Chapter 28
Aging Veterans: Needs and Provisions

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Current knowledge about aging is primarily based on cohorts that were born during the early part of the twentieth century. A substantial percentage of men in these cohorts, and subsequent cohorts who are currently middle aged, served in the military during war, peace, Cold War, or some combination thereof. Consequently, veterans are a sizeable demographic group in the United States. In 2000, over 26 million Americans were veterans, representing approximately 12.7% of those aged 18 years or older (U.S. Census Bureau 2003). Military service is particularly prevalent among older cohorts who served in World War II (WWII) and the Korean War (Hogan 1981); almost 9.2 million men age 65 years and older were veterans in 2000, which represents 64% of men in this age group (Interagency Forum on Aging-Related Statistics 2008). In addition, participation in the military has increased substantially among women; in 2000, nearly 1.6 million American women were veterans (U.S. Census Bureau 2003).

Military service and war are persistent features of Americans' lives. Because of the high prevalence of military service among men who were young adults during World War I (WWI), World War II (WWII), and the Korean War and the necessary concentration on these cohorts in earlier, large-scale data collection efforts that focus on aging Americans, Settersten and Patterson (2007:5) have argued that "...wartime experiences may be important but largely invisible factors underneath contemporary knowledge about aging." We contend that the role of military service in shaping age-related outcomes has more generally been under-acknowledged in gerontological research on men, as well as women who sometimes served in the military service roles that were made available to them historically, but more often lived their lives linked to men who served in the military. At the same time, the seminal work of Glen H. Elder, Jr. and his colleagues on the lives of the children of the Great Depression, who primarily served during WWII, has elucidated the impact of military service on men's lives, while also providing strong theoretical foundations for life-course scholars to use in studies of the effects of military service on the lives of men, women, and children.

In this chapter, we discuss the extant research that has used life-course perspectives to examine military service, paying particular attention to the theoretical contributions of this work to broader life-course studies. We argue that this area of research is unique in its careful articulation of within- and between-cohort variation, and then use that approach to discuss the characteristics of current and future aging veterans. We also consider the needs of and provisions to aging veterans by focusing on current patterns of benefit and service use, and linking this discussion to how needs for benefits and services may change as younger veterans with different historical experiences and demographic characteristics age. We are careful to distinguish between the needs and provisions

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that are rooted in general aging processes and those that are unique to the experiences of particular veteran cohorts. The chapter concludes with a discussion of the types of theoretical and empirical work that are necessary to understand the changing role of military service in the life course.

Life-Course Studies on Military Service

Over the past 30 years, a growing body of research has drawn on life-course perspectives to investigate the influence of military service on various life-course trajectories and outcomes. This research has demonstrated that the U.S. military is a critical social institution that can (re)shape educational, occupational, income, marital/family, health, and other life-course trajectories (London and Wilmoth 2006; MacLean and Elder 2007; Mettler 2005; Modell and Haggerty 1991; Settersten 2006). Life-course researchers who have addressed questions related to military service recognize that the military has the potential to transform the lives of those who serve in it for better or worse, but also that the transformative potential of the military varies across individual characteristics, the timing of military service in the life course, service experiences, and historical periods (Angrist 1990; Angrist and Krueger 1994; Gimbel and Booth 1994, 1996; Teachman and Call 1996; Teachman 2004, 2005; Teachman and Tedrow 2004). These insights serve as the foundation for much theorizing about how military service (re)shapes life course outcomes, as well as empirical life-course studies that have examined the role of military service in men's and, to a lesser extent, women's lives. This body of exemplary life-course research aims, in the words of Modell and Haggerty (1991) "to connect the micro- and macro-levels of analysis, thus connecting the soldier's story to that of his *[or her]* changing society" (p. 205).

Studying the role of military service in the life course provides researchers with an amazingly rich opportunity to investigate each of the five major principles of the life-course paradigm: human agency; location in time and place; timing; linked lives; and lifelong development (Elder and Johnson 2002; Giele and Elder 1998). Glen H. Elder, Jr. is responsible for the most-influential, early theorizing about the role of military service in the life course (Elder 1986, 1987) and, with a range of colleagues, for demonstrating the importance of military service for life-course studies (Clipp and Elder 1996; Dechter and Elder 2004; Elder and Bailey 1988; Elder and Clipp 1988, 1989; Elder et al. 1991; 1994, 1997; Pavalko and Elder 1990). This seminal body of research articulates each of the five principles of the life-course paradigm and, by focusing on the timing of military service in the life course, motivates and interrogates two corollary hypotheses that have wide-reaching implications for life-course scholarship: the military as turning point and the life-course disruption hypotheses.

The *military as turning point hypothesis* focuses on young age at entry into the military because it maximizes the chances for redirection of the life course and minimizes disruption to established life-course trajectories. Elder (1987) argues that early entry into the military represents a social and psychological moratorium, which both delays the transition to adulthood and allows for the maximal utilization of service benefits. Early entry may reflect selection of the most disadvantaged, who see military service as a route out of difficult life circumstances. While this would suggest that early entrants would have worse life-course trajectories and outcomes, it is theorized that they are precisely the persons who may benefit most from the range of benefits and services available to veterans. The *life-course disruption hypothesis* is a corollary hypothesis, which posits that relatively late entry into the military has the potential to disrupt established marital, parenting, and occupational trajectories, which may have consequences for the subsequent patterning of the life course and later-life outcomes. Later entrants often come from more advantaged backgrounds and may have already completed their educations. Because of the timing of military service in their lives, later entrants have less opportunity to take advantage of educational benefits for veterans. Consequently, the gains that accrue to more disadvantaged, earlier entrants through access to G.I. Bill educational benefits may not materialize to the same degree or with the same effects in their lives. The psychological

effects of military service, especially, but not exclusively, among veterans who have experienced combat, may intersect with disrupted occupational roles in ways that increase strains within families and influence the risk of marriage and family disruption.

Both of these hypotheses emphasize the potential of military service to produce discontinuity in the life course and remind life-course scholars of how participating in social institutions during young adulthood is influenced by and influences the process of cumulative inequality. In that regard, Elder's work laid a theoretical foundation for understanding the role of other institutions, including education, criminal justice, marriage, and family, in shaping life-course outcomes. His work has also spurred other scholars to elaborate the role of military service in the lives of cohorts who served during different historical time periods. This work is concerned with specifying between-cohort variation in employment, earnings, marital, and health outcomes and emphasizing within-cohort variation in experience based on gender and race/ethnicity, and to a lesser extent, sexual orientation.

Characteristics of Aging Veterans

Before turning to a discussion of the needs of aging veterans and the provisions available to them, we now provide a portrait of the current population of older veterans and how this population is projected to change between now and 2030. We believe that it is essential to ground a discussion of needs and provisions within a life-course perspective that takes historical context and individual characteristics into account.

2010

As shown in Fig. 28.1, in 2010, 4% of 25–44 year olds, 11% of 45–64 year olds, and 23% of adults aged 65 and older are veterans. The total number of veterans by age group and period of service is given in Table 28.1, which indicates that the current number of veterans increases from approximately 4.1 million for the 25–45 age group to over 9 million for both the 45–64 year old and 65 year or older age groups. The youngest group served primarily during the ongoing Gulf War: with the largest among them serving prior to 9/30/2001 (48%). The middle-aged group served primarily during the Vietnam Era (53%) or between the Vietnam Era and the Gulf War period (32%).

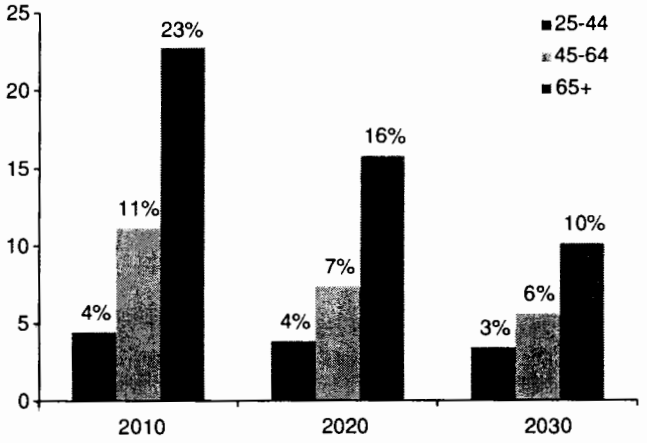

Fig. 28.1 Projected percent of veterans in the total U.S. population by age, 2010, 2020, 2030 (Authors' calculations based on VetPop2007 data (U.S. Department of Veteran Affairs 2008))

Table 28.1 Projected number and percent of veterans by age and period of service

	25–44 Years		45–64 Years		65+ Years	
	Number	%	Number	%	Number	%
2010						
World War II (WWII)	0		0		1,981,216	21.61
Pre-Korean War	0		0		115,440	1.26
Korean War	0		0		2,228,333	24.31
Between Korean War and Vietnam Era	0		17,593	0.19	2,247,980	24.52
Vietnam Era	0		4,756,230	52.59	2,515,536	27.44
Between Vietnam Era and Gulf War	455,173	11.00	2,889,455	31.95	66,683	0.73
Gulf War (Pre-9/30/2001)	1,990,312	48.09	962,681	10.64	9,884	0.11
Gulf War (Post-9/30/2001)	1,692,761	40.90	417,827	4.62	1,209	0.01
Post-Gulf War	761	0.02	0	0.00	0	0.00
Total	4,139,006	100	9,043,786	100	9,166,281	100
2020						
World War II (WWII)	0		0		269,721	3.11
Pre-Korean War	0		0		33,259	0.38
Korean War	0		0		804,947	9.28
Between Korean War and Vietnam Era	0		0		1,311,460	15.12
Vietnam Era	0		173,818	2.79	5,531,833	63.79
Between Vietnam Era and Gulf War	0		2,699,361	43.27	507,485	5.85
Gulf War (Pre-9/30/2001)	409,960	11.86	2,284,136	36.62	165,895	1.91
Gulf War (Post-9/30/2001)	2,080,399	60.18	1,079,714	17.31	47,441	0.55
Post-Gulf War	966,617	27.96	1,051	0	4	0.00
Total	3,456,976	100	6,238,080	100	8,672,045	100
2030						
World War II (WWII)	0		0		7,636	0.10
Pre-Korean War	0		0		3,087	0.04
Korean War	0		0		95,708	1.31
Between Korean War and Vietnam Era	0		0		388,026	5.31
Vietnam Era	0		0		3,341,176	45.70
Between Vietnam Era and Gulf War	0		417,839	8.86	2,313,522	31.64
Gulf War (Pre-9/30/2001)	0	0.00	1,865,246	39.53	756,667	10.35
Gulf War (Post-9/30/2001)	627,962	19.32	2,368,375	50.19	405,007	5.54
Post-Gulf War	2,622,466	80.68	67,065	1.42	169	0.00
Total	3,250,428	100	4,718,526	100	7,310,999	100

Source: Authors' calculations based on VetPop2007 data (U.S. Department of Veteran Affairs 2008). Percentages may not add to exactly 100% due to rounding error.

Notes: The VetPop2007 data draws information from the Census Bureau, the Defense Manpower Data Center, and the Department of Defense's Office of Actuary GORGO data.

Veterans are assigned to the period of war in which they first served. For example, a veteran who served in World War II (WWII) and the Korean War is assigned to World War II. (WWII) Similarly, a veteran from the Pre-9/30/2001 stage of the Gulf War may or may not have continued on to serve in the Post-9/30/2001 stage of the Gulf War.

The dates associated with the periods of service are as follows:

World War II (WWII)– September 1941 to July 1947;

Pre-Korean War – August 1947 to May 1950;

Korean War – June 1950 to January 1955;

Between Korean War and the Vietnam Era – February 1955 to July 1964;

Vietnam Era – August 1964 to April 1975;

Between Vietnam Era and Gulf War – May 1975 to July 1990;

Gulf War – August 1990 through a date to be prescribed by Presidential proclamation or law

Post-Gulf War – Hypothetical period of service after the Gulf War has ended, based on assumptions regarding continued stable enlistment rates.

The oldest group contains a mix of veterans who served in various mid-twentieth century wars prior to the establishment of the All-Volunteer Force (AVF) at the end of conscription in 1973. Among this group, the oldest-old, whose members are in their 80s, served in WWII (22%); the next oldest subgroup, whose member are at least 68 years old, served during Korea (24%) or between Korea and Vietnam (25%); and the youngest subgroup, whose member are mostly in their mid- to late-60s, served in Vietnam (28%).

Table 28.2, which presents the age, sex, and race/ethnicity distribution of veterans by time period, shows that the overwhelming majority of these older veterans are white men (86%). This reflects the gender and racial/ethnic composition of veterans who served during the pre-AVF era (see Lutz 2008 for a detailed review of historical changes in the racial/ethnic characteristics of those serving in the U.S. military). Despite their underrepresentation in terms of percentages, a substantial number of racial and ethnic minorities served in the military during the first half of the twentieth century. For example, it is estimated that over one million African Americans and one-half million Hispanics served in WWII (Lutz 2008; Allsup 1982). Research suggests that serving in the military during this time period profoundly affected the identities and lives of these veterans, and that their

Table 28.2 Projected number and percent of veterans by age, sex, and race/ethnicity

	25–44 Years		45–64 Years		65+ Years	
	Number	%	Number	%	Number	%
2010						
White Men	2,423,350	58.55	6,294,529	69.60	7,759,261	84.65
Black Men	508,852	12.29	1,106,493	12.23	574,052	6.26
Hispanic Men	349,703	8.45	508,853	5.63	314,039	3.43
Other Race Men	180,169	4.35	322,454	3.57	217,301	2.37
White Women	403,010	9.74	546,435	6.04	253,881	2.77
Black Women	161,999	3.91	171,601	1.90	24,816	0.27
Hispanic Women	69,677	1.68	51,281	0.57	11,839	0.13
Other Race Women	42,248	1.02	42,141	0.47	11,092	0.12
Total	4,139,006	100	9,043,786	100	9,166,281	100
2020						
White Men	2,002,274	57.92	3,786,323	60.70	6,865,405	79.17
Black Men	392,946	11.37	871,628	13.97	744,754	8.59
Hispanic Men	306,976	8.88	434,089	6.96	377,277	4.35
Other Race Men	160,652	4.65	246,575	3.95	259,140	2.99
White Women	353,103	10.21	565,166	9.06	316,765	3.65
Black Women	134,996	3.91	215,868	3.46	63,996	0.74
Hispanic Women	67,111	1.94	68,799	1.10	23,512	0.27
Other Race Women	38,918	1.13	49,632	0.80	21,195	0.24
Total	3,456,976	100	6,238,080	100	8,672,045	100
2030						
White Men	1,918,465	59.02	2,758,092	58.45	5,101,586	69.78
Black Men	364,037	11.20	583,849	12.37	851,643	11.65
Hispanic Men	273,266	8.41	386,591	8.19	394,535	5.40
Other Race Men	152,443	4.69	203,520	4.31	251,547	3.44
White Women	327,307	10.07	469,556	9.95	482,735	6.60
Black Women	119,693	3.68	189,939	4.03	147,817	2.02
Hispanic Women	59,425	1.83	78,434	1.66	44,579	0.61
Other Race Women	35,792	1.10	48,545	1.03	36,557	0.50
Total	3,250,428	100	4,718,526	100	7,310,999	100

Source: Authors' calculations based on VetPop2007 data (U.S. Department of Veteran Affairs 2008). Percentages may not add to exactly 100% due to rounding error.

honorable service helped pave the way for desegregation within the military and throughout the broader society (MacGregor 1981; Moskos and Butler 1996; Rivas-Rodriguez 2005).

Among the more than 70% of veterans aged 65 years and older who served prior to the current AVF era, the oldest served during WWII and are members of the birth cohorts that experienced higher rates of economic deprivation as children of the Great Depression, but went on to benefit from the post-WWII economic boom. The younger veterans in this group, who served between WWII and the Korean War or during the Korean War, were part of a relatively smaller set of birth cohorts that experienced WWII as children and came of age during the height of the Cold War. Military service provided men from these pre-Vietnam Era cohorts access to on-the-job training and higher education through generous G.I. Bill benefits. This had positive impacts on these veterans' subsequent life-course outcomes, including employment, earnings, occupational status, and marital stability, particularly among those from disadvantaged backgrounds, those who were officers, those who did not experience combat, and those who were white men (Bound and Turner 2002; Dechter and Elder 2004; Mettler 2005; Turner and Bound 2003). However, there is evidence that older pre-AVF veterans have higher mortality risk than nonveterans (London and Wilmoth 2006), which may be due in part to the pro-tobacco military policy (i.e., free and reduced price distribution of cigarettes) during WWII (Bedard and Deschênes 2006) and exposure to atomic radiation associated with the detonation of nuclear testing devices and the occupation of Hiroshima and Nagasaki, Japan (Bice-Stephans and Wynona 2000).

It is important to note that the G.I. Bill was not available to those who served from 1955 to 1965. Research indicates that during this time period men who were drafted were less likely to attend college than nonveterans and those who were not drafted, and that military service redirected academically ambitious men away from college attendance (MacLean 2005). This suggests that veterans who served during the period between the Korean War and the Vietnam Era might not have reaped the same benefits of service as those who served during WWII and the Korean War. In addition, the benefits of service were not as likely to be experienced by men who entered military service late. A series of studies indicate that late entry reduced the economic and job benefits associated with military service, increased the risk of life-course disruption, and resulted in poorer physical health trajectories over the life course (Elder et al. 1994, 1997; MacLean and Elder 2007).

2020

As shown in Table 28.1, it is projected that by 2020 there will be approximately 3.5 million veterans in the 25–45 year old age group, 6.2 million in the 45–64 year old age group, and 8.7 million in the 65 year and older age group. The youngest group of veterans will increasingly include individuals who served during the post-9/30/2001 period of the Gulf War (60%), which encompasses the Global War on Terror, including Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Vietnam Era veterans will begin to move out of the middle age group and be replaced by the cohorts who served during the initial, peaceful years of the AVF era (43%) and the first 10 years of the Gulf War (37%). The oldest age group will overwhelmingly contain veterans from the Vietnam Era (64%), although the oldest and frailest among this group will be the nearly 1.1 million surviving veterans of WWII (3%) and the Korean War (9%). Although it is a small group, some existing research documents the specific needs of and provisions for current centenarian veterans (Selim et al. 2005). Table 28.2 demonstrates that the shift to veterans from the Vietnam Era is accompanied by increasing racial and ethnic diversity among veterans ages 65 years and older, as well as a notable increase in the proportion of older veterans who are women, from 3% in 2010 to 5% in 2020. By 2020, white men will represent 79% of all older veterans. The percentage of this older age group comprised of black men, Hispanic men, and men of other races/ethnicities will increase to almost 8, 4, and 3%, respectively.

The Vietnam Era veterans will have several unique characteristics compared to the cohorts that preceded them. These veterans are part of the large Baby Boom cohort that experienced increased competition for jobs during early adulthood, the economic downturn of the early 1970s, dropping rates of marriage and fertility, and rising divorce rates. In addition, there is evidence that the Vietnam War was more disruptive to the lives of veterans than previous wars (Frey-Wouters and Laufer 1986; Kulka et al. 1990) and that the economic outcomes of Vietnam veterans are lower than veteran cohorts who served earlier in the twentieth century (Angrist 1990; Cohen et al. 1986; Teachman and Call 1996). Due to advances in medical treatment, more wounded and injured soldiers survived, creating unique long-term health care needs due to war-related disability. Vietnam veterans also faced increased cancer risk due to exposure to Agent Orange (Pavuk et al. 2005). In addition, the nature of combat engagement, drug use during service, the relatively quick return to civilian life after assignments in combat zones, and antiwar sentiment in the United States contributed to the emergence of distinct mental health and substance abuse issues for Vietnam veterans.

2030

The projected profile of veterans in 2030 looks quite different than the one that exists today. As shown in Fig. 28.1, a smaller percentage of the total population will be a veteran in 2030: approximately 3, 6, and 10% of the 25–44 year old, 45–64 year old, and 65 year and older age groups, respectively. However, Table 28.1 indicates that the number of veterans will continue to be high: 3.2 million 25–44 year olds, 4.7 million 45–64 year olds, and 7.3 million 65 years and older. The majority of the youngest 25–44 year olds will be veterans the Post-Gulf War group (81%), which is a hypothetical cohort based on assumptions by the Department of Veterans Affairs regarding the end of the Gulf War and stable future enlistment rates. Nearly all of the middle-aged group will be veterans from the Gulf War: 40% will be from the Pre-9/30/2001 period and 50% will be from the Post-9/30/2001 period. The oldest veterans will represent three sets of veterans with distinct service histories. The oldest and largest group will be the surviving veterans of the Vietnam War (47%). There will also be a large number of veterans who served during the early years of the AVF Era that occurred after the end of the Vietnam Era (32%). The leading edge of the Pre-9/30/2001 Gulf War veterans will just be reaching retirement ages by 2030 (10%). The gender and racial/ethnic diversity of older veterans will become increasingly salient as the AVF-era veterans enter later life (see Table 28.2). White men will comprise 70% of veterans and the percentage of black and Hispanic men will increase to approximately 12 and 5%, respectively. The percentage of older veterans who are white and black women will increase to 6 and 2%, respectively.

In 2030, the characteristics of older Vietnam Era veterans are likely to dominate concerns about aging veterans. Not only will these veterans be among the oldest and frailest, but they are likely to have more needs relative to the slightly younger veterans who served during the early AVF era. These AVF-era veterans include the end of the Baby Boom and the beginning of the Baby Bust cohorts who came of age between the Vietnam Era and the start of the Gulf War. Young adults coming of aging during this period of relative peace experienced economic recession in the early 1980s, the rise of service sector employment, delayed ages of first marriage and childbearing, and continued high divorce rates. The experience of serving in the military also changed; as fewer young adults opted to enlist, military service became a less normative part of early adulthood, and more of those who enlisted chose military careers. Fewer veterans from this era took advantage of G.I. Bill benefits, in part because veterans became required to voluntarily contribute some of their own earnings in order to access the military's portion of the benefit. But, there is evidence that military service is associated with higher earnings for AVF-era veterans than nonveterans, particularly for

those from disadvantaged backgrounds (Teachman and Tedrow 2007; Angrist 1998; MacLean and Elder 2007). One recent study suggests that the downsizing of the military in the early 1990s had little effect on men's employment, but was associated with substantial increases in college attendance, especially among black men (Kleykamp 2009). In addition, the emerging literature on military service, race, and marriage (Lundquist 2004, 2006; Lundquist and Smith 2005; Teachman 2007; Usdansky et al. 2009), which posits a range of arguments to support the hypothesis that the American military became a relatively "pro-family," "pro-marriage" institution partly to recruit and retain personnel, suggests AVF-era veterans might not experience as much disruption in marital and family relationships as pre-AVF cohorts and that military service might be associated with increased marriage rates particularly among blacks.

Needs of and Provisions for Aging Veterans

The needs of aging veterans are shaped by their earlier premilitary, military, and postmilitary experiences, as well as the provisions they are able to make for themselves privately and obtain from family members, universal and means-tested social welfare programs, and benefits available through the Veterans Administration/Department of Veterans Affairs (VA). Veterans who experience significant life course disruption may find themselves aging without adequate economic and social resources to sustain themselves in the community. Those veterans who experience substantial physical and mental health problems as a result of combat experiences, being a prisoner of war, a sexual assault, or a service-related accident may need special health care services, as well as economic supports as they age.

A considerable literature documents the co-occurring struggles many veterans face with respect to mental health and substance abuse problems (Gatnache et al. 2000; Kang and Hyams 2005; Schinka et al. 1998; Sher 2009; Tessler et al. 2005), employment problems (Cohany 1990; Rosenheck and Mares 2007), incarceration, and homelessness (Kasprow et al. 2000; McGuire 2007; O'Connell et al. 2008; Tessler et al. 2003), as well as programs that aim to address these problems among veterans. As Vietnam Era veterans, whose military service is thought to have been particularly disruptive to their lives and who may have relatively high rates of midlife mental health, substance abuse, employment, and housing problems, become a larger proportion of the older veteran population in the next two decades, these earlier life-course experiences will have to be taken into account. For example, the lifetime prevalence of posttraumatic stress disorder (PTSD) (an anxiety disorder that was formally defined in 1980 in the American Psychological Association's third edition of the *Diagnostic and Statistical Manual of Mental Disorders*) is 30% among Vietnam veterans compared to 8% in the general U.S. population (Kulka et al. 1990; Kessler et al. 1995). In addition, among Vietnam Era veterans, those who served in Vietnam have poorer mental and self-rated health, higher cancer risk, and more treatment for specific health conditions than those who served elsewhere (Brooks et al. 2008a, b). This suggests that geriatric health care providers will need to become increasingly responsive to mental health conditions like PTSD and the unique health needs of veterans who served in different geographic venues as the veteran composition of the older adult population changes. Veterans whose transitions into and out of the military were less disruptive may have been able to capitalize on a range of educational and training benefits that led them to have better socioeconomic and more stable family outcomes. Such stability and status attainment may enhance their ability to care for themselves and obtain informal care from family members as they age.

The increasing gender and racial/ethnic diversity among older veterans may pose unique and complex challenges in terms of service provision. For example, there is some evidence that women and racial/ethnic minorities from disadvantaged socioeconomic backgrounds are more likely to join the military. Given this, some of that early life disadvantage might be carrying through the life

course and increasing the later-life needs of these veterans. However, among men, there is evidence that military service actually offsets early-life socioeconomic disadvantage, at least in terms of health outcomes (Parker, Wilmoth, and London 2009). Therefore, among older adults from disadvantaged backgrounds, those who are veterans may be doing better in later life than those who are not veterans. Still, female and racial/ethnic minority veterans face unique challenges as they age.

There is evidence that female veterans have comparable or worse health than male veterans, and more physical and mental health problems than female nonveterans (Frayne et al. 2006; Skinner et al. 1999; Skinner and Furey 1998). In addition, women who have served in the military often have experiences that are related to negative health outcomes, such as sexual assault during military service and weak social ties after military service (Frayne et al. 2006; Suris and Lind 2008; Turner et al. 2004). These negative outcomes appear to be more prevalent among younger female veterans who served during the Vietnam and AVF Eras (Cotton et al. 2000; Wolfe et al. 2000). However, female veterans are less likely than male veterans to have a service-connected disability, which may place them at a disadvantage in terms of accessing VA health care services because veterans with conditions related to or aggravated by military service receive priority for enrollment into the VA health care system. This potential disadvantage is offset to some extent by the expansion of VA services that aim to meet the specific needs of women veterans. Despite the existence of such services, older female veterans' knowledge about VA benefits and services is low, particularly their knowledge of VA aging-related services, such as long-term care (Silverstein and Moorhead 2001). This suggests that more needs to be done to inform older female veterans of the VA services available to them and to educate care providers in the community about these options for older female veterans. There is evidence that female veterans are more likely to use VA outpatient services than male veterans, particularly among those with medical and mental health conditions, which has implications for the necessity of providing integrated delivery of those VA services (Frayne et al. 2007). Integrated VA service delivery is also likely to be increasingly important as relatively advantaged older cohorts of female veterans are replaced by more disadvantaged younger cohorts of female veterans, who are more likely to be racial/ethnic minorities, have lower levels of education, and earn less income (Wolfe et al. 2000).

Thus, when considering the needs of and provisions for aging veterans, it is important to keep in mind that veterans and those to whom their lives are linked are a heterogeneous group. The composition of the veteran population is partly shaped by individual decisions about serving in the military, historical context, and military policies, including the size of, and restrictions on serving in, particular branches of the military. These restrictions on serving are particularly consequential for women, who have been barred from certain types of occupational specialties (Manning 2005; Segal and Segal 2004). These factors, in turn, influence combat exposure and service-related experiences among veterans with different sociodemographic characteristics, which shape the needs of and provisions to particular groups of veterans. Those needs for and provision of benefits to aging veterans are also shaped by the historical contexts in which veterans lived their lives outside of the military and the provisions made available to veterans from the time they re-enter civilian life through their later years. Such benefit and service provision will undoubtedly need to change as the size and composition of the older veteran population changes. Coordinating care for older veterans residing in rural areas will continue to be a specific challenge (Fortney et al. 2005; Ritchie et al. 2002), as will attending to the specific needs of persons with particular health conditions (Hwang et al. 2004; Trudel et al. 2007; U.S. Department of Veterans Affairs 2009c), women and racial/ethnic minority veterans (Frayne et al. 2006, 2007; Silverstein and Moorhead 2001; Skinner et al. 1999; Washington 2004), and LGBT-identified veterans. Coordinating care for veterans' family members will also pose significant challenges.

Provisions from the Department of Veterans Affairs most directly aim to address service-related needs. These provisions try to mitigate some of the disruption that military service can cause in

certain circumstances, such as during war-time mobilization, compensate and care for persons who have been harmed in the course of their service, as well as their dependents, and generally reward those who have taken risks and made personal sacrifices of various kinds in service to their country. The tradition of providing benefits to individuals who have served in the armed forces has roots in the founding of the United States (U.S. Department of Veteran Affairs 2009a). However, the social contract shaping benefits provision did not take its current form until after the establishment of the Veterans Administration in 1930 (which became known as the Department of Veterans Affairs when the agency was elevated to Cabinet-level status in 1989). Over time, provisions for veterans have expanded, but the basic types of provisions have remained the same since WWII.

VA benefits and services address the needs of aging veterans from two approaches. Some are designed to meet the general aging-related needs of veterans that are similar to the needs of any subgroup of the population that is aging. These benefits work in tandem with social insurance programs, such as Social Security and Medicare, which are available to all qualifying members of the U.S. population, and social assistance programs, such as Supplemental Security Income and Medicaid, which are used by a subset of the U.S. population with demonstrated need. Other aspects of these VA benefits and services are designed to accommodate the unique needs of specific subgroups of aging veterans, such as veterans with service-connected PTSD and disabilities, veterans from specific wars, and other veterans with unique service-related experiences. Currently, there are nine main categories of VA benefits and services: health care; service-connected disability compensation; pensions; education and training; home loan guaranty; life insurance; burial and memorial benefits; transition assistance, including vocational rehabilitation and employment; and dependent and survivors benefits (U.S. Department of Veterans Affairs 2009b). To qualify for VA benefits, the service member must have been other than dishonorably discharged from full-time active duty service, and in some cases must have served during wartime. Members of Reserve and National Guard qualify for these benefits under certain conditions. Special provisions are made for other historically relevant groups including WWII Merchant Marine Seamen, WWI and WWII Allied Veterans, and WWII Filipino Veterans, and 33 specific civilian groups who provided military-related services during WWI and WWII, such as Women Air Force Service Pilots (WASPs), and U.S civilians of the American Field Service, who served overseas under U.S. armies and U.S. Army groups in WWII (U.S. Department of Veterans Affairs 2009c).

Veterans with service-connected disabilities are given priority in access to benefits and premiums in resource allocations. For example, veterans with service-connected disabilities are given the highest priority for enrollment in the VA health care system (U.S. Department of Veterans Affairs 2009c). The VA's integrated health care system is the nation's largest with more than 1,400 sites of care, including hospitals, community clinics, community living centers, domiciliaries, readjustment counseling centers, and other types of facilities. Veterans are enrolled in priority groups that the VA uses to balance available resources with demand for enrollment; changes in available resources can lead to reductions in the number of priority groups that can be enrolled, with those in higher-rated priority groups retaining access. The top three of the eight priority groups that are currently defined are comprised of veterans with combat-related disabilities: Group 1 includes "veterans with service-connected disabilities rated 50 percent or more and/or veterans determined by VA to be unemployable due to service-connected conditions"; Group 2 includes "veterans with service-connected disabilities rated 30 or 40 percent"; and Group 3 includes "veterans with service-connected disabilities rated 10 and 20 percent, veterans who are former Prisoners of War (POW) or were awarded a Purple Heart medal, veterans awarded special eligibility for disabilities incurred in treatment or participation in a VA Vocational Rehabilitation program, and veterans whose discharge was for a disability incurred or aggravated in the line of duty" (U.S. Department of Veterans Affairs 2009c:2). Additionally, the compensation given to veterans with service-connected disabilities vary from $123/month in 2009 for veterans with a 10% VA disability rating to $376, $770, and $2,673 for veterans with 30, 50, and 100% VA disability ratings, respectively (U.S Department of Veterans

Affairs 2009c). Those with a VA disability rating of 30% or more are eligible for additional allowances for dependents, including spouses, minor children, children between the ages of 18 and 23 years who are attending school, children who are permanently incapable of self-support due to a disability arising before the age of 18 years, and dependent parents. Accounting for both the service member's disability and the access to additional benefits for dependents is important for life-course studies that focus on those whose lives are linked to veterans.

In addition to veterans with service-connected disabilities, other subpopulations of veterans are highlighted in policies governing benefits and services. For example, there are special programs that target homeless veterans, and those at risk of homelessness, including veterans who are re-entering public life after a spell of incarceration (U.S. Department of Veterans Affairs 2009c). Women veterans are eligible for the same VA benefits as men; however, comprehensive health services to address women's specific health care needs are available, including the management of acute and chronic illnesses, preventive care, mental health care, contraceptive services, Pap smears and mammography, gynecological and maternity care, and infertility evaluation at VA health care facilities; referral to community-based providers; and special initiatives. Certain groups of veterans participate in health registries in order to obtain free medical examinations and diagnostic tests. These include the Gulf War Registry, the Depleted Uranium Registries for veterans who served, respectively, in the Gulf War and OIF and those who served elsewhere, including Bosnia and Afghanistan; the Agent Orange Registry for veterans possibly exposed to dioxin or other toxic substances in herbicides used during the Vietnam War, while serving in Korea in 1968 or 1969, or as a result of testing, transporting, or spraying herbicides for military purposes; and the Ionizing Radiation Registry for veterans possibly exposed to atomic radiation across a broad range of historical circumstances (U.S. Department of Veterans Affairs 2009c).

Given that veterans have access to public social insurance and assistance programs, and that some VA programs are only available to veterans who meet certain criteria, not all veterans use VA benefits and services. Of the approximately 23 million currently living veterans, 36% (8,493,700) received at least one VA benefit or service in fiscal year 2008 (U.S. Department of Veteran Affairs 2009d). Among those who received a benefit or service, 68% (5.76 million) received only one, while 32% (2.74 million) used more than one. More veterans used VA health care than any other benefit or service: 61% of veterans who used benefits or services used VA health care; 33% (2.78 million) used VA health care only; and 28% (2.36 million) used VA health care and at least one other benefit or service. Forty percent of veterans receiving VA disability compensation did not use VA health care. Patterns of nonhealth single benefit or service use in declining order of prevalence are loan guaranty (11%), compensation (10%), insurance (9%), burial services (2%), education (2%), pension (1%), and vocational rehabilitation (0%). Patterns of multiple benefit use in declining order of prevalence are health and compensation (46%); health, compensation, and insurance (8%); health and pension (8%); health and insurance (6%); health, compensation, and loan guaranty (5%); compensation and insurance (5%); and compensation and loan guaranty (5%). Seventeen percent use some other combination of VA benefits and services.

The pattern of using VA benefit and services varies by gender and age. Overall, 87% of those who received a benefit or service were male and 81% were 45 years old or older, which indicates that the majority of benefits and services are currently used by older male veterans. Of the veterans who received at least one benefit or service, approximately 37% (3.14 million) were between the ages of 45 and 54 years and 44% (3.75 million) were aged 65 years or older. There is an interesting difference in the age patterns of single versus multiple benefit and service use, which suggests that benefit and service use changes dynamically over the life course. Focusing first on those who only used one benefit or service, 34% (1.93 million) were between the ages of 45 and 64 years, while 48% (2.75 million) were 65 years old or older. Among those using more than one service or benefit, 44% (1.21 million) were in the 45–64 year age category, while only 36% (1.00 million) were 65 years or older.

Although it is only part of the story that is relevant to tell in relation to the needs and provisions for aging veterans, careful consideration of the VA benefits and services available to and used by veterans in the past and present is essential. The snapshot of VA benefits and service use by veterans in one recent year that is provided above suggests considerable use by a sizeable portion of the veteran population, and that benefit and service use is concentrated among older veterans. As the population of aging veterans changes over the next two decades, adjustments to benefits and services will need to be made. Such adjustments should take into account VA benefit and service use histories of aging veterans across the life course, as well as the barriers to benefit and service use that older veterans with particular characteristics experience, such as veterans living in rural areas, homebound veterans, the oldest-old veterans, veterans with histories of homelessness, and veterans with psychiatric and/or substance abuse disorders. Efforts to determine unmet needs for benefits and services and underserved populations are also warranted. For example, even though most of the approximately 12,600 lesbian, gay, and bisexual service members dismissed from the military during the 15 years that Don't Ask, Don't Tell has been in effect were discharged honorably and maintain eligibility for VA benefits, it is unclear to what extent they know they are eligible for VA benefits and services, feel comfortable using them, and do use them. Even if they use benefits and services, they may withhold specific kinds of information about behaviors and social relationships from service providers and have unmet needs because of their sexual orientation. To address these issues and concerns, new data collection efforts will be necessary that allow us to more fully understand how institutionalized military practices, historical context, and human agency jointly affect needs for and use of benefits and services among groups of veterans with different social locations and experiences of cumulative inequality.

Future Directions for Research on Military Service and the Life Course

As we look toward the future of research in this area, we have to acknowledge the importance of the past in shaping what is known and what needs to be known. By necessity, the study of military service and the life course is grounded in historical periods of war and peace. Given this, the research in this area focuses on a classic concern of life-course scholarship: how lives unfold for individuals who experience certain historical times from the vantage point of particular social locations. The next generation of studies on military service and the life course must pay renewed attention to understanding the nexus of historical circumstance and individual biography. Of particular concern is how the structure of institutionalized practices related to military personnel and veterans influences individual choices and chances in ways that shape cumulative inequality. As noted by Ferraro et al. (2009:423), "life course trajectories are shaped by the accumulation of risk, available resources, and human agency." From this perspective, the individual decision to join the military is a critical turning point in early adulthood that creates life-course discontinuity by differentiating a subpopulation who experiences a powerful, potentially transformative, and resourceful social institution from a subpopulation who does not accrue a military service history or the possibility of enduring connections to the military through the use of the benefits and services offered by the VA to veterans and their dependents. This turning point has the potential to mitigate or accelerate unfavorable trajectories (and conversely accelerate or undermine favorable trajectories), depending on the timing, intensity, and duration of the resources provided to military personnel while they are serving and to veterans after being discharged from service. Thus, social structure–in this case represented by the policies and programs of the Department of Defense and Department of Veterans Affairs–acts in tandem with human agency–in this case embodied by individual decisions related to military service–to shape life-course trajectories.

Research on military service and the life course must continue to articulate the interplay between social structure and human agency in the lives of military personnel and veterans, as well as those

whose lives are linked to them. Pressing questions include: how historical conditions and personal circumstances influence individual decisions regarding the timing and duration of military service; how military policies shape the timing and sequence of other events during the demographically dense period of early adulthood; and how veterans mobilize the resources provided through VA programs and services over the life course. As the demographic profile of veterans becomes more diverse, it becomes increasingly important to recognize the ways in which intersectionality influences experiences during and after military service. It is also crucial that we develop a better understanding of the lives of those who are linked to veterans, including spouses/partners, children, and parents. All of this work must articulate clearly its contributions to understanding variation between cohorts whose members served during different historical time periods and/or variation within cohorts whose members served in a given period of war or peace.

The primary challenge to research on military service and the life course lies not in developing its theoretical underpinnings, but in collecting appropriate data. There are ample surveys of military personnel and veterans who use VA health care facilities. While these surveys are rich in the information they contain about military service experience, their exclusion of nonveterans precludes making comparisons on the basis of veteran status. Such comparisons, with controls for the selectivity of military service, are essential for understanding how the lives of those who participate in the military are different from the lives of those who do not serve in the military. There are also a number of under-researched nationally representative datasets that contain measures of veteran status. These datasets allow for direct comparisons between veterans and nonveterans, but, often, there are an insufficient number of female and racial/ethnic minority veterans to examine issues related to intersectionality. In addition, these nationally representative surveys typically have very limited information about military service experiences or the timing of military service in relation to other life-course trajectories, such as educational attainment or family formation. Often, all that is known is whether the respondent is a veteran and, if so, the time period of his or her service. Information regarding preservice circumstances, duration of service, branch of service, rank, exposure to combat, and service-related disability is infrequently gathered. The most promising avenues for advancing the scholarship in this area involve merging military and VA benefit usage records with prospective, longitudinal studies of samples that include both veterans and nonveterans.

Data collection efforts will also need to focus on gathering detailed information on veterans' use of VA and non-VA benefits and services across the life course in order to make it possible to determine how such resources shape the life course. It is clear from available data that patterns of VA benefit and service use are complex, vary with age and other characteristics, and are established shortly after deployment ends. But extant research tells us little about changes in use or cumulative use over the life course and how that varies between cohorts with different histories of service or among individuals within the same cohort who entered the military from and exited it to different social locations. This is an important gap in the extant literature and will affect what we know moving forward in the absence of efforts to collect better data. For example, descriptive data suggests that, compared to previous veteran cohorts, recent veterans may be using more benefits and services in early- and mid-adulthood. Specifically, a higher percentage of OEF/OIF veterans are using benefits and services relative to all veterans, and a higher percentage is using multiple benefits and services (U.S. Department of Veterans Affairs 2009d). This is noteworthy given the younger ages of OEF/OIF veterans relative to all veterans. This might reflect needs that are related to postservice adjustment. But, it could also be indicative of a higher pattern of service use that might persist as this cohort ages. These patterns of benefit and service use also reflect early- to mid-life course access to resources that have the potential to affect later life-course trajectories and outcomes as these veterans age. Given the relatively large percentage of OEF/OIF veterans who are women, analysis of how patterns of benefit and service use vary by sex, and sex differences in the effects of benefit and service use as veterans age, will be important topics for future data collection, research, and policy.

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