



The effect of race and birth cohort on the veteran mortality differential



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ABSTRACT

Research on veteran versus nonveteran mortality outcomes provides contrary results, with some studies reporting a veteran mortality advantage while others report a veteran mortality disadvantage. Life course scholars suggest these conflicting results may be explained by a crossover in the veteran–nonveteran mortality differential, with veterans having a mortality advantage during early and midlife and a mortality disadvantage during older age. We conducted discrete time hazard analysis of a veteran–nonveteran mortality crossover among black and white men in the United States by birth cohort using data from the 1986–2009(2011) National Health Interview Survey-Linked Mortality Files. Among men who turned age 18 during non-war eras, veterans had an early to midlife mortality advantage and later life mortality disadvantage, with differences more pronounced among black men. However, differences between veteran and nonveteran mortality risk were not significant among the majority of men who turned age 18 during war eras. Findings clarify that the mortality related benefits of military service may only apply to veterans who came of age during non-war eras. Furthermore, results suggest that military service may provide a greater mortality benefit to black veterans than white veterans.

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Competing factors appear to influence health outcomes for military veterans. On one hand, recruits are screened for health problems upon entry into the military and may gain a socioeconomic boost as a result of their subsequent military service. In turn, military personnel are likely healthier at younger ages and have access to needed health care as they grow older. On the other hand, military personnel often are exposed to service related hazards not encountered by non-military personnel. The physical and mental hazards experienced during war and peacetime can both directly and indirectly lead to poorer health outcomes. Based on an understanding of these competing influences on health, it is reasonable to think that veterans and nonveterans will have different mortality risk across the life course.

In this study, we use nationally representative data to examine the veteran mortality differential among U.S. males. Informed by research on veteran health and mortality across the life course, we predict a distinct veteran–nonveteran mortality crossover, with veterans having lower mortality risk earlier in life, and higher mortality risk later in life. However, we argue that differences in veteran–nonveteran mortality will vary by birth cohort and race.

1. Background

Life course scholars suggest that differences between veteran and nonveteran morbidity and mortality may result from the positive and negative health effects of military service, and aspects of age-related timing of health exposures and outcomes for veterans (MacLean, 2013; Wilmoth et al., 2010). On the positive side, military veterans may be healthier than those in the general population due to a selection effect, and due to the improved socioeconomic standing afforded through post-service veteran benefits. The selection effect, termed the “healthy soldier effect,” refers to the practice of the military pre-screening recruits for health problems, likely resulting in active military personnel and military veterans having better health than the general population (McLaughlin et al., 2008; Waller and McGuire, 2011; Wilmoth et al., 2010).

The prospect of improved socioeconomic standing for veterans post-military service results from personal and socioeconomic benefits garnered from military service, as well employer perception of job related skills acquired during military service. Beginning in 1944 veterans have been afforded increased vocational and postsecondary educational opportunities through the GI Bill (Altschuler and Blumin, 2009). In addition, those who served in the military have access to the Veterans Health Care system for medical mental health care post-military service (T. W. Miller, 2012). As a

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result, veterans often have increased educational achievement, employment and related earned income, marital stability, and access to health care (Angrist, 1998; Elder, 1986; MacLean & Glen H. Elder, 2007; Sampson and Laub, 1996; Teachman, 2009; Teachman and Tedrow, 2004; Xie, 1992). Military personnel also gain valuable experience during service that can lead to greater self-efficacy, increased competence, discipline and job-related skills that are viewed favorably in the civilian employment sector (Elder, 1986; Sharp and Krasnesor, 1968). Due to this training, employers may give preference to hiring veterans based upon the perception that they can be productive in a bureaucratic structure (De Tray, 1982; Villemez and Kasarda, 1976; Xie, 1992).

Each of the socioeconomic benefits afforded veterans is recognized as being closely linked with better health outcomes that can lead to reduced mortality risk (Link and Phelan, 1995; Lutfey and Freese, 2005; Phelan et al., 2004; Wilper et al., 2009). It would seem reasonable to think that the selection of healthy individuals for military service, and improved socioeconomic benefits of veterans would translate into better health and lower mortality risk. Although not delineating the influence of a healthy soldier effect or improved socioeconomic standing on mortality outcomes, multiple studies report that service members and veterans have lower mortality risk than their peers in the general population (Adena et al., 1985; Dalager and Kang, 1997; Kang and Bullman, 1996; McLaughlin et al., 2008; Rothberg et al., 1990; Wilson et al., 2005).

On the negative side, military veterans may have poorer mid to late life health than the general population. This poorer mid to late life health is due to the hazards they encounter during their military service and negative health behaviors developed during military service that continue into their post-military lives (MacLean, 2013; Wilmoth et al., 2010). During military service, soldiers can be exposed to hazardous situations that result in injury and/or long-term mental and physical health problems during training or during combat (Elder and Clipp, 1989; Elder et al., 1997; Hoge et al., 2004; T. C. Smith et al., 2011; Wilmoth et al., 2010). In addition, service members may develop detrimental health behaviors that continue post-service, such as smoking or substance abuse (Bedard and Deschênes, 2006a; Clipp and Elder, 1996; Elder and Clipp, 1989; Landes et al., 2017, Forthcoming; McKinney et al., 1997). Each of these negative health outcomes of military service may result in increased mortality risk for veterans across the life course.

Due to the cumulative effect of co-morbidities and negative health behaviors, increased mortality risk for veterans is more likely to manifest in later life (London and Wilmoth, 2006; MacLean, 2013; Wilmoth et al., 2010). This is especially true for veterans who served during a war era. Compared to veterans who served during a non-war era, war era veterans typically experienced increased levels of stress and/or injury during their military service, tend to have more health problems due to physical or psychological injury incurred during service, and are more likely to be current or former smokers (Bedard and Deschênes, 2006b; Elder and Clipp, 1989; Elder et al., 2009; Landes et al., 2017, Forthcoming; Ren et al., 1999; Wilmoth et al., 2010). By the time veterans reach older age, the cumulative effect of co-morbidities and increased smoking behavior can result in poorer health outcomes (Kramarow and Pastor, 2012; Wilmoth et al., 2010). In turn, while younger veterans may have lower mortality risk than nonveterans, Waller and McGuire (2011) found that this benefit can fade over time. Limited evidence also suggests that older veterans have similar to higher mortality risk than nonveterans (London and Wilmoth, 2006), and that this mortality disadvantage grows with age (Liu et al., 2005). Though not empirically demonstrated to date, these findings suggest that there may be a crossover in the veteran mortality differential (Liu et al., 2005; Wilmoth et al., 2015). As with other mortality crossovers, this would entail younger veterans

having lower mortality risk than nonveterans, mortality risk among veterans and nonveterans converging at some point in later life, then veterans developing higher mortality risk than nonveterans with increased age (Nam, 1995).

Though findings from prior studies are not conclusive, based upon a life course perspective that veterans likely have better early life health outcomes than nonveterans but poorer later life health outcomes, we test the following hypotheses:

Hypothesis 1. There will be a distinct crossover in the veteran mortality differential, as compared to nonveterans, veterans will have a mortality advantage in early to mid-life, but a mortality disadvantage in later life.

Hypothesis 2. The early life veteran mortality advantage will be more pronounced for those who came of age during a non-war era as compared to those who came of age during a war era.

1.1. Differences by race

Scholars note the impact of race-based prejudice and discrimination upon minorities in the United States, particularly black Americans (Bonilla-Silva, 2006; Du Bois, [1903] 2007; Feagin, 2010). As Feagin explains, “being black in U.S. society means always having to be prepared for anti-black actions from whites—in most places and at many times of the day, week, month, or year. Being black means ... living with various types of racial discrimination from the cradle to the grave” (Feagin, 2010, 187). In fact, the cumulative impact of racism shapes many aspects of life for black Americans throughout the life course, including socioeconomic opportunity and status (Farley, 1984, 1988; Grodsky and Pager, 2001). It is widely accepted that these cultural dynamics of racial discrimination—in conjunction with class status—have a negative effect on health outcomes and mortality (Gee et al., 2012; Hummer, 1996; Krieger, 2000). Within the context of the current study, it is plausible that military service reduces mortality risk for black men, possibly by mitigating socioeconomic racial inequalities post-military service through an employment advantage.

There is germinal empirical evidence that the veteran mortality differential may vary by race. In a study of US Army military personnel, Rothberg et al. (1990) found that while all service members had lower mortality rates than the general population, this difference was most stark among black men. Black men in the Army in 1986 were 5.6 times less likely to die from disease, and 11.1 times less likely to experience death by homicide than black men in the general population. In comparison, white men in the Army in 1986 were 2.7 times less likely to die from disease, and 3.1 times less likely to die from homicide than white men in the general population. Further adding evidence to possible racial differences in the veteran mortality differential, London and Wilmoth (2006) report on analysis of HRS and AHEAD data that white veterans had a higher mortality risk than white nonveterans, but black veterans had a lower mortality risk than black nonveterans. Findings from these two studies lend credence to the argument that the socioeconomic benefits afforded to military veterans may have a more advantageous effect for black veterans than white veterans, especially during the years following military service (Xie, 1992), but also stretching across the life course (Fredland and Little, 1984; I. Smith et al., 2012; Teachman, 2007; Teachman and Tedrow, 2004).

While not possible to pinpoint the exact mechanism informing the differential in the effect of military experience on mortality outcomes, one possible mechanism is through employment experiences post-military service. Research on social determinants of health details that improved employment opportunities and

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