Overall Health and Wellbeing of Female Veterans Compared to Their Male Counterparts

Women serving in the military are a growing demographic amongst those who seek medical assistance from the Veterans Association (VA). In recent years, the VA has reconstructed its facilities to accommodate women and their needs associated with women’s health. My aim is to understand the gender gap in service members. I want to find out if women veterans are receiving adequate health care and how they feel about their overall health and well-being, in order to improve health care, benefits, and understanding of healthy living within the VA. Adequate, for the purpose of this essay, will be explored through various facets and meanings of health. Health will be explained through the traditional medical definition as it pertains to physical health, as well as expanding on that definition to include the overall well-being of the individual through social, mental, and emotional needs.

I hypothesize that female soldiers are not receiving adequate health care. “Adequate” means that these facilities are at par, or better, than services provided to the general public in addressing the specific needs of female veterans at equal value to male veterans. To test this theory I will be looking at data provided by The General Social Survey from 2013. My data concerns female respondents who have served in the armed forces and their responses to questions about their overall health, relationships, and views on life. To figure out intervening variables, I will compare this data to those respondents who answered similarly but who have not served in the armed forces in order to see if female veterans’ views are significantly different than any other group.
Literature Review

In a 2006 study, John E. Zeber, Laurel A. Copeland, and Kyle L. Grazier looked at a 1995 study in which the number of veterans utilizing total outpatient stops for treating depression, bipolar disorder, schizophrenia, and alcoholism have increased particularly for younger vets who are in their 20s. However, the team of researchers notes, “lower OP [outpatient] utilization among older patients is not equivalent to a lack of need, nor necessarily to system deficiencies in resource allocation or capacity.” This could be due to a growing issue with older cohorts in which seeking help for mental issues is grossly unappreciated and unrecognized problems and can be masked by other issues tied to aging.

Overall the health of veterans is much lower than that of the national average. While looking at a nationally representative survey by the Behavioral Risk Factor Surveillance System, Larson and Gilbert found that male veterans who utilize only the VA have increased risk factors related to socioeconomics and lifestyle (Larson & Welch, 2007). These risk factors include increased populations of smokers and those who have reported poorer health linked to having multiple chronic issues. Some of this may be attributed to the fact that those who only utilized the VA had significantly lower socioeconomic status than men in the general public. However, certain risk factors did not differ in younger men across both populations in areas like alcoholism, but were considerably higher in the veterans’ population in chronic concerns. For example, over 50% of veterans were more likely to have hypertension, diabetes, and arthritis. Perhaps the most surprising factor was that one in five VA-only users reported having poor mental health, but this statistical finding was still twice the number of reports by non-VA users (Larson & Welch 2007). This management of care can be understood in the scope of those who only utilize the VA as their sole provider of healthcare coverage. The type of care provided by the VA may be greater than that needed by the general population, but mostly because most VA patients need more care than the average person seeking medical assistance.
In Donna L. Washington’s 2007 ethnographic study, the female veteran volunteers were generally satisfied with the way in which the VA handled the health needs of their female soldiers. There were several themes considered, such as gender appropriateness, decision making, quality, and access. Those who did not use the VA assumed that the treatment was poor, but female veterans who utilized the VA for their medical needs were satisfied with the care that they received. However, one main concern was the lack of information on eligibility. Although the services provided to female veterans were adequate or exceptional, many female veterans were not aware that they qualified for these services under the VA health plans. Singh and Murdoch (2007) found that although overall women’s health for chronic illness in female veterans was better than that of their male counterparts, this could be explained because female veterans were more likely to seek primary care than male veterans. When observing care for veterans outside the metro area, they found that women’s care in regards to mental health, and assistance for chronic illness, was lower than men’s care; simply put, they were worse off overall.

This poses an interesting revelation. Why is it that those on the outside of VA care regard the services as poor? This can only be explained by looking comparatively at VA care and that of private healthcare. Although VA care may be adequate in terms of service for women, when compared to alternative care providers for women, it falls short. Overall both female and male veterans have a shorter lifespan compared to that of civilian Americans of the same age.

The truth is that there simply is not a lot of research into the care of female veterans. In a study by Yano et al. (2009), we see that part of the problem in gaining any understanding into women’s issues within the VA is because the VA does not provide adequate care in providing other support systems. Women may be able to participate in studies by saying, “Women veterans’ younger age distribution may present barriers to research participation during usual VA hours of business due to work and/or childcare obligations. Few facilities can readily accommodate alternate hours of participation, which may bias
sample enrollment. Provision of childcare also runs counter to the liability policies of many VA facilities” (p. 60).

Method

The purpose of this study was to determine the health and well-being of women who have served in the armed forces. The previous literature defined “veteran” as anyone who has served in any branch of the armed forces for any given amount of time. This definition is the one most widely used in literature. The General Social Survey asked respondents how many years they served in the armed forces on active duty: starting with none, less than two years, two-to-four years, more than four years, and some, but unsure how long. I collapsed these variables into whether or not they served any time in the armed forces, or not at all, to be more consistent with previous literature. Therefore, this study will use the term veteran and “someone who has served in the armed forces on active duty” interchangeably. For this study, health and well-being have been broadened to include physical, social, and emotional factors, and mental health has been redefined to include factors outside the realm of psychiatric care of issues, such as bipolar disorder and depression, to include the educational attainment of the respondent. This was chosen to demonstrate that educational attainment is often associated with job skills and ability to think through complex and often abstract ideas.

My study specifically focuses on the health and well-being of female veterans, and to do so, the statistics will be compared between the sexes as well as if the respondent has served in the armed forces. There is a 99% statistical significance that the possibility of being in the armed forces was strongly correlated to sex, with a degree of freedom of 2, and a Pearson chi-square value of 211.498a. However, even though the sample size of women was small, the statistics analyzed are representative of the whole population due to the fact that female veterans make up a small percent of those serving in the armed forces overall.
In order for the data to be representative of the overall population, the GSS provides several weighted variables. I used the variable WTSS which is calculated to essentially maintain the sample size, but also considers sub-sampling of non-respondents and the number of adults in the household before 2004 (Smith, Mardson, Hout, & Kim, 2013). By weighting variables, I could more accurately assess the statistical analysis to reflect the possible responses of the total population.

### Table 1: Condition of Respondents' Health by Veteran Status (Between Sex)

<table>
<thead>
<tr>
<th>CONDITION OF HEALTH</th>
<th>VETERAN STATUS</th>
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<tbody>
<tr>
<td></td>
<td>R Did Not Serve in Armed Forces</td>
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<tr>
<td>MALE</td>
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<tr>
<td>FAIR</td>
<td>6.8%</td>
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<tr>
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</tbody>
</table>

Data provided by the General Social Survey 2010

### Findings

When looking at physical health, the General Social Survey asked respondents how they rate their condition of health (Smith, Mardson, Hout, & Kim, 2013). R refers to the respondent. Overall, more veterans experienced worse health than those who had not served in the armed forces. One surprising thing to note in the initial test before weighting the variables was that nearly 41% of female
veterans did not answer the question. Why did these women opt out of answering a question about their health? I believe this point is very telling to the nature of how female veterans perceive their own health and what they are willing to share, especially if they are actively serving in the armed forces. This is more apparent when the data suggests that they are the group with the smallest percentage of respondents who stated they felt their health was fair or poor, even after the variables were weighted (Smith 2010).

When trying to understand emotional health, a good predictor is the level of general happiness experienced by an individual. The general Social Survey asked respondents to rate their level of happiness. I took this data and applied it to the groupings by sex and veteran status (See Graph 1).
Much like the wellness chart, veterans overall had significantly lower ratings of happiness. Most female veterans rated
their happiness as “pretty happy” with the rest stating that they were “very happy.” Initially, before weighted variables were applied, female veterans were more likely to not answer the question about their level of happiness. After the weighted variables were applied, both male and female veterans reported having marginal or low rates of happiness than the general population (See Table 2). Furthermore, female veterans were spread further apart on the spectrum. This could be explained through a variety of social reasons including the culture of the military and the stigma of reporting being unhappy, especially as it pertains to their job satisfaction. Since the change in weighted variables changed the outcome for this data set of those who answered the questions, which also corresponds with the military cultural views towards female respondents, to reflect the possible outcome of the total respondents currently, I predict that future data sets will have more female veterans who opt out of answering the question entirely.

Perhaps the most startling information came from analyzing the social well-being of the respondent. To determine the social well-being I looked at the divorce rate among veterans. Divorce rate, I felt, was an applicable representation of the ability to form lasting relationship bonds with others. Initially, when running a cross tabulation with weighted variables, female veterans had an overwhelming percent of divorce rates compared to any other group. At that rate, the initial test showed that almost half of all females who have served in the armed forces had gotten a divorce at some point in their lives. However after weighting the variables to reflect a wider population, that number dropped. Yet, even after running a weighted variable test, veterans consistently had higher percentages in both categories (See Table 3). This suggests that veterans still have higher rates of divorce than the national average. Also, between male and female veterans, female veterans had almost a 9% higher rate of divorce. I ran an Anova test to see the level of statistical significance between groupings. The degrees of freedom was two within groups and showed a level of significance of 0.000, showing that the relationship between divorce rates and veteran status, especially for women, was high. I can thus confidently say that female veterans have a particularly high risk of getting a divorce at some point in their life.
To understand mental well-being, I broadened the spectrum from the general, psychiatric model of understanding mental health to include the educational attainment of those who served in the armed forces or not. Education attainment is often associated with job skills and ability to think through complex and often abstract ideas. This showed the most surprising results. Although I cannot definitively say that serving in the armed forces has a positive impact on female veterans, there were some interesting correlations (See Table 4). For one, male veterans were more likely to have less than a high school education than any other group. Conversely, there were no female veterans that had less than a high school education. Female veterans were also more likely to receive a graduate college degree than any other group.
Conclusion

One thing was consistent throughout this research: veterans tended to have less satisfactory ratings when it comes to their health. For female veterans, especially, the numbers showed a consistent failure to achieve high ratings in overall health and well-being. The previous literature suggested that female veterans’ health was consistently good. However, when broadening this term to include overall well-being of the individual, including relationships and happiness, we can see that female veterans either performed lower than the men or opted out of answering questions all together.

One reason for this may be the culture of the military. Women often view their ability to perform at the same level of men as only comparative to the men. Female veterans’ answers, or lack thereof, to questions about happiness and health may be more reflective of their belief that stating that they feel in poor health or well-being may be a sign of weakness.

The only category in which female veterans excelled higher than their male counterparts was educational attainment. Further research would have to be done to understand why it is that female veterans excel higher than the men and why male veterans are more likely to have less than a high school education than anyone else.

With a growing demographic of female veterans coming to the VA for their healthcare, it is important to understand how overall well-being may affect the health of these veterans. The definition of health should be broadened to include the overall well-being of the person. In this way, we are treating the individual completely, not just one part of the puzzle. More research needs to be conducted to better understand the influence of chronic disease, substance abuse, and psychiatric care on these outcomes. It is more important now than ever to solve these issues amongst a growing group, especially as those who have seen armed combat have combated other issues during their time serving in the armed forces.
References


