness Research, Education and Clinical Centers and Centers of Excellence – Education and clinical products (undertaken by MIRECCs/CoEs)	Veterans (mental health)
Five Eyes – Five Eyes International Collaboration – Focus on mental-health research publications	Military and Veterans
NATO Centre of Excellence for Military Medicine – Medical Knowledge Management Portal (requires approval for registration)	Military

We found many sources of **domestic research priorities, as well as supports to those engaged in conducting research**, but these are typically not useful to those seeking existing evidence to draw upon in supporting advisory and decision-making processes on short timelines.

Sources of domestic research priorities and supports, by jurisdiction	Focus (military personnel, Veterans and families)
Australia – Joint Health Command, Department of Defence – Health Research Framework will describe its approach military health research (under development)	Military personnel
Australia – Department of Defence – Australian Defence Science and Universities Network connects the department with researchers	Military personnel
Australia – Department of Veterans' Affairs – Strategic research framework provides principles, objectives and priorities for research	Veterans
Australia – Department of Veterans' Affairs – Applied research program procures research for the department	Veterans
Australia – Departments of Defence and Veterans' Affairs – Military and Veteran Research Study Roll enables researchers to get in touch with military personnel and Veterans about becoming involved in research	Military personnel and Veterans
New Zealand – Veterans' Affairs New Zealand – Veterans' Medical Research Trust Fund supports research relevant to Veterans' health according to eight guiding principles	Veterans
U.K. – Ministry of Defence – List of areas of research interest, some of which touch on health and well-being (which is part of a cross-government effort to elicit department-level areas of research interest)	Military personnel
U.K. – Office for Veterans' Affairs – Data and research framework sets out the office's plan to put evidence at the heart of government decision-making on Veterans' matters (note that this framework was also described in the introduction to this section)	Veterans
U.K. – Office for Veterans' Affairs – Veterans' Strategy Action Plan notes that a Health Innovation Fund will be used to fund research to better meet Veterans' healthcare needs	Veterans
U.S. – Department of Defence – Military health system research grant program, including a list of priority topic areas	Military personnel

U.S. – Veterans Affairs – Strategic priorities for research, some of which are focused on Veterans' health and well-being	Veterans
U.S. – VA Health Services Research & Development – Toolkit for Veteran engagement in research	Veterans

We found no information about other military- and Veteran-specific sources drawn upon in providing timely, demand-driven support for decision-making, including about complementary processes (e.g., jurisdictional scan, horizon scan, key-informant interviews and deliberative processes), approaches to and standards for expert groups, approaches to and standards for stakeholder and citizen engagement, approaches to elicit people's lived experiences, or approaches to incorporate Indigenous ways of knowing.

Waddell K, Wilson MG, Bhuiya A, Bain T, Alam S, Sharma K, Phelps A, Chen K, DeMaio P, Ali A, Kahn Z, Lavis JN. Rapid evidence profile #52: Understanding the health-system context and evidence-support system assets for decision-making about the health and well-being of military personnel, Veterans and their families in the Five Eyes countries, 4 August 2023.

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